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Ideas into Action

REVISED

Michelle H., et al. v. McMaster and Catone

Progress Report: South Carolina Department of Social Services

April 1, 2025 – September 30, 2025

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Released September 25, 2026

Statement of Revision

Immediately after the April 7, 2026 release of the *Michelle H., et al. v. McMaster and Catone* Progress Report for the period of April 1, 2025 – September 30, 2025 (Monitoring Period 18 or MP18), the Monitor, Judith Meltzer, was informed by the South Carolina Department of Social Services (DSS) of issues affecting the accuracy and reliability of data provided by DSS to the Monitor and included in the MP18 report. These data limitations, as first identified, were related to the licensure of kinship foster homes and emergency placements. In the course of correcting emergency placement data an additional limitation was identified, which impacted data related to placement moves as well as emergency placements. These data limitations, described in more detail below, have been addressed and are reflected in this revised progress report and in the Revised Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County, found in Appendix F.

First, the availability and reliability of kinship licensure data has been affected by DSS's use of a software platform, Binti, to manage the foster care licensing process; consequently, kinship licensure data are no longer included in this revised report in the same manner as in previous reports.[i] Specifically, in late July to early August of 2025, DSS began using Binti to manage the foster care licensing process and due to ongoing data integration issues between Binti and CAPSS since that time, DSS has been unable to validate and provide kinship licensure data.

Second, immediately following the April 7, 2025 release of the *Michelle H.* Progress Report, DSS informed the Monitor and the Court, that a number of placements occurring at newly licensed Welcome Centers had not been correctly coded as emergency placements.[ii] While working to correct the emergency placement data, it was discovered that a data linkage issue resulted in approximately 80 children being omitted from the file containing records of all placements during the monitoring period, which is used to derive the number of children who were in foster care at any point during the monitoring period. This file is also used for measures related to placement moves and emergency placements. Records were most often omitted for children who entered and exited care very quickly. DSS has corrected this issue, and the data in this revised report for Monitoring Period 18 adhere to the corrected process. However, data from prior monitoring periods presented in this revised report may still be affected by a small number of missing records (approximately 1-2% of children).[iii]

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[i] For more information see: https://binti.com/.

[ii] Prior to licensure, placements in these "unlicensed cottages"—as they were known at that time—were considered overnight stays. After becoming licensed as "Welcome Centers" in August – September 2025, placements in these facilities should have been counted as emergency placements.

[iii] DSS has informed the Monitor that it has reviewed prior monitoring periods, and it does not believe missing records impacted performance for placement-related measures. The Monitor will work with DSS to confirm that prior performance assessments do not require revision.

Overall, the corrected data resulted in few substantive changes and did not impact performance toward FSA requirements.[iv] The corrections did result in increases to the emergency placement data provided in the report. Most notably, the increase in nights spent in emergency placements from Monitoring Period 17 to Monitoring Period 18 was 13 percent rather than 12 percent as originally reported, and the increase in nights spent in short-term placements (overnight stays and emergency placements combined) was six percent rather than five percent as originally reported. Also, of note is the removal of data and figures related to kinship licensure throughout the report due the Monitor's inability to validate the data. Finally, other non-substantive, corrections unrelated to the noted data limitations have also been made.

[iv] Note: that the number of children who experienced subsequent emergency placements lasting more than 7 days, which is prohibited by FSA requirement IV.E.5., did increase from 144 to 149. However, because no child is to experience a subsequent emergency placement lasting more than 7 days, the assessment of DSS's performance toward this requirement did not change.

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I. Introduction

This report assesses the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) in *Michelle H., et al. v. McMaster and Catone*, for the period of April 1, 2025 through September 30, 2025. The report has been prepared by court-appointed independent Monitor Judith Meltzer with the assistance of Monitor staff and is presented to the Honorable Richard M. Gergel, U.S. District Court Judge, the Parties to the lawsuit, and the public.

A. Summary of Litigation and Settlement Agreement

The *Michelle H. v. McMaster and Catone* lawsuit was filed in the United States District Court for South Carolina in January 2015 on behalf of a Class of children in foster care against the Governor of South Carolina and the State's Department of Social Services (DSS).[1] The suit alleged DSS failed to maintain an adequate number of foster homes and other appropriate living placements for children; did not provide basic monitoring of children's safety due to excessive case manager caseloads and an unstable foster care workforce; and failed to provide basic health care services to children in foster care. The Parties negotiated a Final Settlement Agreement (FSA) that was approved by the Court on October 4, 2016.[2,3]

The FSA outlines South Carolina's obligations to significantly improve the experiences of, and outcomes for, "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system (FSA II.A.). State leaders and Plaintiffs crafted the FSA to guide a multi-year reform effort to address:

- Appropriate placements for children in foster care
- Workloads of case managers and team leaders
- Case manager contacts with children
- Investigations of allegations of abuse and/or neglect of children in the State's custody by a caregiver
- Family connections – visits between children and their parent(s), the placement of children with their siblings, and visits between siblings who are not placed together
- Access to timely physical and mental health care

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[1] *Michelle H., et al. v. McMaster and Catone*, 2:15-cv-00134, (D.S.C.) (originally filed as *Michelle H., et al. v. Haley and Alford*).
[2] Final Settlement Agreement (October 4, 2016, Dkt. 32-1).
[3] The FSA incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (hereinafter, Interim Order or IO) (September 28, 2015, Dkt. 29).

Since the development of the FSA, implementation plans for key bodies of work – which are also tracked by the Monitor – have been approved and ordered by the Court.[4]

B. Role of the Monitor and Methodology

The Final Settlement Agreement appointed Judith Meltzer and Paul Vincent as independent and equal Co-Monitors.[5] Mr. Vincent sadly passed away on July 27, 2025. Since that time, Ms. Meltzer has continued to act as an impartial Monitor, responsible for conducting the factual investigation and verification of data and documentation necessary to compile and issue semi-annual public reports on the State's progress and performance in meeting the terms of the FSA (FSA III.).[6]

To determine the State's performance on the FSA requirements, the Monitor and the monitoring team utilized a range of sources and activities to collect information and to inform the overall assessment of the State's progress.[7] These include, among others, analysis of quantitative data provided by DSS including data extracted from DSS's Child and Adult Protective Services System (CAPSS) and other sources; review of children's case records in CAPSS; analysis and validation of qualitative data collected by DSS and Monitor staff through structured reviews; observations and discussions from county office site visits; information provided through focus groups; data and information provided in DSS's reports to the Court; discussions with case managers, other DSS staff, private providers, and community members; meetings with leaders from DSS and other state agencies; and discussions with Plaintiffs' counsel.[8]

Additionally, this report draws on information provided through the Monitor's engagement with the Richland County Child Welfare Improvement Task Force (referred to hereinafter as the Richland County Task Force).[9] The Richland County Task Force was created at the direction of the Court in October 2024 and charged with the development and implementation of an improvement plan to urgently address the placement instability crisis experienced by children in Richland County as well as problems related to the physical condition of the Richland County DSS office.[10,11] During the monitoring period (April 1, 2025 – September 30, 2025), and continuing as

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[4] To view Implementation Plans and Addendums for the *Michelle H.* FSA, see: https://dss.sc.gov/child-welfare-transformation/.

[5] Judith Meltzer is former President and now Senior Fellow of the Center for the Study of Social Policy (CSSP) and is supported by Monitor staff including Molly Dunn, Lisa Mishraky-Javier, Shira Davidson, and Alyssa Liehr. More information about CSSP can be found at https://cssp.org/.

[6] Hereinafter, Ms. Meltzer is referred to as the Monitor.

[7] Appendix B. includes a list of specific activities the Monitor and her team used to assess DSS's performance during this period.

[8] CAPSS is DSS's State Automated Child Welfare Information System.

[9] The Monitor's engagement includes participating in Richland County Task Force workgroup meetings and review of the following: improvement plans, monthly reports produced by DSS to the Court, and meeting presentations.

[10] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

[11] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

of the writing of this report, the work of the Richland County Task Force has been a primary area of focus for DSS. This report includes discussion of the work of the Richland County Task Force as it relates to the FSA requirements, and throughout this report, county-level data are provided, as relevant, with a focus on Richland County and other counties with significant numbers of children in DSS custody. County-level data are included within the body of the report for the 10 DSS county offices with case management responsibility for the largest numbers of children in foster care on the final day of the monitoring period, September 30, 2025 (this includes Richland County). Data on the number of children placed in and out of their counties of origin are also included for these 10 counties. For each of these data points, complete data for all 46 South Carolina counties can be found in Appendix D. This report is accompanied by the Monitor's April 7, 2026 letter to the Court providing an update on DSS's efforts and early outcomes in Richland County, including key themes and findings from the Monitor's March 2026 site visit.[12] The letter is included in Appendix F of this report.

C. Report Structure

This report assesses the State of South Carolina's progress toward meeting the requirements of the *Michelle H.* Final Settlement Agreement between April 1 and September 30, 2025 (Monitoring Period 18 or MP18).[13] The report is presented in four sections:

- Section I outlines the *Michelle H.* FSA and describes the role of the Monitor and the methodology used to assess performance.
- Section II summarizes the State's progress toward meeting the FSA requirements during the monitoring period ending September 30, 2025, and includes an overview of the Richland County Task Force.
- Section III provides an overview of the child welfare system in South Carolina and a description of the State's fiscal resources supporting child welfare activities. It also includes demographic information about children in the State's foster care system between April 1, 2025 and September 30, 2025 (MP18).
- Section IV details the State's performance toward meeting each FSA requirement between April 1, 2025 and September 30, 2025 (MP18).

[12] Letter from the Monitor Providing Updates and Findings Regarding Efforts to Address Placement Instability in Richland County, submitted to the Court on April 7, 2026.

[13] This report refers to monitoring periods by date range (e.g., April – September 2025) and number (e.g., MP18). Guideposts to time frames and monitoring periods are provided throughout this report and a table listing the date range of each monitoring period is provided in Appendix A.

II. Areas of Improvement and Challenge

During the six-month monitoring period from April 1, 2025 through September 30, 2025 (MP18), DSS's performance in meeting the *Michelle H.* FSA requirements improved or was maintained at target levels in many areas. The number of overnight stays in DSS offices declined dramatically and, for the first time, FSA targets were met for both sibling visitation and contacts with core witnesses in Out of Home Abuse and Neglect (OHAN) investigations. Performance was maintained at required levels for the three other remaining OHAN provisions for which Maintenance of Effort designation was granted in December 2025.[14] Performance was also maintained on the following FSA requirements for which Termination and Exit was granted in December 2025: the placement of children aged 12 and under; the placement of children aged six and under outside of congregate care settings; and timely referral of Class Members under 36 months of age for developmental assessments.[15]

Significant bodies of work designed to improve overall performance were also advanced during the monitoring period and in the months that followed, including continued implementation of strategies that are part of the Richland County DSS Improvement Plan; efforts to amend state law to allow kin to be licensed/approved by separate standards and be provided with equal financial supports; the development of methodologies to measure DSS's performance in meeting children's needs for therapeutic placements and services; and the development of a revised Health Care Improvement Plan.

Challenges also remain. Children in foster care in South Carolina continue to experience very high rates of placement instability. The annual placement instability rate climbed to 7.90 — the highest instability rate and the largest one-year increase since the inception of the lawsuit. During the monitoring period (MP18), there was a sizeable increase in the number of nights children spent in emergency placements, and two-thirds of children in foster care were placed outside of their counties of origin. Performance declined and continued to be unacceptably below the FSA target for parent-child visits. DSS performance fell short of many established health care targets, and substantial work remains in critical areas, including expanding the availability, quality, and accessibility of community-based health and behavioral health services statewide.

[14] Maintenance of Effort means that Defendants have achieved compliance for the specific obligation as reflected in the monitoring report (FSA V.E.).
[15] Once a compliance target falls into Maintenance of Effort status and substantial compliance on that target is sustained for a year, Defendants may seek the termination of the Court's jurisdiction over that specific provision of the Settlement Agreement (FSA V.F.).

A. Areas of Improvement

Since the start of implementation of the Final Settlement Agreement (FSA) and continuing through Monitoring Period 18 (April 1 – September 30, 2025), the Department has demonstrated progress in key areas:

- *Increase in Placement of Children in Family-Based Settings:* Overall, far more children are in family-based placements, and very young children are no longer in congregate care settings. On October 18, 2024, the Court granted Maintenance of Effort Status for FSA provision IV.E.3., requiring that 98 percent of Class Members 12 years old and under be placed outside of congregate care, and for FSA provision IV.D.2., requiring DSS to prevent, with exceptions, the placement of any Class Member aged six or under in any non-family group placement.[16] The State has continued to meet or exceed these FSA targets since that time, including during the current monitoring period (MP18), and on December 17, 2025, the Court granted the Parties' Joint Motion for Termination and Exit from Court supervision on these two FSA provisions.[17]
- *Increase in Placement of Children with Kin and Increased Support of Kin Placements:* Recognizing the improved outcomes for children successfully placed with relatives, over the last five years, the Department has more than tripled the percentage of children placed with kin. Thirty-one percent of children were placed with kin as of the last day of the monitoring period (September 30, 2025), compared to eight percent as of September 30, 2019. As part of efforts to move toward a "kin first" culture, DSS has been advancing strategies to offer payments to kin caregivers, including supporting kin to be licensed.

  Over the past two years, DSS has been seeking statutory amendments to enable the Department to implement streamlined, kin-specific licensing/approval standards.[18] While these amendments were being sought through the state Legislature, in September 2025 DSS began piloting the kin-specific approval standards in several counties within the Midlands Region of the state. Kin who participate in the pilot are assessed using the new standards; those who are approved, whether provisionally or fully, receive the same board payments provided to licensed foster parents. In November 2025, DSS received federal approval to adopt separate licensing standards for kin, allowing South Carolina to claim federal funds for otherwise eligible children placed with kin approved under the kin-specific standards.[19] Finally, on February 27, 2026, Governor McMaster signed Senate Bill

[16] Order finding DSS has met the performance standards of the FSA with respect to sections IV.D.2., IV.E.3., and Appendix B and granting Maintenance of Effort Status in those areas and granting Termination and Exit with Respect to Sections IV.C.2. and IV.C.4.(d), (e), and (f) of the FSA and terminating jurisdiction over those sections [Hereinafter "Order on Motion for Miscellaneous Relief"] (October 18, 2024, Dkt. 329).
[17] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).
[18] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt.378).
[19] Letter from Joseph J. Bock, Acting Associate Commissioner, Children's Bureau, to Tony Catone, State Director, SCDSS, approving title IV-E plan amendment adopting separate licensing standards for relative and kin foster homes (November 21, 2025).

415, codifying the kin-specific approval standards into state law, and, as of that date, kin caregivers across South Carolina who are approved using the kin-specific standards will receive the same board payment that is provided to licensed foster parents.

- *Significant Reduction in Overnight Stays:* During Monitoring Period 18 (April 1 – September 30, 2025), there was a significant decline in the number of children who experienced an overnight stay in a DSS office and a dramatic reduction in the total number of nights children spent in offices. Throughout the monitoring period, 190 children experienced a total of 622 overnight stays at DSS offices, a 12 percent decrease in the number of children and a 42 percent decrease in the number of overnight stays since the prior monitoring period. This reduction was in part due to a significant decline in overnight stays in Richland County during last two months of the monitoring period (August—September 2025) when cottages that had been developed and made available for overnight placements were officially licensed by DSS. While the performance target on this FSA requirement was not met, the State's efforts and achievement in reducing overnight stays are noteworthy.
- *Efforts to Enhance the Placement Array in Richland County and in Other Parts of the State:* Through the Capacity Building for Placement Array Workgroup of the Richland County Task Force, DSS made significant efforts to begin building out the array of placements in Richland County, some of which have been extended to other parts of the state. These strategies include: the development of Welcome and Assessment Centers to provide short-term, structured 24-hour care to up to six children experiencing placement instability to help them stabilize and transition to longer-term placements; licensing small capacity group homes to provide longer-term care to up to three children who have specialized care needs, with the goal of stabilizing the child so they can then be successful in a less restrictive placement setting; collaboration with a Child Placing Agency (CPA) to pilot a "professional foster parent model;" and engagement with CPAs to develop targeted plans to recruit more foster families to care for children with acute needs in Richland County.
- *Improvement in Case Managers and Team Leaders with Caseloads and Workloads within Required Standards:* During Monitoring Period 18, DSS showed overall improvement toward meeting two FSA workload requirements: (1) 90 percent of case managers and team leaders have caseloads and workloads within applicable limits (FSA IV.A.2.(b)) and (2) no case manager or team leader shall have more than 125 percent of the applicable limit (FSA IV.A.2.(c)). One hundred percent of OHAN case managers and team leaders had workloads within the applicable limits. Performance on both FSA measures improved slightly for foster care case managers, and foster care team leaders met both targets. There was a slight improvement in the number of permanency specialists (formerly referred to as adoptions case managers) with caseloads within the applicable limit but a significant increase in the number with caseloads in excess of 125 percent of the limit.[20]

[20] In September 2025, DSS changed the internal titles of adoptions staff to "permanency specialist" and the offices to "regional permanency offices". This change aligns with the agency's pursuit of all paths to permanency for legally free children, with adoption being one path.

Performance improved slightly for permanency specialist team leaders on both FSA measures but continued to fall short of the target. The State's ongoing attention to and continued improvements in meeting caseload/workload measures is an important result of the *Michelle H.* Settlement Agreement.

- *Improvement in Investigations of Allegations of Abuse or Neglect of Children in Foster Care:* The Department now more thoroughly investigates reports of allegations of abuse or neglect of children in foster care and in Monitoring Period 18 met all four remaining FSA targets related to Out of Home Abuse and Neglect (OHAN), three of which were granted Maintenance of Effort designation by the Court in December 2025.[21,22] Notably, during this monitoring period, the State met and exceeded the FSA target for contact with core witnesses for the first time (FSA IV.C.4.(c)), and this requirement may now also be eligible for Maintenance of Effort designation.
- *Improvement in Ensuring Children are Visiting with Their Siblings:* During the period of April 1 through September 30, 2025, 92 percent of children in foster care had the required number of visits with their siblings, surpassing the FSA target of 85 percent. This is the first time DSS met the FSA requirement, and it now may be eligible for Maintenance of Effort designation. Ensuring that children in foster care can maintain connections with their siblings is a significant accomplishment.
- *Submission of Approved Revised Health Care Improvement Plan:* On December 30, 2025, DSS submitted the required revised Health Care Improvement Plan to the Court.[23] It was provisionally approved by the Monitor pending determination of, and agreement upon, the methodology that will be used to assess DSS's performance.[24] The final Plan was approved by the Monitor and Submitted to the Court on April 3, 2026.[25] The Plan reflects increased alignment and collaboration among key state partners, clarifies roles and responsibilities, strengthens data sharing mechanisms, and outlines new strategies for meeting the health and well-being needs of children in foster care. The completion of this Plan was long delayed, and its accomplishment, in collaboration with the Monitor and

[21] In October 2024, the Court terminated jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4.(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4.(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4.(f)) Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).
[22] Order on Motion for Miscellaneous Relief granting Maintenance of Effort Designation for the following OHAN FSA requirements: (1) timely initiation of investigations (FSA IV.C.4.(a)); (2) timely face-to-face contact with alleged child victims (FSA IV.C.4.(b)); and (3) appropriate investigatory findings and decision making (FSA IV.C.3.) (December 17, 2025, Dkt. 387).
[23] Letter from J. Michael Montgomery Providing December 28, 2025 Health Care Improvement Plan with Appendices (December 30, 2025, Dkt. 389).
[24] Letter re: Co-Monitor's Provisional Approval of the *Michelle H.* Revised Health Care Improvement Plan, dated December 30, 2025 (January 27, 2026, Dkt. 391).
[25] Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan (April 3, 2026, Dkt. 398).

with input from Plaintiffs, reflects a significant and commendable effort by DSS staff and its state agency and private partners.[26]

- *Sustained Progress in Referrals for Developmental Assessments:* The State maintained its performance in meeting FSA targets for the timely referral of Class Members under 36 months of age for developmental assessments, for which Maintenance of Effort status was granted on October 18, 2024, and Exit and Termination was granted on December 17, 2025.[27,28]

B. Areas of Challenge

While the areas of success are significant and provide optimism for continuing improvements, key challenges remain:

- *Very High Rates of Placement Instability:* Children in foster care in South Carolina continue to experience very high rates of placement instability. The 2024-2025 annual placement instability rate climbed to 7.90, meaning Class Members were moved an average of 7.90 times per 1,000 days in care. This is both the highest instability rate and the largest one-year increase since the inception of the lawsuit. While the number of children who experienced overnights stays in DSS offices decreased significantly, and the total number of nights children spent in offices decreased dramatically, the use of emergency placements increased. During Monitoring Period 18 (April 1 – September 30, 2025), 606children spent 7,677 nights in an emergency placement. Although the reduction in overnight stays is a significant step forward, placement instability overall remains unacceptably high throughout South Carolina.
- *Increased Use of Emergency Placements:* During the monitoring period, the use of emergency placements increased. Overall, 13 percent of children (606 of 4,616) who were in foster care at any point during April - September 2025 had an emergency placement. In total, these 606 children had 1,634 emergency placements and spent 7,677 nights in those placements. This is an increase from the prior monitoring period in terms of the number of children and the number of emergency placements and is a significant (13%) increase in the total number of nights children spent in emergency placements. Moreover, the combined use of emergency placements and overnight stays as unplanned, short-term placements for children increased by six percent during the April 1 to September 30, 2025 monitoring period, despite the 42 percent decline in the number of overnight office stays.

[26] Key provisions of this plan are outlined in *Section IV.E. Health Care* of this report. The revised Health Care Improvement Plan and Methodology for Performance Assessment were approved by the Monitor and submitted to the Court for approval on April 3, 2026. The Plan including the addendum on methodology are attached as Appendix G.
[27] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).
[28] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

- *Many Children are Placed Outside of Their Counties of Origin:* As the Court noted during the October 14, 2025, status conference, placing children far from their homes contributes to, and exacerbates the problems that stem from, placement instability: "It creates so many problems for the kids and for the caseworkers in terms of working with them. And it just taxes the whole system…"[29] Overall, as of September 30, 2025, 34 percent of children were in placement settings located within their counties of origin, and 66 percent of children in foster care were in out-of-county placements. In compliance with the Court's order, as of June 1, 2025, DSS placed a 5-day moratorium on making Richland County foster care placements available to out-of-county children with a goal of addressing the severe shortage of appropriate placements for Richland County children.[30] It will be important that data and information about the moratorium are analyzed in the coming months to evaluate the effectiveness of this strategy.
- *Lack of Adequate Support for Maintaining Family Connections:* During the monitoring period, performance declined and continued to be unacceptably below the FSA target for parent-child visits (52% of the 85% target). Performance also continued to be well below the FSA target for the placement of children with *all* of their siblings (53% of the 80% target).
- *Unaddressed Health Care Needs of Children:* DSS's performance related to initial comprehensive medical assessments continues to fall short of most established targets.[31] Substantial work remains in critical areas, including expanding the availability, quality, and accessibility of community-based health and behavioral health services statewide. Improved health outcomes for children in foster care will depend on effective implementation of the newly developed Health Care Improvement Plan which requires coordinated cross-agency collaboration, and shared accountability.

Overall, DSS was able to maintain or incrementally improve its performance on many FSA requirements while also making meaningful advancements in several key areas. One of those areas has been the effort to reduce the high rate of placement instability through implementation of the Richland County DSS Improvement Plan and the beginning deployment of strategies that prove successful in that county throughout the state. From April 1, 2025 to September 30, 2025 (Monitoring Period 18), and continuing as of the writing of this report, the work in Richland County has been a primary area of focus for DSS.

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[29] Official Transcript of Status Conference held on October 14, 2025, before Judge Richard M. Gergel (February 9, 2026, Dkt. 393).
[30] Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348).
[31] Note, DSS performance is currently measured for the following health care FSA requirements: (1) Initial Comprehensive Medical Assessment; (2) Initial Dental Examination; and (3) Developmental Assessments (FSA IV.K.5.; FSA Health Care Outcomes). DSS, in collaboration with the Monitor, worked to determine and agree upon the methodologies that will be used to assess DSS's performance for all health care FSA requirements. These are described within the Health Care Improvement Plan submitted to the Court on April 3, 2026 and included as Appendix G in this report.

To meet its challenges in Richland County and beyond, DSS will need to continue to deepen its implementation of its Guiding Principles and Standards (GPS) Case Practice Model, advance work with Medicaid and the behavioral health system to expand the availability of and access to community-based services for children and families, and strengthen its partnerships with other state agencies, private providers, schools, foster families, and especially children, youth, and families.

Richland County Child Welfare Improvement Task Force

Richland County is the South Carolina county with the largest number of children in foster care.[32] On October 18, 2024, the Court prompted important action to address a placement instability crisis experienced by children in Richland County by directing the creation of a Task Force to prepare and implement an improvement plan for Richland County DSS (RCDSS) to meet specific goals, including eliminating overnight stays of children in the RCDSS office and use of out-of-county emergency foster care placements; ending the routine presence of Class Members in the RCDSS office; and eliminating excessive late night work shifts for RCDSS staff, which includes consideration of dedicated staff for second and third shifts.[33] The Task Force includes members representing the South Carolina Department of Health and Human Services (SC DHHS); South Carolina Department of Juvenile Justice (SC DJJ); Department of Behavioral Health and Developmental Disabilities' Office of Mental Health (DBHDD OMH); South Carolina Department of Children's Advocacy; Richland County Sherriff's Office; City of Columbia Police Department; Richland/Lexington School District Five and Richland School Districts One and Two; Richland County Family Court Public Defender; Richland County Court Appointed Special Advocates; Palmetto Association for Children and Families; SCDSS State, Regional, and County leadership; Plaintiffs' counsel; and Monitor staff.

The initial Richland County DSS Improvement Plan, submitted to the Court on December 23, 2024, included multiple efforts to address critical issues previously identified by the Co-Monitors.[34] After reviewing the plan, the Court found that "further refinements are necessary to meet the considerable challenges confronting DSS operations in Richland County," and ordered that a supplemental plan be submitted. In so ordering, however, the Court noted that, "[t]he preparation of the supplemental plan should in no way hold up full implementation of the present plan presented to the Court."[35] The Supplemental Richland County DSS Improvement Plan was submitted to the Court on May 19, 2025.[36]

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[32] CAPSS data provided by DSS.
[33] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays of children in the Richland County DSS office (October 18, 2024, Dkt. 331).
[34] Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23, 2024, Dkt. 339).
[35] Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348).
[36] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

The Supplemental Plan was designed to support both children in foster care from Richland County who are experiencing placement instability and the staff managing their cases. The Plan included strategies to increase placement resources and services in Richland County that are tailored to meet the individual needs of children; remove barriers to placement and promote placement stability; increase supports for kinship caregivers to help them meet the unique needs of children in their care; and prevent unnecessary removals to foster care through strengthened relationships with local law enforcement. Additionally, the Plan includes strategies to support the workforce such as creating and fully staffing second and third shifts, increasing retention efforts, and providing mentoring and other support focused on improving practice.

Many strategies in the Supplemental Plan reflect a commitment to a fuller implementation of DSS's GPS Case Practice Model—a model of quality case practice that requires intensive engagement with children and families through teamwork, comprehensive assessments, and the crafting and resourcing of individualized case plans that address both immediate and ongoing needs.[37] This commitment includes development and implementation of a "Whatever it Takes" approach to meeting the unique needs of children in foster care in Richland County through individualized placement and service planning within Child and Family Teams.

Implementation of the Plan has been carried out by DSS in partnership with the Task Force and its five workgroups: (1) Capacity Building for Placement Array, which is co-facilitated by the Monitor; (2) Enhancing Skills and Capacity of Staff and Caregivers to Meet the Needs of Children and Youth in Foster Care; (3) Community Action; (4) Kin First Implementation; and (5) Educational Needs for Children and Youth in Foster Care. Each workgroup met at least monthly through the first half of 2025 and then as needed, while the full Task Force met quarterly. On March 27, 2026, a final meeting of the Task Force was held and DSS announced that the work would be sustained and carried forward through the pre-existing Richland County Child Welfare Improvement Team. Task Force members were invited to join the Improvement Team to continue the work on remaining challenges and to assess the effectiveness of strategies and modify them as needed.

The Monitor and staff have been actively engaged in supporting the efforts in Richland County and in tracking DSS's progress in implementing the Supplemental Plan. This report is accompanied by the Monitor's April 7, 2026 letter to the Court providing an update on DSS's efforts and early outcomes in Richland County, including key themes and findings from the Monitor's March 2026 site visit.[38] The letter is included in Appendix F of this report.

[37] To view the GPS Case Practice Model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

[38] Letter from the Monitor Providing Updates and Findings Regarding Efforts to Address Placement Instability in Richland County, submitted to the Court on April 7, 2026.

III. South Carolina's Foster Care System and the Children it Serves

A. Overview of the State Child Welfare System

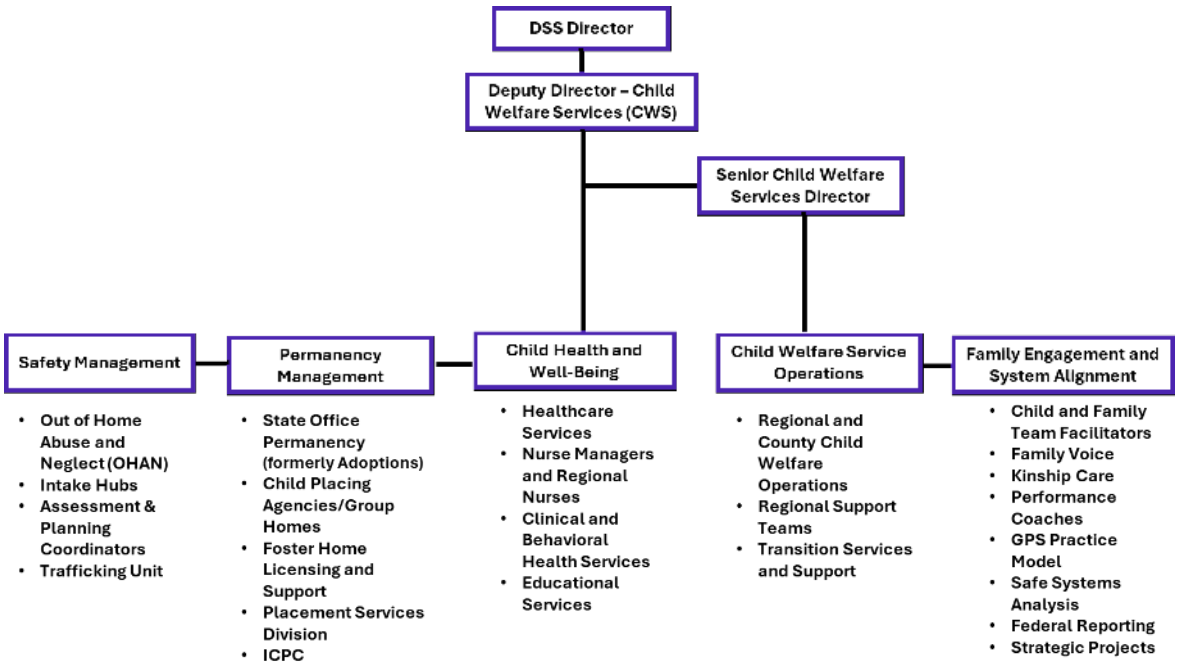
South Carolina's Department of Social Services (DSS) is a cabinet-level agency, led by State Director Tony Catone who reports to Governor McMaster. DSS is responsible for the temporary custody and care of children who have been involuntarily separated from their parent(s) or guardian(s) due to a finding of abuse or neglect. While children are in foster care, DSS is responsible for meeting their needs, including ensuring they: are safe; have stable places to live with caring adults, preferably family members; have their health care needs monitored and addressed; and are supported in maintaining connections with their communities and families – this includes DSS's obligation to engage with and support parents and guardians so children can return home safely and quickly. If reunification of a child with their parent(s) or guardian(s) is determined not to be possible, DSS must pursue another permanent, long-term plan, such as guardianship or adoption.

South Carolina's child welfare system is administered at the state level by DSS's Child Welfare Services Division, which is organized into five primary areas: Safety Management, Permanency Management, Child Health and Well-Being, Child Welfare Service Operations, and Family Engagement and System Alignment (Figure 1). Services are delivered to children and families through county DSS offices. The State's 46 counties are organized into four regions – Lowcountry, Midlands, Pee Dee, and Upstate, and some DSS functions are delivered regionally, including adoptions, child health and well-being, foster care placement, and as of November 2023, transition services and supports for older youth who are transitioning from foster care to adulthood.

Figure 1. DSS Child Welfare Services Division Organizational Chart

March 21, 2026

Source: DSS



Fiscal Resources and Budget

South Carolina's child welfare system is financed through a blend of federal and state funding streams.[39] At the federal level, the Children's Bureau, part of the Administration for Children and Families, distributes funds to states for defined child welfare functions and services through mandatory spending programs. The largest of these programs – the Foster Care, Prevention, and Permanency Program – is authorized under Title IV-E of the Social Security Act and entitles states to federal reimbursement for part of the cost of providing foster care to children.[40] The program operates as an "uncapped" source of matched funding, meaning states are entitled to receive reimbursement for a portion of every dollar spent on a defined service on behalf of an "eligible"

[39] Additionally, per state law, each county in South Carolina is required to provide office space and facility services – including janitorial, utility, telephone services, and related supplies – for its county DSS (SC Code § 43-3-65 (2024)).

[40] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). Under Title IV-E, states may seek federal reimbursement for a portion of "foster care maintenance payments," defined as "payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for a child to remain in the school in which the child is enrolled at the time of placement" (42 USC § 675(4)).

child.[41] The child's eligibility depends on a number of factors, including the income level of the parents(s) from whose custody the child was removed.[42] To meet the Title IV-E income test, the income of the home of removal must be within eligibility guidelines, *as they were in effect on July 16, 1996*, for a former federal-state cash assistance program known as Aid to Families with Dependent Children (AFDC).[43] In South Carolina, this means the State can claim federal reimbursement if the child in foster care meets all other non-income eligibility requirements and the annual income of the home the child was removed from is not more than $6,288 for a family of three or $7,572 for a family of four.[44] Because Title IV-E eligibility is linked to 1996 income limits, generally fewer children are determined to be federally eligible each year, resulting in lower amounts of federal reimbursement to states. As of the writing of this report, 45 percent of children in foster care in South Carolina meet the Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).

Additionally, the federal Family First Prevention Services Act (FFPSA), passed in 2018, has financial implications for South Carolina's support of children in foster care.[45] Most relevant to *Michelle H.*, the FFPSA aligns with the FSA by creating financial disincentives for the placement of children in congregate care.[46] The FFPSA prevents federal reimbursement for most congregate placements beyond 14 days unless the child is placed in a specified child-care institution.[47] The FFPSA also incentivizes the provision of prevention services in the community to reduce the need for out-of-home placement by allowing states to use federal IV-E funding for evidence-based prevention

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[41] Federal reimbursement is made at a state's Federal Medical Assistance Percentage (FMAP) rate. South Carolina's FMAP rate for Federal Fiscal Year 2026 (October 1, 2025 – September 30, 2026) is 69.53%. See Kaiser Family Foundation. State Health Facts. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&selectedRows=%7B%22states%22:%7B%22south-carolina%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[42] Emilie Stoltzfus. (2019). *The Title IV-E Income Test Included in the "Lookback."* (Congressional Research Service Memorandum). https://www.cwla.org/wp-content/uploads/2019/09/CD_lookback_4_2019.pdf.

[43] Ibid. Note, AFDC was repealed by Congress in 1996 (P.L. 104-193) when it was replaced by the Temporary Assistance to Needy Families block grant. However, eligibility for the Title-IV-E program remains linked to certain AFDC provisions. This linkage is often referred to as the "look back" because in determining income eligibility, states are required to *look back to* eligibility provisions from the prior AFDC law as they were in effect on July 16, 1996.

[44] Ibid.

[45] Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017).

[46] Ibid.

[47] Federal reimbursement is available after 14 days for placement of a child in one of the following settings: qualified residential treatment programs (QRTPs); settings specializing in providing prenatal, post-partum, or parenting supports for youth; settings providing high-quality residential care and supportive services to children who have been found to be, or are at risk of becoming sex trafficking victims; and supervised settings in which the youth is living independently if the child has attained 18 years of age (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)).

services.[48] In South Carolina, prevention services in its FFPSA Plan include motivational interviewing, in-home parenting skills, mental health prevention, and concrete economic assistance.

Medicaid is another essential source of federal revenue for state child welfare systems. Nearly all children in foster care are eligible for health insurance through Medicaid. States authorizing payment for Medicaid services included in their federally approved state plans and waiver programs receive federal matching funds for state expenditures at the state's Federal Medical Assistance Percentage (FMAP) rate—the same reimbursement rate used for Title IV-E foster care maintenance payments. In South Carolina, the FMAP rate for Federal Fiscal Year 2026 (October 1, 2025 – September 30, 2026) is 69.53 percent.[49] This means that for each dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member, the federal government reimburses the State almost 70 cents. Because Medicaid reimbursement is applicable to nearly all children in foster care (as opposed Title IV-E reimbursement which applies to a fraction of children in foster care —e.g., 45% in South Carolina), 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.[50] Additionally, Medicaid's coverage requirements are broad. Its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions require that children be provided with all necessary medical treatment and services, and Medicaid can be used to cover non-direct medical care expenses such as transportation to medical appointments and necessary home modifications. In South Carolina, most children in foster care are enrolled in Select Health, the State's contracted managed care organization (MCO)responsible for the provision of their medical and behavioral health services.

At the state level, funding obligations specific to the *Michelle H.* lawsuit are appropriated by South Carolina's General Assembly as part of the state budget process. For the State Fiscal Year (SFY) 2025-2026 (July 1, 2025 – June 30, 2026), DSS requested $31 million in additional recurring state

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[48] In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plan. DSS began making IV-E claims under the FFPSA for all allowable prevention services during the third quarter of 2025. Previously, DSS had been using 100% federal funding received through the Family First Transition Act grant to support prevention services. Those funds expired on September 30, 2025. See: https://acf.gov/sites/default/files/documents/acyfcb_93556_families_first_transition_act_supplemental_terms_and_0.pdf. To view South Carolina's Family First Prevention Services plan, see: https://dss.sc.gov/media/e0vle5k4/south-carolina-dss-title-iv-e-prevention-plan.pdf.

[49] *Supra* note 41.

[50] In July 2024, two community-based programs, for which children and families involved in the foster care system are eligible, became covered under Medicaid: (1) Homebuilders serving children at imminent risk of foster care entry or close to reunification to support family stability and improve overall function; and (2) Multi-Systemic Therapy (MST) serving youth between the ages of 12 and 17 to address delinquent and/or maladaptive behaviors to prevent out-of-home placement and juvenile justice involvement. DSS reported that in from August 2025 to February 2026, Homebuilders received 50 foster care referrals with 1 family successfully completing the service and 7 families actively receiving the service as of the end of February 2026. MST is available to eligible Medicaid beneficiaries in the Upstate and Midlands regions of the state. Since the addition of MST to the Medicaid State Plan, 195 children have received MST services, 26 of whom were children in foster care. As the data suggest, utilization of these services by foster children and their families remains very limited.

general funds for child welfare services which, with federal and other fund estimates, would have generated a total of $40.8 million in additional state, federal, and other funds. The final approved SFY 2025-2026 Appropriations Act, passed in May 2025, allocated $10.2 million in new state recurring funds and authorized the use of $5.7 million in federal funds for continued child welfare reform efforts and promotion of compliance with the terms of the *Michelle H.* settlement.[51] In addition to funds specifically tied to *Michelle H.* implementation efforts, $2.5 million in new state recurring funds were allocated and the use of $800,000 in federal funds were authorized to support foster care prevention services. The appropriated funds provided state general funds of $1.7 million for foster home rate increases; $3.4 million for monthly board payment for children who are placed in a licensed or approved kinship foster family home using licensing standards that differ from the standards used for non-kinship foster family homes; $3.7 million for continued implementation of the salary plan ordered by the Court as part of DSS's Workload Implementation Plan; $1.1 million to provide a time-limited child placing agency foster family supplement for SFY 2025-2026; $271,000 to add 4 full-time equivalent positions (FTEs) for case management staffing.[52] Additionally, $2.6 million in state general funds was allocated as a separate line item for the expansion of evidence-based prevention services.

DSS's SFY 2026-2027 budget request includes $48.6 million in additional recurring state general funds for child welfare services which, with $8.9 million in federal and other fund estimates, would generate a total of $57.5 million in additional state, federal, and other funds for DSS's budget priority, "Enhancing the Future of South Carolina Children and Families."[53] DSS's budget plan includes requests in total funding (state, federal, and other funds) to address: (1) placement stabilization, (2) board and care rates, and (3) salaries and staffing. More specific details on what is being requested in the agency's SFY 2026-2027 budget are included below:

Placement Stabilization
$22.4M Total: $20.7M state general funds; $1.7M federal authorization

- *Small Group Home Model ($9.4M Total: $9.2M state general funds; $220k federal authorization):* Funding for the small group home model, which will provide structured 24-hour care and treatment to children who have specialized care needs, with the goal of stabilizing the child's behavior so they can then be stepped down to placement in a less restrictive setting.
- *Transition Youth Day Services Programs ($4.3M state general funds):* Funding for day services programs for youth to have educational activities, counseling, and services while awaiting placement or between placements.
- *Welcome and Assessment Center ($3.3M Total: $2.7 state general funds; $650k federal authorization):* Funding for welcome centers to eliminate the time youth spend in DSS

[51] To view the SFY 2025-2026 General Assembly Appropriation, see: https://www.scstatehouse.gov/sess126_2025-2026/appropriations2025/gab4025.php.
[52] To view the Workload Implementation Plan, see: https://dss.sc.gov/media/i3qlwxka/dss-workload-implementation-plan.pdf.
[53] To view DSS's SFY 2026-2027 Agency Budget Plan, see: https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY27%20L040%20-%20Department%20of%20Social%20Services.pdf.

offices, improve working conditions for DSS staff, and reduce the trauma that children experience due to foster care entry or placement changes.

- *Professional Foster Parent Model ($3.2M Total: $2.7M state general funds; $490k federal authorization)*: Funding for the professional foster parent model to provide services to children and youth between the ages of six and 21 with acute needs due to mental health, behavioral health, intellectual, and/or developmental disability.[54]
- *Community Based Preservation and Stabilization ($2.1M Total: $1.7M state general funds; $330k federal authorization)*: Funding to expand adoption and preservation services to assist families with adopted children when they are experiencing challenges that could result in re-entry into foster care.
- *Individualized Stabilization Services ($100k state general funds)*: Funding for support services to prevent unnecessary foster care entry and improve placement stability for children. Funds would be used for services to address individual needs identified by the Child and Family Team such as family/individual counseling, specialized therapies, one-on-one support, tutoring, extracurricular activities, and concrete supports such as assistance with security deposits, utility bills, and transportation.

Foster Care Board Rates, Cost of Care Adjustments, and Support Network Expansion
$16.5M Total: $14.1M state general funds; $2.4M federal authorization

- *Group Home—Cost of Care Adjustment ($9.1M Total: $8.5M state general funds; $620K federal authorization):* Funding to adjust rates for group homes to keep pace with the increasing cost of providing this level of care.
- *Child Placing Agency Foster Family Support ($3.3M Total: $2.5M state general funds; $790K federal authorization):* Funding to increase rates for CPA's to keep pace with rising costs.
- *Foster Family Board Rate Increase ($2.4M Total: $1.7M state general funds; $700k federal authorization):* Funding to increase board rates for regular foster care, difficulty of care, and kinship care to ensure monthly rates continue to meet the USDA cost of raising a child.[55]
- *Therapeutic and Medical Therapeutic Foster Care ($1.2M state general funds):* Funding to adjust, for the first time since 2022, rates for foster parents providing therapeutic and medical therapeutic foster care.
- *Foster Family Support Network Expansion ($500k Total: $240k state general funds; 260k federal authorization):* Funding for expansion of foster family support networks to increase awareness, recruit foster families, and build community-based support systems.

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[54] Ibid. Professional foster parents must meet all licensing and regulatory standards required of Therapeutic Foster Parents and must have one parent who does not work outside of the home.
[55] If funded, foster family board rates would increase from $700 to $733 per month for children aged 0 – 5, $818 to $856 per month for children aged 6 – 12, and $863 to $904 per month for children aged 13 and older.

Salaries, Staff, and Training
$18.6M Total: $13.7M state general funds; $4.8M federal authorization; $100k other funds

- *Child Welfare Salary Plan Administration Maintenance of Effort ($13M Total: $9.7M state general fund; $3.3M federal authorization):* Funding for the continued implementation of the salary plan ordered by the Court as part of the Workload Implementation Plan required by the *Michelle H.* FSA.
- *Placement and Foster Family Licensing Staffing ($2M Total; $1.5M state general funds; $430k federal authorization; $110k other funds):* Funding for 22 additional FTE positions to increase capacity for DSS to accept all non-kin, non-therapeutic foster family applicants who desire to have their license managed by DSS and additional positions to support targeted foster family recruitment.
- *Family Search & Engagement Staffing ($2M Total: $1.5M state general funds; $430k federal authorization):* Funding for 18 additional FTE positions to support statewide implementation of dedicated Family Search and Engagement staff for the early and ongoing identification of kin to serve as placements and to support connections between children and their families.
- *Child and Family Teaming (CFTM) Staffing ($1.4M Total: $910k state general funds; $460k federal authorization):* Funding for 14 additional FTE positions to assist with the expansion of mandatory pre-removal CFTMs and initial 24-hour CFTMs to prevent unnecessary entries into foster care and to reduce the number of children who experience short stays in foster care.
- *Other Requests ($260k Total: $120k state general funds; $140k federal authorization):* Additionally, DSS has requested funding for one additional FTE position for a Human Trafficking Coordinator *($120k Total: $60k state general funds; $60k federal authorization)* and funding to support the transition of the external training system used for foster parent, adoptive parent, and kinship caregiver training to an in-house system *($140k Total: $60k state general funds; $80k federal authorization)*.

The Governor's SFY 2026-2027 Executive Budget, submitted to the Legislature on January 12, 2026, included $46.9 million of the recommended $48.6 million recurring state general fund request, with $8.9 million federal authorization and other funding, for a total of $55.8 million to DSS for continued child welfare reform efforts and promoting compliance with the terms of the *Michelle H.* settlement.[56,57] As of the writing of this report, the SFY 2026-2027 budget is currently under consideration by the South Carolina Legislature.

[56] The Governor's budget proposal is $1.7M less than DSS's request.
[57] To view the Governor's SFY 2026-2027 Executive Budget, see: https://governor.sc.gov/sites/governor/files/Documents/Executive-Budget/FY27%20Executive%20Budget%20Book%20-%20FINAL%200112026.pdf.

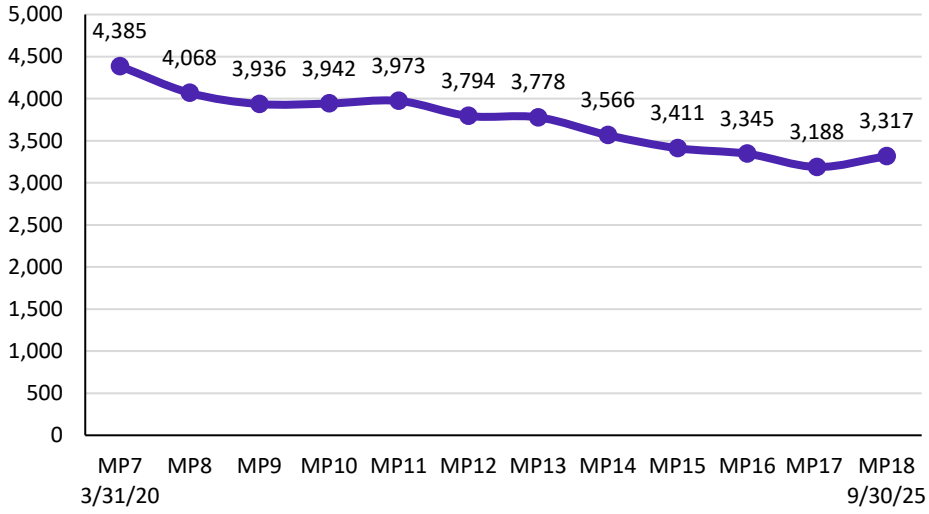
B. Population of Children in Foster Care

Number of Children in Foster Care

On September 30, 2025 (the last day of Monitoring Period 18), there were 3,317 children in foster care statewide.[58] This is an increase of four percent over the last day of the prior monitoring period (March 31, 2025), and a deviation from the downward trend in South Carolina's foster care population over the past five and a half years (11 monitoring periods). Overall, however, the number of children in foster care has decreased by 24 percent since March 31, 2020 (Figure 2).

Figure 2. Number of Children in Foster Care

Children in foster care, MP7 – 18 (March 31, 2020 – September 30, 2025)
Source: CAPSS data provided by DSS



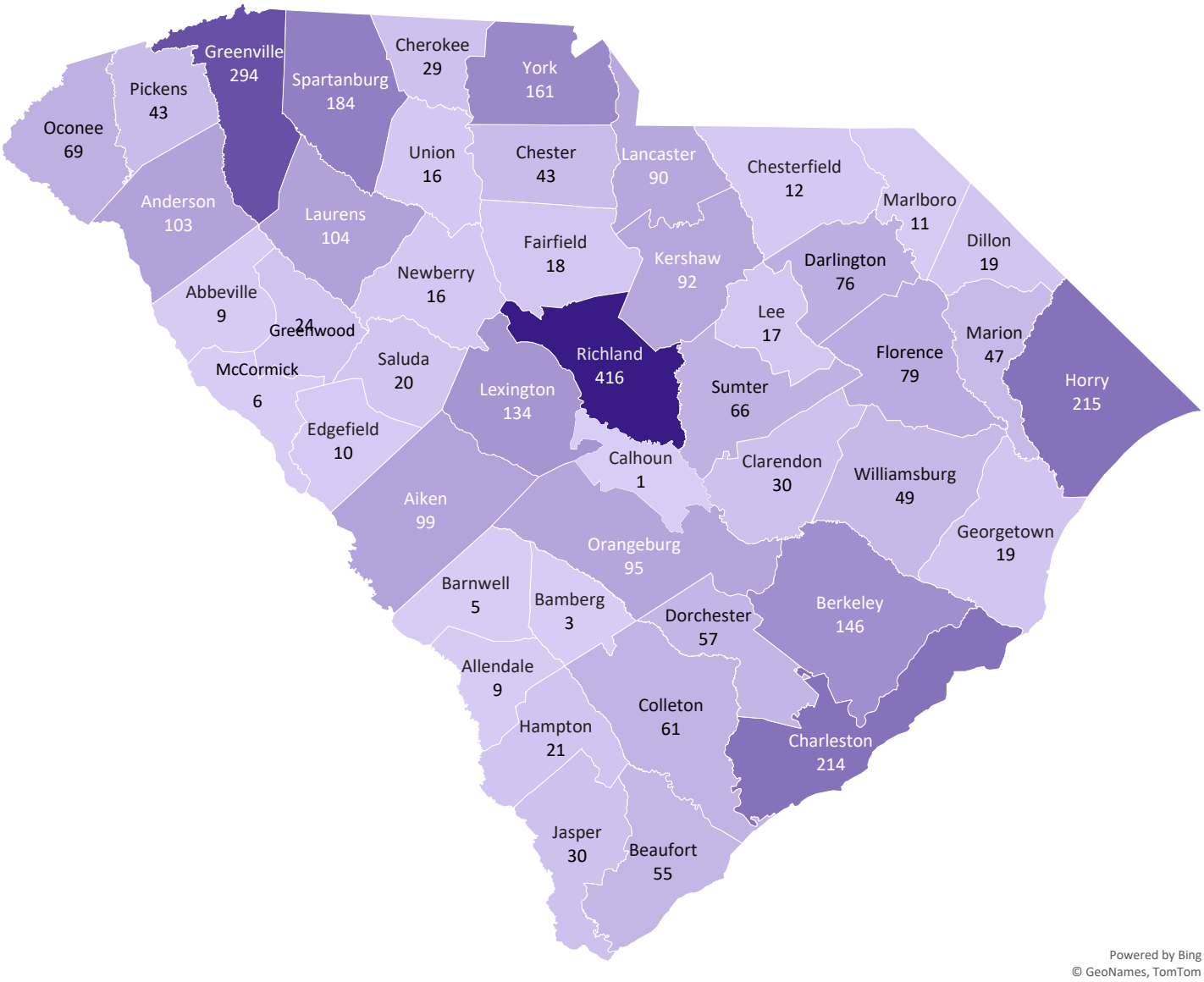
The rate of children in foster care per 1,000 in South Carolina's child population was 2.9, meaning that for every 1,000 children in the state, nearly three were in foster care. The map provided in Figure 3 shows the number of children in foster care on September 30, 2025, by county of origin. The rate of children in foster care per 1,000 for each county is provided in Appendix D.

[58] This includes 31 children who resided in other institutional settings, including 14 who were hospitalized for 30 days or more and 17 who were in a DJJ or other correctional facility on September 30, 2025, and may not match the data in *Section IV.A. Placements* of this report.

Figure 3. Number of Children in Foster Care, by County of Origin[59]

September 30, 2025

Source: CAPSS data provided by DSS



[59] DSS publishes real-time data on children in foster care on its public website. To view this map with current data, see: https://reports.dss.sc.gov/ReportServer/Pages/ ReportViewer.aspx?/Foster+Care. Data from DSS's data dashboard include children in foster care who do not fall within the definition of *Michelle H*. Class Members under the FSA.

Throughout this report, as relevant, county-level data are provided for the 10 DSS county offices that had case management responsibility for the largest numbers of children in foster care on September 30, 2025 (Table 1).[60] Complete data for all 46 South Carolina counties for this and other county-level data points included throughout the report can be found in Appendix D.

Table 1. DSS County Offices with Case Management Responsibility for Largest Numbers of Children in Foster Care[61]

September 30, 2025
Source: CAPSS data provided by DSS

Rank	County Office of Case Management	Children in Foster Care
1.	Richland	357
2.	Greenville	234
3.	Charleston	191
4.	Horry	181
5.	Spartanburg	151
6.	Berkeley	135
7.	York	120
8.	Lexington	105
9.	Anderson	91
10.	Orangeburg	91

Demographics of Children in Foster Care

Of the children in foster care on September 30, 2025 (the last day of MP18), 44 percent were identified as White, 37 percent as Black, and 10 percent as children of multiple races (Figure 4).[62] White children were underrepresented in foster care, composing 44 percent of children in foster care and 53 percent of the state child population. Comparatively, Black children were overrepresented in foster care, composing 37 percent of children in foster care but just over 25

[60] Note that the DSS office with case management responsibility for a child may differ from the child's county of origin, for example, if the child's case has been transferred to Regional Permanency; consequently, county of origin and office of case management totals are not the same.
[61] Regional Permanency Offices and Transition Services and Support Divisions have been omitted.
[62] Data included herein were provided by DSS and have not been independently validated by the Monitor.

percent of the state child population. Hispanic children were underrepresented in foster care, composing seven percent of children in foster care and 13 percent of the state child population.[63]

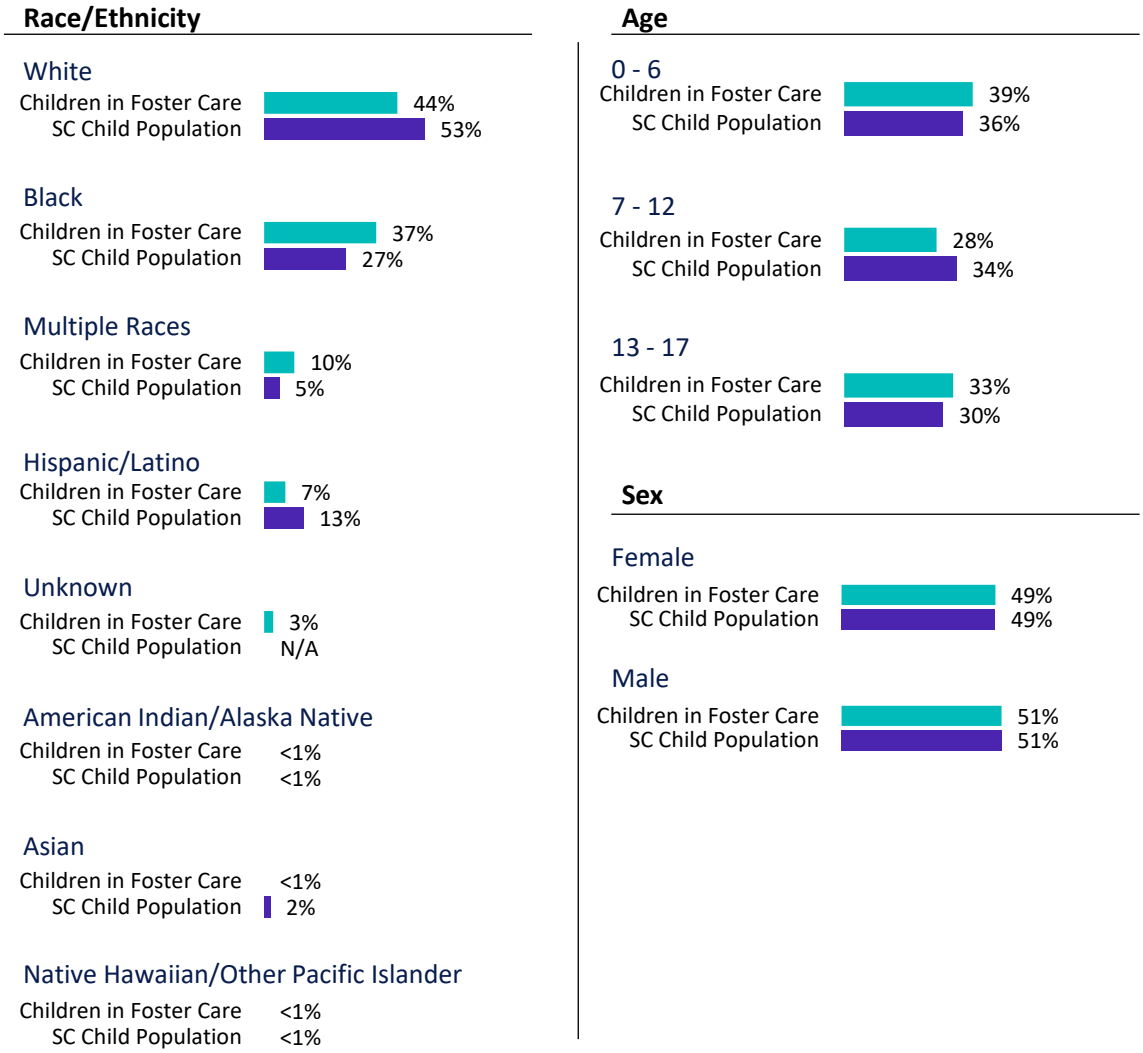
On September 30, 2025, almost 40 percent of children in foster care were aged six and under, 28 percent were aged seven through 12, and one-third (33%) were aged 13 through 17 (Figure 4). Both young children (six and under) and youth (13 through 17) were slightly overrepresented in foster care when compared to their proportion of the state child population; children aged six and under made up 39 percent of the foster care population and 36 percent of the state child population, while youth (13 through 17) represented 33 percent of the foster care population and 30 percent of the state child population. About half (49%) of the children in foster care on September 30, 2025, were reported to be female. These demographics have remained consistent for multiple monitoring periods.

[63] In Figure 4, to allow for comparison to state-level data, children identified as being of Hispanic origin are counted as Hispanic and are not included in any other racial or ethnic categories. Federal standards define Hispanic or Latino identity as a standalone race/ethnicity category; however, demographic data published by DSS on its public dashboard and in analysis of CAPSS data provided to the Monitor by DSS do not reflect this approach. Elsewhere in this report, children of Hispanic or Latino ethnicity are included within other racial categories, consistent with the underlying DSS sources. For federal standards see: https://www.federalregister.gov/ documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and.

Figure 4. Children in Foster Care by Race/Ethnicity,[64] Age,[65] and Sex[66]

September 30, 2025; compared to the child population of South Carolina (2024)

Sources: CAPSS data provided by DSS; Kids Count Data Center from the Annie E. Casey Foundation



[64] Child population by race and ethnicity | KIDS COUNT Data Center. (2025, September.). KIDS COUNT Data Center. https://datacenter.aecf.org/data/tables/103-child-population-by-race-and-ethnicity?loc=1&loct=1#detailed/ 2/42/false/1096/72,66,67,8367,69,70,71,12/423,424.

[65] Child population by single age | KIDS COUNT Data Center. (2025, September). KIDS COUNT Data Center. https://datacenter.aecf.org/data/tables/100-child-population-by-single-age?loc=1&loct=2#detailed/2/42/false/1096/42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,8454/418.

[66] Child Population by Gender Statistics. (2025, September). KIDS COUNT Data Center. https://datacenter.aecf.org/ data/tables/102-child-population-by-gender?loc=1&loct=2#detailed/2/42/false/1096/14,15,65/421,422.

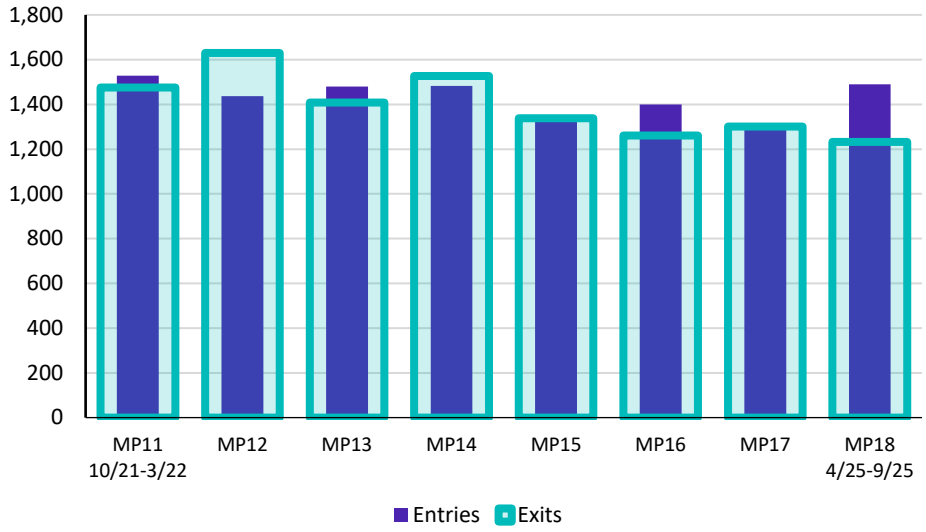
Entries into Foster Care

Between April 1, 2025 and September 30, 2025 (MP18) more children entered foster care (1,490) than exited (1,232) (Figure 5). Statewide, 1.3 children per 1,000 in the state child population entered foster care. Comparing foster care entries among the 10 counties in South Carolina with the largest numbers of children in foster care, Richland County had the greatest number of children (178) enter foster care during MP18, while Orangeburg County had the highest rate of entry per 1,000 children (2.7) in the county child population (Figure 6).[67]

Figure 5. Foster Care Entries and Exits

MP11– 18 (October 2021 – September 2025)

Source: CAPSS data provided by DSS

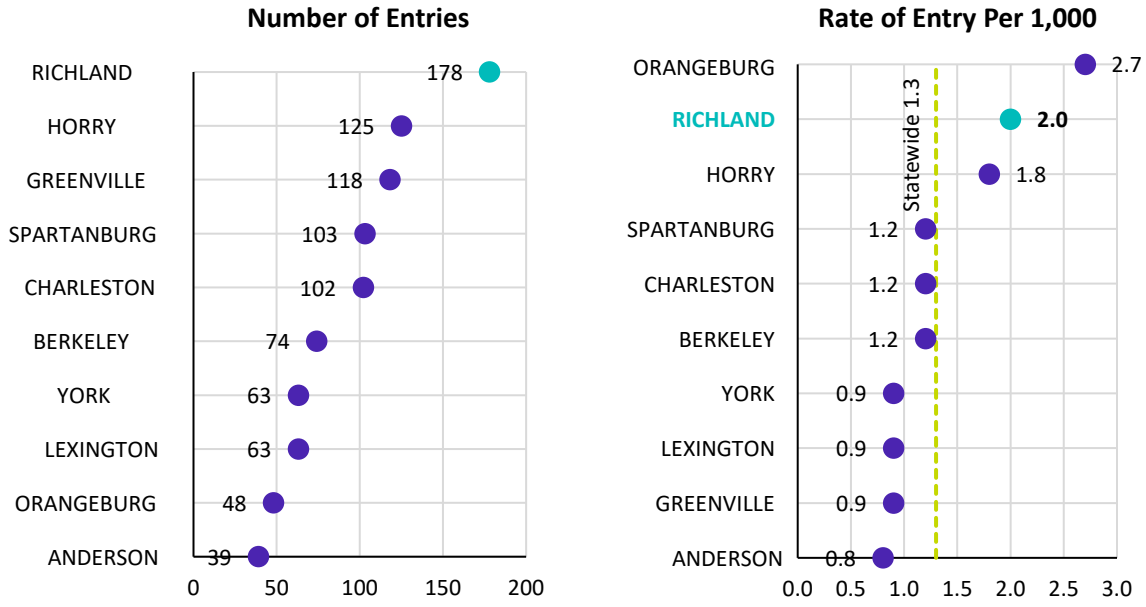


[67] See Table 4 in Appendix D showing these data for all South Carolina counties.

Figure 6. Foster Care Entries, by County

Entries and rates of entry per 1,000 children, MP18 (April – September 2025)

Source: CAPSS data provided by DSS; U.S. Census Bureau[68]



Most children who enter foster care in South Carolina enter through law enforcement action placing them in emergency protective custody (EPC). State statute authorizes law enforcement officers to unilaterally remove children from their homes and place them in EPC in certain circumstances.[69,70] Statewide, 72 percent of all foster care entries between April 1, 2025 and September 30, 2025 (MP18) were through EPC actions by law enforcement (Figure 7). This is a slight decrease from the prior monitoring period when 73 percent of children entered foster care

[68] U.S. Census Bureau. (2024). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2024 (CC-EST2024-AGESEX-45)* — South Carolina.

[69] See SC Code § 63-7-620 (2024), authorizing law enforcement to use an EPC when, among other circumstances: (1) the officer has probable cause to believe that by reason of abuse or neglect the child is in substantial and imminent danger if not taken into emergency protective custody, and there is not time for a court order; (2) the child's parent(s) or guardian(s) has been arrested and as a result, the child's welfare is threatened due to loss of adult protection and supervision, and the parent(s) or guardian(s) does not consent to another person assuming physical custody of the child; or (3) a child has become lost accidentally and a search by law enforcement has not located the parent(s) or guardian(s).

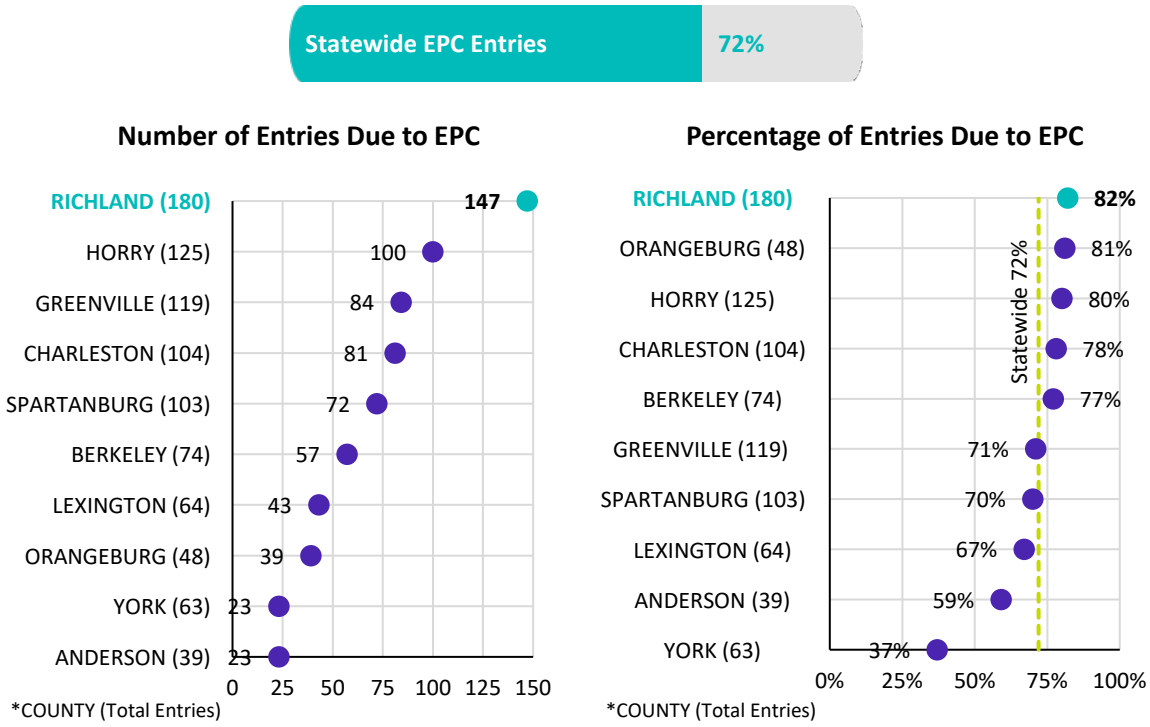
[70] Note, pursuant to SC Code § 63-7-740 (2024), family court judges are authorized to order ex parte that a child be taken into emergency protective custody without the consent of parents, guardians, or others, exercising temporary or permanent control over the child if: (1) the family court judge determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent and substantial danger to the child's life, health, or physical safety; and (2) parents, guardians, or others exercising temporary or permanent control over the child are unavailable or do not consent to the child's removal from their custody. During MP18, 19% of children who entered foster care entered due to an ex parte order by a family court judge. Combined with entries pursuant to EPC actions by law enforcement, 91% percent of children who entered foster care during the monitoring period entered via an emergency action.

due to an EPC by law enforcement. Comparing the 10 counties with the largest numbers of children in foster care, Richland County had both the greatest number of children (147) enter foster care due to an EPC by law enforcement and the greatest percentage of EPC entries (82%).[71]

Figure 7. Entries to Foster Care via Emergency Protective Custody by Law Enforcement

Statewide and by counties with largest foster care populations, MP18 (April – September 2025)

Source: CAPSS data provided by DSS



[71] See Table 5 in Appendix D showing these data for all South Carolina counties.

Placement Settings for Children in Foster Care

On September 30, 2025 (the last day of Monitoring Period 18), 3,286 Class Members were in out-of-home foster care placements, with 86 percent (2,837) residing in family-like settings (Figure 8).[72] Family-like settings include non-kin foster homes where 1,056 children (32%) resided, kin homes where 1,005 children (31%) resided, and therapeutic foster homes where 776 children (24%) resided. Fourteen percent of children (449) resided in congregate care placements, including 399 children (12%) placed in group homes and 50 children (2%) placed in residential treatment facilities.

When children are placed far from their communities of origin, they may lose contact with their schools, friends, siblings, relatives, places of worship, and communities.[73] Federal law prioritizes the placement of children in foster care in their communities of origin, by requiring, to the extent possible, that children are placed in the least-restrictive setting near to their parents' home and their school of origin.[74] Overall, as of September 30, 2025, 34 percent of children were in placement settings located within their counties of origin and 66 percent of children in foster care were in out-of-county placements (Figure 9).[75]

DSS tracks the number of children who are placed within their regions and counties of origin by placement type. On September 30, 2025, children being cared for by kin were placed within their counties of origin at a higher rate than children placed in other placement setting: 59 percent of children placed with kin resided within their counties of origin. Children placed in group homes and residential treatment facilities had the highest rates of out-of-county placement, 88 percent and 89 percent respectively (Figure 9). Among the 10 counties with the greatest numbers of children in foster care, Richland County had the largest number of children placed outside of the county (222), but the lowest percentage of out-of-county placements, 54 percent, which was below the statewide average of 66 percent (Figure 10).[76] Anderson County had the highest percentage of out-of-county placements (74%).

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[72] This number excludes 31 children who resided in other institutional settings. On September 30, 2025, 14 children, including 6 children aged 6 or under, were hospitalized for 30 days or more and 17 children were in a DJJ or other correctional facility. There was a sizeable increase in the number of children who were in other institutional settings compared to six months prior when 17 children were in these placements.
[73] Font, S. A., Sattler, K. M., & Gershoff, E. T. (2018). Measurement and correlates of foster care placement moves. *Children and Youth Services Review*, *91*, 248–258. https://doi.org/10.1016/j.childyouth.2018.06.019.
[74] 42 U.S.C. §675(5) and §675(1)(G)(i).
[75] *Supra* note 72.
[76] See Table 6 in Appendix D showing these data for all South Carolina counties.

Figure 8. Placement Settings of Children in Foster Care

September 30, 2025

Source: CAPSS data provided by DSS

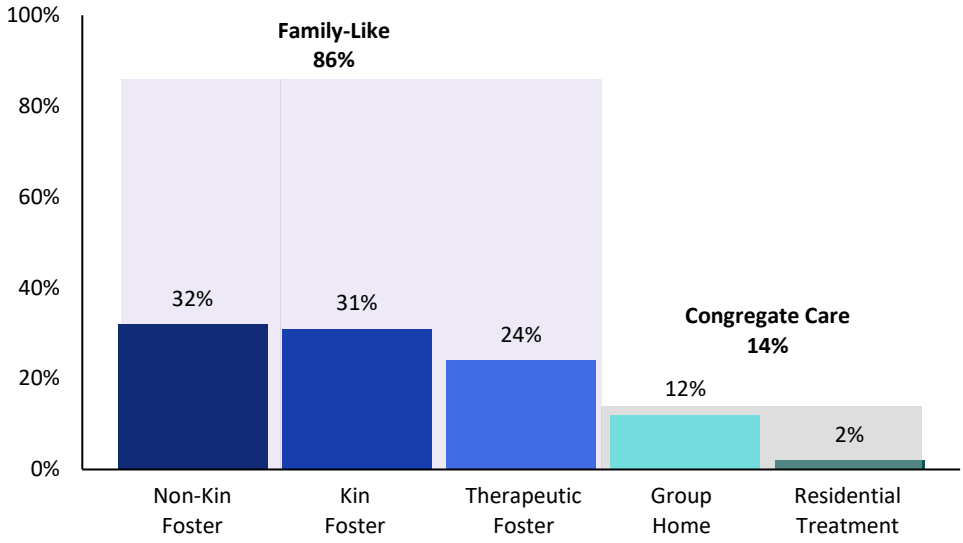


Figure 9. In- and Out-of-County Placements, by Placement Setting

September 30, 2025

Source: CAPSS data provided by DSS

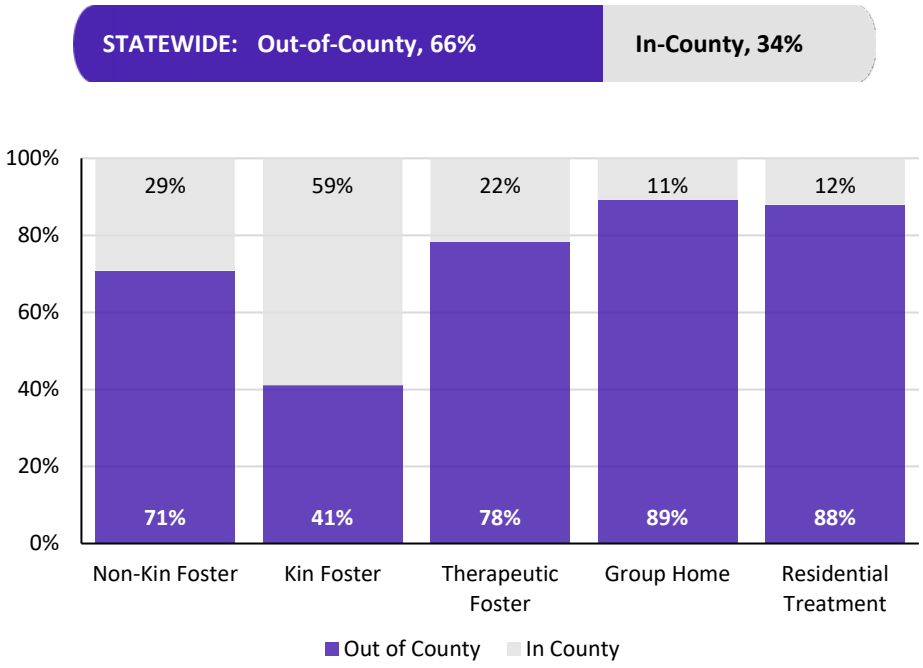
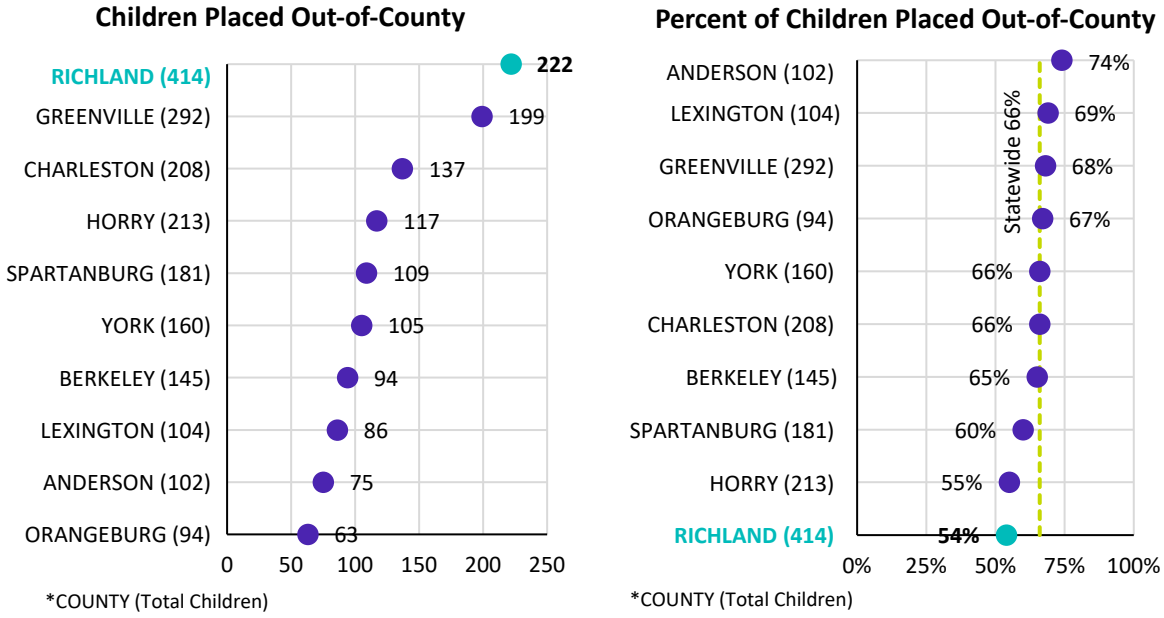


Figure 10. Children Placed Out-of-County, by County of Origin

September 30, 2025

Source: CAPSS data provided by DSS



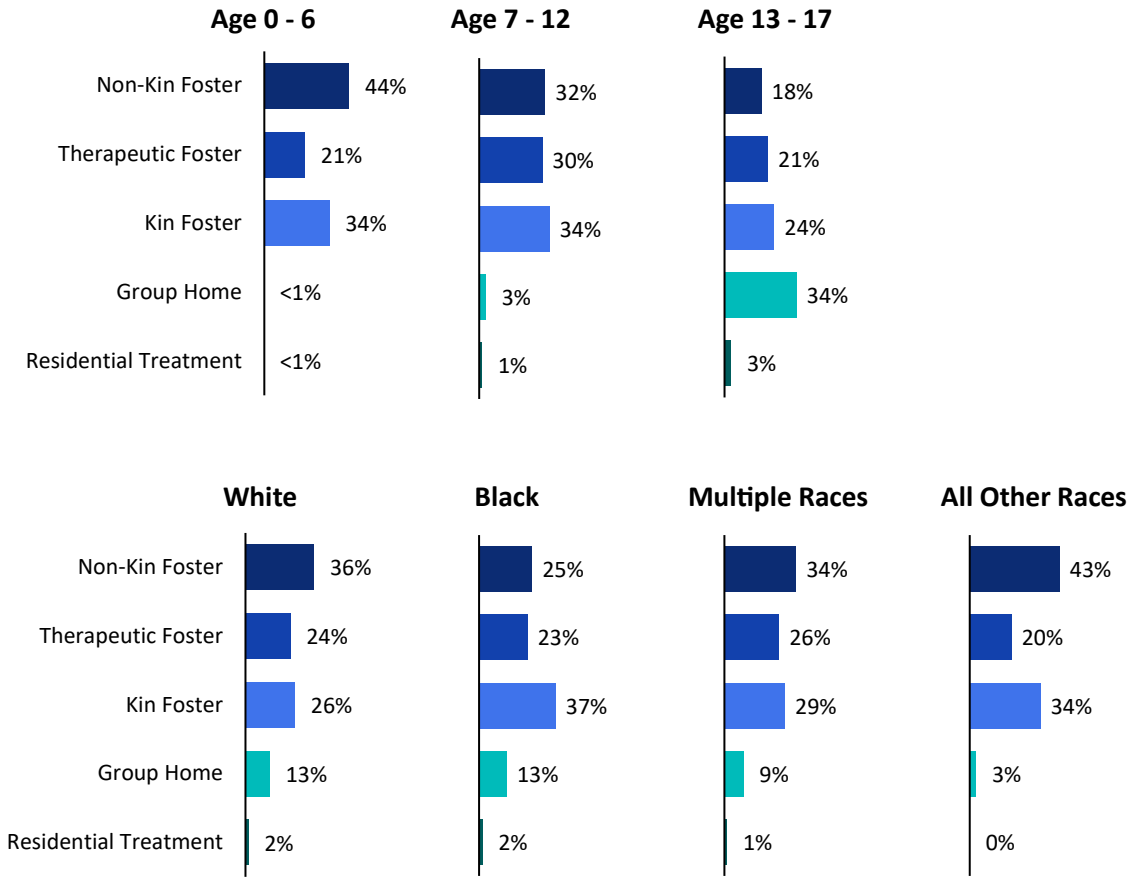
Placement setting data were also disaggregated by age and race (Figure 11). Older age groups of children were placed in congregate settings at exponentially higher rates than younger age groups of children. Less than one percent of children (9 of 1,295) aged six and under were placed in congregate care, while five percent of children (42 of 933) aged seven through 12, and 38 percent of children (398 of 1,058) aged 13 through 17 were placed in a group home or residential treatment facility.[77] Black children were placed with kin at a higher rate than children of other races.

[77] Note: combined congregate care totals (Group Home + Residential Treatment) differ from what is shown in Figure 11 due to rounding.

Figure 11. Placement Settings, by Age and Race[78,79]

September 30, 2025

Source: CAPSS data provided by DSS



[78] Hispanic or Latino identity is not shown as a separate category in this figure; children of Hispanic or Latino ethnicity are included within other racial categories. See *supra* note 63.

[79] "All Other Races" includes children identified as Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, or an unknown race.

Length of Stay and Exits from Foster Care

During Monitoring Period 18 (April – September 2025), 1,232 children exited foster care, with lengths of stays in foster care ranging from one to 3,836 days (or 10.5 years). The median length of stay among children exiting during MP18 was 238 days.

Focusing on children who experience foster care for shorter periods of time can help child welfare agencies better identify when the trauma of separating children from their families could have been avoided through improved cross-agency collaboration and the provision of in-home and community-based services. When successful, it prevents the lasting harm that children and families experience when separated by removals to foster care even for very short periods of time.[80] Accordingly, DSS's Office of Accountability, Data, and Research (ADR) analyzes the amount of time children spend in foster care, with an emphasis on children who remain in foster care for less than six months. The Monitor focuses the following analysis on "short stays" (60 days or fewer) and "very short stays" in foster care (7 days or fewer) experienced by children during MP18. Children may have had more than one stay during the monitoring period.

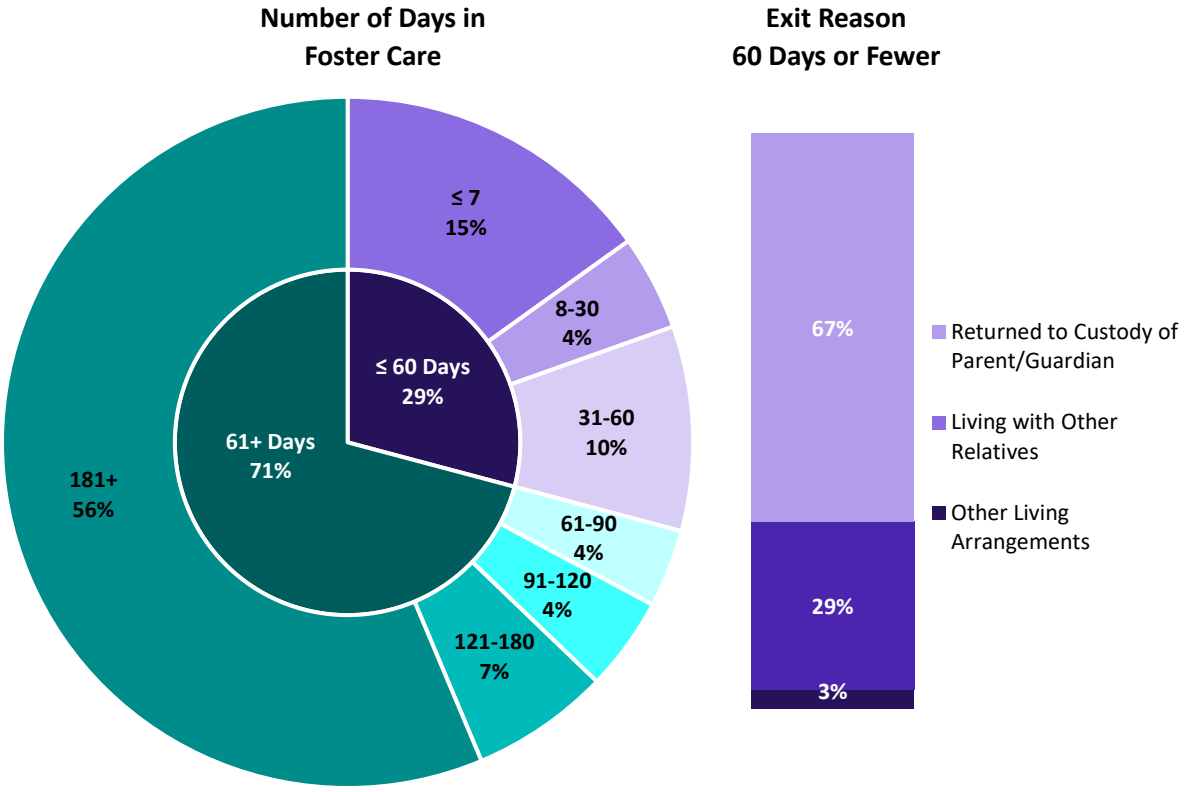
Among all exits from foster care occurring between April 1, 2025 and September 30, 2025 (MP18) 71 percent (873) occurred after a stay of 60 days or more, while 29 percent (359) occurred after a short stay of 60 days or fewer. Fifteen percent (159) of exits were within seven days of entry (Figure 12). Among exits occurring after 60 days or fewer, 67 percent of children returned to the custody of their parent or guardian, 29 percent exited to live with other relatives, and three percent exited to other living arrangements.

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

Figure 12. Length of Stay and Exit Reason for Stays of 60 Days or Less in Foster Care

Among children who exited foster care during MP18 (April – September 2025)

Source: CAPSS data provided by DSS

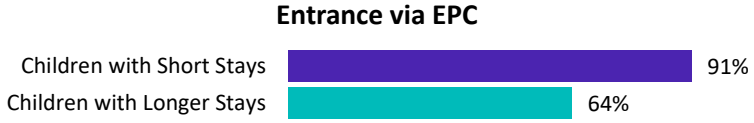


Among children who exited foster care during MP18, entry circumstances differed by length of stay. Although entry through Emergency Protective Custody (EPC) orders was common among both short and longer stay exits, it accounted for a substantially larger proportion of short stay exits during the monitoring period (April – September 2025). Of children who exited after a short stay of 60 days or less, 91 percent had entered foster care due to law enforcement action placing them in emergency protective custody (Figure 13). In contrast, among children who exited during MP18 following a longer stay of more than 60 days in foster care, 64 percent entered due to emergency protective custody.

Figure 13. Comparison of Children with Short Stays (≤ 60 Days) and Longer Stays (61+ Days)

By entrance via EPC from law enforcement among children who exited during MP18 (April – September 2025)

Source: CAPSS data provided by DSS

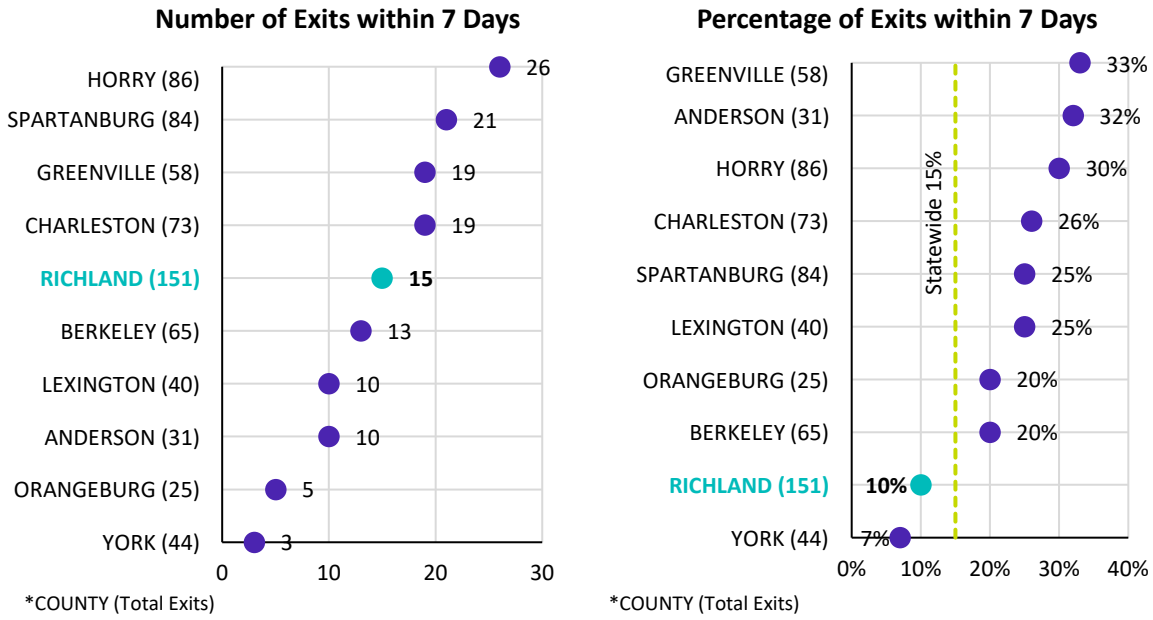


Statewide, 15 percent of children who exited foster care between April 1, 2025 and September 30, 2025, experienced very short stays (7 days or fewer) in foster care (Figure 12). Among South Carolina's 10 counties with the largest numbers of children in foster care, Horry County had the highest number of children (26) who experienced a very short stay (Figure 14). These 26 children made up 30 percent of all foster care exits in Horry County during Monitoring Period 18 (26 of 86). Of the 10 counties, Richland County had the fifth highest number of children (15) who experienced foster care for seven days or fewer during the period. These 15 children made up 10 percent of all exits from foster care in Richland County during the monitoring period. Among the 10 counties, this is the second lowest rate of very short stays and is below the statewide rate of 15 percent.[81]

Figure 14. Exits from Foster Care within 7 Days of Entry, by County

Among children who exited during MP18 (April – September 2025)

Source: CAPSS data provided by DSS



[81] See Table 7 in Appendix D showing these data for all South Carolina counties.

IV. Performance

A. Placements

Children who are separated from their parent(s) and guardian(s) and placed into foster care need to be cared for in settings where they are safe, stable, and supported. This means ensuring that children are in family-like environments, with kin and siblings, and within their communities. 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.

This expectation is embedded within FSA requirements related to placement stability, placement of children in family-like settings, placement of children with their siblings, and placement of children in the least-restrictive settings that can appropriately meet their therapeutic needs. The FSA includes a specific requirement relating to the placement of children who are also involved with the juvenile justice system.

Ensuring the availability of appropriate, stable placements for children throughout South Carolina has been a significant challenge for DSS for many years. That challenge became acute in Richland County, and in October 2024, the Court ordered DSS to address high rates of placement instability through the creation of the Richland County Child Welfare Task Force and the development of an Improvement Plan.[82] As of January 2026, DSS and the Task Force have been engaged in addressing placement instability in Richland County as well as in other areas of the state for a full year. Many strategies have been developed and are being implemented. Though it is still too soon to assess the long-term effectiveness of some strategies, DSS is already deploying those strategies showing promise in Richland County to other parts of the state.

[82] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

1. Placement Instability

Placement Moves

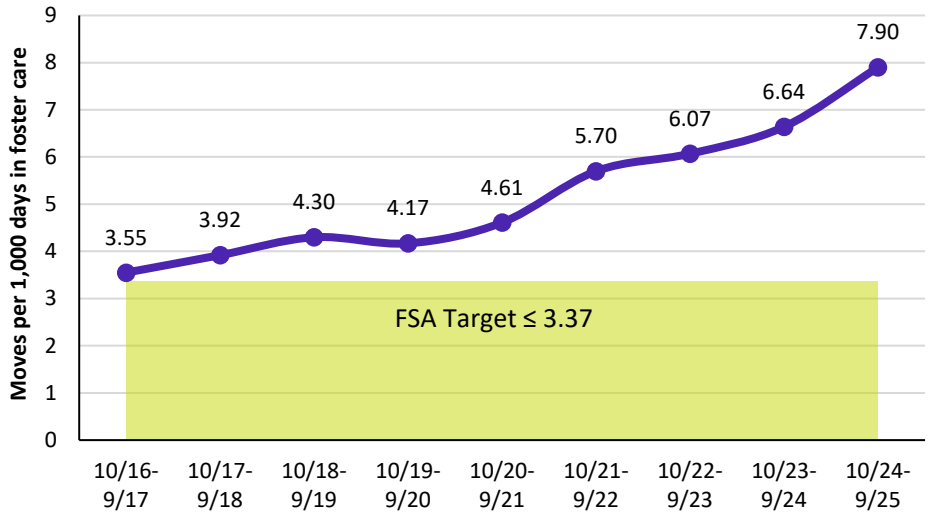
FSA Requirement	*For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37* (FSA IV.F.1.).
Performance Assessment	**FSA Requirement Not Met:** The annual 2024-2025 placement instability rate was **7.90**.

Section IV.F.1. of the FSA requires that the placement instability rate for all Class Members in foster care for eight days or more during the 12-month period be less than or equal to 3.37. Placement instability is defined as the rate of placement moves per 1,000 days of foster care (FSA II.O.). Placement moves are changes in foster care placements, excluding the removal to foster care, temporary absences from an ongoing placement (such as trial home visits), and moves occurring after a Class Member's 18th birthday (FSA II.N.).[83] Performance on this provision is reported annually for the period between October 1st and September 30th. The 2024-2025 placement instability rate was 7.90, meaning Class Members were moved an average of 7.90 times per 1,000 days in foster care (Figure 15). This is the largest increase in placement instability since the inception of the lawsuit and more than double the FSA target.

Figure 15. Placement Instability Rate

October 2024 – September 2025

CAPSS data provided by DSS



[83] Additionally, the re-designation of an emergency placement, that is not a congregate care placement, within 30 days as a long-term foster or therapeutic foster home when the child does not physically move is not considered a placement move (FSA IV.E.4-5.).

In addition to the annual placement instability rate, DSS reports the number of placement moves children experience during each monitoring period. Among children who were in foster care at any point between April 1, 2025 and September 30, 2025 (MP18), 53 percent of children (2,449 of4,616) remained stable in their placement with no placement move. Forty-seven percent of children (2,167 of 4,616) experienced at least one placement move, meaning they were in at least two placements during the six-month period (Figure 16). This is an increase over MP17 when 42 percent of children had at least one placement move. During the current monitoring period, older children were most likely to experience one placement move and to move two or more times (Figure 17). Black children were slightly more likely to have at least one placement move than children of other races.

Figure 16. Percentage of Children Experiencing Placement Moves, by Number of Moves

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

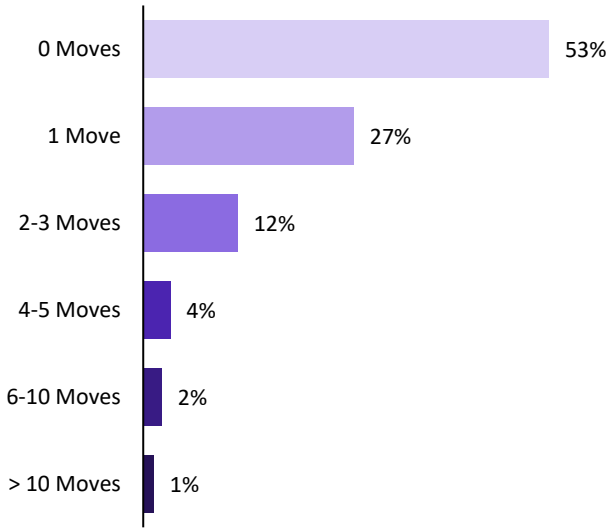
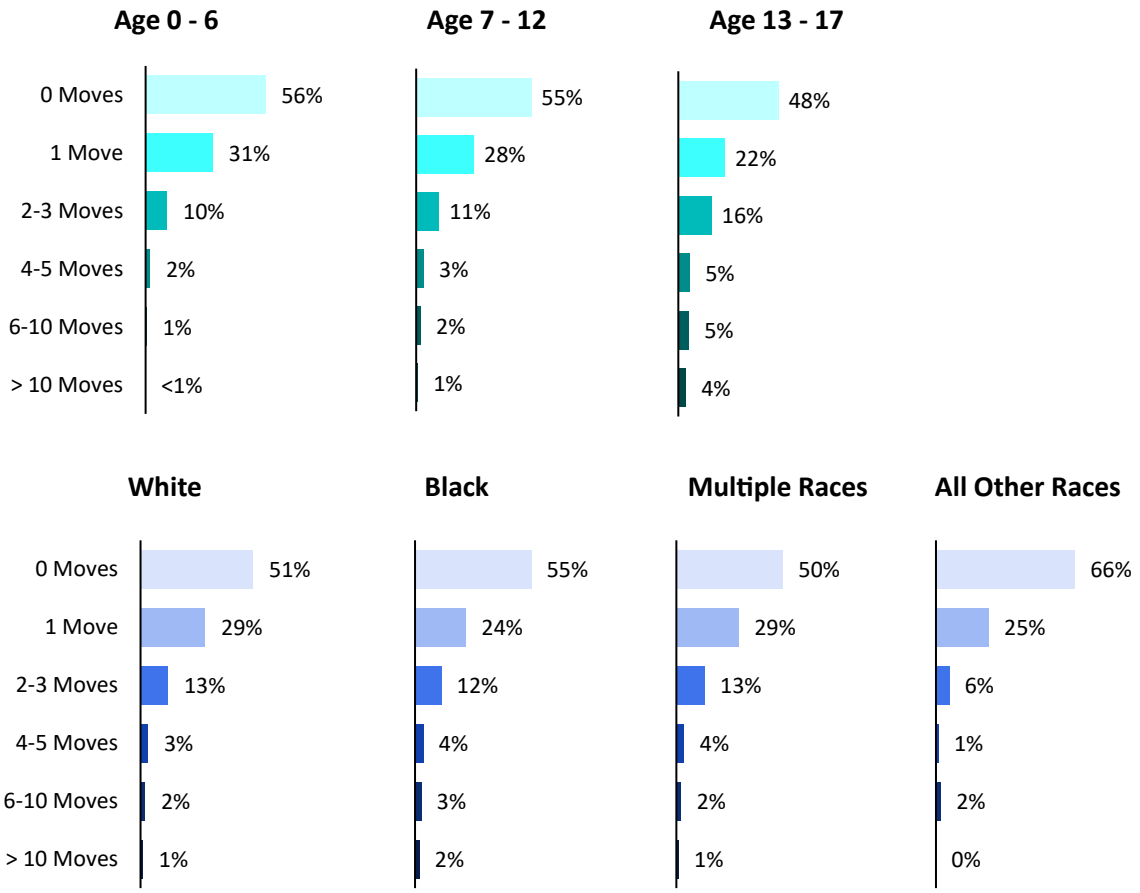


Figure 17. Placement Moves, by Age and Race[84,85]

MP18 (April – September 2025)

Source: CAPSS data provided by DSS



Data regarding placement moves were also analyzed by county. Among the 10 counties with the greatest numbers of children in foster care, children in Richland County had the highest number of placement moves (719) during MP18. Greenville County had the highest percentage of children experiencing at least one placement move (54%). In Richland County, the percentage was 45, an increase from MP17 when 33 percent of children had at least one placement move (Figure 18).[86]

[84] Hispanic or Latino identity is not shown as a separate category in this figure; children of Hispanic or Latino ethnicity are included within other racial categories. See *supra* note 63.

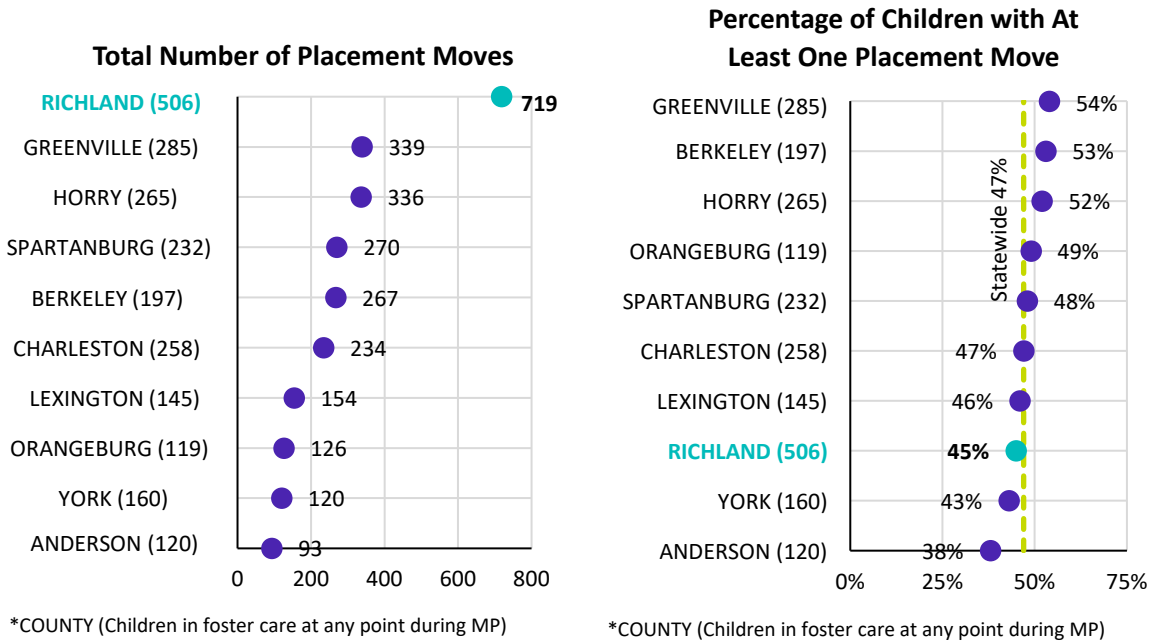
[85] "All Other Races" includes children identified as Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, or an unknown race.

[86] See Table 8 in Appendix D showing these data for all South Carolina counties.

Figure 18. Placement Moves, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS



Overnight Stays in DSS Offices and Hotels

FSA Requirement	[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.).
Performance Assessment	**FSA Requirement Not Met: 190** children spent a total of **622** nights in a DSS office, hotel, motel, or other commercial non-foster care placement.

The FSA requires DSS to cease using DSS offices as overnight placements for children. An "overnight stay" is defined as a minimum four-hour period in a DSS office, hotel, motel, or other commercial non-foster care establishment between the hours of 10:00 p.m. and 6:00 a.m.[87] Each night a child spends in a DSS office is counted as an overnight stay (e.g., if a child spends two consecutive nights in a DSS office, that is counted as two overnight stays.) DSS provides daily notification of any overnight stay to the Monitor and tracks overnight stays weekly, monthly, and by monitoring period.

Between April 1, 2025 and September 30, 2025 (MP18), 190 children had a total of 622 overnight stays in a DSS office or hotel, motel, or other commercial non-foster care establishment (Figure 19). This is a 12 percent decrease in the number of children and a 42 percent decrease in the number of overnight stays since MP17 when 216 children experienced 1,064 overnight stays. This decrease is the result of a dramatic decline in overnight stays during the last two months of the monitoring period (August—September 2025) when unlicensed cottages used for overnight placements were officially licensed by DSS (Figure 20).[88,89] While the performance target for this FSA requirement was not met, the State's efforts and improvement in reducing overnight stays toward the end of the monitoring period is noteworthy.

[87] Note, this currently operative definition of "overnight stay" is included in the Short-Term Plan to Address Overnight Stays, which was approved by the Court on March 23, 2022. See Joint Motion for Approval of Overnight Stay Plan (March 4, 2022, Dkt. 236) at pg. 3 and Order Approving Overnight Stay Plan (March 23, 2022, Dkt. 238).

[88] To become licensed, facilities must meet the following requirements, among others, establishment of formal policies and procedures, qualifications for staff employment, additional training, fire and sanitation, nutrition, and medication management.

[89] As noted in the Supplemental Richland County DSS Improvement Plan, when a child spends one night in an unlicensed cottage, it is considered an "overnight stay"; once these emergency, small capacity facilities become licensed as group homes, a child's placement at the facility is considered an "emergency placement" rather than an overnight stay. See Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

Figure 19. Overnight Stays

Number of unduplicated children who experienced an overnight stay and total number of overnight stays, MP10 – 18 (April 2021 – September 2025)

Source: CAPSS data provided by DSS

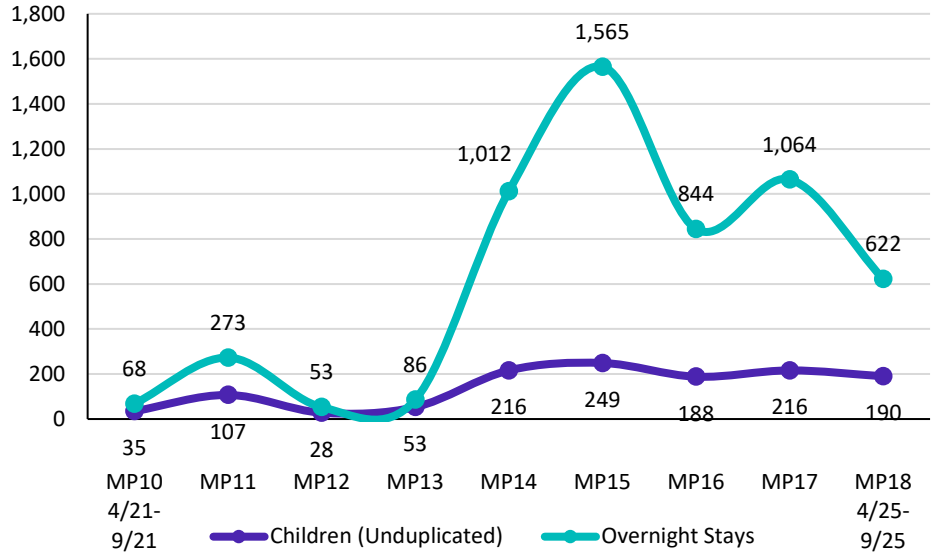
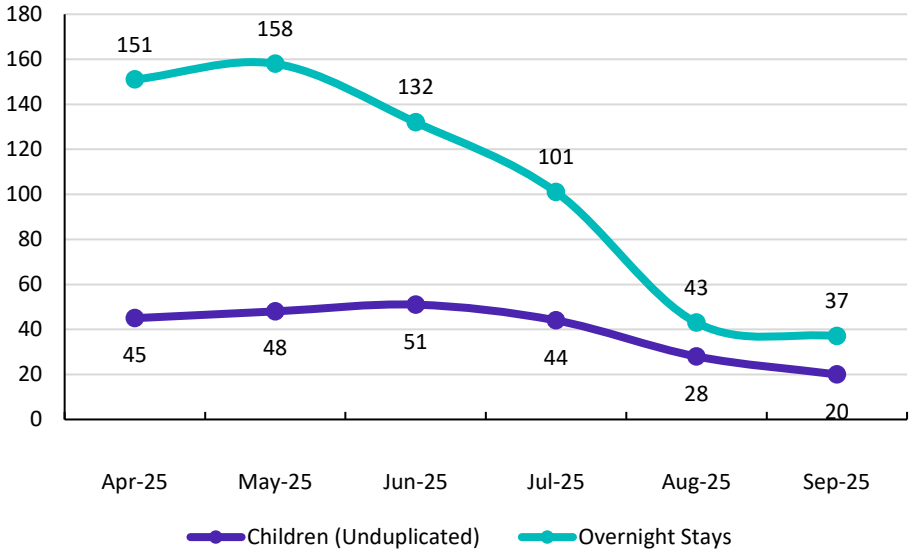


Figure 20. Overnight Stays During MP18, By Month

Number of unduplicated children who experienced an overnight stay and total number of overnight stays, MP18 (April – September 2025)

Source: CAPSS data provided by DSS

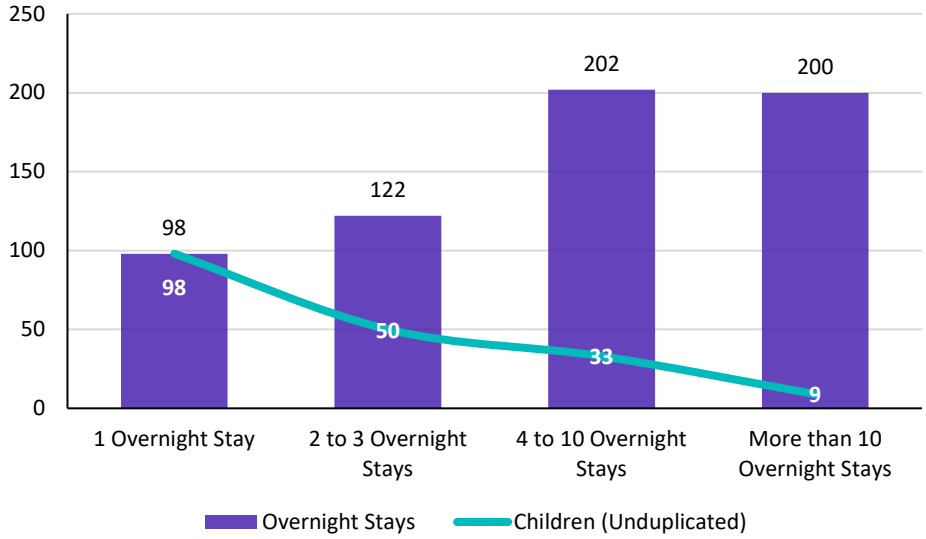


Overall, a small number of children accounted for a large portion of the total number of overnight stays. Children had between one and 42 overnight stays during the six-month period between April 1, 2025 and September 30, 2025. Among the 190 children who experienced an overnight stay during the monitoring period, nine children (5%) had more than 10 overnight stays. These nine children had a combined total of 200 overnight stays in a DSS office, which accounts for 32 percent (200 of 622) of all overnight stays during MP18 (Figure 21).

Figure 21. Distribution of Overnight Stays Experienced by Children

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

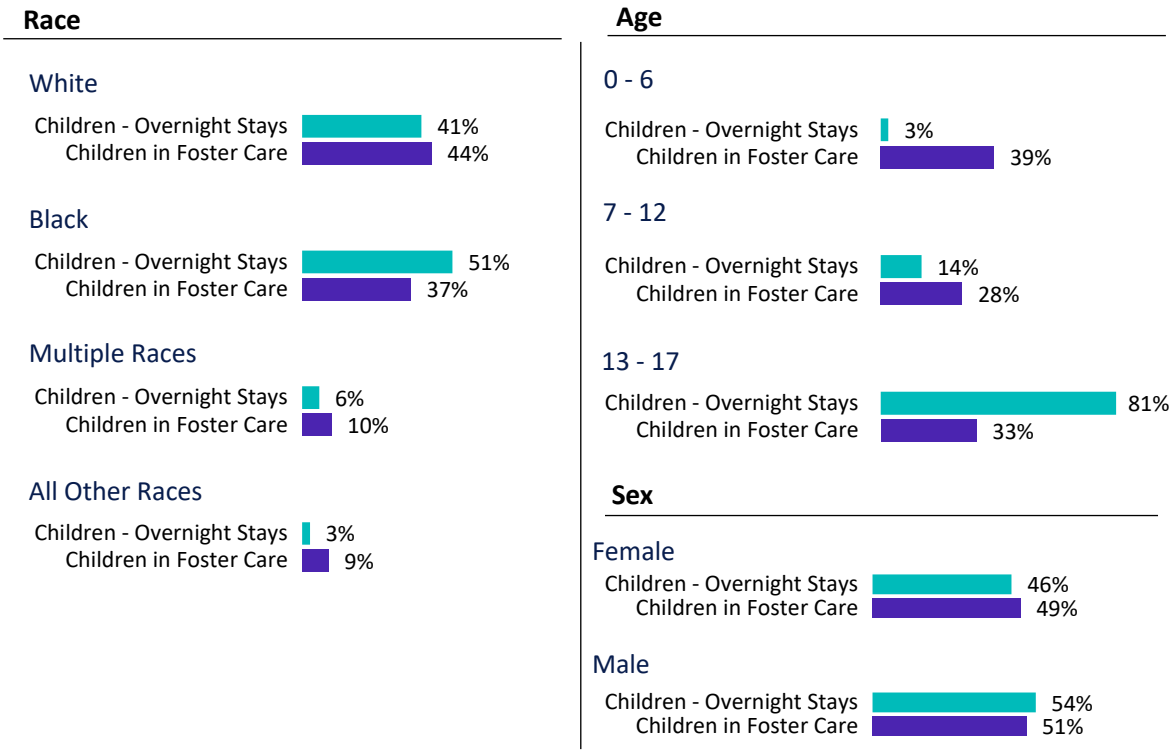


The majority of children who experienced an overnight stay during the monitoring period were aged 13 through 17 (81%) (Figure 22). Black children were overrepresented among children who had an overnight stay (51%) when compared to their proportion of South Carolina's foster care population (37%), and male children who had an overnight stay were slightly overrepresented (54%) compared to their proportion of the foster care population (51%).

Figure 22. Children who Experienced Overnight Stays, by Race, Age, and Sex[90,91]

MP18 (April – September 2025) compared to the state foster care population on September 30, 2025

Source: CAPSS data provided by DSS



Data regarding overnight stays were also analyzed at the county level. Among South Carolina's 10 counties with the largest foster care populations, Richland County had the highest total number of overnight stays (189) during Monitoring Period 18 (April – September 2025), a decrease from MP17 when there were a total of 427 overnight stays (Figure 23).[92] In MP18, Berkeley County had the highest percentage of children (10%) who experienced an overnight stay followed by Richland County (7%).

[90] Hispanic or Latino identity is not shown as a separate category in this figure; children of Hispanic or Latino ethnicity are included within other racial categories. See *supra* note 63.

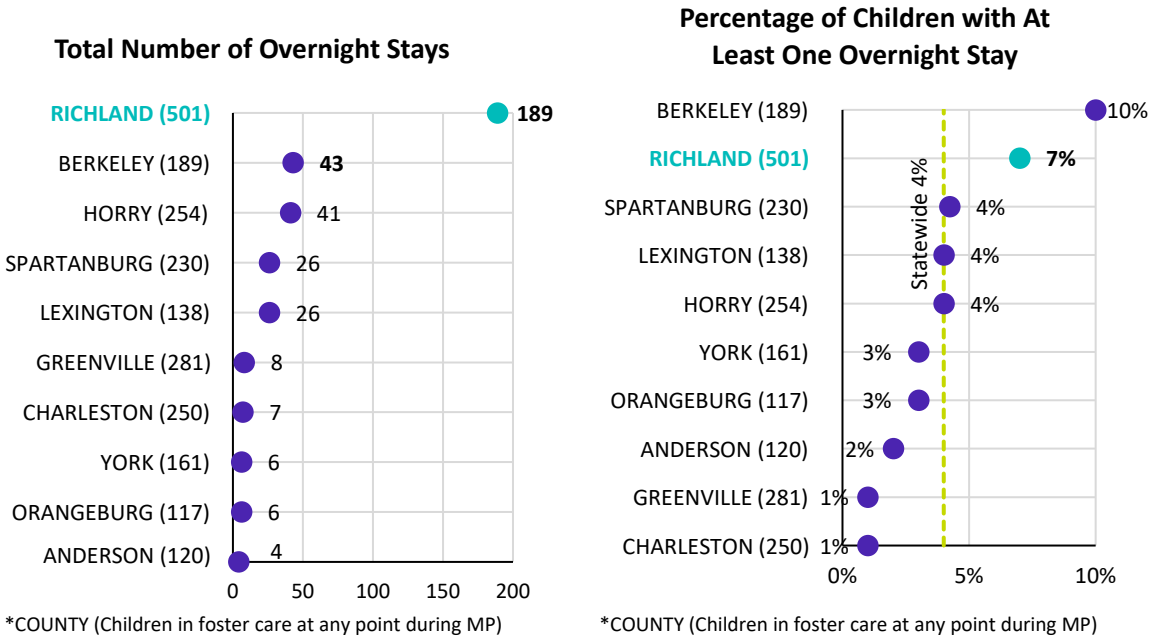
[91] "All Other Races" includes children identified as Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, or an unknown race.

[92] See Table 9 in Appendix D showing these data for all South Carolina counties.

Figure 23. Overnight Stays, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS



Emergency Placements

FSA Requirements	*Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days* (FSA IV.E.4.) [and] C*lass 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.).
Performance Assessment	**FSA Requirements Not Met: Six** children experienced an initial emergency placement lasting more than 30 days, and **149** children experienced subsequent emergency placements within 12 months lasting more than seven days.

An emergency placement is any licensed foster care placement used as a short-term placement for a child when all efforts to identify a permanent, long-term placement have been

unsuccessful.[93] The FSA places time limits on the use of emergency placements, including limiting initial emergency placements to 30 days or less and subsequent emergency placements to seven days or less.[94]

Overall, 13 percent of children (606 of 4,616) who were in foster care at any point during MP18 (April - September 2025) had an emergency placement. In total, these 606 children had 1,634 emergency placements and spent 7,677 nights in those placements (Figure 24). This is an increase from the prior monitoring period when 11 percent of children (515 of 4,509) had 1,457 emergency placements and is a significant increase (13%) in the total number of nights (6,802) spent in emergency placements.

With regard to the specific FSA requirements, of the 606 children who experienced an emergency placement in MP18, six had initial emergency placements lasting longer than 30 days, a decrease from MP17 when 10 children had initial emergency placements lasting more than 30 days. Among the 606 children who had an emergency placement during MP18, 149 children had more than one emergency placement within the prior 12 months that lasted more than seven days, a slight increase over MP17 when the number was 137 children. The State did not meet either FSA target related to emergency placements in MP18.

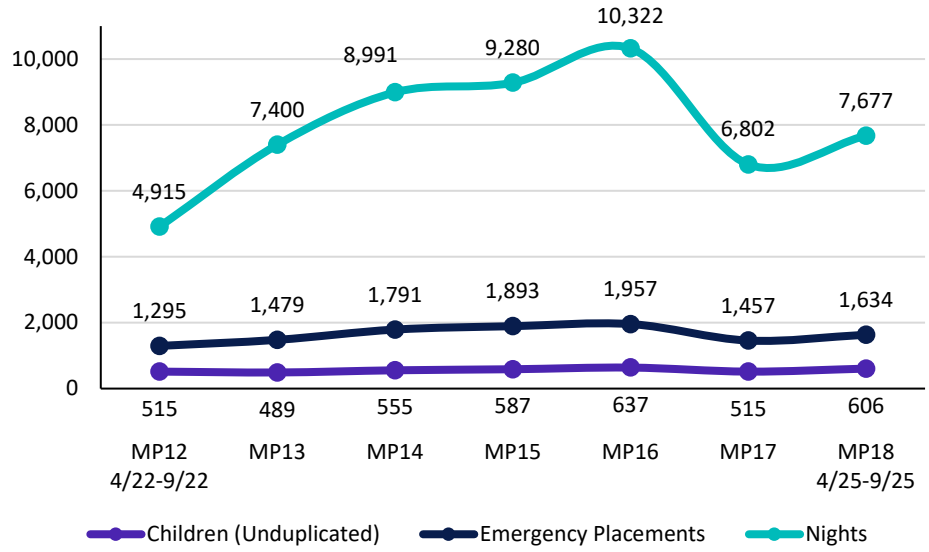
[93] DSS's policy defines an emergency placement as a short-term placement that is only utilized after all efforts have been made to identify a permanent long-term placement and those efforts were unsuccessful. This currently operative definition differs from the definition provided in Section II.H. of the FSA, which is "an emergency shelter or other placement used as an emergency or temporary facility to house children as described by Human Services Policy and Procedure Manual § 817." The current definition is included in Chapter 5: Foster Care, Policy 510.2.4: Non-Kin Family Foster Home Placement of DSS's Child Welfare Services Manual and is referenced in DSS's court filings related to the Richland County DSS Improvement Plan. See Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23,2024, Dkt. 339) at pg. 4; see also Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365) at pg. 7.

[94] For the purposes of this measure, emergency placements that are re-designated within 30 days as a long-term foster home or therapeutic foster home are excluded (FSA IV.E.4-5.).

Figure 24. Emergency Placements

Number of children who experienced an emergency placement, number of emergency placements, and total number of nights spent in emergency placements, MP12 – 18 (April 2022 – September 2025)

Source: CAPSS data provided by DSS

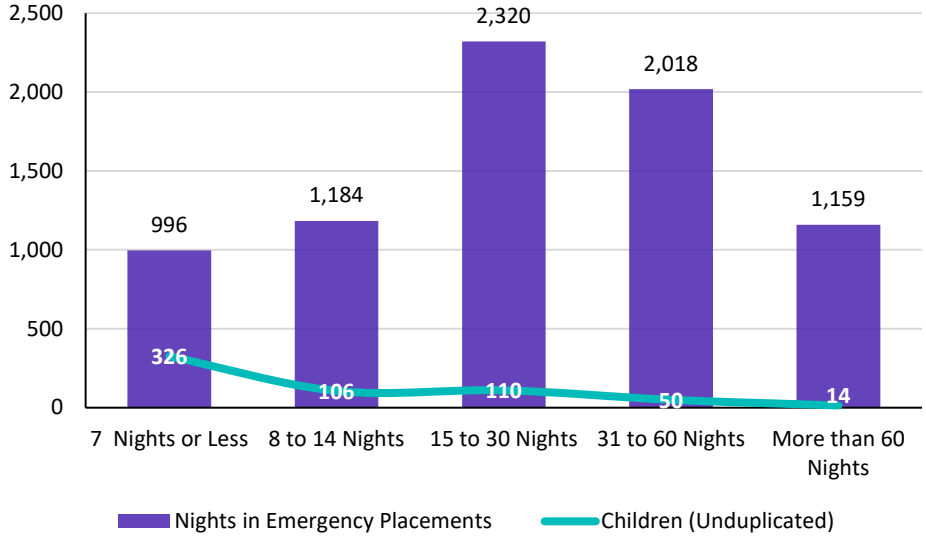


Children spent between one and 141 nights in emergency placements during MP18. Fourteen children experienced more than 60 nights in emergency placements, with a combined total of 1,159 nights. These 14 children made up two percent of those who were in emergency placements but accounted for 15 percent of the total number of nights spent in emergency placements during the monitoring period (Figure 25).

Figure 25. Distribution of Nights Children Spent in Emergency Placements

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

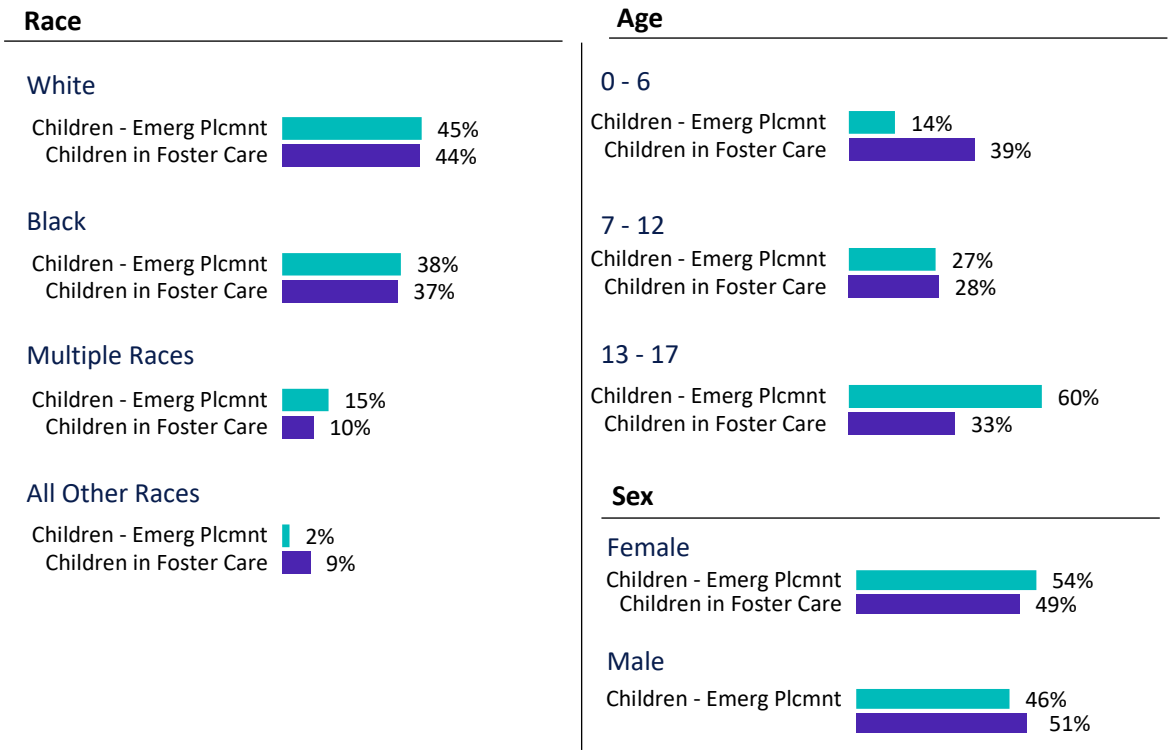


The majority of children who experienced an emergency placement during the monitoring period (April – September 2025) were aged 13 through 17 (60%) (Figure 26). Female children and children of multiple races were overrepresented when compared to their proportion of South Carolina's foster care population.

Figure 26. Children who Experienced Emergency Placements, by Race, Age, and Sex[95,96]

MP18 (April – September 2025) compared to the state foster care population on September 30, 2025

Source: CAPSS data provided by DSS



Data regarding the use of emergency placements were also analyzed at the county level. Among South Carolina's 10 counties with the largest foster care populations, Richland County had the greatest total number of nights children spent in emergency placements (1,219) during the monitoring period (April – September 2025) but did not have the highest percentage of children who experienced at least one emergency placement (18%) (Figure 27).[97] Spartanburg County and Greenville County both had higher percentages of children who had emergency placements, at 21 percent and 20 percent respectively. These data suggest that although Richland County usage of emergency placements is high, the use of emergency placements is also a problem in other counties.

[95] Hispanic or Latino identity is not shown as a separate category in this figure; children of Hispanic or Latino ethnicity are included within other racial categories. See *supra* note 63.

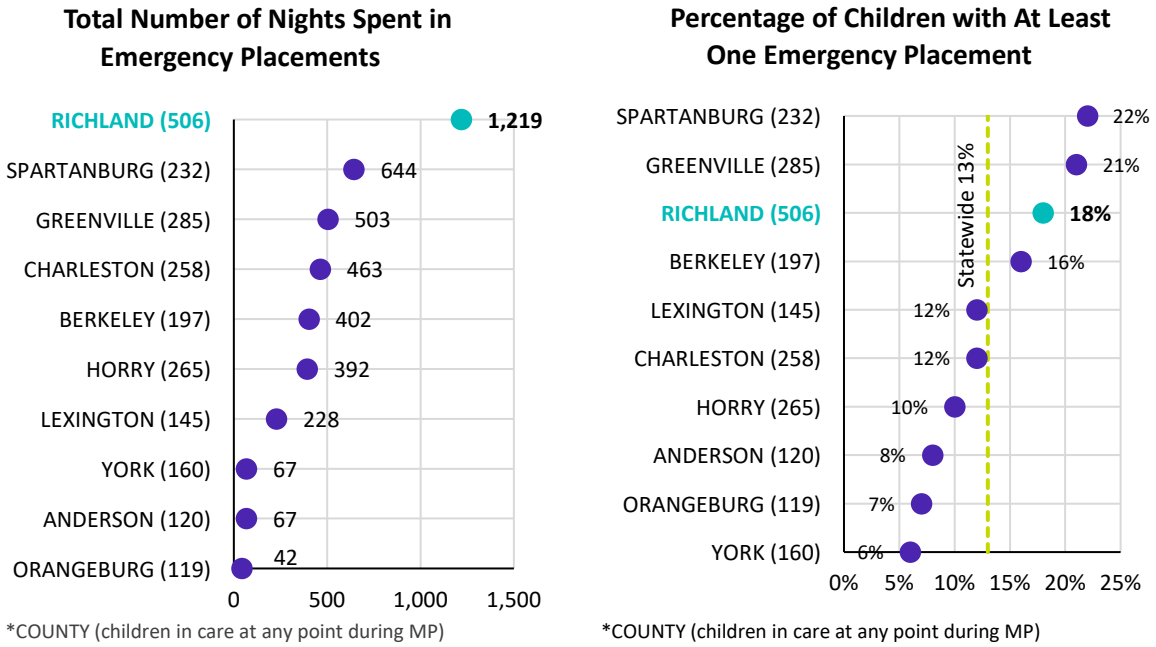
[96] "All Other Races" includes children identified as Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, or an unknown race.

[97] See Table 10 in Appendix D showing these data for all South Carolina counties.

Figure 27. Emergency Placements, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS



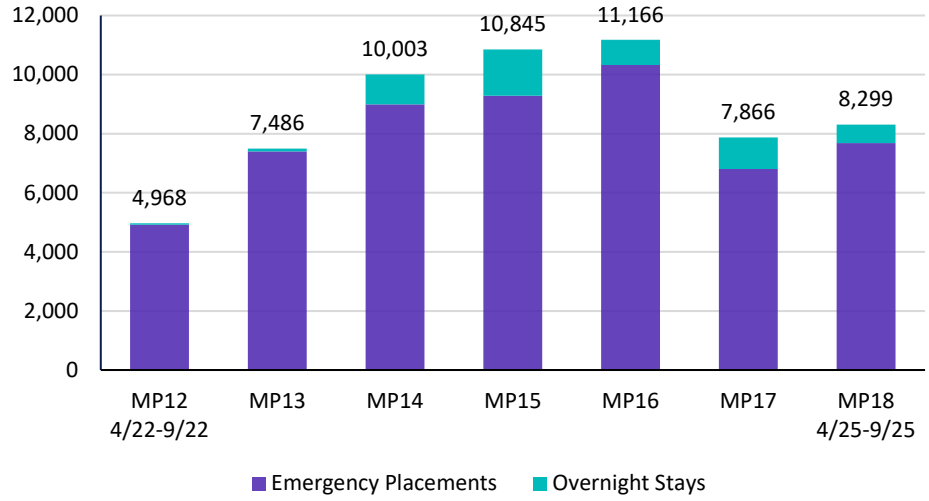
Short-Term Placements

The FSA has distinct requirements regarding overnight stays and emergency placements; however, in practice, children often experience these "short-term placements" interchangeably and/or successively. For example, a child may move from a DSS office to an emergency placement or between a series of emergency placements while staff search for, and children await, appropriate and stable placements. Data regarding the combined use of overnight stays and emergency placements as unplanned, short-term placements for children were also analyzed. In MP18 (April – September 2025), despite the 42 percent decline in the number of overnight office stays, the total number of nights children spent in a short-term placement increased by six percent, climbing from 7,866 total nights in MP17 to 8,299 nights MP18 (Figure 28). While it bears noting that this number is considerably lower than in MP16 (April 2024 – September 2024) when children spent 11,166 nights in short-term placements and that the use of licensed emergency placements is preferable to children spending overnights in DSS offices and other unlicensed settings, DSS's overall use of short-term placements remains unacceptably high.

Figure 28. Number of Nights Children Spent in Short-Term Placements

Combined overnight stays and emergency placement nights, MP12 - 18 (April 2022 – September 2025)

Source: CAPSS data provided by DSS

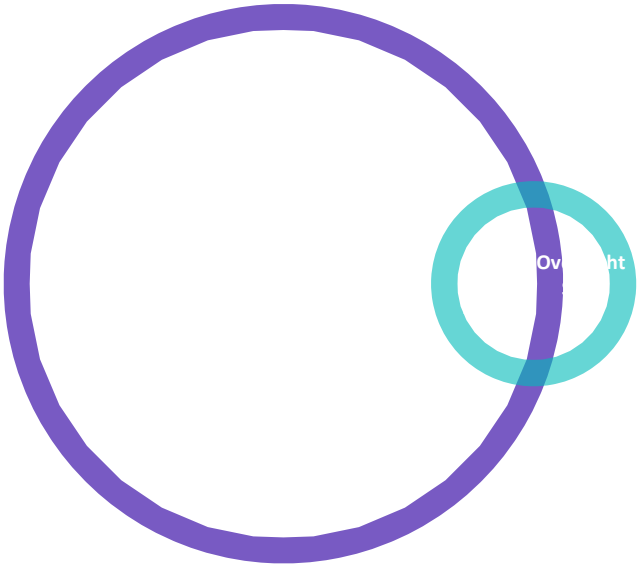


Over the course of Monitoring Period 18 (April – September 2025), 665 children experienced short-term placements, 131 (20%) of whom experienced both an emergency placement and an overnight stay (Figure 29). Those 131 children represent 69 percent of the total number of children (131 of 190) who had an overnight office stay during MP18. In other words, 69 percent of children who had an overnight stay also experienced an emergency placement during the monitoring period. DSS's ADR analyzed the "placement paths" of children with overnight stays during MP18 and found that 66 of the 190 children (35%) who had an overnight stay were in an emergency placement immediately prior to the overnight stay and 119 (63%) were moved to an emergency placement immediately following the overnight stay.

Figure 29. Children who Experienced an Overnight Stay, an Emergency Placement, or Both

MP18 (April – September 2025)

Source: CAPSS data provided by DSS



Discussion

High rates of placement instability are a pronounced challenge across South Carolina's foster care population, including in Richland County. The 2024-2025 placement instability rate climbed to 7.90, meaning Class Members were moved an average of 7.90 times per 1,000 days in care. This is both the highest instability rate and the largest one-year increase since the inception of the lawsuit.

During the six-month monitoring period (April – September 2025), 47 percent of children had at least one or more placement moves, an increase over MP17 (October 2024 – March 2025) when the number was 42 percent. Although there was a dramatic 42 percent decline in the number of nights children spent in DSS offices since the prior monitoring period, there was a 13 percent increase in the number of nights children spent in emergency placements and an overall increase of six percent in the combined number of nights children spent in unplanned, short-term placements (overnight stays and emergency placements). These data confirm that high placement instability is unabated throughout the state and in Richland County. However, DSS's ability to greatly reduce the total number of overnight stays in the Richland County DSS office may be an early indicator of positive, interim progress in ameliorating placement instability.

As acknowledged in the State's Supplemental Richland County DSS Improvement Plan, addressing placement instability in Richland County and throughout the state is necessarily a multi-pronged

effort.[98] The Plan relies on shorter-term strategies to slow the revolving door of inappropriate, short-term placements that are detrimental to children and untenably taxing on DSS staff, private providers, and the system as a whole. These strategies include ending the use of emergency placements of 12-hours or less, making rapid response interventions available 24/7 to children experiencing behavioral crises, holding family stabilization meetings to identify needed support services to help stabilize placements that are at risk of disruption, creating Welcome and Assessment Centers to provide short-term, structured 24-hour care to up to six children experiencing placement instability to help them stabilize and transition to longer-term placements, licensing small capacity group homes to provide longer-term care to up to three children who have specialized care needs, with the goal of stabilizing the child so they can then be successful in a less restrictive placement setting.[99]

The dramatic decline in the number of overnight stays in Richland County, and consequently throughout the state, in August and September 2025 when the new Welcome Center and small-capacity group homes became licensed, indicates that these strategies are beginning to show effectiveness in moderating the intensity of the placement instability crisis in Richland County. Assessing their implementation and outcome going forward will remain important.

Though providing some optimism for the future, these strategies mostly provide short-term fixes and on their own will not resolve the placement instability crisis. Equally important are the state's longer-term strategies to prevent children from entering foster care unnecessarily and, for those children who must enter foster care, ensure the availability of a robust array of well-supported kin and non-kin placements that can meet children's needs in the least-restrictive and most family-like setting. Strategies within the Supplemental Plan aimed to prevent unnecessary entries into foster care outline the development and use of protocols between DSS and law enforcement agencies in Richland County, including making available a DSS law enforcement liaison to provide consultation to law enforcement officers in the field, quickly deploying staff when needed, supporting the convening of a Removal Prevention Child and Family Team Meeting, and designating staff for Family Search and Engagement efforts to identify kin who may be able to provide care and support to children, helping to prevent children's entry into foster care.[100] Strategies to increase the placement array include collaborating with a CPA to pilot a "professional foster parent model" and engaging with CPAs to develop targeted plans to recruit more foster families in Richland County. As a result of targeted recruitment, child placing agencies (CPAs) recruited and licensed 33 new therapeutic foster homes and two regular foster homes in Richland County between June and September 2025; additionally, DSS licensed a total of 27 new kin and regular foster homes in Richland County during the same timeframe.[101]

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[98] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).
[99] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt.378).
[100] Ibid.
[101] Ibid.

As DSS uses these and other strategies to address placement instability in Richland County and begins to deploy them in other parts of the state, it will be important to engage in active and ongoing CQI to determine which strategies are proving effective, why they are effective, what inputs and conditions support their success, and how the strategies can be adapted with partners in other communities. Additional progress on the full implementation of the GPS Case Practice Model will also be essential to longer-term achievement of results. Finally, continued partnership with private providers throughout the state and with the Medicaid and behavioral health system to expand the availability of community-based services for children and families remains vital.

2. Placement of Children in Family-Like Settings

FSA Requirement	*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.).
Performance Assessment	**FSA Requirement Met**: **86%** of children resided in family-like placements.

The FSA requires that 86 percent of Class Members be placed outside of congregate care placements on the last day of the monitoring period. On September 30, 2025, 86 percent of Class Members (2,837 of 3,286) were placed in family-like settings and outside of congregate care (Figure 30).[102] The State met the final FSA target in MP18 (April – September 2025), as it has done each monitoring period since MP10. This provision may be eligible for Maintenance of Effort designation.

FSA Requirement	*At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file* (FSA IV.E.3.).
Performance Assessment	**FSA Requirement Met**: **98%** of children aged 12 and under resided in family-like placements.

The FSA requires that at least 98 percent of Class Members aged 12 and under be placed outside of congregate care placements on the last day of the monitoring period, unless an exception approved by the Monitor is documented in the Class Member's case file.[103] The Court granted

[102] Children residing in other institutional settings on the last day of the monitoring period are excluded from the universe. On the last day of MP18, 31 children resided in other institutional settings; 17 were in DJJ or other correctional facilities; and 14, including 7 children aged 12 or under, were in non-temporary (30-days or more) hospital settings. Children in emergency placements on the last day of the monitoring period are categorized as residing in family-like placements, and children experiencing an overnight stay in a DSS office, hotel, motel, or other commercial non-foster care establishment are categorized as residing in congregate care.

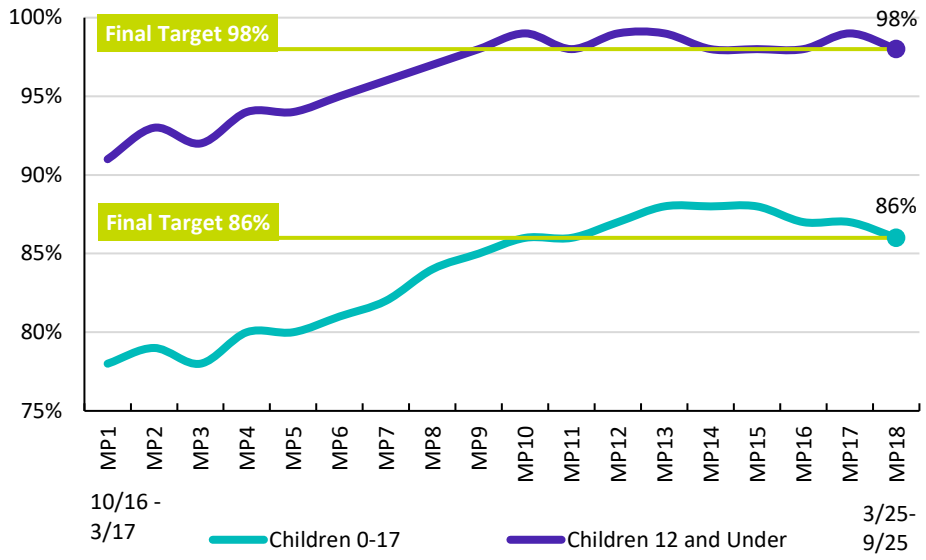
[103] The Monitor has approved the following exceptions to the requirement that children aged 12 and under be placed outside of congregate care: (1) the child has clinical and medical needs that can only be met in a congregate care setting; (2) the child is the son or daughter of another child placed in a group care setting; (3) sibling group 4 or larger; and (4) the child has been removed and is in the legal custody of DSS and is placed with a parent who is not in DSS custody but who is temporarily in a residential group setting for treatment (DSS Placement Implementation Plan, pg. 55). Additionally, per DSS policy, placement of a child aged 12 and under in a congregate care placement pursuant to an approved exception requires prior approval of a Regional Director (SCDSS Child Welfare Services Manual, Chapter 5: Foster Care, Policy 511: Group Care Utilization Management (effective February 28, 2025, pg. 2).

Maintenance of Effort status for this provision on October 18, 2024.[104] Subsequently, DSS met the final performance target in MP16 and MP17 and continued to meet the target in MP18. On September 30, 2025 (the last day of MP18), 98 percent of Class Members aged 12 and under (2,186 of 2,228) resided in a family-like setting and outside of a congregate care placement (Figure 30).[105] On December 17, 2025, the Court granted the Parties' Joint Motion for Termination and Exit from Court supervision on this FSA provision.[106] Consequently, performance on this requirement will no longer be monitored or included in future reports.

Figure 30. Placement of Children in Family-Based Settings

MP1 – 18 (March 31, 2017 - September 30, 2025)

Source: CAPSS data provided by DSS



While the FSA does not include targets for the placement of children aged 13 to 17 outside of congregate care settings, data have consistently shown that children in this age range are far more likely than younger children to be placed in congregate settings and at high rates. On September 30, 2025, 38 percent of children aged 13 to 17 (398 of 1,058) resided in a congregate care facility. This number is consistent with prior monitoring periods. Since the period ending September 30, 2021 (MP10), the percentage of children aged 13 to 17 placed in congregate care on the last day of the monitoring period has ranged from 33 percent to 38 percent.

[104] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).
[105] On the last day of MP18, 9 children aged 6 and under were placed in congregate care pursuant to a valid exception. All 9 resided with their parent in a residential facility.
[106] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

FSA Requirement	*[P]revent…, 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)* (FSA IV.D.2.).
Performance Assessment	**FSA Requirement Met**: No child aged six or under was placed in a non-family group placement without a valid exception.

The FSA requires DSS to prevent, with approved exceptions, the placement of children aged six and under in non-family group placement.[107] The Court granted Maintenance of Effort status for this provision on October 18, 2024.[108] DSS met the final performance target in MP16 and MP17 and continued to prevent the placement of children aged six and under in non-family settings between April 1, 2025 and September 30, 2025 (MP18). All 19 children aged six and under who resided in congregate care at any point during MP18 were placed in those settings pursuant to a valid exception.[109] On December 17, 2025, the Court granted the Parties' Joint Motion for Termination and Exit from Court supervision on this FSA provision.[110] Consequently, performance on this requirement will no longer be monitored or included in future reports.

Placement with Kin

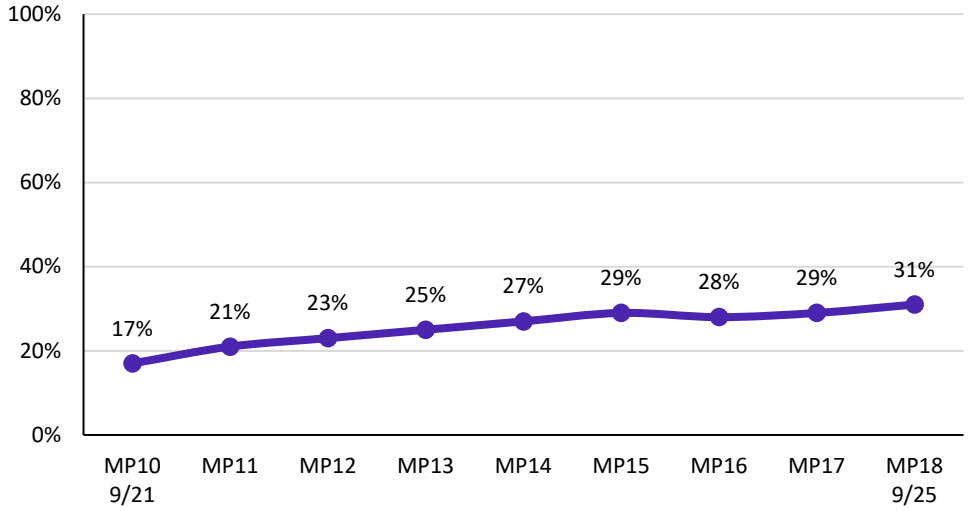
DSS has identified that placing children with kin and increasing financial and other supports provided to children and their kin caregivers is an important strategy to improve children's stability and well-being and to reduce the use of congregate care placements. Kin placements have, for the most part, incrementally increased each monitoring period. On September 30, 2025 (the last day of the monitoring period), 31 percent of children in foster care were placed with kin (Figure 31), a dramatic increase since September 30, 2019, when eight percent of children were placed with kin.[111]

[107] *Supra* note 103.
[108] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).
[109] All 19 children were residing with their parent in a congregate care facility.
[110] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).
[111] DSS has also prioritized licensing kinship placements, because licensed homes are eligible for full foster care board payments while unlicensed kinship homes are not eligible for board payments. Prior monitoring reports have included kinship licensure rates; however, these data are not included in this revised MP18 report. The availability and reliability of kinship licensure data was affected when DSS began to use Binti to manage the foster care licensing process in late July to early August of 2025. DSS has been unable to provide kinship licensure data since that time due to ongoing data integration issues between Binti and CAPSS.

Figure 31. Percentage of Children Placed with Kin

MP10 – 18 (September 2021 – September 2025)

Source: CAPSS data provided by DSS



Discussion

DSS has met three of the FSA requirements related to the placement of children in foster care in family-like settings for this monitoring period (April 2025 – September 2025). On September 30, 2025, 86 percent of children aged 17 and under (FSA IV.E.2.) and 98 percent of children aged 12 and under (FSA IV.E.3.) resided in family-based placements, and no child aged six or younger resided in a non-family group placement without a valid exception (FSA IV.D.2.). The Court granted Maintenance of Effort status for the latter two provisions on October 18, 2024, and on December 17, 2025, after the State continued to meet these FSA targets for two additional monitoring periods, the Court granted the Parties' Joint Motion for Termination and Exit from Court supervision on these FSA provisions.[112]

DSS has continued to prioritize the development of its kinship foster care program, recognizing that kin foster care placements often keep children in and/or connected to their communities of origin (Figure 9), help to reduce the trauma associated with removal, provide greater placement stability, and increase the likelihood of siblings being placed together; these kin placements also lead to fewer instances of institutional abuse and repeat maltreatment, and improve mental and behavioral health and educational stability. As part of the effort to move toward a kin-first culture, DSS advanced statutory amendments enabling it to streamline licensing and approval standards for kin caregivers. Kin caregivers who are licensed or approved are eligible to receive payments equal to those received by non-relative foster parents.

[112] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

The statutory amendments were needed to take advantage of a September 2023 change in federal regulations allowing state child welfare agencies to utilize separate licensing and approval standards for kin placements and receive Title IV-E federal reimbursement for foster care board payments on behalf of otherwise eligible children who are placed in those homes.[113] Before the rule change, state child welfare agencies could only claim Title IV-E reimbursement for foster care board payments if the agency applied the same licensing or approval standards to kin and non-relative foster homes. Throughout the monitoring period and in the months that followed, DSS worked to achieve the necessary changes to adopt the use of separate licensing and approval standards for kin foster homes in South Carolina. Those steps included securing the General Assembly's passage of statutory amendments and approval of the associated state regulations and obtaining federal approval of the kin-specific standards. The Kin Specific Licensing and Approval regulations were presented to the General Assembly in January 2025 and received approval on May 8, 2025. The necessary statutory amendments were introduced in Senate Bill 415 on March 4, 2025, passed by the Legislature on February 11, 2026, and signed into law by Governor McMaster on February 27, 2026. [114] As of that date, kin caregivers across South Carolina who are approved using the kin-specific standards are entitled to receive the same board payment that is provided to licensed foster parents. Additionally, on November 21, 2025, DSS was notified by the U.S. Children's Bureau that its State's Title IV-E plan amendment to adopt separate licensing standards for relative and kin homes had been approved, allowing South Carolina to claim Title IV-E federal financial participation for the cost of foster care maintenance payments on behalf of an otherwise eligible child placed with kin approved under the kin-specific standards.[115] With the necessary amendments and approvals in place, the kin-specific licensing standards, which were in the process of being piloted in select counties, were applied statewide on March 2, 2026.

While the necessary amendments and approvals were pending, DSS began to pilot the kin-specific approval standards on September 15, 2025, with an initial, phase one focus on Aiken, Fairfield, Lexington, Saluda, and York counties within the Midlands region. Phase two began in January 2026, and included the remaining Midlands region counties: Bamberg, Barnwell, Chester, Edgefield, Kershaw, Lancaster, and Richland as well as Midlands Regional Permanency. Through the pilot, kin who were willing to go through the approval process were assessed using the new standards, and those who were approved, whether provisionally or fully, received the same board payment provided to licensed foster parents. The pilot showed promising results. During the pilot, DSS reported an increase in the number of referrals of kin placements for licensure and as of March 2026, 22 provisional licenses had been issued using the kin-specific standards. DSS also reported that the time it takes for families to become licensed has decreased from a range of 90

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[113] For information on separate licensing/approval standards for relative or kin family foster homes, see: https://www.federalregister.gov/documents/2023/09/28/ 2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes.

[114] See 415, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/bills/415.htm and S. 598, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/prever/598_20250423a.htm.

[115] Letter from Joseph J. Bock, Acting Associate Commissioner, Children's Bureau, to Tony Catone, State Director, SCDSS, approving title IV-E plan amendment adopting separate licensing standards for relative and kin foster homes (November 21, 2025).

to 120 days prior to the pilot to 75 to 90 days during the pilot. With the passage of Senate Bill 415, any unlicensed kin placement may now pursue licensure under the kin-specific standards. DSS reports that its regional Foster Family and Licensing Support offices are working in conjunction with county DSS offices to outreach to families regarding the kin-specific standards and the benefits of being licensed, and families who are interested are referred for provisional licensure while they complete the process.

As the State continues to grapple with high rates of placement instability, it is important that it has measures in place to guard against moving back towards overreliance on congregate care for children of all ages. As noted, the FSA does not include specific targets for the placement of children aged 13 to 17 outside of congregate care settings. However, children in this age range are placed in congregate care at unacceptably high rates, with nearly 90 percent of these placements located outside of the child's county of origin as of September 30, 2025 (Figure 9). Children aged 13 to 17 are also more likely to experience placement instability than younger children. Further, while the FSA does not require specific targets for placement of children aged 13 to 17 outside of congregate care settings, it does require—through provisions related to therapeutic foster care placement and services—that placement recommendations for children of all ages who have been identified as needing therapeutic placement and/or services be "driven by the least restrictive, most normalized care philosophy suitable to a child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections" (FSA IV.I.2.).[116] To increase the number of foster homes and therapeutic foster homes for youth aged 13 – 17, DSS reported that it is expanding targeted recruitment efforts beyond Richland County to Greenville, Charleston and Horry counties. The initial goal across the three counties is to recruit a total of 20 TFC and 10 regular foster homes specifically for older youth.

[116] See *Section IV.A.4. Therapeutic Placements* of this report for further discussion.

3. Juvenile Justice Placements

FSA Requirement	*When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement* (FSA IV.H.1.).
Performance Assessment	**Not Reported**: Performance data are not available.

The FSA prevents DSS from recommending to the family court or Department of Juvenile Justice (DJJ) that a Class Member remain in juvenile justice detention or another juvenile justice placement without pending charges or beyond the term of the Class Member's plea or adjudicated sentence because DSS does not have a foster care placement for the Class Member. The FSA further requires DSS to take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea and provide for the Class Member's appropriate placement.

Due to the lack of tracking data regarding these requirements, the Monitor has historically had to rely on reports from community members and limited information from DSS about practice and performance related to this FSA requirement.[117] Because of the lack of data, the Monitor is unable to assess DSS's performance on this FSA measure during MP18. The Monitor expects to reopen discussion with DSS and DJJ on obtaining data to assess performance on this requirement during this next monitoring period.

Discussion

During the monitoring period, DSS and DJJ reaffirmed a Memorandum of Understanding (MOU), that seeks to achieve the best outcomes for children who are dually involved with DSS and DJJ through timely communication and information sharing at critical decision-making points within the child protective services and juvenile justice processes.[118]

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[117] In November 2022, the Co-Monitors and DSS, with the South Carolina DJJ's permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children involved with both DSS and DJJ. To view the report, including key findings and recommendations, see: https://cssp.org/wp-content/uploads/2025/03/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf.

[118] Memorandum of Understanding Between the South Carolina Department of Social Services and the South Carolina Department of Juvenile Justice for the Sharing of Information, executed on August 8, 2025.

As part of the Community Action Workgroup of the Richland County Task Force, DSS and law enforcement agencies in Richland County agreed to protocols that outline a collaborative process to prevent unnecessary removals of children from their families.[119] The protocol includes the 24/7 availability of a DSS Law Enforcement Liaison to provide consultation to law enforcement officers in the field, quick deployment of DSS staff when needed, and support in the convening of a Removal Prevention CFTM. DSS reported that from September 2025 through February 2026, Richland County conducted 68 Removal Prevention CFTMs involving 104 children brought to DSS's attention by law enforcement. Of those, 30 CFTMs were successful in preventing foster care entry for 51 children (49%). DSS has also informed the Monitor that it is actively working to scale county-level protocols with law enforcement statewide. As of the writing of this report, DSS has 59 signed MOUs with local law enforcement agencies across the state and another seven in process.

DSS also continues to hold Removal Prevention CFTMs in Greenville, Anderson, and Spartanburg counties as part of its Teaming for Teens work to reduce the number of unnecessary entries of DJJ-involved children into foster care, which can include entries due to EPCs by law enforcement and the DJJ court.[120] DSS reported that between September 1, 2025 and January 31, 2026, a total of 78 Removal Prevention CFTMs involving 99 children in those counties had been completed, and 71 of those children (72%) did not enter foster care during the 30-day period following the CFTM.

[119] DSS and Law Enforcement Protocol with Richland County Sheriff's Department executed on May 6, 2025, and DSS and Law Enforcement Protocol with City of Columbia Police Department executed on May 28, 2025.
[120] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378).

4. Therapeutic Placements

FSA Requirement	*At least 95% of Class Members that are both identified through an approved CANS (with fidelity to the CANS model) as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) (with fidelity to the CFTM model) will be referred for such recommended placement and/or services within 30 days of the date of the CFTM. The recommendation(s) may include but are not limited to diagnostic assessment; community support services; rehabilitative behavioral health services; therapeutic foster care; moderate, enhanced, or QRTP levels of group care; and placement in a psychiatric residential treatment facility. If a non-family-based placement is recommended, it shall identify why the youth's needs cannot be met in a family setting. The placement recommendation shall be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections. If a Class Member is placed in congregate care because a less restrictive, family-like setting to meet their individual needs is unavailable, then that placement shall be considered inconsistent with the child's needs under this Section* (FSA IV.I.2.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this requirement will begin in MP19.

FSA Requirement	*At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. The updated assessment will re-invoke the processes in I.2, consistent with DSS policies case planning and assessment* (FSA IV.I.3.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this requirement will begin in MP19.

FSA Requirement	*At least 90% of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family team and incorporated into DSS' case and service plan within sixty (60) days following the date of the CFTM during which the recommendations were made* (FSA IV.I.6.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on interim benchmarks for this requirement will begin in MP19.

The FSA requires that DSS timely and appropriately identify and meet Class Members' needs for therapeutic foster care placements and/or services in the least restrictive family-like setting that preserves family and community connections. The Parties successfully negotiated a joint motion to modify FSA Section IV.I. *Therapeutic Foster Care Placements and Services*, which was approved by the Court on November 1, 2024.[121] The modified FSA requirements include provisions to ensure children identified as needing therapeutic placements and/or services are referred to and receive those placements and/or services on a timely basis and that they are provided with updated assessments at least annually, upon a placement disruption, or upon a material change in their needs.

The modified FSA also requires that recommendations for therapeutic placements and/or services "be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least-restrictive family-like setting that preserves family and community connections" (FSA IV.I.2.). Additionally, it requires DSS, in collaboration with the Co-Monitors, to develop and implement a quality service review process to establish baseline data for measuring DSS practice regarding the assessment and provision of therapeutic placement and/or services to children in foster care and that the baseline performance data be used to establish interim performance benchmarks, the final objective outcome measure, and due date for FSA requirement IV.I.6.

DSS staff from Child Welfare Services; Internal Monitoring; Quality Assurance and CQI; and Accountability, Data, and Research, in collaboration with Monitor staff, convened a working group that met weekly from April through September 2025 to establish baseline performance and interim benchmarks. The working group conducted data analysis; reviewed policies and practices related to the Child and Adolescent Needs and Strengths tool (CANS), CFTMs, and placement decisions; and developed a qualitative review tool and process.[122]

[121] Order Granting October 25, 2024 (EFC 332) Joint Motion to Amend Final Settlement Agreement Section IV.I. (November 1, 2024, Dkt. 333).
[122] For more information about the Child and Adolescent Needs and Strengths (CANS), see: https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans.

The working group identified a cohort of 66 children for whom a final CANS was completed in September 2024 that included a recommendation for a therapeutic level of placement and for whom a subsequent CFTM occurred. Quantitative analysis indicated that 26 percent of these children (17 of 66) were placed in the CANS-recommended level of therapeutic placement within 60 days of the CFTM following the CANS. The remaining 49 children were not in the CANS-recommended level of therapeutic placement.

A sample of 23 children was selected from the 49 who were not placed in the CANS-recommended therapeutic placement for the qualitative review process. During the review process, the CFTM recommendations, referrals to services, and other related documentation in the record were examined in addition to interviews with case managers and team leaders. Of the 23 children reviewed, 14 were determined to have received therapeutic placements and/or services in the least-restrictive setting consistent with their needs. For example, the CANS-recommended placement may have been a therapeutic foster home, but the qualitative review determined that the child's placement with kin with the recommended therapeutic services in place was what was best aligned with the child's needs. Based on the combined quantitative (17 of 66) and qualitative review results (14 of 23), the baseline of DSS performance was established at 47 percent (31 of 66 children).[123]

Pursuant to the FSA, the following interim benchmarks have been established for the first and second successive 12-month periods of review:

First successive 12-month period of review

- 60 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 60 days following the date of the CFTM during which the recommendations were made.
- 70 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 90 days following the date of the CFTM during which the recommendations were made.

Second successive 12-month period of review

- 75 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and

[123] In addition to establishing the baseline for the final objective outcome measure, a baseline for updating the CANS assessment at least once annually (FSA IV.I.3.) was established at 100% (23 of 23 cases reviewed). Further, a baseline for referral to therapeutic services within 30 days from the CFTM (FSA IV.I.2.) was established at 84% (16 of 19 cases reviewed; 4 of the 23 cases reviewed were excluded because they did not include CFTM recommendations).

receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 60 days following the date of the CFTM during which the recommendations were made.

- 85 percent of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS's case and service plan within 90 days following the date of the CFTM during which the recommendations were made.

The Monitor and DSS will modify the qualitative review process to incorporate lessons learned from the baseline review. The revised methodology and DSS's progress toward meeting the interim benchmarks will be included in the MP19 report for the period of October 2025 through March 2026.

Discussion

Based on the findings of the baseline review, DSS identified areas of strengths in practice as well as opportunities for improvement. A notable strength was DSS's emphasis on placing children in family-like settings. Consistent with the quantitative data discussed earlier in this report, a greater number of children in the review were placed in family-based settings than in congregate care. Placement with kin was also prioritized when appropriate, supporting children's connections to family. While timely CANS reassessments were completed for all children reviewed, the practice of assessing children's strengths, needs, and progress toward identified goals was identified as an area in need of improvement.

DSS reported that it is implementing targeted strategies through its GPS Case Practice Model with a focus on systematically, comprehensively, and timely assessing and addressing children's underlying needs while preserving family and community connections. These efforts create an opportunity for DSS to identify gaps in the availability of therapeutic placements and services to increase access and ensure that children's therapeutic placement and/or service needs are met in the least-restrictive, appropriate setting. DSS will incorporate these strategies into forthcoming revisions to the Placement Implementation Plan, which it anticipates submitting to the Parties and the Court in May 2026.

B. Case Manager Caseloads and Contacts with Children

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Case managers must have the resources and support that allow them to conduct meaningful contacts with children and families, assess children's safety and risk of harm, and monitor progress towards individualized case goals, among many other important tasks. Child welfare agencies must ensure that the appropriate number and types of positions — including case managers, team leaders, and support staff — are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled with as little disruption as possible to children, families, and co-workers.

1. Caseloads and Workloads

Caseload and Workload Limits for Out of Home Abuse and Neglect, Permanency Specialist, and Foster Care Case Managers

FSA Requirement	*At least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit* (FSA IV.A.2.(b)).
Performance Assessment	**FSA Requirement Partially Met:** • OHAN: **100%** of case managers and **100%** of team leaders met the standard. • Foster care: **85%** of case managers and **92%** of team leaders met the standard. • Permanency**: 75%** of case managers and **86%** of team leaders met the standard.

The FSA requires that at least 90 percent of case managers have caseloads and 90 percent of team leaders have workloads within the standard.[124] For the purpose of communicating performance on workload-related FSA measures, "caseload" is used throughout this report to refer to the work of case-carrying staff with at least one Class Member on their caseload, while "workload" is used to refer to the work of team leaders overseeing case-carrying staff with at least one Class Member on their caseload. The Workload Implementation Plan set the final targets for caseloads and workloads to be reached by DSS in March 2021.[125] Approved standards differ between case managers and team leaders, by worker type (foster care, permanency, or OHAN), and by length of time employed (Table 2). ADR selected a random day in each month of MP18 to measure caseload

[124] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its GPS Case Practice Model development and work to define enhanced job expectations, DSS now utilizes the term "team leader" for this role, effective May 2023.
[125] To view the Workload Implementation Plan, see: https://dss.sc.gov/media/i3qlwxka/dss-workload-implementation-plan.pdf.

and workload compliance. While ADR and the Monitor assessed performance monthly, only performance data for September 30, 2025, is reported.[126]

Table 2. Caseload and Workload Standards, by Worker Type
Source: Approved DSS Workload Implementation Plan (February 2019)

Worker Type	Standard	Standard for New Case Managers[127]	More than 125% of Standard
Case Manager Caseloads			
Foster Care[128] (ratio of case manager to children)	1:15	1:8	> 18 children
Permanency (ratio of case manager to children)	1:15	1:8	> 18 children
OHAN (ratio of case manager to investigations)	1:8	1:4	> 10 investigations
Team Leader Workloads			
Foster Care (ratio of team leader to case managers)	1:5	N/A	> 6 case managers
Permanency (ratio of team leader to case managers)	1:5	N/A	> 6 case managers
OHAN[129] (ratio of team leader to case managers)	1:6	N/A	> 7 case managers

As of September 30, 2025, 85 percent of foster care case managers, 75 percent of permanency specialist case managers, and 100 percent of OHAN case managers had caseloads within the applicable limit (Figure 32). Performance across all case manager types improved or was maintained at 100 percent compared to the prior monitoring period. Both OHAN and foster care team leaders continue to meet the FSA requirement with 100 percent and 92 percent,

[126] The random dates that caseloads were validated this monitoring period were: April 11, 2025; May 17, 2025; June 10, 2025; July 23, 2025; August 19, 2025; and September 30, 2025. Although only September 30, 2025 data are reported, the Monitor reviewed performance data for each month during the monitoring period.
[127] "New case managers" refers to those case managers who have been employed less than six months since completing Child Welfare Pre-Service Certification training.
[128] DSS has many staff with "mixed" caseloads that include different types of cases involving both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of children in foster care (Class Members) they serve to the total number of families (cases) of Non-Class Members also served. The following types of cases are currently counted by family (case): CPS investigations; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on the Placement of Children. This methodology is only applied to foster care case managers with mixed caseloads and is not applied to permanency or OHAN case managers.
[129] The Co-Monitors approved a higher workload standard for OHAN team leaders in recognition of the fact that the OHAN case managers they supervise have lower caseload standards than other direct service case managers.

respectively, within the required limits; performance for permanency specialist team leaders improved slightly yet remains below the FSA target at 86 percent (Figure 33). The State has demonstrated progress and has partially met this FSA requirement.

Figure 32. Caseloads within Required Limits, by Case Manager Type

MP15 – 18 (March 2024 – September 2025)

Source: CAPSS data provided by DSS

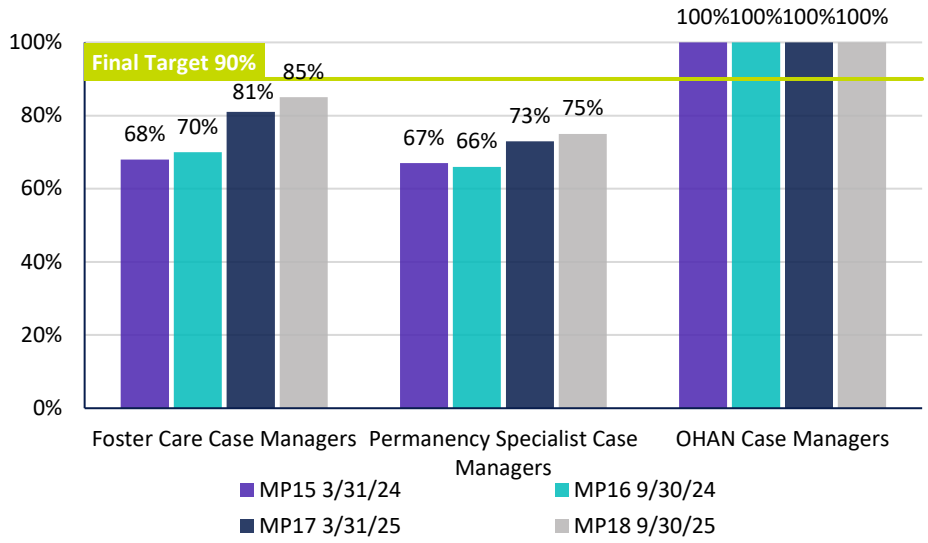
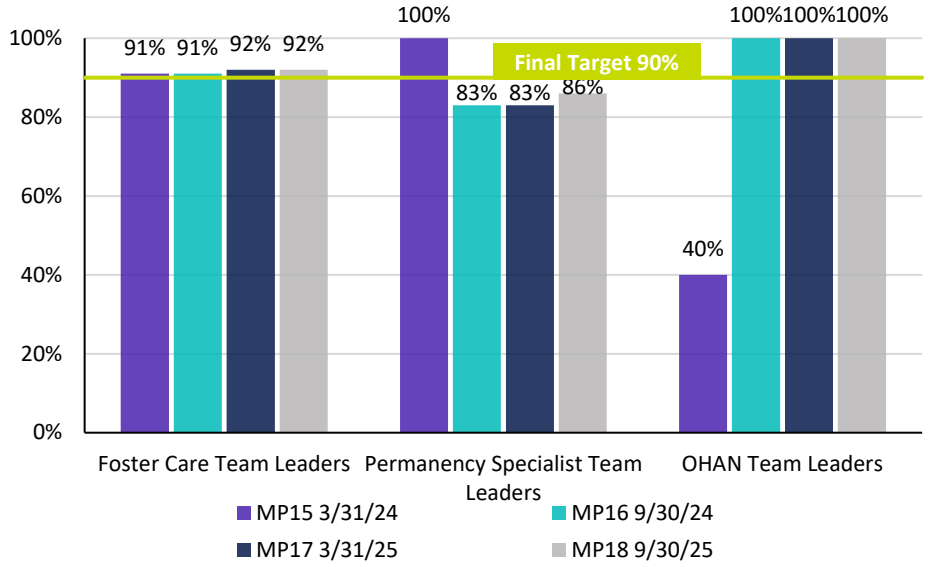


Figure 33. Workloads within the Required Limits, by Team Leader Type

MP15– 18 (March 2024 – September 2025)

Source: CAPSS data provided by DSS



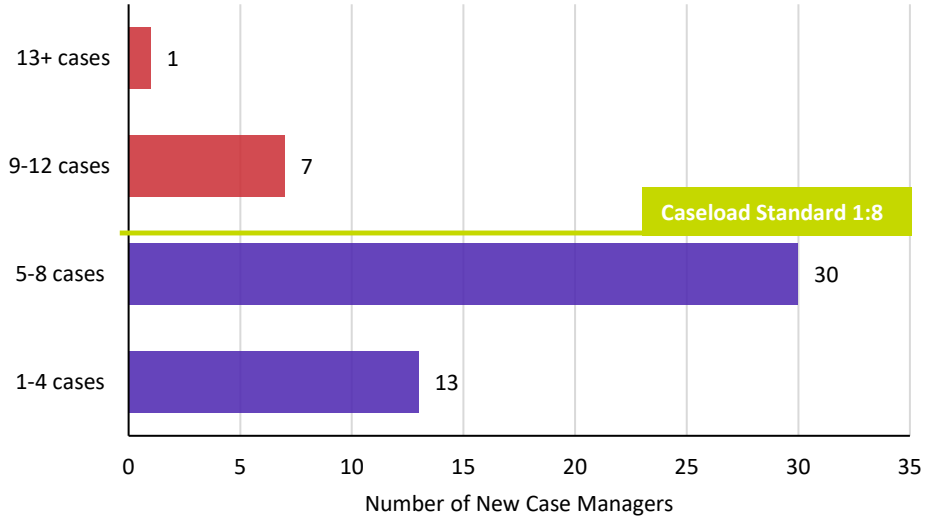
It is important to note that overall performance for foster care case managers is based on two different standards – one for new case managers (within six months of completing the required Child Welfare Pre-Service Certification training) and one for those who have been employed for six months or longer since completing the training. These graduated caseload standards are important staff retention and quality of practice strategies, allowing new staff the time to develop their skills and learn how to practice in accordance with the GPS Case Practice Model before acquiring a full caseload.[130] Data regarding caseload compliance for both sets of case managers were analyzed.

On September 30, 2025, there were 51 new foster care managers; 43 (of 51, or 84%) had caseloads within the standard, a sizeable improvement from 32 (of 51, or 63%) in MP17 (Figure 34). Among the 283 foster care case managers who had completed Child Welfare Pre-Service Certification training more than six months prior, 241 (of 283, or 85%) had caseloads within the standard, consistent with the prior monitoring period (Figure 35).

Figure 34. Number of Cases Assigned to New Foster Care Case Managers

September 30, 2025; N = 51

Source: CAPSS data provided by DSS

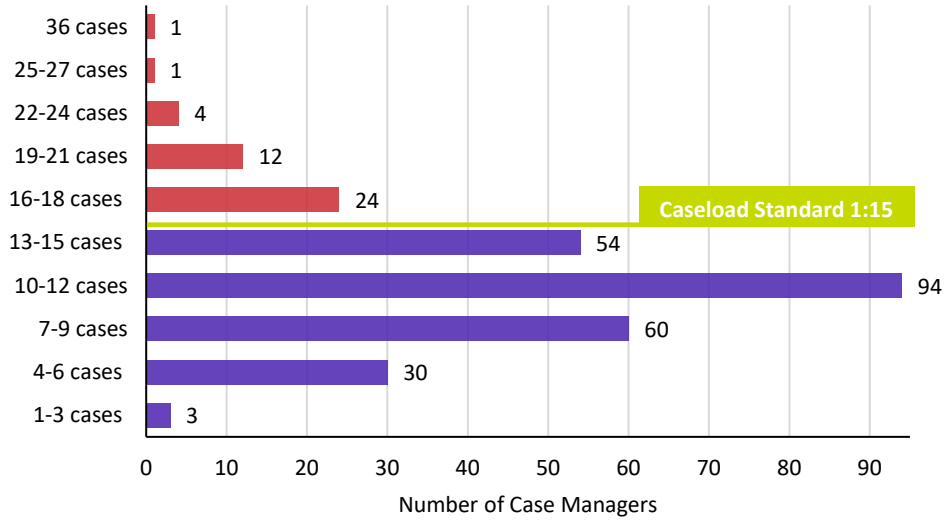


[130] To view the GPS case practice model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

Figure 35. Number of Cases Assigned to Foster Care Case Managers After 6+ Months Employment

September 30, 2025; N = 283

Source: CAPSS data provided by DSS



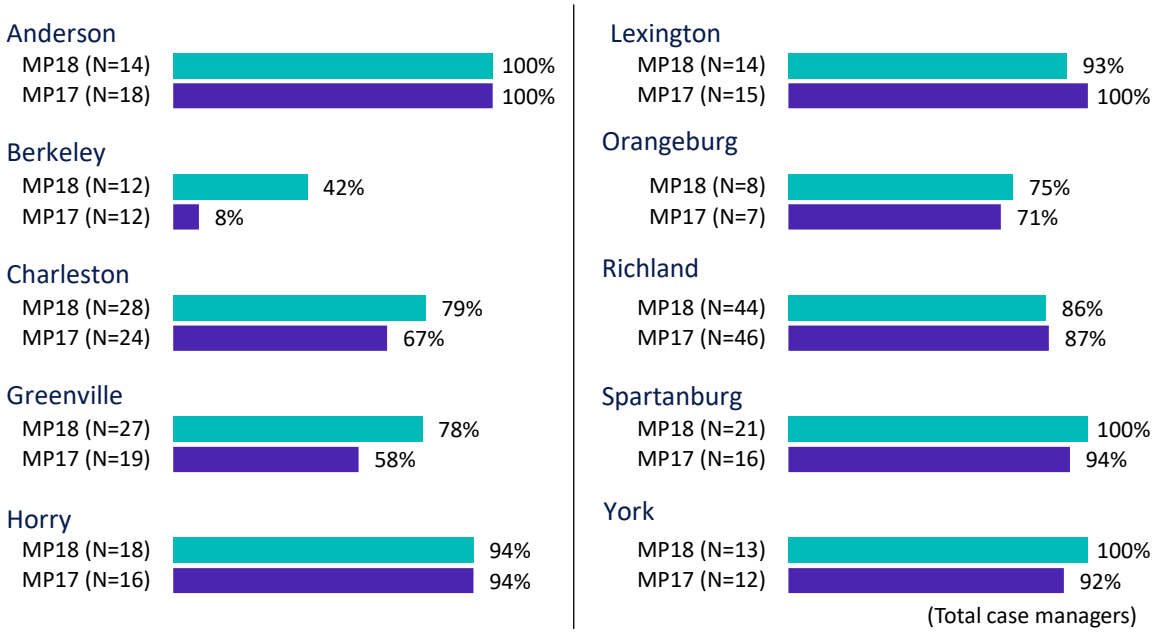
From MP17 to MP18, six of the 10 counties with the largest numbers of children in foster care demonstrated improvement in the percentage of foster care case managers with caseloads within the standard, and two maintained a performance level surpassing the standard. Compared to MP17, several counties showed notable improvement in MP18, with foster care case manager caseload compliance increasing in Charleston County from 67 percent to 79 percent, in Greenville County from 58 percent to 78 percent, and in Berkeley County from eight percent to 42 percent. In Greenville, DSS stated that this progress may be attributed to close involvement of county leadership in case consultation, with considered attention given to cases not moving toward permanency in a timely manner. DSS reports that in Charleston and Berkeley, hiring and onboarding of new staff to fill vacancies likely contributed to the lower caseloads. In MP18, Richland County's compliance decreased slightly with 86 percent of foster care case managers with caseloads within the standard compared to 87 percent during the prior monitoring period (Figure 36).[131]

[131] See Table 11 in Appendix D showing these data for all South Carolina counties.

Figure 36. Comparison of Foster Care Case Manager Caseload Compliance, by County

MP17 – 18 (March 31 and September 30, 2025)

Source: CAPSS data provided by DSS



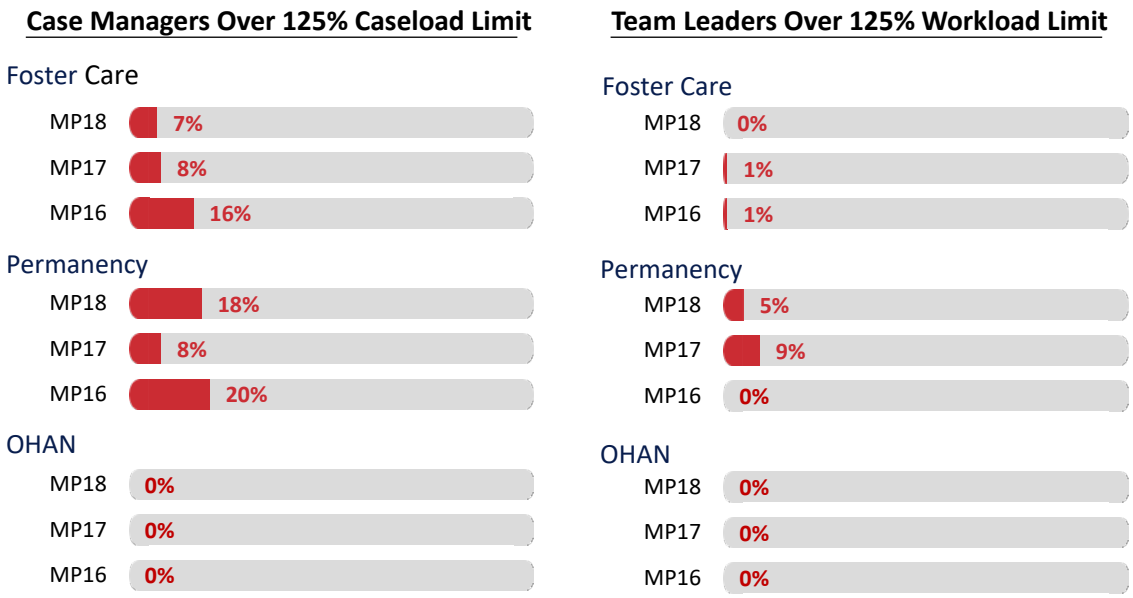
FSA Requirement	*No Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit* (FSA IV.A.2.(c)).
Performance Assessment	**FSA Requirement Partially Met:** • OHAN: **0 (of 26)** case managers and **0 (of 6)** team leaders were above 125% of the standard. • Foster care: **22 (of 334)** case managers and **0 (of 125)** team leaders were above 125% of the standard. • Permanency**: 17 (of 92)** case managers and **1 (of 21**) team leaders were above 125% of the standard.

The FSA requires that case managers and team leaders do not carry caseloads or workloads over 125 percent of the applicable caseload limit. On September 30, 2025, the last day of Monitoring Period 18, no OHAN case manager had a caseload over 125 percent of the applicable caseload limit. Seven percent of foster care case managers (22 of 334) had caseloads over 125 percent of the limit, similar to the prior period, and 18 percent of permanency specialist case managers (17 of 92) had caseloads over 125 percent of the limit, an increase from eight percent (8 of 96) in MP17 (Figure 37). On September 30, 2025, there were no OHAN team leaders or foster care team leaders with a workload over 125 percent of the applicable limit, and there was only one permanency specialist team leader (of 21, or 5%) over 125 percent of the limit (Figure 37).

Figure 37. Case Managers and Team Leaders with More than 125% of the Caseload or Workload Limit

September 30, 2025

Source: CAPSS data provided by DSS



Though not currently reflected in the FSA performance measure, the Workload Implementation Plan states that team leaders should not be directly responsible for carrying cases, with certain exceptions. Data were analyzed regarding the number of team leaders who were directly responsible for cases in addition to overseeing a team of case managers.[132] As of September 30,

[132] Note, in accordance with the Workload Implementation Plan, team leaders are not intended to carry cases. There are limited exceptions in which DSS has identified situations where it may be necessary for team leaders to be directly responsible for carrying cases for short periods of time. These include circumstances in which a case manager is promoted to team leader and may temporarily retain case management responsibilities for up to 45 days if a case is nearing closure, there are complexities regarding the case that need to be addressed, or an important legal event will occur within the timeframe. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving team leader for up to 5 days until the team leader assigns the case to the receiving case manager. DSS has also identified that team leaders sometimes carry cases when a case manager leaves the agency and creates a vacancy that takes some time to fill or when case managers are on extended leave. While the team leader is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child; monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent(s); and other activities as necessary. For these circumstances, DSS requires Regional Director approval for team leaders to carry cases for more than 5 days and documentation of the case(s) the team leader will carry, the circumstances leading to the team leader carrying cases, and a specific plan and timeline be created to address the issue. This documentation must be shared with DSS's ADR unit. At this time, the Monitor has not reviewed data to determine if these exceptions apply when team leaders are carrying cases.

2025, there were 24 team leaders statewide carrying a total of 144 cases.[133] On average, cases were open for 166 days, while 21 cases were open for longer than one year, including one case that had been open for 893 days.[134] Individual team leaders' caseloads ranged from one to 21 cases. These team leaders worked across 12 of the 46 county offices and two of the Regional Permanency offices in the state; the number of combined cases held by the team leaders within each office ranged from one to 38 per office.

Discussion

DSS continued to demonstrate overall improvement in the percentage of case manager caseloads and team leader workloads within the required limits, even with the increased number of children in foster care this monitoring period (Figure 2). DSS's progress in reducing worker caseloads and workloads since the inception of the lawsuit has been significant and has benefited from additional financial resources for child welfare services provided by the legislature over several years.

Performance this monitoring period (April – September 2025) may have been aided by DSS's ability to grow its workforce over the past year; DSS reported in its October 7, 2025, Data Submission to the Court that it had 648 total allocated positions in August of 2024 compared to 665 in August 2025.[135] As of September 30, 2025, the department reported having 90 percent of positions filled across all program areas within Child Welfare Services, which is a slight increase from 88 percent in March of 2025.[136,137] Specifically, Child Welfare Services was reported to have 88 percent of positions across all frontline case manager positions and 95 percent across all frontline team leader positions filled.[138] In the last month of MP18 (September 2025), the total turnover rate was 2.0%, almost equal to the rate six months prior (March 2025) (2.1%).

DSS, in its October 7, 2025 Data Submission to the Court, attributes the significant progress it has made toward hiring and training workers and reducing worker turnover since the inception of the lawsuit, in part, to implementation of the court-ordered salary plan which has raised worker compensation.[139] Despite this progress, DSS acknowledges that challenges remain in creating and sustaining a skilled and stable workforce and in ensuring that all workers have caseloads that permit them to practice in accordance with DSS's GPS Case Practice Model. Case practice challenges include mentoring and training case managers to work as a team engaging children,

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[133] CAPSS data provided by DSS.
[134] The following counties had team leaders with cases open for longer than a year: Jasper County (1 case), Berkeley County (1 case), Beaufort County (1 case), Richland County (9 cases), and Charleston County (9 cases).
[135] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378).
[136] Ibid.
[137] Letter from J. Michael Montgomery Providing Information Required by October 18, 2024, Order (EFC 330) prior to March 21, 2025 Status Conference (March 14, 2025, Dkt.354).
[138] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378).
[139] Ibid.

families, and others who support them; and assessing the underlying needs of children and families so that interventions can be appropriately tailored and matched to meet those needs.

To address these challenges, DSS reported that it had invested in an array of activities aimed at supporting new and existing staff. Efforts to recruit new staff included partnering with universities and finalizing the DSS Referral Bonus Program, reported to launch in November 2025, which identifies hard-to-fill positions as bonus-eligible. In addition, 46 interns from 25 different colleges and universities were placed within Child Welfare Services for the Fall 2025 semester. Efforts aimed at staff retention included counseling services and trauma support; compensated peer support and extended performance coach mentoring to bolster growth and development of new staff; and additional opportunities for leadership development. Further, DSS reported continuing to allocate funding to increase recruitment and retention through tuition assistance and reimbursement programs.

Another strategy DSS reported that promotes staff retention is the implementation of Regional Support Teams, aimed at balancing the work of county case managers. These teams travel to counties experiencing spikes in turnover and/or high caseloads to provide support with making contacts with children, facilitating visitation, family search and engagement, and transportation. From May 1, 2025, to September 30, 2025, DSS reported 981 services were provided.[140] Private contractors providing 24/7 transportation services statewide received 6,696 requests and completed 6,096 in MP18 (April – September 2025).[141]

Placement issues previously discussed, both in Richland County and across the state, notably increased the demands on case managers who must handle the stress and workload involved with children who do not have stable placements. Such demands, which became acute in Richland County but persist throughout the State, include late-night hours requiring staff to respond to and transport children without placement, sometimes shuttling children to and from night-to-night emergency placements, creating an additional burden on staff and additional instability on children. To address the implications of these late-night work hours on staff wellness and address the goals as outlined in the Richland County Improvement Plan, RCDSS hired case management staff specifically dedicated to working eight-hour second and third shifts in Richland County, some falling outside of normal business hours, to help reduce reliance on first-shift case managers for after-hours calls. As of July 2025, DSS reported in their monthly data submission to the court, that all of these positions had been filled. DSS has subsequently reported a reduction in the total number of days each month in which staff were called in for after-hours and weekend duty. Starting July 2025, there was a reduction in the number of days staff were called in with no more than one person called in any month.

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[140] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378). Note, beginning May 1, 2025, DSS adjusted the method for counting requests to the Regional Support Team. As of that date, the methodology no longer counts transports but instead counts each person receiving a service.
[141] Ibid.

2. Case Manager Contacts with Children

FSA Requirement	*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* (FSA IV.B.2.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this provision was suspended in October 2021 and will resume in MP19.

FSA Requirement	*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.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this provision was suspended in October 2021 and will resume in MP19.

In October 2021, after years of consistently low performance and poor documentation of contacts between case managers and children, and upon agreement of all Parties, the Co-Monitors suspended case record reviews and reporting on these FSA requirements. The Parties agreed that reviews would be paused for at least four monitoring periods or until DSS's internal data indicate there has been substantial increase in performance. The Monitor will resume case reviews on this requirement during the next monitoring period and is working with DSS staff to implement this process.

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

Ensuring the safety and well-being of children in foster care is a primary obligation of any child welfare system. This obligation is recognized by FSA requirements for the timely and appropriate screening and investigation of allegations of abuse and/or neglect of children in foster care. In South Carolina, DSS's Intake Hub screens all reports of abuse and neglect and assigns allegations against a caregiver of a child in foster care to the Out of Home Abuse and Neglect (OHAN) unit for investigation.[142]

In October 2024, the Court found that DSS had made sufficient improvement to terminate its jurisdiction over four FSA provisions regarding allegations of institutional abuse and neglect; consequently, performance on those requirements is no longer monitored or reported.[143] Additionally, in December 2025, the Court granted Maintenance of Effort Designation on three of the remaining four OHAN FSA requirements: (1) timely initiation of investigations (FSA IV.C.4.(a)); (2) timely face-to-face contact with alleged child victims (FSA IV.C.4.(b)); and (3) appropriate investigatory findings and decision making (FSA IV.C.3.).[144] Performance on these three FSA requirements, as well as the fourth remaining requirement—contact with core witnesses (FSA IV.C.4.(c)) – continues to be assessed through twice-yearly case record reviews.

[142] SC Code § 63-7-1210 (2024); SCDSS Child Welfare Services Manual, Chapter 13: Out of Home Abuse and Neglect (OHAN), Policy 1300: Out of Home Abuse and Neglect Investigations (effective September 18, 2024).
[143] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-Five (45) Days of Initiation (FSA IV.C.4.(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4.(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4.(f)).
[144] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

1. Timely Initiation of Investigation and Timely Face-to-Face Contact with the Alleged Victim

FSA Requirements	*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* (FSA IV.C.4.(a)) [and] *[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors* (FSA IV.C.4.(b)).
Performance Assessment	**FSA Requirements Met**: **96%** of OHAN investigations were initiated in 24 hours of DSS's receipt of the report and included a face-to-face contact with the alleged victim within 24 hours.

The FSA requires that at least 95 percent of referrals of abuse or neglect of children in foster care are initiated within 24 hours (FSA IV.C.4.(a)) and that the investigation includes face-to-face contact with the alleged victim within 24 hours, with approved exceptions for good-faith efforts, in at least 95 percent of investigations (FSA IV.C.4.(b)).[145,146] The Monitor measures performance for both FSA requirements IV.C.4.(a) and (b) using the same methodology and timeframes, requiring face-to-face contact with the alleged child victim within 24 hours of receiving a report. The Monitor and DSS staff review records of all investigations assigned to OHAN in the last month of the monitoring period (September 2025) to report on performance.

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[145] On September 24, 2024, the Co-Monitors and the Parties agreed that for the purposes of the review, OHAN case managers would have a maximum of two additional hours from the time of the receipt of the report to initiate the investigation, including making face-to-face contact with the alleged victim child(ren) (i.e., OHAN case managers would have up to 26 hours from the receipt of a report to initiate the investigation).

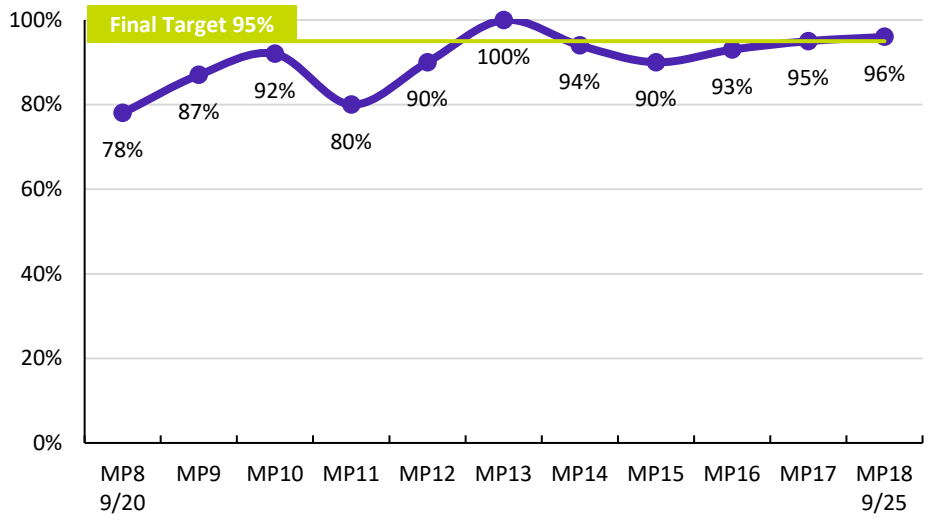
[146] The Co-Monitors approved the following efforts as "good-faith efforts" for timely initiation which must be completed and documented, as applicable, to make contact with an alleged victim child(ren) within 24 hours: case manager attempted to see child(ren) at school or child care facility; case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

In September 2025, OHAN received 26 investigations involving Class Members. Case managers met with all alleged victim children within 24 hours in 23 investigations, and in two additional investigations, all applicable good-faith efforts were made to contact each of the alleged victim children. Therefore, 25 of 26 investigations (96%) were initiated timely and included face-to-face contact with alleged victims (Figure 38). The State met the FSA requirement in both MP18 and the prior monitoring period. The Court granted Maintenance of Effort status for these provisions on December 17, 2025.[147]

Figure 38. OHAN Investigations with Timely Initiation and Face-to-Face Contact with Alleged Victims

MP8 - 18 (September 2020 – September 2025)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff



[147] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

2. Contact with Core Witnesses

FSA Requirement	*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)).
Performance Assessment	**FSA Requirement Met**: Contact was made with all necessary core witnesses in **100%** of investigations.

The FSA requires that DSS contact core witnesses in at least 90 percent of investigations of a referral of institutional abuse or neglect, with exceptions approved by the Monitor (FSA IV.C.4.(c)).[148] 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.[149] Core witnesses may differ from investigation to investigation but in all cases must include alleged child victim(s); reporter(s); alleged perpetrator(s); law enforcement, when involved; the child's DSS case manager; and other adult(s) and/or child(ren) in the home. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses. Performance on this FSA requirement is determined by a case record review of all OHAN investigations involving Class Members that were initiated in the last month of the monitoring period.

Of the 26 investigations initiated in September 2025 and reviewed by the Monitor staff and DSS, all records (100%) contained documented contact with all necessary core witnesses during the investigation, a significant improvement from 86 percent during MP17 (Figure 39). Figure 40 shows the frequency of contact across all categories of core witnesses for investigations initiated in September 2025 (MP18) compared to the prior review of investigations initiated in March 2025 (MP17). The State met this FSA requirement for the first time during this monitoring period. This provision may be eligible for Maintenance of Effort designation.

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

[149] Out of Home Abuse and Neglect Implementation Plan, pg. 4; see https://dss.sc.gov/media/oagnwbjr/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf.

Figure 39. OHAN Investigations with Contact with All Necessary Core Witnesses

MP8 - 18 (September 2020 – September 2025)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff

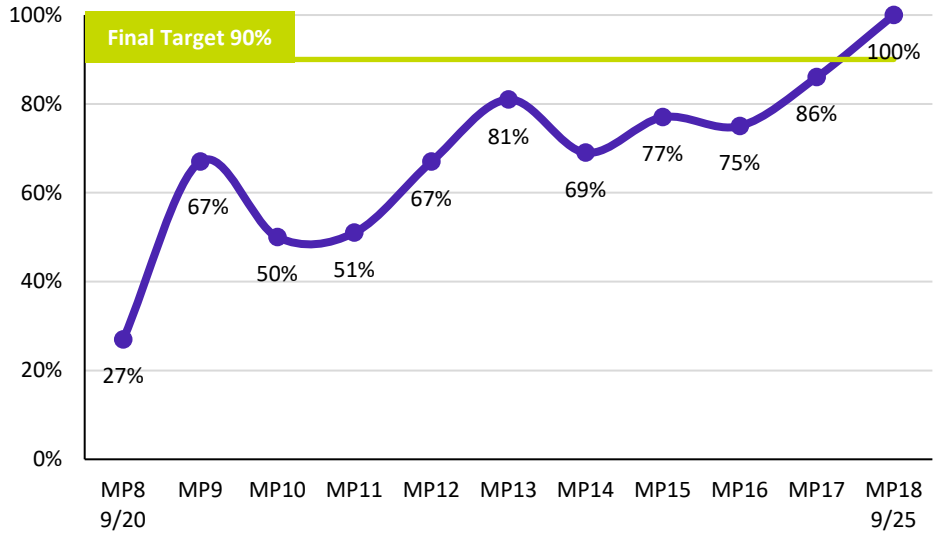
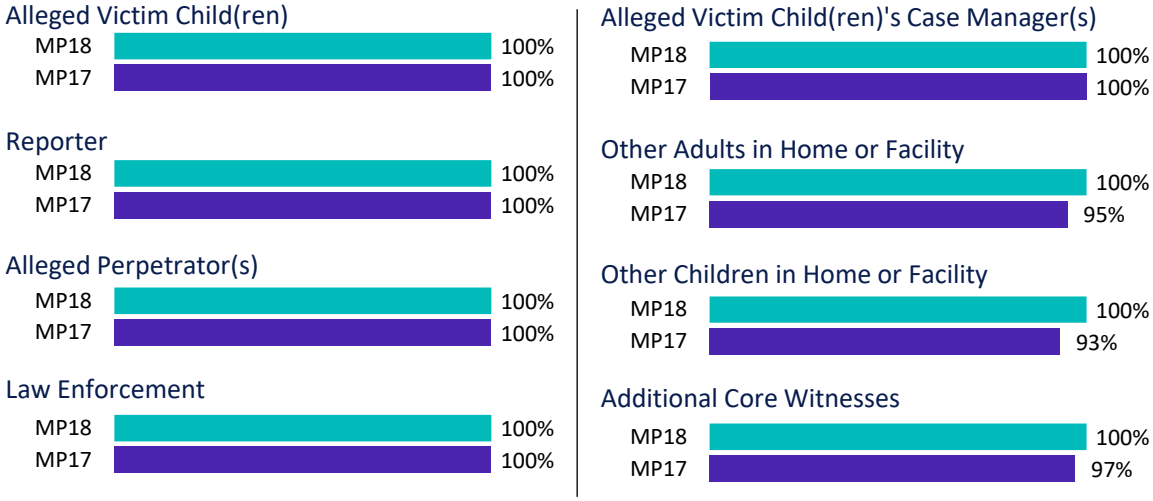


Figure 40. Frequency of OHAN Investigation Contacts, by Witness Type[150]

MP17 (March 2025) compared to MP18 (September 2025)

Source: Case record reviews completed by DSS and Monitor staff



[150] Good-faith exceptions were applied as follows: reporter (2 of 26); alleged perpetrator(s) (2 of 26); other adults in the home or facility (1 of 12); other children in the home or facility (2 of 15); and additional core witnesses (1 of 22).

3. Investigation Decisions

FSA Requirement	*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.).
Performance Assessment	**FSA Requirement Met**: **96%** of decisions to "unfound" investigations of referrals for institutional abuse or neglect were determined to be appropriate.

The FSA requires that 95 percent of decisions to "unfound" allegations of institutional abuse and neglect be based on DSS ruling out abuse or neglect or determining that an investigation did not produce a preponderance of the evidence that a Class Member was abused or neglected (FSA IV.C.3.).[151]

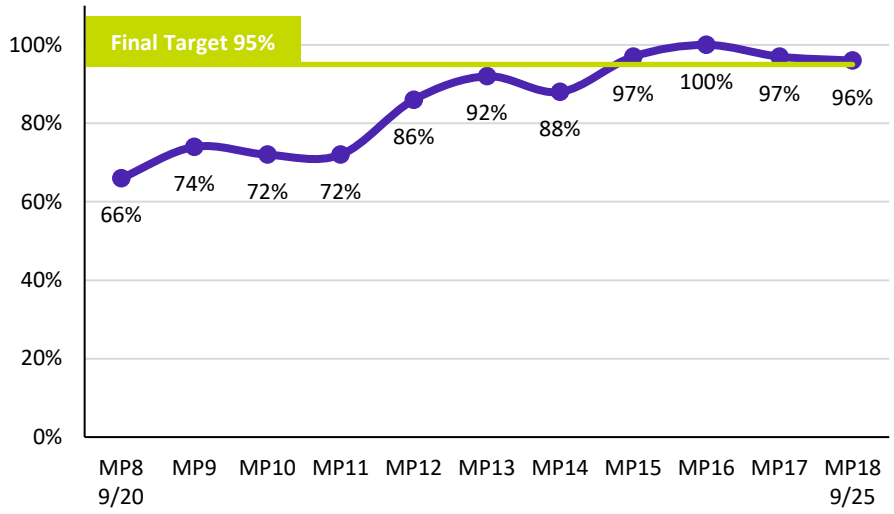
In 24 of the 26 OHAN investigations initiated in September 2025 and reviewed by the Monitor staff and DSS, the final decision was to unfound the allegations of abuse and neglect. Reviewers agreed that the decision to unfound was appropriate in 96 percent of the investigations (23 of 24) (Figure 41). This is the fourth consecutive monitoring period in which the State's performance has met and exceeded the final target of 95 percent. The Court granted Maintenance of Effort status for this provision on December 17, 2025.[152]

[151] DSS policy provides that a decision to "indicate" or "unfound" allegations of abuse and neglect at the conclusion of an investigation be based upon the totality of information collected, with facts supported by a preponderance of the evidence. SCDSS Child Welfare Services Manual, Chapter 13: Out of Home Abuse and Neglect (OHAN), Policy 1300: Out of Home Abuse and Neglect Investigations (effective September 18, 2024).
[152] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 387).

Figure 41. Appropriate Decisions to Unfound OHAN Investigations

MP8 - 18 (September 2020 – September 2025)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and Monitor staff



Discussion

DSS continues to demonstrate consistent practice in investigating allegations of institutional abuse and neglect involving Class Members. A review of investigations initiated in September 2025 (MP18) indicates that DSS met all four remaining FSA performance targets. On December 17, 2025, the Court granted a Maintenance of Effort designation for the following measures: (1) timely initiation of investigations (FSA IV.C.4.(a)); (2) timely face-to-face contact with alleged child victims (FSA IV.C.4.(b)); and (3) appropriate investigatory findings and decision making (FSA IV.C.3.). During Monitoring Period 18, the State met the FSA target for contact with core witnesses for the first time (FSA IV.C.4.(c)), and this requirement may now also be eligible for Maintenance of Effort designation. The consistency of these results indicates ongoing adherence to required OHAN investigative practices.

D. Family Connections

If children who enter foster care are to successfully reunify with their families, it is essential that they have meaningful contact with their parent(s), sibling(s), relative(s), and other individuals significant to them while they are apart. Family visits sustain connections and alleviate the trauma of separation. These visits further provide opportunities for parents and children to stay engaged in the case process; learn about steps necessary to achieve safety, permanency, and well-being; and heal together. Regular, frequent, and dedicated time with family members should occur in comfortable settings and foster positive and nurturing relationships between the child in foster care and the significant people in their life, including siblings in foster care for whom placement together is not possible. Visitation plans are created with input from the child, parent(s)/ guardian(s), other significant persons, foster parents or group home providers, and clinical providers as applicable.[153] The plan details visit logistics, necessary supports, and barriers to visits with plans to address them. In line with needs, and as appropriate, family visits may be unsupervised, supervised, or monitored by a case manager or other designated person, including a relative, foster parent, or clinician.

1. Children's Visits with Their Parents

FSA Requirement	*At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice very month; or (2) based on exceptions approved by the Co-Monitors* (FSA IV.J.3.).
Performance Assessment	**FSA Requirement Not Met**: **52%** of children had the required number of visits with parents.

[153] SC Code § 63-7-1680 (2024); SCDSS Child Welfare Services Manual, Chapter 5: Foster Care, Policy 510.3: Family Visitation (effective February 22, 2022).

The FSA requires that at least 85 percent of Class Members with the goal of reunification have in-person visits twice each month with the parent(s) with whom reunification is sought.[154] DSS's Foster Care Visitation Policy states that within 30 days of a child entering foster care, a visitation plan must be created collaboratively with the child and family team.[155,156] Unless required by court order, visitation should not be less than twice monthly, with other communication (e.g., text messages, phone calls, etc.) allowed and encouraged as appropriate.

Reviews of CAPSS documentation for the last month of the monitoring period (September 2025) are conducted to determine performance. As of September 30, 2025, there were 1,539 children who had been in foster care for at least 30 days with a permanency goal of "Reunification," "Extension for Reunification," or "Not Yet Established." A sample of 308 cases from this universe was reviewed.[157] Upon review, DSS and Monitor staff determined that there were 48 cases for which an approved exception applied to both required monthly visits with the parent(s) with whom reunification was sought. Removing these 48 cases resulted in a representative sample of 260 cases. Results from the case record review found that 52 percent (134) of these 260 cases met the standard of the child visiting twice with the parent(s) with whom reunification was sought. Performance has declined from MP17 when 55 percent of children had the required number of visits with their parents. Performance on this FSA requirement continues to fall significantly below the target of 85 percent (Figure 42).

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

[155] SCDSS Child Welfare Services Manual, Chapter 5: Foster Care, Policy 510.7.3: Family Visitation (effective February 22, 2022).

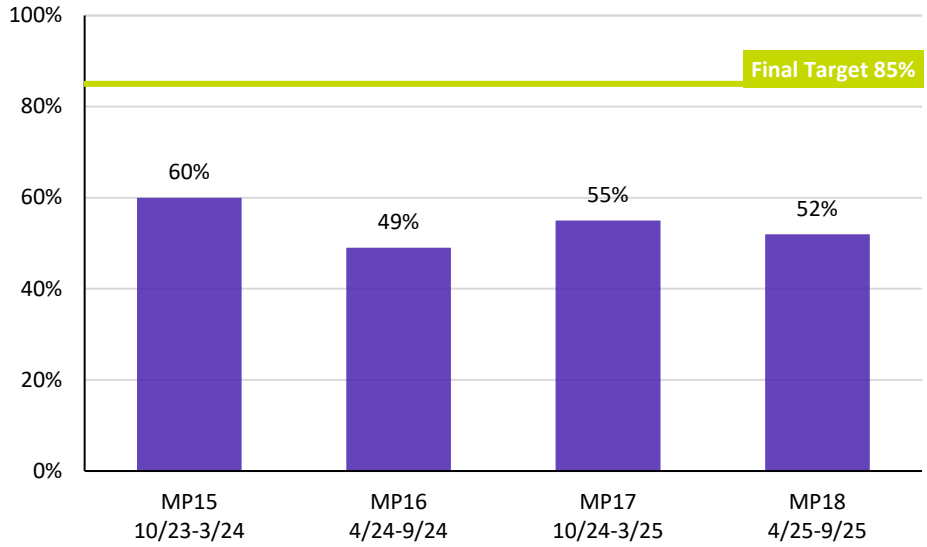
[156] To view the Visitation Implementation Plan, see: https://dss.sc.gov/media/4evhcpky/3-28-2019-final-dss-visitation-implementation-plan.pdf.

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

Figure 42. Parent-Child Visits

Percentage of children visiting with their parent(s) at least twice a month (March 2024 – September 2025)

Source: Case record reviews completed by DSS and Monitor staff



Discussion

In its October 7, 2025 Data Submission to the Court, DSS reported on several strategies it was pursuing to increase visits between children in foster care and their parents, including conducting periodic skills labs for frontline staff, issuing quarterly "Visitation Matters Tip Sheets," and the use of Regional Support Teams to provide as-needed assistance to counties with facilitating family visitation and transportation.[158] During the period between May 1, 2025 and September 30, 2025, 68 percent of all requests made by field staff for transport requests were for family or sibling visits.[159] DSS also contracts with private providers to provide 24/7 emergency transportation support. From August 1, 2024 to September 30, 2025, 33 percent of these requests were for parent visitation.

DSS reported that Child Welfare Services leadership continue to utilize the Data Dashboard, which includes metrics on parent and child visitation by county and region, to monitor month-to-month performance.[160] These data are used to identify and recognize counties that are performing above the state average and to understand what strategies are contributing to their better outcomes and could be implemented in other counties, and to identify counties performing below the state average to assess barriers and develop strategies for intentional improvement. Given the

[158] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378).
[159] Ibid. Note, beginning May 1, 2025, DSS adjusted the method for counting requests to the Regional Support Team. As of that date, the methodology no longer counts transports but instead counts each person receiving a service.
[160] Ibid.

persistently low performance on parent-child visits, additional efforts to identify and address barriers to improving the rate of visits between children in foster care and their parents are necessary.

2. Sibling Connections

Placement of Children with Their Siblings

FSA Requirements	*At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings* (FSA IV.G.2.) [and] [a]*t least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with* all *their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors.* (FSA IV.G.3.).
Performance Assessment	**FSA Requirements Not Met**: **76%** of children who entered foster care within 30 days of their siblings were placed with at least one of their siblings, and **53%** were placed with all of their siblings.

When Class Members enter foster care with or within 30 days of their siblings, the FSA requires that at least 85 percent be placed with *at least one* of their siblings (FSA IV.G.2.), and that at least 80 percent be placed with *all* of their siblings (FSA IV.G.3.).[161,162] Performance is measured based on whether a child is placed with their sibling(s) 45-days after entering foster care. Between April 1 and September 30, 2025, 76 percent of children (552 of 729) who entered foster care with or within 30 days of their siblings were placed with *at least one* of their siblings (Figure 43), and 53 percent of children (385 of 729) were placed with *all* of their siblings (Figure 44). Performance in placing children with *all* of their siblings improved since the last monitoring period, however the State did not meet either FSA requirement regarding sibling placement in this monitoring period.

[161] The term "siblings" is defined as "[c]hildren in foster care who have one or more parents in common either biologically, through adoption, or through marriage of their parents, and with whom the child lived before [their] foster care placement" (Placement Implementation Plan,) pg. 58, https://dss.sc.gov/media/cgnjurvv/dss-placement-implementation-plan.pdf.

[162] The FSA allows for the following exceptions to the placement of children with their siblings: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors (FSA IV.G.2 & 3.). No exceptions were applied during MP18; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in a future monitoring period.

Figure 43. Placement of Children Entering Foster Care with at Least One Sibling

MP10 – 18 (September 2021 – September 2025)

Source: CAPSS data provided by DSS

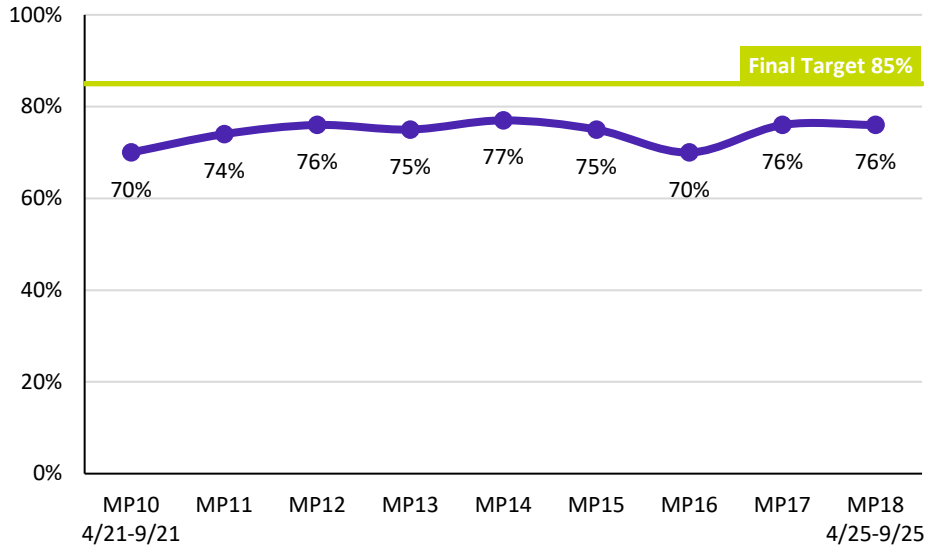
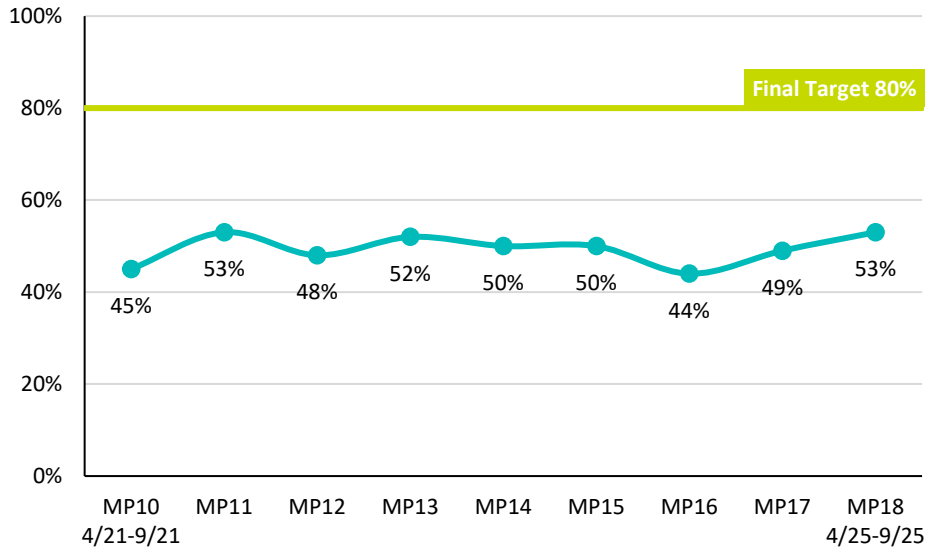


Figure 44. Placement of Children Entering Foster Care with All Siblings

MP10 – 18 (September 2021 – September 2025)

Source: CAPSS data provided by DSS



Children's Visits with Their Siblings

FSA Requirement	*At least 85% of the total minimum number of monthly sibling visits for all sibling not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interests of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors* (FSA IV.J.2.).
Performance Assessment	**FSA Requirement Met**: **92%** of children had the required number of visits.

The FSA requires that at least 85 percent of monthly sibling visits for all siblings occur. Assessing performance on this target is done through a combination of results from a SafeMeasures® visitation report and a case review of CAPSS documentation.[163] SafeMeasures® reliably reports sibling visits that occur but does not account for whether there was an approved exception for a sibling visit when a visit does not occur. DSS and Monitor staff review, from a statistically representative sample, each case in which a visit did not occur to determine whether an exception for a visit applies.[164]

[163] For more information about SafeMeasures®, see: https://evidentchange.org.

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

DSS generated a universe of 1,800 sibling pairs of children meeting the definition of siblings and pulled a statistically representative sample of 317 sibling pairs. [165,166,167] The SafeMeasures® report indicated that 262 of 317 sibling pairs visited each other in September 2025, and 55 sibling pairs did not. Results from the record review of those 55 sibling pairs without a documented required visit concluded that 12 sibling pairs met criteria for an approved exception to a visit during the month, lowering the sample of cases reviewed from 317 to 305.[168] Findings further determined that 19 of the 55 sibling pairs were incorrectly identified in the initial report as not having had a visit in September 2025, although a visit did occur. This resulted in a final determination that 92 percent of sibling pairs (281 of 305) had the required visits in September 2025 (Figure 45). This improvement from 84 percent in MP17 also marks the first monitoring period in which the State has met the FSA target of 85 percent. This provision may be eligible for Maintenance of Effort designation.

[165] For the purposes of the review, "siblings" are defined as, "children in foster care not placed together who have one or more parents in common either biologically, through adoption, or through the marriage of their parents, and with whom the child lived before his or her foster care placement", see the Visitation Implementation Plan: https://dss.sc.gov/media/4evhcpky/3-28-2019-final-dss-visitation-implementation-plan.pdf.

[166] A child is counted for every sibling for whom they should have visitation during the month under review; therefore, a child may be included multiple times in the universe. The universe further includes only those siblings who entered foster care within 30 days of each other and resided apart the entire month under review. Class Members who resided out of state during the month under review are excluded from the analysis.

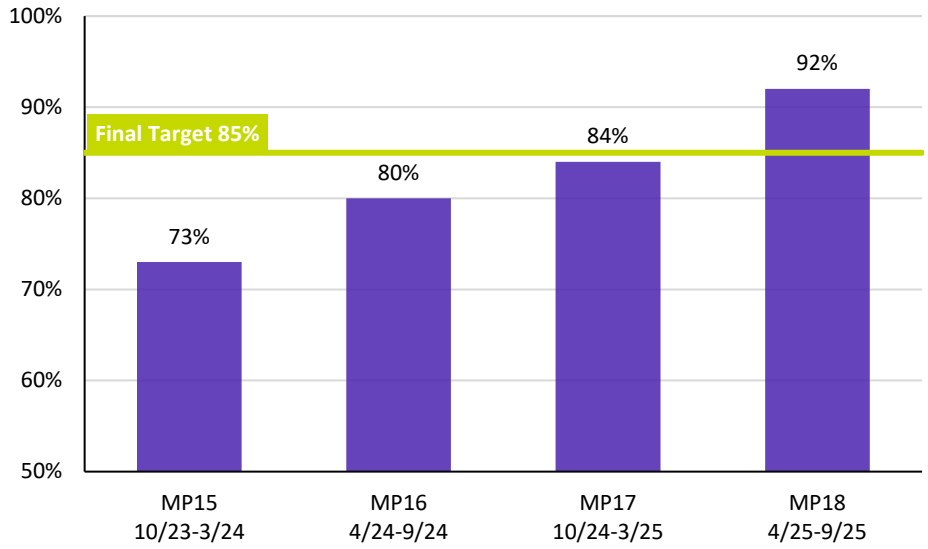
[167] Data are from a CAPSS record review conducted by Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

[168] The 12 exceptions identified in September 2025 were due to one of the following documented instances: (1) one or both children refusing to participate, (2) one or both children were residing in a facility in which visitation was not possible, (3) an immediate safety incident or concern resulted in the visit being cancelled or stopped, or (4) visitation deemed psychologically harmful to one or both children.

Figure 45. Percentage of Sibling Pairs Visiting at Least Once a Month

(March 2024 - September 2025)

Source: Case record reviews completed by DSS and Monitor staff



Discussion

Being separated from family is a life-altering event for a child. The placement of children with their siblings is a high priority, and when that is not possible, it is imperative that DSS ensure consistent contact between siblings. DSS has made significant progress towards these ends and improved its performance in placing siblings together over the prior monitoring period but still falls short of reaching the FSA targets, especially in its placement of all siblings together.

For those children who are not placed together, the State's performance in ensuring sibling visits are occurring as required has steadily improved over time, and in September 2025, performance surpassed the final target of 85 percent for the first time. DSS reports working to increase both the frequency of sibling visits and quality of visit documentation as part of its overall efforts to improve performance on FSA measures related to maintaining family connections.[169]

The Monitor's staff conducted a focus group with youth in foster care to gauge the importance of sibling connections.

> *I asked for a foster home with my little brother, but I'm still stuck in a group home for three years while he is in a foster home across town and I barely get to see him.*

[169] Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt. 378). For additional discussion of DSS's efforts to improve performance, see *Section D.I.* of this report.

E. Health Care

Child welfare systems are responsible for ensuring that children in foster care receive the health care services necessary to support their physical, developmental, mental, and behavioral well-being. Meeting this responsibility requires the capacity to promptly identify children's health needs; ensure timely access to high-quality preventive, acute, and ongoing care; and maintain systems that track service delivery and support the effective sharing of critical health information. The provision of health care to children in foster care is a legal obligation of the State under federal Medicaid mandates for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for all Medicaid-eligible children, which includes children in foster care. Guidance issued by the Centers for Medicare and Medicaid Services (CMS) on September 26, 2024, affirms states' obligations to provide medically necessary services to address children's physical, developmental, mental, and behavioral health needs. This guidance also supports states in strengthening EPSDT implementation to improve health outcomes for children enrolled in Medicaid.[170]

The FSA required the development of a Health Care Improvement Plan with enforceable dates and targets for phased implementation of initial and periodic screening services, documentation, and health care 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. Per the FSA, The Health Care Improvement 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 service (FSA IV.K.1.(a-c)).

The initial Health Care Improvement Plan, Health Care Outcomes, and Health Care Addendum—approved by the Co-Monitors and the Court on August 23, 2018; December 21, 2018; and February 25, 2019, respectively — established commitments to outcomes and a framework for health care coordination. The framework assigned interrelated responsibilities to the DSS Office of Health and Well-Being, DSS case managers, the South Carolina Department of Health and Human Services (DHHS) and its contracted managed care organizations (MCOs), and foster caregivers and

[170] To view the CMS's new guidance in the form of a State Health Official letter entitled, *Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements*, see: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

families.[171] The Plan, Outcomes, and Addendum were approved and ordered by the Court with the understanding that additional details would be determined during implementation and that the efficacy and adequacy of the model and methodology for measuring outcomes would be assessed on an ongoing basis to determine what changes or additions are needed. Beginning in 2023, the Monitor identified in its report to the Court the need to review the Health Care Plan, Outcomes and Addendum, and make the modifications necessary for improved performance.

The work to develop a revised Health Care Improvement Plan (HCIP) did not proceed rapidly and was stalled on multiple occasions. On October 15, 2025, the Court ordered the Parties to develop a revised Health Care Improvement Plan (HCIP) to be approved by the Monitor on or before December 31, 2025.[172] DSS submitted a revised plan to the Parties and the Court on December 30, 2025.[173] The Monitor provisionally approved the HCIP pending the development of agreed-upon methodologies for measuring DSS's performance in meeting the Health Care Outcomes included in the Plan and required by the FSA.[174] The Court set February 27, 2026, as the deadline for final approval of the revised Health Care Improvement Plan by the Monitor and later extended the deadline to April 3, 2026, at the Monitor's recommendation and the joint request of the Parties.[175,176] The HCIP, including methodologies, was approved by the Monitor and submitted to the Court on April 3, 2026 date and will be applied in future monitoring periods.[177] The Plan is included in Appendix G of this report.

For this monitoring period, the Monitor is unable to assess performance in the following areas: initial medical screens, mental health assessments (following a screening which identified a need for such an assessment), and follow-up care. Performance on periodic preventive visits is also not assessed; however, available and related DSS data are provided.

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[171] To view the Health Care Improvement Plan, see: https://dss.sc.gov/media/nesgioju/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf. To view the FSA Health Care Outcomes, see: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf. To view the Health Care Addendum, see: https://dss.sc.gov/media/0bdpenal/2-25-2019-approved-health-plan-addendum.pdf.
[172] Order directing the Parties to finalize a revised Health Care Plan approved by the Monitor on or before December 31, 2025 (October 15, 2025, Dkt. 382).
[173] Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan Required by October 15, 2025 Order (EFC 382) (December 30, 2025, Dkt. 389).
[174] Letter re: Co-Monitor's Provisional Approval of the *Michelle H.* Revised Health Care Improvement Plan, dated December 30, 2025 (January 27, 2026, Dkt. 391).
[175] Order setting February 27, 2026, as the deadline for final approval of the revised Health Care Improvement Plan by the Monitor (January 27, 2026, Dkt. 392).
[176] Order setting April 3, 2026, as the deadline for final approval of the revised Health Care Improvement Plan by the Monitor (February 27, 2026, Dkt 395).
[177] Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan (April 3, 2026, Dkt. 398).

Initial Medical Screens

FSA Requirement	*At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care.* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** There is not yet an approved methodology for measuring this outcome. The Monitor and DSS are engaged in conversations regarding potential approaches to methodology. New methodology will be included within the approved HCIP.

Comprehensive Medical Assessments

FSA Requirement	*At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care;* [and] *at least 95% will receive a comprehensive medical assessment within 60 days of entering care* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirements Not Met**: **45%** of children received a comprehensive medical assessment within 30 days of entering care, and **64%** received a comprehensive medical assessment within 60 days of entering care.

Health care data reporting timelines are adjusted each monitoring period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, data on initial comprehensive medical visits are reported for all children who entered care between March and August 2025. Data included in this section were extracted by DSS and DHHS from Medicaid administrative claims data and have not been validated by the Monitor.

Of the 1,069 children who entered foster care between March and August 2025 and who were in foster care for at least 30 days, 45 percent (482 of 1,069) received a comprehensive medical assessment within 30 days of entering care (Figure 46). Of those children who entered foster care during the months cited and who were in foster care for at least 60 days, 64 percent (528 of 826) received a comprehensive medical assessment within 60 days (Figure 47). Performance slightly decreased from MP17 and remains substantially below the final targets of 85 percent of children receiving an initial exam within 30 days, and 95 percent of children receiving an initial exam within 60 days.

Figure 46. Comprehensive Medical Assessments within 30 Days

Percentage of children who received a comprehensive medical assessment within 30 days of entering foster care, MP10 - 18 (September 2021 - August 2025)

Source: Medicaid claims data provided by DSS

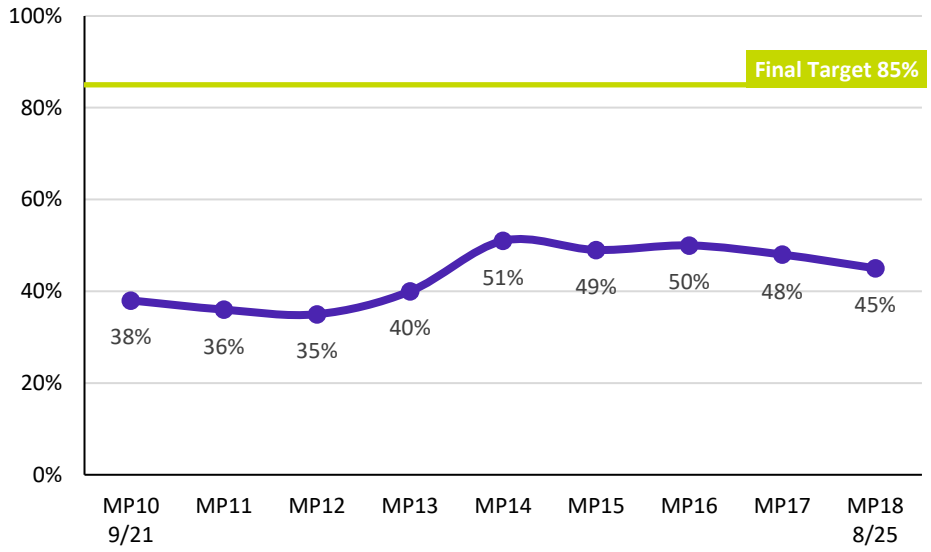
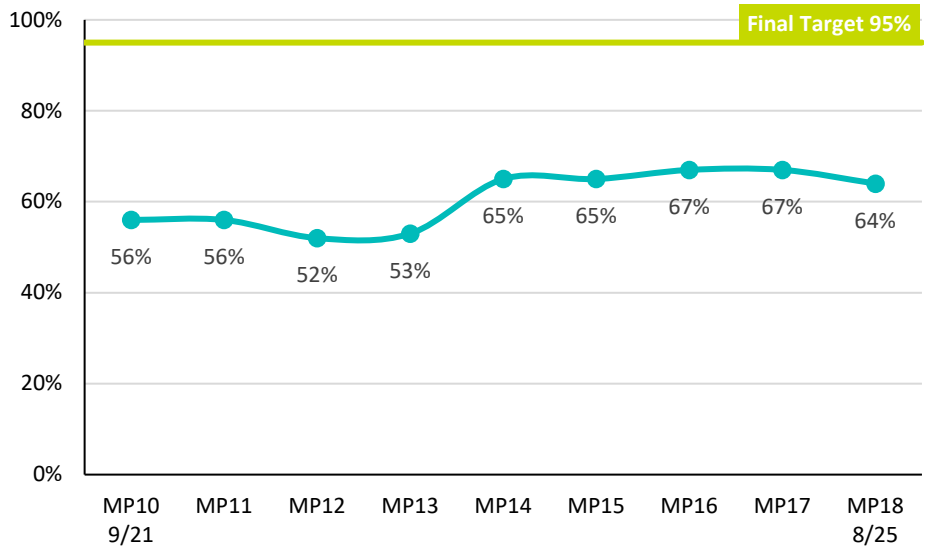


Figure 47. Comprehensive Medical Assessments within 60 Days

Percentage of children who received a comprehensive medical assessment within 60 days of entering foster care, MP10 - 18 (September 2021 - August 2025)

Source: Medicaid claims data provided by DSS



Developmental Assessments

FSA Requirement	*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;* [and] *at least 95% shall be referred within 45 days* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Met**: **93%** of children under 36 months of age were referred to developmental assessments within 30 days of entering care, and **95%** were referred within 45 days of entering care.

DSS provided data from CAPSS on referrals for developmental assessment of all children under 36 months of age who entered care during the monitoring period (April - September 2025). These data convey whether a child was referred for a developmental assessment and do not capture whether and when an assessment occurred.

According to DSS data, 93 percent of children (244 of 262) under 36 months of age who entered care in MP18 and who were in care for at least 30 days were referred to BabyNet — the state entity responsible for developmental assessments — within 30 days of their entry into foster care (Figure 48); and 95 percent of children (212 of 223) who were in foster care for at least 45 days were referred to BabyNet within 45 days (Figure 49).

The Court granted Maintenance of Effort status for this provision on October 18, 2024.[178] Since that time and through MP18, DSS continued to meet this FSA performance target. On December 17, 2025, the Court granted the Parties' Joint Motion for Termination and Exit from Court supervision on this FSA provision.[179] Consequently, performance on this requirement will no longer be monitored or included in future reports.

[178] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt. 329).
[179] Order on Motion for Miscellaneous Relief (December 17, 2025, Dkt. 388).

Figure 48. Developmental Assessments within 30 Days

Percentage of children under 36 months of age who were referred for a developmental assessment within 30 days of entering care, MP10 - 18 (September 2021 - September 2025)

Source: CAPSS data provided by DSS

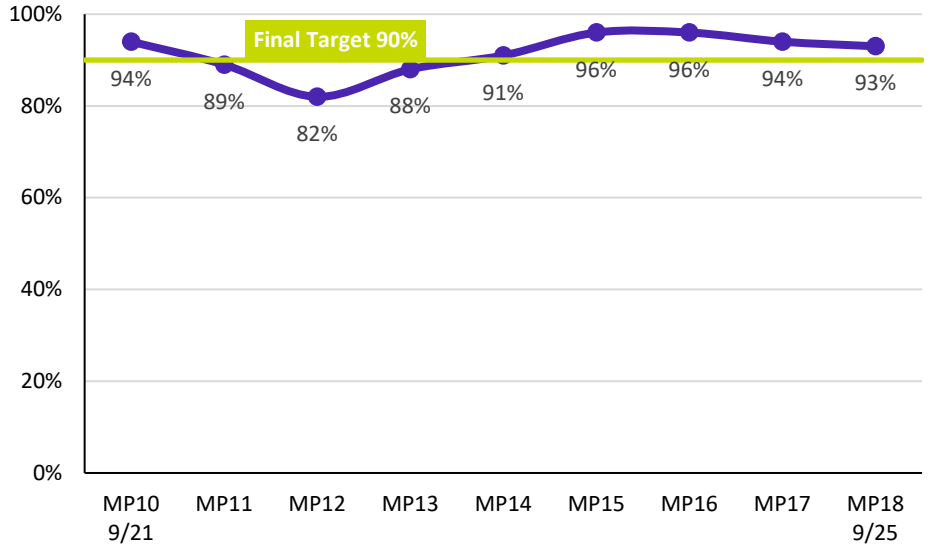
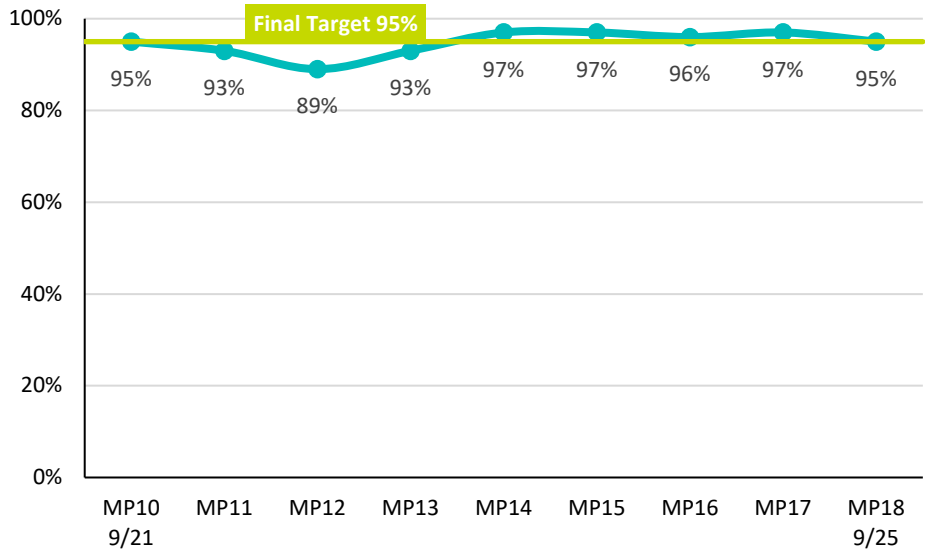


Figure 49. Developmental Assessments within 45 Days

Percentage of children under 36 months of age who were referred for a developmental assessment within 45 days of entering care, MP10 -18 (September 2021 - September 2025)

Source: CAPSS data provided by DSS



Dental Examination

FSA Requirements	*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;* [and] *at least 90% will receive a dental examination within 90 days of entering care* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Partially Met**: **60%** of children aged two and above received a dental examination within 60 days of entering care, and **70%** of children aged two and above received a dental examination within 90 days of entering care.

Health care data reporting timelines are adjusted each monitoring period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, data on initial dental visits are reported for all children who entered care between March and August 2025. Data included were extracted by DSS and DHHS from Medicaid administrative claims data and have not been validated by the Monitor.

DSS reported that 60 percent of children (361 of 598) aged two and older who entered foster care between March and August 2025 and who were in foster care for at least 60 days had a dental exam within 60 days (Figure 50), and 70 percent of children (306 of 439) aged two and older who remained in care for at least 90 days had a dental exam within 90 days (Figure 51).

Performance met the target for dental examination within 60 days of entering foster care but failed to meet the target of 90 percent of children receiving a dental examination within 90 days of entering foster care.

Figure 50. Initial Dental Examinations 60 Days

Percentage of children aged two and older who received a dental examination within 60 days of entering care, MP10 - 18 (September 2021 – August 2025)

Source: Medicaid claims data provided by DSS

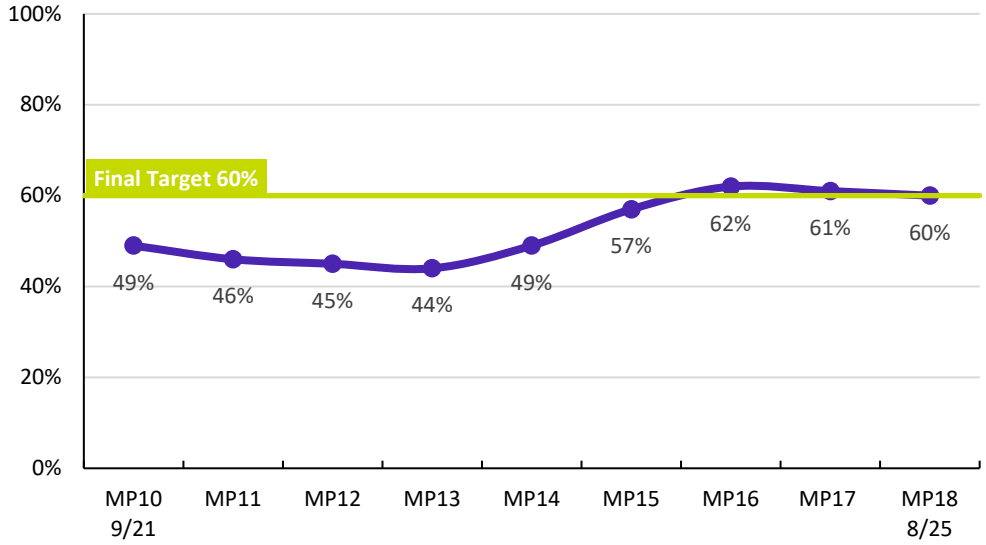
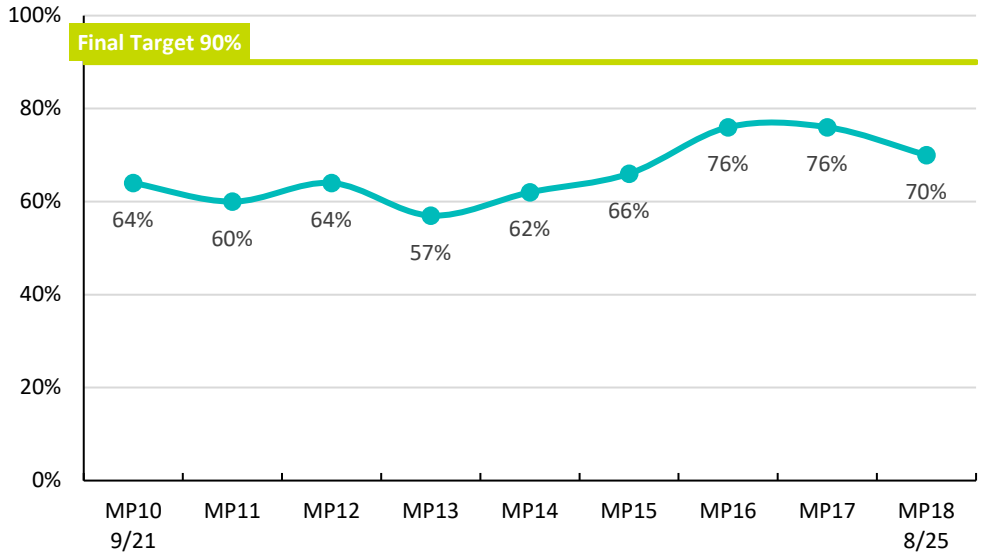


Figure 51. Initial Dental Examinations 90 Days

Percentage of children aged two and older who received a dental examination within 90 days of entering care, MP10 - 18 (September 2021 – August 2025)

Source: Medicaid claims data provided by DSS



Comprehensive Mental Health Assessment

FSA Requirement	*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* [and] *at least 95% will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** There is not yet an approved methodology for measuring this outcome. The Monitor and DSS are engaged in conversations regarding potential approaches to methodology. New methodology will be included within the approved HCIP.

Periodic Preventive Care

FSA Requirement	• At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. • At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines; and at least 98% will receive a periodic preventative visit semi-annually. • At least 90% of Class Members aged three and older in care for six months or more will receive a periodic preventative visit semi-annually; and at least 98% will receive a periodic preventative visit annually (FSA IV.K.5.).
Performance Assessment	**FSA Requirement Not Reported:** There is not yet an approved methodology for measuring this outcome. The Monitor and DSS are engaged in conversations regarding potential approaches to methodology. New methodology will be included within the approved HCIP.

DSS committed in its Health Care Outcomes that children within its care receive periodic preventative medical visits in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.[180] DSS and the Monitor determined that the initially approved methodology did not produce information that DSS leadership and frontline staff were able to use

[180] To view the AAP Recommendations for Preventative Pediatric Health Care, see: https://publications.aap.org/pediatrics/article/155/5/e2025071066/200933/2025-Recommendations-for-Preventive-Pediatric .

to improve health care delivery and outcomes for children in its care. As a result, performance for these FSA requirements is not reported. As part of the work to reach approval on the revised HCIP, the Monitor and DSS are engaged in conversations regarding potential approaches to a new methodology. The new methodology will be included within the approved HCIP.

While performance is not reported for these FSA requirements, related data provided by DSS that are used for day-to-day management and quality improvement are provided below. These data are validated by DSS regional nurses who review CAPSS for health care encounters entered by case managers and after-visit summaries completed by medical professionals. Data are also cross-checked with administrative data from DHHS and its MCO partner.

DSS reported that of all children 17 years and younger who were in foster care for at least 30 days, 68 percent (2,081 of 3,052) were up to date on their well-child visits as of September 2025 (Figure 52). Of the remaining children, 30 percent (921) were past due for their well-child visits, and two percent (50) did not have a well-child visit documented. These data are also reported by the age of the children (Figure 53). As determined by DSS, 13 percent of children under six months of age were up to date on their well-child visits as of September 2025. This represents a decline in performance from March 2025 when 25 percent of children were determined to be up to date.

Figure 52. Well-Child Visits

Percentage of children who were up to date on their well-child visits, MP10 – 18 (September 2021 - September 2025)

Source: CAPSS, DHHS, and MCO data provided by DSS

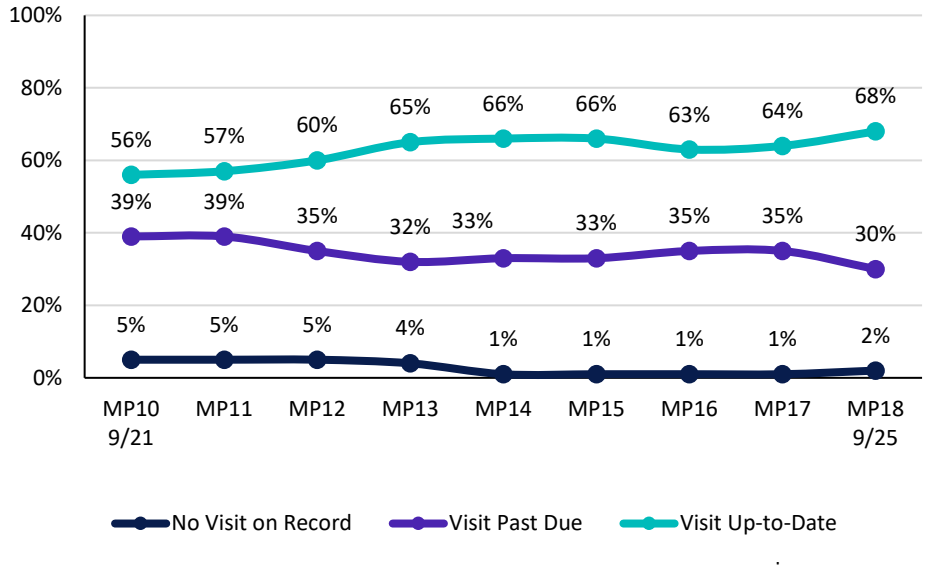
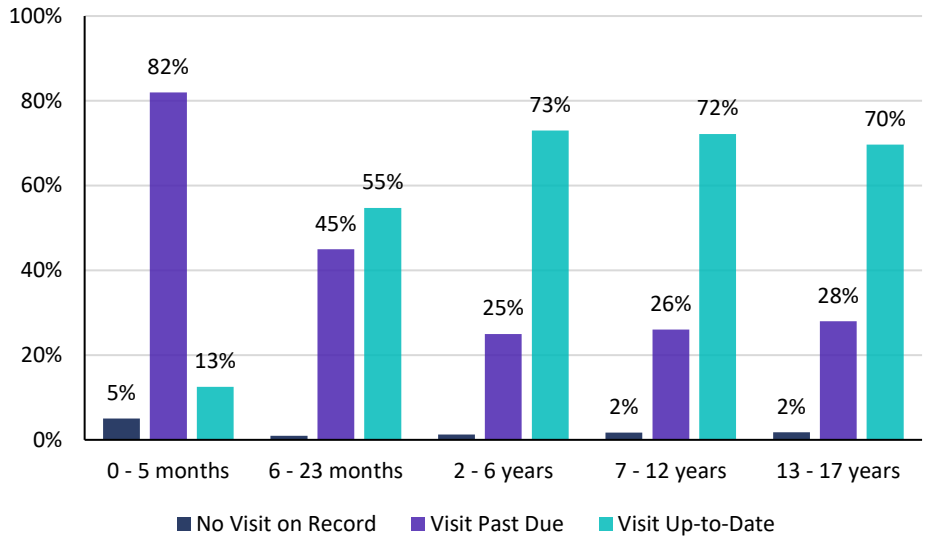


Figure 53. Well-Child Visits, by Age

Percentage of children who were up to date on their well-child visits by age, September 30, 2025
Source: CAPSS, DHHS, and MCO data provided by DSS



Periodic Preventive Dental Care

FSA Requirement	*At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually* [and] *at least 90% will receive a dental examination annually* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** There is not yet an approved methodology for measuring this outcome. The Monitor and DSS are engaged in conversations regarding potential approaches to methodology. New methodology will be included within the approved HCIP.

DSS and the Monitor determined that the initially approved methodology did not produce information that DSS leadership and frontline staff were able to use to improve health care delivery and outcomes for children in its care. As a result, performance for these FSA requirements is not reported. As part of the work to reach approval on the revised HCIP, the Monitor and DSS are engaged in conversations regarding potential approaches to a new methodology. The new methodology will be included within the approved HCIP.

While performance is not reported for these FSA requirements, data regarding semi-annual dental examinations used by DSS for day-to-day management and quality improvement are provided below. These data are validated by DSS regional nurses who review CAPSS for health care encounters entered by case managers and for after-visit summaries completed by medical

professionals. Data are also cross-checked with administrative data from DHHS and its MCO partner.

DSS reported that of children aged two through 17 who were in care for at least 30 days, 72 percent (1,915 of 2,654) were up to date on their semi-annual dental examination as of September 2025 (Figure 54). Of the remaining children, 25 percent (652) were past due for their dental exam, and three percent (87) had no dental examination documented. These data are also reported by age (Figure 55). As determined by DSS, performance slightly increased for children aged two through six, with 73 percent up to date on their dental exams as compared to 69 percent during the last monitoring period. Performance was unchanged for children aged seven through 12 who were up to date on their dental examination; for children aged 13 through 17 who were up to date on their dental examination, performance slightly increased to 72 percent in MP18 from 68 percent in MP17.

Figure 54. Periodic Dental Examinations

Percentage of children aged two to 17 years who were up to date on their dental examinations, MP10 – 18 (September 2021 -September 2025)

Source: CAPSS, DHHS, and MCO data provided by DSS

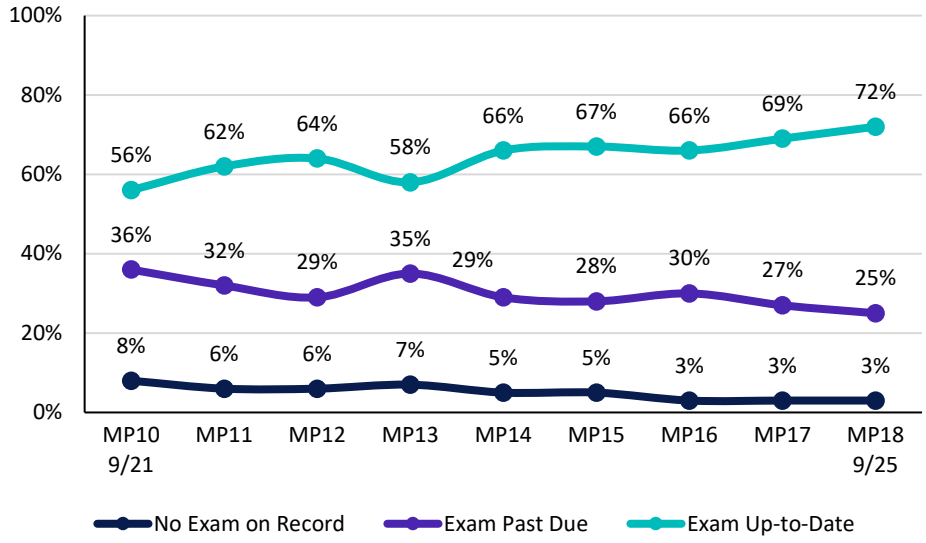
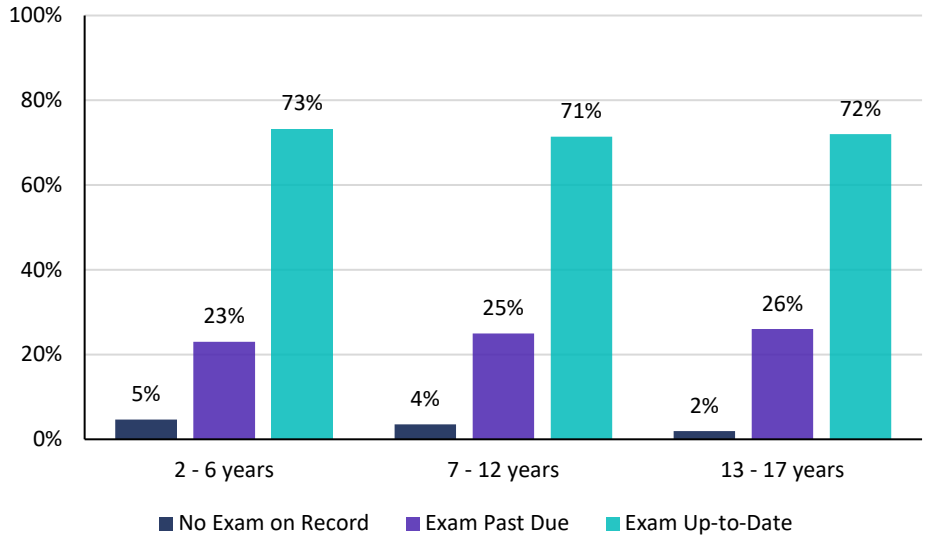


Figure 55. Periodic Dental Examinations, by Age

Percentage of children aged two to 17 years who were up to date on their dental examinations, September 2025

Source: CAPSS, DHHS, and MCO data provided by DSS



Follow-up Care

FSA Requirements	*At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.* (FSA IV.K.5.; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** There is not yet an approved methodology for measuring this outcome. The Monitor and DSS are engaged in conversations regarding potential approaches to methodology. New methodology will be included within the approved HCIP

Discussion

The revised HCIP including the methodologies that will be used to assess DSS's performance in meeting the Health Care Outcomes was recently submitted to the Court and reflects the State's clear commitment and significant work by DSS and its partners towards meeting the health care needs of children in foster care. The Plan importantly demonstrates increased alignment and collaboration among DSS and its many key partners – DHHS, MCOs, CPAs and group home providers and the Department of Behavioral Health and Developmental Disabilities' Office of Mental Health (DBHDD OMH) – who must work together to improve health and well-being

outcomes of children in foster care.[181] The revised HCIP outlines DSS's strategies for addressing the underlying health and well-being needs of children in foster care, including implementation timelines, performance targets, and processes for continuous quality improvement. DSS, in collaboration with the Monitor and with input from Plaintiffs' counsel, worked to finalize methodologies for measuring performance toward meeting outcomes within the Plan and as required by the FSA. These methodologies were included as an addendum to the revised HCIP which was submitted for full approval from the Court on April 3, 2026.[182] The Plan is included in Appendix G of this report.

Key components of the HCIP include:

- *Cross-sector collaboration and data sharing mechanisms* among DHHS, DBHDD OMH, MCO, CPA/group home providers, caregivers, and DSS staff. These include: agreements to share data; interagency staffings to address the complex needs of children in care; development of a process for authorizing and accessing specialized Medicaid EPSDT services; partner access to input information into DSS's Child and Adolescent Information Portal; and ongoing interagency meetings to coordinate efforts and resolve barriers.
- *Clarified MCO roles and responsibilities* including the provision of a care coordination and case management system that assigns children into one of four tiers based on assessed risk (low, moderate, high risk, and intensive case management). The MCO is also responsible for ensuring continuity of care across providers and transitions, as well as scheduling and following up on physical, dental, and behavioral health appointments for children in foster care.
- *Plans to conduct a landscape analysis* of behavioral health services to identify gaps and develop strategies to address unmet needs.
- *Establishment of the Foster Care Oversight Committee* a new iteration of the Foster Care Health Advisory Committee, charged with supporting HCIP implementation. The committee is led by DSS and DHHS, and includes representatives from DBHDD OMH, the MCO, and a diverse array of medical and behavioral professionals across the state.
- *Implementing standardized initial medical screening practices* by transitioning from DSS staff-conducted initial medical screens to screenings performed by community-based healthcare providers within 72 hours of a child's entry into foster care, thereby promoting timely and consistent access to care.
- *Strengthening early identification of mental and behavioral health needs* by aligning practice with methodology and utilizing each child's first finalized, fidelity-administered

[181] An Act to Amend the South Carolina Code of Laws (S.B. 2) was signed by the Governor on April 28, 2025, creating the new agency within the executive branch overseeing behavioral health and developmental disability services. To view bill text and legislative history, see https://www.scstatehouse.gov/sess126_2025-2026/bills/2.htm.

[182] Letter from J. Michael Montgomery Providing Revised Health Care Improvement Plan (April 3, 2026, Dkt. 398).

Child and Adolescent Needs and Strengths tool (CANS) assessment to determine the need for a comprehensive mental health evaluation.

- *Operationalizing measurement of previously untracked outcomes* by defining metrics and processes for establishing baseline and interim benchmarks for outcome measures where DSS performance has not been assessed since the inception of the lawsuit (FSA requirements for: initial medical screens, initial mental health assessments, and follow-up care).
- *Enhancing DSS's CAPSS data system* by refining existing data fields, developing additional fields to capture critical information, and enabling partner access for timely data entry and information sharing.
- *Implementing robust continuous quality improvement processes* to monitor and make data-guided improvements in the quality of health care provided.

It remains essential that DSS's collaboration with its partners to expand Medicaid-funded behavioral health services is successful. Significant work remains in key areas, including assessing and ensuring provider network adequacy, and expanding quality and accessible, community-based services and resources statewide.

In addition to efforts undertaken over the past year to revise the HCIP, DHHS's January 2025 amendments to the MCO contract more clearly defined the MCO's roles and responsibilities and established a tiered care coordination and case management model designed to match service intensity to each child's assessed needs. A key contractual enhancement is the requirement that children in foster care with four co-occurring conditions who meet eligibility criteria receive intensive case management. Under this model, eligible children are to receive face-to-face visits from MCO staff and a person-centered care plan that includes identification of strengths, preferences, needs, and desired outcomes; specification of supports and services to meet identified needs, regardless of current availability; identification of service providers; and transition planning for children moving from institutional to community-based settings.

As of March 4, 2026, 879 children in foster care statewide were enrolled in intensive case management statewide. In addition, on August 1, 2025, DHHS implemented a pilot program in Richland County under which all children in foster care receive intensive case management through the MCO partner. As of March 4, 2026, 416 of 419 (99%) children in Richland County were enrolled in the pilot. These contractual and programmatic changes represent important steps toward clarifying care coordination responsibilities and improving health care outcomes for children in DSS's care.

The Monitor believes that effective implementation of the HCIP and its commitments discussed above have the potential to improve health care outcomes for Class Members. This will require sustained cooperation and collaboration among all of DSS's partners.

V. Appendix/Sources

A. Table of Monitoring Periods

Table 3. Monitoring Periods

Monitoring Periods		
MP18	April 1, 2025	September 30, 2025
MP17	October 1, 2024	March 31, 2025
MP16	April 1, 2024	September 30, 2024
MP15	October 1, 2023	March 31, 2024
MP14	April 1, 2023	September 30, 2023
MP13	October 1, 2022	March 31, 2023
MP12	April 1, 2022	September 30, 2022
MP11	October 1, 2021	March 31, 2022
MP10	April 1, 2021	September 30, 2021
MP9	October 1, 2020	March 31, 2021
MP8	April 1, 2020	September 30, 2020
MP7	October 1, 2019	March 31, 2020
MP6	April 1, 2019	September 30, 2019
MP5	October 1, 2018	March 31, 2019
MP4	April 1, 2018	September 30, 2018
MP3	October 1, 2017	March 31, 2018
MP2	April 1, 2017	September 30, 2017
MP1	October 1, 2016	March 31, 2017

B. Monitoring Activities

The Monitor is responsible for independent validation of data and documentation to compile and issue public reports on the State's performance with respect to the terms of the FSA. In carrying out this responsibility, the Monitor and staff have worked closely with DSS leadership and staff. The Monitor used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external partners, including providers, advocates, and community organizations. The Monitor worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Monitor and staff conducted an in-person site visit to the Richland County DSS office, a small capacity group home, Welcome Center, and one a Day Center in Richland County and additionally met with DSS and provider leadership and direct service staff. The site visit also included visits to an Assessment and Placement Center and Activity Center in Darlington County. The Monitor participated in the Richland County Task Force and with each of the five workgroups. Additionally, the Monitor also met with a range of involved parties throughout and following the monitoring period.

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

- Review of monthly caseload and workload reports for foster care, permanency, and out-of-home abuse and neglect (OHAN) case managers and team leaders (FSA IV.A.2.(b)&(c)).
- Review of all OHAN investigation records in CAPSS involving Class Members as an alleged victim and accepted in September 2025, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.).
- Review of 20 case records in CAPSS for Class Members with documented face-to-face contact between the case manager and the child during the month of September 2025. (FSA IV.B.3).
- Qualitative review of 23 Class Members for whom a final CANS was completed in September 2024 that included a recommendation for a therapeutic level of placement, for whom a subsequent CFTM occurred, and who were not placed in the CANS recommended level of therapeutic placement (FSA IV.I.2.3.&6.).
- Review of case files of Class Members aged six and under who were placed in a congregate setting between April 1, 2025 to September 30, 2025 (FSA IV.D.2.).
- Review of a statistically valid sample of case records in CAPSS for Class Members who had been in foster care for 30 days or more on September 30, 2025, and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in September 2025 (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, 2025, to assess whether the child visited with the parent(s) with whom reunification was sought during September 2025 (FSA IV.J.3.).
- Site visits to Richland County DSS office, a small group home, Welcome Center, and a Day Center in Richland County as well as an Assessment and Placement Center and Activity Center in Darlington County between March 12 and March 13, to meet with leadership and staff. Facilitation of focus groups with the Palmetto Association for Children and Families, mobile rapid response staff, and the YEA! (Youth Education Advocates) group.
- Participation in the quarterly Richland County Task Force meetings on April 24, 2025; July 31, 2025; and October 30, 2025.
- Co-facilitation of one of the five Richland County Task Force workgroups: Capacity Building for Placement Array and participation in Enhancing Skills and Capacity, Kin-First Implementation, Community Action, and Educational Needs for Children in Foster Care.

C. Glossary of Acronyms

AAP: American Academy of Pediatrics

ADR: Office of Accountability, Data, and Research

AFDC: Aid to Families with Dependent Children

CAPSS: Child and Adult Protective Services System

CFTM: Child and Family Team Meeting

CMS: Center for Medicare and Medicaid Services

CPA: Child Placing Agency

CQI: Continued Quality Improvement

CSSP: Center for the Study of Social Policy

CWIT: Child Welfare Improvement Team

DBH DDOMH: the Department of Behavioral Health and Developmental Disabilities' Office of Mental Health

DHHS: Department of Health and Human Services

DJJ: Department of Juvenile Justice

DSS: Department of Social Services

EPC: Emergency Protective Custody

EPSDT: Early and Periodic, Screening, Diagnostic and Treatment

FFPSA: Family First Prevention Services Act

FMAP: Federal Medical Assistance Percentage

FFY: Federal Fiscal Year

FSA: Final Settlement Agreement

FTE: Full-Time Equivalent

GPS: Guiding Principles and Standards Case Practice Model

LPHA: Licensed Practitioner of the Healing Arts

MCO: Managed Care Organization

MST: Multi-Systemic Therapy

OHAN: Out of Home Abuse and Neglect Unit

QRTP: Qualified Residential Treatment Program

RC/RCDSS: Richland County/ Richland County DSS

SFY: State Fiscal Year

D. County-Level Data

Table 4. Children in Foster Care by County of Origin and Rate Per 1,000 Children in the County Child Population[183]

September 30, 2025

Source: CAPSS data provided by DSS; U.S. Census Bureau

County of Origin	Children in Foster Care	County Child Population (2024)	Children in Foster Care Per 1,000
Abbeville	9	4,735	1.9
Aiken	99	38,448	2.6
Allendale	9	1,313	6.9
Anderson	103	48,251	2.1
Bamberg	3	2,310	1.3
Barnwell	5	4,821	1.0
Beaufort	55	34,009	1.6
Berkeley	146	60,828	2.4
Calhoun	1	2,612	0.4
Charleston	214	82,390	2.6
Cherokee	29	12,952	2.2
Chester	43	6,972	6.2
Chesterfield	12	9,832	1.2
Clarendon	30	5,424	5.5
Colleton	61	8,859	6.9
Darlington	76	13,887	5.5
Dillon	19	6,870	2.8
Dorchester	57	41,233	1.4
Edgefield	10	4,695	2.1
Fairfield	18	3,609	5.0
Florence	79	31,981	2.5
Georgetown	19	10,675	1.8
Greenville	294	128,128	2.3
Greenwood	24	15,291	1.6
Hampton	21	3,697	5.7
Horry	215	67,685	3.2
Jasper	30	6,128	4.9
Kershaw	92	16,575	5.6
Lancaster	90	24,040	3.7

[183] U.S. Census Bureau. (2024). *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2024 (CC-EST2024-AGESEX-45)* — South Carolina.

County of Origin	Children in Foster Care	County Child Population (2024)	Children in Foster Care Per 1,000
Laurens	104	15,205	6.8
Lee	17	3,111	5.5
Lexington	134	71,117	1.9
Marion	47	6,128	7.7
Marlboro	11	5,002	2.2
McCormick	6	990	6.1
Newberry	16	8,256	1.9
Oconee	69	15,261	4.5
Orangeburg	95	17,459	5.4
Pickens	43	25,255	1.7
Richland	416	91,043	4.6
Saluda	20	4,329	4.6
Spartanburg	184	85,399	2.2
Sumter	66	24,360	2.7
Union	16	5,396	3.0
Williamsburg	49	5,545	8.8
York	161	69,965	2.3
State	**3,317**	**1,152,071**	**2.9**

Table 5. Entries to Foster Care and Entries via EPC from Law Enforcement (EPC-LE), by County September 30, 2025

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

Office Of Case Management	EPC-LE Entries	All Entries	Percent EPC-LE Entry
Abbeville	0	0	–
Aiken	24	43	56%
Allendale	0	1	0%
Anderson	23	39	59%
Bamberg	2	2	100%
Barnwell	3	4	75%
Beaufort	12	24	50%
Berkeley	57	74	77%
Calhoun	0	0	–
Charleston	81	104	78%
Cherokee	10	19	53%

Office Of Case Management	EPC-LE Entries	All Entries	Percent EPC-LE Entry
Chester	4	19	21%
Chesterfield	9	9	100%
Clarendon	4	10	40%
Colleton	25	27	93%
Darlington	39	39	100%
Dillon	13	14	93%
Dorchester	13	15	87%
Edgefield	0	0	–
Fairfield	2	4	50%
Florence	38	40	95%
Georgetown	4	6	67%
Greenville	84	119	71%
Greenwood	7	9	78%
Hampton	9	13	69%
Horry	100	125	80%
Jasper	8	11	73%
Kershaw	14	28	50%
Lancaster	22	37	59%
Laurens	29	31	94%
Lee	8	8	100%
Lexington	43	64	67%
Marion	31	34	91%
Marlboro	6	6	100%
McCormick	2	3	67%
Newberry	5	5	100%
Oconee	19	28	68%
Orangeburg	39	48	81%
Pickens	17	22	77%
Richland	147	180	82%
Saluda	6	9	67%
Spartanburg	72	103	70%
Sumter	6	24	25%
Union	2	8	25%
Williamsburg	11	19	58%
York	23	63	37%
State	**1,073**	**1,490**	**72%**

Table 6. Out-of-County Placements, by County[184]

September 30, 2025

Source: CAPSS data provided by DSS

County of Origin	Children placed Out-of-County	Children in Foster Care	Percent Placed Out-of-County
Abbeville	9	9	100%
Aiken	62	97	64%
Allendale	9	9	100%
Anderson	75	102	74%
Bamberg	3	3	100%
Barnwell	3	5	60%
Beaufort	27	55	49%
Berkeley	94	145	65%
Calhoun	1	1	100%
Charleston	137	208	66%
Cherokee	22	29	76%
Chester	39	43	91%
Chesterfield	8	12	67%
Clarendon	27	30	90%
Colleton	50	61	82%
Darlington	64	76	84%
Dillon	15	18	83%
Dorchester	40	56	71%
Edgefield	10	10	100%
Fairfield	16	18	89%
Florence	47	78	60%
Georgetown	10	19	53%
Greenville	199	292	68%
Greenwood	22	23	96%
Hampton	9	21	43%
Horry	117	213	55%
Jasper	27	30	90%
Kershaw	72	92	78%
Lancaster	53	90	59%
Laurens	86	104	83%
Lee	11	16	69%
Lexington	90	131	69%
Marion	24	46	52%
Marlboro	11	11	100%

[184] This data excludes 31 children who resided in other institutional settings on September 30, 2025.

County of Origin	Children placed Out-of-County	Children in Foster Care	Percent Placed Out-of-County
McCormick	6	6	100%
Newberry	13	16	81%
Oconee	46	69	67%
Orangeburg	63	94	67%
Pickens	34	43	79%
Richland	222	414	54%
Saluda	14	20	70%
Spartanburg	109	181	60%
Sumter	34	65	52%
Union	8	16	50%
Williamsburg	24	49	49%
York	105	160	66%
State	**2,167**	**3,286**	**66%**

Table 7. Exits from Foster Care within 7 Days of Entry, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

County of Origin	Number of Exits within 7 Days	Total Number of Exits During MP18	Percentage of Exits within 7 Days
Aiken	8	17	47%
Anderson	10	31	32%
Beaufort	2	12	17%
Berkeley	13	65	20%
Charleston	19	73	26%
Cherokee	2	17	12%
Darlington	2	36	6%
Dorchester	2	5	40%
Florence	5	16	31%
Greenville	19	58	33%
Greenwood	1	13	8%
Horry	26	86	30%
Kershaw	4	18	22%
Lancaster	2	11	18%
Laurens	4	14	29%
Lexington	10	40	25%
Marion	7	31	23%

County of Origin	Number of Exits within 7 Days	Total Number of Exits During MP18	Percentage of Exits within 7 Days
Marlboro	1	8	13%
Oconee	1	20	5%
Orangeburg	5	25	20%
Pickens	3	19	16%
Richland	15	151	10%
Spartanburg	21	84	25%
Union	1	4	25%
York	3	44	7%
State	**186**	**1,232**	**15%**

Table 8. Placement Moves, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Placement Moves	Number of Children with Placement Move	Children In Care at Any Point During MP18	Percentage of Children with Placement Move
Abbeville	5	2	11	18%
Aiken	111	46	100	46%
Allendale	12	3	12	25%
Anderson	93	46	120	38%
Bamberg	4	1	2	50%
Barnwell	21	5	7	71%
Beaufort	78	40	61	66%
Berkeley	267	105	197	53%
Calhoun	0		1	0%
Charleston	234	120	258	47%
Cherokee	59	26	41	63%
Chester	84	20	50	40%
Chesterfield	19	7	14	50%
Clarendon	17	13	27	48%
Colleton	55	31	68	46%
Darlington	123	54	91	59%
Dillon	24	20	33	61%
Dorchester	60	23	58	40%
Edgefield	31	5	10	50%
Fairfield	13	7	12	58%

Office Of Case Management	Number of Placement Moves	Number of Children with Placement Move	Children In Care at Any Point During MP18	Percentage of Children with Placement Move
Florence	63	28	86	33%
Georgetown	53	8	18	44%
Greenville	339	154	285	54%
Greenwood	30	12	32	38%
Hampton	23	15	33	45%
Horry	336	137	265	52%
Jasper	29	17	40	43%
Kershaw	79	31	75	41%
Lancaster	49	35	84	42%
Laurens	87	52	95	55%
Lee	24	10	21	48%
Lexington	154	66	145	46%
Marion	120	26	75	35%
Marlboro	9	6	9	67%
Mccormick	7	5	8	63%
Newberry	9	5	12	42%
Oconee	129	44	78	56%
Orangeburg	126	58	119	49%
Pickens	77	14	52	27%
Regional Permanency Lowcountry Charleston	120	48	101	48%
Regional Permanency Midlands Columbia	168	69	142	49%
Regional Permanency Midlands Orangeburg	24	18	39	46%
Regional Permanency Midlands Rock Hill	76	39	119	33%
Regional Permanency Pee Dee Florence	88	52	138	38%
Regional Permanency Upstate Greenville	320	147	276	53%
Richland	719	227	506	45%
Saluda	31	9	20	45%
Spartanburg	270	112	232	48%
Sumter	72	31	60	52%
TSS Division--Low Country	4	3	7	43%
TSS Division--Midlands	11	3	18	17%
TSS Division--Pee Dee	6	3	12	25%
TSS Division--Upstate	79	12	25	48%
Union	10	9	19	47%
Williamsburg	51	29	46	63%
York	120	68	160	43%

Office Of Case Management	Number of Placement Moves	Number of Children with Placement Move	Children In Care at Any Point During MP18	Percentage of Children with Placement Move
State	**5,222**	**2,176**[185]	**4,625**[186]	**47%**

Table 9. Overnight Stays, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Overnight Stays	Number of Children with At Least One Overnight Stay	Children In Care at Any Point During MP18	Percentage of Children with at Least One Overnight Stay
Aiken	52	20	99	20%
Anderson	4	2	120	2%
Bamberg	1	1	2	50%
Barnwell	1	1	7	14%
Berkeley	43	18	189	10%
Charleston	7	3	250	1%
Cherokee	2	1	40	3%
Chester	4	2	50	4%
Chesterfield	2	1	14	7%
Colleton	21	5	68	7%
Darlington	10	4	90	4%
Dillon	1	1	33	3%
Edgefield	7	3	10	30%
Fairfield	1	1	12	8%
Florence	10	4	86	5%
Georgetown	25	5	18	28%
Greenville	8	4	281	1%
Greenwood	6	3	31	10%
Horry	41	10	254	4%

[185] The number of children that moved at least once sums to 2,176 rather than 2,167 due to nine children who had two different episodes in foster care during MP 18 in two different counties.

[186] The number of children in care at any point during MP18 sums to 4,625, while the unduplicated total is 4,616 due to nine children who had two different episodes in foster care during MP18 in two different counties.

Office Of Case Management	Number of Overnight Stays	Number of Children with At Least One Overnight Stay	Children In Care at Any Point During MP18	Percentage of Children with at Least One Overnight Stay
Kershaw	4	2	75	3%
Lancaster	3	1	84	1%
Laurens	1	1	95	1%
Lee	1	1	21	5%
Lexington	26	5	138	4%
Marion	32	10	74	14%
Marlboro	1	1	9	11%
Newberry	1	1	12	8%
Oconee	2	1	77	1%
Orangeburg	6	3	117	3%
Pickens	13	5	49	10%
Regional Permanency Lowcountry	2	1	101	1%
Regional Permanency Midlands	26	6	300	2%
Regional Permanency Pee Dee	11	4	138	3%
Regional Permanency Upstate	12	5	275	2%
Richland	189	34	501	7%
Saluda	6	3	20	15%
Spartanburg	26	9	230	4%
Sumter	1	1	60	2%
Williamsburg	7	4	46	9%
York	6	3	161	2%
State	**622**	**190**	**4,566**	**4%**

Table 10. Emergency Placements, by County

MP18 (April – September 2025)

Source: CAPSS data provided by DSS

Office Of Case Management	Number of Nights Spent in Emergency Placements	Number of Children with At Least One Emergency Placement	Children In Care at Any Point During MP18	Percentage of Children with at Least One Emergency Placement
Abbeville	--	--	11	0%
Aiken	194	9	100	9%
Allendale	31	1	12	8%
Anderson	67	10	120	8%
Bamberg	--	--	2	0%
Barnwell	16	1	7	14%
Beaufort	68	6	61	10%
Berkeley	402	31	197	16%
Calhoun	--	--	1	0%
Charleston	463	32	258	12%
Cherokee	53	9	41	22%
Chester	101	7	50	14%
Chesterfield	6	2	14	14%
Clarendon	1	1	27	4%
Colleton	20	4	68	6%
Darlington	148	9	91	10%
Dillon	--	--	33	0%
Dorchester	54	7	58	12%
Edgefield	6	1	10	10%
Fairfield	--	--	12	0%
Florence	134	13	86	15%
Georgetown	80	5	18	28%
Greenville	503	61	285	21%
Greenwood	32	5	32	16%
Hampton	16	2	33	6%
Horry	392	26	265	10%
Jasper	8	2	40	5%
Kershaw	21	6	75	8%
Lancaster	48	7	84	8%
Laurens	106	20	95	21%
Lee	4	3	21	14%
Lexington	228	18	145	12%
Marion	155	10	75	13%
Marlboro	7	2	9	22%

Office Of Case Management	Number of Nights Spent in Emergency Placements	Number of Children with At Least One Emergency Placement	Children In Care at Any Point During MP18	Percentage of Children with at Least One Emergency Placement
McCormick	10	2	8	25%
Newberry	3	3	12	25%
Oconee	223	25	78	32%
Orangeburg	42	8	119	7%
Pickens	247	14	52	27%
Regional Permanency Lowcountry Charleston	228	10	101	10%
Regional Permanency Midlands Columbia	361	16	142	11%
Regional Permanency Midlands Orangeburg	85	3	39	8%
Regional Permanency Midlands Rock Hill	68	4	119	3%
Regional Permanency Pee Dee Florence	105	7	138	5%
Regional Permanency Upstate Greenville	412	21	276	8%
Richland	1219	89	506	18%
Saluda	42	3	20	15%
Spartanburg	644	50	232	22%
Sumter	48	2	60	3%
TSS Division--Low Country	36	3	7	43%
TSS Division--Midlands	102	7	18	39%
TSS Division--Pee Dee	32	2	12	17%
TSS Division--Upstate	247	11	25	44%
Union	56	3	19	16%
Williamsburg	36	3	46	7%
York	67	10	160	6%
State	**7,677**	**606**	**4,625**[187]	**13%**

[187] The number of children in care at any point during MP18 sums to 4,625, while the unduplicated total is 4,616 due to nine children who had two different episodes in foster care during MP18 in two different counties.

Table 11. Foster Care Case Manager Caseload Compliance, by County

MP18 (September 30, 2025)

Source: CAPSS data provided by DSS

Office Of Case Management	Total Number of Case Managers Serving 1 Or More Class Members	Number of Case Managers Within the Standard	Percentage of Case Managers Within the Standard
Abbeville	2	2	100%
Aiken	10	8	80%
Allendale	2	2	100%
Anderson	14	14	100%
Bamberg	1	1	100%
Barnwell	1	1	100%
Beaufort	7	4	57%
Berkeley	12	5	42%
Calhoun	1	1	100%
Charleston	28	22	79%
Cherokee	2	2	100%
Chester	5	4	80%
Chesterfield	2	2	100%
Clarendon	3	2	67%
Colleton	4	2	50%
Darlington	7	7	100%
Dillon	5	5	100%
Dorchester	5	5	100%
Edgefield	-	-	-
Fairfield	2	2	100%
Florence	5	4	80%
Georgetown	2	2	100%
Greenville	27	21	78%
Greenwood	3	3	100%
Hampton	2	2	100%
Horry	18	17	94%
Jasper	6	5	83%
Kershaw	10	10	100%
Lancaster	5	0	0%
Laurens	6	3	50%
Lee	2	2	100%
Lexington	14	13	93%
Marion	4	3	75%
Marlboro	2	2	100%

Office Of Case Management	Total Number of Case Managers Serving 1 Or More Class Members	Number of Case Managers Within the Standard	Percentage of Case Managers Within the Standard
McCormick	1	1	100%
Newberry	1	1	100%
Oconee	9	9	100%
Orangeburg	8	6	75%
Pickens	6	6	100%
Regional Permanency Lowcountry Charleston	11	5	45%
Regional Permanency Midlands Columbia	8	0	0%
Regional Permanency Midlands Orangeburg	5	4	80%
Regional Permanency Midlands Rock Hill	10	4	40%
Regional Permanency Pee Dee Florence	19	17	89%
Regional Permanency Upstate Greenville	39	39	100%
Richland	44	38	86%
Saluda	1	0	0%
Spartanburg	21	21	100%
Sumter	5	5	100%
Union	2	2	100%
Williamsburg	4	4	100%
York	13	13	100%
State	**334**	**284**	**85%**

E. Summary Performance on FSA Requirements

Summary of Performance on Final Settlement Agreement Requirements						
PLACEMENTS						
1. Placement Moves: 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.). *(Data for this requirement are produced on an annual basis.)*						
Target	**Baseline**	**10/21-9/22**	**10/22-9/23**	**10/23-9/24**	**10/24-9/25**	**Current Status**
≤ 3.37 moves per 1,000 days	**3.55** (10/16-9/17)	5.70	6.07	6.64	7.90	Target Not Met
2. Overnight Stays in DSS Offices and Hotels: DSS shall cease using DSS offices as overnight placement for Class Members and shall cease placing or housing any Class Members in hotels, motels, and other commercial non-foster care establishments (FSA IV.D.3.).						
Target	**Baseline**	**MP15**	**MP16**	**MP17**	**MP18**	**Current Status**
= 0 children	N/A	249	188	216	190	Target Not Met
3. Emergency or Temporary Placements for More than 30 Days: Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. (FSA IV.E.4.).						
Target	**Baseline**	**MP15**	**MP16**	**MP17**	**MP18**	**Current Status**
= 0 children	N/A	25	22	20	6	Target Not Met
4. Emergency or Temporary Placements for More than Seven Days: 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.).						
Target	**Baseline**	**MP15**	**MP16**	**MP17**	**MP18**	**Current Status**
= 0 children	N/A	170	216	137	149	Target Not Met

Summary of Performance on Final Settlement Agreement Requirements

5. Congregate Care Placements: 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.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 86%	78% (3/2018)	88%	87%	87%	86%	Target Met

6. Congregate Care Placements – Children Ages 12 and Under: 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 (FSA IV.E.3.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 98%	92% (3/2018)	98%	98%	99%	98%	Exit and Termination (Granted 12/17/25)

7. Congregate Care Placements—Children Ages 6 and Under: Prevent, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family placement (FSA IV.D.2.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
= 0 children	N/A	0	0	0	0	Exit and Termination (Granted 12/17/25)

8. Juvenile Justice Placements: 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 (FSA IV.H.1.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
= 0 children	N/A	N/A	N/A	N/A	N/A	Not Reported

Summary of Performance on Final Settlement Agreement Requirements

9. Therapeutic Placements and/or Services – Referral for Placement and/or Services: At least 95% of Class Members that are both identified through an approved CANS as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) will be referred for such recommended placement and/or services within 30 days of the date of the CFTM (FSA IV.I.2.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	**84%** (10/2025)	N/A	N/A	N/A	N/A	**Reporting to Begin MP19**

10. Therapeutic Placements and/or Services – Reassessment: At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs (FSA IV.I.3.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	**100%** (10/2025)	N/A	N/A	N/A	N/A	**Reporting to Begin MP19**

11. Therapeutic Placements and/or Services – Receipt of Placement and Services: At least 90% of children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family team and incorporated into DSS' case and service plan within sixty (60) days following the date of the CFTM during which the recommendations were made (FSA IV.I.6.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**47%** (10/2025)	N/A	N/A	N/A	N/A	**Reporting on Interim Benchmarks to Begin MP19**

Summary of Performance on Final Settlement Agreement Requirements

CASE MANAGER CASELOADS AND CONTACTS WITH CHILDREN

12. Workload within Applicable Limit: At least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit (FSA IV.A.2.(b)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
Case Managers						
OHAN ≥ 90%	**0%** (9/2017)	100%	100%	100%	100%	Target Met
Foster Care ≥ 90%	**28%** (9/2017)	68%	70%	81%	85%	Target Not Met
Permanency ≥ 90%	**23%** (9/2017)	67%	66%	73%	75%	Target Not Met
Team Leaders						
OHAN ≥ 90%	**100%** (3/2018)	40%	100%	100%	100%	Target Met
Foster Care ≥ 90%	**42%** (3/2018)	91%	91%	92%	92%	Target Met
Permanency ≥ 90%	**38%** (3/2018)	100%	83%	83%	86%	Target Not Met

Summary of Performance on Final Settlement Agreement Requirements

13. Workloads Not More Than 125% of Applicable Limit: No Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit (FSA IV.A.2.(c)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
Case Managers						
OHAN **0 (0%)**	**7 (100%)** (9/2017)	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**Target Met**
Foster Care **0 (0%)**	**136 (59%)** (9/2017)	**44 (16%)**	**46 (16%)**	**26 (8%)**	**22 (7%)**	**Target Not Met**
Permanency **0 (0%)**	**45 (62%)** (9/2017)	**20 (22%)**	**17 (19%)**	**8 (8%)**	**17 (18%)**	**Target Not Met**
Team Leaders						
OHAN **0 (0%)**	**0 (0%)** (3/2018)	**0 (0%)**	**0 (0%)**	**0 (0%)**	**0 (0%)**	**Target Met**
Foster Care **0 (0%)**	**26 (36%)** (3/2018)	**1 (1%)**	**1 (1%)**	**1 (1%)**	**0 (0%)**	**Target Met**
Permanency **0 (0%)**	**3 (19%)** (3/2018)	**0 (0%)**	**0 (0%)**	**2 (9%)**	**1 (5%)**	**Target Not Met**

14. Minimum Monthly Contacts: At least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during the 12-month period shall have taken place (FSA IV.B.2.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**24%** (9/2019)	N/A	N/A	N/A	N/A	**Reporting to Resume MP19**

15. Minimum Monthly Contacts in Child's Residence: 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.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 50%	**22%** (9/2019)	N/A	N/A	N/A	N/A	**Reporting to Resume MP19**

Summary of Performance on Final Settlement Agreement Requirements

OUT OF HOME ABUSE AND NEGLECT

16. Intake—No Investigation: At least 95% of decisions not to investigate a Referral of Institutional Abuse or neglect about a Class Member must be made in accordance with South Carolina law and DSS Policy (FSA IV.C.2.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	44% (3/2017)	98%	100%	N/A	N/A	Exit and Termination (Granted 10/18/24)

17. Investigations – Case Decisions: 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.)

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	47% (3/2017)	97%	100%	97%	96%	MOE (Designated 12/17/25)

18. Investigations – Timely Initiation: 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 (FSA IV.C.4.(a)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	78% (3/2017)	90%	93%	95%	96%	MOE (Designated 12/17/25)

19. Investigations – Face to Face: 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 (FSA IV.C.4.(b)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	78% (3/2017)	90%	93%	95%	96%	MOE (Designated 12/17/25)

Summary of Performance on Final Settlement Agreement Requirements

20. Investigations – Contact with Core Witnesses: 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)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	27% (3/2017)	77%	75%	86%	100%	Target Met

21. Investigations – Timely Completion: 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 (FSA IV.C.4.(d)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 60%	95% (3/2017)	100%	90%	N/A	N/A	Exit and Termination (Granted 10/18/2024)

22. Investigations – Timely Completion: 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 (FSA IV.C.4.(e)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 80%	96% (3/2017)	100%	100%	N/A	N/A	Exit and Termination (Granted 10/18/2024)

23. Investigations – Timely Completion: 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 (FSA IV.C.4.(f)).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	93% (9/2017)	100%	100%	N/A	N/A	Exit and Termination (Granted 10/18/2024)

Summary of Performance on Final Settlement Agreement Requirements

FAMILY CONNECTIONS

24. Children's Visits with Their Parents: 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.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 85%	12% (3/2018)	60%	49%	55%	52%	Target Not Met

25. Placement of Children with At Least One Sibling: At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within 30 days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.3.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 85%	63% (3/2018)	75%	70%	76%	76%	Target Not Met

26. Placement of Children with All of Their Siblings: At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within 30 days of their siblings shall be placed with all of their siblings unless an exception applies (FSA IV.G.3.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 80%	38% (3/2018)	50%	44%	49%	53%	Target Not Met

27. Children's Visits with Their Siblings: 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.).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 85%	66% (3/2018)	73%	80%	84%	92%	Target Met

Summary of Performance on Final Settlement Agreement Requirements

HEALTH CARE

28. Initial Medical Screens: At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	N/A	N/A	N/A	N/A	N/A	Not Reported

29. Comprehensive Medical Assessments within 30 Days: At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 85%	36% (3/2019)	49%	50%	48%	45%	Target Not Met

30. Comprehensive Medical Assessments within 60 Days: At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	52% (3/2019)	65%	67%	67%	64%	Target Not Met

31. Referral to Developmental Assessments within 30 Days: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	19% (7/2017-12/2017)	96%	96%	94%	93%	Exit and Termination (Granted 12/17/25)

Summary of Performance on Final Settlement Agreement Requirements

32. Referral to Developmental Assessments within 45 Days: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	20% (7/2017-12/2017)	97%	96%	97%	95%	Exit and Termination (Granted 12/17/25)

33. Initial Dental Examinations within 60 Days: At least 60% of Class Members aged 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 60%	35% (3/2018)	57%	62%	61%	60%	Target Met

34. Initial Dental Examinations within 90 Days: At least 90% of Class Members aged two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	48% (3/2018)	66%	76%	76%	70%	Target Not Met

35. Comprehensive Mental Health Assessment within 30 Days: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 85%	N/A	N/A	N/A	N/A	N/A	Not Reported

Summary of Performance on Final Settlement Agreement Requirements

36. Comprehensive Mental Health Assessment within 60 Days: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 95%	N/A	N/A	N/A	N/A	N/A	Not Reported

37. Periodic Preventative Care—Children Under 6 Months Old: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**49%** (3/2019)	N/A	N/A	N/A	N/A	Not Reported

38. Periodic Preventative Care—Children Aged 6 to 36 Months—AAP Guidelines: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**38%** (3/2019)	N/A	N/A	N/A	N/A	Not Reported

39. Periodic Preventative Care—Children Aged 6 to 36 Months—Semi-Annual: At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 98%	**62%** (3/2019)	N/A	N/A	N/A	N/A	Not Reported

Summary of Performance on Final Settlement Agreement Requirements

40. Periodic Preventative Care—Children Aged 3 and Older—Semi-Annual: 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 (FSA IV.K.5; FSA Health Care Outcomes).

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**12%** (3/2019)	N/A	N/A	N/A	N/A	**Not Reported**

41. Periodic Preventative Care—Children Aged 3 and Older—Annual: At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 98%	**58%** (3/2019)	N/A	N/A	N/A	N/A	**Not Reported**

42. Periodic Dental Care—Semi-Annual: At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 75%	**54%** (3/2019)	N/A	N/A	N/A	N/A	**Not Reported**

43. Periodic Dental Care—Annual: At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	**81%** (3/2019)	N/A	N/A	N/A	N/A	**Not Reported**

44. Follow Up Care: At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.

Target	Baseline	MP15	MP16	MP17	MP18	Current Status
≥ 90%	N/A	N/A	N/A	N/A	N/A	**Not Reported**

F. REVISED Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County

Center for the Study of Social Policy
Ideas into Action

September 25, 2026

By Electronic Mail

The Honorable Richard M. Gergel
United States District Judge
83 Meeting Street
Charleston, South Carolina 29401

Re: Cover Letter to REVISED Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County

Dear Judge Gergel:

As we shared with you prior to the last Status Conference, , immediately after the April 7, 2026 release of both the *Michelle H., et al. v. McMaster and Catone* Progress Report for the period of April 1, 2025 – September 30, 2025 (Monitoring Period 18 or MP18) and the Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County, the South Carolina Department of Social Services (DSS), informed the Court, Parties, and the Monitor of issues affecting the accuracy and reliability of data, including emergency placement data, presented in both documents. The data errors and limitations related to emergency placements, described in more detail below, have now been addressed and resulted in modest changes that are presented in the attached Revised Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County.

As context, following the release of the Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County (hereinafter "Monitor's Updates and Findings re Richland County"), DSS identified that a number of placements occurring at newly licensed Welcome Centers, located primarily in Richland County, had not been correctly coded as emergency placements.[1] Additionally, while working to correct the emergency placement data, it was discovered that a data linkage issue resulted in approximately 80 children being omitted from the file containing records of all placements during Monitoring Period 18. This file is used to derive the number of children who were in foster care at any point during the monitoring period and is also used for measures related to placement moves and emergency placements. Records were most often omitted for children who entered and exited care very quickly. DSS has now corrected this issue, and the data in the attached Revised Monitor's Updates and Findings re Richland County incorporate the data from the corrected process.

[1] Prior to licensure, placements in these "unlicensed cottages"—as they were known at that time—were considered overnight stays. After becoming licensed as "Welcome Centers" in August – September 2025, placements in these facilities should have been counted as emergency placements.

Historical data in this report may still be affected by a small number of missing records (approximately 1-2 % of children). In particular, data prior to April 2025 included in Figure 3 showing the monthly number of emergency placements, children who experienced emergency placements, and number of nights spent in emergency placements between October 2024 and December 2025 may be affected. While DSS provided the monitor with corrected data since the start of Monitoring Period 18 on April 1, 2025, corrected data before that date are not available.[2]

Overall, inclusion of the corrected data has only a modest impact as the primary purpose of the Monitor's Updates and Findings re Richland County was to broadly share the Monitor's impressions of key strategies and activities being undertaken to address placement instability in the county.

Sincerely,



Judith Meltzer, Senior Fellow
Center for the Study of Social Policy

[2] DSS has informed the Monitor that it has reviewed prior monitoring periods, and it does not believe missing records impacted performance for placement-related measures. The Monitor will work with DSS to confirm that prior performance assessments do not require revision.

Center for the Study of Social Policy
Ideas into Action

September 25, 2026

By Electronic Mail

The Honorable Richard M. Gergel
United States District Judge
83 Meeting Street
Charleston, South Carolina 29401

Re: REVISED Monitor's Updates and Findings Regarding Efforts to Address Placement Instability in Richland County

Dear Judge Gergel:

We write to share the Monitor's updates and findings regarding efforts by the Department of Social Services (DSS) to address the placement instability crisis in Richland County through the efforts of the Richland County Child Welfare Improvement Task Force (Task Force) and the Richland County DSS Improvement and Supplemental Plans. Note this letter, first provided on April 7, 2026, has been revised to make necessary data corrections that were identified following its original submission, and accompanies and is included within Appendix F of the Revised *Michelle H., et al v. McMaster and Catone Progress Report for the period of April 1, 2025 – September 30, 2025*. It focuses broadly on key strategies and activities employed in Richland County since October 2024 and includes themes and findings from the Monitor's site visit on March 11 – 13, 2026.

BACKGROUND

The formation of the Task Force and the creation of the Richland County Child Welfare Improvement and Supplemental Plans were sparked by trends that began in mid-2021 when DSS began experiencing increasing numbers of children spending the night in DSS offices or in emergency placements. By mid-2023, it was apparent that there was a placement instability crisis in South Carolina. The Co-Monitors[3] documented the negative impact of the escalating crisis on children, DSS staff, and private providers in their July 2023 Supplemental Report Regarding South Carolina's Placement Crisis and offered recommendations for additional strategies to address the crisis.[4] A year later, the crisis had worsened: emergency placements had continued to increase

[3] The Final Settlement Agreement appointed Judith Meltzer and Paul Vincent as independent and equal Co-Monitors. Mr. Vincent sadly passed away on July 27, 2025. Since that time, Ms. Meltzer has continued to act as an impartial Monitor and is hereinafter referred to as the Monitor.
[4] Letter from Co-Monitors Re: Submission of Co-Monitors' Supplemental Report Regarding SC Placement Crisis, with Attachment #1 Supplemental Report (August 1, 2023, DKt. 288-1).

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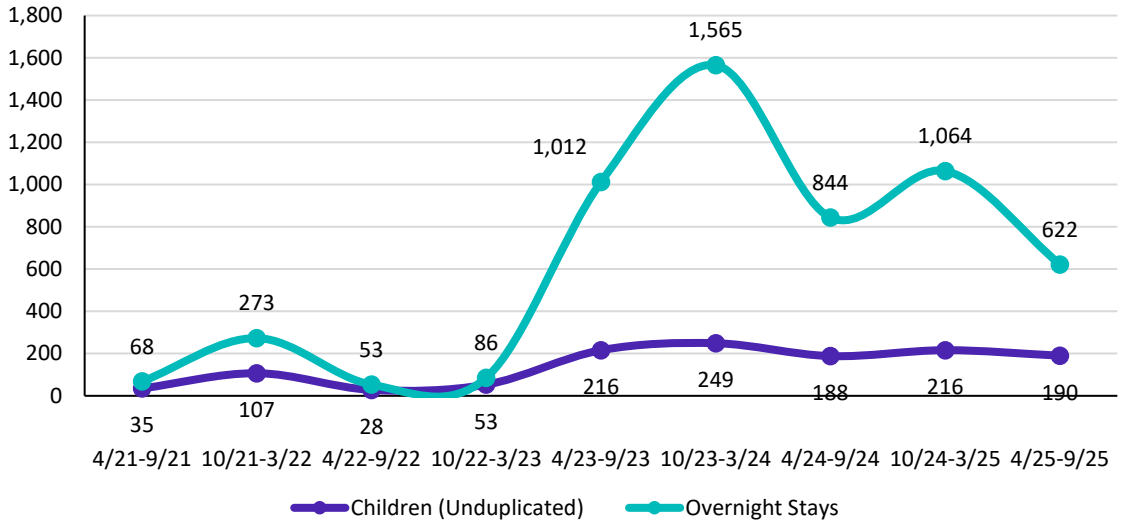
and overnight stays in DSS offices had reached an all-time high during the six-month period between October 2023 and March 2024 (Figure 1).

Figure 1. Overnight Stays in South Carolina

Number of unduplicated children who experienced an overnight stay and total number of overnight stays, MP10 - 18 (April 2021 –September 2025)
Source: CAPSS data provided by DSS



The crisis was especially acute in Richland County, which serves more foster children than any other county in the state.[5] Data showed increasing overnight stays in the Richland County DSS (RCDSS) Office and frequent use of emergency placements, including one-night and out-of-county emergency placements. Observations and discussions with RCDSS staff during site visits made by the Co-Monitors in April and September 2024 underscored the strain placed on frontline workers and the harm caused to children because of the escalating placement instability crisis. During the site visits, the Co-Monitors found conditions in the RCDSS to be dire and that urgent, coordinated actions were needed to upgrade the physical conditions, change the culture and practice of the office, address the placement instability crisis, and improve relationships across the county with law enforcement, schools and private providers. Serious concerns were documented in the Co-Monitors' October 2, 2024 letter to the Court and included:[6]

- Placement instability was placing great strain on staff and causing harm to children.
- Children experiencing placement instability did not have appropriate daytime activities and supervision.

[5] Note also that, according to CAPSS data provided by DSS, when compared to the statewide foster care population, Richland County serves a higher proportion of Black children (59% vs. 37% as of September 30, 2025); has a higher percentage of children who enter foster care through emergency protective custody (EPC) by law enforcement (82% vs. 72% during the period of April – September 2025); places more children with kin (41% vs. 31% as of September 30, 2025); and places more children within their county of origin (46% vs. 34% as of September 30, 2025).
[6] Co-Monitors Progress Report for Period October 1, 2023 – March 31, 2024 (Attachments: #1 Co-Monitor recommendations, #2 October 2, 2024 Letter (October, 4, 2024, DKt. 323).

- Staff were required to work excessive late-night hours caring for children in the RCDSS office or driving children to and from emergency placements.
- The physical condition of the RCDSS office was deplorable and not conducive to either a stable workforce or a safe and welcoming environment for children and families.
- Security at the RCDSS office was insufficient, placing both children and staff at risk of harm.
- Relationships between RCDSS, law enforcement, school districts, private providers and other advocates had deteriorated and offered little space for collaborative problem-solving.

During an October 18, 2024 status conference, the Court raised concerns noted during the September 2024 RCDSS site visit, at which Judge Gergel and a member of his staff were present. To address these concerns, the Court issued an order directing DSS to create a Richland County Task Force to prepare and implement an improvement plan to achieve five goals:

1. Eliminate overnight stays of children in the RCDSS office and out-of-county emergency placements,
2. End the routine presence of children in the RCDSS office,
3. Eliminate excessive late-night work shifts for RCDSS staff,
4. Improve the maintenance and cleanliness of the RCDSS office, and
5. Improve security in the RCDSS office.[7]

The Task Force first met on November 18, 2024 and includes approximately 50 members representing the South Carolina Department of Health and Human Services (SC DHHS); South Carolina Department of Juvenile Justice (SC DJJ); Department of Behavioral Health and Developmental Disabilities' Office of Mental Health (DBHDD OMH); South Carolina Department of Children's Advocacy; Richland County Sherriff's Office; City of Columbia Police Department; Richland/Lexington School District Five and Richland School Districts One and Two; Richland County Family Court Public Defender; Richland County Court Appointed Special Advocates; Palmetto Association for Children and Families; SCDSS State, Regional, and County leadership; Plaintiffs' counsel; and Monitor staff.

The initial Richland County DSS Improvement Plan, submitted to the Court on December 23, 2024, included multiple efforts to address critical issues previously identified by the Co-Monitors.[8] After reviewing the plan, the Court found that "further refinements are necessary to meet the considerable challenges confronting DSS operations in Richland County," and ordered that a supplemental plan be submitted.[9] In so ordering, however, the Court noted that, "[t]he preparation of the supplemental plan should in no way hold up full implementation of the present

[7] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays of children in the Richland County DSS office (October 18, 2024, Dkt. 331).
[8] Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23, 2024, Dkt. 339).
[9] Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348).

plan presented to the Court."[10] The Supplemental Richland County DSS Improvement Plan was submitted to the Court on May 19, 2025.[11]

Implementation of the Plan has been led by DSS in partnership with the Task Force and five Task Force workgroups: (1) Capacity Building for Placement Array, which is co-facilitated by the Monitor; (2) Enhancing Skills and Capacity of Staff and Caregivers to Meet the Needs of Children and Youth in Foster Care; (3) Community Action; (4) Kin First Implementation; and (5) Educational Needs for Children and Youth in Foster Care. Each workgroup met at least monthly through the first half of 2025 and then as needed, while the full Task Force met quarterly. On March 27, 2026, a final meeting of the Task Force was held and DSS announced that the work would be sustained and carried forward through the pre-existing Richland County Child Welfare Improvement Team. Task Force members were invited to join the Improvement Team to continue the work on remaining challenges and to assess the effectiveness of strategies and make modifications as needed.

The Monitor and staff have been actively engaged in supporting the efforts in Richland County and in tracking DSS's progress toward achieving the goals of the Child Welfare Improvement Plan. A site visit was conducted in Richland County in March 2026, to observe on-the-ground operations and gather insights from DSS staff and contracted private providers on current strengths and challenges. During the visit, the Monitor met with Richland County DSS staff including foster care case managers, foster care team leaders, coordinators, and leadership, as well as with the Removal Prevention CFTM team, Law Enforcement Liaisons, and the "Whatever it Takes" team. In addition, the Monitor met with direct service staff and leadership from a small capacity group home, Welcome Center, Assessment Center, and two Day Centers. Focus groups were conducted with private providers, staff from Mobile Rapid Response staff, the Professional Foster Parent Program pilot (PFP) and young people with lived experience in South Carolina's foster care system. Observation and findings from the site visit are included in the discussion below of DSS's efforts to achieve the goals of the Supplemental Plan.

[10] Ibid.
[11] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

PROGRESS TOWARD IMPLEMENTING THE RICHLAND COUNTY SUPPLEMENTAL PLAN

DSS's efforts toward achieving the goals of the Richland County Supplemental Plan are discussed below with a focus on selected key strategies and action steps.

GOAL 1: Ending overnight stays in the Richland County DSS Office and Out-of-County Emergency Placements by December 31, 2025.[12]

Key strategies and action steps to support achievement of this goal include:

- *Partnering with provider agencies to increase short- and longer-term placements in Richland County*. Key supporting activities include developing Welcome and Assessment Centers for short-term placements, small capacity group homes for longer term placements; targeted recruiting of foster home placements and creating a Professional Foster Parent program pilot (PFP);[13] promoting in-county placement by piloting a policy to hold placements open for a short period of time so they can be used for Richland County children; shifting practice to better identify children's strengths and underlying needs to create individually tailored placements and services using a "whatever it takes" approach; and increasing the availability of mental health services including 24/7 rapid mobile response interventions.

- *Implementing initiatives to remove barriers to placement and to promote placement stability through the provision of mental health, behavioral health, educational supports and other services.* Supporting action steps include limiting the use of one-night placements through an escalating approval process and phasing out the use of foster home placements with a duration of 12-hours or less; using Child and Family Team Meetings (CFTM) to prevent unnecessary removals of children to foster care and to support children who are experiencing placement instability; and increasing knowledge and understanding of trauma and child development among RCDSS staff, contracted private providers, and foster parents, and promote strengths and needs based practices through training and coaching by a clinical consultant with input from children with lived experience in foster care.

- *Creating accountable relationships and enhancing communication and partnership with local law enforcement.* Key action steps include developing a protocol between DSS and local law enforcement to facilitate joint efforts to prevent unnecessary use of emergency protective custody (EPC) and dedicating staff with specific responsibility to liaise with and promptly respond to law enforcement.

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[12] Ibid.

[13] As a result of targeted recruitment, child placing agencies (CPAs) recruited and licensed 33 new therapeutic foster homes and two regular foster homes in Richland County between June and September 2025; additionally, DSS licensed a total of 27 new kin and regular foster homes in Richland County during the same timeframe. See Letter from J. Michael Montgomery Providing Information Required by March 25, 2025 Order (EFC 357) prior to October 14, 2025 Status Conference (October 7, 2025, Dkt.378).

Overall, overnight stays in the RCDSS Office have been eliminated (Figure 2); *the number of emergency placements* (Figure 3) *including out-of-county emergency placements* (Figure 4) *has trended downward*; *and placements lasting 12-hours or less are no longer used* (Figure 5).

Figure 2. Overnight Stays of Richland County Foster Children

Monthly number of unduplicated children who experienced an overnight stay and total number of overnight stays, October 2024 – February 2026

Source: DSS Monthly Richland County Updates to the Court

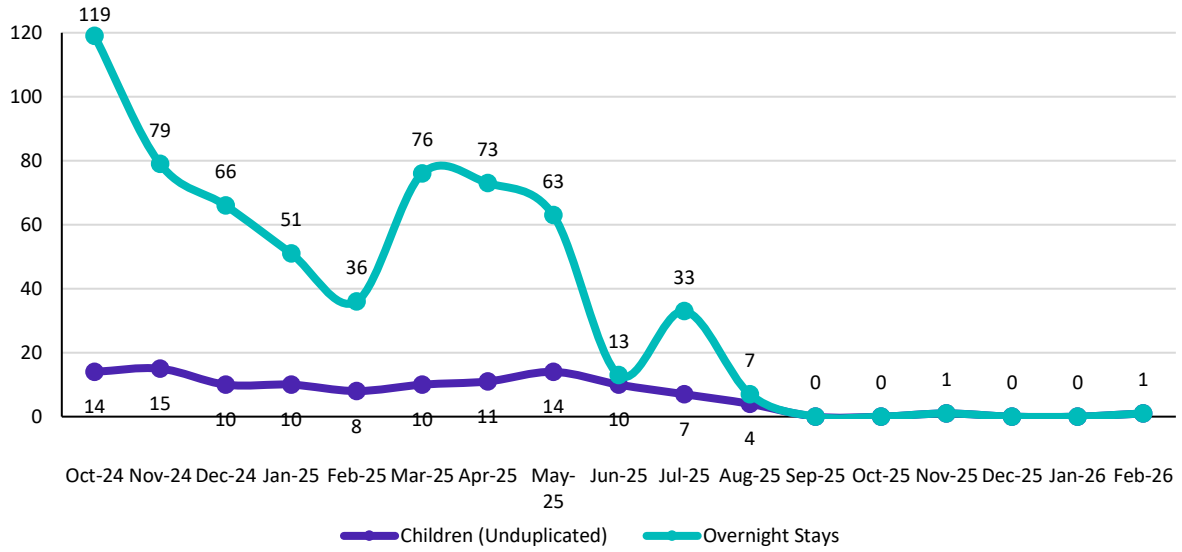
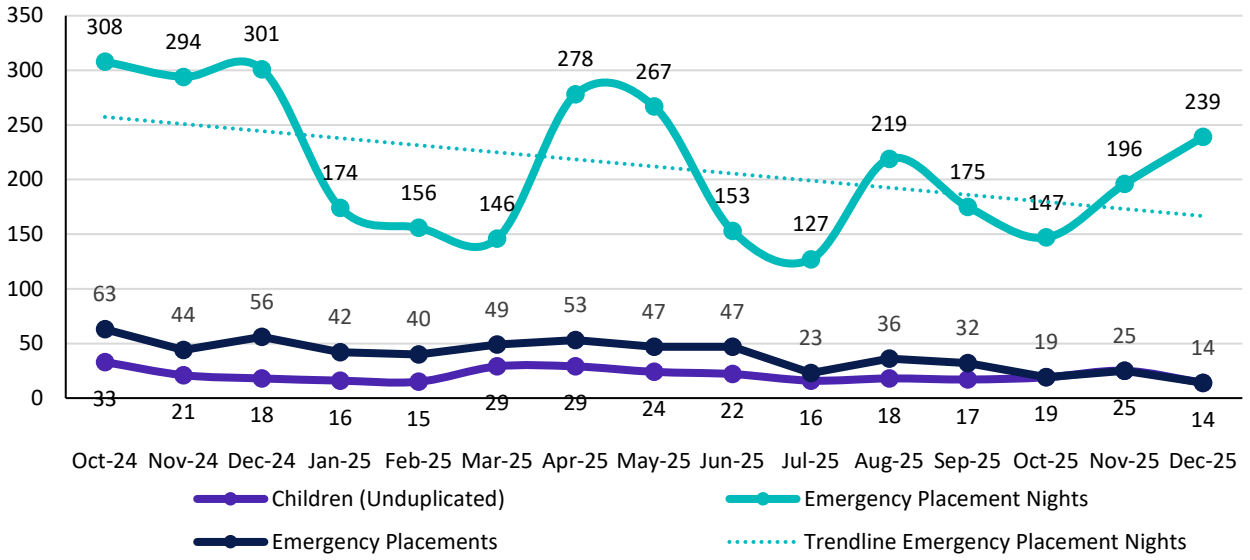


Figure 3. Emergency Placements of Richland County Foster Children[14,15]
Monthly number of unduplicated children who experienced an emergency placement, number of emergency placements, and total number of nights children spent in emergency placements, October 2024 – December 2025
Source: CAPSS data provided by DSS



[14] Note: Data included in Figure 3 prior to April 2025 may be affected by a small number of missing records (approximately 1-2% of children).
[15] Note: The data in Figure 3, especially with regard to the number of nights children from Richland County spent in emergency placements, has changed significantly since the original release of this letter on April 7, 2026, especially from September – December 2025. The table below shows number of nights spent in emergency placements during these months as originally presented on April 7, 2026 and as of September 15, 2026 and presented above in Figure 3. Although some of the difference may be explained by the above-described data limitations that necessitated the revision of this letter, the majority of the discrepancy is more likely explained by the passage of time resulting in more complete data entry into DSS's CAPSS system.

Nights in Emergency Placement		
Month	**As of April 7, 2026**	**As of September 15, 2026**
September 2025	123	175
October 2025	94	147
November 2025	122	196
December 2025	42	239

Figure 4. In- and Out-of-County Emergency Placements of Richland County Foster Children
October 2024 – December 2025
Source: DSS Monthly Richland County Updates to the Court

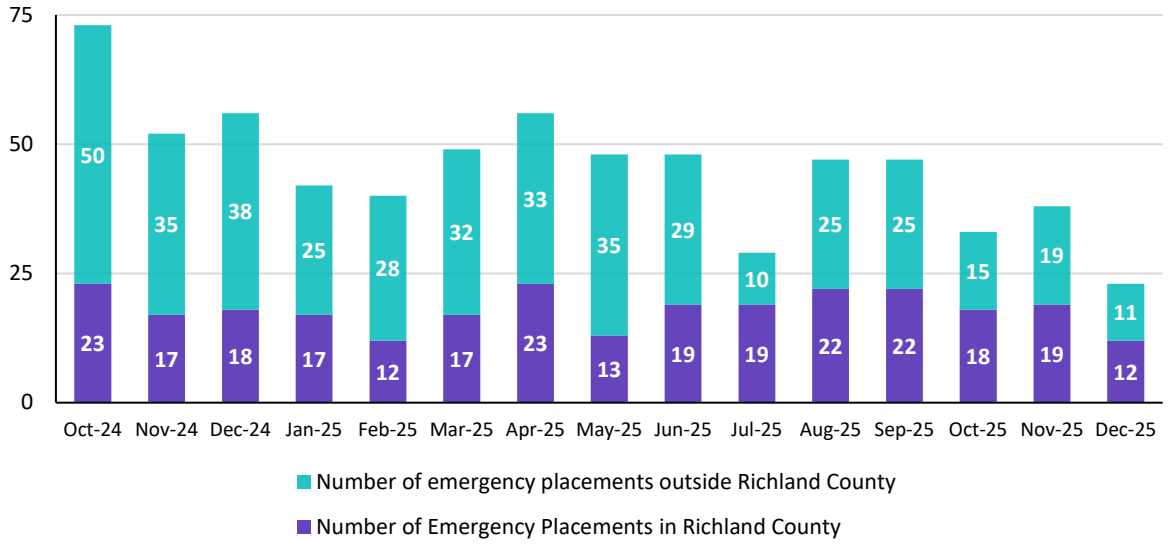
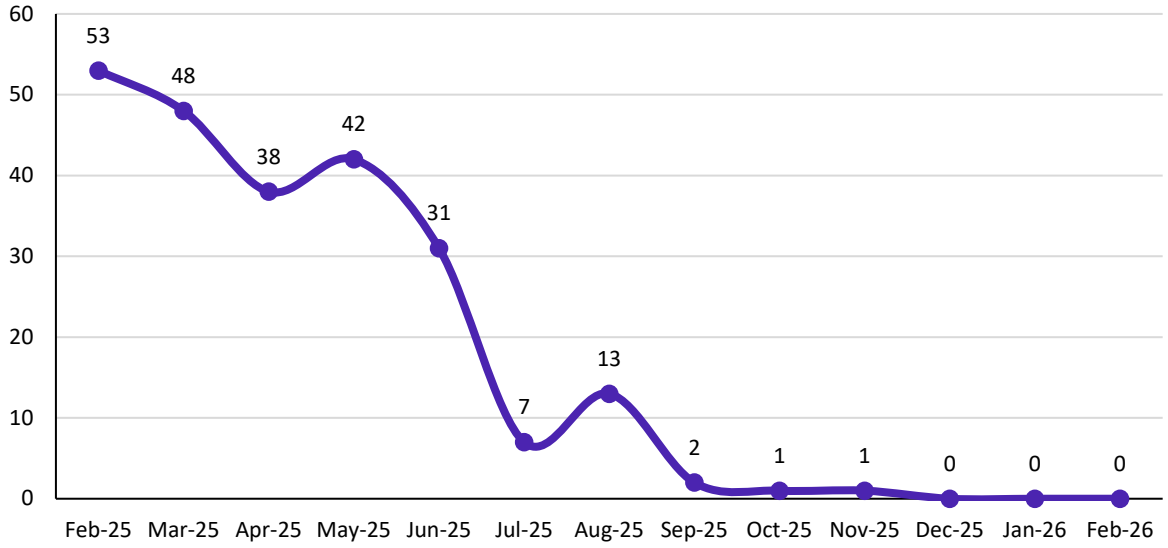


Figure 5. Emergency Placements of Richland County Foster Children for 12-Hours or Less
February 2025 – February 2026
Source: DSS Monthly Richland County Updates to the Court



While implementation of strategies remains in the early stages, several strategies appear instrumental to efforts to curtail the use of overnight stays and emergency placements—most notably, the expansion of the placement array through the addition of Welcome and Assessment Centers, small-capacity group homes, and the PFP program pilot. DSS also reports and staff noted that the addition of Family Support and Engagement specialists has helped identify family resources for youth.

Welcome Centers and Assessment Centers provide short-term placement for children experiencing placement instability due either to foster care entry or disruptions in placement, offering assessments and other support and services to identify and successfully transition children to long-term placements aligned with their needs. In July 2025, a Welcome Center was opened in Richland County through a partnership with a private provider. The Welcome Center has the capacity to serve up to five children for up to seven days, with the ability to extend for an additional seven days, if approved. In December 2025, an Assessment and Placement Center was opened in Darlington County, with the capacity to serve up to six children for up to 21 business days. Small capacity group homes provide longer-term, structured 24/hour care and individualized treatment for children who have specialized care needs, with the goals of addressing children's unique needs and stabilizing behaviors so they can then be successfully transitioned to less restrictive placements. To date, there are six small capacity group homes in South Carolina, each with a licensing capacity of up to three children. Two are located in Richland County.

The Welcome and Assessment Centers and small capacity group homes provide structured and supportive environments where, as early data suggest, children are experiencing greater stability and benefiting from individualized attention and access to enrichment activities. Similarly, the PFP pilot launched in October 2025, shows strong early results. The program's staffing structure includes full-time foster parents who receive additional training on how to support children with complex needs and are provided with respite and ongoing support, a full-time therapist, a full-time behavioral interventionist and a multidisciplinary team that meets weekly to develop and update individualized service plans for each child. There are currently six PFP homes with one child placed in each of the homes. All homes are currently filled and participating children, some of whom previously experienced extreme placement instability (averaging 56 placements, with some as high as 196)—are now experiencing stability. The model's staffing structure, and wraparound support represents a promising and potentially scalable approach. During the March 2026 site visit, both DSS staff and youth spoke favorably about these new placements:

> *We are seeing a lot of success with the professional foster parent program pilot and three bed group homes, but we need more. The three bed group home model is a lot better for youth who are struggling—they like the smaller setting because it's like a home—and we can sell it to them more. But we're limited. Children do well in professional foster parent homes and small capacity group homes, so beds stay full and aren't opening up. –DSS staff*

> *It's perfect here. They treat us right over here, ask us what we need, and let us be who we are. –Youth in foster care*

The implementation of mobile rapid response mental health services is also demonstrating early effectiveness. Rapid response services available through a contract with a private provider are available 24/7 to provide adaptive de-escalation and intervention for children and youth placed in Richland County who experience behavioral crises.[16] Since its launch in September 2025, the program has responded to 41 calls, primarily from DSS, with a reported 96 percent stabilization rate and minimal reliance on hospitalization or law enforcement intervention.[17] These findings indicate that timely, clinically informed de-escalation can reduce the likelihood of crisis escalation and placement disruption. However, as reported during the March 2026 site visit, relatively low utilization in the recent months of January – March 2026 and limited engagement from private providers suggest a need for increased awareness and stronger integration into the broader service continuum.

Efforts to address unnecessary removals to foster care, including the development of protocols with local law enforcement[18] and the addition of a team of facilitators who can be deployed to a family's home to convene a removal prevention CFTM when law enforcement is on scene and contemplating an EPC, are showing promising results. While data show a small downward trend in the proportion of foster care entries due to EPC in Richland County (Figure 6 and Figure 7), the use of prevention removal CFTMs has demonstrated measurable success. Since November 2024, 104 CFTMs involving 154 children have resulted in 95 children being diverted from foster care; of the 25 of these children who were in the sole custody of DJJ, only three entered care.[19] This suggests that structured, team decision-making processes can effectively reduce unnecessary removals. Nonetheless, ongoing challenges in coordination with law enforcement—particularly related to timing, role clarity, and differing interpretations of safety and removal decisions—limit consistent implementation. These challenges are further compounded by staff turnover and inconsistent use of established communication protocols.

[16] Effective March 13, 2026, rapid response services were expanded to Lexington, Kershaw, and Fairfield Counties, where children from Richland County are often placed.
[17] Data provided by the Rapid Response Team during the March 12, 2026 site visit to Epworth.
[18] DSS and Law Enforcement Protocol with Richland County Sheriff's Department executed on May 6, 2025, and DSS and Law Enforcement Protocol with City of Columbia Police Department executed on May 28, 2025 (attached).
[19] Data provided by the Richland County DSS CFTM team during the March 11, 2026 site visit to the RCDSS office.

Figure 6. Percentage of Entries to Foster Care in Richland County via EPC by Law Enforcement
December 2024 – February 2026
Source: CAPSS data provided by DSS

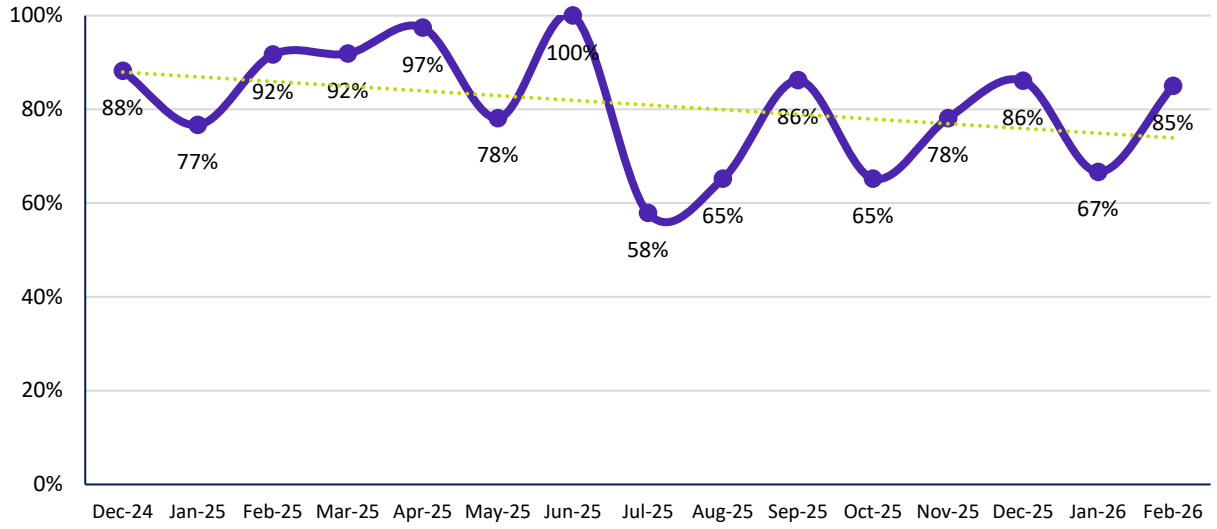
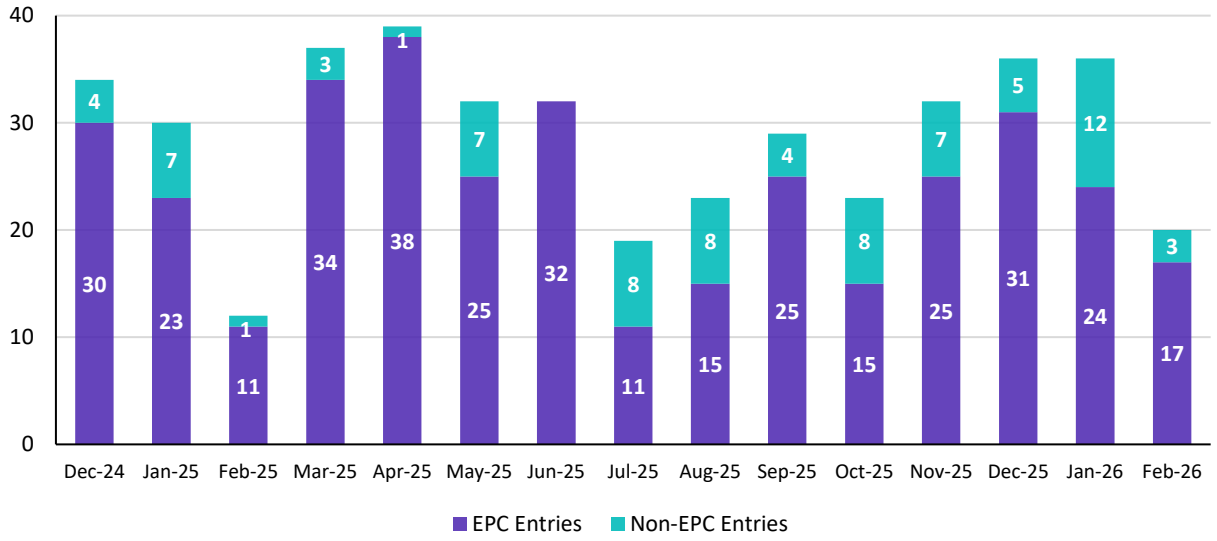


Figure 7. Number of EPC and Non-EPC Entries to Foster Care in Richland County
December 2024 – February 2026
Source: CAPSS data provided by DSS



The effectiveness of other strategies and action steps in the Plan remains unclear or limited. This includes implementation of the "Whatever It Takes" (WIT) approach, the 5-day bed hold to prioritize the use of Richland placements for Richland children, and guidance on appropriate access to and use of cell phones by youth. In particular, the WIT approach does not appear to be implemented with fidelity. Staff report limited understanding of what constitutes a WIT

intervention, as well as uncertainty regarding available resources and approval processes for use of flexible funds. The process itself is perceived as cumbersome, requiring multiple approvals and creating delays that undermine its intended purpose of enabling flexible, innovative and individualized solutions. Feedback from private providers indicates that successful use of flexible support often depends on informal escalation rather than established procedures, suggesting inconsistencies in implementation. The WIT approach has not yet produced the intended level of innovation or responsiveness to addressing placement and service needs of children in foster care.

Additionally, implementation of a 5-day bed hold to open up additional placement resources within Richland County and allow time for children from Richland County to be placed in the County, does not appear to be producing the intended result. During the last meeting of the Task Force on March 27, 2026, DSS shared data showing that between March 2025 and February 2026, placements of children from Richland County into Richland County therapeutic foster care homes decreased and placements into non-therapeutic foster homes remained flat.[20] During the Monitor's latest site visit, providers shared that they believe that other strategies to encourage longer term placements, such as providing a $150 incentive for foster parents to maintain placements past the initial 30 days, are more effective than the bed hold.

Lastly, efforts to address placement refusals by youth due to restrictive cell phone policies through the development of guidelines for providers, have not yet taken root. The Task Force workgroup establish guidelines for providers to allow youth access to cell phones as appropriate, but during the Monitor's March 2026 site visit, most DSS staff, provider staff, and youth stated that they were not aware of the guidelines.[21] Staff and providers commented that restrictive cell phone policies continue to be one of the major reasons youth, who do not want to give up their sense of normalcy and connection to community, refuse placement. One private provider commented:

> *Cell phones are lifelines and when youth refuse placement because they can't have their phones, they are exercising the only power they have. –Provider staff*

Systemic barriers also continue to affect placement stability and service delivery. These include challenges in accessing flexible funding, constraints to easily accessing transportation when needed,[22] and availability of and access to community-based behavioral health services. In addition, gaps remain in practice related to identifying and responding to children's strengths and underlying needs. While training initiatives—such as those led by a clinical consultant—represent a meaningful investment in capacity building, their impact on day-to-day practice is evolving.

[20] Richland County Task Force Steering Committee Update Slide Deck (March 27, 2026).
[21] Youth Personal Device Use & Access Guidelines (attached).
[22] Note, DSS currently contracts with 11 transportation providers with 24/7 services, in addition to the resources available through the Regional Support Teams. Despite this increased capacity, DSS staff report that access to transportation can be cumbersome and that hours of operation are limited for the Regional Support Teams.

Reports from staff and providers suggest ongoing difficulty in translating training into greater role clarity and actionable, individualized service planning.

DSS has made substantial progress in reducing overnight stays and emergency placements, supported by targeted placement strategies and clinical interventions that show promising early results. However, continued progress will require ongoing efforts to identify and address implementation challenges, particularly in operationalizing flexible and individualized service approaches, reducing systemic barriers, and strengthening cross-system collaboration.

> *There is a lot of confusion on what the services are in Richland County and when to use what (day center, welcome center, etc.) So many new initiatives—there needs to be training of what all the services are with all staff and providers. – Provider staff*

GOAL 2: Ending the daytime presence of children in the Richland County DSS office without a prescheduled appointment by March 31, 2025.[23]

Key strategies and supporting action steps for achievement of this goal include:

- *Raising awareness of existing programs and services to meet the needs of foster children in Richland County.* Supporting activities include evaluation of the services and staffing provided at Day Centers and Activity Centers to ensure they are sufficient to meet the needs of youth and developing and disseminating guidance for RCDSS staff to raise awareness of these services

- *Creating accountable relationships and enhanced communication and partnerships with local school districts.* Key supporting activities include co-developing a protocol with county school leaders that includes commitments and actions to maintain children's educational stability; providing a dedicated educational advocate to support the educational rights of foster children in Richland County; training Richland County foster care staff and foster parents on the educational rights afforded to children in care and the services and support school districts are required to provide; and establishing recurring meetings between Richland County DSS and county schools.

Children are no longer spending their days in the Richland County Office. Ending the daytime presence of children in the RCDSS office has increased utilization of Day and Activity Centers. These Centers offer children who are experiencing placement instability and school disruptions services such as education, mental health counseling, and experiential learning, and with necessities like showers, donated clothes, and toiletries available as needed. Several staff members at different Centers reported it is common for children to show up without their clothes, sometimes even without shoes. Many children arrive at the centers after a long car rides and/or after an early pick-up from a one-night emergency placement.

[23] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

While Day Center staff invest significant effort into education and programming, leadership and staff report ongoing communication challenges with DSS staff that limit the extent of planning and preparation the Centers are able to do. Day Centers also report inconsistent receipt of information about children whom they are serving, including whether the Universal Application is provided. Overall, Day Center staff stated that although refusals to go to placement have decreased—as it is no longer an option to stay at the RCDSS office—strict provider cell phone policies remain a barrier to placement. Day Center staff also report that many children were not enrolled in either in-person or virtual school, and when children were enrolled in virtual school, they often arrived at the Center without their school-issued laptop. Despite these challenges, children consistently expressed a desire to attend school, although the two Day Centers visited by the Monitor reported varying levels of success coordinating with DSS case managers and local school districts to enroll children or maintain virtual attendance during placement transitions.

Notable efforts have been undertaken to improve educational stability for children in foster care in Richland County. Placement instability—especially frequent, night-to-night placements—disrupt a child's education by causing enrollment delays, gaps in assignments, decreased academic performance, increased absenteeism, and higher dropout rates. These disruptions impact school success in the short term as well as long term opportunities and outcomes. To address this problem, the Task Force's Educational Needs for Children and Youth in Foster Care Workgroup, created a Stability Protocol for Students in Foster Care,[24] which was approved by DSS and the State Department of Education. The protocol promotes collaboration between school districts and DSS and provides guidance for maintaining educational stability for children in care. Successful implementation of this protocol was demonstrated by one of the Assessment Centers that had adapted the protocol to include specific timelines and procedures for providing required notifications, conducting meetings with schools to determine if it is in the child's best interest to remain in their school of origin, coordinating technology and access, and facilitating transition planning. The Assessment Center also uses the time children are in its care to close education gaps, for example by assisting with credit recovery or ensuring special education plans are updated. One young person shared:

> *All I want is to enroll in school and graduate high school. I am in my last year, and the school here will not enroll me because I don't have an address. –Youth in foster care*

Richland County DSS leadership and staff spoke positively about efforts to address educational stability, including improved relationships with local schools, the availability of DSS education advocates, and focused attention on maintaining children at their schools of origin during periods of placement instability.[25] RCDSS staff reported that children are being enrolled in school more promptly, and that communication and coordination between DSS and local school districts are

[24] Stability Protocol for Students in Foster Care (attached).
[25] In March 2025, DSS expanded the provider contract with Family Connections of South Carolina to include a dedicated educational advocate to support the educational rights of foster children in Richland County. The advocate provides support when a child needs assistance in developing special education plans and conducts advocacy to help reduce or prevent suspensions and expulsions.

improving. Recently, Richland County DSS trained over 100 school social workers and school counselors on DSS processes.

While important progress has been made toward improving educational stability for children in foster care in Richland County, challenges remain. Conversations with RCDSS staff, as well as staff from Day and Activity Centers, revealed that problems persist getting children who are experiencing night-to-night placements into school, that there are varying degrees of familiarity with the Education Stability Protocol, and a lack of awareness about new education advocacy resources. Additional outreach and coordination is needed between DSS, Day Centers, and schools as efforts to promote educational stability still appear to be reactive, with education frequently treated as an afterthought in placement decisions.

GOAL 3: Addressing excessive late night work hours of Richland County DSS staff.[26]

A key strategy and action steps for achievement of this goal include:

- *Phasing out the need for mandatory on-call shifts during the work week to support the care of children in foster care by creating and fully staffing second and third shifts at RCDSS.* Key supporting activities include hiring and maintaining specified numbers of team leaders and case managers for the mid, second, and third shifts and increasing stand-by on-call pay for RCDSS staff working after-hours and on the weekends.

DSS has significantly reduced the excessive late working hours of Richland County staff since October 2024. Previously, case managers were expected to stay after hours to babysit children in the RCDSS office and/or transport children to emergency placements, frequently at far distances. This burden has been eased with the development and staffing of second shifts (4:00pm – 12:30am) and third shifts (12:00am – 8:30am).

RCDSS maintains a voluntary on call process in which staff may sign up for after-hours or weekend on call shifts, however when slots are not taken voluntarily, staff are assigned from a rotating list with 10 shifts required per quarter. This is a decrease from the first quarter of 2026 when 13 shifts were required per quarter. In addition, staff reported that even when on call, they are called for duty less often. Between January 1, 2025 and January 31, 2025, there were 22 days where at least one case manager had to be assigned to an after-hours or weekend on call shift because there were not enough volunteers.[27]

DSS reported that six second/third shift case managers had completed training on July 17, 2025. In the following months, there was a reduction in the number of first shift case managers being called in for after-hours duty during the work week; starting July 2025, there were no days in which more than one case manager was called to work after hours (Figure 8).[28] The improvement in

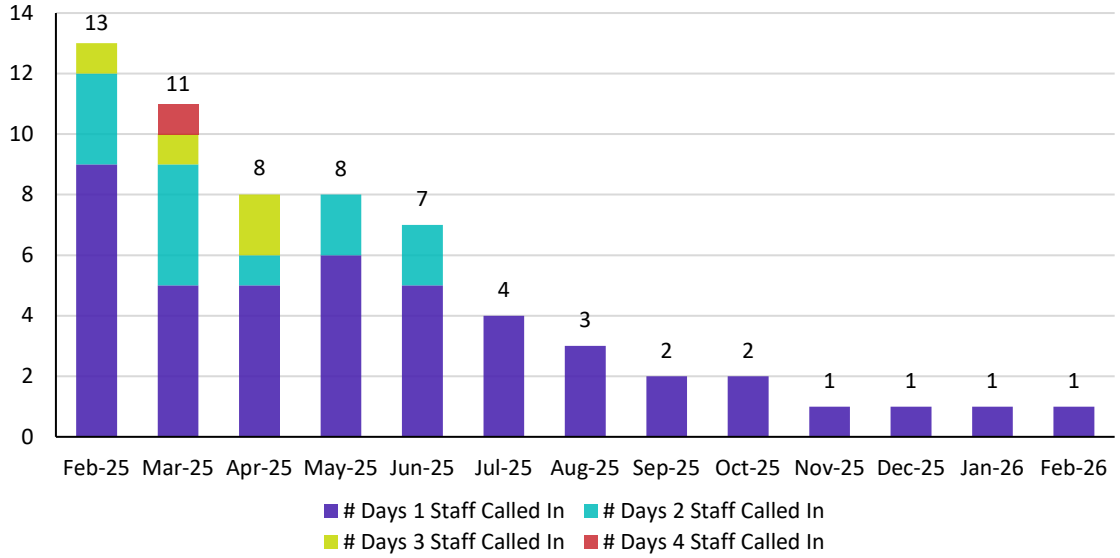
[26] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).
[27] Letter from DSS Providing Update Pursuant to Order EFC 348 (September, 15, 2025, Dkt. 376).
[28] Letter from DSS Providing Update Pursuant to Order EFC 348 (December, 15, 2025, Dkt. 386).

excessive late-night hours and mandatory on call shifts was echoed by staff at all levels who acknowledge the changes and felt they now had more time to focus on casework and their core responsibilities without having to spend considerable time babysitting children in offices after placement disruptions.

> *On-call has changed tremendously. We barely get called and things have gotten better knowing we have rapid response on hand. –RCDSS staff*

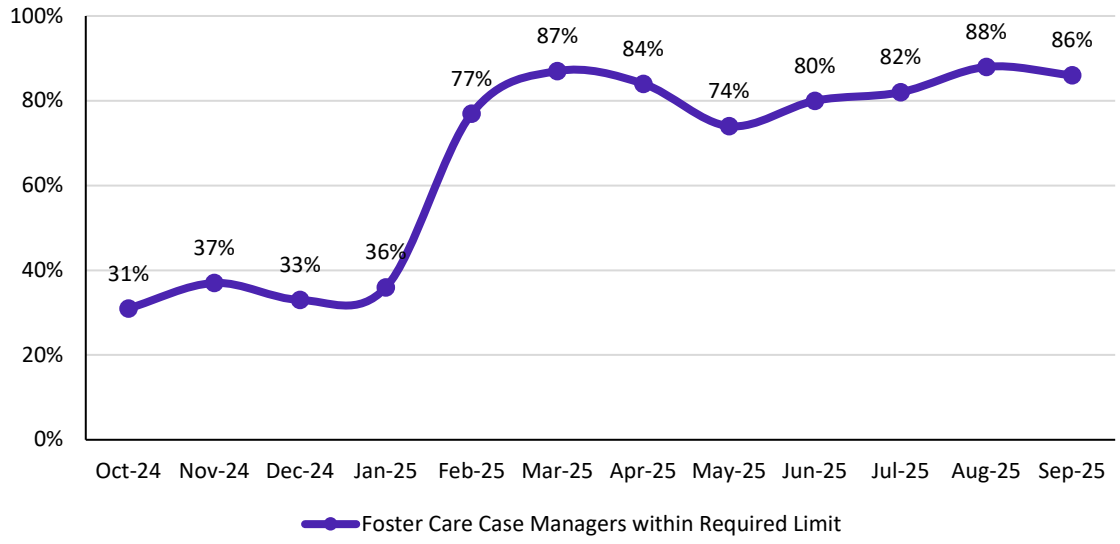
Despite the significant overall improvement, DSS staff shared with the Monitor that there are still some occasions when children are in the RCDSS office while they await placement, requiring staff to sit in the office for hours with a child or drive around with a child until a placement is found. Additionally, staff shared that during those times, there is no food available for the children, so staff are paying out of pocket to ensure the children are fed.

Figure 8. Number of Days Richland County DSS Staff Was Called In to Work Shifts Outside of Normal Business Hours
Monthly number of days and number of staff called in to work outside of normal business hours, February 2025 – February 2026
Source: DSS Monthly Richland County Updates to the Court



Since October 2024, RCDSS has also improved the number of staff serving Class Members through focused efforts on both hiring and retention. In October 2024, there were 29 foster care case managers serving Class Members compared to 44 foster care case managers serving Class Members one year later (September 2025). The addition of workforce capacity was accompanied by an increased number of foster care case managers within required caseload limits (Figure 9). At this time, the Monitor does not have data on the turnover rate of staff in Richland County and plans to collect this going forward.

Figure 9. Percentage of Richland County Foster Care Case Managers with Caseloads within Required Limits
October 2024 – September 2025)
Source: CAPSS data provided by DSS



During the March 2026 site visit, DSS leadership and staff identified several factors supporting staff retention and improved morale, including reduced caseloads, improved feelings of safety, enhanced office space, and strong mentorship and peer support. In a focus group with foster case managers, the majority of whom were new case managers with less than two years of experience, staff spoke highly of the support provided by team leaders and the mentoring program. They did not, however, feel that the formal training they received adequately prepared them for their roles.

Given past turnover, the workforce in Richland County is overwhelmingly new to DSS, and thus the importance of solid pre-service training, on-the job training, supervision and peer mentorship cannot be overstated. Team leaders echoed this concern, stating that gaps in formal training leave new case managers underprepared and require team leaders to provide additional support.

> *Peer support and on the job training prepared me for my job, but formal training did not. –RCDSS staff*

While Regional Support Teams were implemented to support case manager workloads, their effectiveness appears mixed in practice.[29] Some staff report never using the service, while others cite the limited hours, inconsistent availability, and cumbersome process as barriers. Conversely, staff report consistent success coordinating with the newly created Family Search and

[29] Regional support teams travel to counties experiencing spikes in turnover and/or high caseloads to provide support with making contacts with children, facilitating visitation, family search and engagement, and transportation.

Engagement team and helpful consultation and support from nurses and clinicians within the Office of Child Health and Well-Being (OCHW).

> *Nurses and clinicians from the OCHW are very helpful. –RCDSS staff*

Above all, the most significant factor contributing to a reduction in excessive late-night hours has been the decline in overnight stays, out of county emergency placements, and emergency placements of 12-hours or less. These changes have resulted in fewer children in the office and reduced strain on staff. To further improve working conditions and staff retention, additional efforts may be needed in the following areas: increasing compensation, improving initial case manager training, strengthening communication across all levels of staff, streamlining processes for accessing support and approvals for use of flexible funding, and developing staff well-being activities

GOAL 4: Improving the maintenance and cleanliness of the Richland County DSS office.[30]

This goal is supported by the following action step:

- *Relocate the RCDSS staff to another building until the Family Service Center is completed*.

Between October 2024 and the end of January 2025, DSS completed a number of action steps to address the poor physical condition of the RCDSS building. It subsequently pursued and was approved to relocate the RCDSS staff to another building until the Family Service Center is completed. The move took place in May 2025. DSS continues to use the Lily Pad rooms at the old office for visitation when needed, although staff noted access is limited.

Following the relocation in May 2025, there have been notable operational improvements. Most significantly, staff are no longer required to supervise children in the office for extended periods, reducing strain on both staff and the physical space and contributing to a more stable and manageable work environment. Leadership noted that prior to the move, staff were frequently pulled away from their core responsibilities to monitor children in the office, leading to overcrowding and challenges in maintaining a clean workspace. The reduction in children's presence in the office, both overnight and during the day, appears to have alleviated many of these pressures. During the March 2026 site visit, both team leaders and case managers reported they are happy to be at the new location and feel safer there.

> *I'm happy to be at this location. It's much brighter and has windows and more life. Restrooms are clean and there is a decent breakroom to warm up food. We have a sense of security here. –DSS staff*

[30] Letter from J. Michael Montgomery (May 19, 2025, Dkt. 364) with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 365).

GOAL 5: Improving staff and child safety and well-being while at the RCDSS office.[31]

Supporting strategies and action steps for achievement of this goal include:

- *Creating a staff well-being committee and securing a co-located mental health clinician who can address and coordinate care for any ongoing mental health needs of foster children in Richland County with placement instability*.

Efforts to improve security within the RCDSS office are closely tied to broader system changes that have reduced the number of children physically present in the office during the day and at night. Since the implementation of strategies to reduce the presence of children in the RCDSS office, there has been a reported shift in how the office environment functions. Leadership indicates that staff are now better able to focus on casework rather than crisis supervision, which contributes to an overall safer and more controlled environment. As a result, some security strategies that were necessary in the prior setting are no longer needed in the new office.

OVERARCHING FINDINGS AND THEMES

Through the Monitor's engagement with DSS and the Task Force, and especially through information and observations from the site visit to Richland County in March 2026, several overarching themes have emerged.

- *Systems-Level Collaboration and Innovation:* The work of the Task Force and steps taken to implement the Improvement and Supplemental Plans represent a significant systems-level effort to convene diverse partners to collaboratively design and implement new and enhanced strategies aimed at addressing placement instability in the county. This collaborative approach has resulted in several promising initiatives, including the professional foster parent pilot, rapid response, and small-capacity group homes, which show early potential to improve placement stability and scale over time. These initiatives remain in the early stages of implementation, and there is limited evidence to date that they have been fully integrated into day-to-day practice or consistently utilized across DSS and partner agencies. It will be important for these initiatives to be monitored and tracked for accountability, and that they are a focus of DSS's continuous quality improvement (CQI) efforts. Sustained focus on implementation, coordination, and integration into daily operations is critical to achieving the full impact of these efforts and improving placement stability for children in DSS's care.

- *Use of Overnight Stays and Emergency Placements:* DSS has made notable progress in reducing the overall use of overnight stays in the DSS office and the use of emergency placements has trended downward; however, emergency placements continue to occur and occur with frequency for a small subset of children. For these children, reliance on unstable, short-term placements remains significant and contributes to continued harms, including disruptions to services, education, and overall well-being. Additionally,

[31] Ibid.

the rapid response model—intended to stabilize placements and prevent disruptions—appears to be underutilized.[32] These observations highlight the ongoing need for targeted strategies to better support children with complex needs and to ensure that crisis response resources are effectively deployed. Significant work remains to reduce placement instability overall and to reduce the prevalence of short-term and night-to-night emergency placements for children with more complex needs.

- *Operational Alignment Challenges for New Initiatives:* DSS staff and partners report ongoing confusion regarding the purpose of some new initiatives, eligibility criteria, and roles and responsibilities. The rapid rollout of new programs, combined with inconsistent communication and limited guidance, has made it difficult for DSS staff and contracted providers to fully understand and utilize these new resources. These challenges require robust CQI processes to monitor implementation, collect and share data, and inform adjustments. These factors contribute to variability in how initiatives are understood and applied in practice, underscoring the need for clearer guidance, strengthened communication, and more robust CQI mechanisms.

- *Inconsistent Implementation of Child and Family Team Meetings (CFTMs):* CFTMs are a key strategy to prevent foster care entry and address placement instability; however, their implementation in Richland County and across the State is inconsistent. Variation in facilitation—between trained facilitators and case managers—affects the structure and quality of meetings. Additionally, natural supports, service providers, and child-placing agencies are not consistently included, limiting the ability to develop comprehensive and coordinated plans that address the strengths and underlying needs of children in foster care. While CFTMs have demonstrated success in some cases in preventing removals, their use to inform placement decisions, prevent placement disruptions and promote reunification and permanency appears uneven. Greater clarity, training, and oversight are needed to ensure consistent implementation.

- *Progress Toward Trauma-Informed and Individualized Practice:* Despite efforts to promote a trauma-informed approach and to identify children's strengths and underlying needs so that services can align with individual needs, these practices have not yet been fully realized. DSS practice is too often reactive, responding to crises rather than proactively identifying and addressing the underlying needs to prevent foster care entry and placement instability. While some contracted providers have demonstrated meaningful progress in adopting these approaches, this shift appears less consistent among DSS staff. Continued emphasis on training, supervision, and organizational alignment is needed to support a more proactive, trauma-informed and individualized approach.

- *DSS and Contracted Provider Partnership and Coordination:* Since the early stages of the lawsuit, there have been evident improvements in communication and collaboration between DSS and child placing agencies (CPAs) and group home providers. Providers

[32] Note, DSS expects utilization to increase with the expansion of rapid response services to neighboring counties, particularly to Lexington County. See *supra* note 16.

and DSS have made increased efforts to work as partners in placement and service planning. However, lapses in collaboration and coordination remain and these relationships are still fragile and require further strengthening to ensure effectiveness. Ongoing challenges include delays or gaps in the sharing of critical information, such as Universal Applications, CANS assessments, inconsistent inclusion of providers in CFTMs, and limited coordination in placement and service planning processes. Strengthening and sustaining these partnerships is essential to improving placement stability and ensuring that children receive timely, coordinated services that align with their needs.

- *Cross-System Collaboration with Law Enforcement and Department of Education:* DSS has taken steps to formalize collaboration with external systems, including education and law enforcement, through communication protocols and memoranda of understanding. While these structures represent important progress, there is limited evidence that they consistently function as intended or that roles and responsibilities are clearly understood and executed across systems. Further work is needed to ensure these partnerships contribute to coordinated efforts in preventing foster care entry and supporting children who are in foster care.

- *Workforce Development and Support:* Workforce development and support remain critical factors for the successful implementation of new initiatives and improving placement stability for children in foster care. While recent hiring has filled vacancies, many case managers are relatively new, with one to two years of experience. DSS staff report improved morale, a clean and safe office environment, and positive reviews of the on-the-job peer support training. They also reported challenges related to classroom training, accessing transportation services, workload demands, and limited access to flexible funding. Reducing staff turnover and fully developing a stable and well-trained workforce is essential to strengthening implementation and improving practice.

- *Access to Quality Community-Based Services:* Access to and utilization of community-based and behavioral health services remain inconsistent across the system. It is unclear whether these challenges stem primarily from limited-service availability or from gaps in staff awareness and understanding of how to access available resources. DSS staff report difficulties navigating service systems and securing timely approvals, which may delay or limit service provision. Improving service mapping, access processes, and staff guidance is important to ensuring timely and appropriate service delivery for children and families.

Conclusion

In summary, there is much to recognize, commend and celebrate in the work of the Richland County Task Force. Supported by the leadership and significant efforts of DSS, the Task Force has made meaningful progress in addressing the placement instability crisis in a relatively short period of time. DSS leadership demonstrated a clear commitment to urgently addressing the unsafe and unacceptable experiences of children in their care and as well as the conditions faced by DSS staff responsible for serving them. Equally noteworthy is DSS's willingness to engage partners, to communicate openly about challenges, and to work collaboratively toward solutions. Task Force members demonstrated their shared commitment to improving placement stability and outcomes for children through active and sustained participation in the workgroups. As reflected in observations from the Monitor's March 2026 site visit, and the data presented in this letter and the most recent monitoring report, several challenges remain. Children continue to experience night-to-night placements and placement instability. However, important foundations have been established, including strengthened partnerships, and a clearer framework for ongoing collaboration and improvement.

Moving forward, efforts in Richland County should focus on the following priorities:

- Full implementation and integration of strategies, including data collection and CQI efforts to assess effectiveness of strategies and inform needed adjustments.
- Deepening and sustaining changes in practice so that the improvements become consistent and durable, rather than isolated efforts.
- Continued work to reduce the number of children entering foster care unnecessarily and to improve the placement and educational stability of those in care.
- Maintaining active engagement among all partners through information sharing, ongoing dialogue and joint problem-solving.
- Scaling successful strategies and initiatives across the state.
- Ensuring sustained funding for new initiatives and providing resources to expand those that demonstrate positive results.

We learned a lot during the site visit and from the interviews with providers and others but there is still much to learn about the new initiatives and their impacts. Going forward, we will be working with DSS to track and assess data and explore strategies for addressing remaining issues that were identified.

Sincerely,



Judith Meltzer, Senior Fellow
Center for the Study of Social Policy

Attachments:
DSS and Law Enforcement Protocol with Richland County Sheriff's Department
DSS and Law Enforcement Protocol with City of Columbia Police Department
Youth Personal Device Use & Access Guidelines
Stability Protocol for Students in Foster Care

Cc:

Tony Catone, State Director, SCDSS
Dawn Barton, Deputy State Director of Child Welfare Services, SCDSS
Taron B. Davis, Acting General Counsel, SCDSS
Elizabeth Stroup, Michelle H. Internal Monitor, SCDSS
Lauren Tinman, Michelle H. Internal Monitor, SCDSS
Diana Tester, Accountability, Data and Research Director, SCDSS
Becky Laffitte, Robinson Gray Stepp & Laffitte, LLP
Michael Montgomery, Robinson Gray Stepp & Laffitte, LLP
Thomas Limehouse, Jr., Limehouse LLC
Grayson Lambert, Chief Legal Counsel at Office of South Carolina Governor Henry Dargan McMaster
Ira Lustbader, Children's Rights
Valerie Achille, Children's Rights
Susan Berkowitz, South Carolina Appleseed Legal Justice Center
Chris Turluck, South Carolina Appleseed Legal Justice Center
Matthew Richardson, Wyche P.A.

ATTACHMENTS

DSS AND LAW ENFORCEMENT PROTOCOL

I. PURPOSE

This document establishes a protocol between the parties pursuant to the requirements of SC Code 63-7-760.

The following are relevant DSS contacts:

Monita Dawkins, Richland County Director	803-714-7598	monita.dawkins@dss.sc.gov
Sean Fay, Inspector General	803-898-1755	sean.fay@dss.sc.gov
Intake HUB	888 CARE4US	

This protocol covers Information exchange between the department and local law enforcement agencies, consultation on decisions to assume legal custody, and the transfer of responsibility over the child.

II. Information Exchange

DSS shall:

1. Provide access to records of indicated cases to investigating law enforcement agency. S.C. code Ann. § 63-7-1990(B)(4).
2. Allow LE access to unfounded records when LE is investigating a suspected false report or subsequent allegations of abuse or neglect. S.C. Code Ann. §63-7-940

LE shall:

1. Provide to the department copies of incident reports generated in any case reported to law enforcement by the department and in any case in which the officer responsible for the case knows the department is involved with the family or the child. S.C. Code Ann. § 63-7-980(C).

Both shall:

1. Share documentation of intervention, subject to limitations of applicable laws, regulations, and policies.
2. Be provided access to records or a summary of records concerning an adult residing in the home of a child who is the subject of a report of suspected child abuse or neglect or in a home which it is proposed that the child be placed. S.C. Code Ann. §63-7-990.

III. Consultation on Decisions to assume legal custody and the transfer of responsibility over the child.

DSS shall:

Designate and train selected staff to liaise with law enforcement and be available 24/7 to respond to questions, and provide information, resources, and consultation in support of their response to situations involving suspected abuse or neglect and/or potential EPCs.

Accept appropriate reports of abuse or neglect that are made orally by telephone or otherwise in the county where the child, under the age of eighteen, resides or is found. S.C. Code Ann. §63-7-310.

Where appropriate, notify mandated reporters of the requirement to report to LE allegations of abuse or neglect when the alleged perpetrator is not a parent, guardian, or person responsible for the child. DSS should

also notify LE to avoid the possibility of a non-report. S.C. Code Ann. §63-7-310(B). When appropriate, DSS shall assist other reporters in facilitating a report to law enforcement.

Make reports to LE when information received suggests a violation of criminal law within 24 hours of the Department's finding. S.C. Code Ann. § 63-7-980(B)(1).

When the initial report involves sexual abuse, notify LE within twenty-four hours. S.C. Code Ann. § 63-7-980(B)(2).

In coordination with LE, determine if a joint investigation is needed and clarify roles.

Notify LE of its case decision for all reports that are jointly investigated.

LE shall:

Accept reports of abuse or neglect and notify DSS of LE's response to a report of alleged abuse or neglect at the earliest possible time. S.C. Code Ann. § 63-7-320.

Act as the sole investigative agency when the allegation deals with a person other than a parent, guardian, or person responsible for the child.

All officers shall report cases of suspected abuse or neglect when the information is received in their professional capacity. S.C. Code Ann. § 63-7-310(A).

May report cases of domestic violence to DSS, and DSS may investigate to determine if the child has been harmed. S.C. Code Ann. § 63-7-370.

Provide DSS with a copy of the incident report relating to alleged abuse or neglect. S.C. Code Ann. § 63-7-980(C).

Notify DSS of LE's response to a report of alleged abuse, neglect, self-neglect or exploitation of a vulnerable adult at the earliest possible time.

Provide DSS with a copy of the incident report relating to alleged abuse, neglect, self-neglect or exploitation of a vulnerable adult.

Both shall:

Share information about the identity of the reporter of child abuse or neglect with the other as provided in S.C. Code Ann. §63-7-330

Maintain confidentiality of the reporter. The name can only be used by law enforcement for the purpose of the criminal investigation, and if the reporter must testify at the criminal trial, it cannot be disclosed that he or she was the reporter. S.C. Code Ann. §63-7-330.

DSS sharing of reporter's identity will be provided to LE's assigned investigative officer to ensure information is not recorded on incident reports.

LE shall:

If practicable, accompany DSS upon request on home visits when there is a potential threat to the worker's safety.

Pursuant to S.C. Code Ann. §63-7-990, fulfill requests for state and local criminal history record information and/or local law enforcement records including conviction data, non-conviction data, arrests, and incident reports.

Provide copies of incident reports to DSS. S.C. Code Ann. § 63-7-980(C).

Document in the case file that LE is requesting a forensic interview and/or forensic medical exam of the minor child(ren).

Both shall:

In joint investigations:
- When appropriate, coordinate activities.
- Coordinate services to minimize the numbers of interviews of the child (S.C. Code Ann. § 63-7-920(C));
- Inform one another of significant developments in a timely manner such as arrests, release on bond, court dates, visitations between child and suspected perpetrator, receipt of material new information, and disposition of charges. S.C. Code Ann. § 63-7-980(C)

IV. Safe Haven for Abandoned Babies Act - AKA Daniel's Law

DSS shall:

1. Have legal custody of the infant immediately upon receipt of the notice, written or verbal, from the hospital. S.C. Code Ann. § 63-7-40(C).

2. Assume physical control of the infant as soon as practicable after notification but no later than 24 hours after receiving notice that the infant is ready for discharge. S.C. Code Ann. §63-7-40.

3. Within 48 hours, publish notice in a newspaper of general circulation in the hospital/hospital facility where the infant is located and send a news release to area broadcast and print media. S.C. Code Ann. §63-7-40(E).

4. Refer cases that appear to indicate a violation of criminal law to law enforcement.

LE shall:

1. Take reports of abuse and neglect on all infants covered under the Safe Haven for Abandoned Babies Act who are discovered to have physical evidence of abuse and neglect when information suggests violation of a criminal law. Report to DSS when infant appears to be the victim of child abuse, neglect, or harm as defined in S.C. Code Ann. § 63-7-20.

V. Inspection Warrants

DSS Shall:

1. When circumstances require, obtain an inspection warrant pursuant to S.C. Code Ann. § 63-7-920(B). Warrants shall contain language that "It will be the duty of accompanying law enforcement officer to use all

reasonable means necessary to effect the inspection of the children or premises as specified in the warrant. Law enforcement shall have authority to enter the identified premises, above the objections of the owner or occupant of the premises and/or dwelling."

2. In the event SCDSS believes it is necessary for the safety and well being of the minor child to effect a forcible entry of the premises for purposes of inspecting the premises or the condition of the minor children, a separate inspection warrant shall be sought from the Family Court specifically authorizing forcible entry into the premises.

LE shall:

1. Assist DSS in executing inspection warrants obtained pursuant to S.C. Code Ann. § 63-7-920(B).

2. In the event entry onto the premises that are the subject of the warrant is not possible due to no response at the time of execution, law enforcement will assist with a follow up attempt to inspect the premises or children subject to the warrant at a time requested by SCDSS or at a mutually agreed upon time.

Acknowledged by

(Name) Monita Dawkins
(County) County DSS, County Director

Date 6 May 2025

(Name)
(name) Head of Law Enforcement Agency

Date 5/8/2025

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

DSS AND LAW ENFORCEMENT PROTOCOL

I. PURPOSE

This document establishes a protocol between the parties pursuant to the requirements of S.C. Code §63-7-760.

This protocol shall outline and incorporate consultations and decisions on the imminent removal of minor children from their homes, information exchange, response times and coordination procedures, and any other matters as outlined in S.C. Code §63-7-760.

II. CONTACT

The following are relevant contacts for both agencies, Columbia Police Department (hereafter CPD) and the Richland County Department of Social Services (hereafter DSS):

CPD:

Watch Commander	*As personnel rotates based upon a 24-hour rotation schedule please contact by and through Columbia-Richland 9-1-1 Communications Center*

DSS:

Monita Dawkins, Richland County Director	803-714-7598	monita.dawkins@dss.sc.gov
Sean Fay, Inspector General	803-898-1755	sean.fay@dss.sc.gov
Intake HUB	888 CARE4US	

III. INFORMATION EXCHANGE

DSS shall:

1. Provide CPD with access and copies of records of indicated cases to pursuant to S.C. Code Ann. § 63-7-1990(B)(4).
2. Allow CPD access to unfounded records when there is an investigation of a suspected false report or subsequent allegations of abuse or neglect. (See S.C. Code Ann. §63-7-940(A)(1-2).)
3. During its investigation phase, communicate with the assigned CPD officer/investigator weekly regarding case information and case determination outcomes.
4. Assign personnel to retrieve physical copies of any and all requested incident reports from CPD on a weekly basis, on a particular day as identified and agreed upon by both parties.
5. Provide a summary of any and all Removal Prevention Child and Family Team Meeting to the assigned CPD officer/investigator on a weekly basis, unless said decisions shall affect or impede the criminal investigation upon which said summary shall be provided within 24 hours.

CPD shall:

1. Make available any and all physical copies of requested incident reports on a weekly basis to be retrieved by DSS personnel, on a particular day as identified and agreed upon by both parties. Subject to any redactions as necessary prior to disclosure.

2. Provide copies of incident reports generated from any emergency removals effectuated to DSS by the next business day.
3. Communicate consistently with the assigned DSS investigator/case manager regarding case updates wherein both parties are actively involved or investigating.

CPD and *DSS* (hereafter *The Parties*) shall:

1. Share documentation of intervention, subject to limitations of applicable laws, regulations, and policies.
2. Share records, summaries, reports, and information for any instances regarding an adult residing in the home with a minor child, who is the subject of a report of suspected child abuse or neglect, as outlined in S.C. Code Ann. §63-7-990.

III. NOTIFICATIONS AND CONSULTATION ON DECISIONS

DSS shall:

1. Designate and train selected staff to liaise with CPD and be available 24/7 to respond to questions, and provide information, resources, and consultation in support of their response to situations involving suspected abuse or neglect and/or potential emergency removal of minor children from their respective homes.
2. Accept appropriate reports of abuse or neglect that are made orally by telephone or otherwise in the county where the child, under the age of eighteen, resides or is found pursuant to S.C. Code Ann. §63-7-310.
3. Where appropriate, notify mandated reporters of the requirement to report to CPD allegations of abuse or neglect when the alleged perpetrator is not a parent, guardian, or person responsible for the child.
4. Notify CPD of any suspected child abuse or neglect, as mandated pursuant to S.C. Code Ann. §63-7-310(B), and when appropriate, assist other mandated reporters in facilitating notification to CPD.
5. Make reports to CPD when information received suggests a violation of criminal law within 24 hours of DSS' finding pursuant to S.C. Code Ann. § 63-7-980(B)(1).
6. When the initial report involves sexual abuse, notify CPD within twenty-four (24) hours pursuant to S.C. Code Ann. § 63-7-980(B)(2).
7. In coordination with CPD, determine if a joint investigation is needed and clarify roles.
8. Notify CPD of its case decision for all reports and incidents that are jointly investigated.

CPD shall:

1. Investigate allegations of abuse or neglect and notify DSS and consult with DSS on any and all reports of alleged abuse or neglect at the earliest reasonable time pursuant to S.C. Code Ann.§ 63-7-320.
2. Investigate matters/incidents that involve allegations of abuse and neglect wherein the perpetrator is not a parent, guardian, or person responsible for the child.
3. Report cases of suspected abuse or neglect when the information is received in their professional capacity as provide by S.C. Code Ann. § 63-7-310(A).
4. Notify DSS of their response to a report of alleged abuse, neglect, self-neglect or exploitation of a vulnerable adult at the earliest possible time.
5. Provide DSS with a copy of the incident report relating to alleged abuse, neglect, self-neglect or exploitation of a vulnerable adult

6. **May** notify DSS, where possible and identifiable, of incidents where a minor child(ren) perceived any allegations of domestic violence so that DSS may initiate a joint inquiry or investigation into the matter as provided in S.C. Code Ann. § 63-7-370.

The Parties shall:

1. Share information about the identity of the reporter of child abuse or neglect with the other as provided in S.C. Code Ann. §63-7-330
2. Maintain confidentiality of the reporter's name and contact information. The information can only be used by law enforcement for the purpose of the criminal investigation, and if the reporter must testify at the criminal trial, it cannot be disclosed that he or she was the reporter as provided in S.C. Code Ann. §63-7-330.
3. DSS sharing of the reporter's identity will be provided to the assigned officer/investigator to ensure information is not recorded on incident reports.

IV. EMERGENCY REMOVAL PROCOTOL AND JOINT INVESTIGATIVE SUPPORT

DSS shall:

1. Provide the current contact number of the Team Coordinator who will serve as the liaison between CPD and DSS. This coordinator shall be available 24/7 to CPD for any and all calls to discuss risk factors of imminent danger and assist in identifying opportunities and resources to avoid an emergency removal of a minor child. The coordinator shall also assist in convening a Removal Prevention Child and Family Team Meeting.
2. Provide CPD with an estimated response time for any and all calls received through the Intake HUB within a one (1) hour time frame.
3. Assign an investigator to respond to an incident scene wherein CPD has communicated by and through the Intake HUB that an immediate response is necessary for safety, severity, or other significant and emergent reasons.
4. Request CPD to accompany them on home visits wherein there is a potential threat to the worker's safety by and through notifying CPD's Watch Commander.
5. Request and consult with CPD's Watch Commander regarding the safest course of action for any and all emergency removals that are requested by and through an Ex Parte Order at least one hour upon receipt of its execution.

CPD shall:

1. Accompany, when possible, DSS on home visits wherein there is a potential threat to the worker's safety by and through notifying CPD's Watch Commander
2. Make any and all reports of abuse and/or neglect to the Intake Hub to ensure an estimated response times are provided.
3. Consult with a DSS Team Coordinator, when appropriate, to discuss risk factors of imminent danger and to identify opportunities and resources to avoid emergency removal, including but not limited to, allowing the convening of a removal prevention and family team meeting.
4. Inform the Intake Hub when immediate response is necessary and request that an investigator with DSS be dispatched to the scene when immediate response is necessary for safety, severity, or other significant and emergent reasons.
5. Proceed with any emergency removals wherein DSS personnel cannot respond to the scene within a reasonable amount of time considering the circumstances.

The Parties shall:

IN JOINT INVESTIGATIONS:

1. Coordinate any activities with any involved parties, when applicable, reasonable, and allowable based on privacy and disclosures parameters.
2. Coordinate services to minimize the numbers of interviews of the minor child(ren) pursuant to S.C. Code Ann. § 63-7-920(C).
3. Inform one another of significant developments in a timely manner such as arrests, release on bond, court dates, visitations between child and suspected perpetrator, receipt of material new information, and disposition of charges as outlined in S.C. Code Ann. § 63-7-980(C)

V. SAFE HAVEN FOR ABANDONED BABIES ACT - AKA DANIEL'S LAW

DSS shall:

1. Have legal custody of the infant child immediately upon receipt of the notice, written or verbal, from the hospital pursuant to S.C. Code Ann. § 63-7-40(C).

2. Assume physical control of the infant child as soon as practicable after notification but, no later than 24 hours after receiving notice, that the infant child is ready for discharge pursuant to S.C. Code Ann. §63-7-40.

3. Within 48 hours, publish notice in a newspaper of general circulation in the hospital/hospital facility where the infant is located and send a news release to area broadcast and print media as outlined in S.C. Code Ann. §63-7-40(E).

4. Refer cases that appear to indicate a violation of criminal law to CPD and are outside the protections afforded under Daniel's Law.

CPD shall:

1. Take reports of abuse and neglect on any and all infants covered under the Safe Haven for Abandoned Babies Act who are discovered to have physical evidence of abuse and neglect when information suggests a potential violation of a criminal law.
2. Report to DSS when an infant appears to be the victim of child abuse, neglect, or harm as defined in S.C. Code Ann. § 63-7-20.

VI. INSPECTION WARRANTS

DSS shall:

1. When circumstances require, obtain an inspection warrant pursuant to S.C. Code Ann. § 63-7-920(B). Warrants shall contain language that **"It will be the duty of accompanying law enforcement officer to use all reasonable means necessary to affect the inspection of the minor child(ren) or premises as specified in the warrant.** In addition, the warrant shall provide that, **"law enforcement shall have authority to enter the identified premises, above the objections of the owner or occupant of the premises and/or dwelling."**
2. In the event SCDSS consults with CPD and both parties believes it is necessary for the safety and well-being of the minor child(ren) to affect a forcible entry of the premises for

purposes of inspecting the premises or the condition of the minor children, a separate inspection warrant shall be sought from the Family Court specifically authorizing forcible entry into the premises. Said warrant shall in include explicit language that states that **"usage of any force that is reasonable to accomplish said inspection shall be permitted."**

3. Notify CPD's Watch Commander upon receipt of any inspection warrant within one (1) hour of it being issued so that an officer can be assigned to accompany the case manger/investigator.

CPD shall:

1. Assist DSS in executing inspection warrants obtained, within a reasonable time, pursuant to S.C. Code Ann. § 63-7-920(B) upon receipt of notification that said warrant has been issued.
2. In the event entry onto the premises that are the subject of the warrant is not possible due to a lack of response at the time of execution, CPD will assist, when reasonably able to, with a follow up attempt to inspect the premises or children subject to the warrant at a time provided that the Watch Commander has been notified and consulted at least one (1) hour prior to the reattempt.

VII. TRAINING

DSS shall:

1. Provide training at least once per year, to include but not limited to, the intake process, response times, investigations typologies, and other requested and pertinent topics as identified to them by and through CPD Personnel.
2. Provide training at least once per year to DSS staff regarding the intake process, response times, and specialized protocols and guidelines as outlined in this document.

CPD shall:

1. Ensure that all of its officers/investigators/ and personnel are advised and adhere to the protocols as outlined in this document.
2. Notify DSS personnel of any issues that arise under this agreement within a timely matter to include matters identified as requiring more training or in depth discussions.

The Parties shall:

1. Conduct ongoing training at least one time per year to share roles and responsibilities available community services, internal processes, DSS response times, and trauma responsiveness.
2. Review the MOU on an annual basis to ensure that information and agreements align with current laws, policies, and standards, and internal protocols.

[SIGNATURES ON FOLLOWING PAGE]

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

Acknowledged by

Monita Dawkins
Richland County DSS, County Director

Date 28 May 2025

W.H. Holbrook / mst Hall
Head of Law Enforcement Agency

Date 5/27/2025

Head of Law Enforcement Agency

Date

Head of Law Enforcement Agency

Date

APPROVED AS TO FORM

Legal Department City of Columbia, SC

Youth Personal Device Use & Access Guidelines

Note: ***The term Provider is used in this document to include foster parents and group home staff.***

Purpose

To support youth in developing responsible digital habits while recognizing their right to connect with family, friends, and communities. These guidelines ensure safety, consistency, and respect, while honoring youth voices in shaping how devices are used. These guidelines and the associated Youth Friendly Device Agreement are designed to guide a conversation between the provider and the youth regarding responsible personal device usage and safety issues related to usage.

Guiding Principles

- **Youth Voice First**: These guidelines were developed in collaboration with the youth, providers, and DSS staff.
- **Strengths-Based**: Expectations are based on the belief that all youth are capable of growth, responsibility, and informed decision-making.
- **Transparency and Accountability**: Youth, providers, and staff will be clearly informed about web-based monitoring systems if they are used.

Why These Guidelines Matters

This agreement exists to:

- Protect all youth and Providers. For example: posting your location can put you, other youth, and adults in the home at risk if it notifies people who want to harm you, or others, of your whereabouts.
- Protect youth from online dangers like bullying, exploitation, and long-term digital consequences. There are adults posing as youth who prey on youth on-line. You NEVER know who you maybe actually chatting with.
- Encourage safe, age-appropriate use of technology.
- Provide clear expectations around how devices are maintained, used, and monitored.
- Prevent arbitrary or emotionally driven consequences.

Definitions

- **Violence**: Refers to physical harm or injury caused to an individual or group. It can include physical attacks, sexual violence, and other forms of physical harm.
- **Pornography**: Involves the creation or distribution of sexually explicit material, often without the consent of one or both parties involved. It can include images, videos, or other media.
- **Hate speech**: Consists of statements that promote malicious stereotypes, incite hatred or violence against a group, and perpetuate inequality.
- **Supportive redirection**: A technique that combines extinction with gentle guidance to validate a learner's feelings, pause reinforcement for challenging behavior, and immediately direct them to a more helpful skill. Effective strategies for redirecting behavior in children include offering choices, using distractions, and providing positive reinforcement to guide youth toward more acceptable actions.

Device Expectations

Expectations and rules should be grounded in safety and protection, not control:

- Avoid allowing others to use your devices. Device sharing puts your information and possibly other people at risk if someone shares your location.
- Use devices in designated areas.
- Charge devices in designated areas during quiet or nighttime hours. Each home will designate their own area for devices to be stored.
- Respect privacy and dignity of others (e.g., no recording or sharing images/videos without permission).
- Avoid creating or viewing inappropriate content, including violence, pornography, or hate speech.
- Use social media responsibly, knowing it may affect future opportunities (e.g., jobs, college).
- Report concerns, such as online threats, harassment, or scams.

Maintenance and Loss of Privileges

Devices may be restricted when:

- The youth refuses to follow this agreement after supportive redirection from provider.
- There is documented risk of harm to self or others.
- The youth may file a grievance with their DSS case manager if they disagree with the loss of privileges.

NOTE: Devices should not be taken due to personal frustration, control, or without explanation. Providers are not permitted to prevent youth from contacting their DSS case manager. Providers will receive training each year on these guidelines.

All removals should be reported to DSS staff within 24 hours by email or text. If it is determined by the provider and DSS staff that the loss of cell phone/device privileges should last longer than 24 hours, then the youth and provider should collaborate to create a joint written agreement addressing the following:

a) What expectation was not met
b) What support will be offered
c) How to regain the privilege

NOTE: The youth will help determine what supports they need and what they must do to regain the privilege.

Within the group care setting, removals lasting longer than 24 hours will be reviewed weekly by the supervisor and youth representative or advocate. Within a foster care setting the DSS worker will review removals on a weekly basis with the provider.

Monitoring Using Web Filtering Software

Providers may have web filtering software such as Wi-Fi X or Go Guardian to:

a) Alert providers to dangerous or harmful content
b) Track usage patterns
c) Allow providers to limit access to the internet

Other examples of web filtering software can be found at this link:

The Best Parental Control App Services of 2025

Review and Amendments

1. Guidelines Applicability

This agreement is intended to serve as a guide for all parties involved in the care and support of youth placed in care, including the youth themselves, DSS staff, providers, and other stakeholders. The agreement may be adapted with input from the youth residing in a placement.

2. Monitoring Using Web Filtering Software

Monitoring using web filtering software is left to each providers discretion.

3. Youth Review Timeline

The agreement and its implementation shall be reviewed with youth every three (3) months, to ensure understanding, assess compliance, and allow room for youth to express needed changes or improvements.

4. Real-Life Examples

For example, if a youth posts something inappropriate on social media, a conversation will occur to help the youth understand why it is a concern. The provider will then outline what steps the youth can take to re-establish trust. Restrictions, if necessary, will be time-bound and tied to specific goals, such as attending a digital safety session or a restorative dialogue.

5. Provider Awareness

Providers should engage in ongoing conversations with the youth in their care regarding device usage and safety to encourage youth to feel comfortable sharing any concerns the youth have regarding content sent to them or observed by them on their device.

Signatures

NOTE: Youth and staff will collaboratively co-sign this agreement, as well as the youth-friendly agreement, to ensure mutual understanding and commitment. This will take place after both documents have been thoroughly reviewed and finalized by the youth committee, which consists of representatives from the YEA! committee. The process aims to promote transparency and ensure that all voices are heard in the creation of these important agreements.

Provider's Signature Date

Youth's Signature Date

SOUTH CAROLINA DEPARTMENT OF EDUCATION

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Stability Protocol for Students in Foster Care

This document is designed to increase stability and provide consistency for students as well as highlight needed collaboration between School Districts and the Department of Social Services.

Education is a vital part of stability for students in foster care:

Frequent changes in placement significantly challenge educational stability for students in foster care. The inconsistency in placements disrupts access to educational resources and continuity in academic instruction. As students transition between different placements, they may encounter delays in enrollment, gaps in assignments, and other emotional stressors, all of which can hinder their ability to focus on and succeed in school. Unfortunately, these disruptions can lead to decreased academic performance, increased absenteeism, and higher dropout rates, ultimately impacting their long-term educational outcomes and future opportunities.

This instability is often caused by a quick change in placement, where a student is withdrawn from their School of Origin (SOO), followed by the lack of permanent placement options. There are strategies that can assist in mitigating disruption and meet the educational needs of the student in foster care. Local School Districts and DSS County Offices should utilize these opportunities to exercise collaboration and increase educational stability for students in foster care.

In accordance with the Every Student Succeeds Act Title I, Part A requirement, when a student comes into foster care or experiences a placement change or disruption, a Best Interest Determination (BID) meeting is required to decide school placement. This process should be completed as expeditiously as possible, within three business days of the placement change.

Please take these items into consideration when navigating educational instability:

1. A student should NOT be withdrawn from their SOO until a BID meeting is conducted, and it is determined that changing schools is in the student's best interest.

2. BID participants should discuss the following questions to promote educational stability (addressed in question #3 on the BID document). 'Is the student's new living arrangement expected to be short- or long-term? How is this impacted by school selection?'

3. If a student receives individualized education services, this must be discussed in the BID, as the Individualized Education Program (IEP), Individualized Language Acquisition Plan (ILAP), accommodations plan under Section 504 of the Rehabilitation Act of 1973 (Section 504), etc., may require specific considerations. A representative of the IEP team should attend the BID meeting for a student with an IEP. Please reference the Office of Special Education Services (OSES) Addendum for more guidance. If unsure if the student has an IEP or you are unable to find an IEP, contact an OSES representative to clarify.

4. DSS may utilize its Regional Day Centers (when educationally appropriate) to accommodate students during the school day when they are unable to attend their SOO. These day centers are operated by

staff who can offer technical support to students while they access their education. These centers also have computers available for students to use.

5. It is important for DSS to be mindful of the student's educational device and any other district-owned material; if a student is coming into care for the first time, this device should be retrieved at the time of removal or change of placement. In accordance with the technology needs for each option, school districts are encouraged to allow the student to retain the district's device when appropriate.

6. If issues, concerns, or disagreements arise, involve the appropriate local level contacts, including the District's Foster Care Point of Contact and the DSS Regional Education Specialist. If necessary, utilize the District's dispute process.

Foster Care Glossary of Terms

Fostering Connections to Success and Increasing Adoptions Act of 2008 and Every Student Succeeds Act of 2015 (ESSA), which reauthorizes the Elementary and Secondary Education Act of 1965: Includes the Federal and State Statutory (S.C. Code Ann. § 59-38-10) requirements for students in Foster Care through Title I Part A.

Foster Care: 24-hour substitute care for children placed away from their parents or guardians and for whom the Child Welfare Agency (CWA) has placement and care responsibility.

School of Origin (SOO) (could be referred to as Home School): School of Origin is the school the student was enrolled in when first placed into foster care. If a student's foster care placement changes, the school of origin would then be considered the school in which the student is enrolled at the time of the placement change.

Best Interest Determination (BID): A meeting that discusses the factors that must be considered when making decisions about a student's appropriate educational placement. The local DSS caseworker is responsible for initiating the BID meeting. The caseworker should collaborate with the LEA to schedule a BID meeting prior to the student entering custody or a placement change and invite the potential placement district if a move is likely.

Individualized Education Program (IEP): This document ensures that a student with a disability identified under the Individuals with Disabilities Education Act (IDEA) receives services, supports, and accommodations that will ensure their academic success and access to the learning environment.

504 Plan: The 504 Plan is a plan developed to ensure that a student who has a disability identified under the law receives accommodations that will ensure their academic success and access to learning.

Individualized Language Acquisition Plan (ILAP): This plan provides information about a Multilingual Learner and the support they must receive in order to have meaningful and equal access to the curriculum.

SOUTH CAROLINA DEPARTMENT OF EDUCATION DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

Options to Provide Educational Stability	Additional Instructions
1. Student to remain enrolled in their current school, and transportation is provided to the SOO.	✓ Student is not withdrawn from their current school. ✓ DSS Case Worker collaborates with the District Foster Care Point of Contact to provide transportation to and from school. ✓ This process is laid out on page 4 of the BID document. ✓ The Regional Education Specialist should be part of this conversation to assist with arranging transportation.
2. Student to remain enrolled in SOO and receive assignments from current teachers to complete while at a DSS Day Center or other location.	✓ Student is not withdrawn from their current school. ✓ DSS Case Worker collaborates with the District Foster Care Point of Contact to coordinate a process to keep the student connected with academic requirements. ✓ Student remains enrolled and keeps their computer/device to access instruction, if applicable. ✓ Student will log onto the district-specific platform (Google Classroom, Schoology, etc.) to engage in their learning, if applicable. ✓ Student can be coded as 'virtually present' or 'alternate education setting' in PowerSchool to note student's participation. ✓ District should utilize pacing guides, virtual tutoring services, and other appropriate supports. ✓ DSS provides support at the day centers for students to access additional support while engaging in their learning.
3. Student utilizes a virtual education platform (such as Edgenuity, Acellus, VirtualSC, or other option).	✓ Student is not withdrawn from their current school. ✓ Student remains enrolled in the current school, dependent on the specific program and the District's Proficiency Based System. ✓ Virtual SC is a statewide program where the district will sponsor a student to access available courses or credit recovery. See dates and deadlines here. ✓ Depending on the needs of the virtual platform, the DSS Case Worker collaborates with the District Foster Care Point of Contact to provide the next steps for accessing the virtual educational program.
4. Student will enroll in the Richland County DSS Office resident school as a last resort option. (Reference E-5 in Ensuring Educational Stability and Success for Students in Foster Care, Non-Regulatory Guidance, November 2024)	✓ Student is withdrawn from their current school. ✓ DSS Case Worker collaborates with District Foster Care Point of Contact to transfer records to the new school. ✓ DSS Regional Educational Specialist facilitates connection with the new district's Foster Care Point of Contact for immediate enrollment. ✓ New school utilizes virtual, in-person programs to help students receive credits that might otherwise be lost during school transitions, if applicable.

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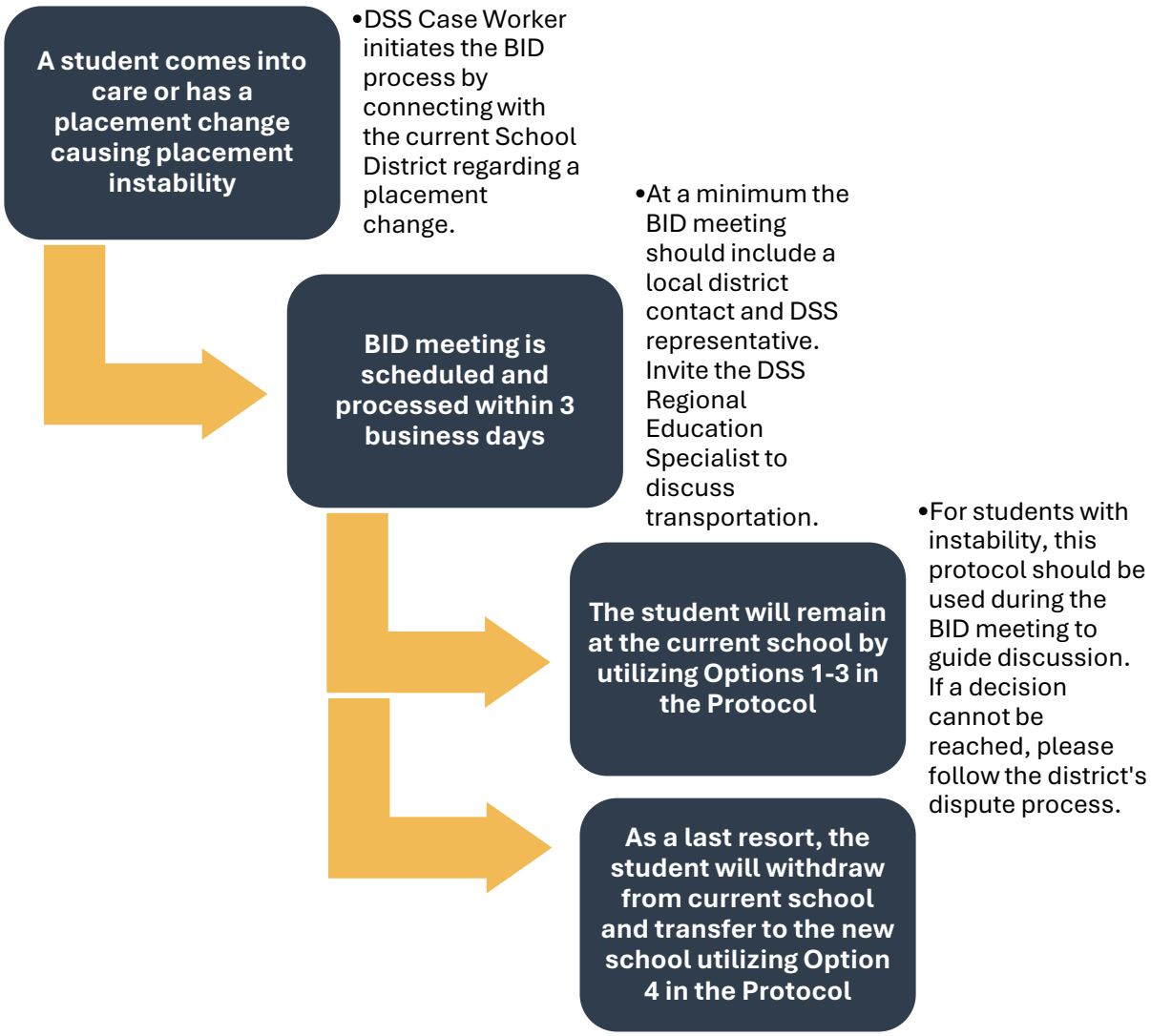
Flowchart for the Protocol



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Addendum

Guidance: Considerations for Enrolling a Student with an IEP Following a Foster Care Placement Change

When a student in foster care who has an Individualized Education Program (IEP) experiences a change in placement, careful consideration must be given to the best interest determination (BID) regarding school enrollment. The following guidance is intended to assist the BID team, such as social workers and local educational agency (LEA) liaisons, in navigating this process.

Understanding "Change of Placement" in Different Contexts

a. **Foster Care Definition:**
In child welfare terms, a "change of placement" refers to a change in the child's living arrangement or home address (e.g., from one foster home to another, or from a foster home to another facility)

b. **IDEA Definition:**
Under the Individuals with Disabilities Education Act (IDEA), a "change of placement" refers to a change in the educational program or services provided to a student with a disability. This may include changes in the amount, type, setting, or intensity of services.

It is important to note that a change of home address due to a foster care placement **does not automatically require** a change in the student's educational placement under the IDEA. The educational team must still ensure that the student continues to receive services that are **comparable** to those in their current IEP.

Best Interest Determination (BID) Considerations

1. When a student with an IEP experiences a placement change, the BID process should include a member from the IEP team familiar with the student. **Who might be invited to participate in the BID discussion**
This list is not exhaustive due to the individualized needs of the student, and everyone may not necessarily be involved; however, all individuals should be familiar with the student if they are providing input.

School psychologist	Speech-language pathologist (SLP)
Board Certified Behavior Analyst (BCBA)	General education teacher
Special education teacher	Special education teaching assistant
Any related services professional (e.g., occupational therapist, physical therapist, etc.)	LEA representative/building or district administrator

2. **Continuity of Services**

   a. Will the new school be able to implement the IEP as written?
   b. Are comparable services available at the new school?
   c. Is there a risk of regression or disruption to learning due to the transition?
3. **Availability of Comparable Services**
   a. Under the IDEA, the receiving school is required to provide comparable services to those outlined in the student's existing IEP until the new IEP team convenes and adopts or revises the IEP.
4. **Transportation and Accessibility**
   a. Can transportation be arranged to maintain the student in their school of origin if it is in the student's best interest?
   b. Does the IEP include transportation as a related service?
5. **Role of DSS case worker in the transition process**
   a. Contact the Special Education Director in the district to obtain contact information for an IEP team representative to attend the BID process.
   b. Ensure all educational records are collected for seamless transition between schools/districts.
6. **Role of representative of the IEP team member familiar with the child in the transition process**
   a. Describe the child's strengths and weaknesses
   b. How has the child handled other transitions (e.g., substitute teacher, change in school day, etc)?
   c. Is there a strong positive or negative relationship with adults and peers in the current setting?

G. Health Care Improvement Plan: Addressing the Health and Well-Being Needs of Children and Youth in Foster Care

Health Care Improvement Plan: Addressing the Health and Well-Being Needs of Children and Youth in Foster Care

December 2025

Introduction

The South Carolina Department of Social Services (SCDSS) continues its comprehensive reform of its child welfare system with a special focus on the health care needs of children in foster care. In partnership with the South Carolina Department of Health and Human Services (SCDHHS), SCDSS continues to assess and improve the way health care services are organized and delivered to children in SCDSS custody. Underlying this work is a vision of a fundamentally transformed system that can be a national model for other child welfare systems.

In August 2018, SCDSS entered into a Healthcare Improvement Plan (HCIP). The HCIP was followed in February 2019 by a further specification of commitments in the HCIP Care Coordination Addendum. These documents, both of which were approved by federally appointed Co-Monitors and entered with the federal court[i], were developed pursuant to the final Settlement Agreement (FSA) in *Michelle H. v. McMaster and Catone*.[ii] The addendum outlined specific healthcare outcomes for children in foster care centering around initial medical screens; initial comprehensive medical, dental, metal health, and developmental assessments; as well as periodic preventative care, follow-up care, and the development and implementation of a care coordination model.

Over the course of the last seven years, SCDSS has worked diligently to enhance cross-sector partnerships and build necessary infrastructure so that every child in care receives essential support and coordinated services with the goal of promoting best health outcomes. These efforts have resulted in the implementation of new data tracking protocols, dedicated nursing, and clinical oversight units to provide case consultation and support to frontline staff. This additional capacity has helped not only to promote access to timely services, but also to create a robust process that supports continuous quality improvement.

Similarly, the South Carolina Department of Health and Human Services (SCDHHS) has played a pivotal role in advancing system-wide healthcare improvements, particularly for children in foster care. By strategically leveraging its policy and funding flexibilities, SCDHHS has implemented a series of impactful initiatives aimed at strengthening access to and quality of care as outlined on the following page.

[i] SCDSS and Co-Monitors agreed to reassess and modify the plan as knowledge was gained through implementation. More recently, the Court's order from October 15, 2025 (DKT #382) required the development of a revised Health Care Improvement Plan that meets the requirements of the Final Settlement Agreement and that can be approved by the Co-Monitor and the Court by December 31, 2025.

[ii] According to the FSA, the HCIP was to include enforceable dates and targets for phased implementation related to initial assessment services, periodic assessment services, documentation, and health care treatment services for children in foster care in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health.

- On January 1, 2022, SCDHHS increased rates for individual applied behavior analysis by 30%. Public Notice of Final Action for Rate Increases for Certain Incontinence Supplies, DAODAS and ASD Services | SCDHHS
- On April 1, 2022, SCDHHS increased rates for all contracting Medicaid Psychiatric Residential Treatment Facilities to $500 per patient for day for service provided to South Carolina Medicaid-eligible children. Rate Increase for Psychiatric Residential Treatment Facilities (PRTFs) | SCDHHS
- On July 1, 2022, SCDHHS kicked off its initiative for increasing access to behavioral health services in the school setting. The goal was to reduce the counselor-to-student ratio. These efforts served to reduce the ratio from 1:1,300 to 1:829 in 2023. Gov. Henry McMaster, SCDHHS Release Update on Mental Health Counselors in S.C. Schools | S.C. Governor Henry McMaster
- On September 1, 2022, SCDHHS issued a reminder provider bulletin to physicians serving foster care children about the opportunity to receive an enhanced rate that has been in effect since July 2020 for evaluation and management services (well and sick child).
- On October 1, 2022, SCDHHS increased rates for Therapeutic Childcare by 50% for all four Medicaid-covered procedure codes. Updates to State Plan Therapeutic Child Care Rates | SCDHHS
- On July 1, 2023, SCDHHS increased rates for certain substance abuse services provided by 301's and increased rates for certain applied behavioral analysis services by 32% and added new covered procedure codes. ASD Addition of New Covered Codes, Rate and Service Limit Increases | SCDHHS
- On January 1, 2024 SCDHHS completed the lift of the provider moratorium enabling new providers to enroll and went live with the coverage of the first evidence-based practice for intensive in-home service delivery through Multisystemic Therapy (MST) New LIP and RBHS Provider Enrollment Requirements; New LIP, MTCM and RBHS Revalidation Requirements | SCDHHS; Addition of Multisystemic Therapy (MST) for Intensive In-home Service | SCDHHS
- On July 1, 2024, SCDHHS increased rates for Pediatricians to 106% of Medicare for well and sick child visits; added new specialized assessment and treatment service codes; included coverage for another intensive in-home service known as HOMEBUILDERS to the rehabilitative service array; increased rates by 5% for licensed psychology and master's level practitioners to support access to rehabilitative behavioral health services. Physicians Services Provider Manual and Reimbursement Rate Updates | SCDHHS; UPDATE to Addition of New Covered Autism Spectrum Disorder Services | SCDHHS; Addition of Intensive In-home Services Using the Homebuilders® Model and Updates to Peer Support Services | SCDHHS; Rate Increases for Services Provided by Master's-level Practitioners and Licensed Psychologists in Private Organizations | SCDHHS
- On October 1, 2024, SCDHHS included coverage for Collaborative Care Codes to integrate behavioral health in pediatric practices. The Collaborative Care Model (CoCM) is a systematic strategy for treating behavioral health conditions in a primary care setting through the integration of care coordination using a behavioral health care manager, psychiatric consultant, and primary care practitioner. Addition of Psychiatric Collaborative Care Model to Physicians Services | SCDHHS
- On December 1, 2025, SCDHHS increased rates for rehabilitative behavioral health and substance use services. Addition of Psychiatric Collaborative Care Model to Physicians Services | SCDHHS

SCDSS has observed measurable improvements in healthcare outcomes for children in foster care. For

example, using an internal monthly report developed by SCDSS for field and management use, the percentage of children in foster care who are up to date on well-child visits rose from 38% at baseline (February 2020) to 68% in October's report 2025. At the same time, the percentage of children with no recorded well-child visit dropped significantly—from 15% in February 2020 to 2% in October's report 2025. That performance has varied by age. For example, while overall 68% of all children and youth were up to date on their well child visits; infants (0-5 months) were at 13%, toddlers (6-23 months) were 55%, children 2-6 years were 73%, children 7-12 years were 72%, and youth 13-17 years were 70%. This report is not used to assess FSA performance.

Similar progress has also been observed in dental care. The percentage of children in foster care who are up to date on dental visits increased from 57% at baseline (April 2020) to 73% in October 2025. Meanwhile, the percentage of children with no recorded dental visit declined from 11% in February 2020 to 3% in October 2025.

Recognizing that additional improvement is still needed, in partnership with SCDHHS and other state agencies, SCDSS will continue to assess and improve the way the health and well-being needs of children in foster care are met. In acknowledgement of evolving needs and learning through the initial implementation period, SCDSS submits this revised HCIP. The plan includes the Department's goals, system components, activities underway, and to be undertaken, timeframes for implementation, deliverables, performance targets and process for quality monitoring and performance review.

Child Health Goals

The initial HCIP was anchored around four child health goals that remain paramount. These child focused goals, set out below, guide the way SCDSS and its partners will continue to collaborate, assess, plan, and monitor physical health, behavioral health and dental services to children in foster care.



Strategic Priorities

SCDSS and other key partners have identified the five strategic priorities in support of child health goals to advance the health and well-being needs of children and families in the state's foster care custody: (1) developing and enhancing structures for cross-sector collaboration; (2) defining and communicating roles and responsibilities for cross-sector coordination of care and accountability; (3) implementing shared mechanisms for assessing health and well-being needs; (4) increasing timely access to a quality and medically necessary service array; and (5) tracking progress through data and quality assurance. These strategic priorities will continue to lead to improved health outcomes for children in foster care, foster strong partnerships among stakeholders, and ultimately create the conditions of change that will result in a more effective system of care that addresses the unique needs of each child in a timely and efficient manner.



Developing and Enhancing Structures for Cross-Sector Collaboration

- Strategic Priority 1: Enhancing mechanisms for effective partnership and accountability between stakeholders.



Defining and Communicating Roles and Responsibilities for Cross-Sector Coordination of Care and Accountability

- Strategic Priority 2: Clearly outline roles and responsibilities for seamless care coordination.



Implementing Shared Mechanisms for Assessing Health and Well-Being Needs

- Strategic Priority 3: Implement shared processes for identifying and understanding underlying health and well-being needs.



Increasing Timely Access to a Quality and Medically Necessary Service Array

- Strategic Priority 4: Improve availability and timely access to quality healthcare, including behavioral healthcare.



Tracking Progress through Data and Quality Assurance

- Strategic Priority 5: Oversight and monitoring of progress toward goals through data tracking and quality assurance.

Strategic Priority 1: Developing and Enhancing Structures for Cross-Sector Collaboration



SCDSS recognizes that it is one part of a larger, shared, child and family serving system. To achieve the best outcomes for children in foster care, it must systemically engage in cross-sector partnerships, including direct service providers and those with lived experience.

Children in foster care face unique and significant health and behavioral health challenges, requiring a comprehensive and coordinated approach to healthcare. To meet these challenges so that children and families receive the services and support they need to thrive, strong structures for cross-sector and stakeholder collaboration and accountability are essential. Absent this coordinated approach and a shared focus, services become inaccessible to families and fragmentation between systems often results.

Outlined in the following section is a list of key stakeholders whose alignment and enhanced collaboration will support attaining the outcomes associated with this strategic priority.

Stakeholder Roles and Responsibilities

SCDSS

The mission of SCDSS is to serve South Carolina by promoting the safety, permanency, and well-being of children and vulnerable adults, helping individuals achieve stability and strengthening families. As the legal guardian for children and youth in foster care, SCDSS is responsible for meeting the health and well-being needs of children and youth in its custody.

SCDHHS

The State Medicaid Agency, the South Carolina Department of Health and Human Services (SCDHHS), operates, among other activities, the state's Medicaid program and is an essential partner with SCDSS in meeting the health care needs of children in foster care. SCDHHS manages Medicaid eligibility and enrollment; determines covered services; pays for covered services; holds the contract with the managed care organization (MCO) that serves these children; and provides fee-for-service payment for dental care to a small number of children in foster care with complex needs. SCDHHS is also responsible for federal Medicaid requirements, including implementation of the state Medicaid plan, Home and Community-Based (HCBS) waiver services, and ensuring that all children and youth enrolled in Medicaid receive all services to which they are entitled under the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

SCDHHS requires all managed care plans to operate a comprehensive Care Coordination and Case Management System. This requirement has traditionally covered three tiers of stratification (low, moderate, high risk), but in January of 2025, SCDHHS implemented a new tier of case management into the managed care contract. Managed care plans must now implement a care coordination and case management system that screens new members, stratifies all members into four tiers (low,

moderate, high risk, and Intensive Case Management (ICM), and ensures continuity of care across providers and transitions. Case management activities must include assessment, person-centered planning, referrals, coordination of services (including those outside the plan's benefit package), monitoring, and family involvement.

ICM is explicitly defined as the highest level of case management and is mandated for members with serious mental illness, frequent behavioral health hospitalizations or suicide attempts, foster care youth with multiple conditions, juvenile justice-involved youth, and other high-need populations designated by the Department. For these members, the managed care plan must complete assessments and develop a person-centered care plan within 30 days, conduct monthly telephonic check-ins, and perform in-person plan reviews every 90 days. ICM case managers must be specially trained, assigned at a maximum caseload of 1:60, and hold advanced degrees or documented behavioral health training.[iii]

SCDHHS is responsible for the oversight of case management programming across the managed care plans, and the inclusion of ICM ensures a distinct, enforceable obligation with clear eligibility criteria, staffing standards, timelines, and reporting requirements—elevating it from general case management into a formalized program for the state's most complex members. In South Carolina, SCDHHS and the MCO have been key partners in building out the availability of services and addressing any barriers that would result in delayed ability to access services. As such, their participation in ongoing system improvement efforts is critical to the effective implementation of core healthcare improvement strategies.

Managed Care Organization (MCO)

South Carolina serves children and youth in foster care through Medicaid Managed Care (MMC). This is consistent with national trends. As of 2021, 42 states and the District of Columbia used some form of MMC to provide health care services to children in foster care. In many states, involvement in foster care triggers enrollment in a specific MCO. As of the writing of this Plan, nearly all children in SCDSS custody are enrolled in a single Medicaid managed care plan. [iv]

Through participation with one MCO, children in foster care have a coordinated healthcare delivery model that streamlines access to physical, behavioral, and dental health services to improve their overall well-being and health outcomes.

In South Carolina, SCDHHS and the MCO have been key partners in building out the availability of services and addressing any barriers that would result in delayed ability to access services. As such,

[iii] These are contracted responsibilities in general. Requirements for children in foster care in SCDSS custody are different as addressed in this plan (see Appendix E).

[iv] A small percentage of children in foster care are not covered by the MCO. Children who are undocumented are ineligible for Medicaid and receive identical physical, mental and dental benefits paid by 100% state dollars until age 18. A small number of children are enrolled in SCDHHS fee-for-service waivers. Children with complex medical or behavioral health needs may also receive services outside of the MCO network.

their participation in on-going system improvement efforts is critical to the effective implementation of core healthcare improvement strategies. As noted throughout this plan, South Carolina's MCO for children in foster care, and its network of providers is responsible and accountable for many of the efforts to ensure that children's health and behavioral health needs are identified and met.

South Carolina Department of Behavioral Health and Developmental Disabilities (SCDBHDD)

SCDBHDD's Office of Mental Health (OMH) is South Carolina's primary public mental health authority, offering outpatient care through 17 Community Mental Health Centers (CMHCs) and operating over 60 clinics, with at least one clinical location in every county. These CMHCs provide an array of outpatient mental health services, including psychiatric services and medication management, delivered by staff trained in trauma-informed care and various other clinical modalities (e.g. Alternatives for Families- Cognitive Behavioral Therapy, Infant and Early Childhood Mental Health Consultation, Multidimensional Family Therapy, Motivational Interviewing, Parent-Child Interaction Therapy, Child-Parent Psychotherapy, etc.). To maintain effective communication, OMH submits a monthly report to SCDSS, detailing the full spectrum of services available through the CMHCs. This reporting process allows SCDSS staff to stay abreast of the coverage and availability of services across specific geographic catchment areas. While the current monthly report is aggregate and designed for several state agencies, it does provide operational information on each of the centers, such as number of FTEs, turnover, patients served, new cases, readmissions, staff cancellations, no show rates, availability of primary care, and extended hours. SCDSS also receives updates on the crisis stabilization units and school mental health information on the education level of staff and the availability of bilingual staff is provided for each center. Types of therapy available by center is part of the report. There is also information on programs such as mobile crisis and suicide prevention. Currently, the report does not enable DSS to assess the provision of OMH services to individual children in its custody. The available information is used by Office of Child Health & Well-Being (OCHWB) staff to locate evidenced-based services by geography. For example, if during a staffing it is determined that a child needs a particular therapy, this information helps staff to locate where that specific service is provided and may be available. To the extent possible, OCHWB staff want to use either community or school-based services available through OMH before referring a child to a private provider.

SCDSS recently sent a request to OMH for more detailed information on services provided to foster care children by mental health center by type of service. While the resulting report provided aggregate data only, it was information specific to children in foster care. The report provided aggregate volume counts by mental health center for crisis calls. There was information by center on total foster care children for information and administrative calls. In addition, information was provided on the receipt of services and total foster care children by type of school-based mental health services. SCDSS also knows the number of emergent versus urgent needs recorded at intake. Finally, OMH provided a chart showing the evidence-based practices for children available at each center. SCDSS recognizes that while the aggregate report is useful, it is opening discussions with OMH in early 2026 to explore the provision of this information at the child level.

To support clinical evaluation of behavioral health needs, the State's CMHCs and clinics are equipped to conduct initial diagnostic assessments either in person or through telehealth. The timeline to be seen by OMH varies based on urgency: emergent needs are to be addressed within 3 hours, urgent needs within 48 hours, and routine appointments within 7 days. For emergent cases, services can also be initiated through mobile crisis.

Additionally, OMH offers aftercare for children and youth in SCDSS foster care within 5 days of discharge from acute crisis stabilization or a Psychiatric Residential Treatment Facility, along with follow-up care from qualified psychiatric practitioners within 30 days – either in the clinic or via telehealth.

As of November 20, 2025, OMH Community Mental Health Clinics have served approximately 654 youth in foster care providing over 3,963 distinct services across their centers year to date for State Fiscal Year 2025-2026. Of those served, approximately 40 patients were identified as having an emergent need at intake and 110 having an urgent need. In addition, 269 youth were provided 1,296 distinct services through School Mental Health. Approximately 46 youth in foster care received telepsychiatry and 27 received crisis response services during the same review period.

As the OMH does not maintain waitlists, when timely services are unavailable, SCDSS routinely refers to community-based partners to support access to care, with many of these providers enrolled in SC Medicaid.

South Carolina Provider Partners

Private provider partners and community-based organizations play an essential role in supporting children in foster care by offering a wide range of therapeutic and medically necessary services. These partnerships include but are not limited to pediatric services providers, rehabilitative behavioral health service providers, federally qualified health centers, licensed independent practitioners, and other Licensed Practitioners of the Healing Arts (LPHAs). Their expertise and dedication are vital in addressing the diverse needs of children in foster care and are a crucial part of the care equation. Over the last seven years, these providers have partnered with SCDSS to pilot new and innovative interventions to support placement stability, increase timely well-child and dental visits, and address complex behavioral health needs.

Two providers have partnered together to coordinate transitional services to promote continuity of care and support reunification and step-down from residential to family-like settings. Another provider invested in Trust-Based Relational Intervention (TBRI) and trained their workforce on trauma-informed practices to effectively engage with youth during when they experience dysregulation. Other providers have invested in the development of non-traditional therapeutic intervention such as music therapy, equine therapy, experiential therapy, etc.

Enhanced Governance Structure and Strategic Collaboration for Child Health and Well-Being

To enhance communication and accountability among partners, a tiered governance structure led

by SCDSS in collaboration with SCDHHS has been used to keep the lines of communication open, resolve issues that arise, and establish accountability mechanisms for SCDSS internal, cross-agency, and external partners. With an emphasis on increased collaboration and reduction in service fragmentation and siloing, these structures will be further developed so that all key agency partners and stakeholders meet regularly to implement and track HCIP strategies.

Internal Implementation and Oversight

SCDSS will convene an internal oversight team to monitor all HCIP activities and support timely completion. This team will be comprised of the Deputy State Director for Child Welfare, the Michelle H. Internal Monitor, the OCHWB Director, Chief Financial Officer, Director of Accountability Data and Research, Senior Director of Child Welfare Services, Director of County Operations, and other key staff as needed for implementation.

Strategic Alignment: Foster Care Oversight Committee

The Foster Care Oversight Committee (FCOC), formerly known as the Foster Care Health Advisory Committee (FCHAC), has been charged with supporting implementation and monitoring fidelity to the HCIP. The committee is responsible for addressing service accessibility, the timeliness of care provided, and the quality of care for all children in foster care. Additionally, the committee offers consultation on resolving systemic issues, including access to care, trauma-informed care, medical assessments, data sharing, and supporting SCDSS healthcare improvement efforts.

Led by SCDSS and SCDHHS, the FCOC is comprised of representatives from various sectors, including SCDBHDD, the MCO serving foster children, and a diverse array of professionals from the medical and behavioral healthcare field from across the state. These representatives include nurses, pediatricians, Child Advocacy Center professionals, private community-based providers, Licensed Practitioners of the Healing Arts, Q-TIP providers, and Federally Qualified Health Center representatives. The FCOC will be convened monthly.

Additionally, in a continued effort to elevate the voices of youth and families and to foster a more comprehensive approach to healthcare improvement, SCDSS is actively recruiting appropriate lived expert(s) to serve on this committee. By integrating these perspectives, the FCOC can enhance the quality and relevance of the medical and mental health services provided, with the ultimate goal of supporting better outcomes for those served.

Lastly, this team will be charged with supporting implementation of the approved healthcare plan and will make recommendations for operationalizing objectives and tactical priorities. Recommendations will focus on achieving the desired healthcare outcomes for children and youth in foster care. SCDSS will review with the FCOC on a quarterly basis progress, challenges, outcomes, and target measures for the HCIP. As appropriate, SCDSS will leverage actionable recommendations from the FCOC to implement new process improvement strategies. The OCHWB Director will submit recommendations from the FCOC to the Child Welfare Leadership team for review and

consideration. The FCOC will be notified in writing of the decisions made by the Child Welfare Leadership Team and actions to be taken[v].

Internal Alignment: Child Health and Well-Being

Internal to SCDSS, the Office of Child Health and Well-Being (OCHWB) is responsible for managing daily operations and overseeing system-wide health-related planning and practice. This streamlined approach fosters coordination among various units within SCDSS so that child health initiatives are integrated into planning and practice, monitored for effectiveness, and adjusted as needed for continuous quality improvement. OCHWB leadership will also track and discuss on-going systemic barriers identified and elevate to the FCOC for feedback and recommendation.

Tactical Alignment: Cross-Sector Engagement Strategies

Important components of SCDSS' collaboration with relevant stakeholders to achieve healthcare outcomes are cross-sector staffings, rounds, CFTMs, and regional huddles, which are often comprised of members from SCDSS, SCDHHS, the Managed Care Organization (MCO), and other key partners. These collaborative efforts vary in their purpose, but all focus on addressing gaps in healthcare services and coordinating resources for individual children in foster care. By reviewing individual cases, these groups work collectively to identify and overcome challenges, thereby enhancing the overall care experience for these vulnerable populations and aligning case/care planning.

By fostering collaboration through structured, cross-sector meetings, SCDSS aims to strengthen frontline practice by enabling staff to build meaningful interagency relationships, enhance the depth and quality of case conceptualization and planning, and expand their awareness of available resources for children and families. This intentional engagement not only clarifies roles and responsibilities across systems but also minimizes duplication of efforts—resulting in more integrated, coordinated, and efficient service delivery. Ultimately, this approach translates into improved outcomes for children through more informed decision-making, timely access to supports, and a unified response across service providers.

The table below outlines several key staffings:

Type	Purpose	Participants	Frequency	Process
Interagency Staffings (IAS)	Convened with partner state agencies and CPA/GH providers as applicable to coordinate services for children and youth with complex needs who require higher levels of intervention, collaborative decision-making, and shared	SCDSS OCHWB staff, SCDSS Case Manager, SCDSS Team Leader, MCO, other state agencies (as applicable), CPA/GH providers, IAS coordinator	2x Monthly & PRN	If a case manager gains knowledge of an unmet medical, dental or behavioral health need through a CFTM, a placement provider or during routine case practice, the case manager can request an IAS by emailing IAS

[v] See Appendix D. FCOC Charter for additional details

	investment across systems. These staffings typically involve detailed discussions focused on clinical needs, service gaps, and individualized supports. IAS may be initiated to facilitate interdisciplinary complex case consultation, align care coordination and clinical strategies across agencies, and identify fiscal solutions to secure services beyond the existing shared service array. The goal is to provide each child or youth responsive, comprehensive care tailored to their unique circumstances.			referrals@dss.sc.gov which is monitored by the SCDSS IAS coordinator. Other agencies may may schedule an IAS and reach out to the IAS coordinator at IASreferrals@dss.sc.gov An IAS will be held within two weeks of the request or sooner depending on the acuity of need. A summary of the IAS will be shared with all attendees and uploaded into CAPSS (which will show in the modified CAIP)
Child and Family Team Meetings (CFTMs)	Convened at critical junctures in the life of a case, as well as on an as-needed basis, to help the family, the department and caregivers work together to achieve permanency for children as soon as possible	SCDSS Case Manager, CFTM Facilitator (varies), MCO Care Coordinator, GAL, RCS/Nurses (as appropriate), children (as developmentally appropriate), foster parents, relatives, family, and other supports as identified by the family, placement, CPA/GH providers and services providers (as applicable)	Varied based on policy, need, and placement type.	CFTM timelines, facilitation, and documentation is outlined in SCDSS CWS policy 1642 and work-aid 16.5.
Rounds	A brief, structured teaming opportunity convened with the Managed Care Organization (MCO) to collaboratively address barriers impacting the well-being and stability of children and youth in care. These sessions focus on individual cases involving placement disruptions, intensive case management	MCO Care Coordinator, MCO Medical and Behavioral Health Directors, Regional Well- Being Managers, SCDSS Case Managers/Team Leaders, private providers (if applicable)	Weekly	Cases for rounds are identified through case consultation between case management and OCHWB based on identified need where OCHWB believes the MCO can facilitate meeting that need. A referral to rounds can also come from the MCO if a need is identified during their

	needs, and clinical concerns such as polypharmacy or antipsychotic medication use. Through multidisciplinary discussion, the team identifies actionable next steps, coordinates support and promotes alignment across systems to better meet the needs of children and youth with high acuity and specialized care requirements.			care coordination process. Case managers and CPA/GH providers may also request rounds if needs are identified through routine case practice. Requests for inclusion in rounds are made to the Medicaid/MCO Relationship Coordinator. Cases will be included in rounds within 7-calendar days. The Medicaid/MCO Relationship Coordinator takes notes and sends notes with action steps to relevant parties. During subsequent rounds, the case is re-reviewed for progress and completion of action steps. If a need is unable to be met through this process, a referral for an IAS will be made.
Medically Complex Children's Waiver (MCCW) Rounds	Convened to review children and youth covered by the MCCW, and to identify needs or barriers associated with their medical care	SCDSS MCCW Liaison, SCDHHS Special Populations Manager, SCDSS Nursing Staff, SCDSS Case Managers/Team Leaders, CPA/GH providers (if applicable)	Monthly	Requests are emailed to the SCDSS nursing team. Requests can be made by either internal DSS staff or the FFS Medically Complex Care Coordination team (sun solutions)

Note: 1 DSS OCHWB staff will take lead in DSS healthcare related meetings unless convened by another agency or office within DSS

If a case manager gains knowledge of an unmet medical, dental or behavioral health need through a CFTM or during routine case practice, the case manager can request an IAS by emailing IAS referrals@dss.sc.gov which is monitored by the SCDSS IAS coordinator. SCDSS is responsible for facilitating such meetings, with Nursing staff providing support for medical / dental needs, and a Wellbeing Manager or designee assisting with behavioral health needs. Outside agencies can also

request an IAS through the same email. Form 1493 is completed and sent to the IAS Coordinator. When a service is identified as necessary, and it is either not covered under the current state plan array or exceeds established service limits, a designee from the SCDSS OCHWB team will contact the MCO or SCDHHS medical director or their designee (if in FFS) to initiate an EPSDT coverage review.

The table below outlines SCDSS' HCIP commitments for this strategic priority area.

Strategic Priority 1. Action Steps		
Commitment	Responsible Parties	Timeline
Convene the FCOC for implementation and monitoring	SCDSS (lead) SCDHHS SCDBHDD, MCO, additional community stakeholders	Within 30 days of the approval of the HCIP and every 30-days thereafter
Submit to the FCOC on a quarterly basis a report containing progress on HCIP activities and FSA health care outcomes	SCDSS	Within 6 months of the approval of the HCIP and every 3 months thereafter
Implement revised reporting process from SCBHDD's OMH to capture mental health service provision to FC children	SCDSS, SCDBHDD	Quarter 1 2026 and monthly thereafter
Implement a quantitative review process to evaluate health outcomes by placement provider, age groups, or other key fields and to pinpoint areas for continuous quality improvement efforts	SCDSS, Provider Partners	Quarter 2 2026 and quarterly thereafter



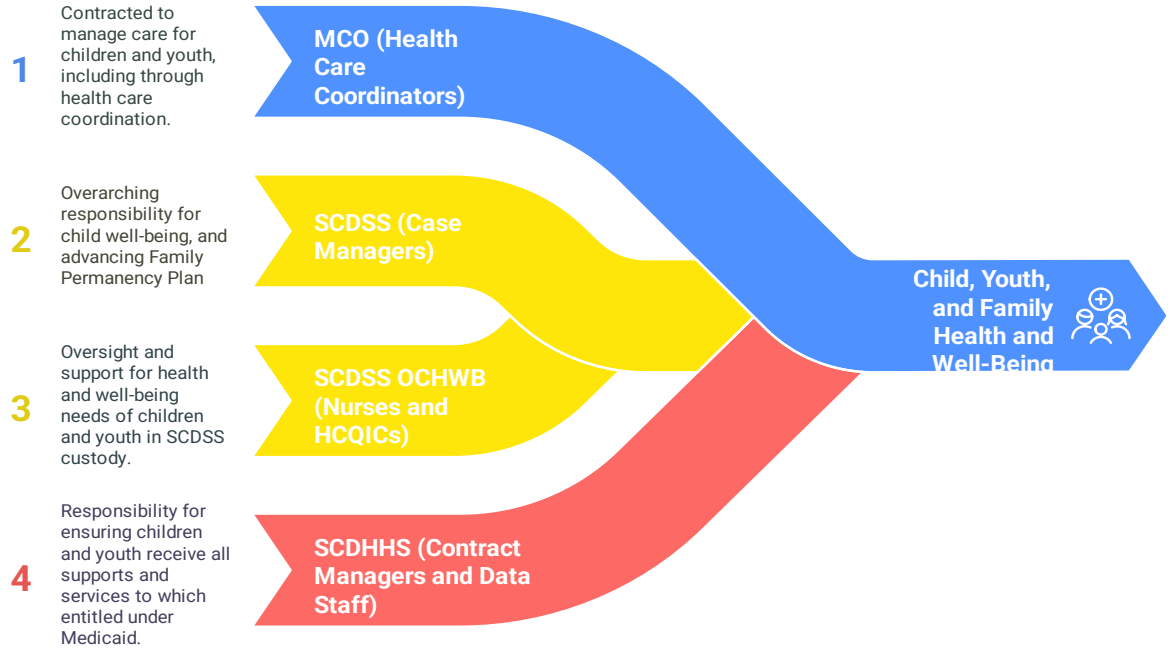
Strategic Priority 2: Defining and Communicating Roles and Responsibilities for Coordination of Care

The Health Care Addendum, approved by the Co-Monitors in February 2019, envisioned an integrated model of care coordination in which SCDSS and SCDHHS would assume distinct yet complementary roles in supporting the health and well-being of children and youth. Initial implementation efforts led to the development of new processes aimed at strengthening healthcare oversight, including the introduction of clinical rounds, staffings, and overall improvements in case collaboration.

While these efforts established a stronger infrastructure, their impact was more limited than originally anticipated, as significant gaps in case-level coordination and role clarity persisted.

In July 2024, SCDHHS incorporated a new Medicaid Managed Care Coordination service into its managed care contracts. This service builds upon prior healthcare improvement efforts and has the potential to support more integrated care. However, its implementation has also introduced additional complexity, leading to some duplication of efforts and overlapping communication resulting in role confusion amongst foster parents, healthcare providers, and private provider partners where children are placed. One of the goals of this plan is to resolve these issues by having clarity on roles and responsibilities, communication channels and accountability.

Integrated Supports to Meet the Health and Well-Being Needs of Children, Youth, and Families



Recognizing the inherent complexities of cross-sector care coordination, the continued strategic alignment between SCDSS and SCDHHS remains essential. By reinforcing role clarity and establishing well-defined, collaborative processes, the system is positioned to evolve toward a more cohesive model of care. These improvements will help reduce fragmentation, enhance continuity, and ultimately lead to better health outcomes for children and youth in foster care and their families.

If a child is denied a service by the MCO, SCDSS OCHWB staff will assist the case manager and caregiver in filing an appeal through the MCO appeals process. An appeal can be filed with the MCO when an authorized representative (e.g. SCDSS) requests the MCO to review an adverse benefit determination (i.e. denial or limited authorization of requested service, reduction in previously

authorized service, denial, etc.). If the appeal decision is upheld by the MCO, SCDSS may request a Fair Hearing through SCDHHS.

Office of Child Health and Well-Being

As part of its initial development work towards the reform of its child welfare system, SCDSS created the Office of Child Health and Well-Being (OCHWB). The office was designed to have a strategic focus on the health and well-being needs of children in foster care, providing expertise, tracking, and coordination with key partners at all levels.

The primary role of the OCHWB is to help frontline staff meet the medical, behavioral health, dental and educational needs of children served by SCDSS through education, training, and oversight at the state and regional levels. This involves assisting staff, families, children, youth and foster parents with understanding, executing recommendations, and/or taking the necessary steps to promote appropriate and timely interventions to meet health and well-being needs. The OCHWB, led by the OCHWB Director, includes a Consulting Child Psychiatrist, one full-time Lead Clinical Specialist, one full-time Lead Nurse Manager, one full-time Education Specialist/Non-Citizen Advocate, one full-time SCDHHS/MCO Relations Coordinator and one full-time Contract Administrator. These roles serve as the OCHWB leadership team and represent four distinct programs within the office.

The OCHWB Director oversees the OCHWB leadership team and is responsible for monitoring healthcare outcomes, daily operations of the team, and monitoring the efficacy of healthcare related efforts. This role is also responsible for developing continuous quality improvement processes and identifying and employing strategies to address any technical or adaptive challenges and barriers related to child-health and well-being.

The Medicaid/MCO Relationship Manager oversees a team comprised of a Statewide Foster Care Health Liaison, a Medicaid/MCO Relationship Coordinator, Difficulty of Care Board Rate (DCBR) Coordinator, and BabyNet Coordinator. This team is responsible for coordinating with SCDHHS and the MCO Care Management Unit so that every child is linked to care coordination and the health, behavioral health and dental services they need.

The Lead Nurse Manager supervises a team of registered nurses (currently nine), assigned to specific counties. OCHWB nurses serve several key functions, including reviewing medical, dental, and specialty dental after visit summaries to flag any follow up identified by the provider, and creating action steps for case manager completion and a due date in the Child and Adult Protective Services System (CAPSS).

The Lead Clinical Specialist oversees regional well-being teams across the Pee Dee, Lowcountry, Midlands, and Upstate regions, with staffing levels tailored to each area's needs. These teams are comprised of four (4) Therapeutic Services Coordinators (TSC), six (6) Healthcare Quality Improvement Coordinators (HQIC), four (4) Healthcare Data Coordinators (HDC), and ten (10) Regional Clinical Specialists (RCS). Each member of these teams works in tandem to support the field in addressing clinical needs via consultations, medication monitoring, training, and supporting referrals for medical

and dental appointments. When youth score a "2" or higher on the CANS, the RCS are responsible for obtaining Diagnostic Assessment (DA) summaries and uploading to CAPSS. The Lead Clinical Specialist also supervises the Interagency Staffing (IAS) Coordinator, who is responsible for managing and coordinating IAS processes for complex, multi-agency, or high-needs clients. This includes facilitating meetings, organizing staffing efforts, and ensuring that youth receive agreed-upon services through consistent follow-up. Additionally, the IAS Coordinator serves as the liaison to the Office of Intellectual and Developmental Disabilities, supporting youth transitioning out of care. The role requires a degree in human services and a specified number of years of experience in social work and child welfare.

The Statewide Education Specialist and Non-Citizen Advocate oversees four regional Education Specialists & Advocates who serve as liaisons between SCDSS and SC Department of Education. These roles serve as resources to assist in supporting educational and immigration related needs. Examples of this work include assisting in obtaining immigration status for non-citizen youth in foster care and working with the South Carolina Department of Education so that the educational rights of children in foster care are upheld.

Additionally, the OCHWB Lead Nurse Manager and team of nine (9) nurses mentioned above work alongside OCHWB Regional Clinical Specialists to meet the health needs of non-citizen children. The nursing team provides intensive case management and follow-up for the direct healthcare, dental, and mental health needs of this population.

As part of SCDSS' commitment to best practices related to optimal health outcomes for children and families involved with SCDSS, the OCHWB undergoes reassessment of organizational infrastructure periodically so that appropriate resources are allocated to adequately support the needs of children and families.

Organizational Review and Strategic Recommendations for OCHWB

In Fall 2025, the Deputy State Director of Child Welfare Services, in collaboration with the Annie E. Casey Foundation, conducted a comprehensive review of the Office of Child Health and Well-Being (OCHWB) organizational structure. This review focused on clarifying roles and functions within the OCHWB and identified several opportunities to enhance efficiency, reduce duplication of efforts between OCHWB and Managed Care Organization (MCO) care coordination, and optimize support for the healthcare needs of children in foster care.

Key findings from the OCHWB Focus Group emphasized the need for clearer role definitions and stronger interagency collaboration. A major concern was the overlapping responsibilities between OCHWB and the MCO, particularly in areas such as well-child visit management, provider oversight, and Medicaid eligibility. These overlaps, driven by unclear boundaries, have contributed to fragmented service delivery.

Additional systemic challenges include:

- Inconsistent communication between Child Welfare Services (CWS), county offices, and

healthcare partners.

- Delays in medical authorizations and therapeutic placements, often made out of urgency rather than clinical appropriateness.
- Limited understanding among case managers regarding clinical consults and healthcare staffings.
- Insufficient engagement with foster parents and providers to fully assess children's needs.
- Inconsistent adherence to existing healthcare coordination policies.

Strategic Recommendations

To address these challenges, the focus group proposed several strategic actions:

1. **Define a Clear Framework for Aligned Coordination:** Establish distinct responsibilities to reduce overlap and improve accountability.
2. **Increase Consistent Participation in Healthcare Staffings:** OCHWB, MCO, and Operations must regularly engage in healthcare-related meetings to enhance coordination.
3. **Strengthen Communication and Information Sharing:** Implement structured communication protocols across agencies and prioritize transparency.
4. **Enhance Training for Operations Staff:** Build awareness of OCHWB resources and processes to improve collaboration.
5. **Reinforce Accountability Mechanisms:** Monitor follow-through on clinical recommendations and consistent policy compliance.

Implementation Steps

To support these recommendations, the Deputy State Director of Child Welfare Services will work closely with OCHWB to redefine the roles and responsibilities of HQICs. This includes initiating the collection of Behavioral Health summaries—such as diagnostic assessments and progress reports—and implementing a new process for nurses to share health-related after-visit summaries. For children with a therapeutic level of care the placement team sends the universal application (UA) to the Therapeutic Services Coordinator in OCHWB to review the UA for accuracy.

Additionally, the SCDSS Nursing Team will begin prioritizing information sharing with the State MCO to support the development of patient-centered care plans for children and youth in foster care. This exchange will include all after-visit summaries received by the Nursing Team or Health Care Data Coordinators, as well as any relevant medical records collected or reviewed. This proactive process of sharing after visit summaries increases efficiency by reducing multiple attempts of the MCO Care Coordinator in obtaining the after-visit summary as providers often will not share that information without express permission from SCDSS or caregiver. Upon modification of the Child and Adolescent Information Portal (CAIP), SCDSS will implement an alert process for all parties (i.e. DSS case manager, MCO Care Coordinator, provider, and other CAIP users) so that any time health related information is updated/uploaded in CAPSS or the CAIP an alert notification is generated.

MCO Medicaid Managed Care Coordination

As previously mentioned, demonstrating its commitment to improving health outcomes for Medicaid beneficiaries in South Carolina, in 2024 SCDHHS incorporated a MCO Health Care Case Management program into its managed care contracts. The MCO has primary responsibility for health care coordination and case management for all children and youth in foster care, regardless of acuity level, and making available a network of qualified providers to meet identified needs. The intensity of intervention and support provided by the MCO's care management team is based on initial and ongoing assessments of needs for the child or youth in foster care. SCDHHS' MCO Health Care Case Management program is a pathway to support that embodies principles of the SCDSS Guiding Principles and Standards (GPS) Practice Model, placing the voices of children, youth, and families at the center of their service planning.

Upon assignment to a Managed Care Organization, the MCO Care Coordinator assumes responsibility for meeting 100% of the healthcare needs for the foster children to which they are assigned. The standards outlined in the SCDHHS Medicaid Managed Care Contract are applicable to all children in Medicaid and subject to change over time or through refinements of current processes. Updates to the these standards can be found on the SCDHHS website where an MCO contract template is posted: MCO Reference Materials | SCDHHS. [vi]

SCDHHS engages in routine contract monitoring of its contracts. If the MCO does not fulfill its contractually obligated responsibilities, SCDHHS is able to take appropriate corrective measures to bring the MCO into contract compliance.

Tiered Health Care Coordination and Case Management: Defining Supports at Each Assessed Level of Risk

As part of the Care Coordination and Case Management System, the MCO shall be responsible for the management, coordination, and Continuity of Care for all its members, including children and youth in foster care, and shall develop and maintain policies and procedures to address this responsibility. For children and youth in foster care, the MCO must complete an initial screen of each enrollee's needs within thirty (30) days of the effective date of enrollment. The MCO will utilize appropriate assessment tools and Health Care Professionals in assessing a child's physical and behavioral health care needs. This care coordination and case management is a continuous process which occurs throughout the life of a case and for the duration of a child's coverage by the MCO.

ICM is explicitly defined as the highest level of case management and is mandated for members with serious mental illness, frequent behavioral health hospitalizations or suicide attempts, foster care

[vi] If, as a result of the six-month review process of the contract between DHHS and the MCO, DHHS contemplates the discontinuation of activities and/or services that are integral to meeting the Michelle H. commitments, DSS will provide advance notice to the Co-Monitor and should those activities and/or services be discontinued, DSS will assume responsibility for their provision to Class Members.

youth with multiple conditions, juvenile justice-involved youth, and other high-need populations designated by the Department. For these members, the plan must complete assessments and develop a person-centered care plan within 30 days, conduct monthly telephonic check-ins, and perform in-person plan reviews every 90 days. ICM case managers must be specially trained, assigned at a maximum caseload of 1:60, and hold advanced degrees or documented behavioral health training.

SCDHHS is responsible for the oversight of case management programming across the managed care plans, and the inclusion of ICM ensures a distinct, enforceable obligation with clear eligibility criteria, staffing standards, timelines, and reporting requirements—elevating it from general case management into a formalized program for the state's most complex members. In South Carolina, SCDHHS and the MCO have been key partners in building out the availability of services and addressing any barriers that would result in delayed ability to access services. As such, their participation in ongoing system improvement efforts is critical to the effective implementation of core healthcare improvement strategies.

The role of the MCO case manager is to help identify health and well-being needs, provide relevant information to caregivers, and connect children and youth with appropriate, quality services and supports to meet these needs. Accomplishing this goal requires a different level of support, depending upon the acuity level of a child or youth. This includes assurance of timely access to, and provision, coordination and monitoring of the identified services associated with physical health, behavioral health, special needs, and social support services, as well as assistance to help the child or youth maintain or improve their health status—including coordinating access to services not covered by the plan.

The MCO level of risk is based on client and caregiver interviews that help the MCO case manager determine the risk stratification category. Because children and youth in foster care are considered a priority population and require a higher level of care and coordination, other than the intensive members who qualify for the intensive program based on the contract specifications, all other children in foster care currently receive a high-risk level of intervention. This allows every child in foster care, regardless of stratification, to receive the necessary care coordination and services provided by the MCO's telephonic case managers.

Children and youth in foster care are moved to Moderate or Low-Risk Care Coordination when goals are met, appointments are up to date, medications are being filled in a timely manner, education has been completed, and they are stable in the current foster home. Currently, this information is gathered from DSS case managers, OCHWB staff, foster parents, and provider partners to assess whether children are ready to transition to a lower level of care coordination. SCDSS plans to streamline this information gathering and sharing process through a modification of its Child and Adolescent Information Portal (CAIP). Based on current functioning and a child's needs, they can be referred again to Intensive Case Management (ICM) or high level of intervention at any time. If a child or youth is identified as needing to be referred back to ICM, the case manager will request an IAS using the process described on p. 10.

Fostering Alignment and Role Clarity

To strengthen alignment and clarify roles between SCDSS Case Managers, MCO Care Coordinators, private providers, and caregivers (to include kinship caregivers), SCDSS has revised its Care Coordination model, with detailed roles and responsibilities outlined in Appendix E of this plan. For children enrolled in an MCO, the MCO Care Coordinator is responsible for meeting 100% of the child's healthcare needs. This means that the MCO Care Coordinator will be responsible for scheduling, following up, and coordinating appointment schedules with the caregiver. For children not enrolled in an MCO, SCDSS retains full responsibility for addressing all healthcare needs. Regardless of MCO enrollment, SCDSS remains fully responsible for 100% of the placement-related and non-medical well-being needs of children in foster care, including areas such as education and social development. While MCO Care Coordinators are accountable for healthcare coordination for their assigned children, SCDSS Case Managers will continue to support this work through routine case practice, such as checking in on how appointments went and reminding caregivers of upcoming visits. If a healthcare need is identified during the course of regular case management, the Case Manager will notify the MCO Care Coordinator and work collaboratively to address the need in a timely and coordinated manner. SCDSS Nurses and Healthcare Data Coordinators will be responsible for obtaining copies of after-visit summaries and sharing them with the MCO Care Coordinator (outlined further on p.20). OCHWB staff will continue to provide notification to the case manager of any follow-up items identified on the after-visit summary.

Upon approval of the HCIP, SCDSS will work to co-create one-pagers and other supportive resources to enhance role clarification. These resources will be created by designated SCDSS and SCDHHS/ MCO personnel and tested with frontline staff to make sure they're helpful and easy to use. Once finalized, these materials will be distributed to provider partners, shared internally, and included in Child and Family Team meetings with the goal of creating clarity to support on-going practice. SCDSS plans to have materials created by February 2026. Following the development of materials SCDSS will disseminate this information via regional country meetings for case managers to begin priming them for subsequent training, revise and scale care coordination training foster parent & providers that was implemented in Richland County. The communications and initial training process will be completed by March 2026.

SCDSS will also leverage its internal training and CQI infrastructure to provide opportunities for SCDHSS or the MCO Care Coordination team to train SCDSS case managers on the use and scope of care coordination and case management. These efforts will be undertaken during Winter 2025 and conclude in the Spring of 2026. Conversely, the MCO will also distribute guidance to their MCO Care Coordinators when they need to contact SCDSS to provide updates on emergent situations that require rapid response from SCDSS. During the case planning process, both agencies will work alongside the child and family team to develop family-centered and aligned plans for care coordination and service provision.

SCDSS and the MCO have also developed and implemented a process to escalate instances where the MCO Care Coordinator is unable to contact the child and caregiver so that SCDSS can facilitate and broker the relationship between the MCO Care Coordinator and caregiver. This process serves to

enhance communication amongst relevant parties to support the healthcare needs of children and youth. A clear process map will be developed and shared with partners as implementation proceeds.

Further, SCDSS will work with SCDHHS to develop a process that ensures timely and on-going updates on staffing changes, assignment or reassignment of MCO Care Coordinators s or SCDSS case managers. Having a well-defined process to identify changes in staffing will support continuity of care. SCDSS will work with the MCO to receive periodic updates on their MCO Care Coordinator staffing plan. If any changes to personnel occur, SCDSS OCHWB team will notify impacted frontline staff within SCDSS and provider agencies of updated care coordination contacts. SCDSS currently receives monthly reports outlining MCO Care Coordinators and the children to which they are assigned. This delay in communication has the potential to delay critical information sharing and coordination amongst relevant stakeholders. To address this need in the near term, SCDSS will work with the MCO to develop a new interim solution to send care coordination assignments on a weekly basis for all new children enrolled in the MCO to the OCHWB DHHS/MCO Relationship Manager who will provide notification to the field. A long-term solution is addressed in the section titled Strategic Priority 4 which would streamline the notification process of staffing changes by enabling an integrated process for staffing updates.

SCDSS has designated a staff person from OCHWB to support all case manager inquiries related to care coordination/case management on an as needed basis. This process includes reviewing NaviNet as a first line response to initial inquiry. If additional information is needed, the SCDSS OCHWB staff will contact the SCDHHS Special Populations Manager to address any outstanding questions or issues that were unable to be resolved through collaboration with the MCO Care Coordinator and their chain of supervision (as appropriate). SCDSS will also work with the MCO during its standing monthly meetings to address any barriers or challenges related to care coordination or alignment of practices. SCDSS will include this process in training curriculum around the utility and function of MCO Care Coordinators vs that of a DSS case manager.

Additionally, to provide more immediate responses to needs, SCDSS has worked with SCDHHS to identify a streamlined protocol for expedited review of coverage under the EPSDT benefit. When a service is identified as medically necessary, and it is either not covered under the current state plan array or exceeds established service limits, a designee from the SCDSS OCHWB team will contact the MCO or if in fee for service (FFS) the SCDHHS medical director or their designee, to initiate an EPSDT coverage review. SCDSS will share relevant information detailing the need and requested justification for the need. The MCO or the SCDHHS medical director or their designee will evaluate the request based on medical necessity within seven calendar days of the request. Following this review, SCDHHS will inform the OCHWB of their coverage determination. If approved, SCDSS will work with the MCO Care Coordinator to acquire the services. If denied, OCHWB staff will work with the MCO Care Coordinator to explore alternative options and resources that may serve as a viable alternative to service provision. 1905(a) services deemed medically necessary in accordance with the EPSDT medical necessity definition. EPSDT determinations will be processed in accordance with federal regulations. If a

determination is denied, SCDSS will be responsible for covering services. This process will prioritize the child's health and well-being while addressing any service gaps effectively.

Strategic Priority 2: Action Steps		
Commitment	Responsible Parties	Timeline
Implement Interim MCO Care Coordinator reporting process (weekly)	SCDSS and SCDHHS/MCO	December 2025
Develop informational materials and training on MCO Care Coordinator process for internal and external stakeholders	SCDSS	February 2026
Train SCDSS Case Managers and Team Leaders on the MCO care coordination process and responsibilities	SCDSS	March 2026
Train providers on MCO care coordination process and DSS/MCO care coordination roles and responsibilities	SCDSS and SCDHHS/MCO	March 2026

Strategic Priority 3: Developing and Implementing Shared Mechanisms for Identification of Health and Well-Being Needs



SCDSS recognizes that every child is unique, with individual health and well-being needs that require a comprehensive understanding. Adopting a multidimensional approach is critical for effectively addressing the complex challenges faced by children and youth, particularly those in foster care. A multidimensional approach necessitates systemic alignment and coordinated cross-functional planning among the various helping professionals serving these children.

In this context, DSS case managers, MCO Care Coordinators, and private providers play a role in creating a holistic support network. To mitigate any potential fragmentation in the service planning process, it is essential to establish a clear alignment and shared understanding of each child's needs. To do so, by March 2026, SCDSS and SCDHHS will undertake a systematic appraisal of their respective assessment processes and co-developing collaborative protocols to facilitate shared understanding of child specific needs and inform the modification of SCDSS CAIP portal.

DSS Assessment Process

Assessing the needs of children and families is an ongoing, family-centered practice that spans the life of the case, bringing together multiple perspectives. The assessment process employs both formal and informal strategies for identifying needs through active engagement with the child, family, and other relevant stakeholders. A collaborative approach is taken with the child and family team, with Child and Family Team Meetings serving as crucial juncture points for alignment and intentional coordination.

In this context, child welfare case managers and team leaders utilize evidence-based tools such as the Family Advocacy and Support Tool (FAST) and Child and Adolescent Needs and Strengths (CANS) assessment. These tools play a key role in informing an understanding of the strengths and needs of the child and family. However, while they are essential to gauging the health and well-being of children in foster care, they provide only part of a fuller picture. Additional assessments and perspectives are needed to provide a more holistic and comprehensive understanding.

The child welfare case manager utilizes the information gathered from the functional assessment and through the teaming process to address immediate safety and risk concerns, as well as to develop the individualized Family Permanency Plans (FPP) in partnership with the child and family team.

Outlined below are descriptions of the SCDSS assessment tools:

- The Family Advocacy and Support Tool (FAST) is used to assess the needs of children and youth. This includes assessment of the child's level of functioning and medical, physical, developmental and behavioral/mental health needs. The FAST was developed as a communication tool to support interventions and facilitate the linkage between the assessment process and the development of the FPP. Based on the ratings in each section along with input from families, the FAST helps guide the decision-making process for service planning. The case manager is responsible for beginning the FAST during the initial contact with a family and documenting the FAST safety assessment into CAPSS within 72 hours of making initial contact. The full FAST is completed by day 15 of the report of abuse or neglect being accepted for investigation.
- The Child and Adolescent Needs and Strengths (CANS) assessment is a multi-purpose tool developed to support care planning and level of care decision making for children in foster care. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the development of the FPP. The CANS assessment process involves a review of documents, discussion/observation with the child/youth, and discussion with their caregiver(s), family and other community supports. The use of this standardized tool allows SCDSS to share information with DHHS and the MCO as a comprehensive way of understanding the needs of children and youth in foster care. The initial CANS is completed within 48 hours following the 25-day CFTM with a full review being completed by day 30 of the foster care line opening and re-reviewed a minimum of every 90 days. When a child or youth scores a '2', or '3' on Behavioral/Emotional Needs or Risk Behaviors the case manager is responsible for notifying the Regional Clinical Specialist to discuss the need for a clinical assessment. Similarly, SCDSS

Nurses review all FAST, CANS, and medical alerts and make recommendations for follow up.

Currently information sharing related to the FAST/CANS is limited, requiring the frontline or members of the OCHWB team to manually send information related to these assessments. As a part of the CAIP modification commitment in this plan, SCDSS will include the FAST/CANS as accessible information to streamline information sharing.

SCDHHS/MCO Assessment Process

MCOs complete a comprehensive health risk assessment that collects self-reported information about the child or youth's health, risk factors, and social determinants of health, and identifies the child or youth's unmet health-related needs to determine care management needs. The MCO conducts the initial screening of each foster care child's needs within ninety (90) days of the effective date of enrollment and formally every ninety (90) days thereafter; however, assessment is on-going, and care plans are updated as needs are identified.

If there are identified areas of disagreement between the needs identified by the MCO and the DSS case manager, both parties will come to alignment through either a CFTM or IAS depending on the complexity of the need and variance in opinions.

Systemic Alignment of Needs Identification, Planning, and Communication

SCDSS will share its initial assessment information with SCDHHS and/or the MCO. SCDSS OCHWB will share the medical module of the FAST completed within the first 48 hours of a child entering care when SCDSS receives notification of the youth's assigned care coordinator. Assessment information will also be shared during the weekly huddles outlined in strategic priority 4.

Additionally, the SCDSS Nursing Team will place a strong emphasis on sharing information with the MCO, to support and guide their work in addressing the health care needs of children and youth in foster care and in developing patient-centered plans. This exchange will include all after-visit summaries received by either the Nursing Team or Health Care Data Coordinators, as well as any medical records collected or reviewed. The MCO will also share relevant health-related service information (e.g. identified needs, recommendations, or updated records) with SCDSS.

If there are identified areas of disagreement between the needs identified or recommendations by the MCO and the DSS case manager, both parties will come to alignment through either a CFTM or IAS depending on the complexity of the need and variance in opinions.

Currently, the SCDSS case manager or OCHWB staff are responsible for entering data received from the DHHS/MCO into CAPSS as soon as possible upon receipt. With the modification of the CAIP, all users will be able to add or upload health related information into the child's case record. Following the launch of the CAIP modifications in September 2026 users will be responsible for directly entering in relevant information within 7-calendar days of receipt.

Beginning Spring 2026, all additional OCHWB staff who need access will receive access to the MCO's NaviNet portal to review the member clinical summary which includes demographic information, medications, office visits, chronic conditions, ER visits, observation stays, Plan MCO Care Coordinator name and contact information, along with other relevant clinical information. Access to this information will assist OCHWB and front-line SCDSS staff to stay abreast of any changes and to access any collateral information to support coordination efforts.

Child and Family Team Meetings (CFTMs) and Interagency Staffings will serve as a nexus point for needs identification and case planning. SCDSS will define when MCO Care Coordinators should be immediately included, such as in cases with high medical or behavioral health needs or when placements are at risk of disruption. Guidance around inclusion will be adaptive to the acuity of the child's needs, enabling the right stakeholders to be involved at the most opportune time. MCO Care Coordinators are always considered a part of the child and family team regardless of whether they attend a particular meeting. If an MCO Care Coordinator is unable to attend a CFTM, DSS will solicit any feedback to be shared with the group and will provide the MCO Care Coordinator with a copy of the summary from the CFTM. As with MCO Care Coordinators, CPA/GH providers are always considered part of the child and family team, however, if a provider is unable to attend the CFTM, DSS will solicit any feedback to be shared with the group and will provide them with a copy of the summary from the CFTM. The CFTM coaches will continue ongoing training and communication efforts to assist with enhancing on-going collaboration with CPA/GH providers and MCO Care Coordinators.

Similarly, to enhance information sharing that is directly translatable to practice, SCDSS will modify the functionality of its Child and Adult Information Portal (CAIP) to enable MCO Care Coordinators to access and add information in DSS's system related to child information, health information, education information, awards & achievements, family, adult & community connections, special interests, events, and the ability to upload files. The CAIP was initially developed to allow provider partners to access and add child related information to the DSS case record system. SCDSS will work with the MCO to review the current functionality for any gaps or additional data entry fields that may be needed and gather requisite business requirements for system improvements.

Through the modification and use of the CAIP and role alignment, DSS staff, MCO Care Coordinators and provider partners will have access to the relevant collateral information to inform aligned case practice. This process will not supplant the inclusion of MCO Care Coordinators in CFTMs and staffings but will serve to supplement gaps in knowledge sharing related to a child's health needs.

During the first 12 months of implementation, SCDSS will facilitate monthly open calls for CAIP users as a method of CQI to troubleshoot technical and adaptive changes related to implementation and inform any requisite system modifications.

Strategic Priority 3: Action Steps		
Commitment	Responsible Parties	Timeline
Finalize business requirements for modified CAIP to enhance collaboration between SCDSS and MCO	SCDSS and MCO	March 2026
Modify the CAIP to enable MCO to input additional information and send notification alerts to Case Managers when new appointments or information is shared by the MCO Care Coordinators	SCDSS	July 2026
Implement Modified CAIP	SCDSS	September 2026
Develop and implement a training protocol for MCO Care Coordinators on use of modified CAIP	SCDSS	July 2026
Develop and implement a training protocol for DSS frontline staff on new healthcare alerts	SCDSS	July 2026
All OCHWB Staff who need NaviNet access will receive access	MCO	April 2026

Strategic Priority 4: Improve Availability and Timely Access to Quality Healthcare, Including Behavioral Health.



As the state Child Welfare Agency, SCDSS is responsible for the overall safety, permanency, and well-being of children, including coordinated access to the services they need to help them thrive. This means that SCDSS has responsibility for obtaining non-medical services and is responsible for the ongoing evaluation of its contracted service array to continue to meet any unmet needs that have been identified.

Similarly, SCDHHS serves as the state Medicaid agency, responsible for ensuring an adequate network of qualified providers to meet the needs of children on Medicaid throughout the state, including all children in foster care. The South Carolina Medicaid State Plan provides a comprehensive range of medical and therapeutic services for children in foster care. These services include but are not limited to, autism spectrum disorder services, ambulance services, clinic services, community mental health

services, dental services, durable medical equipment services, early intervention services, Federally Qualified Health Center (FQHC) services, waiver services, hospital services, rehabilitative behavioral health services, pharmacy services, physician services, psychiatric hospital services, rehabilitative, therapy, audiological services, and rural health services. Additionally, federal EPSDT requirements provide that the state, and by contract its MCO, are required to cover and provide all 1905(a) services necessary to correct or ameliorate identified medical needs for children eligible for EPSDT and to implement policies and procedures, including medical necessity criteria and prior authorization requirements, that are consistent with that mandate. Through its contracts with MCOs and other quality assurance mechanisms, SCDHHS ensures appropriate "network adequacy" consistent with federal requirements. Federal rules for Medicaid Managed Care define responsibility of MCOs for network adequacy to (1) offer an appropriate range and access to preventive and primary care services and 2) to maintain a sufficient number, mix and geographic distribution of providers of services, including specialty services (42CFR 438.68 and Social Security Act 42 USC 13960-2 and 1932(b)(5)(A) and(B)). Federal rules give states the responsibility to define standards for geographic distribution and access and allowable wait times for services.

As with all Medicaid beneficiaries, children in foster care are eligible for these services when the services are deemed medically necessary. This allows foster children to receive the vital care and support they need to maintain their health and well-being.

Strategies for improving availability and timely access to quality healthcare, including behavioral health

Improving Timely Initial Well-Child and Dental Visits

Initial well-child visits and dental are critical to addressing the healthcare needs of children as they enter foster care. To better understand the challenges impacting the timeliness of these visits, SCDSS conducted a process review to identify root causes and contributing factors behind delays.

The review revealed that one of the primary contributors to delayed initial well-child visits is the timing of insurance enrollment. Although SCDSS transmits eligibility information to SCDHHS through a nightly data exchange, any delay in data entry or in opening the foster care case can affect the timeliness of eligibility determination. Additionally, because SCDHHS eligibility staff operate on a standard business-day schedule, this can further delay enrollment with an MCO. Once enrolled, additional time has been needed to assign a MCO Care Coordinator, compounding the delay.

These delays can create a cascading effect, ultimately impacting the scheduling and completion of the initial well-child and dental visits. Compounding the issue, medical practices are often hesitant to schedule appointments without a Medicaid ID or proof of insurance coverage. Furthermore, confusion persists among stakeholders regarding who is responsible for scheduling the initial visit. Both foster parents and providers have reported receiving multiple, sometimes conflicting, calls about appointment coordination.

By agreement, the expected timeframes for all of these actions to enroll a child, assign an MCO Care Coordinator and schedule visits are within 30 days of foster care entry.

To address these challenges and improve the timeliness of initial well-child visits, SCDSS Child Welfare Operations will implement a quarterly review process. This review will analyze the time elapsed between a child's entry into foster care and the opening of the foster care service line, with data disaggregated by county and case manager. The insights gained will inform targeted actions to support more timely data entry and service line activation.

Responsibility for scheduling and coordinating the initial well-child visit will be shared based on the child's enrollment status with a Managed Care Organization (MCO). For children and youth enrolled with an MCO within seven calendar days of entering care, the MCO will take the lead in scheduling and coordinating the visit. For those not enrolled within that timeframe, SCDSS will assume responsibility for visit scheduling and completion.

Additionally, SCDSS OCHWB will initiate weekly regional foster care alignment calls with the MCO, Child Placing Agencies (CPAs), Group Homes (GH), and Foster Parent/Kinship Caregivers. These calls will serve as a platform to exchange key case information, provide updates, and promote a smooth handoff of health-related responsibilities—both those already undertaken and those still pending.

Evaluation of Availability and Accessibility of Behavioral Health Services

Both SCDSS and SCDHHS understand the complexity of the availability and accessibility to quality for children in foster care. SCDSS conceptualizes this effort area as being functionally comprised of the evaluation of two components: non-medical behavioral health support services and services covered under the Medicaid State Plan.

Considering the emerging youth mental health crisis and increased number of children and youth with a higher acuity of presenting behavioral needs, factors that contribute to higher rates of placement instability and poorer health outcomes, SCDSS is particularly interested in assessing the availability and accessibility of behavioral health services. SCDSS believes that this evaluation, and the subsequent improvements it will lead to, has the potential to significantly enhance the well-being of children and youth in foster care.

SCDSS seeks to understand the global landscape and availability of behavioral health services in South Carolina via two targeted multivariable analyses, which include specific trends in behavioral needs, service typology, intervention level information, and the composition of providers rendering services to individuals under 18 years of age. SCDSS believes that by taking a global approach to understanding the nuances of these variables, it can engage in targeted outreach and service array development for interventions that may not be deemed medically necessary, but support placement stability, or aid in reunification efforts. SCDHHS is committed to working with SCDSS to determine what data are needed and whether the needed information is available. SCDHHS and SCDSS will work together to determine how the available data will be produced and provided to SCDSS.

As a system, South Carolina does not routinely engage in an evaluation of its service provider workforce, which presents an opportunity for SCDSS and DHHS to conduct a comprehensive analysis. This landscape analysis would provide valuable insights into the training and interventions utilized by the behavioral health workforce, as well as help identify any emerging trends in the behavioral presentations of the youth they serve, determining if they are currently serving DSS clients or would like to, and if they are enrolled as a Medicaid provider. Understanding these dynamics is important as SCDHHS covers specific service types (e.g. individual psychotherapy, family psychotherapy, etc.) with limited intervention specific coverage (e.g. HOMEBUILDERS, MST, etc.), resulting in systemic knowledge gaps around specific interventions. These efforts would aid both agencies in the development of their service array.

For instance, if a child exhibits high impulsivity along with externalizing behaviors, including self-harm, interventions such as Dialectical Behavioral Therapy (DBT) can be employed to target these behaviors and equip youth with essential self-regulation skills. Therefore, determining the availability of DBT practitioners across the state would be advantageous for developing rapid response strategies, whether that involves engaging existing providers or exploring opportunities to expand service capacity.

The SCDSS Chief Transformation Officer (CTO) will be responsible for facilitating the landscape analysis of the behavioral health workforce. SCDHHS will review and collaborate with DSS on the recommendations. This survey will be based of work completed in 2020 when SCDSS partnered with the Institute for Families in Society to design an anonymous, online survey to enhance SCDSS knowledge of the characteristics of the behavioral health workforce in South Carolina, and to help SCDSS to understand what evidence-based practices are being used with children and families. The survey was distributed by multiple state agencies, cross-sector partners, and professional organizations. Over 2,600 professionals responded, with approximately 50.34% reporting they do not serve children, families or caregivers and approximately 49.66% reporting they do. Of the sample group of professionals (n=1,298), every county of the state was represented and categories of respondents included but were not limited to social workers, counselors, physicians, school-based counselors, parent educators, school psychologists, marriage and family therapists, psychologists, behavior specialists, criminal justice professionals, etc. Findings from this survey, in addition to multiple advisory groups, helped to inform the development of SCDSS' Title IV-E Prevention Plan and service array development.

This evaluation will be completed by Spring 2026, with findings shared with the Child Welfare Leadership Team and DHHS leadership in the same period and will include survey response data and analysis of FAST/CANS data to outline trends and possible recommendations for service array development. These findings will also be shared with the FCOC.

Similarly, CWS Operations team in conjunction with DSS CQI will be responsible for facilitating regional focus groups with front line staff. These groups will focus on understanding front line knowledge of service availability, service array needs, and service array strengths across all provider types (i.e. medical, dental, and behavioral). Findings from these focus groups will inform the development of region-specific strategies to address identified needs. These focus groups will begin in February 2026

and conclude in March 2026.

Additionally, SCDHHS, in partnership with SCDSS, will engage in phase two of the foster care analysis SCDHHS completed in 2024, which evaluated the utilization of behavioral health services for children in foster care. This process will build upon the work completed in phase one and utilize newer needs identification processes made possible via the new care coordination infrastructure while concurrently evaluating other systemic factors identified by SCDHHS. This phase two analysis (Foster Care 2.0 Analysis) will look at trends in utilization, diagnosis, and location of services by both county and setting as defined by SCDHHS (i.e. community, office, etc.). This analysis will be completed by May 2026 and shared with DSS.

While no composite evaluation will result in a single solution or recommendation, the combination of assessing multiple variables and understanding the point-in-time disposition of the service array landscape will enable SCDSS and SCDHHS to make targeted investments in its service array and implement strategic provider outreach efforts. Regardless of the findings, SCDSS is committed to providing needed services to children in foster care, along with enhancing awareness of the current array of services covered under the Medicaid state plan.

SCDSS will periodically reassess any gaps in the availability of behavioral health services through internal data metrics and internal and cross-agency staffings. If trends are identified at the local level, they will escalate to the FCOC team and to SCDSS and DHHS leadership to determine the appropriate course of action for service array development to include whether to plan for implementation.

Rapid Response Evaluation and Expansion

In the summer of 2025, the South Carolina Department of Social Services (SCDSS) partnered with a provider agency to launch and pilot an innovative rapid response strategy aimed at supporting foster children in Richland County. This initiative delivers mobile, crisis-oriented behavioral health interventions to youth experiencing acute emotional or behavioral distress.

The program is staffed by licensed clinicians who provide short-term, trauma-informed crisis intervention and facilitate connections to ongoing behavioral health services for children not currently engaged in treatment. Upon deployment, the rapid response clinician is responsible for notifying the SCDSS Regional Clinical Specialist and, when known, the child's case manager to promote appropriate follow-up and continuity of care. The Regional Clinical Specialist then communicates with the case manager and the child's placement provider to coordinate next steps.

Rapid response services can be requested by foster parents, Child Placing Agencies, day treatment providers, and other stakeholders when a foster youth is experiencing a behavioral health crisis. Currently, this service is available exclusively to foster children residing in or placed within Richland County.

SCDSS would like to expand this program to additional counties, including Horry, Charleston, and Greenville, in 2026. Expansion of this program would be contingent upon the availability of funding.

Increasing Awareness of Local Service Providers

The Medicaid State Plan offers a comprehensive array of service benefits for children in foster care and meets national network adequacy standards. A recent data analysis conducted by the South Carolina Department of Health and Human Services (SCDHHS) in December 2025 reviewed provider enrollment with the MCO and identified the following unduplicated number of providers by type:

- Behavioral Health Providers (Independent vs. Group) N=2332
  - Licensed Independent Practitioners (n=2253)
  - Rehabilitative Behavioral Health Service Provider Groups (n=69)
- Federally Qualified Health Centers (N=512)
- Physicians (regardless of specialty) N=55844
  - Pediatricians (n=3226)
  - Psychiatric Provider (n=487)
- Rural Health Clinics (N=156)

A review of DentaQuest's interactive provider directory found that there were 6844 dental providers that accept Medicaid and serve children under the age of 18.

While the data demonstrates that a range of providers are available to serve children and youth in foster care, DSS hypothesizes that a perceived shortage of accessible providers may reflect delays in appointment availability or from providers not accepting new patients at the time of referral. DSS will test this hypothesis as part of the landscape analysis. Additionally, to address this, SCDSS is partnering with the MCO to train Case Managers and Team Leaders on how to effectively navigate the MCO's provider directory. This collaboration aims to improve access by helping staff identify additional providers and make more timely referrals.

The MCO provider directory is a user friendly publicly accessible database updated by the MCO that enables the querent to search for a provider by name, location, and specialty. This directory also has the functionality to search providers within a specific geographic radius and by need (e.g. mental health, ADHD, counseling, child neurology, ingrown toenail, etc.). Additionally, this database has a feature where the querent can download a directory of specific providers to meet the identified need with their contact information in a digestible and easy to read format. The MCO provider directory can be located at Find Care - Select Health of South Carolina. Similarly, to locate dental providers who serve Medicaid enrolled beneficiaries, case managers will be trained in navigating the DentaQuest provider directory which has similar functionality to the MCO provider directory. The DentaQuest provider directory can be located at Search Results | DentaQuest.

The SCDSS CWS Operations team in partnership with the OCWHB will create PDF provider directories from the MCO provider directory database by the following provider types: Pediatrician, Psychiatry Provider, Occupational Therapy, Speech Therapy, Physical Therapy, Vision, and Behavioral Health Providers for each county. This will enable staff assisting with identifying providers to locate all available options in their area. Additionally, this team will also work to create listings of dental providers for

counties to serve as a companion to the PDF listings.

EPSDT Benefit

In considering the array of services and supports necessary to meet the needs of children and youth in foster care, SCDSS has the authority to procure services that are not deemed medically necessary by Medicaid. Similarly, SCDHHS can provide coverage for additional services deemed medically necessary under its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

The EPSDT benefit provides comprehensive and preventive health care services for children under the age of 21 who are enrolled in Medicaid. The state, and by contract its MCO, are required to cover and provide all 1905(a) services necessary to correct or ameliorate identified medical needs for children eligible for EPSDT and to implement policies and procedures, including medical necessity criteria and prior authorization requirements, that are consistent with that mandate.

To this end, SCDSS and SCDHHS have deployed a process by which services deemed medically necessary but not in the state plan can be rapidly approved by SCDHHS/MCO for coverage under the EPSDT benefit. In doing so, both agencies can collaboratively bridge service gaps at the child level. This will occur using the IAS staffing process referenced on page 10.

The following table outlines the HCIP commitments for this strategic priority area:

Strategic Priority 4: Action Steps		
Commitment	Responsible Parties	Timeline
Landscape analysis of behavioral health services workforce	SCDSS (lead)	April 2026
Foster Care 2.0 Analysis	SCDSS and SCDHHS (leads)	May 2026
SCDSS CM training on navigating MCO provider directory	SCDSS and MCO	February 2026
Evaluate fiscal impact for scaling Rapid Response to additional counties.	SCDSS and Provider	March 2026
Implement new weekly huddles with OCHBW HQIC, CM, and MCO, Kinship Caregivers/Foster Parents, CPA, GH to provide warm handoff for children who have entered foster care and have been enrolled in the MCO	SCDSS and MCO	January 2026



Strategic Priority 5: Data Tracking and Quality Assurance

Background: Foster Care Affinity Group and Continued DHHS and MCO Coordination

In June 2021, the South Carolina Foster Care Affinity Group was launched. Through this learning collaborative, SCDHHS, SCDSS and the MCO, along with other states, worked to expand understanding of data-driven interventions to improve timely access to medical care, while learning about the science of quality improvement. The Affinity Group was a result of strong collaboration between SCDSS, SCDHHS, and the MCO, and allowed the three organizations space to test out new theories and ideas. While the Foster Care Affinity Group has officially ended, many of the strategies and lessons learned have continued amongst the members. Many of the members continue to meet in various forums examining issues and sharing successes related to healthcare outcomes. Though meeting topics vary, they focus on care coordination, network adequacy, and addressing identified barriers to timely care. One of the biggest successes from the Affinity Group has been to create a team across the agencies with shared values and accountability.

Development of Data Extracts & Data Reports

When SCDSS entered into the Healthcare Improvement Plan (HCIP) in August 2018, there was very little information in CAPSS and few data reports that were focused on health care. Since that initial period, SCDSS has diligently created numerous reports that are focused on various aspects of the healthcare processes now developed. Some of these reports are referenced in the section on monthly core datasets received from SCDHHS and the primary MCO. Many of these reports were created to respond to the needs of the field and staff in OCHWB. SCDSS has had reports developed from CAPSS IT, Accountability, Data, and Research (ADR), and, most recently, Evident Change. Because data needs evolve, SCDSS continues to revamp and refocus its reports and prioritizes any new reports for Evident Change to develop.

Healthcare Services Case Reviews

As another method of assessing whether the individual needs of children are met, SCDSS will undertake a case review to assess case management compliance through a practice related to the provision of health and well-being services to meet the needs of children and youth. This approach will use internal and external data to evaluate the impact of the agency's service delivery, system-wide access to services, and healthcare outcomes. This process will provide an opportunity to assess barriers and challenges to receiving services and determine if there is an internal practice issue or access to care at the county level.

This review team will primarily include SCDSS Nurses, the OCHWB director and other assigned staff. Findings from the case review will be shared with the FCOC and county leadership to include identified strengths and needs, so that appropriate improvement strategies can be implemented to support

improved outcomes. Information related to access challenges will be shared with SCDHHS and the MCO for follow up.

The methodology for this review is outlined in further detail in Appendix A. Proposed Michelle H Healthcare Targets Methodology.

SCDSS Specific Data Tracking and Quality Assurance Goals

Periodic Review of Behavioral Health Indicators

As a method of ongoing review of behavioral health indicators and to support the continued appropriateness of the SC behavioral health service array, SCDSS ADR and OCHWB staff will periodically review behavioral health indicators. This will include periodic analyses of FAST/CANS data, reports from SCDHHS that focus on children with mental health assessments and regular updates on the behavioral diagnoses of children and youth. By integrating these data points, SCDSS will be better equipped to develop an adaptive service array. Currently using information in monthly files from SCDHHS and in CAPSS on children who do not have a mental health assessment, SCDSS ADR has constructed a report that cross-references the child with their CANS information. If the child has a behavioral need score of 2 or higher with no evidence of a mental health assessment, information on the child goes into a listing to be reviewed by OCHWB staff. Once information is received on the behavioral diagnoses of children and youth through SCDHHS, that information will further be incorporated into reports.

SCDSS currently receives the initial mental health assessment, well-child, dental, and psychotropic related information, but is requesting additional data as outlined on page 38. *Additional Monthly Datasets on Children in Foster Care Requested.*

Quantitative Review Process to Evaluate Health Outcomes

As described in Strategic Priority 1 as an action step, SCDSS will implement a quantitative review process to evaluate health outcomes by placement provider type and specific placement providers, by geography, age groups, and other key fields. While that review process focus may vary, it may also incorporate some of the CQI processes as outlined in the methodology. It may also incorporate data from the monthly core datasets received from SCDHHS and through the primary MCO.

Monthly Core Datasets on Children in Foster Care

For oversight and internal accountability, SCDSS relies heavily upon several monthly core datasets from SCDHHS (and the primary MCO). It will continue to utilize the information from the datasets outlined below.

From SCDHHS:

SCDSS receives a monthly file from DHHS that includes the dates of claims filed for well-child, dental, and behavioral health visits linked to SCDSS core CAPSS identifiers of the child, geography such as Region and County, the Medicaid number, age of the child, foster care entry date, and SCDSS provider types. This data is for all open foster care cases at a point in time. SCDSS sends the point in time CAPSS extract

with the information on the foster care children to use for linking. It also includes key information on the use of psychotropic medications. Additionally, there is information on the MCO. While the predominant MCO is Select Health, there are children on other MCOs, or some children are paid through the state.

Uses

This data is then distributed in a series of reports targeted for Child Welfare Operations field personnel, OCHWB, and leadership. Key metrics include some of the following [not a comprehensive list]: no well child visit on record, well child visit past due, well child visit up to date, no dental visit on record, dental visit past due, and dental visit up to date. These metrics are all evaluated by age, SCDSS provider types and geography. SCDSS mines that information to determine gaps in its system and coordinates with the field.

Monthly information is also sent to Child Welfare Operations field personnel and key individuals in the OCHWB on the use of psychotropics with several "red flag" indicators (including the use of psychotropics for children less than 6 years of age). Through the leadership of SCDSS Child Psychiatrist and through SCDHHS, the following indicators were developed: any child on an antipsychotic, children six or younger on psychotropics, and children on four or more psychotropics in any calendar month of the report. SCDSS Child Psychiatrist, who receives a monthly report, carefully monitors these indicators and their medications. [Please note that the SCDSS Child Psychiatrist researched indicators used by other states in the development for SC.] Other reports from these monthly core data extracts are focused on specific needs from the field or key individuals in OCHWB. For example, one report is focused on which children are on medically complex waivers. There is another set of data focused on children who are not served by the primary MCO. SCDSS also uses information from the monthly exchange to clean up any data discrepancies in the Medicaid beneficiary number.

SCDSS monthly core datasets are not limited to claims-based information. SCDSS also receives a monthly file on the results of BabyNet referrals from SCDHHS. While the FSA metric focused on the referral of the child for assessment by BabyNet (SCDSS has met that metric); SCDSS goes further to learn of the results and the services that are recommended for those children. This data and collaboration with SCDHHS become increasingly important as the child ages out of BabyNet eligibility into school-based programs.

From the Primary MCO:

SCDSS receives a monthly file from the MCO that includes the dates of claims filed for well-child (with dates) linked to SCDSS core CAPSS identifiers of the child, geography such as Region and County, the Medicaid number, age of the child, foster care entry date, and SCDSS provider types. This data is for all open foster care cases at a point in time. It also includes other information such as Immunizations. Not all information provided are applicable to class members.

Uses

This data is incorporated into a series of reports targeted for Child Welfare Operations field personnel,

OCHWB, and leadership as referenced above. Since the primary MCO sometimes has more recent information on well child visits, DSS felt that this was necessary. [DSS also pulls health data from CAPSS to incorporate into these reports and un-duplicates all three sources.]

Please note that the Primary MCO does not have information on dental examinations. Additionally, there are some class members who are not in the primary MCO. Therefore, DSS must also have monthly files from both DHHS and the primary MCO.

Quarterly Core Datasets on Children in Foster Care

SCDSS receives quarterly claims-based data on the receipt of well-child, dental, and mental health assessments for children in foster care. Current metrics through the FSA require examining the receipt of these critical health visits within 30 and 60 days for well-child and within 60 and 90 days for dental visits upon entering care. This data is used to measure performance on FSA metrics, as well as, mining the information for gaps in performance by geography, age, SCDSS provider types and other pertinent variables.

Additional Monthly Datasets on Children in Foster Care Requested

SCDHHS is committed working with SCDSS to determine what data are needed and whether the needed information is available. SCDHHS and SCDSS will work together to determine how the available data will be produced and provided to SCDSS. DSS is requesting data from SCDHHS on behavioral health diagnoses, associated claims for children and youth in foster care, and their providers (including name of the provider, address information such as street name, city, county, and zip code). In support of this request, SCDSS will create a monthly point in time file of all children in foster care and send it securely through the SharePoint that SCDSS has with SCDHHS. SCDSS needs this child-level information monthly to support its operations, advocacy for the children in our care, and ongoing evaluation of the behavioral health service array in collaboration with DHHS.

SCDSS is requesting monthly data from SCDHHS on the child's assigned care coordination level for all children in foster care from the primary MCO with the appropriate MCO coordinator assigned. Optimally, SCDSS could receive batch reports through a data exchange between the primary MCO and CAPSS systems containing information related to the child's assigned care coordination level. One mechanism for a more frequent exchange could be through CAIP or some other portal. Since that data exchange is not yet in place, in the interim, SCDSS is requesting to receive this information via other electronic means. Since SCDSS sends a monthly point in time extract of its children in care to the primary MCO, ideally it would be efficient to attach information on the child's assigned care coordination level. [SCDSS recognizes that the information on the child's assigned care coordination level will (and is expected to) change.] SCDSS needs this child-level information monthly to support its operations, for accountability (tying into Goal 1), and for our advocacy for the children in our care.

FSA Health Care Methodologies

When SCDSS entered into the Healthcare Improvement Plan (HCIP) in August 2018, SCDSS had little information on the health of the children in its care. There was little information in CAPSS. It knew little about the data from SCDHHS and the primary MCO. Since then, SCDSS has learned more on the nuances of healthcare. With that increased knowledge and understanding, SCDSS has carefully reviewed the FSA Metrics and associated methodologies. At the beginning of these measurements, SCDSS, along with its partners, built the best set of methodologies based on their current knowledge of the data and processes at that time. Based on updated or new information in CAPSS, changed processes and, often through conversations with the co-monitoring staff, SCDSS has suggested changes to several methodologies. Please reference attachment Michelle H Healthcare Targets Methodology which includes FSA healthcare measures, methodologies, baselines / benchmarks / targets where applicable, and strategies to improve performance.

VI. Conclusion

By aligning efforts around the FSA metrics, SCDSS and its partners are advancing a shared vision of improved health outcomes for children in foster care. Through individualized care coordination, timely and preventive screenings, and expanded access to health services, this collaborative approach is strengthening the infrastructure necessary to support the long-term well-being of children and youth in care. These efforts not only reflect measurable progress but also lay the groundwork for a more responsive and equitable system of care.[vii]

[vii] It is the position of Governor McMaster that any references to the plans, intentions, undertakings, responsibilities, agreements, or activities of state agencies other than DSS or officials are included solely for purposes of memorializing ongoing collaborative efforts or responding to inquiries related to the same, or both, and any such references are not intended to obligate or commit, and do not obligate or commit, any agency or official that is not a party to the FSA or subject to the Court's jurisdiction. It is the position of Governor McMaster that neither this Plan nor any terms, phrases, or provisions contained herein, whether included in any initial proposal or incorporated by the Monitoring Team, shall be read, interpreted, or construed as having legal significance or as requiring specific action by the Governor or DSS, or any other entity or official, that is not specifically addressed in the FSA or as expanding the scope of the FSA to require actions by separate agencies or entities that were not parties to the FSA and are not subject to the Court's jurisdiction.

Appendix A. South Carolina Department of Social Services Michelle H. Healthcare Outcomes, Baseline Data, Interim Benchmarks, and Methodology Plan

I. PURPOSE

This Healthcare Outcomes Methodology Plan establishes standardized processes by which the South Carolina Department of Social Services (SCDSS) will measure and report performance on healthcare outcomes required under the Michelle H. Final Settlement Agreement (FSA). The Plan outlines health care outcomes, and specifies data sources, methodologies and timeframes for measurement and reporting.[1]

SCDSS relies on several data sources for measuring health outcomes: administrative claims data from the state's Medicaid system of record; data available from the primary managed care organization (MCO) serving children in foster care; DSS' case management system of record, the Child and Adult Protective Services System (CAPSS), and case record reviews for documentation of service provision. Appendix B provides the South Carolina Department of Health and Human Services (SCDHHS) Target Measure Definitions and Medicaid Codes, that serve as a reference for terminology and naming conventions in Medicaid administrative claims data. For each of the FSA Health Care Outcomes below, the document provides the current FSA Outcome; a newly proposed Outcome if modified by the revised Healthcare Improvement plan; baseline data and interim benchmarks and a more detailed description and discussion of methodology.

II. FSA HEALTH CARE OUTCOMES AND METHODOLOGIES

A. Initial Medical Screens

Current FSA Healthcare Outcome
At least 90% of class members will receive an initial medical screen prior to initial placement or within 48 hours of entering care.

Modified FSA Healthcare Outcome[2]
At least 90% of class members will receive an initial medical screen from a medical professional prior to initial placement or within 72 hours of entering care.

DSS will modify its practice for carrying out initial medical screens for children entering its custody by utilizing community-based medical professionals to conduct initial medical screening, rather than relying on DSS staff as is current practice.

Upon entry into foster care, DSS will transport the child to a community health care

[1] SCDSS and the Michelle H. Monitor acknowledge that the FSA Healthcare Outcomes apply exclusively to class members, as defined in the Michelle H. FSA.

[2] Note, the FSA authorizes the Monitor to set the interim and final outcomes for this and all health care measures. The American Academy of Pediatrics, through its Health Care Standards for children in foster care, recommends that an initial medical screening occur within 72 hours of a child's entry into care. Nationally, practice varies across jurisdictions, with initial screening timeframes commonly set at 24, 48, or 72 hours.

provider for an in-person screening. These medical providers may include registered nurses, nurse practitioners and physician assistants located within South Carolina's Department of Public Health (SCDPH), local clinics or private community clinics such as CVS's MinuteClinics; additional settings and health care providers may be incorporated through future partnerships and contractual agreements.[3] DSS will collaborate with these providers to implement a standardized screening form, which will be completed and provided to DSS staff or caregivers accompanying the child. The draft medical screening form is included in Appendix C. DSS is currently engaging with SCDPH to develop an implementation plan within 120 days which is anticipated to be executed by the end of October 2026.[4]

Baseline Data and Interim Benchmarks:

Final Outcome Measure	At least 90% of Class Members will receive an initial medical screen from a medical professional prior to initial placement or no later than 72 hours of entering care.
Baseline	To be established by DSS and validated by the Monitor following six months of implementation of this new practice, expected to be by the end of April 2027.
Interim Benchmarks	To be established by the Monitor in consultation with DSS following the establishment of the baseline, expected to be by the end of May 2027.

Methodology: DSS will generate data extracts from CAPSS to support measurement and continuous quality improvement. Specifically, DSS will create an electronic file identifying all children under 18 years of age who entered foster care and remained in care for at least 72 hours during each six-month monitoring period. The file will include key identifiers such as the child's name, date of birth, DSS case ID, service ID, person ID, office location, assigned case manager, and team leader; additional fields may be incorporated as needed. Each six-month cohort roster will include the date of entry into foster care and, where applicable, the date of exit.

DSS will link this file to CAPSS data on medical encounters entered as "72-Hour Medical Screening at Entry to Care." Extracted data will include the date and time of the encounter, provider, service location, and documentation of receipt of the completed medical screening tool. DSS will also explore methodologies to make the process more efficient by validating the presence of the 72-hour medical screening within the linked files.

Universe: All children under 18 years of age who entered foster care during the six-month

[3] DSS will provide the Monitor, Plaintiffs and the Court with information regarding any future contracts and/or partnerships.
[4] Should this strategy with the SCDPH not prove viable, DSS will secure this service from community healthcare providers that are currently being considered for after hours, weekends and holidays.

monitoring period and remain in care for at least 72 hours.

Implementation Strategies: Because this represents a new practice utilizing medical providers to conduct an initial screen and new measurement methodology, DSS will develop corresponding policies, work aids, and training to support DSS staff and medical providers in completing the 72-hour medical screening. These materials are expected to be finalized and disseminated by September 30, 2026.

In the short term, DSS will add a medical encounter designation, "72-Hour Medical Screening at Entry to Care," within CAPSS. Case managers will be required to document the screening as a medical encounter and upload the completed screening form as a linked file. Entry into CAPSS must occur within five days of the screening date. DSS acknowledges typical data entry lags of up to one month and will therefore rely on the most complete data extracts available for analysis.

In the long term, DSS will pursue electronic data collection strategies through data-sharing agreements with SCDPH local clinics and other community healthcare providers such as CVS MinuteClinics. DSS has submitted an initial data request to the DHHS to support this methodology. Upon identifying the relevant billing codes, DSS will formalize its request for inclusion of these codes in the quarterly entry cohorts submitted to DHHS for related measures. Until such agreements or data integrations are established through DHHS, DSS will continue to rely on staff entry of screening information into CAPSS as a medical encounter.

Continuous Quality Improvement (CQI): Following implementation of this new practice and the creation of a medical encounter designation, "72-Hour Medical Screening at Entry to Care," into CAPSS to capture the data, DSS will build a PowerBI dashboard that will capture the 72-hour medical encounters for entries into care from CAPSS. This dashboard will be updated daily and will support program staff in ensuring all children in foster care receive the initial medical screen. Additionally, DSS will generate summary statistics and a detailed roster of all children in the cohort, including documentation of their receipt of the initial medical weekly. Children who do not receive an initial medical screen within 72 hours of entry into care will be flagged and followed up by well-being and the field staff. A detailed roster and summary statistics will be emailed to field staff and county and state leadership on a weekly basis. This will include data disaggregated by geography, demographics, and timeliness measures. DSS will analyze these data to identify patterns and inform targeted quality improvement efforts. DSS will also coordinate with Safe Measures on a daily report showing entries into care and the presence of the 72-hour medical screenings.

DSS will use the detailed roster to identify cases requiring follow-up and will direct case managers to upload missing documentation of completed screenings. If a screening has not been conducted, case managers will be required to complete and document the screening within 72 hours.

Additionally, staff from DSS's Office of Accountability, Data, and Research (ADR) will provide ongoing technical assistance to the Director of Operations and to Regional Directors through weekly operational meetings and will present key findings during quarterly meetings with team leaders and county directors.

B. Entry Comprehensive Medical Assessments

FSA Healthcare Outcome

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.

Baseline Data and Interim Benchmarks[5]:

Final Outcome Measure	85% of Class members with a comprehensive medical assessment within 30 days of entering care and 95% of class members with a comprehensive medical assessment within 60 days of entering
Baseline (7/1/2017 – 12/31/2017 using 30 & 60 days)	37% within 30 days and 51% within 60 days
Interim Benchmark, September 2019	57% within 30 days and 71% within 60 days
Interim Benchmark, March 2020	76% within 30 days and 79% within 60 days
Interim Benchmark, September 2020	80% within 30 days and 92% within 60 days

Methodology: The originally approved Health Care Plan relies primarily on administrative claims data obtained from DHHS for determining performance. DSS now proposes adopting a hybrid methodology that combines administrative claims data with data from a targeted case record review. DSS has monitored trends in healthcare measures at entry into foster care and observed that performance metrics have largely plateaued. However, internal analyses and discussions with providers suggest that DHHS claims data may not capture all comprehensive medical assessments conducted. An exploratory review, conducted jointly by DSS and the Monitor using a random sample of cases from MP18, found documented evidence in several children's cases that a timely comprehensive

[5] Note: DSS developed the original methodology in collaboration with SCDHHS, incorporating input from DSS Health Care Consultants and methodological guidance from Chapin Hall through their data audit process. DSS considers the baseline data, covering the period July 1, 2017, through December 31, 2017, to be valid and to provide a sound basis for the development of interim benchmarks.

medical examination had been completed that was not matched to Medicaid claims data.

Universe: All class members under 18 years of age who enter foster care during the six-month monitoring period. DSS will report on the number and percentage of children in foster care for two populations: 1) children in care for 30 days or more who receive a comprehensive medical assessment within 30 days of entry, and 2) children in care for 60 days or more who receive a comprehensive medical assessment within 60 days of entry.

DSS currently develops an electronic file using the following criteria:

- Children who entered during a monitoring period, who remained in foster care at least one day, and whose entry was not added in error. The file includes key identifiers such as name, date of birth, DSS Case ID, DSS Person ID, Medicaid number, DSS office, caseworker name, entry date into foster care and an exit date if applicable
- Entry age is calculated on the day the child entered care
- Children whose entry legal authorization was voluntary placement or whose entry age was 18 and older are removed
- Each child's 18th birthday is calculated
- An adjusted close date is calculated if a child's 18th birthday occurred during the monitoring period or the months following
- Days in care are based on the adjusted close date if occurring prior to the end of the monitoring period and based on the end of the monitoring period if not closed or after this date. Based on their time in care, children/youth are assigned categories of "less than 30", "at least 30", "at least 60", and "at least 90"

DSS securely sends the electronic files to DHHS, which:

- Matches children to their Medicaid database and identifies the first comprehensive medical assessment after the foster care service open date using Medicaid CPT-4 codes (see Appendix B SCDHHS Target Measure Definitions and Medicaid Codes). The data are then assigned to the 30-day and 60-day cohorts.
- Excludes children without a Medicaid ID from the summary. These children without a Medicaid ID will be included in the DSS case record review.
- Summarizes children in care by the number of days between foster care entry and the first comprehensive medical assessment, calculating the percentage of children who received the assessment within 0-30 days; 31-60 days; 61-90 days; 91-120 days; and at 30-day intervals up to 1801 + days.

Sampling: DSS will draw a random sample from children who do not match a DHHS encounter, with a sample size sufficient to achieve a 95% confidence level and a ±5% margin of error. The sample will be reviewed by DSS reviewers and validated by the Monitor for evidence in the case record of a completed and timely comprehensive medical assessment. Acceptable evidence includes an after-visit summary in Linked Files, detailed information in the Encounters tab regarding diagnoses, required medical equipment, medications, or dictated notes confirming the date, time, and outcome of the appointment. The timely rate observed in the review sample will be extrapolated to the

full unmatched group, and this estimate will be combined with confirmed DHHS claims data from the matched group to calculate the final weighted performance rate

Implementation Strategies: Typically, 74%–75% of an entry cohort is matched to DHHS comprehensive medical assessment claims using a three-month lag, leaving roughly one quarter of the cohort unmatched. DSS has hypothesized that some non-matches result from late claim submissions. An analysis conducted by DHHS for DSS, comparing MP10 results using both a two-month and three-month claims lag, showed increases of at least one percentage point for most measures. Similarly, using a four-month lag for an additional entry cohort produced increases of at least one percentage point compared to an earlier six-month cohort.

DHHS analysts have emphasized that claims data are not considered complete for a calendar year until 12 months after the services are rendered, though most claims are typically submitted within three to four months. To improve matching rates for Medicaid claims data, DSS will collaborate with DHHS and the primary MCO to review current billing codes and other components of the query. DSS has also identified that some providers may not be submitting claims to Medicaid for reimbursement. In response, ADR, in coordination with program staff, will develop a follow-up and outreach plan. DSS anticipates that identifying these providers and engaging them to utilize the Child and Adolescent Information Portal (CAIP) which provides a direct portal for data entry may increase the number of comprehensive medical assessments captured in claims data.

DSS recognizes that CAIP is a key strategy for improving data capture and care coordination. A team from ADR, Internal Monitoring, and Child Health and Wellbeing has been collaborating with CAPSS IT to revise the CAIP module to allow direct access by Select Health, the state's MCO for children in foster care. CAPSS IT has developed a mockup, which has been reviewed by program staff. The next steps include finalizing the mockup and building the module enhancements. DSS plans to develop and implement a training protocol for MCO Care Coordinators on the use of the modified CAIP and a separate training protocol for frontline DSS staff on new healthcare alerts, targeted for July 2026. CAPSS IT projects to launch the module in September 2026. Additionally, ADR has submitted a data request to enhance the CAIP transactions file to include provider names for further analysis.

To improve CAPSS data quality, DSS will develop refresher training within its Learning Management System (LMS) to reinforce expectations for accurate encounter documentation and clarify appropriate encounter selection. As part of this effort, DSS reviewed encounter naming conventions in CAPSS and is streamlining options with clearer names and definitions. DSS will update guidance and training materials to promote more consistent encounter coding, thereby improving the reliability of CAPSS data used for monitoring and reporting purposes.

Additionally, DSS will explore opportunities to obtain data directly from providers, such as the Medical University of South Carolina (MUSC), to better capture health services received by children in foster care. As additional potential data sources are identified, DSS may pursue further data-sharing agreements with other providers. Through training and the development of work aids, DSS will support field staff in improving the consistency of obtaining and uploading after-visit summaries into CAPSS. DSS will also create a cleanup report to flag encounters where an after-visit summary was not uploaded. Additionally, DSS will collaborate with Safe Measures to explore potential methodologies for detecting the presence of after-visit summaries within CAPSS records.

Continuous Quality Improvement: DSS will provide program and field staff with quarterly summary statistics and detailed rosters of children who have not received a comprehensive medical assessment. These reports will be distributed to the field through the established cadencing process. DSS will also conduct ongoing analyses of cases in which children receive a comprehensive medical assessment outside the required timeframe. These analyses will examine potential contributing factors, including geographic variation and placement type, to identify patterns and inform strategies for improving timeliness. Additionally, ADR will provide ongoing technical assistance to the Director of Operations and Regional Directors through weekly operational meetings and will present key findings during quarterly meetings with team leaders and county directors.

C. Comprehensive Mental Health Assessments

Current FSA Healthcare Outcome

At least 85% of class members aged 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; at least 95% will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment.

Modified FSA Healthcare Outcome

At least 85% of class members aged three and above for whom a mental health need is identified in the initial finalized CANS will receive a comprehensive mental health assessment within 30 days of the finalized CANS*; at least 95% will receive a comprehensive mental health assessment within 60 days of initial finalized CANS.*

While performance data for the original outcome measure focused on the after-visit summary of the comprehensive medical assessment, DSS, in collaboration with the Monitor, observed in an exploratory review that these summaries often lacked documentation of mental health needs. Additionally, DSS policy and practice now emphasizes the use of the Child and Adolescent Needs and Strengths tool (CANS) to assess and identify children's mental health needs and recommends using the first finalized

CANS (administered with fidelity)[6] closest to entry into foster care to determine those needs.[7] The CANS is typically initiated after the Probable Cause hearing and completed within 48 hours following the 25-day Child and Family Team Meeting (CFTM).

Baseline and Interim Benchmarks:

Final Outcome Measure	85% of Class members aged three years and above for whom a mental health need is identified in the initial finalized CANS will receive a comprehensive mental health assessment within 30 days of the finalized CANS; at least 95% will receive a comprehensive mental health assessment within 60 days of initial finalized CANS.
Baseline	To be established by DSS and validated by the Monitor by January 2027
Interim Benchmarks	To be established by the Monitor in consultation with DSS by January 2027

Methodology: DSS collects detailed, item-level information from the CANS to identify children who require a comprehensive mental health assessment. These items include:

- Behavioral/Mental Health Needs Module (CANS; ages 6–21): Psychosis (Thought Disorder), Impulsivity/Hyperactivity, Depression, Anxiety, Oppositional (Non-Compliance with Authority), Conduct (Antisocial Behavior), Anger Control, Substance Use, and Eating Disturbance.
- Risk Behaviors Module (CANS; ages 6–21): Suicide Risk, Non-Suicidal Self-Injurious Behavior, Other Self-Harm (Recklessness), Danger to Others, Sexual Aggression, Delinquent Behavior, Runaway, Intentional Misbehavior, and Victimization/Exploitation.
- For children aged 3–5, DSS incorporates early childhood-specific CANS items, including Challenges (Impulsivity/Hyperactivity, Depression, Anxiety, Oppositional, Attachment Difficulties, Adjustment to Trauma, Regulatory or Sleep issues) and Risk Behaviors/Factors (Self-Harm, Exploited, Exposure, and Failure to Thrive).

DSS tracks the number and percentage of children at entry into foster care who receive a comprehensive mental health assessment within 30 and 60 days. This information currently comes from DHHS through an established process that exchanges electronic files. DSS is exploring additional sources for comprehensive mental health assessment

[6] A CANS is considered "finalized" after it has gone through both review by a Team Leader as well as a review by an Assessment and Planning Coordinator who determines fidelity and provides final approval.

[7] During an exploratory review of CANS data linked to foster care entries, DSS had a 94% rate of CANS completion for Class Members who are in care for at least 30 days. Although not an FSA requirement nor an obligation under which DSS will be measured under the FSA, DSS will continue to monitor CANS completion via the continuous quality improvement activities detailed on page 11, with the goal of maintaining this rate of completion.

data, including getting data from the Department of Behavioral Health and Developmental Disabilities' (DBHDD), Office of Mental Health (OMH). The methodology for capturing and reporting receipt of comprehensive mental health assessments mirrors the approach used for comprehensive medical assessments and initial dental exams from DHHS. DSS collects detailed item level information from the CANS that identify children who need a comprehensive mental health assessment.

The Monitor has approved the following to be used for initial comprehensive mental health assessments:

Service / Assessment	Typical CPT codes used by Providers
Initial Diagnostic Assessment	90791, 90792
Follow-Up Diagnostic Assessment	90791, 90792
Psychiatric Evaluation	90791, 90792
Psychological / Neuropsychological Testing and Evaluation	96130, 96131, 96136, 96137

Universe: An entry cohort of all class members aged three and older who remain in foster care for 60 days or more during the six-month monitoring period. These children will be linked to their first finalized CANS assessment. Children who score "1" or higher on any relevant CANS item in first finalized CANS assessment will be identified as needing a comprehensive mental health assessment and included in the denominator.
Receipt of the initial comprehensive mental health assessment will be linked to these identified children and counted in the numerator. Timeliness will be measured from the date of the finalized (with fidelity) CANS to the date of the initial comprehensive mental health assessment as recorded by claims data from DHHS. Additional initial comprehensive mental health assessment encounters will be used if data is obtained from other providers and as agreed upon by the Monitor. If a comprehensive mental health assessment occurred prior to the initial finalized CANS, it will be counted as part of the numerator.

Sampling: DSS will draw a random sample from children who do not match a DHHS encounter, with a sample size sufficient to achieve a 95% confidence level and a ±5% margin of error. This sample will be reviewed by DSS and validated by the Monitor for evidence of a completed, timely comprehensive mental health assessment. Acceptable evidence may include an after-visit summary in linked files, detailed information in the encounters tab regarding diagnoses, medications, or dictated notes confirming the date, time, and outcome of the appointment. The timely rate observed in the review sample will be extrapolated to the full unmatched group. This estimate will then be combined with confirmed DHHS claims data from the matched group to calculate the final weighted performance rate.

Implementation Strategies: Typically, 62%–64% of an entry cohort is matched to DHHS comprehensive mental health assessment claims using a three-month lag, leaving nearly

40% unmatched. DSS has hypothesized that some non-matches result from late claim submissions. Additionally, DSS has learned that some providers do not submit claims to Medicaid for reimbursement. Evidence from the MP18 exploratory review indicated that some CPAs use their own medical providers. DSS believes that identifying these providers and engaging them to utilize CAIP could increase the number of captured assessments. As a strategy to improve the matching rate for Medicaid Claims data, DSS will collaborate with DHHS to identify strategies for improving Medicaid claims matching, which may include reviewing and refining codes and queries. DSS will also explore additional data sources, including OMH and MUSC, to capture services received by children in care. Additionally, DSS has requested codes for behavioral health information claims data from DHHS.

To improve the quality of CAPSS data, DSS will develop refresher training within its LMS. DSS has reviewed encounter naming conventions in CAPSS and is working to streamline data with clearer names and definitions that will be developed and communicated to the field.

Through training and work aids, DSS will support field staff in improving the consistency of obtaining and uploading documentation of mental health assessments into CAPSS. DSS will also create a cleanup report flagging encounters where a mental health assessment was not uploaded. Additionally, DSS will explore methodologies with Safe Measures to detect the presence of mental health assessments within CAPSS records.

Continuous Quality Improvement: DSS currently distributes multiple reports focused on CANS completion to field staff. These reports are also integrated into the CWS Dashboard. In addition, Safe Measures provides a suite of reports on CANS, including Initial CANS Completion and Ongoing CANS Completion, to support monitoring and quality improvement efforts. DSS will create ongoing rosters of cases that appear to lack a finalized CANS for follow-up by field staff. DSS also provides program and field staff with summary statistics and detailed rosters of children identified as needing a comprehensive mental health assessment, but who have not yet received one. These reports are distributed to the field through the established cadencing process. Additionally, DSS conducts ongoing analyses of cases with timeliness issues, examining instances where children received a comprehensive mental health assessment outside the required timeframe. Analyses consider factors such as geographic location and placement type to identify patterns and inform improvement strategies.

D. Initial Dental Exams

FSA Healthcare Outcome

At least 60% of class members aged two and above for whom there is no documented evidence of receiving a dental examination in the three 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.

Baseline Data and Interim Benchmarks:

Final Outcome Measure	60% of class members aged two and above for whom there is no documented evidence of receiving a dental examination in the three 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
Baseline (7/1/2017 – 12/31/2017	47% within 60 days and 60% within 90 days
Interim Benchmark, Sept 2019	50% within 60 days and 68% within 90 days
Interim Benchmark, March 2020	54% within 60 days and 75% within 90 days
Interim Benchmark, Sept 2020	60% within 60 days and 83% within 90 days

Methodology: The methodology in the originally approved Health Care Plan relies primarily on administrative encounter data obtained from DHHS. While this approach has been in place since the Plan's initial approval, DSS proposes adopting a hybrid methodology that combines administrative claims data with a targeted case record review. DSS has monitored trends in healthcare measures at entry into foster care and observed that performance metrics have largely plateaued. However, internal analyses and discussions with providers suggest that DHHS claims data may not capture all initial dental exams conducted. An exploratory review, conducted jointly by DSS and the Monitor using a random sample of cases from MP18, found that several children not matched to DHHS claims data had documented evidence in their case records showing that a timely initial dental exam had been completed.

Universe: All class members aged two to under 18 years of age entering foster care during the six-month monitoring period with no dental exam in the three months prior to entering care. DSS will report on the number and percentage of children in foster for two populations: 1) children in care for 60 days or more who receive an initial dental exam within 60 days of entry, and 2) children in care for 90 days or more who receive an initial dental exam within 90 days of entry.

DSS currently prepares an electronic file using the following criteria:

- Children who entered during a monitoring period, who remained in foster care at least one day, and whose entry was not added in error. The file includes key identifiers such as name, date of birth, DSS Case ID, DSS Person ID, Medicaid

number, DSS office, caseworker name, entry date into foster care and an exit date if applicable
- Entry age is calculated on the day the child entered care
- Children whose entry legal authorization was voluntary placement or whose entry age was 18 and older are removed
- Each child's 18th birthday is calculated
- An adjusted close date is calculated if a child's 18th birthday occurred during the monitoring period or the months following
- Days in care are based on the adjusted close date if occurring prior to the end of the monitoring period and based on the end of the monitoring period if not closed or after this date. Based on their time in care, children/youth are assigned categories of "less than 30", "at least 30", "at least 60", and "at least 90"

DSS securely sends the electronic files to DHHS, which:
- Matches children to their Medicaid database and identifies the first dental visit after the foster care service open date using Medicaid CPT-4 codes (see Appendix B SCDHHS Target Measure Definitions and Medicaid Codes). The data are then assigned to the 60-day and 90-day cohorts.
- Excludes children without a Medicaid ID from the summary. Children without a Medicaid ID will be included in the DSS case record review.
- Summarizes children in care by the number of days between foster care entry and the first dental exam, calculating the percentage of children who received the assessment within 0-30 days; 31-60 days; 61-90 days; 91-120 days, and at 30-day intervals up to 1801 + days.

Sampling: DSS will draw a random sample from children who do not match a DHHS encounter, with a sample size sufficient to achieve a 95% confidence level and a ±5% margin of error. This sample will be reviewed by DSS and validated by the Monitor for evidence of a completed, timely initial dental exam. Acceptable evidence includes an after-visit summary in linked files, detailed information in the encounters tab regarding diagnoses, required medical equipment, medications, or dictated notes confirming the date, time, and outcome of the appointment. The timely rate observed in the review sample will be extrapolated to the full unmatched group, and this estimate will be combined with confirmed DHHS claims data from the matched group to calculate the final weighted performance rate

Implementation Strategies: Typically, 80% of an entry cohort is matched to DHHS dental claims using a three-month lag, leaving nearly 20% unmatched. DSS has hypothesized that some non-matches result from late claim submissions. Additionally, DSS has learned that some providers do not submit claims to Medicaid for reimbursement. DSS believes that identifying these providers and engaging them to utilize CAIP could increase the number of captured assessments. DSS will collaborate with DHHS to identify strategies for improving Medicaid claims matching, which may include reviewing and refining codes and queries.

To improve the quality of CAPSS data, DSS will develop refresher training within its LMS. DSS has reviewed encounter naming conventions in CAPSS and is working to streamline data with clearer names and definitions that will be developed and communicated to the field.

Through training and work aids, DSS will support field staff in improving the consistency of obtaining and uploading after-visit summaries into CAPSS. DSS will also create a cleanup report flagging encounters where an after-visit summary was not uploaded. Additionally, DSS will explore methodologies with Safe Measures to detect the presence of after-visit summaries within CAPSS records.

Continuous quality improvement: DSS will provide program and field staff with quarterly summary statistics and detailed rosters of children who have not received an initial dental exam. These reports will be distributed to the field through the established cadencing process. DSS will also conduct ongoing analyses of cases in which children receive an initial dental exam outside the required timeframe. These analyses will examine potential contributing factors, including geographic variation and placement type, to identify patterns and inform strategies for improving timeliness.

E. Periodic Comprehensive Medical Assessments (Preventative Visits)

FSA Healthcare Outcomes

At least 90% of class members under the age of six months in care for one month or more will receive a periodic preventive visit monthly.

At least 90% of class members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current *American Academy of Pediatrics* periodicity guidelines; at least 98% will receive a periodic preventative visit semi-annually.

At least 90% of class members aged three and older in care for six months or more will receive a periodic preventive visit semi-annually; at least 98% will receive a periodic preventative visit annually.

Baseline and Interim Benchmarks:

	Class members under the age of 6 months in care for 1 month or more receive a periodic preventive visit	Class members between 6 months & 36 months in care for 1 month or more receive a periodic preventive visit	Class members between 6 months & 36 months in care for 1 month or more receive a periodic preventive visit	Class members 3 years or older in care for 6 months or more receive a periodic preventive visit semi-annually	Class members 3 years or above in care for 6 months or more receive a periodic preventive visit annually

	monthly	in accordance with current American Academy of Pediatrics periodicity guidelines	semi-annually		
Final Outcome Measure	90%	90%	98%	90%	98%
Baseline (for the period of July 1 2017 – Dec 31 2017	76%	74%	80%	40%	79%
Interim Benchmarks	To be established by the Monitor in consultation with DSS by September 30, 2026	To be established by the Monitor in consultation with DSS by September 30, 2026	To be established by the Monitor in consultation with DSS by September 30, 2026	To be established by the Monitor in consultation with DSS by September 30, 2026	To be established by the Monitor in consultation with DSS by September 30, 2026

Methodology: The methodology for measuring periodic comprehensive medical assessments and preventive care was based on standards from the American Academy of Pediatrics' Brighter Futures and Fostering Health, with outcomes measured through comprehensive medical assessments or EPSDT visits using the Centers for Medicare & Medicaid Services (CMS) methodology.

However, both DSS and the Monitor acknowledge that results from the original methodology were difficult to interpret and not operationally useful. DSS currently employs an internal methodology, used by the Well-Being Team and field staff, which focuses on whether comprehensive medical assessments are "up to date." Results from this methodology are incorporated into the agency's CWS Data Dashboard. DSS also shares the most recent monthly report for each monitoring period with the Monitor and reports findings to the court.

This methodology will be modified to allow DSS to report r a visit as "on time" if it occurs within seven days after the scheduled due date. This adjustment applies to all periodic comprehensive medical visits, ensuring that visits completed shortly after the scheduled date are counted as compliant for measurement purposes.

Universe: All class members under 18 years of age who enter foster care during the six-month monitoring period and who are in care for 30 days or more.

Monthly Snapshot Creation: On the third Monday of each month (or the next working day after a holiday), DSS generates a snapshot of children currently in foster care. This list is securely shared electronically with DHHS and the primary MCO. The list includes

identifiers such as name, date of birth, and Medicaid number, enabling DHHS and the primary MCO to link to their databases. DSS identifiers are also included in the original and returned files to allow for cross-source comparison. If additional data sources are identified, DSS may incorporate them as agreed upon with the Monitor.

Return of Periodic Preventive Visit Data: DHHS typically returns the list with periodic preventive visit information within one week, while the primary MCO returns the information within three weeks.

Data Integration: Using the two return files and an extract from DSS's CAPSS system, DSS currently identifies the most recent periodic preventive visit for each child by source and also collects the associated medical provider information. DSS begins with a list of children in care as of the first day of the previous month to ensure each child has been in care for at least 30 days. Children who exited foster care between the first of the previous month and the report creation date are removed to maintain an accurate, up-to-date list for field and healthcare staff. Youth who are 18 years of age or older are excluded from the list.

Linking Encounters: DSS links this filtered list to the latest encounters using DSS identifiers. Determination of Latest Visit: DSS calculates the latest date among the three sources and identifies it as the "Latest Comprehensive Medical Assessment Visit on Record." DSS also records which source the date originated from, using the following labels:

"Source" Label	**Description**
CAPSS Verified	The latest date is in CAPSS and at least one of the other Medicaid sources
CAPSS Unverified	The latest date is in CAPSS and is not documented in either of the other two sources
DHHS	The latest date is not in CAPSS, but provided through the DHHS Return File
SHSC	The latest date is not in CAPSS or the DHHS Return File, but is provided through the primary MCO return file

Calculate Age: DSS calculates each child or youth's age.

Determine Future Due Date: Based on the date of the latest visit on record and the child's age, DSS calculates a future due date for the next comprehensive medical or dental visit, adding one month (plus 7 days), three months (plus 7 days), or six months (plus 7 days), as appropriate.

Child/Youth's Age	Future Calculated Date
0 to 5 months	One month after latest visit on record plus 7 days
6 to 23 months	Three months after plus 7 days

24 or more months	Six months after plus 7 days

Classify "Up to Date" Status: DSS compares the calculated future date to the report creation date and assigns a label to classify the child or youth's "Up to Date" status. Categories are designed to provide additional context for the field and include:

- Up to Date (more than 30 days until due)
- Up to Date (less than 30 days until due)
- 0–5 Months Past Due
- 6–11 Months Past Due
- 12–17 Months Past Due
- 18+ Months Past Due
- No Visit on Record

Calculation of Percentage Up to Date: The percentage of children who are "Up to Date" is calculated by adding the number of children in the first two categories—Up to Date (more than 30 days until due) and Up to Date (less than 30 days until due)—and dividing that sum by the total number of children in the comprehensive medical assessment population for each age category.

Continuous quality improvement:

DSS will provide program and field staff with monthly summary statistics and detailed rosters of children who have not received periodic comprehensive medical assessments. These reports will be distributed to the field through the established cadencing process. DSS will also conduct ongoing analyses of cases in which children received periodic comprehensive medical assessments outside the required timeframe. These analyses will examine potential contributing factors, including geographic variation and placement type, to identify patterns and inform strategies for improving timeliness.

F. Periodic Dental Care

FSA Healthcare Outcome

At least 75% of class members aged 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.

Baseline and Interim Benchmarks:

	Class members aged 2 years & above in care for 6 months or longer receive a dental examination semi-annually	Class members aged 2 years & above in care for 12 months or longer who receive a dental examination annually
Final Outcome Measure	75%	90%

Baseline (for the period of July 1 2017 – Dec 31 2017	76%	85%
Interim Benchmarks	To be established by the Monitor in consultation with DSS by September 30, 2026	To be established by the Monitor in consultation with DSS by September 30, 2026

Methodology:

The periodic preventive dental care methodology is based on standards from the AAP's Bright Futures and Fostering Health, with outcomes measured using specific CPT codes, consistent with those used for initial dental exams.

For additional context, SCDHHS developed an Oral Health Section of the Medical Periodicity Schedule for all children enrolled in Medicaid, following recommendations from the American Academy of Pediatric Dentistry (AAPD) on periodicity of examinations, preventive dental services, anticipatory guidance, and oral treatment for infants, children, and adolescents. Compliance with periodicity is measured based on the semi-annual requirement.

This methodology will be modified to allow DSS to report a visit as "on time" if it occurs within seven days after the scheduled due date. This adjustment applies to all periodic dental visits, ensuring that visits completed shortly after the scheduled date are counted as compliant for measurement purposes.

Universe: All class members under 18 years of age who enter foster care during the six-month monitoring period and who are in care for 30 days or more.

Monthly Snapshot Creation: On the third Monday of each month (or the next working day after a holiday), DSS generates a snapshot of children currently in foster care. This list is securely shared electronically with DHHS. The list includes identifiers such as name, date of birth, and Medicaid number, enabling DHHS to link to their databases. DSS identifiers are also included in the original and returned files to allow for cross-source comparison. If additional data sources are identified, DSS may incorporate them as agreed upon with the Monitor.

Return of Periodic Preventive Visit Data: DHHS typically returns the list with periodic dental visit information within one week.

Data Integration: Using the return file and an extract from DSS's CAPSS system, DSS identifies the most recent periodic dental visit for each child by source and also collects the associated medical provider information. DSS begins with a list of children in care as of the first day of the previous month to ensure each child has been in care for at least 30 days. Children who exited foster care between the first of the previous month and the report creation date are removed to maintain an accurate, up-to-date list for field and healthcare staff. Youth who are 18 years of age or older are excluded from the list.

Linking Encounters: DSS links this filtered list to the latest encounters using DSS identifiers.

Determination of Latest Visit: DSS calculates the latest date among the three sources and identifies it as the "Latest Dental Visit on Record." DSS also records which source the date originated from, using the following labels:

"Source" Label	**Description**
CAPSS Verified	The latest date is in CAPSS and is documented in the SCDHHS file
CAPSS Unverified	The latest date is in CAPSS and is not documented in the SCDHHS file
DHHS	The latest date is not in CAPSS, but provided through the DHHS Return File

Calculate Age: DSS calculates each child or youth's age.
Determine Future Due Date: Based on the date of the latest visit on record and the child's age, DSS calculates a future due date for the dental visit, adding six months (plus 7 days).

Child/Youth's Age	Future Calculated Date
24 or more months	Six months after plus 7 days

Note: Since Dental visits are only required for children and youth 24 or more months, all future dental visits are calculated using six months plus 7 days

Classify "Up to Date" Status: DSS compares the calculated future date to the report creation date and assigns a label to classify the child or youth's "Up to Date" status. Categories are designed to provide additional context for the field:

- Up to Date (more than 30 days until due)
- Up to Date (less than 30 days until due)
- 0–5 Months Past Due
- 6–11 Months Past Due
- 12–17 Months Past Due
- 18+ Months Past Due
- No Visit on Record

Calculation of Percentage Up to Date: The percentage of children who are "Up to Date" is calculated by adding the number of children in the first two categories—Up to Date (more than 30 days until due) and Up to Date (less than 30 days until due)—and dividing that sum by the total number of children in the dental exam population for each age category.

Continuous quality improvement:
DSS will provide program and field staff with monthly summary statistics and detailed rosters of children who have not received periodic dental exams. These reports will be distributed to the field through the established cadencing process. DSS will also conduct ongoing analyses of cases in which children received periodic dental exams outside the required timeframe. These analyses will examine potential contributing factors, including geographic variation and placement type, to identify patterns and inform strategies for improving timeliness.

G. Follow-up Care

FSA Healthcare Outcome
At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.

Baseline and Interim Benchmarks:

Target	At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.
Baseline	To be established by DSS and validated by the Monitor following development of the QSR protocol and process and review of 20 cases, expected to be by the end of February 2027.
Interim Benchmarks	To be set by the Monitor in consultation with DSS following the establishment of the baseline, expected to be by the end of March 2027.

DSS recognizes that identifying health care needs and ensuring timely follow-up care are critical for children in foster care. Accordingly, DSS has established processes within its Health Care Plan and throughout this Health Care Target Methodology to support prompt access to and delivery of required health services. These processes are designed to ensure that children entering foster care, as well as those who remain in care over time, receive appropriate assessments and preventive services in accordance with recommended schedules. While DSS will continue to explore electronic solutions with DHHS and other health care providers to supplement data, the following quality service review methodology will be used for measuring performance.

Methodology: This methodology employs a Quality Service Review (QSR) protocol conducted by reviewers from DSS's internal Agency Quality Assurance unit, the Office of Child Health and Well-Being, Internal Monitoring, and Accountability, Data, and Research (ADR) for a sample of class members under 18 years of age in foster care during the two six-month monitoring periods.

Many states, including those involved in lawsuits similar to South Carolina's Michelle H. case, have incorporated QSR protocols that not only provide measurement but also leverage the built-in CQI processes of a QSR. The QSR provides an in-depth case review and practice appraisal method to evaluate how well children and families benefit from services received and how effectively locally coordinated services meet their needs.
For each selected case, administrative data will be pulled to include:

- Detailed child identifiers, including name and demographics, as well as entry and

exit dates from foster care (if applicable). Additional fields deemed helpful to DSS reviewers may be included.

- Review teams will use the CAPSS system to examine health care follow-up entries in the following tabs (other tabs may be included as needed):
  - Health Encounter Screens, Appointments, and other Health-Related Screens
  - Linked Files
  - CAPSS Dictation
  - Child Characteristics Screen and/or Other Information collected during assessments for the period under review
  - Reviewers may also access other systems outside of CAPSS if available.
- Review teams will interview the child, caregivers, health-related service providers, and others as necessary to gather relevant information.

Universe: All class members under 18 years of age who enter foster care during the six-month monitoring period and who are in care for 60 days or more.

Sampling: Because of the significant resources necessary to build up a QSR, for the first year, the suggested sample is 40 cases (20 cases per monitoring period). Ten cases per each of the four regions within the state will be selected. DSS, with the monitor, will evaluate samples sizes in the second year and ongoing.

Implementation Strategies: Because this represents a new practice and measurement methodology, DSS will educate its workforce and leadership on the Quality Service Review (QSR) protocol and its benefits. DSS will adopt the protocol structure—including ratings, processes, and questions—used by other states, incorporating interviews as part of the review. Under the guidance of the Monitor, DSS will identify the specific questions to be used for follow-up care measurement. Once questions are determined, DSS will develop a QSR protocol in collaboration with the Monitor, which will be tested prior to full implementation. An accompanying guide for reviewers will also be developed and tested.

Proper use of the QSR protocol requires reviewer training, certification, and supervision. Reviews will be conducted in teams of two. Prior to implementation, DSS will identify potential reviewers and provide comprehensive training on the protocol. The Monitor will work with DSS staff as they develop and implement the QSR process.

Continuous quality improvement:
DSS will provide program and field staff with summary statistics and detailed rosters of children who have not received follow-up care following each biannual review. These reports will be distributed to the field through the established cadencing process. DSS will also conduct ongoing analyses of cases in which children received follow-up care outside the required timeframe. These analyses will examine potential contributing factors, including geographic variation and placement type, to identify patterns and inform strategies for improving timeliness.

Appendix B
SCDHHS Target Measure Definitions/Medicaid Codes[1]

Comprehensive Medical Assessments

An EPSDT visit as defined by the CMS-416 Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report reporting instructions:

CPT[2]-4 Codes: Preventive Medicine Services*

99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39
years) 99391 Established patient
under one year 99392 Established
patient (ages 1-4 years)
99393 Established patient (ages 5-11 years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant
99463 Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)
*These CPT codes do not require use of a Z code.

OR

CPT-4 Codes: Evaluation and Management Codes **
99202-99205 New Patient

[1] Codes are alpha-numeric descriptors (universal naming conventions) used to facilitate communication among health care professionals and with health insurers/payors. There are two coding systems used in the Medicaid program: CPT (AMA developed) and ICD (International Classification of Diseases developed by the WHO). CPT codes describe the service provided. ICD-10-CM codes describe health conditions or diagnosis. CPT and ICD codes are often used in combination to communicate diagnosis, procedures, types of medical services and equipment. The CMS (Centers for Medicare and Medicaid Services) maintains, updates annually and releases in the Federal Register, the code list. On data reporting. DSS will continue to use the Gap-in-Care Reports for child and case level work between DSS caseworker and SH care manager. DSS will use the Medicaid claims data internally and with DHHS and SH for operations, quality and monitoring work.

[2] CPT (Current Procedural Terminology) Codes are AMA developed listings of descriptive terms and numeric codes for reporting medical services and procedures.

99213-99215 Established Patient
** These CPT-4 codes must be used in conjunction with the following Z codes:

Z76.2[3](Encounter for health supervision and care of other healthy infant and child), **Z00.121** (Encounter for routine child health examination with abnormal findings), **Z00.129** (Encounter for routine child health examination without abnormal findings), **Z00.110** (Health examination for newborn under 8 days old)
Z00.111 (Health examination for newborn 8 to 28 days old)
Z00.00-01 (Encounter for general adult medical examination without/with abnormal findings), and/or
Z02.0 (Encounter for examination for admission to educational institution),
Z02.1 (Encounter or pre-employment examination),
Z02.2 (Encounter for examination for admission to residential institution),
Z02.3 (Encounter for examination for recruitment to armed forces),
Z02.4 (Encounter for examination for driving license),
Z02.5 (Encounter for examination for participation in sport), **Z02.6** (Encounter for insurance purposes),
Z02.81 (Encounter for paternity testing),
Z02.82 (Encounter for adoption services),
Z02.83 (Encounter for blood-alcohol and blood-drug test), **Z02.89** (Encounter for other administrative examinations), **Z00.8** (Encounter for other general examination),
Z00.6 (Encounter for examination for normal comparison and control in clinical research program),
Z00.5 (Encounter for examination of potential donor of organ and tissue),
Z00.70 (Encounter for examination for period of delayed growth in childhood without abnormal findings),
Z00.71 (Encounter for examination for period of delayed growth in childhood with abnormal findings)

Comprehensive Mental Health Assessments

CPT-4 Codes:

90791 Psychiatric diagnostic evaluation
90792 Psychiatric diagnostic evaluation with medical services

[3] Z codes are derived from the ICD-10-CM and used to capture factors that influence health status or contact with health services including examinations with abnormal findings and without abnormal findings. Z codes are used in conjunction with CPT codes. Z codes are used to describe follow-up, aftercare or continuing services that follow initial treatment.

HCPCS Codes:

H0031 Mental health assessment, by non-physician

Initial Dental Exams

CDT Codes[4][19]:

D0000-D0999 Diagnostic Services D1000-D1999 Preventive Services

The SCDHHS has developed the Dental Periodicity Schedule for all children enrolled in Medicaid following the recommendations of the American Academy of Pediatric Dentistry (AAPD) on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents found here: https://msp.scdhhs.gov/epsdt/sites/default/files/EPSDT%20PERIODICITY%20SCHEDU LES%20Dental%200218.pdf

There are billing limitations for dental exam codes and the SCDHHS dental subject matter expert recommended looking for either the diagnostic CDT or the preventive services CDT codes as evidence that a dentist has examined a child.

Periodic Preventative Visits

Uses the same coding as described in the EPSDT visit definition under Comprehensive Medical Assessment.

Periodicity compliance is typically measured retroactively by calculating the age of the child at the end of the period of interest and counting how many visits they have received as compared to the periodicity schedule up to that age adjusting for the months in care. For example, a child who enters foster care at five months of age and is measured for periodic preventive care at 12 months of age should have received an EPSDT visit at six months of age and nine months of age for a total of at least two visits. The child may or may not have already received the visit for 12 months of age but would not be marked as "non-compliant" until they reached 15 months of age with no evidence of the visit for 12 months of age.

The SCDHHS adopted the Bright Futures/American Academy of Pediatrics (AAP)

[4] CDT (Current Dental Terminology) Codes

Medical Periodicity Schedule for all children enrolled in Medicaid found here: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Building on the Bright Futures periodicity standard, SCDSS has developed a new standard of care for periodic visits. The bullets below compare the SCDHHS Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule measures with the new SCDSS periodicity standard of practice:

- DSS Standard of Care: Class members under the age of six months in care for one month or more received a periodic preventative visit monthly
- SCDHHS Bright Futures/AAP: Children under six months of age should receive an evaluation within 3-5 days of birth, by 1 month, at 2 months, and at 4 months
- DSS Standard of Care: Class members 3 years or above in care for six months or more received a periodic preventative visit semi-annually
- SCDHHS Bright Futures/AAP: currently, children 3 years of age and older should have an annual visit.

SCDHHS developed an Oral Health Section of the Medical Periodicity Schedule for all children enrolled in Medicaid following the recommendations of the American Academy of Pediatric Dentistry (AAPD) on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment for Infants, Children and Adolescents found here: https://msp.scdhhs.gov/epsdt/sites/default/files/EPSDT%20PERIODICITY%20SCHEDU LES%20Dental%200218.pdf. (As noted in the initial dental exam definition, there are billing limitations for dental exam codes and the SCDHHS dental subject matter expert recommended looking for either the diagnostic CDT or the preventive services CDT codes as evidence that a dentist has examined a child)

Periodic Dental Care

See CDT codes for Initial Dental Exams.

Follow-up Care

Derived from the CMS-416 Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report reporting instructions for Line 11 -- Total Eligibles Referred for Corrective Treatment:

> Individuals who had a paid, unpaid, or denied claim for a visit/service that

occurred within 90 days from the date of an initial or periodic screening within the reporting period, where none of the following is included as part of the claim: capitation payments, administrative fees, transportation services, nursing home services, ICF-MR services, HIPP payments, inpatient services, dental care, home health services, long-term care services, or pharmacy services.

SCDHHS further refined this to include an ICD-10 Diagnosis Code indicating abnormal findings attached to the EPSDT visit:

Z Codes:

Z00.121 Encounter for routine child health examination with abnormal findings
Z00.71 Encounter for examination for period of delayed growth in childhood with abnormal findings
Z01.01 Encounter for examination of eyes and vision with abnormal findings Z01.11 Encounter for examination of ears and hearing with abnormal findings
-Z01.110 Encounter for hearing examination following failed hearing screening
-Z01.118 Encounter for examination of ears and hearing with other abnormal findings Z01.21 Encounter for dental examination and cleaning with abnormal findings
Z01.31 Encounter for examination of blood pressure with abnormal findings
Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings

Notes on Data Quality

In its approved Health Plan and Addendum, DSS committed to using Medicaid administrative data, CAPSS administrative data and data collected through case review to generate baseline, interim and benchmark targets. This data is derived from both child welfare and health care systems of record for children in foster care.

DSS and the Monitor are aware that data sources vary in the degree of reliability, timeliness, and validity, and that no discussion of methodology is ever complete without a statement on data quality. To this end, we offer a brief discussion below on efforts to ensure data quality on Medicaid claims data:

The Centers for Medicaid and Medicare Services (CMS) issues regular guidance and technical assistance to states on data analytics, quality measurement and performance improvement related to the use of encounter data[5]. CMS requires

[5] Encounter data includes information on the patient, provider, diagnoses (Z code), service date, place of service, procedure code (CPT, CDT) and payments

Medicaid plans to submit eight encounter data files monthly including three Medicare files and five Medicaid files: Medicaid Institutional, Medicaid Professional, Medicaid DME, Medicaid Additional Drugs, and Medicaid Dental Services within 180 days of the date of service. CMS also requires and encourages states to modernize, modify and monitor their MMIS using a number of tools including: required reporting (quarterly or more often for waiver models) data scrubbing, auditing, detection/correction of inconsistencies and limits on use of optional fields. States are advised by CMS to check data quality by scanning encounter data for missing or incomplete fields and checking for missing records and invalid record sequencing. CMS also asks states to evaluate encounter data quality using benchmarking (HEDIS vs actual or actual to expected); data validation (timeliness of submission, record count dates of service, procedure codes, service recipient ID, provider ID (and rosters), claims rejection rates, denial reviews and reconciliation); and, quality scorecards (timely feedback from state to MCO). Other required data quality monitoring includes: EPSDT, timely claims and payments; meeting benchmarks; denials; add-ons or enhancements for the following types of encounters: physician, clinic, outpatient visits (OT); inpatient hospital (IP) and prescriptions (RX).[6]

[6] Data quality background and guidance can be found at https://www.cms.gov

Appendix C

DSS SOUTH CAROLINA DEPARTMENT of SOCIAL SERVICES

DRAFT

72-HOUR INITIAL OUT-OF-HOME PLACEMENT HEALTH SCREEN

***Instructions**: This form is to be completed by a qualified medical practitioner within 72 hours of a child coming into foster care. The purpose of this initial medical screening is to assess the health and disposition of the child. The 72-hour Initial Out-of-Home Placement Health Screen is not meant to serve as or replace the initial comprehensive well-child visit due within 30 days of foster care entry. This initial medical screen is not meant to establish an ongoing patient/provider relationship. If any pharmacological or medical intervention is needed, the qualified medical practitioner will outline follow-up care needs in Section 5 of this document.*

Section 1 Child Information

Child's Name (Last, First, Middle Initial) _____ _____ _____

Brought in by (Name) _____ ☐ DSS Staff ☐ Caregiver ☐ Other

Contact Number _____ Weight _____ Percentile _____ Height _____ Percentile _____ BMI _____ Percentile _____

Head Size _____ Percentile _____ Blood Pressure _____ Temperature _____ Allergies _____

What is the source of medical information you used during this visit?

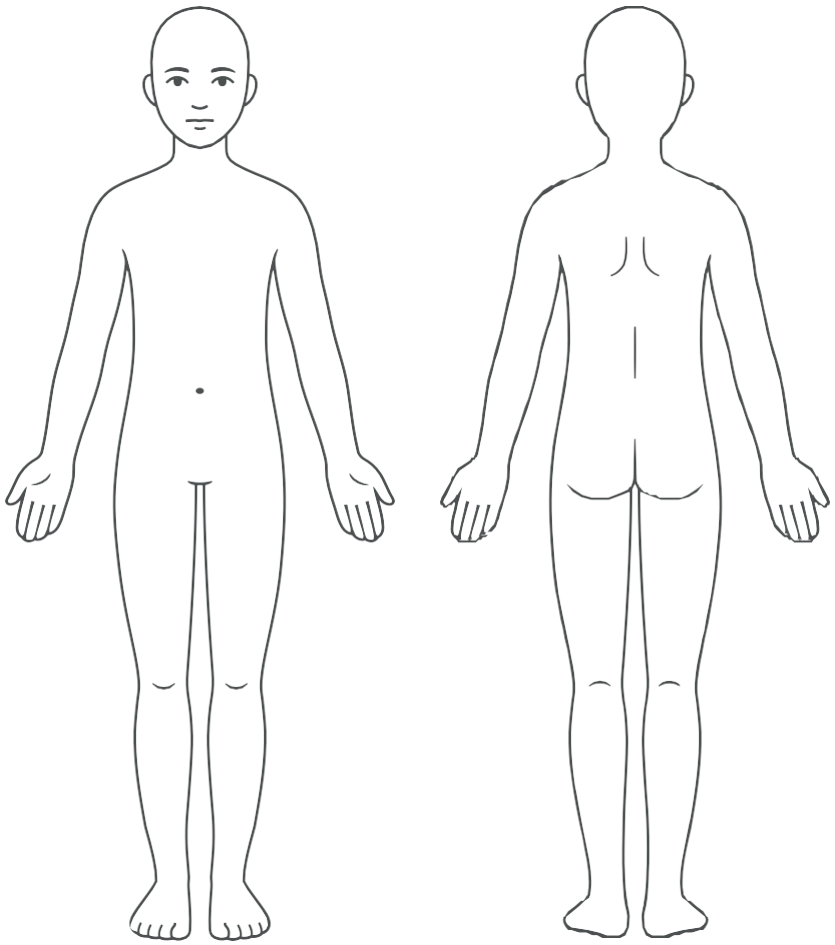
☐ Medical records ☐ Child Information form ☐ None ☐ Child ☐ DSS Staff ☐ Caregiver

Other: _____

Section 2 Examination

Does the child have physical signs or symptoms compatible with abuse or neglect that would require further evaluation by a child abuse pediatrician? ☐ Yes ☐ No

USE SPACE ON THE NEXT PAGE TO SHOW ANY MARKS, BRUISES, AND/OR SCARS



Describe areas with marks, bruises, and/or scars

Head

Left Arm and Hand

Chest

Right Leg and Foot

Right Arm and Hand

Left Leg and Foot

Back

Section 3 Assessment and Comments

Problem List

- ☐ Asthma/allergies
- ☐ Unknown
- ☐ Ear infection/sinusitis
- ☐ Eczema/skin problems
- ☐ Heart disease
- ☐ Neurol/seizures
- ☐ Developmental delay
- ☐ Behavior
- ☐ Mental health
- ☐ Kidney problems

Review of Systems

N	A	
☐	☐	General appearance
☐	☐	HEENT
☐	☐	RESP
☐	☐	GI
☐	☐	Musc/skel
☐	☐	Development
☐	☐	Other
☐	☐	Skin
☐	☐	Dental
☐	☐	Heart
☐	☐	GU
☐	☐	Neuro
☐	☐	Mental Health

Physical

N	A	
☐	☐	General appearance
☐	☐	Eyes
☐	☐	Nose, Mouth, Teeth
☐	☐	Heart
☐	☐	Abdomen
☐	☐	Musc/skel
☐	☐	Skin
☐	☐	Head/neck
☐	☐	Ears
☐	☐	Lungs
☐	☐	Lymph
☐	☐	GU if medically indicated
☐	☐	Neruol
☐	☐	Mental Status

Immunizations

☐ Up to date ☐ Unknown

Medications

Section 4 Diagnosis and Comments

In the following section, please list any acute or chronic conditions if known.

Diagnoses: ☐ None

1. _____
2. _____
3. _____

Comments

Section 5 Follow Up

Describe follow-up needed

Section 6 Approval and Signature

Provider Name

Provider Signature

Date

Clinic Name

Telephone Number

Appendix D. Foster Care Oversight Committee Charter

Workgroup Charter Foster Care Oversight Committee	
Purpose	The Foster Care Oversight Committee (FCOC) provides strategic oversight and expert recommendations to the South Carolina Department of Social Services (SCDSS) to improve healthcare outcomes for children and youth in foster care.
Scope	Operating within the SCDSS Healthcare Improvement governance structure, the FCOC works to enhance policies, procedures, and timely access to healthcare services for children and youth in care. The committee convenes statewide experts in medical, dental, and behavioral health, along with individuals with lived experience, to improve coordination, service delivery, and health outcomes.
Responsibilities	• Review healthcare outcomes of children and care and advise on performance improvement strategies. • Monitor implementation of Healthcare Improvement Plan (HCIP) activities. • Provides recommendations to strengthen care coordination and service delivery. • Promote cross-system collaboration amongst agencies and providers.
Goals	The FCOC aims to: • Support the provision of accessible, timely, and high quality healthcare services to children in foster care. • Promote effective care coordination through information sharing across providers and systems • Develop actionable recommendations to improve healthcare outcomes for children and youth in foster care.
Desired Outcomes	Within 30 days of entering foster care 85% of children and youth will have a detailed, comprehensive medical assessment and 95% within 60 days of entering care. • Within 30 days of entering foster care 85% of children and youth will have a comprehensive mental health assessment and 95% within 60 days of entering care. • Within 30 days of entering foster care 90% of children 36 months and under will have been referred for developmental assessment and 95% will have been referred within 45 days of entering care. • Within 30 days of entering foster care 60% of youth who have no dental exam within six months on record will have received a dental exam within 60 days of entering care and 90% within 90 days of entering care. • Within 30 days of entering foster care 95% children and youth should have an identified “preferred provider” which preferably is a part of a PCMH.

<table>
<tr><td></td><td colspan="4">Youth in foster care ages 3 and older will receive subsequent periodic preventative care, also known as a Well Child Visit (WCV) semi-annually.
Children in foster care ages six months to 36 months to receive periodic preventative care (WCV) in accordance with the AAP guidelines.
Children in foster care 6 months and under to receive monthly periodic preventative care (WCV).</td></tr>
<tr><td>Membership</td><td></td><td colspan="3"><table>
<tr><th>Name</th><th>Title</th><th>Role on Workgroup</th></tr>
<tr><td>Tim Nix</td><td>Director of Office of Child Health and Wellbeing, SCDSS</td><td>Sponsor/ Lead</td></tr>
<tr><td>Anna Bleasdale</td><td>Lead Nurse Manager, SCDSS</td><td>Knowledge around medical services / Co-Lead</td></tr>
<tr><td>Angela Carroll</td><td>Lead Clinical Specialist, SCDHHS</td><td>Knowledge around behavioral health services</td></tr>
<tr><td>Robert Linares</td><td>Medicaid Relationship Manager – Wellbeing, SCDSS</td><td>Expertise around Medicaid Practice and Policy</td></tr>
<tr><td>Ashley Sirianni</td><td>Assistant Medical Director, SCDHHS</td><td>Expertise around Medicaid Practice and Policy</td></tr>
<tr><td>Dr. Kathleen Domm</td><td>Select Health</td><td>Medical Expert</td></tr>
<tr><td>Dr. Jamie Moody</td><td>Mental Health Provider</td><td>Provides MH/BH expertise</td></tr>
<tr><td>Tracey Halasz</td><td>Pediatrician, MUSC Foster Care Clinic</td><td>Medical Expert</td></tr>
<tr><td>Dr. Greg Barabell</td><td>Pediatrician, Consultant</td><td>Medical Expert</td></tr>
<tr><td></td><td></td><td>Dental Expert</td></tr>
<tr><td>Shana Charles</td><td>Statewide Education and Non-Citizen Advocate</td><td>Education Expert</td></tr>
<tr><td>Christina Ricks</td><td>Foster Parent Liaison</td><td>Foster Parent Liaison</td></tr>
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<tr><td></td><td><table>
<tr><td></td><td>Foster Parent</td><td>Lived Experience</td></tr>
<tr><td></td><td>Foster Parent</td><td>Lived Experience</td></tr>
<tr><td></td><td>Former Foster Youth</td><td>Lived Experience (PRN)</td></tr>
<tr><td>Patrice White</td><td>Transitional Services and Support Director, SCDSS</td><td>Youth Lived Expert Liaison</td></tr>
</table></td></tr>
<tr><td>Meeting Frequency</td><td>The FCOC will meet on a monthly basis to:
Review implementation of HCIP activities
Monitor progress toward healthcare improvement goals
Serve as a shared space for the escalation of barriers, challenges, and successes observed or elevated by other interagency meetings, staffings, or as identified through other feedback mechanisms</td></tr>
<tr><td>Monitoring and Evaluation</td><td>The FCOC will conduct a bi-annual review of:
FSA Healthcare Measures
Progress on HCIP
System-level barriers and opportunities for improvement
Develop recommendations to address identified barriers and submit to the SCDSS OCHWB Leadership Team and the Deputy State Director of Child Welfare for consideration</td></tr>
</table>

APPENDIX E. REVISED DSS CARE COORDINATION MODEL

Definitions: R=Responsible A=Accountable C= Consulted I= Informed					
Within the first 48 hours of Entering Care					
Activity	**OCHWB**	**MCO**	**FP/KCG**	**DSS CM**	**CPA/GH PROVIDER**
Perform initial medical screen via the FAST medical module within the first 48-hours to – 1- Identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy (e.g. asthma, diabetes, seizure disorder), signs of abuse or neglect, signs of infection or communicable diseases (e.g. varicella, lice), hygiene, nutritional or dental problems, pregnancy, and significant developmental or mental health disturbances. 2- To identify health conditions that should be considered in making placement decisions.	A/C		I	R	I
Within 7 days of Entering Care					
Activity	**OCHWB**	**MCO**	**FP/KCG**	**DSS CM**	**CPA/GH PROVIDER**
Schedule initial appointment for comprehensive medical assessment (EPSDT). Enter scheduled appointment into CAIP/CAPSS to generate notification to FP/KCG, CM, MCO, CPA/GH	I	R/A	C	I	I
Collect historical behavioral and medical health data about the child from the birthparent and share relevant information with MCO Care Coordinator. Enter relevant information into the CAPSS Person screen to populate the child's Health and Education Passport.	A	I	I	R	I
SCDHHS to determine Medicaid eligibility and address discrepancies as needed and enroll child in MCO	C	R/A	I	I	I
Note: To support timely initial comprehensive medical assessments, SCDSS retains the responsibility for the initial well-child for children and youth who are not assigned to MCO within 7-calendar days of entry into care. Following assignment to an MCO Care Coordinator, the MCO assumes responsibility for meeting 100% of the healthcare need of children.					

Within 30 days of Entering Care					
Activity	**OCHWB**	**MCO**	**FP/KCG**	**DSS CM**	**CPA/GH PROVIDER**
Upon notification of assigned MCO Care Coordinator, reach out to the MCO to introduce self as case manager and inform MCO of CPA/foster parent or GH contact information		I		R/A	
Complete Initial CANS within 48 hours following the 25-day CFTM (document in CAPSS)		C	C	R/A	C
Send CPA/foster parent and case manager the foster care welcome packet for child		R/A	I	I	**I**
Coordinate and facilitate all Child and Family Team Meetings during this timeframe that are not CFTM Facilitator-Led and invite all pertinent team members (i.e. parents, child/youth if appropriate, private providers/caregivers, service providers, MCO)		C	C	R/A	C
Participate in all CFTM Facilitator-Led Child and Family Team Meetings during the first 30 days and provide pertinent team member information to the facilitator for invitations)		R	R	R/A	R
Collect historical behavioral and medical health data about the child from MCO and DHHS claims data	R/A	C		I	
Review child's immunization status and recommend any needed follow- up (MCO Care Coordinator enters information into CAIP/Health and Education Passport) R*= For non-citizens the OCHWB will be responsible for obtaining and following up. Additionally, if the MCO is unable to acquire this information from the healthcare provider they may request the OCHWB to acquire information and upload into CAPSS/CAIP.	R*/A*	R/A	I	I	I
Assign child to preferred provider and communicate selection to Foster Parent/CPA and case manager		R/A	I	I	I
Schedule initial dental examination		R/A	C	I	I
Follow up to confirm attendance of initial medical appointment		R/A	C	R	C

Within 60-days of Entering Care					
Activity	**OCHWB**	**MCO**	**FP/KCG**	**DSS CM**	**CPA/GH PROVIDER**
Request and Review findings from comprehensive medical assessment to determine if comprehensive mental health assessment is needed and/or any other follow-up care (EPSDT). This will be uploaded into CAPSS by OCHWB staff and generate a notification to CM, MCO, FP/KCG, and CPA/GH Provider. R*/A*= For non-citizens the OCHWB will be responsible for obtaining and following up. Additionally, if the MCO is unable to acquire this information from the healthcare provider they may request the OCHWB to acquire information and upload into CAPSS/CAIP.	R*/A*	R/A	I	I	C
If needed, call foster parent/ provider to inform of need for comprehensive mental health assessment and/or any other follow-up care		R/A	C	I	C
If needed, make appointment for comprehensive mental health assessment and/or any other follow-up care. MCO Care Coordinator to update information in CAIP to generate notification to DSS CM, FP/KCG, and CPA/GH Provider.		R/A	C	I	C
Confirm dental appointment completion		R/A	C	R	C
If needed, follow up on missed appointments and assist with rescheduling		R/A	C	R	C
Request and review findings from comprehensive mental health assessment to determine any need for follow-up behavioral health care. R*/A*= For non-citizens the OCHWB will be responsible for obtaining and following up. Additionally, if the MCO is unable to acquire this information from the healthcare provider they may request the OCHWB to acquire information and upload into CAPSS/CAIP.	R*/A*	R/A	C	I	C
If needed, make BabyNet referral (within 45 days)	R*/A*	R/A	I/C	I	I

Ongoing after Entering Care					
Activity	**OCHWB**	**MCO**	**FP/KCG**	**DSS CM**	**CPA/GH PROVIDER**
Create action items for all EPSDT visits according to periodicity and/or DSS requirements	R/A	I		I	
Reach out to foster parents to assist in scheduling all periodic EPSDT and dental visits		R/A	C	I	C
Follow-up to confirm that all required EPSDT visits occurred		R/A	C	R	C
Review findings of periodic EPSDT visits and create action items for all required follow-up care and confirm follow-up visits occurred. R*/A*= For non-citizens the OCHWB will be responsible for obtaining and following up. Additionally, if the MCO is unable to acquire this information from the healthcare provider they may request the OCHWB to acquire information and upload into CAPSS/CAIP.	R*/A*	R/A	I		I
Reach out to foster parents to assist in scheduling all follow-up care and visits identified from periodic EPSDT visits		R/A	C	I	C
Follow-up to confirm follow-up care and visits occurred		R/A	C	R	
If needed, follow up on missed appointments and assist with rescheduling		R/A	C	R	
Notify MCO of any criteria changes for escalation to care management within 1 business day of becoming aware of emerging needs	R/A	C		I	
Enroll child in care management based on confirmed level of need within 5 business days	C	R/A	I	I	
Coordinate and facilitate all Child and Family Team Meetings that are not CFTM Facilitator-Led and invite all pertinent team members (i.e. parents, child/youth if appropriate, CPA/GC providers/caregivers, service providers, MCO)		C	C	R/A	C
Participate in all CFTM Facilitator-Led Child and Family Team Meetings and provide pertinent team member information to the facilitator for invitations		R	R	R/A	R

CANS is completed at a minimum of every 90 days, prior to any FPP revisions, reunification, foster care exit, and/or CFTM		C	C	R/A	C
For initial and on-going re-assessment, if a behavioral health need is identified CM develops or revises goal in Family Permanency Plan (FPP). All health and dental related information is entered into Health and Education Passport		C	C	R/A	C
If a child is denied a service by the MCO, SCDSS OCHWB staff will assist the case manager and caregiver in filing an appeal through the MCO appeals process.	R/A	C	C/I	C	C/I
If the appeal decision is upheld by the MCO, SCDSS may request a Fair Hearing through SCDHHS.	R/A	C	C/I	C	C/I

STAFFING TO SUPPORT CARE COORDINATION MODEL

Staffing Levels to Support the Care Coordination Model	
DSS Office of Child Health and Well-Being	
10	Registered Nurses – Responsible for supporting clinical consultation, medication management, training and case staffing, coordinating with the MCO foster care unit to ensure that every child is linked to the care coordination/management and services they need, monitor care quality provided by MCO network and out of network specialty care, review Medicaid health, behavioral health, and dental data, and troubleshoot cases referred from the field. *Note: includes one dental nurse and one nurse manager.*
6	HQICs- Conducts reviews CAPSS to ensure all youth who have been in care for 30 days have had a completed Well-Child, Dental or Mental Health Assessment to include oversight of vision and health screening information. For those records that have not been received, coordinates with the Case Managers to ensure that appointment occurred.
3	Medicaid/MCO Relationship Manager, Medicaid/MCO Relationship Coordinator, FC Health Liaison – Responsible for annual network adequacy review, managing the MCO/DSS relationship, and manage denials and appeals, select health rounds.
4	Data Analytics and Reporting – Responsible for handling healthcare improvements to CAPSS, daily feeds to DHHS and the MCO, manage and configure data shared from DHHS, the MCO, and other data sources and produce data reports for the field
10	Regional Clinical Specialists- Provides clinical assistance when needed to local interagency staffing's, works closely with case managers to identify therapeutic placement needs and approve higher levels of care, prepares prior authorization materials for Select Health, participates in continued stay reviews, documents psychiatric red flag Staffing's in CAPSS, and provides clinical consultation for assessments.
Total – 33	

Staffing Levels to Support the Care Coordination Model	
DSS Case Managers	
1 case manager: 15 children (Foster Care)	DSS will commit resources to meet the approved caseload standards in compliance with the approved interim enforceable targets.
1 case manager: 15 children (Permanency)	DSS will commit resources to meet the approved caseload standards in compliance with the approved interim enforceable targets.

Staffing Levels to Support the Care Coordination Model	
Care Coordination/Management – The MCO's Integrated Health Care Coordination program uses a holistic approach to evaluate members' physical and behavioral health needs. The program is built on a population health management approach that uses key clinical and nonclinical characteristics, including triggers, to segment the population by risk level and to design and implement tiered interventions appropriate for the level of risk. The MCO will collaborate with DSS and the foster parent to ensure that all initial physical and behavioral health assessments occur. These standards can be found on the SCDHHS website where an MCO contract template is posted: MCO Reference Materials | SCDHHS.	
MCO Foster Care Unit	
10	Nurse Case Manager
13	Nurse Intensive Case Manager
3	Behavioral Health Case Worker
4	Behavioral Health Case Manager
11	Care Connecter
4	Resource Coordinators
3	Supervisors
1	Manager
1	Director
1	Medical Director
Total - 51**	**These resources will be dedicated exclusively to the foster care management unit. In addition to the resources committed to the foster care management unit, the MCO will draw upon its other resources/expertise within its care management structure to meet the commitments outlined in the care coordination model.

**Disclaimer- Staffing levels are subject to change based on contract needs.



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