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

Paul Vincent

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

PROGRESS REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

April 1 - September 30, 2021

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I. Introduction

This report covers the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA)[1] entered in *Michelle H., et al. v. McMaster and Leach*, for the period April 1 through September 30, 2021.[2] Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the approximately 4,000 children in foster care in South Carolina and incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] The report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Elissa Gelber, Rachel Paletta, Gayle Samuels, Ali Jawetz, and Sarah Esposito. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs); and the public.

The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the care of their parent(s) or guardian(s) and placed in DSS's custody, and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system. It was crafted by state leaders and Plaintiffs to guide a multi-year reform effort on behalf of children in DSS's custody. The FSA includes specific provisions governing: the workloads of case managers and supervisors; visits between children in foster care and their case managers; family time, or visits between children in foster care and their parents and siblings; investigations of allegations of abuse and/or neglect of children in foster care by a caregiver; appropriate placements; and access to timely physical and behavioral health care. It also includes provisions which required DSS to complete assessments before designating specific performance outcomes, benchmarks, and timelines. Within this structure, the Co-Monitors worked closely with DSS and Plaintiffs between 2017 and 2019, leading to the development of

[1] Final Settlement Agreement (October 4, 2016, Dkt.32-1)
[2] FSA Section III.D. requires the Co-Monitors to issue reports approximately 120 days after the close of each reporting period, or after the State and/or DSS produces the necessary data to the Co-Monitors.
[3] The class of children covered by the FSA includes "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" (FSA II.A.).
[4] Consent Immediate Interim Relief Order (September 28, 2015, Dkt. 29)

Implementation Plans approved and ordered by the Court.[5] The intention was that these Plans – the implementation of which are tracked by the Co-Monitors – would provide blueprints and accountability for the reform work ahead.

In addition to the Implementation Plans, the Court has issued subsequent Orders since entry of the FSA. These include the Joint Report of Plaintiffs and Defendants (Joint Report), entered in July 2019, specifying priority action steps DSS would take in light of shortfalls in the State FY2019-2020 budget, while it awaited the FY2020-2021 appropriation from the South Carolina General Assembly.[6] When the COVID-19 pandemic further delayed the budget process and the prospect of an adequate appropriation, the Court entered the COVID-19 Pandemic Response Mediation Agreement (Mediation Agreement) in July 2020 to codify further agreement by the Parties regarding what steps DSS was required to take before July 2021.[7]

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

Included in this report is a summary of the Co-Monitors' general findings, followed by a detailed discussion of DSS's performance with respect to the FSA requirements, as well as updates on the implementation of strategies contained in each of the court-ordered Implementation Plans.[9,10] In order to make the report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about key developments beyond September 30, 2021 (the end of the monitoring period), where applicable.

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[5] *See* Court orders approving Workload, Placement, and Health Care Plans (February 27, 2019, Dkt. 109) and Visitation Plan (April 3, 2019, Dkt. 115)
[6] Joint Report of Plaintiffs and Defendants to the Honorable Richard Gergel (July 22, 2019, Dkt. 145)
[7] COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201)
[8] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).
[9] Pursuant to FSA III.K., "The Co-Monitors shall not express any conclusion as to whether Defendants have reached legal compliance on any provision(s)."
[10] To see all Implementation Plans and Addendums for the *Michelle H.* Final Settlement Agreement, go to: https://dss.sc.gov/child-welfare-reform/

II. Summary of Performance

During this monitoring period, the COVID-19 pandemic continued to intensify the pressure on the child welfare system in South Carolina – a system already under resourced and struggling to engage and support families in meaningful, strength-based ways. Under the leadership of Director Leach, DSS worked to push its reform efforts forward where possible, despite challenges. Disbursement of funding from the General Assembly in July 2021 helped DSS to make slow but steady progress in some areas, including salary increases for staff, the placement of children outside of institutional settings (meeting one of the related FSA targets for the first time), and the identification of kin resources for children taken into DSS custody.

Despite staff effort, much work remains. A lack of sufficient fiscal resources; an inadequate system for placement and community supports; a need for more robust agency partnerships; and a new approach to the engagement of children, families, and community providers continue to prevent DSS from meeting the requirements of this lawsuit. As a result, DSS has been unable to actualize the goals of its leadership team or change the outcomes and experiences of the thousands of children and families that have been involuntarily brought under its care.

Caseloads

High caseloads for case managers and supervisors continue to be a challenge. Although there were small improvements noted for Out-of-Home Abuse and Neglect (OHAN) investigators and adoption case managers, less than half of all case managers had caseloads within acceptable limits in September 2021. Record high staff attrition made it consistently more difficult for DSS to give staff any relief. Between April and June 2021, DSS lost 10 percent of its staff – the highest percentage of staff exits during one quarter since 2018. The pace of turnover began to slow towards the end of the monitoring period – with seven percent of child welfare staff leaving their positions between July and September 2021 – suggesting that the implementation of long-awaited case manager salary increases in July 2021 may help sustain and maintain staff going forward. As long as caseloads and staff turnover remain high, case managers' ability to authentically engage families, maintain meaningful connections between children and the family members from whom they have been separated, and effectively plan for children to return home, will be limited.

Family Time

DSS's woefully inadequate performance with respect to maintaining and supporting connections between children in foster care and their family members demonstrates the need for more manageable caseloads and a shift in approach to engaging families. In September 2021, only 17 percent of children visited twice with the parent(s) with whom they are to reunify, as required by DSS policy. The records of more than half (57%) of the children reflected *no* documented contact of any kind, either in person, by video, or by phone with the parent(s) with whom the child is to reunify. In addition, only half (50%) of all siblings in foster care and living apart during the month of September 2021 had any contact during that month. This is despite DSS efforts to emphasize the importance of family time through the distribution of practice resources, visitation awareness trainings, and improvements to electronic records systems to make the documentation of visits less burdensome.

Placements

DSS's progress in further reducing reliance on congregate care during this period – particularly for children ages 12 and under – is a significant accomplishment. The continued increase in placement with kin, and slow but steady shift to embracing a mindset that children belong with their families and loved ones, whenever possible, has the potential to have profound consequences for families in the long-term. For now, however, the identification and maintenance of appropriate placements and supports for children in foster care continues to be a substantial challenge for DSS.

An Escalating Placement Crisis

During this period, placement decisions continued to be based on availability rather than on the unique needs of children. This often resulted in children being placed far from their home communities and schools, and separated from their siblings, family members, and other important people in their lives, sometimes without opportunities for contact. A lack of community-based services has meant that some potentially supportive placements cannot be considered or sustained. These long-standing systemic issues, combined with the realities of the COVID-19 pandemic – ubiquitous staff shortages, overtaxed agency partners, closures of some placements, and exhaustion at all levels – have led to an ever-increasing number of children being held at DSS offices for days or even weeks at a time while DSS searches for appropriate and stable placements. Sometimes these children sleep in offices, and sometimes they are driven to emergency placements for a few hours at night, only to return to

the office the next morning. This trend began toward the end of the prior monitoring period and has continued to escalate to an unprecedented degree. The lack of so much as a stable place to stay sends the message to children who have already been separated from their loved ones that they are not cared for, and makes the maintenance of a sense of stability, continuity in education, and connections to community services near impossible. Some children have reportedly begun to refuse to go to placements that they know are temporary and will not meet their needs, expressing that they would prefer just to wait it out at a DSS office.

Lack of Progress on Placement Implementation Plan

The realities of children staying overnight in DSS offices throughout the state present an acute and immediate challenge for DSS, but, on a broader scale, the trend is symptomatic of significant underlying gaps in implementation of the Court approved Placement Implementation Plan to which DSS committed in early 2019. Meaningful change will be difficult or impossible to achieve without an influx of resources and strong partnerships with other state agencies to ensure that an adequate placement array is developed, and a system of robust community supports is in place. The lack of flexible, intensive home- and community-based resources to support children and foster and kinship providers throughout the state remains a primary concern, as reiterated throughout this report.

Several consistent themes have been highlighted during recent discussions the Co-Monitors have had with DSS staff who have been on the front lines of these placement challenges. These include lack of flexibility or stringent rules and low tolerance for typical adolescent behavior resulting in placement disruptions;[11] limited family-based placements in the state willing to accept older youth; fragmentation in staffing and processes used to identify placements; and lack of services and supports for children, families, and foster parents. A sense of exhaustion has been reported, as more children wait longer periods of time in DSS offices.

As discussed further in Section VIII. *Placements*, there remain important elements of the Placement Implementation Plan that DSS has only partially acted upon or has not yet initiated that have the potential to address placement challenges and bring about long-term change. These include a fully implemented and robust Child and Family Teaming (CFT) process, real partnership with private providers, opportunities to pilot

[11] For example, limiting children's' access to technology when it is their sole method for communicating with friends and/or family; requiring a child to leave a placement after breaking curfew.

programs in targeted areas, and performance-based contracting to incentivize aggressive resource development.

Ongoing Data Capacity Limitations

DSS remains unable to provide performance data with respect to a number of important FSA placement measures. As discussed further in Section VIII. *Placements*, this makes tracking of performance improvement in some areas difficult to impossible.[12]

Health Care

DSS's Office of Child Health and Well-Being continues to serve an important function in documenting and coordinating the health care needs of children in DSS's care. Despite best efforts, DSS is not yet seeing anticipated improvements in ensuring timely initial comprehensive health assessments and periodic well visits for all children, and significant gaps in data capacity and the provision of care remain.[13] DSS's health care infrastructure has been further strained by the demands of the COVID-19 pandemic, which has contributed to vacancies in DSS's already limited nursing staff. It continues to be essential that DSS obtain the resources it needs to do this important work, and that DSS intensify its efforts with the state's Medicaid and mental health agencies and with community partners to develop an array of community treatment and support services that are accessible to children and their families and caregivers. DSS must maximize all funding sources available to provide for children's health and behavioral health care needs, including Medicaid and other federal funding streams.

[12] These include: FSA IV.E.4-5 (placements in emergency settings for more than 30 days; or more than 7 days if more than one emergency placement in 12 months); FSA IV.I.2-3 (completion of interagency staffings and diagnostic assessments to determine eligibility for therapeutic foster care); and FSA IV.I.4-5 (appropriate therapeutic foster placement aligned with assessed need). In addition, shortly before publication of this report, DSS discovered errors in its placement instability data that led it to conclude that these data, which had been collected, analyzed, and provided to the Co-Monitors, were not valid. As a result, accurate and validated performance data with respect to this measure for the period October 2020 through September 2021 could not be included in this report.

[13] As discussed further in Section X. *Health Care*, DSS is not able to produce data with respect to the provision of: Initial Medical Screens (pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020); Initial Mental Health Assessments (pursuant to the DSS Addendum to the Health Care Improvement Plan, these data were also to be reported for all children entering DSS custody between October 2019 and March 2020); or Follow-up Care (pursuant to the DSS Addendum to the Health Care Improvement Plan, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019). Though DSS has provided data with respect to Periodic Preventative Medical Care and Periodic Dental Care, complications with producing reliable data in accordance with approved methodologies have sometimes prevented the inclusion of these data in monitoring reports.

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

Although progress toward some FSA requirements remains stagnant, OHAN staff have continued to show steady growth in meeting the timeframe for responding to allegations of abuse or neglect of children in foster care – a vital practice for assessing children's safety. OHAN leadership and staff have continued to collaborate with Co-Monitor staff in reviewing and reflecting on their practice and have displayed a deepening understanding of best practice in this area. As discussed in prior reports, the unit has been hamstrung in large measure by a persistent lack of resources. The recent addition of a significant number of new staff positions in this unit is a strategic investment by DSS that is likely to pay dividends.

Opportunities Ahead

Looking ahead, though staff attrition is likely to continue to be a challenge, as it is across the country in the wake of the COVID-19 pandemic, DSS leaders are hopeful that the case manager salary increases, which will continue to be implemented over the coming months, will attract new candidates and incentivize a greater number of workers to remain at DSS. A review currently underway, by the Co-Monitors and DSS, in partnership with the Department of Juvenile Justice (DJJ) and community stakeholders, will assess the needs and barriers for children who are involved with both DSS and DJJ, in an effort to learn how to better meet their needs. There is also opportunity for deeper partnership with the new leadership team at the South Carolina Department of Health and Human Services (DHHS), and other cross-agency collaboration, maximizing the use of Medicaid-funded services to expand the array of available community-based supports. Implementation of key elements of the Placement Implementation Plan, which have long been delayed – performance-based contracting, in which DSS would work with private providers to develop a continuum of care aligned with goals to shift away from congregate care and develop more family supports; fully implementing a robust safety monitoring process to address unsafe placements for children as part of its Continuous Quality Improvement (CQI) efforts; further implementing decision-making and family engagement in the context of Child and Family Teams; developing wraparound crisis intervention services, particularly for kin caregivers; and piloting and refining these and other reforms in several geographic areas of the state – have the potential to have a broad-scale impact across areas of practice. Designation of some of the more than $2 billion in new federal COVID-19 funds available to the state to DSS priorities could allow it to move forward on many of the strategic priorities that have long been

stalled due to lack of funding.[14] Taken together, these steps could significantly change the experiences of children and families who have long been waiting to feel the impact of the legal action brought more than five years ago on their behalf.

[14] See Section III. *Background* for more information on the American Recovery Plan Act (ARPA)

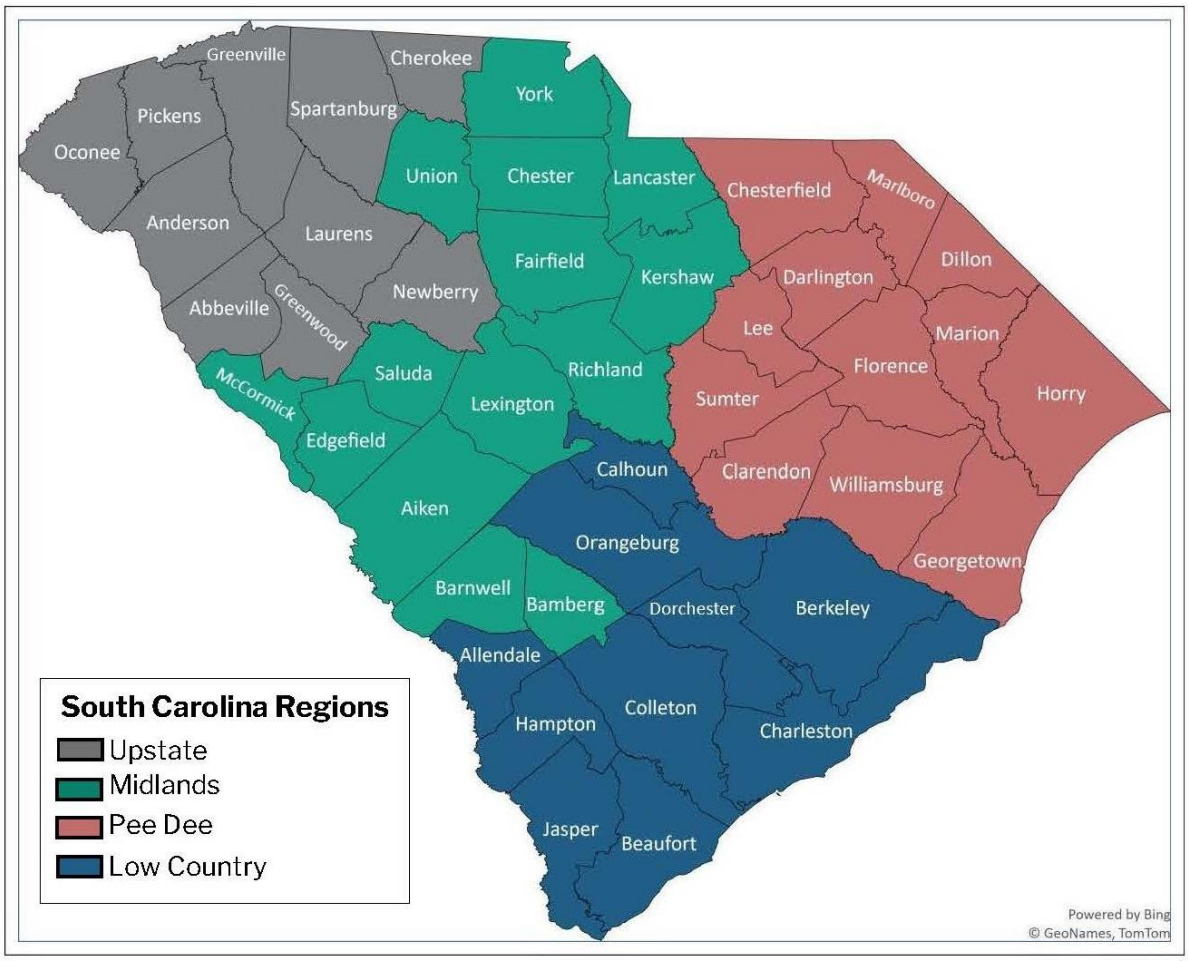
III. Background Information

South Carolina Department of Social Services: Structure and Mission

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

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

Figure 1: South Carolina Counties by Region

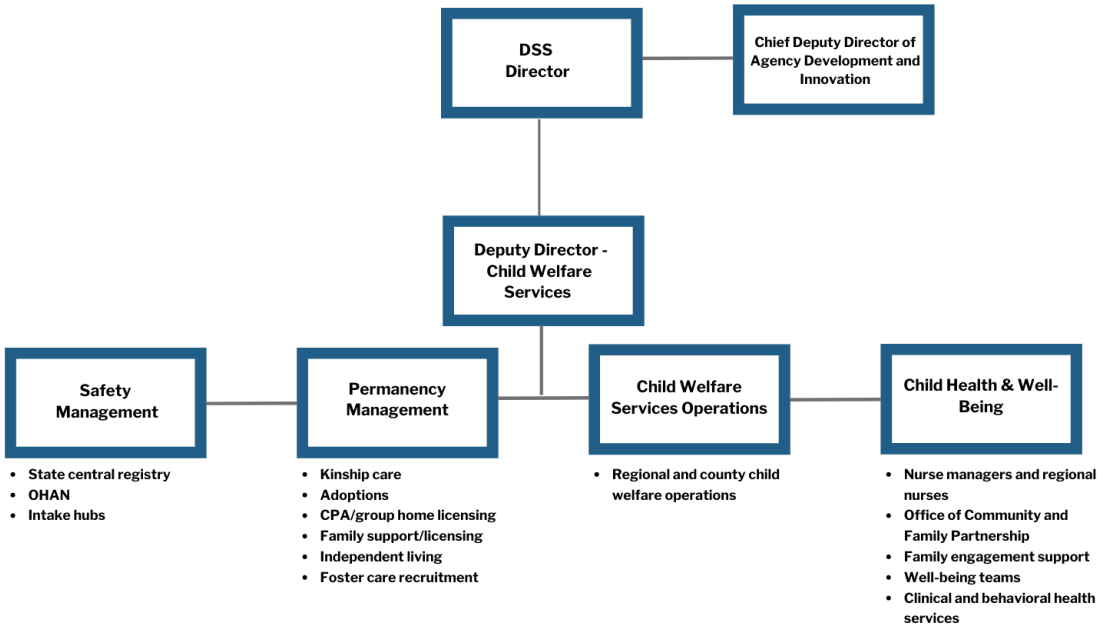


The FSA pertains to children who have been involuntarily removed from the custody of their parents or guardians due to abuse or neglect, and taken into the custody of DSS. These children reside in foster care or "out-of-home" care. DSS, along with its private agency partners, is responsible for caring for them on a temporary basis, preferably while the children remain with their siblings and reside with family members or someone else known to their family, while working to address safety issues so they can return home to their parents or guardians (referred to as reunification). When reunification is not possible, DSS must work towards another permanent, long-term plan, such as guardianship or adoption.

DSS's foster care work is part of its Child Welfare Services Division, overseen by Deputy Director of Child Welfare, Karen Bryant. The Child Welfare Services Division is organized into four primary areas of focus: Safety Management, Permanency

Management, Child Welfare Services Operations, and Child Health and Well-Being.[16] Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

Figure 2: DSS Child Welfare Services Division Organizational Chart



Foster Care Budget and Financing

Federal law establishes legal mandates and provides financial support to child welfare systems through a number of sources and has shown "long-standing interest in helping states improve their services to children and families."[17] Specifically, the federal Children's Bureau, within the Administration for Children and Families, distributes funds to states through mandatory spending programs authorized through the Social Security Act. The largest of these programs is authorized under Title IV-E of the Social Security Act and operates as an "open-ended" matching fund source, meaning states are entitled to receive reimbursement for a portion of every dollar spent on behalf of an "eligible" child.[18] Eligibility depends on the income level of

[16] A fifth area of focus – Performance Management and Accountability – was moved out of the Child Welfare Services Division. This function has been incorporated into the work of the Department's Policy and Continuous Quality Improvement (CQI) Division. Additionally, the Child Fatalities and Near Child Fatalities Unit has been moved under Performance Management and Accountability.
[17] Stoltzfus, Emilie (July 30, 2018). Child Welfare Funding in FY2018. Congressional Research Service. https://fas.org/sgp/crs/misc/R45270.pdf
[18] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).

the parent(s) from whose custody the child was removed. Even if a child's case is found to be Title IV-E eligible, reimbursement is allowed only for specific portions of certain eligible expenses. For example, states receive 50 percent reimbursement for eligible administrative costs, 75 percent reimbursement for eligible training costs, and reimbursement at the Medicaid matching rate (see below) for board payments.[19] The maximization of federal funding available through Title IV-E has been a priority under Director Leach's tenure. As of January 2021, 45.2 percent of children in foster care meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[20]

Nearly all children in foster care are eligible for Medicaid, another important source of revenue for state child welfare systems. States paying for Medicaid services included in federally approved state plans and waiver programs receive federal matching funds for state expenditures at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate is currently 76.95 percent, due in part to an increase authorized in federal COVID-19 legislation.[21] This means that for every dollar South Carolina spends on a Medicaid-reimbursable service, the federal government reimburses the state almost 77 cents. This is both a considerably higher rate than the reimbursement rate for most expenditures under Title IV-E and one that can be applied broadly to *all* children in foster care. Medicaid reimbursement is not limited to services for children who meet the Title IV-E eligibility requirement. 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.[22] Medicaid can be used to cover non-direct health care services, such as behavioral health services, and services as part of therapeutic foster care. Many states have also used Medicaid to support health care case

[19] Section 474(a)(3)(A),(B),(C),(D), and (E) of the Social Security Act

[20] In February 2018, the federal Family First Prevention Services Act (FFPSA) was passed to promote placement of children in family foster care settings as opposed to congregate care settings, and to allow states to use federal IV-E funding to provide evidence-based prevention services in the community to reduce the need for out-of-home placement. FFPSA prevents federal reimbursement of congregate care facilities that do not meet the new criteria for a Qualified Residential Treatment Program (QRTP), which include: a trauma-informed treatment model, on-site registered or licensed nursing and clinical staff, inclusivity of family members in treatment planning, offering aftercare support 6 months post-discharge, and accreditation by a select group of bodies. (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)). In February 2022, the Children's Bureau approved South Carolina's five-year Family First Prevention Services plans. If statutory requirements are met, this will enable the state to access to federal funding to help families stay together and prevent entry into foster care. DSS has been working with community and agency partners on developing implementation strategies. To see South Carolina's Family First Prevention Services plan, go to: https://dss.sc.gov/media/3284/south-carolina-dss-title-iv-e-prevention-plan.pdf

[21] 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/

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

management for children in foster care. South Carolina is largely not utilizing the options for reimbursement of these costs for children in foster care. In addition, the federal government recently issued guidance that increases the reimbursement rate for state expenditures on qualifying community-based mobile crisis intervention, so that states can receive an 85 percent federal match for these services for the first three years.[23] South Carolina has not indicated intent to utilize this option. Though DSS and DHHS leaders have stated interest in exploring ways of tapping into this funding, there has been little to no progress in this area. The recent surge in the number of children staying in DSS offices overnight, or placed out of state, highlights the urgency in quickly expanding Medicaid-funded behavioral health services.

State funding for foster care in South Carolina is allocated on an annual basis through the General Assembly agency appropriation process. The state fiscal year in South Carolina is from July to June, spanning two calendar years.[24] South Carolina's budget process begins in July or August of the year preceding the start of the new fiscal year when the Governor sends budget instructions to state agencies. Agencies generally submit their budget requests to the Governor between September and November, detailing every new and recurring dollar they plan to spend in the following year, and those items that will require state funding. Agencies are also required to estimate anticipated federal funding, and other considerations. In November, upon instruction from the Governor, the state Board of Economic Advisors issues an initial forecast of economic conditions to give the Governor and lawmakers a sense of how much revenue will be available for expenditure in the coming year. In early January, the Governor submits the Executive Budget to the General Assembly. Both houses of the state legislature review the budget, initially in committee (the House Ways and Means and Senate Finance Committee), and ultimately pass budgets through full floor votes. If the House and Senate versions of the budget do not match, a conference committee consisting of both House and Senate members is assembled to reconcile differences. The legislature must pass a budget with a simple majority by the beginning of the fiscal year, July 1. The Governor may exercise line-item veto power on the enacted budget.

[23] To see the December 28, 2021 Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, go to: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

[24] Throughout this report and in accordance with state practice, fiscal year designations reference the July year in which funding is allocated, and the June year in which the fiscal period ends. For example, FY2021-2022 references the period from July 2021 through June 2022.

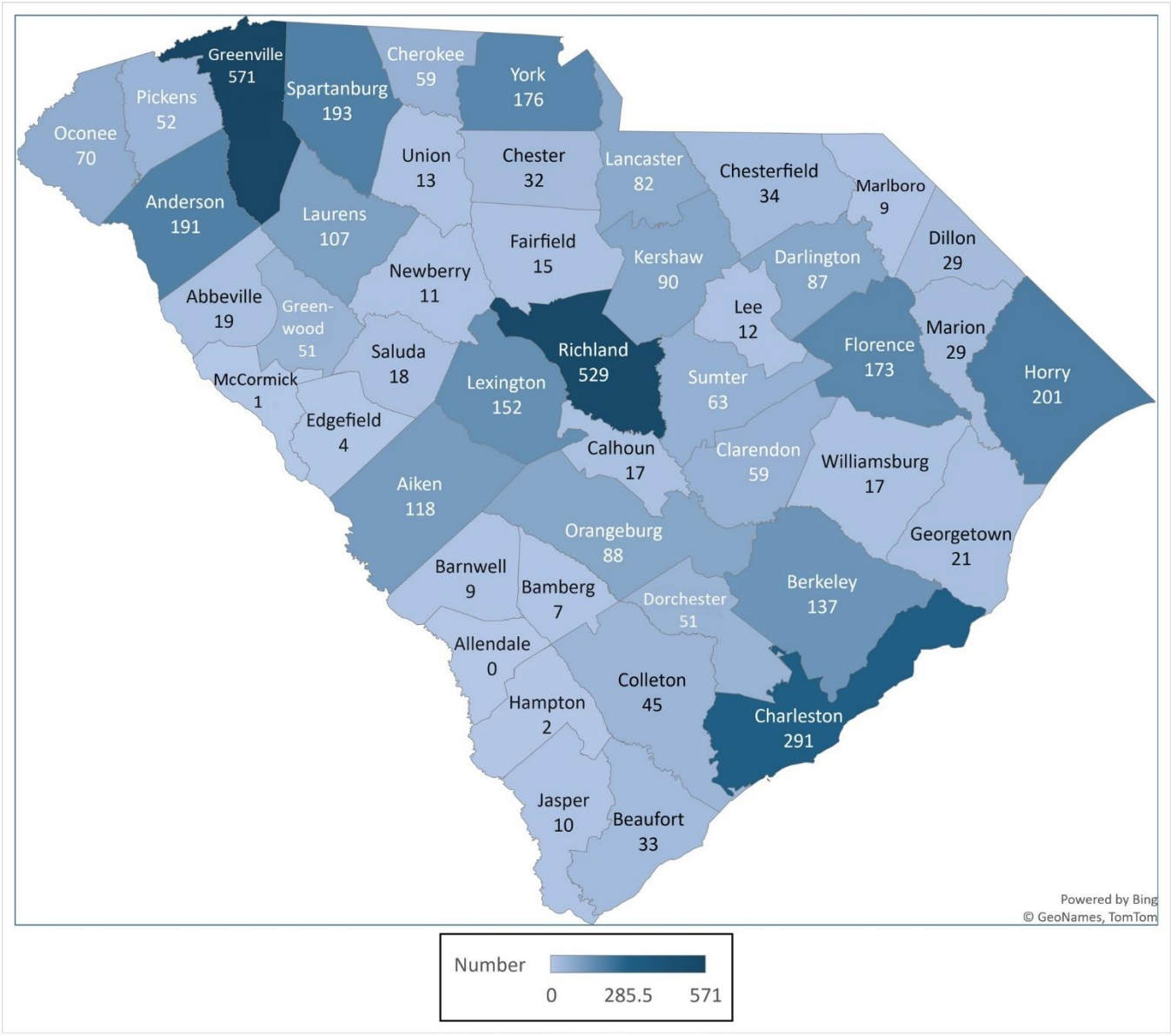
Population and Demographics of Children in Foster Care

Over 1.1 million children under the age of 18 resided in South Carolina in 2020; during the monitoring period, 5,270 children were in foster care at some point.[25,26] DSS regularly publishes real-time data about children in out-of-home care on its public website.[27] Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care. On January 3, 2022, for example, 3,978 children were in DSS's custody, and 1,451 (36%) of these children had been in foster care for 24 months or longer.

The map in Figure 3 shows the number of children from each county in foster care as of January 3, 2022, ranging from none to 571. As expected, counties with larger numbers of children in foster care typically correspond to counties with a higher overall child population. For example, Richland County, where Columbia, the state's capital and largest city is based (total child population 88,924), had the second-highest number of children in foster care in the state, at 529. Allendale County, a primarily rural county and the least populous in the state (total child population 1,655), had no children in foster care on January 3, 2022. Differences among counties contribute to a variation in accessibility of services and programs, and distances that case managers, families, and children in placement must travel to spend time in person with one another, receive treatment, or attend appointments.

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

Figure 3: Number of Children in DSS Custody by County as of January 3, 2022[28]



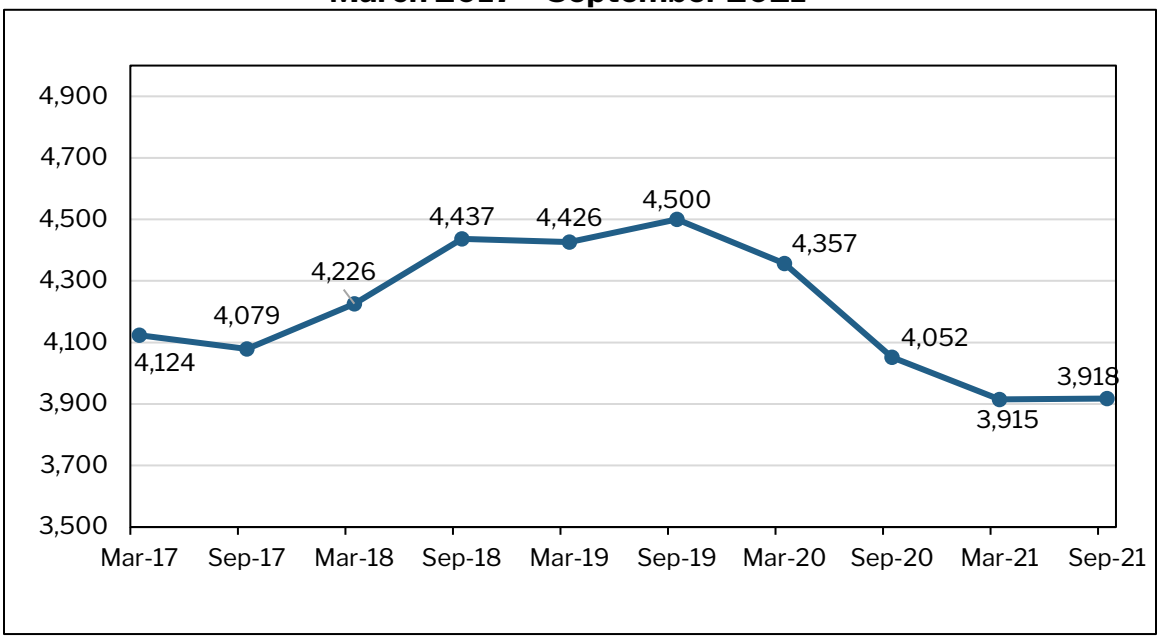
Source: Data from DSS data dashboard, 1/3/22[29]

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

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

The foster care population remained relatively stable from the end of the prior monitoring period (when there were 3,915 Class Members in foster care on March 31, 2021), as seen in Figure 4.[30] As seen in Table 1 and Figure 5, 1,525 children entered foster care and 1,500 children exited foster care during this monitoring period.[31] On September 30, 2021, the last day of the monitoring period, there were 3,918 Class Members under 18 years old in foster care.

Figure 4: Class Members in Foster Care
March 2017 – September 2021[32]



Source: CAPSS data provided by DSS

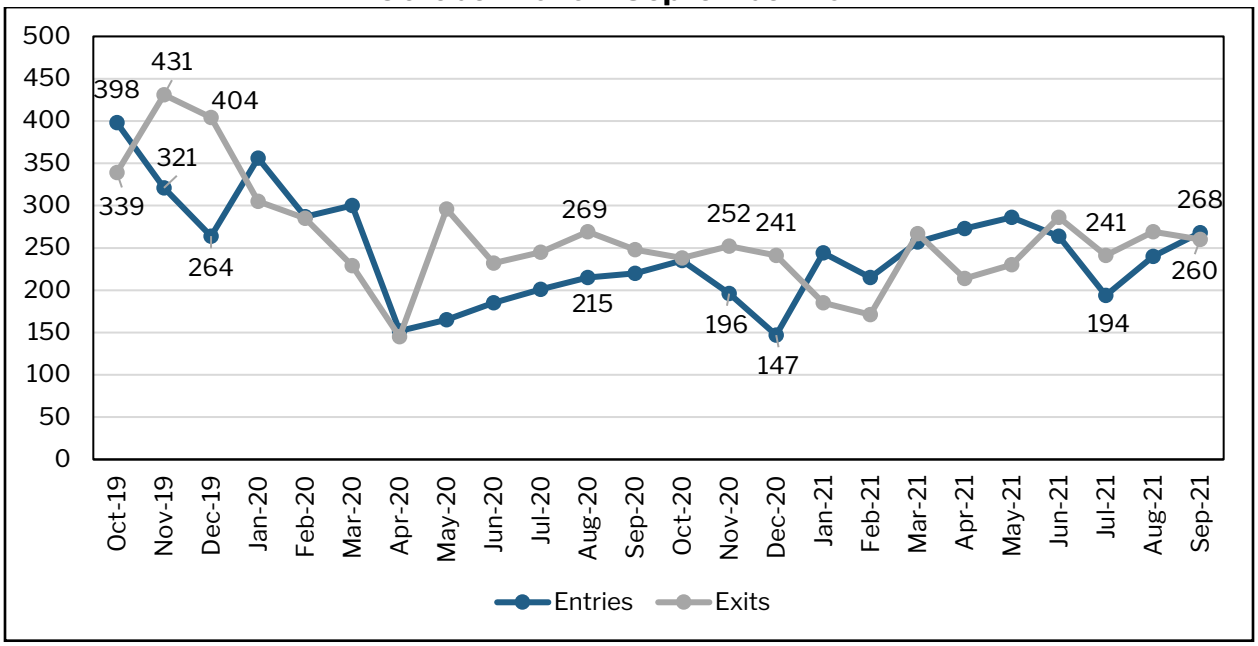
[30] These data do not include children who resided in other institutional settings on the last day of the monitoring period.
[31] These data may include children in foster care who do not fall within the definition of Class Members as per the FSA.
[32] These data do not include children who resided in other institutional settings on the last day of the monitoring period.

Table 1: Foster Care Entries and Exits
April – September 2021

Category	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
Children Served	4,199	4,271	4,304	4,210	4,209	4,203
Entries into Care	272	286	264	192	240	266
Exits from Care	214	231	286	241	272	264
Children in Care on the Last Day of Month[33]	3,985	4,040	4,018	3,969	3,937	3,939

Source: CAPSS data provided by DSS

Figure 5: Foster Care Entries and Exits
October 2019 – September 2021

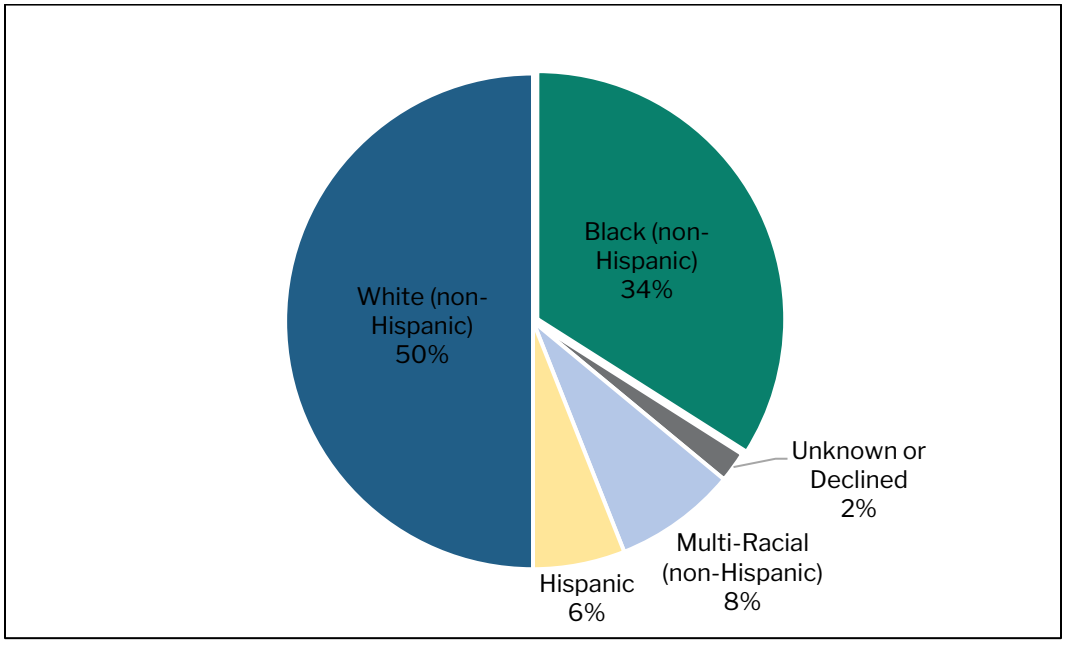


Source: CAPSS data provided by DSS

[33] Some Class Members who are placed in institutions such as hospitals or correctional facilities are included in these data, but excluded from the applicable population for the purpose of measuring performance on some FSA measures. This may result in slight differences between these data and data included in Figure 4 (also included later in this report).

As shown in Figure 6, when comparing race and ethnicity of children in DSS custody to that of the total child population in the state, representation appears slightly disproportionate: 50 percent of children in foster care are identified as White compared to 57 percent of all children in the state; and 34 percent of children in foster care are identified as Black compared to 31 percent of all children in the state. Though Hispanic is an ethnicity and not a race, the calculations herein for White, Black, and Multiracial do not include Hispanic children; those who are indicated to be Hispanic are instead included in the "Hispanic" category.[34]

Figure 6: Population of Children in DSS Custody by Race[35]
as of November 30, 2021
N=3,978



Source: Data pulled from CAPSS on 1/1/22, for children in foster care on 11/30/21

When data on race are analyzed by county, certain areas show a larger disproportionality for Black children. Table 2 depicts specific data from the six largest counties in the state:[36]

[34] DSS does not record Hispanic or Latinx as a category in race data published on its public dashboard but does capture Hispanic ethnicity as a category in placement data. The Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, including 11 children who were indicated as both Black and Hispanic, and 58 children who were indicated as both Multiracial and Hispanic.
[35] Data were rounded to whole numbers. The population of Asian, American Indian or Alaskan Native, and Native Hawaiian or Other Pacific Islander children were each <0.1%.
[36] To see DSS's current race data, go to:http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

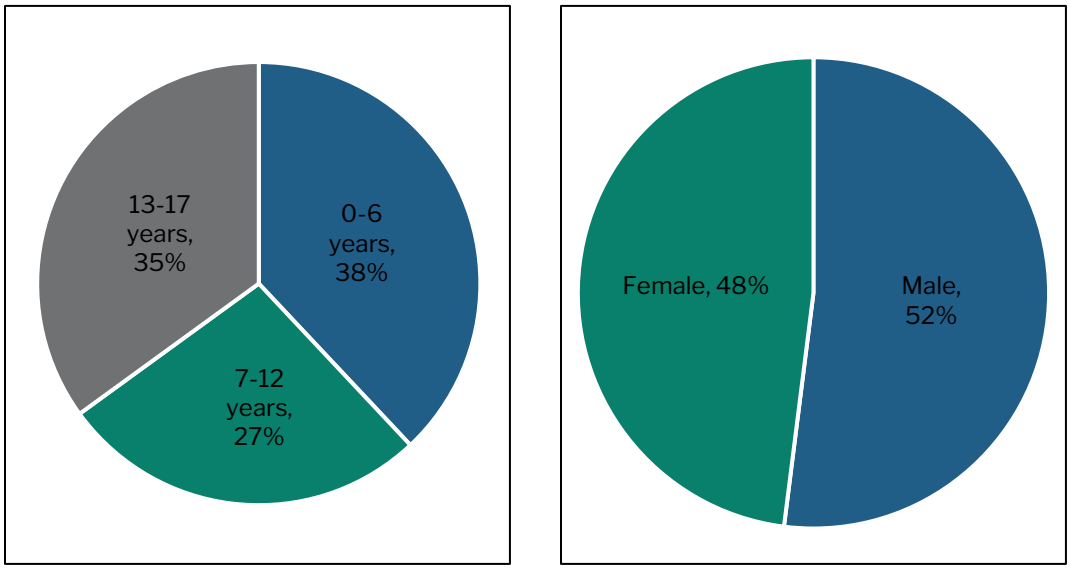
Table 2: Representation of Black Children in Foster Care in DSS's Largest Counties

	Percentage of Black children in county population, 2019	Percentage of Black children in foster care, June 2020	Percentage of Black children in foster care, June 2021	Percentage of Black children in foster care, December 2021
Aiken County	30%	36%	38%	32%
Charleston County	32%	48%	55%	57%
Greenville County	21%	25%	21%	27%
Horry County	19%	25%	32%	30%
Richland County	56%	66%	61%	67%
Spartanburg County	24%	28%	25%	24%

Source: Data from DSS Dashboard and monthly All Placement reports, 6/30/20, 6/30/21, and 12/31/21, and Kids Count Data Center, 2019

In terms of age and gender, Figure 7 reflects that about one-third (35%) of children in the foster care population are adolescents (ages 13 to 17), 27 percent of children in the foster care population are between the ages of seven to 12, and 38 percent of children are ages six and under. Slightly less than half of children in foster care are reported to be female (48%).[37,38]

Figure 7: Children in DSS Custody by Age and Reported Gender as of January 3, 2022 N=3,978



Source: Data from DSS data dashboard, 1/3/22

[37] DSS does not collect data on children who identify as gender neutral or non-binary.
[38] As of January 3, 2022, DSS data indicate that gender identity was unknown for 4 children (<1%) in foster care.

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

IV. Fiscal Resources

In June 2021, the General Assembly passed the FY2021-2022 budget, allocating $28,914,239 in new state recurring funds to DSS for child welfare programs. As discussed in more detail below, this additional appropriation was meant to allow DSS to comply with its obligations to maintain prior increases in payments to foster parents and to increase salaries for case managers.[39,40] The allocation was $23,594,857 short of DSS's request, which had been estimated based on what DSS believed it would require in that year to comply with the obligations outstanding under the FSA at the time of its request.

In October 2021, DSS submitted its budget request for FY2022-2023 to Governor McMaster. In January 2022, the Governor submitted his Executive Budget to the General Assembly. Both include a request for approximately $39 million to DSS for child welfare programs. The General Assembly is currently considering this request. Further updates on the FY2022-2023 budget will be included in the following monitoring report.

The General Assembly also began discussions regarding the allocation of the approximately $2.4 billion in American Rescue Plan Act's (ARPA) State Recovery Fund in the fall. According to the federal legislation, this funding can be used for a broad range of post-pandemic rebuilding activities including: replacement of lost public sector revenue; supporting the COVID-19 public health and economic response and addressing economic harms to households, small businesses, nonprofits, and the public sector; and providing premium pay to eligible essential workers.[41] The Governor's Executive Budget includes requested allocations for ARPA funds, but does not recommend that they be utilized to support DSS recurring child welfare program needs.[42] DSS reports that there is not currently support from

[39] In May 2020, DSS utilized funding available as a result of COVID-related legislation to temporarily increase foster home board rates to the USDA-based rates of $20.03, $23.41, and $24.72 per day for foster family homes including kinship foster homes. DSS has since made this change permanent.
[40] See Table 3 for new salary schedule.
[41] To see the Overview of the Final Rule for the Coronavirus State and Local Fiscal Recovery Fund (SLFRF), go to: https://home.treasury.gov/system/files/136/SLFRF-Final-Rule-Overview.pdf
[42] The Executive Budget recommends that these funds be used for, among others, the "acceleration of construction, expansion, or improvements to our State-owned roads, bridges, highways, and interstates," and development of infrastructure related to water, sewer, and stormwater systems; the "protection of natural resources;" an expansion of Workforce Scholarships for the Future, which allows "residents to earn an industry credential or associate degree in high-demand careers like manufacturing, healthcare, computer science, information technology, transportation, logistics, or construction;" replenishment of the Unemployment Insurance Trust Fund; the construction of a new public health laboratory; and enhancements to "economic development efforts, specifically in the areas of Agribusiness, Motorsports, Manufacturing, and Research; and broadband expansion." More detailed information and the full budget request can be found at:

the Governor or the General Assembly for the use of ARPA funding to support ongoing child welfare priorities, and that there is a focus on using the one-time federal funds to "support investments in water, sewer, infrastructure and broadband expansion in the state."[43]

https://governor.sc.gov/sites/default/files/Documents/Executive-Budget/FY23%20Executive%20Budget%2001102022.pdf

[43] Letter to Judge Gergel by Michael Montgomery (November 16, 2021, Dkt. 226)

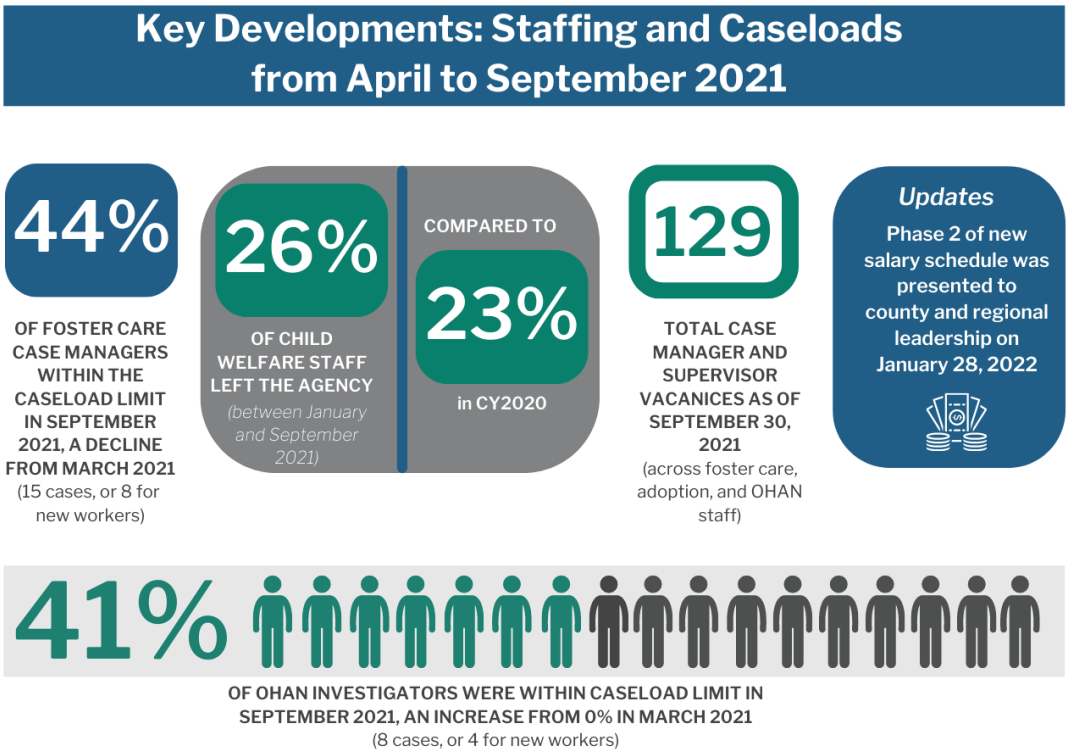
V. Caseloads

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system and has been a priority focus of DSS's reform. Case managers must have the skills, resources, and supports needed to engage families and providers in creating meaningful plans and monitoring progress towards individualized case goals, among many other important tasks.[44] Child welfare systems must ensure that the appropriate number and types of positions – including case managers, supervisors, and support staff – are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled by qualified staff with as little disruption as possible to families and other staff. Case managers also need training and supervision to ensure they have the knowledge and skills required to effectively carry out their roles and must be compensated with salaries and benefits that equate to a professional living wage so they can invest in and pursue their work as a career.

High caseload sizes for case managers and supervisors continued to be a challenge for DSS during this monitoring period. Although there were small improvements noted for Out-of-Home Abuse and Neglect (OHAN) investigators (from 0% meeting the standard of 1:8 in March 2021 to 41% in September 2021), and adoption case managers (from 19% meeting the standard of 1:15 in March 2021 to 25% in September 2021), caseload compliance for all case manager types was below 50 percent in the final month of the monitoring period.

Declines in supervisor workload compliance since the prior period occurred for all types of supervisors. For example, between March 2021 and September 2021, compliance with foster care supervisor workload (1:5) declined from 86 percent to 81 percent, and adoption supervisor workload (1:5) also declined from 86 percent to 74 percent.

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



Workload Progress and Implementation Updates

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

The Workload Implementation Plan was approved by the Co-Monitors on February 20, 2019, and by the Court on February 27, 2019.[45] The Plan's strategies primarily focus on improvements to infrastructure; hiring, training, and retention of case managers and supervisor; and increasing case manager and supervisor salaries. The discussion below includes implementation updates for select Implementation Plan, Joint Report, and Mediation Agreement strategies during this period.

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

Hiring, Training, Onboarding, and Retaining New Case Managers and Supervisors
Recruiting, hiring, and filling vacant and new case manager positions are strategies that can have a significant impact on the current caseload size of staff. As an integral part of this work, DSS must have a sufficient number of positions allocated by the General Assembly to meet the standards. Using a standard of 12 children to one case manager, DSS estimated in prior years a need for 213 new case manager positions, and 43 supervisor positions to meet caseload standards. These positions were included in the budget requests for FY2019-2020, FY2020-2021, and FY2021-2022, however, no new positions were approved by the General Assembly.[46]

In DSS's FY2022-2023 budget request, submitted to the Governor's Office in October 2021, DSS included funding for 286 staff positions; specifically, 120 case managers, 15 OHAN investigators, 24 case manager supervisors, and three OHAN investigator supervisors. The number of staff positions requested in FY2022-2023 is lower than what had been estimated as the need in prior years; DSS informed the Co-Monitors that the most recent estimate was developed by examining the number of children and families being served in September 2021, the number of allocated full-time employee positions (including current vacancies), and a 15 percent over-hire. These requests were also included in Governor McMaster's Executive Budget, provided to the General Assembly in January 2022.

Between January and September 2021, DSS had an average of 1,814 filled positions within adoptions, family preservation, foster care, intake, investigations, licensing, and OHAN; during this nine-month period, 470 (26%) employees left their positions[47], an increase over CY2020 when 23 percent of staff left. The quarter with the highest percentage of staff losses was the second quarter – April and June 2021 – when 10 percent of staff exited; this is the highest percentage of staff exits during one quarter as compared to all quarters since the first quarter of CY2018, and follows Executive Order No. 2021-12 that required all state agency employees return to the workplace by March 15, 2021. The pace of turnover slowed between July and September 2021, when seven percent of child welfare staff exited their positions.

Between January and September 2021, turnover most heavily impacted foster care and investigation staff, with 31 percent (129 of 412.5) of foster care staff and 31

[46] In FY2020-2021, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the state operated under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The FY2021-2022 budget passed by the General Assembly included funding to increase case manager and supervisor salaries, but did not allocate new positions.
[47] This includes 69 staff who remained employed within DSS but accepted a new role.

percent (139 of 442) of investigations staff leaving their jobs. The most frequently cited reasons by staff for leaving between January and September 2021 were personal (86%), and employee movement within the agency (6%). The largest category provided – personal – is broad, and although it is difficult to assess the impact of the COVID-19 pandemic on employee decisions, it is very likely a contributing factor for many.

DSS provided separate data on the number of vacancies and average length of time positions had been vacant as of September 30, 2021. On that date, there were a total of 129 case manager and supervisor vacancies across foster care, adoptions, and OHAN staff.[48] For the 91 vacant foster care case manager positions on that date, the statewide average for length of time they had been vacant was 4.16 months (an increase from March 2021 when the average length of time was 2.33 months). The average time for the 17 vacant adoption case manager positions was 3.29 months, and 2.27 months for the 10 foster care supervisor vacancies. In July 2021, DSS reports Human Resources staff worked with IT and Staff Development and Training to outline a new onboarding process, with specific timelines after an offer letter is submitted to a potential employee to promote finalizing the process more quickly – such as completing necessary forms, and gaining access to equipment and systems so they are able to begin pre-service certification training sooner. This process begins after Human Resources sends an offer letter to the potential employee, and does not include activities prior to that action.

Increased Salaries for Case Managers and Supervisors

South Carolina has taken an important, foundational step toward stabilizing and professionalizing its workforce by adopting a new salary schedule for case managers and supervisors that will raise entry level salaries significantly, and provide for structured increases based on education, training, and longevity. The salary schedule in the approved Workload Implementation Plan provides greater parity with case manager salaries in states with similar demographic characteristics, and ensures staff receive a living wage upon hiring or no later than within two to three years of employment.

To implement this strategy, DSS included a request for $24.7 million in funding in its FY2021-2022 budget, and these funds were appropriated by the General Assembly effective July 1, 2021. The salary adjustments are provided to child welfare case

[48] As of November 30, 2021, DSS reports 9 of these vacancies had been filled, interviews were being conducted for 4 positions, and 116 positions remained posted.

managers and supervisors, and will be implemented in two phases. In the first phase, which began on July 1, 2021, the increased salary schedule is applied to case managers and supervisors, with different ranges based upon the type of degree staff hold (e.g., salaries for case managers with a BSW degree will be 2.5% higher than staff without a BSW degree, and salaries for case managers with a MSW is 5% higher than those staff without a BSW or MSW), and their length of service with DSS (from <1 year up to 10 years of service) (see Table 3). In addition, the new salary schedule provides supervisors with a 10 percent higher starting salary than the baseline salary for case managers (specifically, $40,000 starting salary for case managers without a BSW or MSW, and $44,000 starting salary for supervisors). Staff will automatically receive increases for years of service. These increases occur on a quarterly basis, depending upon the individual anniversary date for the staff. These changes are an important accomplishment.

Table 3: SCDSS Salary Schedule for Case Managers and Supervisors Beginning July 1, 2021

Position and Degree	**Average Salary in 2019**	**Starting Salary for <1 year of Service**[49]	**Salary Range for Level 1** (varies based upon years of service)	**Salary Range for Level 2** (varies based upon years of service)	**Salary Range for Level 3** (varies based upon years of service)
Case Manager - Degree Other than BSW/MSW	$35,541	$40,000 (13% higher than average in 2019)	$46,000 - $48,352	$47,386 - $51,825	$49,056 - $55,261
Case Manager - BSW[50]	$35,885	$41,000 (14% higher than average in 2019)	$47,150 - $49,561	$48,570 - $53,121	$50,283 - $56,643
Case Manager - MSW[51]	$35,417	$42,000 (19% higher than average in 2019)	$48,300 - $49,932	$49,681 - $54,335	$51,432 - $57,938
Supervisor	$40,709	$44,000 (8% higher than in 2019)	$50,600 - $53,188	$52,124 - $57,008	$53,962 - $60,760

Source: DSS Workload Implementation Plan, Appendix D (February 2019)

[49] This also applies to case managers who have not yet completed Child Welfare Services Certification.
[50] In 2019, when the Workload Implementation Plan was approved, approximately 14% of DSS case managers had earned a BSW.
[51] In 2019, when the Workload Implementation Plan was approved, approximately 3% of DSS case managers had earned a MSW.

The first phase of implementation assigned all staff to a trainee level or level 1 salary range. Beginning in January 2022, DSS will implement the second phase of the plan that provides opportunities for case managers and supervisors to advance in their career path based upon level 2 and 3 classifications in the salary schedule. Qualifications for advancement to the next level include advanced training, and a performance and practice evaluation to assess a case manager's demonstration of Child Welfare competencies and Guiding Principles and Standards (GPS) Case Practice Model core practice skills. Level 3 case managers are expected to continue advanced training – including certification in a specialized area for which the case manager will conduct training – and will have the opportunity to serve as mentors to new case managers.[52]

DSS reports that specific details on these qualifications and required documentation was shared with applicable staff on January 28, 2022. Staff will have the opportunity to complete necessary training, as needed, and the evaluation process with their supervisors in the following months, with all documentation due to Human Resources for processing by May 1, 2022. Quarterly thereafter, staff can submit documentation and request an evaluation for ascension to the next level.

University Partnership Program

DSS reports that development of the University Partnership program is ongoing, with an anticipated program launch for the 2022 Fall semester. The program will begin with three University of Social Work Scholars from each of the partner institutions – SC State, UofSC, and Winthrop – for a total of nine Scholars. The Title IV-E award will cover the costs of relevant social work courses (minus any other eligible financial aid) for the final two years of a student's academic program. The University Scholar contractual agreement will include a DSS employment commitment commensurate to each year of receiving funds.

DSS reports that a Technical Assistance Consultant and the DSS Workforce Developer are working with the three university partners to develop marketing and recruitment strategies. Additionally, DSS reports that they are considering the potential use of Title IV-E funds for current DSS employees to pursue their BSW and/or MSW degrees.

[52] For example, DSS reports that case managers can become certified to conduct ACES training, or be certified as CFSR reviewers or CFT facilitators, among other things. In these examples, the case manager would either participate in a certain number of CFSR reviews or facilitate a certain number of CFTs each year to maintain certification.

Pre-Service Training Redesign

DSS reports the development of a new Child Welfare Academy: Pre-Service Certification. This training was created and will be provided internally by DSS's Staff Development and Training office. The training content has been updated to include GPS practice, and current information on the latest initiatives. The training includes 18 days of instructor led training (ILT) and 25 days of on-the-job (OJT) training.[53] After completion of ILT and OJT, there is a final assessment of the core practice skills – including a skill demonstration – and a score of 85 percent is needed for the new case manager to proceed to post-service training and to receive half of a caseload.

Training was piloted in the Upstate region in August 2021, with 19 staff divided into two cohorts. DSS reports that during the pilot, new staff and their supervisors debriefed sessions to offer suggestions for curriculum improvement and processes. All 19 staff received a score of 85 percent or higher on their final assessment and advanced to post-service training.

Following the pilot, statewide roll-out of the new Pre-Service Certification began in the Upstate in December 2021 with an orientation for supervisors, peer support staff, and performance coaches. Training for new staff hired on December 2, 2021 began on December 13, 2021 and concluded on February 25, 2022. A second cohort of staff hired later in December 2021 are currently enrolled in training, and are scheduled to complete their training on March 11, 2022. DSS reports implementation in other regions of the state is as follows:

- Pee Dee Region:
    - January 5, 2022 – orientation for supervisors, peer support staff, and performance coaches.
    - February 10, 2022 – training for new staff hired on February 2, 2022 to begin, with training completed by April 15, 2022.

[53] DSS reports the OJT component of training incorporates the use of the learning support team, which includes the learner, the learner's supervisor, a mentor/host coworker, and a performance coach. The support team works with the learner to enhance knowledge obtained from Instructor-led Training and build skills. Also included are many opportunities for the learner to work with and learn from their peers and begin building a network of support. OJT is comprised of shadowing activities with the mentor or host coworker and gradually taking on more casework responsibilities. Included in ILT is the AWAKEN: Addressing Trauma training. In this component, learners examine and address bias and its impact on engagement with families, the community, and coworkers.

- Midlands Region:
    - January 12, 2022 – orientation for supervisors, peer support staff, and performance coaches.
    - February 24, 2022 – training for new staff hired on February 17, 2022 to begin, with training completed by May 6, 2022.

- Low Country Region:
    - February 1, 2022 – orientation for supervisors, peer support staff, and performance coaches.
    - March 7, 2022 – training for new staff hired on March 2, 2022 to begin, with training completed by May 13, 2022.

New cohorts will be assigned based on a twice-monthly hiring schedule.

Performance Data

The FSA requires that *'[a]t least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit"* (FSA IV.A.2.(b)) and that *'[n]o Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit"* (FSA IV.A.2.(c)). The Workload Implementation Plan set the final target to be reached by DSS in March 2021.

There are different caseload standards dependent upon the types of cases a case manager manages – specifically foster care and adoption, and investigations of allegations of abuse and neglect of children in foster care (OHAN).[54] The approved caseload standards are included in Table 4.

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

Table 4: Caseload Standards by Worker Type

Worker Type	Caseload Standard	Caseload Standard for New Workers*	More than 125% of Standard
Case Managers			
Foster Care Case Manager	One case manager to 15 children (1:15)	No more than 8 children (1:8)	More than 18 children or Non-Class cases[55]
Adoption Case Manager[56]	One case manager to 15 children (1:15)	No more than 8 children (1:8)	More than 18 children
OHAN Investigator	One investigator per eight investigations (1:8)	No more than 4 investigations (1:4)	More than 10 investigations
Supervisors			
Foster Care Supervisor	One supervisor to five case managers (1:5)	N/A	More than 6 case managers
Adoption Supervisor	One supervisor to five case managers (1:5)	N/A	More than 6 case managers
OHAN Supervisor	One supervisor to six investigators (1:6)[57]	N/A	More than 7 investigators

Source: Approved DSS Workload implementation Plan (February 2019)

* Employed less than 6 Months since Completing Child Welfare Certification training

To assist in assessing progress over time, Figure 8 and Figure 9 show performance data on caseloads by case manager and supervisor type for prior and current monitoring periods. As of September 30, 2021, compared to six months prior, the percentage of workers with caseloads within required limits has declined for foster care, and improved for OHAN and adoption case managers. Workloads for supervisors have declined for all supervisor types.

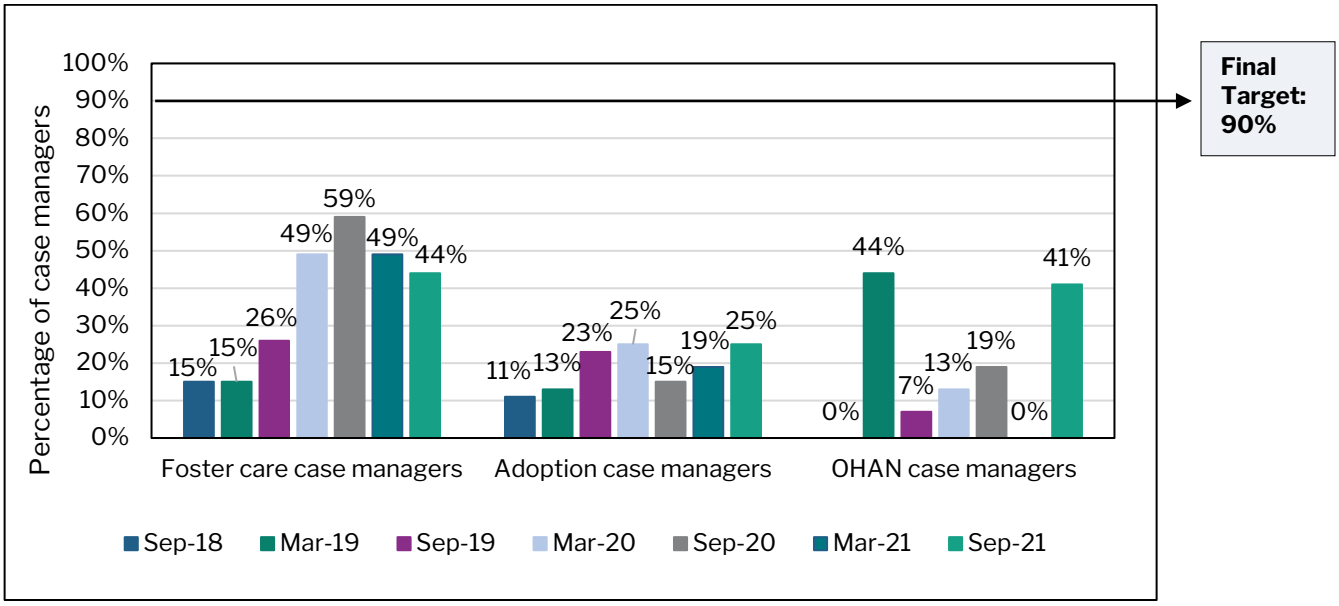
Children (ICPC). This methodology is only applied to foster care case managers with mixed caseloads and is not applied to adoption case managers.

[55] Ibid.

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

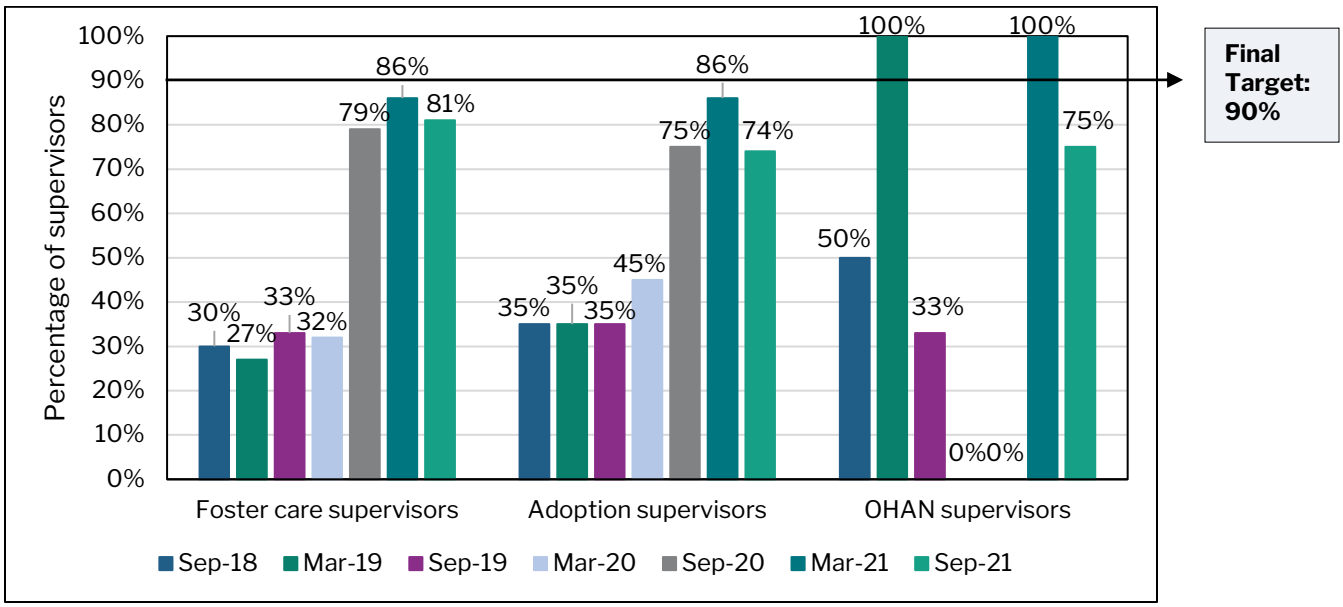
[57] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition of the fact that the OHAN investigators they supervise will have lower caseload standards than other direct service case managers.

Figure 8: Percentage of Case Managers With Caseloads Within the Required Limits, by Case Manager Type September 2018 – September 2021[58]



Source: CAPSS data provided by DSS

Figure 9: Percentage of Supervisors With Workloads Within the Required Limits, by Supervisor Type September 2018 – September 2021



Source: CAPSS data provided by DSS

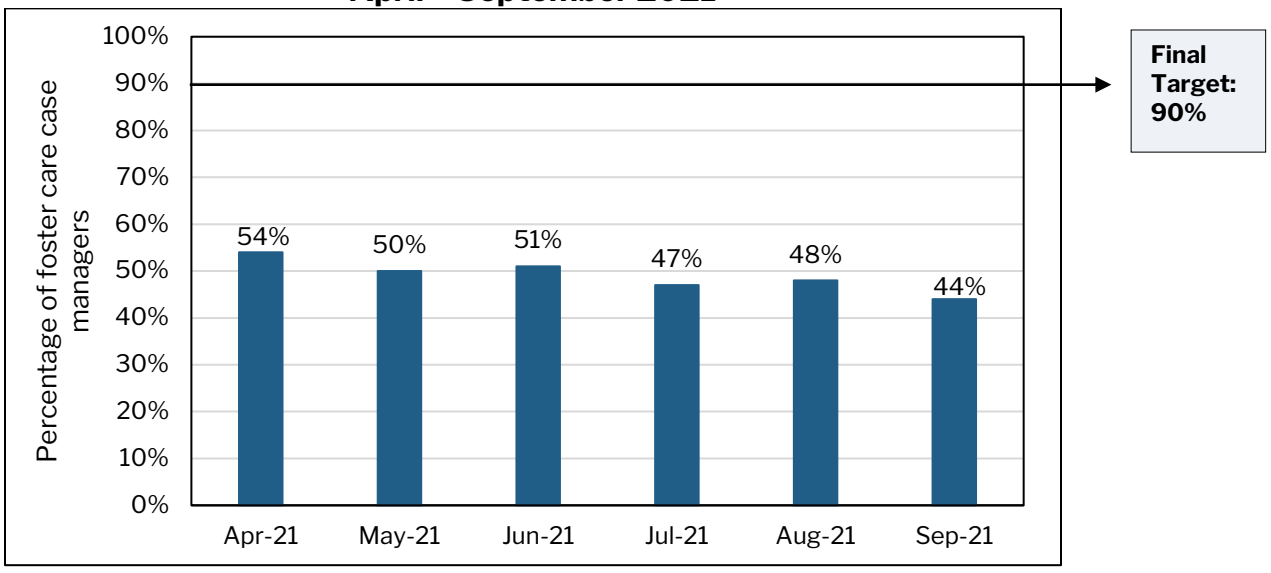
[58] Adoption case manager performance in September 2018, March 2019, and September 2019 was assessed at a standard of 1:17, which changed to 1:15 beginning in January 2020.

Foster Care Case Managers

On September 30, 2021, there were 278 foster care case managers with at least one child in foster care on their caseload.[59] Of these case managers, 44 percent (123) had caseloads within the required limit of 15 cases (or 8 cases for new case managers), and 37 percent (104) of case managers had caseloads more than 125 percent of the caseload limit, meaning they were responsible for more than 18 cases (or more than 10 cases for new case managers).[60,61]

Point in time data for each month from April to September 2021 show that between 44 and 54 percent of foster care case managers, including new case managers, had caseloads within the required limit (see Figure 10); and 31 to 37 percent of foster care case managers had caseloads that were more than 125 percent of the caseload limit.[62] As reflected in Figure 11, performance declined throughout the period.

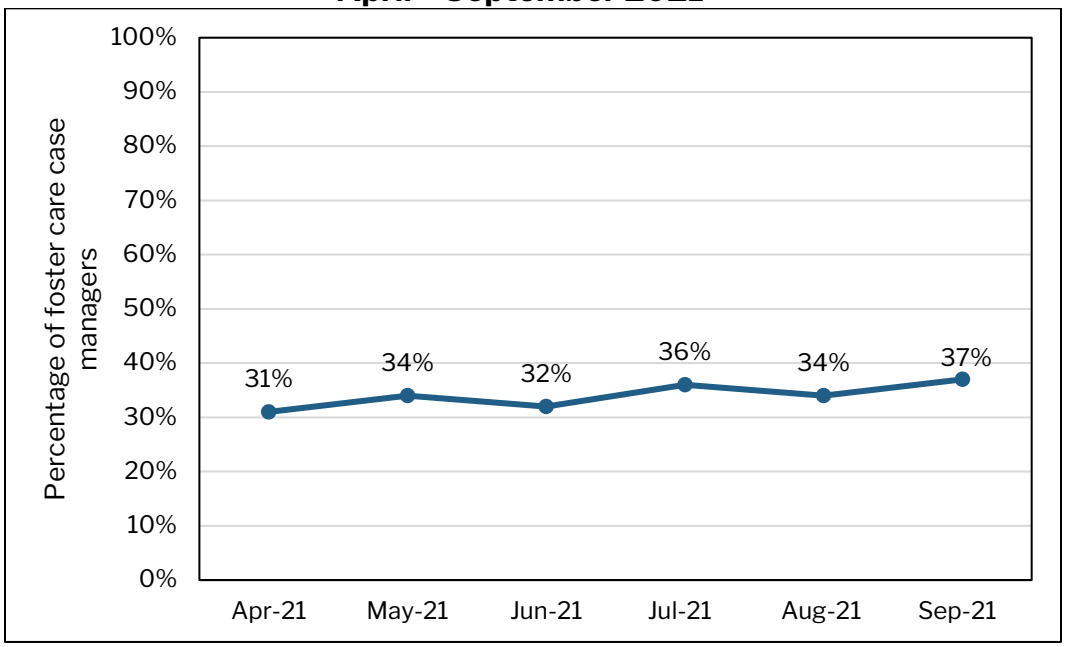
Figure 10: Foster Care Case Managers With Caseloads Within the Required Limits April – September 2021



Source: CAPSS data provided by DSS

[59] This includes 70 newly hired foster care case managers.
[60] The remaining 51 (18%) case managers had caseloads greater than 100 percent, but less than 125 percent (i.e., between 16 and 18 cases for non-new case managers, or 9 to 10 cases for new case managers).
[61] In calculating performance, a limit of 8 children in foster care or Non-Class Member families is applied to newly hired case managers (half of the applicable caseload standard), and 15 children in foster care children or Non-Class Member families is applied to foster care or APS case managers.
[62] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and supervisor. These random dates are as follows: April 15, 2021; May 21, 2021; June 16, 2021; July 7, 2021; August 23, 2021; September 30, 2021.

Figure 11: Foster Care Case Managers With Caseloads over 125% of Required Limits April – September 2021[63]



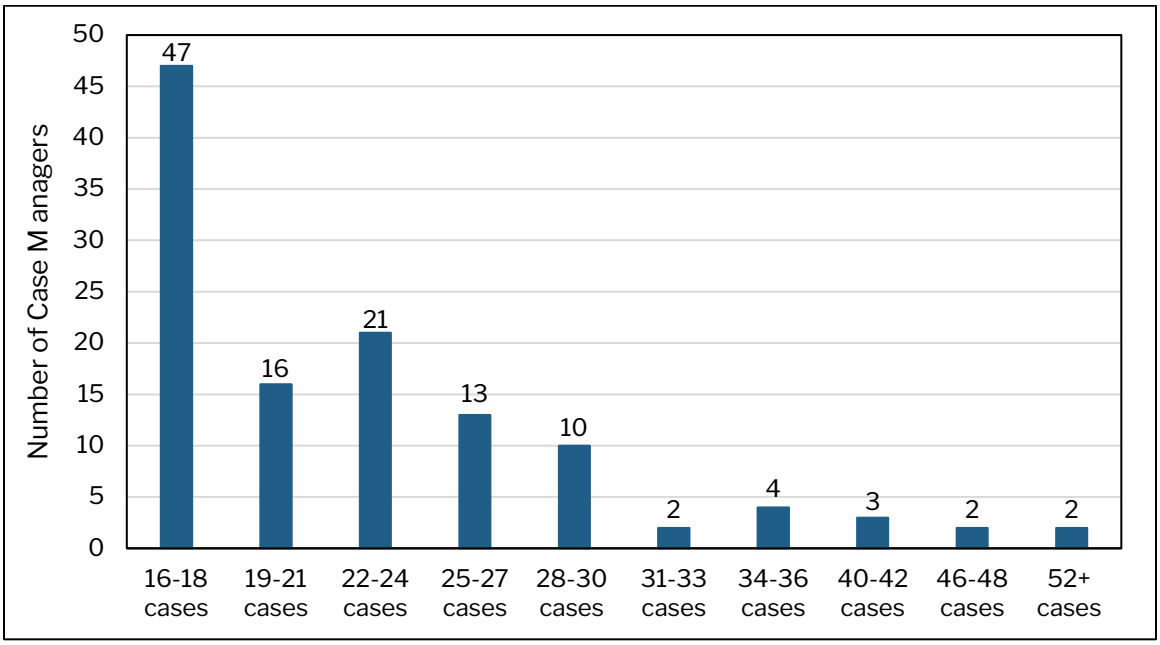
Source: CAPSS data provided by DSS

Figure 10 and Figure 11 above merge data for all foster care case managers – those newly hired as well as those hired more than six months prior to completing training. Figure 12 reflects the number of cases carried by the 120 foster care case managers who had completed Child Welfare Certification training more than six months prior and had responsibility for more than 15 children on September 30, 2021. As of this date, 17 case managers were responsible for 30 or more cases (double the caseload standard), including four case managers with caseloads in the range of 46 to 55 cases (triple the caseload standard).[64]

[63] The final target for case managers is no (0%) case manager should have a caseload more than 125% of the limit by March 2021.

[64] Three case managers with the highest caseloads (55, 54, and 48 cases) work in Lexington County; 4 of the 12 case managers in Lexington County were new staff. The other case manager with a caseload over 45 cases works in Greenwood County, where there were only 3 case managers with Class Member caseloads in September 2021.

Figure 12: Number of Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago With Caseloads that Exceeded the Limit September 30, 2021 N = 120



Source: CAPSS data provided by DSS

DSS offices are divided among four regions, which differ in terms of geographical size, the number of children and families served, and the number of assigned and onboarded case managers. Data on foster care case manager caseloads by region as of September 30, 2021 are shown in Table 5. Although performance for foster care case manager caseloads within the standards continues to be lower than the final target in all four regions, there has been a significant and continued decline in performance in the Low Country region (from 63% in September 2020, to 50% in March 2021, to 38% in September 2021). There has been an improvement over the past six months in the Midlands region.

Table 5: Percentage of Foster Care Case Managers with Caseloads Within the Required Limit by Region September 2020 – September 2021

Region	Percentage of Foster Care Case Managers with Caseloads within the Required Limit on September 30, 2020	Percentage of Foster Care Case Managers with Caseloads within the Required Limit on March 31, 2021	Percentage of Foster Care Case Managers with Caseloads within the Required Limit on September 30, 2021
Low Country	63% N=62	50% N=50	38% N=48
Midlands	30% N=83	27% N=78	34% N=83
Pee Dee	36% N=52	68% N=50	51% N=47
Upstate	73% N=114	55% N=105	53% N=100

Source: CAPSS data provided by DSS

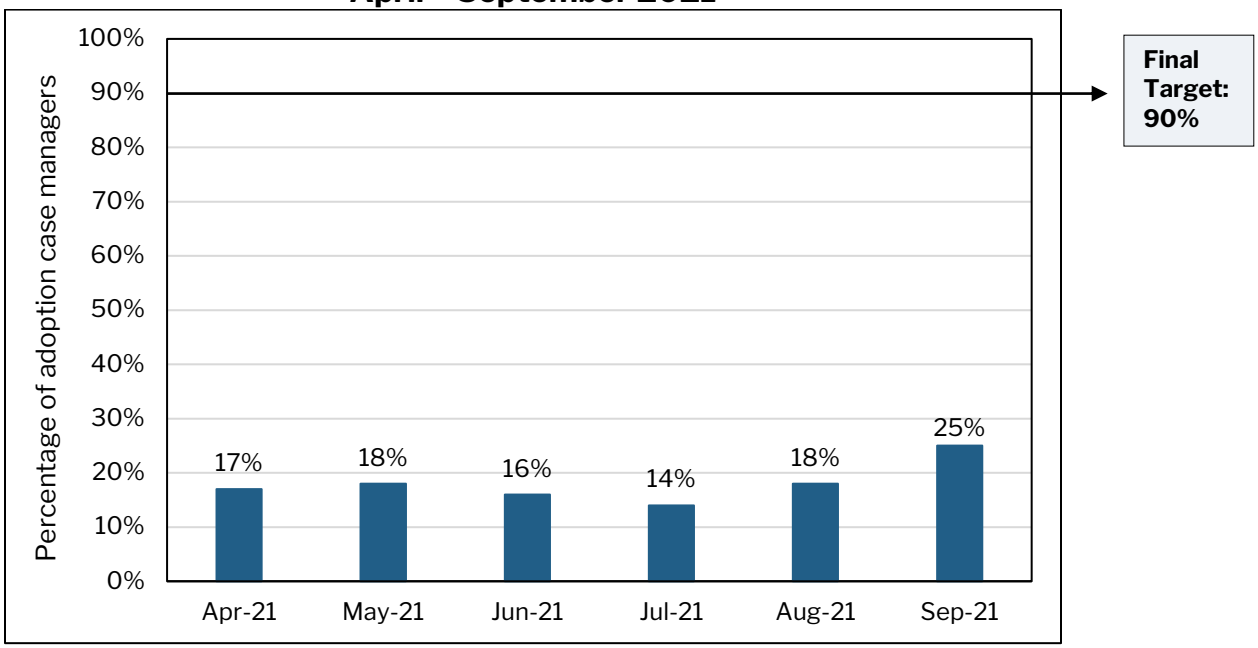
Adoption Case Managers

On September 30, 2021, there were 77 adoption case managers serving at least one Class Member[65]; 19 (25%) case managers had caseloads within the caseload requirement (1:15, or 1:8 for new case managers), and 48 (62%) case managers had caseloads that exceeded 125 percent of the limit (more than 18 children, or more than 10 children for new case managers).[66]

Between April and September 2021, monthly performance increased from 17 to 25 percent of adoption case managers with caseloads within the required limit (see Figure 13); and 61 to 65 percent of adoption case managers with caseloads that exceeded 125 percent of the required limit (see Figure 14).

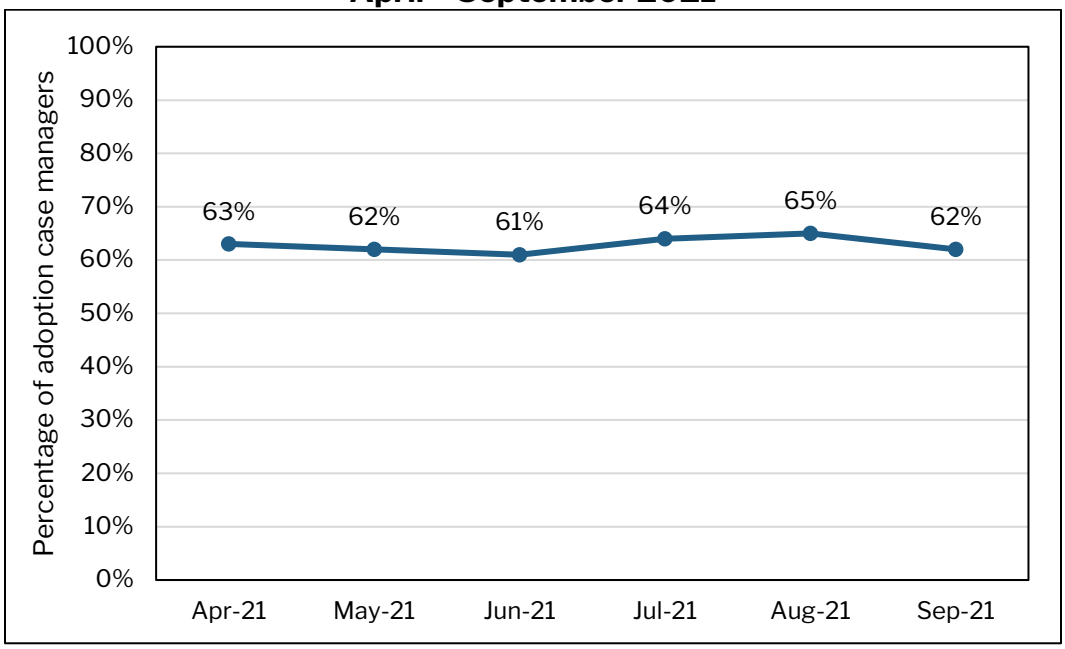
[65] This includes 23 newly hired adoption case managers.
[66] The remaining 10 (13%) case managers had caseloads greater than 100%, but less than 125% (i.e., between 16 and 18 cases).

Figure 13: Adoption Case Managers with Caseloads Within the Required Limits
April – September 2021



Source: CAPSS data provided by DSS

Figure 14: Adoption Case Managers with Caseloads over 125% of Required Limits
April – September 2021



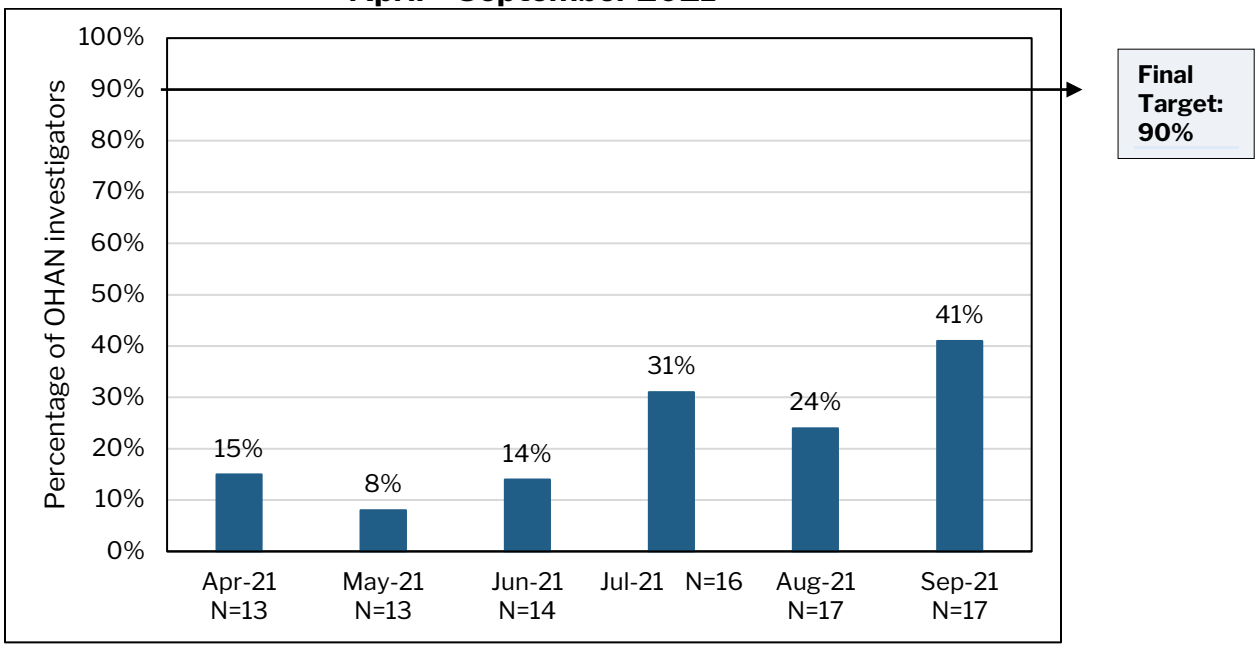
Source: CAPSS data provided by DSS

Out-of-Home Abuse and Neglect Case Managers

In September 2021, OHAN had 17 assigned investigators[67]; seven (41%) investigators had a caseload within the required standard (1:8, or 1:4 for new investigators), and six (35%) investigators had caseloads over 125 percent of the required limit (more than 10 investigations, or more than five for new investigators).[68]

Between April and September 2021, a monthly range of eight to 41 percent of OHAN investigators had caseloads within the required limits (see Figure 15), and 35 to 86 percent of investigators had caseloads that exceeded 125 percent of the required limit (see Figure 16).[69]

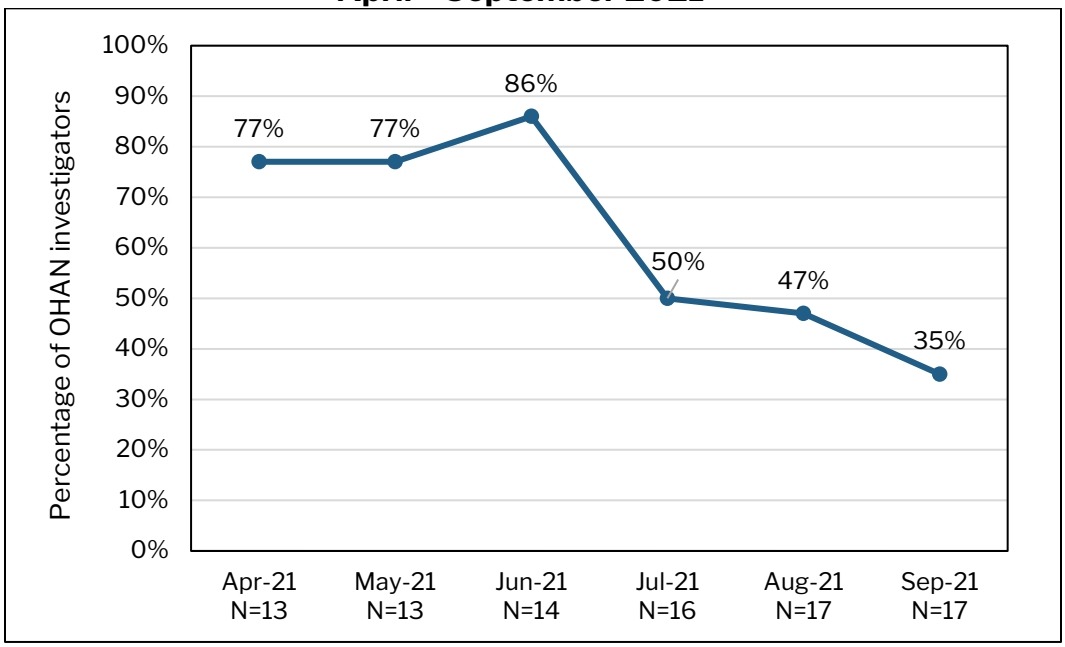
Figure 15: OHAN Investigators with Caseloads Within the Required Limits April – September 2021



Source: CAPSS data provided by DSS

[67] This includes 1 newly hired OHAN investigator.
[68] The remaining 4 OHAN investigators had a caseload of 9 investigations each.
[69] Large fluctuations in performance are due to the small number of OHAN investigators.

Figure 16: OHAN Investigators with Caseloads over 125% of Required Limits April – September 2021[70]

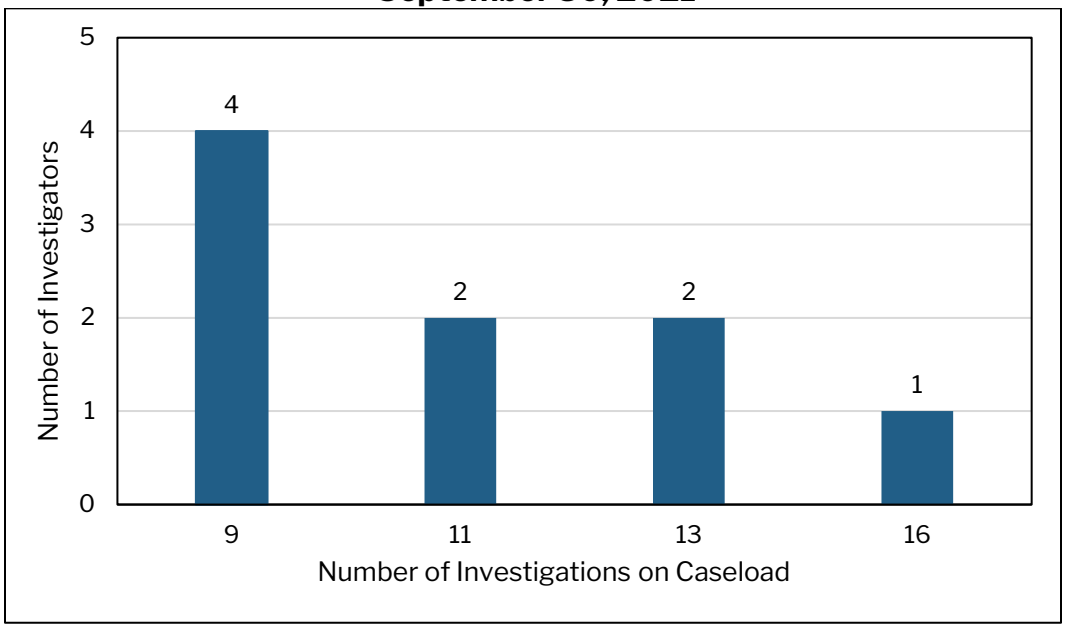


Source: CAPSS data provided by DSS

Figure 17 includes the caseload size of the nine OHAN investigators who were not new workers and had caseloads exceeding the limit on September 30, 2021. As of March 31, 2021, there were five OHAN investigators who had caseloads between 16 and 22 investigations; as of September 30, 2021, one investigator had a caseload of 16 investigations (double the required limit).

[70] The final target for case managers is no (0%) case manager should have a caseload more than 125% of the limit by March 2021.

Figure 17: Caseload Size for OHAN Investigators with Caseloads that Exceeded the Limit
September 30, 2021



Source: CAPSS data provided by DSS

Supervisor Workloads

The Workload Implementation Plan includes separate timelines and interim benchmarks for supervisory workloads. The final target is that at least 90 percent of supervisors will supervise the required number of case managers or fewer (5 case managers for foster care and adoption supervisors, and 6 investigators for OHAN supervisors). No supervisor will be assigned more than 125 percent of the standard (or more than 7 case managers for foster care and adoption supervisors, and more than 8 investigators for OHAN supervisors). The approved Workload Implementation Plan anticipated compliance with the final targets by September 2020.

DSS has identified situations in which supervisors may be directly responsible for a case(s) for a short period of time. [71] Data for April through September 2021 reflect

[71] These include circumstances in which a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is nearing closure; there are complexities regarding the case that need to be addressed; or an important legal event will occur within the timeframe. While the supervisor is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child: monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent, as applicable; and other activities, as necessary. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving supervisor for up to five days until the supervisor assigns the case to the receiving case manager. After reviewing data on supervisors carrying cases for several monitoring periods, DSS has identified additional circumstances which result in supervisors carrying cases. These include when a case manager leaves the agency

that the number of supervisors carrying cases for longer than five days has decreased, from 42 supervisors carrying a total of 277 cases on the last day of April 2021, to 26 supervisors carrying a total of 165 cases on September 30, 2021. Of the 165 cases carried by supervisors on September 30, 2021, one-third (32%) of the cases were foster care cases (the median length of time these cases were open was 111 days), and 22 percent were child protective services treatment cases (the median length of time these cases were open was 193 days). The table below reflects the number of supervisors carrying cases by region, and the most common reason(s) cited for supervisors carrying cases.

Table 6: Number of Supervisors Carrying Cases per Region, and Reasons September 30, 2021

Region	Number of Supervisors Carrying Cases	Most Common Reasons Cited for Supervisors Carrying Cases
Low Country	6	Staff shortages due to turnover in staff within investigations, and foster care
Midlands	10	Staff shortages, and awaiting court orders for cases to close
Pee Dee	3	Staff shortages, and cases in the process of being transferred from investigation staff to family preservation or foster care staff
Upstate	7	Staff shortages

Source: Data provided by DSS

Foster Care Supervisors

Between April through September 2021, a monthly range of 81 to 83 percent of foster care supervisors supervised five or fewer case managers, and seven to 11 percent of foster care supervisors supervised seven or more case managers (or 125 percent of the required limit).[72,73]

and creates a vacancy that takes some time to fill (including onboarding new staff with required training and limiting their caseload to half the required limit during the first 6 months after completing training), or when case managers are on extended leave. DSS has assigned cases to supervisors in these circumstances due to their familiarity with the child and family, and to prevent overburdening other case managers within their unit. The Co-Monitors have reviewed and discussed data with DSS reflecting these situations, and in March 2021, DSS proposed a process to closely monitor these situations. The process requires Regional Director approval for supervisors to carry cases for greater than 5 days; documentation will be shared with staff within Accountability, Data, and Research (ADR) and must describe the cases the supervisor will carry, the circumstances leading to the supervisor carrying cases, and a specific plan and timeline to address the issue. The Co-Monitors approved this process in April 2021, and DSS began tracking and reporting these data in May 2021. The process will be reviewed after 12 months to assess its effectiveness and feasibility.

[72] Monthly performance for foster care supervisors supervising 5 or fewer case managers are as follows: April 2021, 82%; May 2021, 81%; June 2021, 82%; July 2021, 83%; August 2021, 81%; September 2021, 81%.

[73] Monthly performance for foster care supervisors supervising 7 or more case managers are as follows: April 2021, 7%; May 2021, 8%; June 2021, 8%; July 2021, 11%; August 2021, 8%; September 2021, 8%.

Specifically, on September 30, 2021, of the 109 supervisors supervising foster care case managers, 88 (81%) supervised five or fewer case managers, and nine (8%) supervisors supervised seven or more case managers. Current performance is below the final target of 90 percent of supervisors within the required limit, and is not in compliance with the standard that no (0%) supervisor have a workload more than 125 percent of the limit.

Adoption Supervisors

Between April and September 2021, a monthly range of 73 to 91 percent of adoption supervisors supervised five or fewer case managers; [74] two (9%) supervisors in July and September 2021, and one (5%) supervisor in August 2021 supervised seven or more case managers, or 125 percent of the required limit.

On September 30, 2021, of the 23 supervisors supervising adoption case managers, 17 (74%) supervisors supervised five or fewer case managers. Current performance is below the final target of 90 percent of supervisors within the required limit, and is not in compliance with the standard that no (0%) supervisor have a workload more than 125 percent of the limit.

OHAN Supervisors

Between April and September 2021, OHAN had three to four supervisors each month responsible for the 13 to 17 investigators who were accepting investigations. In April, May, and June 2021, all (100%) OHAN supervisors supervised six or fewer case managers. In July and August 2021, two (67%) supervisors supervised two or fewer case managers, and one (33%) supervisor supervised eight or more staff (more than 125% of the standard).[75] Performance improved slightly in September 2021, with three (75%) of the four supervisors within the workload standard, and no (0%) supervisor responsible for more than 125 percent of the standard. Performance in the final three months of the period does not meet the final target.

[74] Monthly performance for adoption supervisors supervising 5 or fewer case managers are as follows: April 2021, 91%; May 2021, 81%; June 2021, 91%; July 2021, 86%; August 2021, 73%; September 2021, 74%.
[75] Between April and July 2021, 1 supervisor was responsible for 2 OHAN investigators, and also carried cases.

VI. Visits Between Case Managers and Children

At least once a month, DSS case managers are required by DSS policy and the FSA to have face-to-face visits with children in foster care and their caregivers.[76] Depending upon the needs of the child, the DSS case manager may see children and their caregivers more often. At least 50 percent of those visits must be in the "residence of the child," or the child's placement.[77] During visits, case managers are required to assess the child's status in multiple areas including safety, physical and emotional health, and to ensure that the child's needs are being met. Case managers are also required to assess the status of any services being provided to the child and/or caregiver to meet the child's needs and support placement stability; discuss progress toward permanency for the child; and support and strengthen the relationship with the child and their caregivers during these visits.

The FSA requirement that at least 90 percent of children receive face-to-face visits by their case managers during a 12-month period can be reported with quantitative data from CAPSS. However, historically, Co-Monitor staff found it difficult to verify reported quantitative data upon review of documentation. At times, the same documentation was repeated over several months or was too minimal to establish that there was indeed contact by the case manager with a child and the substance of that contact. Therefore, Parties agreed that a case manager's documentation of a contact(s) with a child in CAPSS should reflect each of the Department's policy and practice expectations for a visit and that such documentation would be assessed to determine that a *visit* has been held for monitoring and reporting performance.

Case record review results from the last month of the monitoring period provide information on how many children were seen by a case manager during the month, as well as whether documentation of the contact reflects all elements of the Department's policy and practice expectations for visits. Documentation from a statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all of the records reviewed.[78]

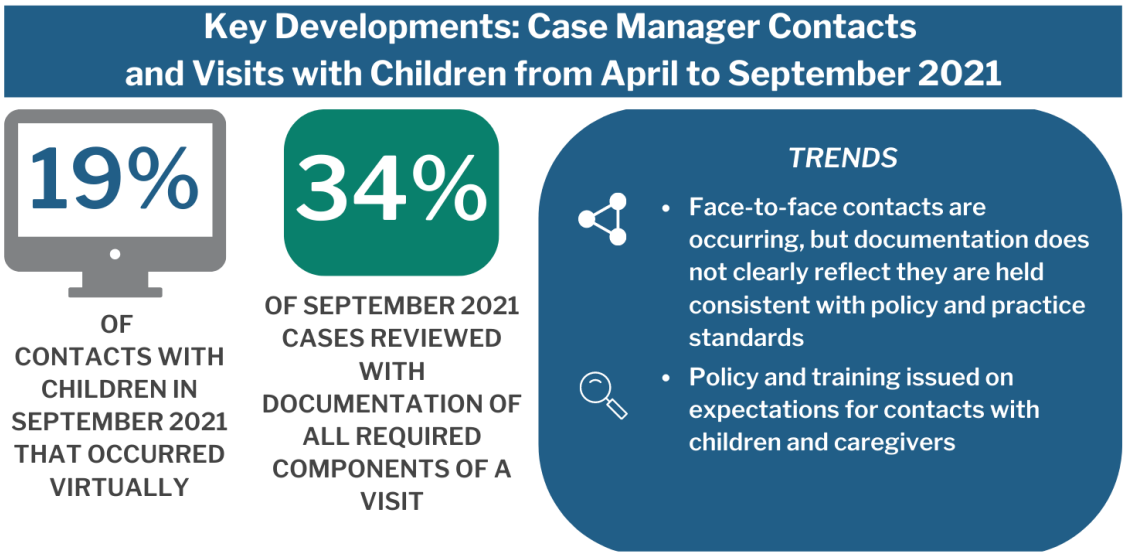
Case managers saw many (275 of 345, or 80%) of the children in person. As allowed by DSS leadership during the COVID-19 pandemic, after posing several questions

[76] FSA IV.B.2.
[77] FSA IV.B.3.
[78] In 1 case, the case manager documented a telephone conversation with a foster parent who stated that another child in the home had tested positive for the coronavirus and that the foster parent could not use their phone for a video call.

about household members to screen for risk of exposure to the COVID-19 virus, some case managers had contact with children via video (66 of 345, or 19%).[79]

Documentation for September 2021 does not reflect that *contacts* were made – either in-person, by video, or by telephone – in accordance with each of the *visit* requirements. Reviewers found documented practices consistent with every required component of a visit pursuant to DSS policy and the FSA in 34 percent (117 of 345) of records.

Improved performance for case managers' visits with children is expected with manageable caseloads, enhanced documentation, and placing children closer to their home counties, where case managers are located.



[79] In 2 cases there was telephone contact between the child and case manager. In 2 additional cases, the reviewer was unable to determine the mode of contact between the child and case manager.

Visits Between Case Managers and Children: Progress and Implementation Updates

DSS's Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and by the Court on April 3, 2019.[80] The Plan includes strategies to clarify the role and function of case manager contacts with children through:

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

DSS is delivering training and practice tips to case managers and supervisors about documentation. Since April 2020, DSS has been offering a combination of online and instructor-led training on the quality of case managers' visits with children and family members. *Quality Contact* training was available for supervisors in June and July 2021, and for case managers between September to December 2021. The July 2021 edition of practice tips focused on case manager's visits with children. Case managers also receive a pop-up reminder in CAPSS on the elements of a quality contact with a child. The reminder prompts case managers on information to include in documentation.

DSS reports continuing monthly case manager contact documentation reviews by county leadership, beginning in February 2021. This process also includes feedback to case managers and is being assessed for effectiveness and any necessary modification.

Performance Data

The FSA requires that *'at least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place,"* and "*at least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child"* (FSA IV.B.2.&3.). The total minimum

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

number of monthly visits between children and a case manager refers to a federal requirement of a minimum of one visit per month.[81]

As stated above, Parties agreed for purposes of compliance with the FSA that case manager visits with children must include the following elements as set out in DSS's Policy and Procedure (Chapter 5, Foster Care Visitation, effective June 1, 2019):

- An interview with the child alone, away from both the caregiver and other children in the home;
- Substantive inquiry as to the child's safety, permanency, and well-being. "Substantive inquiry" means focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the child; and
- Appropriate documentation of the visit in CAPSS. CAPSS documentation must include:
  - a summary of the conversation;
  - the location and circumstances of the interview;
  - an assessment of safety, permanency, and well-being; and
  - a statement reflecting changes in the case plan or service delivery or acknowledging the continued path of the current case plan.

Given the need to assess practice against policy requirements, DSS, USC CCFS, and Co-Monitor staff jointly review case records to assess documentation related to the contacts between children and their case managers. Reviewers assess documentation of case manager contacts with children for the agreed-upon elements of a visit, as described above.

Reviewers assessed a statistically valid sample of 345 DSS case records for children in foster care during the entirety of September 2021 to understand the practices of case managers relative to the expectations for their visits with children.[82] Documentation from this statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all (345 of 345, or 100%) of the records reviewed. During September 2021, consistent with DSS guidance provided in response to COVID-19, case managers were expected to see children in-person, if possible, and were also encouraged to ask a series of screening questions about possible exposure to COVID-19 and symptoms of the illness, and

[81] Social Security Act - Section 422(b)(17)
[82] The sample was derived from a universe of 3,326 cases of children in placement for 30 days or more as of September 30, 2021, with a 95% confidence interval and 5% margin of error.

level of comfort with in-person visits to determine whether to proceed with an in-person contact.

DSS reports that expectations for practice during case manager contacts have not changed, even if the contact is not in-person. If the contact is made by video or telephone because children cannot be seen in-person due to COVID-19 concerns, case managers are expected to conduct assessments as if the contact were in-person, with assistance from children and their caregivers. This may require that the case manager have multiple contacts during a month and the case manager being shown multiple rooms in a child's placement via video.

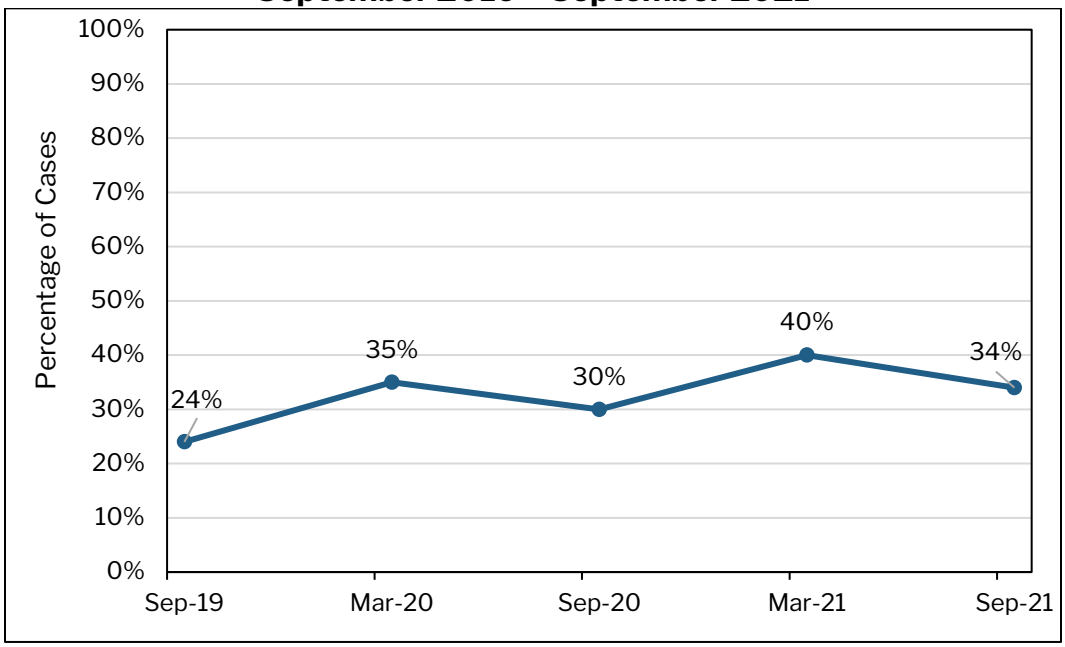
Documentation of practices during contact, however, shows that the interactions and conversations do not routinely meet the agreed upon standard for a visit. Specifically:

- Reviewers found documented practices consistent with each required component of a visit pursuant to DSS policy and the FSA in 34 percent (117 of 345) of records.[83] In an additional 56 (16%) records, all but one of the required components of a visit was found in documentation.
- In 198 (57%) of the cases, reviewers determined that the documentation of the contact did not reflect an adequate safety assessment.[84] This is especially true for infants and young children where viewing the home or environment is needed and the ability to engage with and observe the young child as they interact with their caregivers is limited when the contact is by video.[85]

Figure 18 shows results of case record reviews for all components of a case manager's visit with a child at intervals from September 2019 to September 2021.

[83] In most (101 or 86%) of the 117 cases in which documentation reflected all required components of a case manager's visit with a child, the visit was in-person; 16 were via video.
[84] In 198 cases, documentation did not clearly reflect whether the child was alone during the contact with the case manager.
[85] In reviewing documentation regarding assessment of the child's safety, reviewers also applied the requirement that children be interviewed in private, as developmentally appropriate. In general, the expectation is that infants, toddlers, and children under the age of 4 can be seen in the presence of a caregiver.

Figure 18: Percentage of Reviewed Cases with All Required Components of a Visit Between Case Managers and Children September 2019 – September 2021



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

The majority of children (80% or 275 of 345) whose records were selected for this review were at their placement during the contact with their case manager. Additional results from the September 2021 review show the need for improved practices as well as more complete documentation in CAPSS. Specifically:

- 87 percent (299 of 345) of the records contained a *summary of conversations and observations*.
- 74 percent (256 of 345) of the records contained documentation that the case manager discussed the topics of *well-being* with the child and/or caregiver.
- 58 percent (200 of 345) of the records contained documentation that the case manager discussed the child's *permanency* status with the child and/or caregiver.
- 62 percent (214 of 345) of the records contained documentation that the case manager discussed the *status of services* being delivered with the child and/or caregiver.
- 59 percent (203 of 345) of the cases contained documentation that the case manager discussed the *status of a case plan* with the child and/or caregiver.

Figure 19: Documented Practices during Case Manager Contacts with Children and Caregivers
September 2021
N=345

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

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

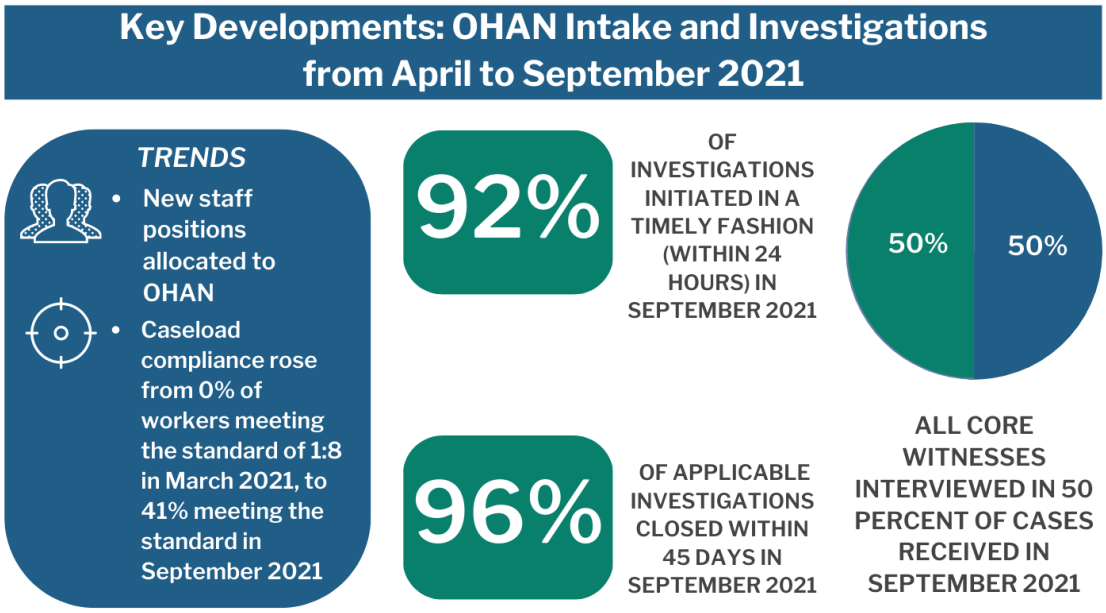
The work of screening and investigating allegations of abuse and neglect of children in foster care – completed by DSS's Intake Hubs[86] and Out-of-Home Abuse and Neglect (OHAN) unit – is a critical function of any child welfare system. Children are separated from their families and taken into foster care based upon a determination that they have been abused or neglected by their caregivers and are not safe with their families, thus ensuring their safety and well-being while in state custody is a primary obligation. OHAN unit staff must be prepared to quickly respond to all allegations that meet the criteria for possible abuse or neglect in foster homes and congregate care settings, and have the tools, skills, and supervision necessary to complete investigative tasks with quality and timeliness to determine if abuse or neglect occurred.

Performance data for the current monitoring period show improvement in one element of OHAN investigative practice, and declines in others. Specifically, timely initiation of investigations – defined as interviewing all alleged victim children with 24 hours of the call to the Intake Hub – improved from 87 percent in March 2021 to 92 percent in September 2021. The most notable practice with a decline in performance was contact with all necessary core contacts during an investigation – from 67 percent in March 2021 to 50 percent in September 2021.

During the current monitoring period, DSS allocated additional staff to the OHAN unit in an effort to bring down caseloads, and improve the quality of investigator's work. The total number of allocated investigator positions as of September 2021 was 26, and five supervisor positions. As of September 2021, OHAN had 17 investigators receiving assignments, which is five more investigators than in March 2021. Less than half (41%) of the 17 investigators had caseloads within the required standard (1:8), which is below the caseload compliance final target of 90 percent but an improvement from March 2021 when no (0%) investigator had a caseload within the required standard of eight investigations. DSS reports that as of September 30, 2021,

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

there were two vacant OHAN positions, and seven of the new positions that were not yet filled had been posted for hire.[87]



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

The FSA required that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to OHAN intake and investigations. The Implementation Plan must have *'enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets […]"* (FSA IV.C.1.). On September 11, 2017, the Co-Monitors approved DSS's OHAN Implementation Plan, and Plaintiffs provided their consent on November 7, 2017.[88]

In addition to setting interim benchmarks and timelines, the OHAN Implementation Plan includes strategies to improve OHAN practice and achieve the targets required by the FSA. These strategies include improvement in case manager time

[87] DSS reports that 15 new OHAN investigator positions and 3 new supervisor positions were included in DSS's FY2022-2023 budget that was presented to the Governor's Office and Executive Budget Office on October 27, 2021.
[88] The OHAN Implementation Plan is available at: https://dss.sc.gov/media/1967/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf

management; implementation of processes to track and monitor timely initiation of investigations and contact with core witnesses; development of checklists and other forms; development and completion of new training for investigators; coordination between OHAN and licensing staff; and improvements in supervision. All strategies were initially scheduled for implementation beginning in December 2017, and ongoing. DSS has adjusted some strategies, as reflected in the Joint Report.

DSS has recognized that a core strategy in meeting the required FSA standards for OHAN practice is to have a sufficient number of filled staff positions to allow for manageable caseloads so staff are able to complete all required tasks on time and with quality. Over the past year in particular, DSS has allocated some of the necessary positions, a number of which remain to be filled. As of September 30, 2021, OHAN had three vacant positions; two positions were in the interview phase, and one position was in the final stages of hiring as of that date. To meet caseload requirements, DSS had estimated that 11 new OHAN staff positions were necessary. Funding for these positions was included in DSS's FY2020-2021 and FY2021-2022 budget requests, but funding was not allocated by the General Assembly. DSS submitted its FY2022-2023 budget request to the Governor's Office in October 2021; this request includes 15 new OHAN investigators and three new OHAN supervisors.

Specialized investigation training, beyond what is provided in Child Welfare Basic for all Child Welfare staff, provides a foundation for specific OHAN practice expectations that are required within DSS policy and procedure. DSS had previously developed Intake and Investigation training curriculums, which has recently been condensed from 10 days to five days of content. For staff who are new to DSS, this training should be provided after completion of Child Welfare Basic. DSS reports that Investigation Training was provided in November 2021 to staff who had recently been hired and completed Child Welfare Basic. DSS is collaborating with community partners on a web-based investigation training to further expand on skills learned in Child Welfare Basic.

Another component for practice improvement is focusing on and strengthening supervision. OHAN continues to hold at least three supervisory staffings during each investigation, including the 10-day staffing with participation by county case managers and supervisors, and staff from Licensing, the Well-Being Team, Adoptions, and Kinship Care, as applicable. These staffings provide an opportunity for increased teaming, coordination, and information sharing across DSS divisions.

Performance Data

OHAN Intake

Beginning in November 2019, DSS's Intake Hubs were responsible for screening all referrals alleging abuse and neglect of children, including allegations involving children in foster care placed in foster homes and congregate settings. Screening decisions are made utilizing a Structured Decision Making® (SDM) intake tool.[89] When referrals are identified as involving a child in foster care, Hub staff routinely consult with OHAN staff regarding the screening decision.

Decisions to either accept a referral for investigation or take no further action on the referral ("screen out") are based upon information collected from reporters to determine if the allegations would, if substantiated, meet the state's statutory definition of abuse or neglect.[90] DSS policy establishes three main screening criteria for investigations of abuse or neglect of children in out-of-home care: (1) the alleged victim child is younger than 18 years of age; (2) there is an allegation of actual harm that has occurred or is occurring to a child, or the caregiver's acts or omissions present a significant risk of harm; and (3) the alleged perpetrator is a person responsible for the child's welfare.[91] All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires that *'[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy"* (FSA IV.C.2.). DSS committed to achieving these targets by March 2021.

All applicable referrals of abuse and neglect received and not approved for investigation by DSS's Intake Hub staff between April and September 2021 were

[89] For more information on SDM, see https://www.evidentchange.org/assessment/sdm-structured-decision-making-systems/child-welfare
[90] SC Code § 63-7-20.
[91] This includes a foster parent; a kinship foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Child Welfare Policy and Procedures, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective 2019).

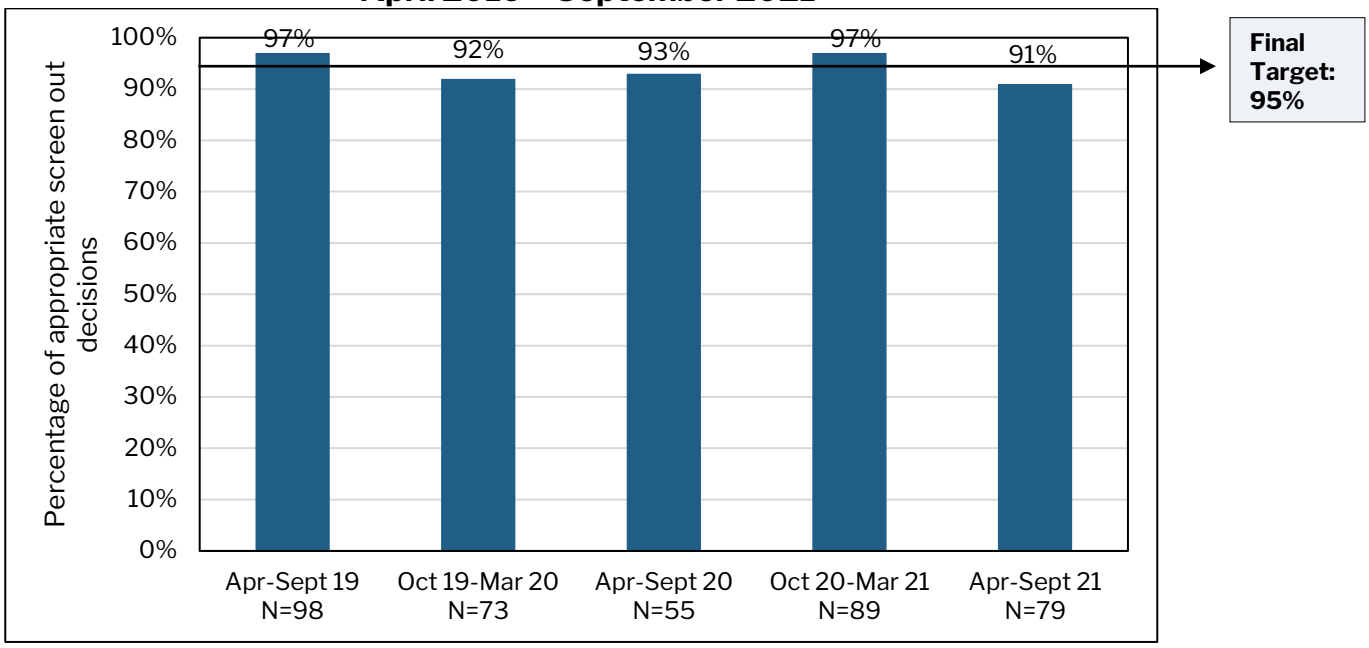
reviewed by Co-Monitor staff to determine appropriateness of the screening decision.[92,93,94,95]

Between April and September 2021, a total of 79 referrals alleging abuse or neglect against a child in foster care were received in which a decision was made by DSS staff not to investigate.[96] The Co-Monitors determined that 72 (91%) of these decisions not to investigate were appropriate. In two of the seven referrals in which the Co-Monitors disagreed with a screening decision, there was insufficient information to make a decision collected and documented by the intake worker. In the remaining five referrals, the Co-Monitors assessed that information collected by the intake worker warranted an investigation by OHAN.

As reflected in Figure 20, performance has declined since the prior period, and is below the final target of 95 percent.

[92] This review includes examining information entered into CAPSS, and listening to recordings of referrals, when available.
[93] Some referrals were found not to be applicable for review because the alleged victim child was not a Class Member (i.e., the child was voluntarily placed by the legal guardian in the congregate care setting or through ICPC from another state, or was the biological or adopted child of the caregiver), or the referral was screened out as a duplicate to a prior report that was under investigation or had previously been investigated.
[94] When assessing performance for this measure, 2 main criteria are considered: (1) the allegation, if true, meets the legal definition of maltreatment; and (2) the Intake Hub staff did not collect all information necessary to make an appropriate screening decision. If either of these questions were answered in the affirmative, the decision not to investigate the referral was determined to be inappropriate.
[95] Similar to prior monitoring periods, Co-Monitor staff identified a number of referrals to the Hub that were processed, screened, and coded as abuse or neglect allegations, however, the information shared did not include an allegation against a foster parent or caregiver. These include reports of children running away from placement when the foster parent or facility staff acted appropriately in response to the child's actions, or reports of incidents that occurred within a foster home or facility setting that required notice to DSS as the child was in foster care but did not allege abuse or neglect by a caretaker. Beginning in June 2021, DSS and Co-Monitor staff agreed to remove these types of referrals from review of performance for this measure as they are not applicable.
[96] Due to fluctuations in the number of applicable screening decisions each month, the Co-Monitors assess performance aggregated across the monitoring period.

Figure 20: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect April 2019 – September 2021



Source: Monthly review data, Co-Monitor staff

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody – in settings including licensed foster homes, residential facilities, and group homes – screened by DSS's Intake Hub for investigation are assigned to OHAN staff.[97,98] The FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours to assess for safety and risk, and the investigation is to be completed within 45 days.[99] OHAN policy also requires that throughout the course of the investigation, the investigator must conduct a safety assessment of the alleged victim child, including a private interview with that child; work with the child's case manager or law enforcement to make arrangements for medical treatment or examinations, as needed; interview core witnesses to inform the investigation; review documents and records related to the incident; and assess the risk of further maltreatment to all children within that setting.[100] All of these activities are critical components of a

[97] SC Code § 63-7-1210; SC DSS Child Welfare Policies and Procedures Manual, Chapter 16 (effective 2019).
[98] Allegations of abuse or neglect by a foster parent of their biological or adopted child should be investigated by child protective service case managers in local county offices.
[99] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16 (effective 2019).
[100] Ibid.

thorough OHAN investigation that results in accurate safety assessments and determination findings.

There are seven FSA measures that relate to investigations – timely initiation (two measures),[101] contact with core witnesses (one measure), investigation determination decisions (one measure), and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted by Co-Monitor staff, USC CCFS, and DSS staff in December 2021 which examined 54 investigations involving Class Members that were accepted for investigation in September 2021.

Demographics of Alleged Victim Children

Table 7 includes demographic information for the 89 alleged victim children identified in the 54 investigations reviewed. Over half (56%, or 30 of 54) of the investigations involved one alleged victim child, 17 (31%) investigations involved two children, and five (9%) investigations involved three children.[102] Nearly two-thirds (63%, or 56 of 89) of the identified alleged victim children were between the ages of 10 and 17, and over one-third (37%, or 33 of 89) were between the ages of five and nine. All investigations involving children ages nine or younger occurred in foster homes.

Most alleged victim children were Black or African American (47%), followed by White (44%), and Multiracial (9%).[103,104] A majority (93%, or 83 of 89) of alleged victim children did not identify as Hispanic, Latino, or Spanish origin.[105]

[101] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes - the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[102] For the remaining 2 investigations, 1 investigation identified 4 alleged victim children, and 1 investigation identified 6 alleged victim children.

[103] As of December 20, 2021, DSS data indicate of all children in foster care, 50% were White, 31% were Black, 4% were Multiracial, <1% were Native Hawaiian or Pacific Islander, and <1% were American Indian or Alaskan Native. For the remaining 14%, the race of 13% was unknown, and 1% declined to provide their race. Data from DSS website, 12/20/21.

[104] To see DSS's current race data on children in foster care, go to: http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

[105] For the remaining 6 alleged victim children, 4 alleged victim children identified as Hispanic, Latino, or Spanish origin; and ethnicity data were not provided for 2 alleged victim children.

Table 7: Demographics of Alleged Victim Children
September 2021
N= 54 investigations, 89 alleged victim children

Number of alleged victim children per investigation	
1 child	30 (56%)
2 children	17 (31%)
3 children	5 (9%)
4 or more children	2 (4%)
Age of alleged victim children	
Birth to 2	8 (9%)
3 to 4	9 (10%)
5 to 9	16 (18%)
10 to 13	23 (26%)
14 to 17	33 (37%)
Race of alleged victim children	
White	39 (44%)
Black or African American	42 (47%)
Multiracial	8 (9%)
Ethnicity of alleged victim children	
Hispanic or Latino or Spanish Origin	4 (4%)
Not Hispanic or Latino or Spanish Origin	83 (93%)
Not provided	2 (2%)
Placement at time of alleged incident	
Outside home county	62 (70%)
Within home county	27 (30%)
Number of alleged victim children by placement type	
Family-Based Setting	77 (87%)
Congregate Care	12 (13%)

Source: Case Record Review completed in December 2021 by USC CCFS, DSS, and Co-Monitor staff

Placement Providers

Over three-quarters (80%) of the 54 investigations involved foster homes, with the remaining 20 percent investigating allegations in group homes or other congregate care facilities.[106] Table 8 reflects the region and county of placement providers who were involved in investigations. Most alleged victim children in the investigations reviewed were placed outside of their home counties; nearly one-third of children were placed within their home region.

[106] All alleged victim children in a congregate care setting except for 1 child were between the ages of 14 to 17.

Table 8: County and Region of Placement Providers with Investigations, and Percent of Children Placed Within their Home County
September 2021

Region and County	Number of Foster Homes and Facilities with Investigations N=54	Percent of Children Placed Within Home County N=89
Upstate	*16*	15%
Abbeville	0	0%
Anderson	4	40%
Cherokee	1	-
Greenville	6	9%
Greenwood	0	0%
Laurens	0	0%
Pickens	0	0%
Spartanburg	5	22%
Midlands	*16*	34%
Aiken	1	0%
Bamberg	1	-
Chester	0	0%
Kershaw	2	0%
Lancaster	2	-
Lexington	3	67%
Richland	5	33%
York	2	50%
Low Country	*6*	67%
Berkeley	2	50%
Charleston	1	100%
Dorchester	1	100%
Jasper	1	-
Orangeburg	1	0%
Pee Dee	*16*	40%
Clarendon	0	0%
Darlington	2	50%
Dillon	0	0%
Florence	2	0%
Georgetown	5	-
Horry	5	100%
Marlboro	0	0%
Sumter	2	0%
Williamsburg	0	0%

Source: Case Record Review completed in December 2021 by USC CCFS, DSS, and Co-Monitor staff

One congregate care facility had four investigations accepted in September 2021, and one foster home had two investigations.

Reporter Type

In one-third of the investigations reviewed, the identified reporter was DSS staff (33%, or 18 of 54), including the assigned case manager, a supervisor, or an OHAN worker who learned of the alleged abuse or neglect while investigating another matter. Reporters also included behavioral health or medical professionals (9%), and foster parents, custodial parent/guardians, family members, provider facility staff, or child placement agency staff (15%) who either witnessed alleged abuse or neglect or were informed of an incident that necessitated reporting.

Allegation Type and Finding[107]

The most frequently identified allegations within the 54 investigations reviewed were physical abuse (52%, or 28 of 54), and physical neglect (44%, or 24 of 54).[108] As shown in Table 9, the most frequent allegation for alleged victim children between the ages of birth and four was physical abuse, while the most frequent allegation for alleged victim children between the ages of 14 and 17 was physical neglect. Table 9 reflects the number of allegations by type against alleged victim children by age.

[107] For state statutory definitions of types of abuse and neglect, see SC Code § 63-7-20.
[108] Investigations can include more than 1 allegation type.

Table 9: Allegation Types[109] against Alleged Victim Children by Age September 2021

	Number (Percentage) of Children Ages Birth – 2 years	Number (Percentage) of Children Ages 3 – 4 years	Number (Percentage) of Children Ages 5 – 9 years	Number (Percentage) of Children Ages 10 – 13 years	Number (Percentage) of Children Ages 14 – 17 years	Number of Children within each Allegation Type
Physical Abuse	5 (11%)	6 (14%)	8 (18%)	14 (32%)	11 (25%)	44
Sexual Abuse	1 (5%)	2 (11%)	5 (26%)	6 (32%)	5 (26%)	19
Mental Injury	1 (8%)	2 (15%)	1 (8%)	4 (31%)	5 (38%)	13
Physical Neglect	3 (7%)	4 (9%)	8 (17%)	8 (17%)	23 (50%)	46
Medical Neglect	1 (50%)	-	-	-	1 (50%)	2
Contributing to the Delinquency of a Minor	-	-	-	-	5 (100%)	5
Other: Suspicious Death of a Child	1 (100%)	-	-	-	-	1
Other: Substantial Risk of Physical Abuse	-	-	-	-	2 (100%)	2

Source: Case Record Review completed in December 2021 by USC CCFS, DSS, and Co-Monitor staff
*Totals may not equal 100% due to rounding

The frequency of allegations by placement type are reflected in Table 10. Of the investigations reviewed from September 2021, most involved foster homes (43 of 54); within foster homes, the most common allegation was physical abuse (25), followed by physical neglect (16) allegations. Of all investigations in congregate care facilities, the most common allegation was physical neglect (8).

[109] Ibid.

Table 10: Allegation Types of Victim Children by Placement Type September 2021

	Foster Home	Congregate Care Facility
Physical Abuse	25	3
Sexual Abuse	8	1
Mental Injury	7	2
Physical Neglect	16	8
Medical Neglect	1	1
Contributing to the Delinquency of a Minor	2	0
Other: Suspicious Death of a Child	1	0
Other: Substantial Risk of Physical Abuse	1	0

Source: Case Record Review conducted in December 2021 by USC CCFS, DSS, and Co-Monitor staff

In four of the 54 investigations, at least one of the allegations was indicated – meaning there was a preponderance of evidence that the victim child(ren) was abused or neglected and the identified maltreater will be placed on the Child Abuse Registry unless they successfully appeal and overturn the finding. One of the four indicated investigations was indicated for physical abuse, one investigation was indicated for physical neglect, and the remaining two indicated investigations included allegations of both physical neglect and physical abuse.

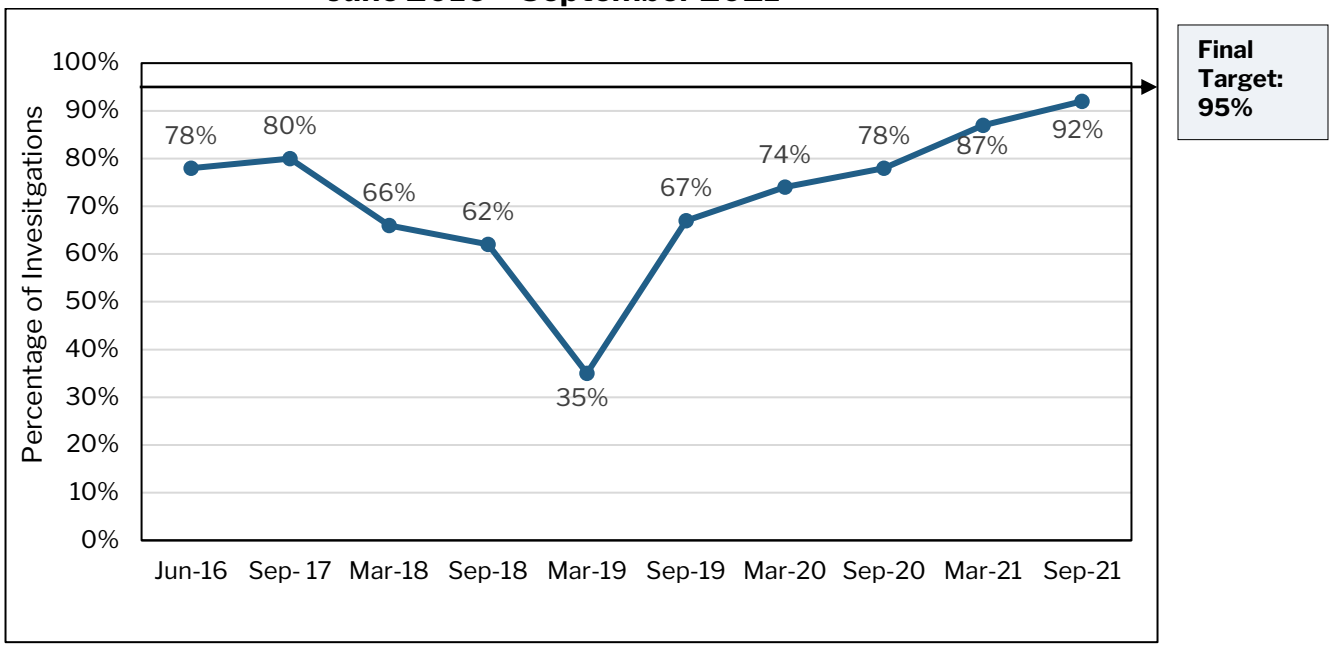
Timely Initiation of Investigations

The FSA requires that *'[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations"* (FSA IV.C.4.(a)). FSA Section IV.C.4.(b) requires *'[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors."* The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of referral by the Intake Hub and face-to-face contact with the alleged child victim must be within 24 hours.[110] DSS committed to achieving these targets by March 2021.

[110] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to contact with an alleged victim child(ren) within 24 hours: investigator attempted to see child(ren) at school or child care facility; investigator attempted to see child(ren) at doctor's visit or hospital; for child(ren) moved to an out-of-state location in order to receive specialized treatment, investigator attempted to interview by Skype or other electronic means; investigator attempted to see child(ren)

Of the 53 applicable investigations accepted in September 2021,[111] contact was made with all alleged victim child(ren) within 24 hours in 47 (89%) investigations,[112] and in an additional two (4%) investigations, all applicable good faith efforts were made to make contact with the alleged victim children;[113] thus, total compliance toward this measure is 92 percent. In one investigation in which DSS did not make contact with all alleged victim children within 24 hours, the investigator made contact with some but not all alleged victim children. Current performance shows continued improvement since March 2019 and is slightly below the final target of 95 percent (see Figure 21).

Figure 21: Timely Initiation of OHAN Investigations
June 2016 – September 2021



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

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

[111] In 1 investigation reviewed, the only alleged victim child was deceased, and could not be interviewed.

[112] In 1 of these investigations, the initial "face-to-face" contact was made via video.

[113] Specifically, in these 2 investigations, the alleged victim child(ren) was reported to be on runaway, and was missing within the 24-hour timeframe despite efforts to locate.

Contact with Core Witnesses during Investigation

The FSA requires that *'[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors"* (FSA IV.C.4.(c)). DSS committed to achieving these targets by March 2021.

A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions, and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ from investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS case manager, other child(ren) and/or adult(s) in the home, and, when involved, law enforcement. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses.[114,115]

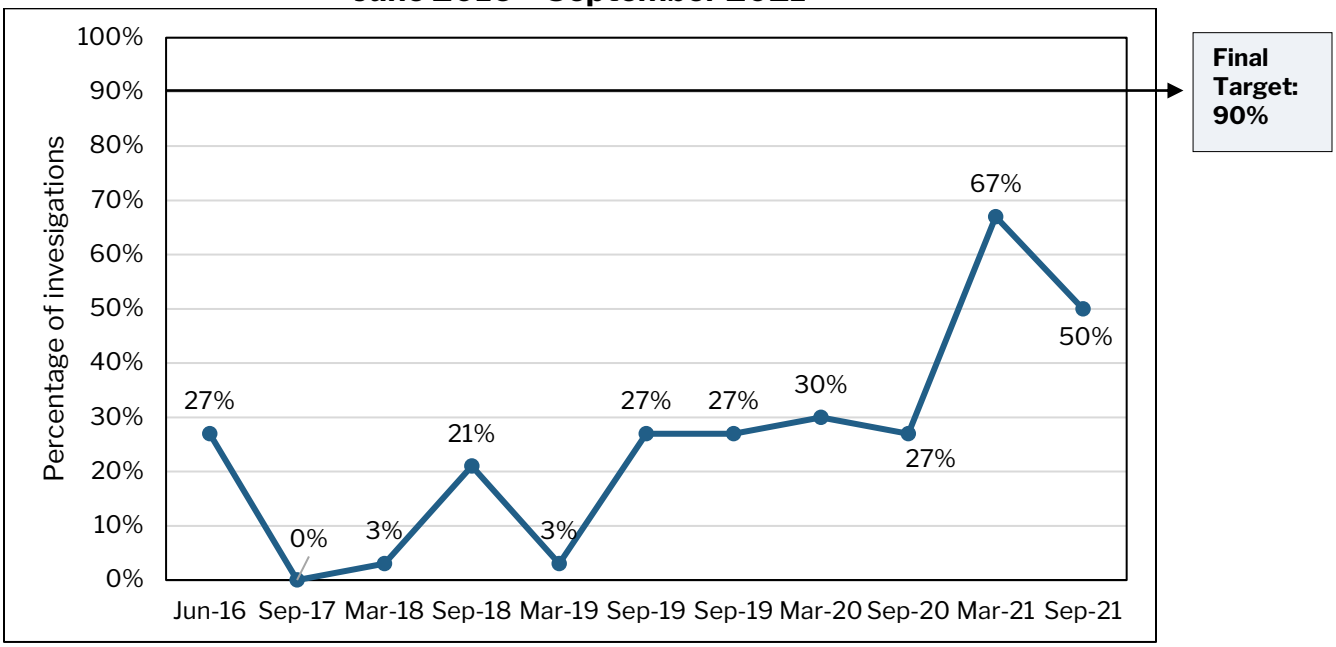
Of the 54 applicable investigations involving Class Members accepted in September 2021, 27 (50%) reflected contact with all necessary core contacts during the investigation.[116] Current performance is a decline from the prior period, and below the final target of 90 percent (see Figure 22).

[114] This definition of core witnesses was proposed in DSS's OHAN Implementation Plan, which was approved by the Co-Monitors and consented to by Plaintiffs.

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

[116] In 8 (30%) of the 27 investigations in which contact with all necessary core contacts was not made, 1 core contact was missing.

Figure 22: Contact with All Necessary Core Witnesses during OHAN Investigations June 2016 – September 2021



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

Data presented in Table 11 shows the frequency of OHAN investigator contact with each type of core witness in the 54 investigations reviewed.

Table 11: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness September 2021 N=54

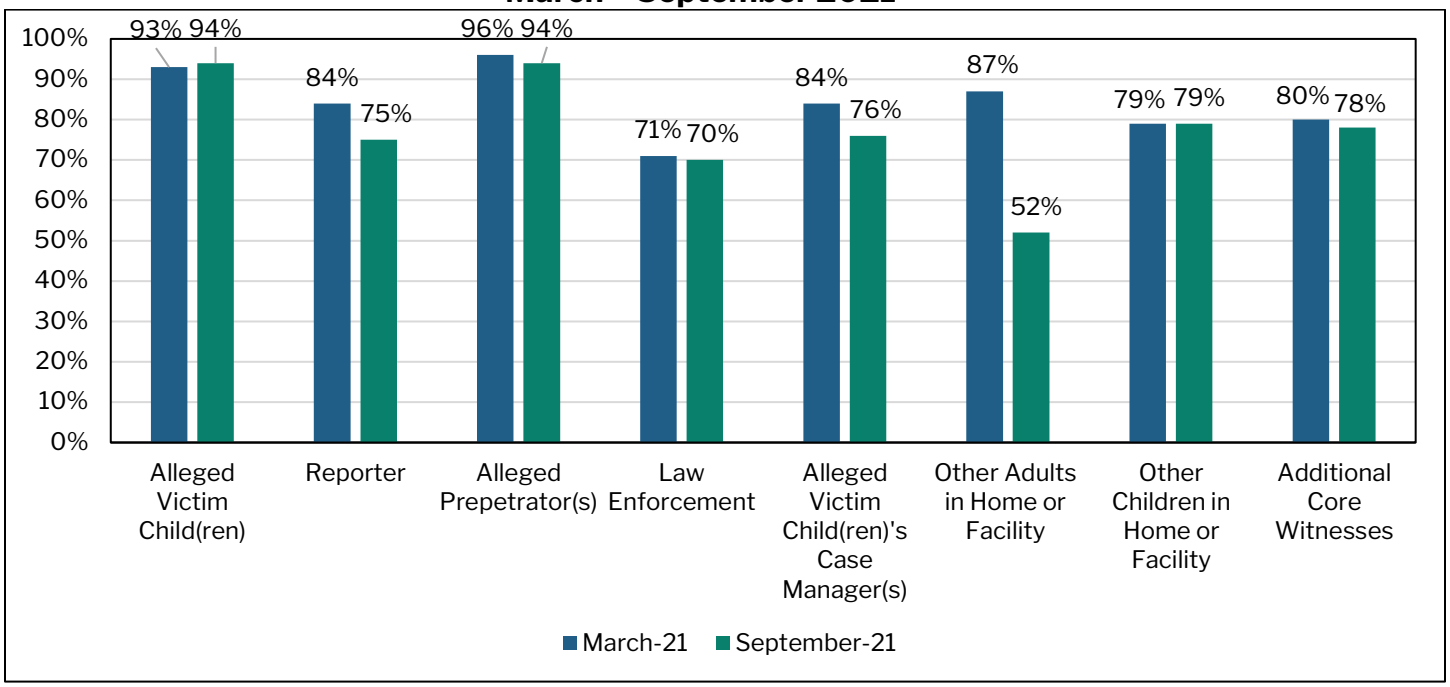
Core Witness	Number of Applicable Investigations	Contact/Interview with All	Contact/Interview with Some	Contact/Interview with None
Alleged Victim Child(ren)	52[117]	49 (94%)[118]	1 (2%)	2 (4%)
Reporter	40[119]	30 (75%)	-	10 (25%)
Alleged Perpetrator(s)	51[120]	48 (94%)[121]	3 (6%)	-
Law Enforcement	10	7 (70%)	-	3 (30%)
Alleged Victim Child(ren)'s Case Manager(s)	54	41 (76%)	3 (6%)	10 (19%)
Other Adults in Home or Facility[122]	23	12 (52%)	7 (30%)	4 (17%)
Other Children in Home or Facility[123]	34[124]	27 (79%)[125]	2 (6%)	5 (15%)
Additional Core Witnesses	50[126]	39 (78%)[127]	9 (18%)	2 (4%)

Source: Case Record Review completed in December 2021 by USC CCFS, DSS, and Co-Monitor staff
*Totals may not equal 100% due to rounding

[117] An exception to contact with the alleged victim child was applicable in 2 investigations for one of the following reasons: the only alleged victim child was deceased, and could not be interviewed; and the alleged victim child was on runaway during the course of the investigation and efforts were made to locate them.
[118] Performance includes 1 investigation in which the OHAN investigator interviewed some of the alleged victim children, and the other alleged victim child was unable to be interviewed due to being on runaway during the course of the investigation and efforts were made to locate them.
[119] In 12 investigations, the reporter was anonymous. In 1 investigation, the investigator was unable to contact the reporter despite attempts, and in 1 other investigation, the reporter refused to cooperate despite efforts.
[120] An exception to contact with alleged perpetrator was applicable in 3 investigations for one of the following reasons: the alleged perpetrator refused to cooperate despite efforts; and the investigator was unable to locate or identify the alleged perpetrator despite efforts.
[121] In 2 investigations, the investigator spoke with some perpetrators, and was unable to contact the remaining perpetrator(s) despite efforts.
[122] For investigations involving foster homes, in addition to speaking with the alleged perpetrator(s), the investigator should speak with all other adults in the household. For investigations involving institutions, the investigator should speak with all other adults who were involved in or who have knowledge of the allegations.
[123] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other children in foster care and biological or adopted children in the home. For investigations involving institutions, as facilities can have many children placed within them, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[124] An exception to contact with other children in the home or facility was applicable in 1 investigation as the legal guardian for the children refused to allow the OHAN investigator to conduct interviews with them.
[125] In 2 investigations, the investigator spoke with some other children in the home or facility, and was unable to contact the remaining other children in the home or facility due to the children refusing to cooperate.
[126] Additional core witnesses identified by reviewers in 50 investigations included: family members, medical and behavioral health providers, school or daycare personnel, GALs, current or previous placement providers, foster home licensing workers, other DSS staff, and staff from the Department of Juvenile Justice (DJJ).
[127] Performance includes 2 investigations in which contact was made with some additional core witnesses, and the other additional core witnesses refused to cooperate.

Data in Figure 23 show the frequency of contact within all categories of core witnesses in September 2021 as compared to the prior review in March 2021. Declines are noted in the frequency of contact with reporters, alleged victim children's case managers, and other adults in the home or facility.

Figure 23: Contact with Necessary Core Witnesses During OHAN Investigations March – September 2021



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

Although performance overall reflects a decline since the prior period, Co-Monitor staff who participated in the review observed improved documentation of interviews that are conducted, and more investigations in which OHAN supervisors and case managers are expanding the type (and number) of core contacts they make as relevant to the individual investigation.

Investigation Case Decisions

At the conclusion of an investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[128]

Section IV.C.3. of the FSA requires that *'[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS*

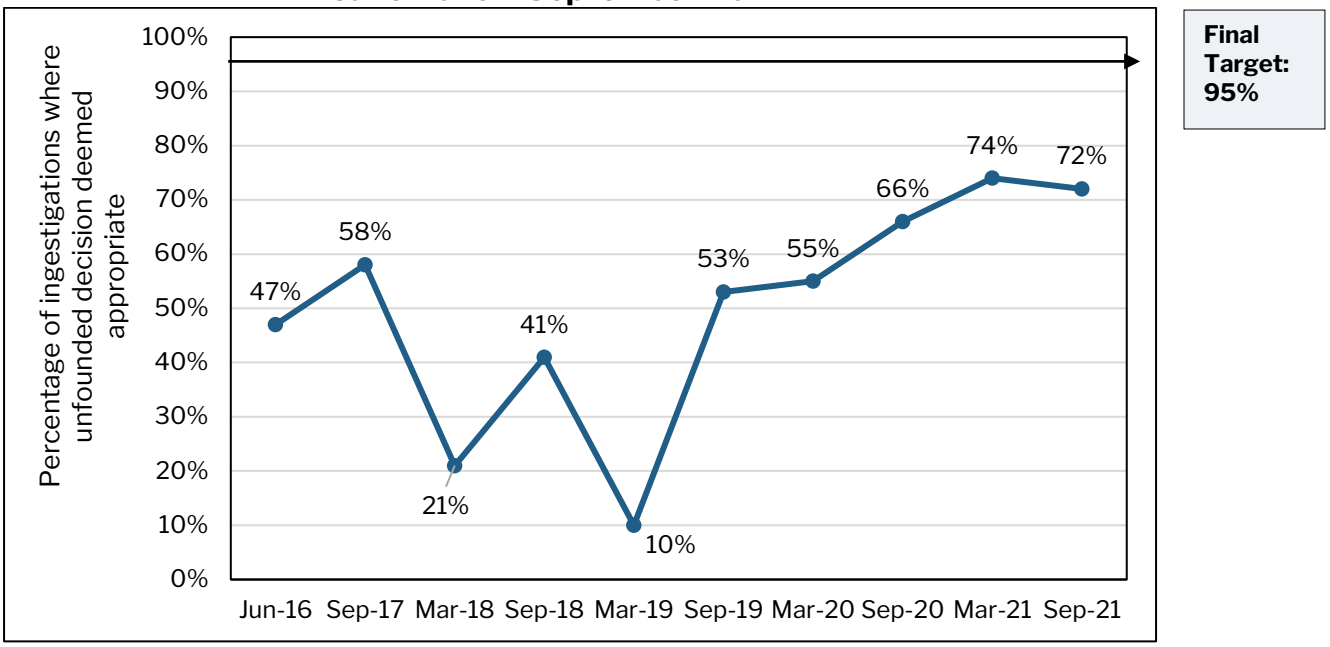
[128] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16 (effective 2019).

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." DSS committed to achieving these targets by March 2021.

Of the 54 applicable investigations reviewed for September 2021, the final case decision was to *unfound* the allegations in 50 investigations. Reviewers agreed that the case decision to *unfound* the investigation was appropriate in 36 (72%) of the investigations.[129] In most (93%, or 13 of 14) investigations in which the reviewer did not agree with the decision to *unfound*, the disagreement was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the case, including, for example, not interviewing a witness with relevant information, not clarifying conflicting information, or not collecting medical or forensic reports.

Performance declined slightly from last period and is below the final target of 95 percent.

Figure 24: Decision to Unfound OHAN Investigations Deemed Appropriate June 2016 – September 2021



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

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

Timely Investigation Completion

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

- *'At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA IV.C.4.(d)). The March 2021 final benchmark for this measure is 95 percent, which is higher than the FSA final target.
- *'At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA IV.C.4.(e)). The March 2021 final benchmark for this measure is 95 percent, which is higher than the FSA final target.
- *'At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA IV.C.4.(f)). DSS committed to achieving these targets by March 2021.

The FSA and OHAN policy provide that the OHAN Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[130] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision.[131]

[130] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16 (effective 2019).

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

Completed within 45 Days

Of the 54 investigations reviewed, in nine investigations, a request for an extension was submitted by the investigator and approved by the OHAN Director for an additional 15 days to complete necessary investigative tasks. Of the remaining 45 investigations, one investigation was not closed within 45 days and did not have an approved extension reason, and reviewers determined that one investigation was prematurely closed as unfounded in an effort to meet the 45 day requirement, which is not considered compliant under the FSA.[132] Thus, of the 45 investigations assessed for the 45-day closure measure, 43 (96%) investigations were timely completed within 45 days (see Figure 25). Current performance meets the final benchmark and target for this measure.

Completed within 60 Days

Fifty-three (98%) of the 54 investigations were completed within 60 days of opening.[133] Performance meets the final benchmark and target for closure within 60 days.

Completed within 90 Days

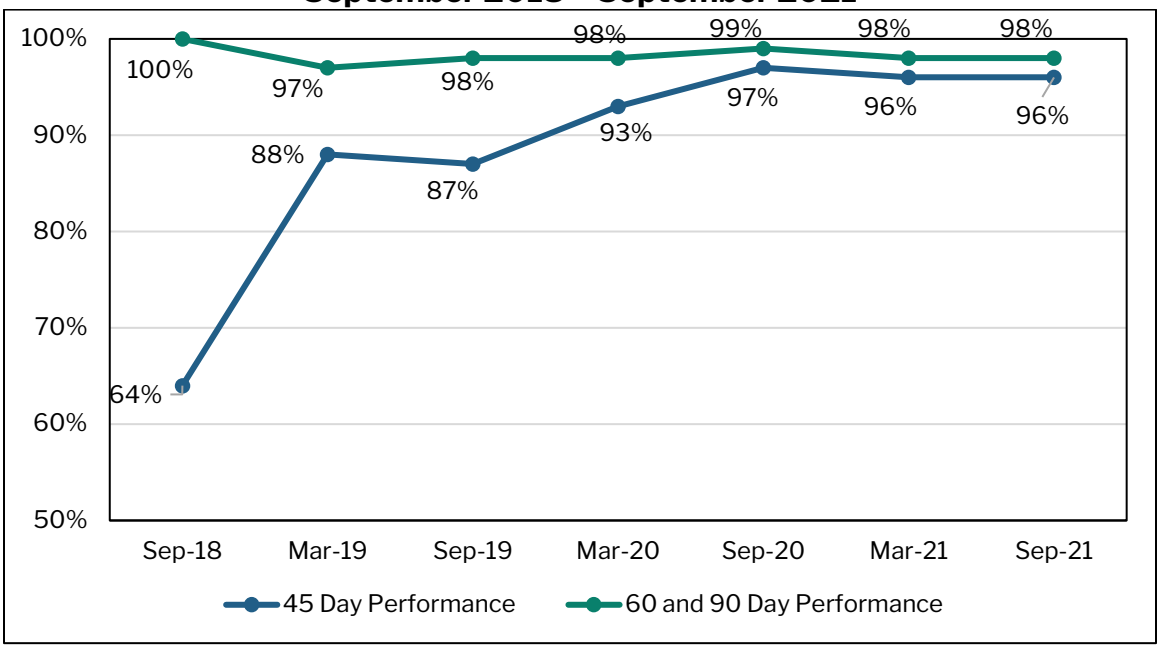
Since all investigations were closed within 60 days, performance toward 90-day closure is also 98 percent, and performance meets the final benchmark and target for this measure.

Figure 25 reflects performance for timely closure from September 2018 to September 2021.

[132] This investigation was closed on the 45th day after intake even though there were documented incomplete tasks. Although closed in DSS's system, this investigation is not included in the numerator as compliant for any of the timely closure measures.

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

Figure 25: Timely Completion of OHAN Investigations
September 2018 – September 2021



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

DSS has met the required performance levels for all three measures assessing timely completion of investigations since September 2018. Pursuant to FSA Section V.E., the Co-Monitors have identified these measures as eligible for Maintenance of Efforts status.[134]

[134] Pursuant to FSA V.E.1-3, the Co-Monitors identify these provisions may be eligible for "Maintenance of Effort" designation by the Court. Defendants have previously achieved compliance with the obligations set forth in FSA IV.C.4.(d), (e), and (f), as reflected in the April 24, 2019, September 16, 2019, February 28, 2020, October 6, 2020, April 16, 2021, and October 6, 2021 monitoring reports.

VIII. Placements

Child welfare policy and best practice require that children in foster care be in family-like environments, in or close to their home communities, and with kin caregivers and siblings whenever possible. To fulfill these requirements, child welfare systems must identify and support kin and family-based caregivers and provide flexible, accessible, individualized interventions to address children's safety, health, and well-being.

During this period, DSS continued to reduce its reliance on congregate care for child placements and nearly all children ages 12 and under were placed in family-based settings at the end of the monitoring period. This is a significant accomplishment. DSS has also slowly but steadily continued to increase children's placements with licensed kin caregivers.

Identifying and maintaining an appropriate array of placements and supports for children in foster care throughout South Carolina continues to be a significant challenge for DSS, however, and there remains a severe shortage of foster homes and quality services to support children and families in their communities. Placement decisions continue to be made based on availability, rather than through purposeful consideration of the unique needs of children and families, the skill sets of foster parents, and the possibility of wrapping supports around children and kin caregivers in ways that allow children to be safe and thrive. Children are often placed far from their home communities and schools, and separated from siblings or other important people in their lives. The lack of community-based services and other supports places untenable pressure on biological, kinship, and foster families, resulting in frequent placement disruptions.

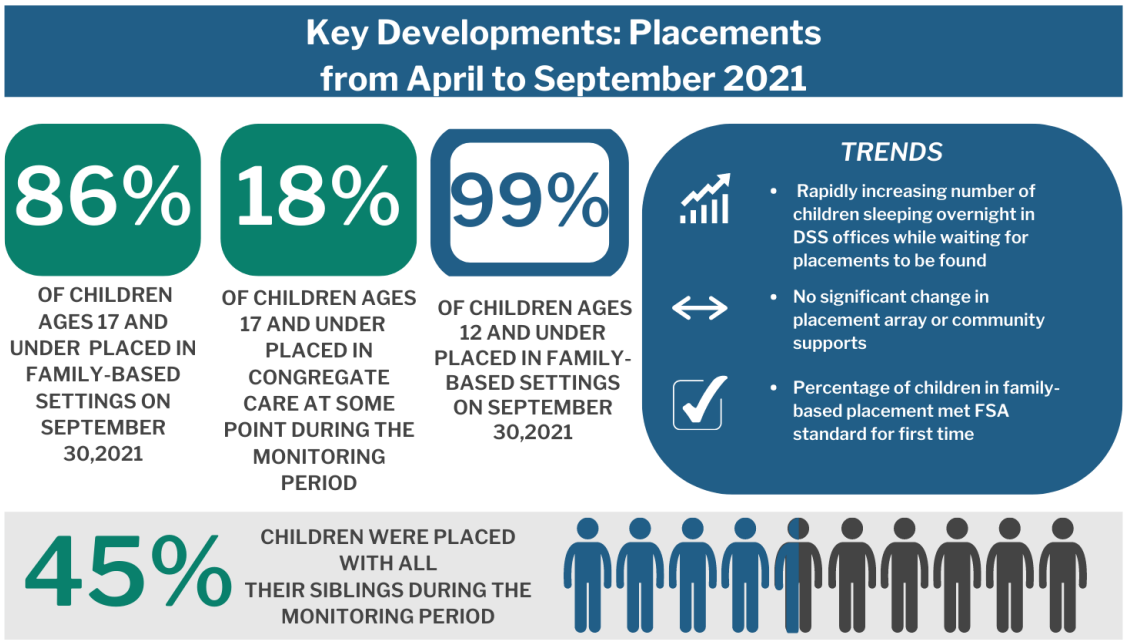
As DSS's placement challenges have grown, an ever-increasing number of children have spent nights sleeping in DSS offices, moving between emergency placements, or sleeping in "sitter cottages."[135] Between April 2018 and March 2021, there were on average three overnight stays by children in DSS offices during any six-month period. In contrast, for the six-month period between April and September 2021, 34 children stayed overnight in DSS offices for a total of 68 nights. The placement crisis has continued to intensify in the months since the close of the monitoring period, with no end in sight. Between October 1, 2021 and March 14, 2022, DSS reported that 99

[135] DSS reports it is utilizing "sitter cottages" on 3 group care campuses, wherein DSS contracts with a group care agency for unused cottages, and separately contracts with a health care or "sitter" agency to provide staffing to monitor children for whom DSS had not yet identified placement. This arrangement was originally developed to provide placements for children who tested positive for COVID-19 or were otherwise required to quarantine.

children spent a total of 250 nights sleeping in offices.[136] And many more children spent long days in the office, moving to emergency placements for the nighttime hours, only to return to the office the next morning to wait again.

In the Co-Monitors' judgement, DSS has not made sufficient progress in implementing the court-ordered Placement Implementation Plan and in redesigning its system of placement array and supports, decision-making, and processes. Although DSS has continued to consider ways to address these significant challenges, and has stated its intention to revise this Plan, meaningful progress remains elusive. There are important elements of the Plan that DSS has only partially acted upon or has not yet initiated that have the potential to bring about real change for children and families. These include a robust Child and Family Teaming process, pilot programming, and performance-based contracting to incentivize aggressive and creative resource development. The Plan also requires significant work with private providers, who remain eager and willing to partner with DSS in developing solutions, but have yet to be meaningfully engaged as partners. DSS is pursuing some medium- and long-term strategies to recruit a greater number of foster parents and access to funding for more community-based services, but in the immediate term, there remain a lot of questions about what is being done to appropriately serve children and their families.[137] DSS's ability to access federal and state resources, work closely and meaningfully with its partners, and commit to aligning the core commitments included in the Placement Implementation Plan with the key strategies of DSS's broader reform effort, is essential to improving the experience and outcomes of the children in its care, and thus far have been insufficient.

[136] Detailed data on overnight stays in DSS offices between October 1, 2021 and March 31, 2022 will be included in the next monitoring report.
[137] DSS has developed and submitted to the Children's Bureau a recruitment and retention plan that includes targets for 2020-2024 and outlines a range of actions that are in various stages of planning.



Placements: Progress and Implementation Updates

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

On February 20, 2019, DSS obtained Co-Monitor approval of its Placement Implementation Plan, and on February 27, 2019, the Plan was approved by the Court.[138] The Plan incorporates Placement Needs Assessment recommendations and reflects a reliance on children's family members and a strong preference for keeping children, with appropriate supports, in family-based settings in their own communities, and with kin or fictive kin whenever possible.[139] The Plan also includes commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making, commitments to closer strategic partnerships with private

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

[139] Fictive kin refers to individuals who are not related to a child by birth, adoption, or marriage, but have emotionally significant relationships with the child.

providers to develop a placement and service array to meet the needs of children and families, and commitments to developing crisis intervention services especially for kin caregivers. These are substantial undertakings, which require not only significant resources, but re-orientation of the workforce and extensive engagement with key partners, such as foster parents, family members, and placement and service providers. More than three years after the finalization of the Placement Implementation Plan, as discussed further below, DSS has still not fully implemented many of the core strategies to which it committed, and in some areas, work has not begun.

In early 2020, DSS leadership sought to amend the Placement Implementation Plan to both account for unanticipated delays in implementation due to funding inadequacies and to align with the (then, new) leadership team's reform vision. The Co-Monitors were open to working with DSS on modifications and a completion date for Plan modifications was set at September 30, 2020 in the Mediation Agreement.[140] This timeline was not met; DSS leadership then anticipated sharing an updated proposal by June 2021, which did not occur.[141]

Although DSS reports that it has continued to move forward its work in this area – meeting with private providers and stakeholders, and collaborating with DHHS on Medicaid strategies – it has not moved with the urgency required. The increasing surge of children sleeping overnight in DSS offices highlights the critical need for full and immediate implementation or modification of this Plan. Until a Placement Implementation Plan modification is completed, approved, and entered by the Court, the current plan is enforceable, and the Co-Monitors have continued to assess progress toward the identified strategies and activities in the approved Plan. The discussion below reviews elements of the Plan under three headers – ensuring an adequate quantity and array of placement resources and supports, ensuring the safety of placements, and achieving individualized, team-based planning – all overarching goals of the Placement Implementation Plan.

Ensuring adequate placement resources and supports

Kin Placement

As of October 2020, DSS policy requires case managers to make "concerted efforts" to identify and place children with kinship caregivers "throughout the life of a case,"

[140] COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201)
[141] DSS Letter to Court (February 1, 2021, Dkt. 207, p.15)

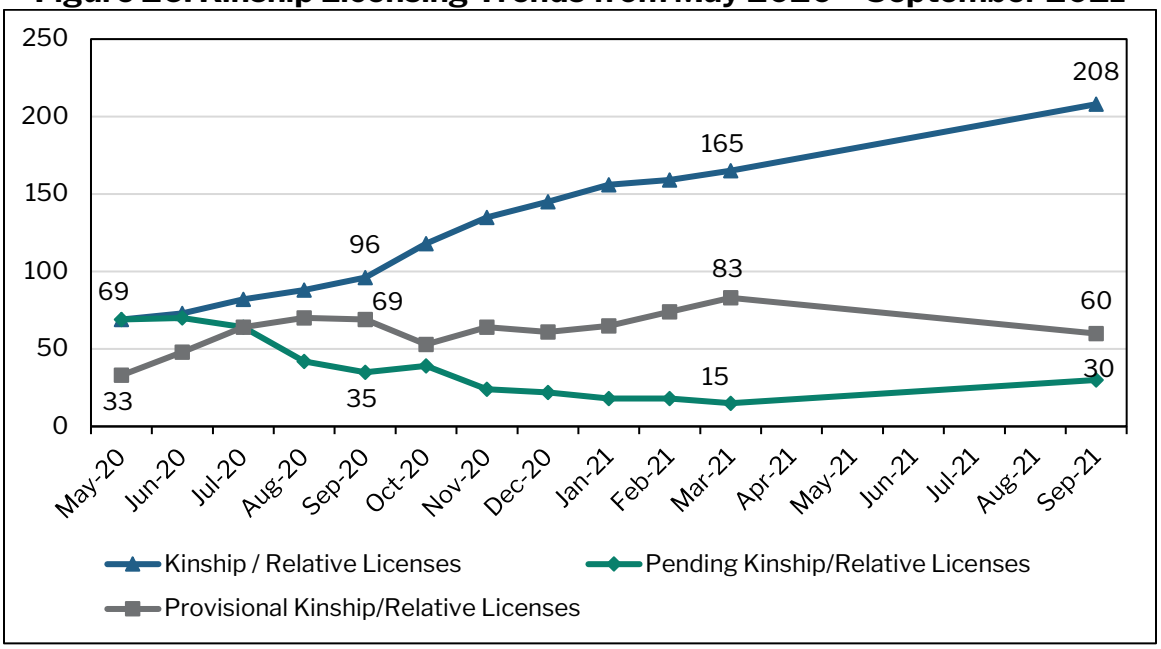
and case managers need to obtain supervisory approval to place a child with an unrelated caregiver when placement with kin is not possible.[142] This has been an important policy and culture shift. DSS reports that staff provide kin with the information and assistance needed to become licensed caregivers, and that they are building an understanding among staff, community partners, and court officials of this approach to kinship foster care. A DSS Kinship Advisory Panel – which includes five kin caregivers, a DSS kinship care manager, four DSS kinship coordinators, and two representatives from community-based advocacy groups – has continued to convene to discuss issues of relevance to the kin care community. A subgroup is also meeting monthly to discuss internal processes and staff communication that could help build a "kin-first" culture within DSS.

DSS has gradually increased the number of kin caregivers applying to be licensed foster placements, allowing those caregivers to access a financial stipend. The number of licensed kin homes is now 208, an increase of 43 homes from the end of the prior monitoring period. As shown below in Figure 26, there were 60 active provisional kinship home licenses as of September 2021.[143,144] Approximately 700 children are now placed with kin caregivers, though half of those are unlicensed placements without access to financial stipends. Figure 26 shows the improvement in kin licensing since May 2020.

DSS is in the process of re-examining the level of staffing capacity needed to license and support kin caregivers. The engagement of private Child Placing Agencies (CPAs)[145] as partners in the licensing process has been helpful in freeing up limited internal DSS licensing staff to focus exclusively on the licensing of kin homes.[146] However, DSS again did not receive funding to support new kin licensing positions in the FY2021-2022 budget, and the ongoing shortage of community supports for kin caregivers can make it difficult to maintain these placements.

[142] Child Welfare Policies and Procedures Manual, Chapter 5, Section 510.2.1 (effective October 2020)
[143] Provisional licensure allows a child to be placed in the kin home before the full foster parent licensure process has been completed.
[144] As per DSS's Joint Report commitments, a permanent regulation to support provisional licensure of kin was published on May 13, 2020.
[145] As in many systems across the country, some private organizations are licensed as Child Placing Agencies (CPAs). These agencies receive funding to provide foster care placement and monitoring through group facilities or by recruiting, training, and licensing foster parents. Approximately 33 percent of children in DSS custody were placed through CPAs at the end of the monitoring period. The responsibility for overseeing CPAs falls under Permanency Management.
[146] Since July 2020, all potential non-kin foster home providers have been referred to CPAs for licensing.

Figure 26: Kinship Licensing Trends from May 2020 – September 2021



Source: Data provided by DSS

DSS requested additional funding to expand Kinship Navigation Services in its FY2022-2023 budget, and in the meantime, is contracting with HALOS, a Charleston-based organization that provides services to support kinship families, for limited kinship navigator services.[147] DSS has continued to provide weekly training sessions for kin caregivers through a curriculum titled *Caring for Our Own*. Between July and September 2021, 34 kinship caregivers had participated. This is a start, but far from a full realization of DSS's vision for a robust Kinship Navigator program.

Foster Parent Board Rates

Due to the COVID-19 pandemic, DSS utilized funding available as part of an increased federal Medicaid match rate under the Families First Coronavirus Response Act (FFCRA)[148] to move ahead with a rate adjustment to foster parents for board payments on a temporary basis.[149] Enabled by the General Assembly's FY2021-2022 allocation, DSS was able to make these enhanced rates to foster parents for board payments permanent as of July 1, 2021. DSS is hoping that as it continues to move children from congregate care placements (which are more costly than family-based placements) into family-based settings, additional savings may be realized that can

[147] To see the services and resources provided by HALOS, go to: https://www.charlestonhalos.org/
[148] The FFCRA, passed by Congress on March 18, 2020, includes a temporary increase to states' Federal Medicaid Assistance Percentage (FMAP) – the federal share for Medicaid health care and health related services. The FFCRA has enabled South Carolina to receive an increase of 6.2% to its FMAP rate, previously set at 70%. (Families First Coronavirus Response Act, Publ. L. No. 116-127, H.R.6201. (2020)).
[149] H.R.748 Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, Public Law 116-136

be repurposed for subsequent increases in payments to family-based providers and for the development of necessary community supports.

Ensuring the safety and quality of placements

In 2018, consultants engaged by the Co-Monitors reported that many facilities, particularly at higher levels of care, offer restrictive environments with inflexible rules that can be arbitrary and punitive, with "little indication of individualization of assessment and case planning, cramped interpersonal settings, often contained in locked or fenced settings, excessive reliance on [medication,] seclusion and restraint."[150] Stakeholders, OHAN investigations, and the notifications of reasons for overnight stays in local DSS offices continue to reveal similar conditions for children who reside in these facilities at present. DSS has begun work to improve the quality and safety of such facilities, but has not yet fully implemented a robust safety monitoring process to address unsafe and/or unnecessarily restrictive placements for children as part of its Continuous Quality Improvement (CQI) efforts. Such a process would include, at a minimum, contractual limitations on harmful practices such as seclusion and restraint; in-depth interviews with children and youth; ceasing placement of children in facilities that have been reported to be inappropriate or overly punitive; and regular in-person and visits from licensing staff that result in real problem solving for root causes of harm.

Safety and Quality Response

DSS reports that it has continued to convene OHAN, Contract Monitoring, and Licensing staff to collaborate in response to concerns about safety at group homes and in foster homes, using the Safety and Quality Response Review Protocol. The protocol was developed in accordance with the Placement Implementation Plan to review placement providers who have received three or more reports of abuse and/or neglect that have been accepted by OHAN for investigation within six months. During this monitoring period, 14 congregate care facilities and two foster homes were reviewed pursuant to this process. In the prior monitoring period, 11 congregate care facilities and three foster homes were reviewed. This is a significant increase from the six-month period between July and December 2020, in which four congregate care facilities and four foster homes were flagged for review.

[150] Taylor, George, and White, Marci (December 21, 2018). Review of South Carolina Residential Treatment Facilities and Group Homes Utilized by DSS. *Technical Assistance to the Michelle H. v. McMaster Co-Monitors*.

According to DSS, some overarching needs that have been identified through this process include the need for more specialized training opportunities for staff to respond appropriately and safely to children's behaviors. The Co-Monitors remain concerned that the Safety and Quality Response process does not yet address the underlying causes of the safety issues in many facilities. This process has been in place for a year and a half and abuse and/or neglect investigations continue to be necessary for many of the same, and a growing number of, providers.

Congregate Care Reduction

DSS has continued to reduce the number of children placed in congregate care. In acknowledgement of the importance of family-based placements, and the heightened risk of harm to children and staff in group settings during the COVID-19 pandemic, DSS continued the comprehensive case review process to which it committed to in the Mediation Agreement in July 2020.

As of September 2021, the cases of 235 children who were placed in congregate care settings had been reviewed in Expedited Permanency Meetings (EPMs) by regionally based teams composed of Performance Coaches, Well-Being Managers, case managers, and supervisors, with the support of a national organization with child welfare expertise. Many of these children were either moved to less restrictive placements or reunified with family.[151] The success of this strategy will ultimately depend upon the expansion and availability of community-based supports necessary for children to remain in their own homes or reside safely and stably in family-based settings while in foster care. Also important will be the implementation of a robust teaming process, consistent with the GPS model of case practice, and partnership with congregate care providers in planning for the smooth transition of children from group care to family-based settings.

[151] In the prior monitoring period, DSS began reviewing the cases of children in Level 1 and Level 2 group care to evaluate if these children could be moved to family-based settings. The first cohort contained 36 children, whose meetings primarily occurred between October and December 2020. The second cohort contained 109 children, whose meetings primarily occurred by April 2021; and the third cohort contained 90 children, whose meetings primarily occurred between June and August 2021. As of November 16, 2021, DSS reports that of the first cohort of 36 children, 28 meetings were held, and 23 children were moved to family-based settings either before or after the meeting occurred. Of the second cohort of 109 children, 51 meetings were held, and 69 children were moved to family-based settings. As reported in the prior monitoring period, 45 of the 69 children who moved to a family-based setting were moved before the EPM occurred. Of the remaining children who did not step down to family settings, 18 remained in group care (43%), 13 had run away (31%), 5 had declined an EPM (12%), and 9 had aged out of foster care (21%). Of the third cohort of 90 children, 41 meetings were held, and 46 children were moved to family settings either before or after the meeting occurred. Of the remaining children who did not move to family settings, 28 children remained in group care (62%), 3 had run away, 1 had declined an EPM, and 13 had aged out of foster care (29%).

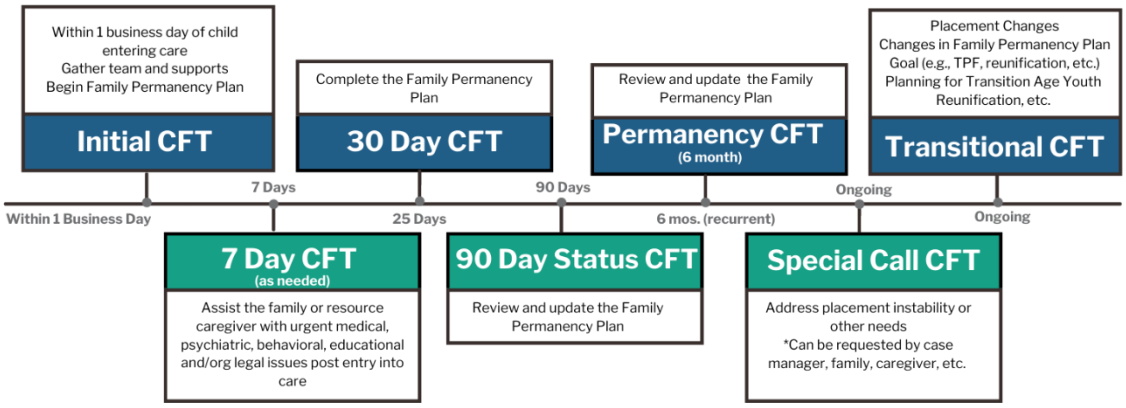
Achieving individualized, team-based planning

DSS leadership has continued its work to develop internal capacity to engage families and community partners through the implementation of a Child and Family Team (CFT) model. In early 2020, DSS Director Leach decided to transition from its former model that outsourced teaming facilitation to a contracted provider to a model based in building the capacity of DSS staff to incorporate CFTs into their own practice. DSS has hired and onboarded for most of its family engagement positions, which includes three family engagement coaches, four supervisors, six administrative assistants, and 25 facilitators. DSS is in the process of hiring a program manager and an additional family engagement coach, after these positions became vacant.

As of September 2021, DSS reports that the CFT model had been introduced to staff in all of the state's 46 counties. As part of this rollout, case managers complete a Family Permanency Plan for each family, which is informed by two assessment tools – the Family Advocacy and Support Tool (FAST), and the Child and Adolescent Needs and Strengths (CANS) tool. These tools are intended to maximize communication and assessment around family needs and to support the teaming and planning process. Technical trainings on FAST and CANS and the Family Permanency Plan began in select counties in July 2021 and were also conducted in September and October 2021. Training modules around CFT have been added to the Child Welfare Certification Training to build the foundational engagement and teaming skills.

The CFT model necessitates that team meetings be held throughout a child's experience in foster care including at five key points in the life of a case; two additional types of CFTs can be held as needed (Figure 27).

Figure 27: Child & Family Teaming Foster Care Timeline[152]



Source: Graphic provided by DSS

During the monitoring period, 732 CFTs were completed statewide; these included a mix of CFTs conducted prior to a child being removed from their home, those conducted after a child entered foster care, those conducted 30-days after a child entered foster care, those conducted six months after a child entered foster care, and other "special call" CFTs during the case. Some counties have conducted over 50 CFTs at this stage, whereas other counties have conducted far fewer. Due to the COVID-19 pandemic, the vast majority of these meetings have been held virtually.

The shift towards an understanding that case managers need the skills and knowledge for effective engagement throughout their work with children and families is foundational. The success of the CFT strategy will depend upon DSS's ability to integrate the approach in a way that enables *all* DSS case managers to facilitate CFTs and practice in ways that are consistent with these values. In addition, the CFT model can only be expected to have an impact on the experiences of families engaged with DSS once there has been full implementation of the GPS Case Practice Model, and widespread availability of community-based services and supports for families statewide.

[152] CFTs indicated in blue are required to be facilitated by a Family Engagement Specialist (FES) Facilitator, while CFTs indicated in green could be facilitated by case managers.

Performance Data

Placement of Children in Family-Based Settings

The FSA contains several provisions related to the placement of children in the most family-like, least restrictive environments necessary to meet their needs. Overall, the FSA requires that "*at least 86 percent of Class Members be placed outside of congregate care on the last day of the reporting period*" (FSA IV.E.2.). DSS committed to achieving these targets by March 2021.

As of September 30, 2021, 86 percent (3,385 of 3,918) of Class Members were placed outside of a congregate care placement and in family-based settings (see Table 12). Twenty-four children resided in other institutional settings outside of DSS's control due to an acute medical need or incarceration.[153] As shown in Figure 298, current performance meets the final FSA target for the first time. This is a notable accomplishment.

Table 12: Types of Placements for Children
September 30, 2021

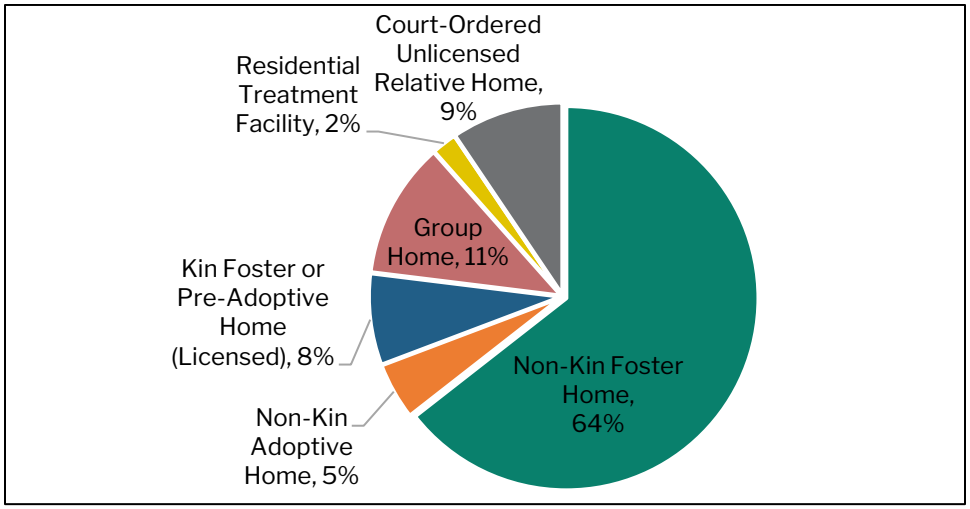
Children in Foster Care	
3,918 (100%)[154]	
Type of Placement	**Number (%) of Children**
Family-Based Setting	3,385 (86%)
Congregate Care	533 (14%)

Source: CAPSS data provided by DSS

Figure 28 depicts the breakdown of placements for all children in foster care, both family-based and congregate care, on the last day of the monitoring period. Most children (64%, or 2,525 of 3,918) were placed in non-kin foster homes; 370 children (9%) were placed in court-ordered unlicensed kin homes; 302 children (8%) resided in licensed relative foster homes; and 83 children (2%) were placed in residential treatment facilities.

[153] Specifically, DSS reports that 13 children were incarcerated in correctional or juvenile detention facilities, and 11 children were hospitalized.
[154] This does not include 24 children who resided in other institutional settings on the last day of the monitoring period.

Figure 28: Percentage of Children in Family-Based and Congregate Care Placements September 30, 2021 N=3,918



Source: CAPSS Data provided by DSS

Children Ages 12 and Under

The FSA includes placement standards specific to certain age groups of children, and requires that *'[a]t least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file"* (FSA IV.E.3.). DSS committed to achieving these targets by March 2021.

As reflected in Table 13, as of September 30, 2021, 2,540 of 2,587 Class Members ages 12 and under resided outside of a congregate care placement and in family-based settings, and 10 children ages six and under resided in congregate care pursuant to a valid exception, resulting in performance of 99 percent.[155] As shown in Figure 29, performance toward this measure has improved steadily since March 2018 and again meets the final target of 98 percent (for the second time).[156,157]

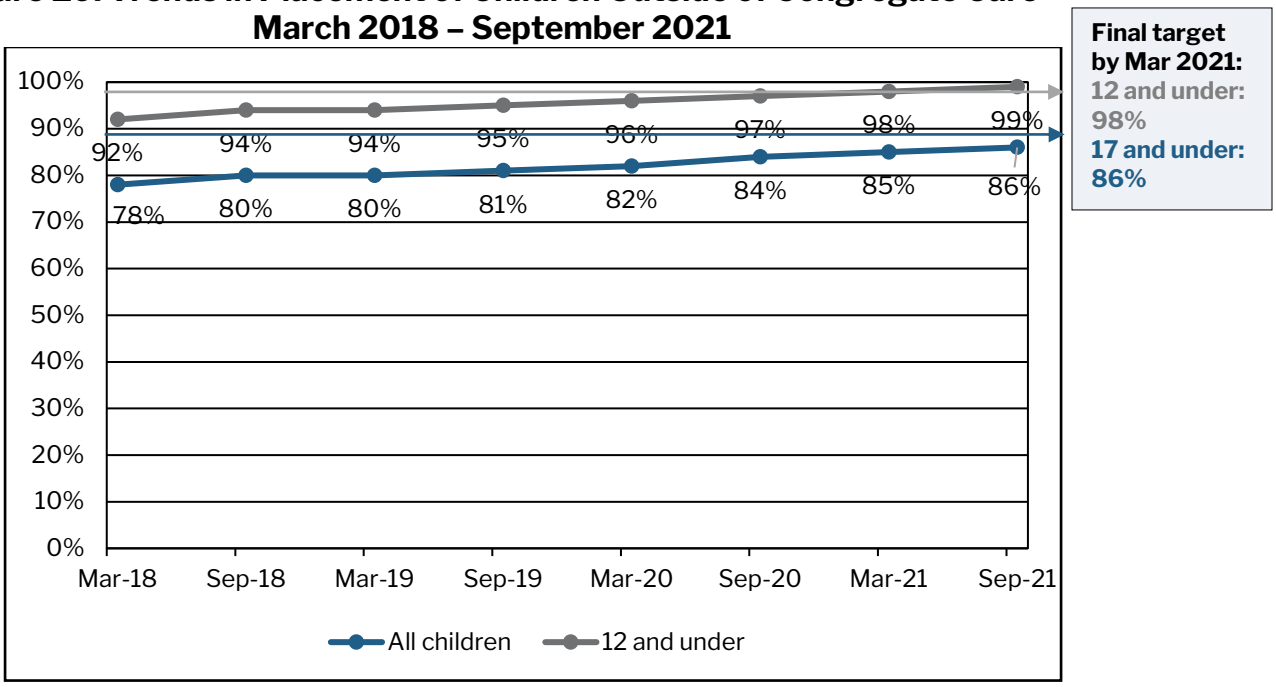
[155] Six additional children were hospitalized on the last day of the monitoring period and are excluded from the calculations.
[156] The Co-Monitors have approved exceptions for placing children ages 7 to 12 in a congregate care facility and built a process for submitting documentation and approval for exceptions during this monitoring period. For those children placed between April and September 2021, DSS did not submit any exceptions.
[157] Pursuant to FSA V.E.1-3, the Co-Monitors identify this provision may be eligible for "Maintenance of Effort" designation by the Court. Defendants have achieved compliance with the obligations set forth in FSA IV.E.3., as reflected in the October 6, 2021 and current monitoring reports.

Table 13: Types of Placements for Children Ages 12 and Under
September 30, 2021

All Children in Foster Care Ages 12 and Under	
2,587 (100%)[158]	
Type of Placement	**Amount of Children**
Family-Based Setting	2,550 (99%)[159]
Congregate Care	37 (1%)
Breakdown of Type of Congregate Care	
Group Home	23
Residential Treatment Facility	14

Source: CAPSS data provided by DSS

Figure 29: Trends in Placement of Children Outside of Congregate Care
March 2018 – September 2021



Source: CAPSS data provided by DSS

These data reflect the percentage of children in each type of placement on the last day of the monitoring period. Data show that three percent (96 of 3,544) of Class Members ages of 12 and under in care at any time during the monitoring period were placed in congregate care at some point between April and September 2021.[160] For

[158] This does not include 6 children who were hospitalized on the last day of the monitoring period.
[159] This includes 10 children ages 6 and under who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[160] These data do not include children who were placed in other institutional settings at some point during the monitoring period, such as children who were hospitalized. The Co-Monitors have not independently validated these categorizations.

children between the ages of seven and 12, five percent (74 of 1,452) were placed in a congregate care setting at some point between April and September 2021.[161] This represents a reduction from the prior monitoring period, when eight percent of Class Members between the ages of seven and 12 were placed in congregate care at some point during that six-month period.

The vast majority (84%, or 450 of 533) of children placed in congregate care – which includes group homes, residential treatment facilities, or emergency shelters – reside in group homes. These facilities are categorized and funded based on the level of support they are expected to provide to a child (either Level 1, 2, or 3). As has been previously reported, the facilities vary in terms of available supports, programming, and level of restriction.

The data in Figure 29 do not capture children's experiences over the entirety of their time in foster care, and do not include children who resided in other institutional settings, such as psychiatric hospitals, DJJ placements, or correctional facilities. Available data on children who experienced congregate care at *any* time during the monitoring period show a greater incidence of congregate care placement, particularly amongst older youth, though incidence for this age group has also been reduced over time. Data show that 18 percent (926 of 5,270) of all children in foster care during this monitoring period were placed in a congregate care setting at some point between April and September 2021, which is approximately the same as the number in the prior monitoring period, but a slight reduction from 22 percent of children between April and September 2020.

Children Ages 13 to 17

As referenced above, children ages 13 to 17 are more likely than younger children to spend time in congregate care. On September 30, 2021, 486 (37%) of 1,331 children ages 13 to 17 resided in congregate care. This is a reduction and improvement from prior periods. Additionally, slightly less than half (48%, or 829 of 1,724) of children ages 13 to 17 in foster care at any time between April and September 2021 were placed in a congregate care setting at some point during that time. This is also a reduction and improvement from prior periods, as seen in Table 14.

[161] Ibid.

Table 14: Adolescents in Congregate Care Placements
April 2019 – September 2021

Monitoring Period (MP)	Percentage of 13 – 17-year-olds in congregate care on the last day of the MP	Percentage of 13 – 17-year-olds who spent time in congregate care at some point during the MP
April to September 2019	52%	64%
October 2019 to March 2020	49%	62%
April to September 2020	42%	57%
October 2020 to March 2021	39%	49%
April to September 2021	37%	48%

Source: CAPSS data provided by DSS

Children Ages Six and Under

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

On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings),[162] and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure requires approval of a Regional Director prior to the placement of any child in a non-family-based setting.

Of the 25 children ages birth to six who resided in congregate care facilities during the monitoring period, most (84%, or 21 of 25) were placed there pursuant to an agreed upon exception. Specifically, 15 children resided in a treatment facility or

[162] The following are exceptions, approved by the Co-Monitors, to the requirement that children ages 6 and under be placed outside of congregate care: the child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family-like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs; the child is the son or daughter of another child placed in a group care setting; or the child coming into care is in a large sibling group and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that the last instance, placement in a facility that can accommodate the sibling group together and maintain daily contact between siblings is an allowable exception. This exception is time-limited for up to 90 days and can be extended for time-limited increments after considering and documenting the best interests of the children and pursuing and documenting intensive efforts to identify and support an appropriate placement or placements.

group care setting with their mothers; nine children were part of a large sibling group for whom DSS reported a single, family-based placement could not be located despite efforts; and one child was in a residential treatment facility after being hospitalized.[163] While the Co-Monitors do not recommend sibling groups be separated in order to meet the terms of this measure, it is essential that efforts be made to secure more family-based placements that can accommodate all siblings. Additionally, a medical necessity exception must be accompanied by evidence that the child has a clinical need that could only be met in a congregate setting *and* that the chosen facility has the capacity and specialized treatment to meet those needs.

Placement Instability

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

Shortly before publication of this report, DSS discovered errors in its placement instability data that led it to conclude that these data, which had been collected, analyzed, and provided to the Co-Monitors, were not valid. As a result, accurate and validated performance data with respect to this measure for the period October 2020 through September 2021 could not be included in this report. DSS reports that it is in the process of assessing the procedures used to pull and analyze these underlying data to determine the causes of the error, and that it will utilize protocols to minimize the likelihood of data inaccuracies in the future.

The Co-Monitors were able to review in CAPSS the files of some children reported to be moved between placements most frequently during the period October 1, 2020 through September 20, 2021. This analysis revealed that many children continued to experience multiple placements, and for some this meant near-constant instability. For example:

- A 17-year-old from Anderson County experienced 19 placements between October 2020 and September 2021. Since entering foster care in 2017, this

[163] Of the 4 cases that did not meet an exception: 2 children were part of a sibling group who remained at a group home beyond 90 days without documented efforts to move the sibling group to a family-based placement; 1 child at a residential treatment facility did not meet the criteria for a medical necessity exception; and 1 child was not placed with their mother in accordance with exception requirements.

youth experienced 40 placements, at least three of which were emergency placements.

- A 16-year-old in Anderson County experienced 21 placements between October 2020 and September 2021. One of these was overnight in the Anderson County DSS office. The child has experienced 27 placements over the course of two episodes of entering and exiting foster care.
- A 14-year-old in Richland County experienced 27 placements between October 2020 and September 2021. Since entering foster care in 2017, this youth experienced 41 placements as of January 2022.

All research available indicates the profound negative consequences of this level of instability for a child's current and future health and well-being. Though placement instability is particularly pervasive among older youth, young children are also subject to frequent moves between homes and institutions. For example, one 10-year-old in Greenville County has been in 25 placements since entering foster care in May 2019. Another 10-year-old, also in Greenville, experienced 14 placements in just four months in foster care (February through June 2021).

Placement in DSS Offices and Hotels

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

This monitoring period was characterized by a significant, sharp increase in the number of children staying overnight in DSS offices. Between April and September 2021, there were 34 unique children who stayed overnight in DSS offices, for a combined total of 68 nights. In addition to these FSA violations, the Co-Monitors have also received reports from case managers and stakeholders that children often spend long periods of time in DSS offices while awaiting placement, and are taken to foster homes or congregate care facilities late at night on an emergency basis and

picked up early in the morning only to return to the DSS office and continue to wait for longer term placement to be found. For some children, this takes days or weeks.

Also, as mentioned above, in the months directly following the monitoring period, notifications of overnight stays increased at an alarming rate – between October 1, 2021 and March 14, 2022, there were 99 unique children who stayed overnight in DSS offices, for a combined total of 250 nights.

The placement crisis at DSS – reflected most clearly in the staggering number of children who have had to stay overnight in DSS offices while awaiting placement – has taken a toll on children, families, and already overburdened case managers who stay overnight to supervise children and drive long distances to move children between placements. In an already difficult time for children and families, the lack of appropriate placement is further destabilizing. All too often, it can mean missed schooling, services, recreational activities, and other connections to community.

Emergency or Temporary Placements

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

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

Since entry into the FSA, DSS has been unable to accurately track all children in emergency or temporary placements.[164] DSS reports that as of August 2021, the Department is tracking the use of emergency placements in CAPSS, although these data have not been validated by the Co-Monitors. The automated system of tracking emergency placements replaces DSS's manual system for tracking enhanced payments to foster parents or group homes for accepting children on an emergency basis. DSS reports they have confidence in the accuracy of the CAPSS automated data as of October 2021, and that these data will be reported for inclusion in the next monitoring report.

Using the manual tracking system available during this monitoring period, DSS reported 86 emergency placements in foster homes for 64 unique children, and 94 emergency placements in group homes for 72 unique children. This is a significant increase from the 31 unique children identified as having experienced an emergency placement in a foster home, and 52 unique children identified as having experienced an emergency placement in a group home in the prior monitoring period. Because this manual system only tracks the use of certain types of incentive payments, DSS does not believe it provides a comprehensive accounting for all instances in which a child is placed on an emergency basis.

Juvenile Justice Placements

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

DSS's ability to identify the children in its care who are also involved in some way with DJJ is still somewhat limited, though it has improved over time.[165] The Co-Monitors

[164] DSS 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. DSS defines a temporary placement as a placement triggered by a specific event; it is of limited duration, is not permanent, and when the triggering event ends, the child returns to the prior long-term placement. Temporary placements include respite care, hospitalizations for less than 30 days, and transitional visits with caregivers.

[165] During the monitoring period, DJJ shared with DSS and the Co-Monitors a list of charges from June 2021 associated with Class Members who were in foster care on December 31, 2020 who also had an open service line

rely on both DSS data reports and anecdotal reports by stakeholders to assess DSS performance with respect to the FSA in this area of practice. During the monitoring period, six violations of this provision were reported to the Co-Monitors by DSS. On any given day, DSS reports between 10 to 20 children in its care are incarcerated in secure DJJ facilities or adult correctional facilities. During the monitoring period, it reports that 44 children spent time in such facilities at some point. Children often come to the attention of DJJ because they run away from DSS placements in which their needs are not being met, leading to law enforcement involvement and delinquency charges. For example:

- In April 2021, a 14-year-old child in Richland County experienced a continuing violation of this FSA provision (also reported in the prior monitoring period) because the child was picked up by law enforcement after running away and was placed at a DJJ detention center. The Court ordered that the child be released to DSS as soon as placement was secured, but the child remained in the detention center for nearly a month before being moved to a congregate care facility that specializes in working with youth victims of sex trafficking. The child experienced seven placements between March and August 2021.
- In April 2021, a 16-year-old child in Richland County entered foster care at a DJJ hearing because the child's parents reportedly refused to take the child home. The child remained in a DJJ facility for one extra day before being moved to a Level 1 group home for 10 days, followed by a therapeutic foster home.
- In April 2021, a 17-year-old child in Spartanburg County remained in a DJJ facility because DSS reported a placement was not available. In the preceding months, the child experienced several emergency placements and had run away. In the months since exiting the DJJ facility, while in DSS custody, the child experienced 11 nights sleeping in a DSS office, and in June 2021 was moved to a residential treatment facility out of state.
- In July 2021, a 14-year-old child in Greenville County remained at a DJJ facility for 48 days because placement could not be found by DSS. The child experienced nine placements between February and September 2021.
- In August 2021, a 13-year-old child in Colleton County was detained after running away, while charges of larceny and assault and battery in the third degree were pending. The charges were dismissed, but the child spent 10 days

with DJJ at some point in the past. Additionally, for the purposes of a joint review discussed later in this section, DJJ provided a list of charges associated with Class Members who were in foster care on September 30, 2021 and who had open service lines with DSS and DJJ at the same time within the prior 12 months.

at a DJJ Evaluation Center and was then moved to a residential treatment facility. The child experienced 10 placements between April and August 2021.

- In September 2021, a 17-year-old child in Dorchester County was detained shortly after being released from a residential treatment facility, where the child had spent 174 days. The child's charges, related to being a victim of sex trafficking, were dismissed, but the child remained in a DJJ facility until they could be moved to a residential treatment facility out of state.

Children who encounter both DSS and DJJ often bear the highest burden posed by the lack of community-based treatment and supports and appropriate placement options. These children often display escalating behaviors that are a manifestation of system failures, such as high levels of placement instability, lack of consistent supports and strength-based engagement, and ongoing separation from their families.

The Co-Monitors and DSS, with DJJ's permission and collaboration, are currently undertaking a comprehensive review of the experiences of children dually involved with both DSS and DJJ, and will publish findings upon completion. The purpose of the review is to better understand the barriers and opportunities for collaboration between DSS and DJJ in meeting the needs of children who experience both systems. The review entails data analysis, reviews of case records, and group interviews with stakeholders.

Sibling Placements

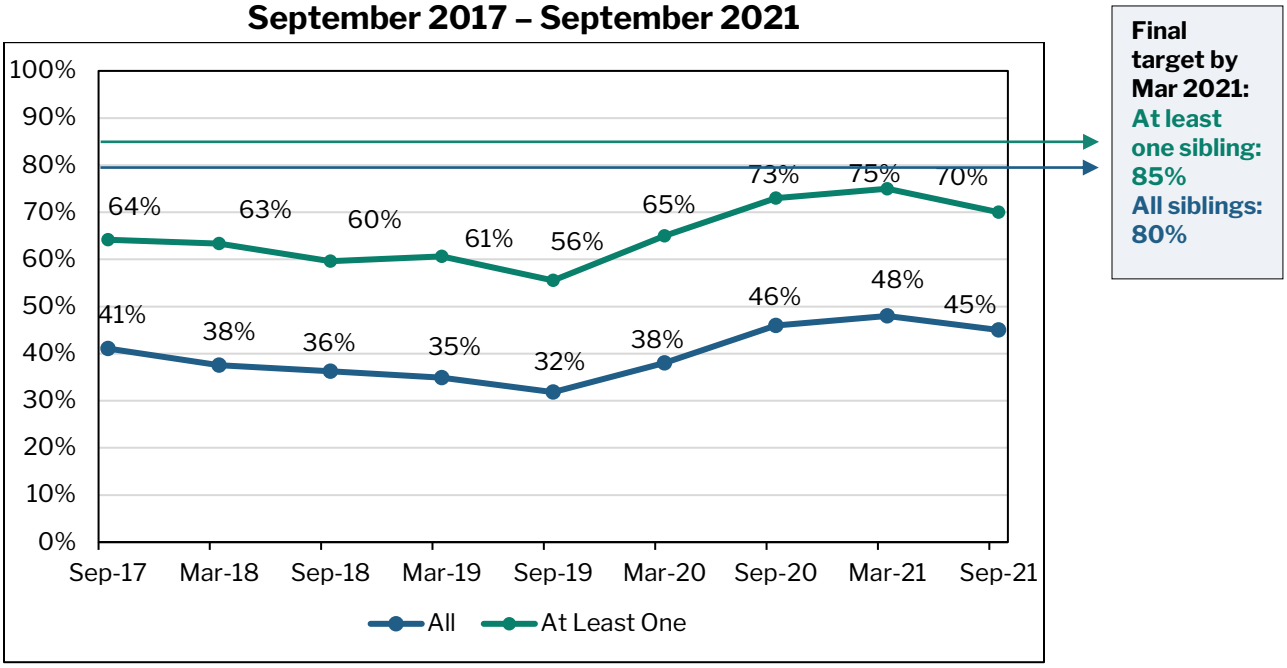
The FSA recognizes the importance of the lifelong and supportive relationship between children and their siblings and *requires that 'at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings"* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).[166] DSS committed to achieving these targets by March 2021.

DSS provided data for 692 children who entered foster care between April and September 2021 with a sibling or within 30 days of a sibling's entry to foster care. For

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

this cohort, 70 percent (486 of 692) of children were placed with at least *one* of their siblings, and 45 percent (313 of 692) of children were placed with *all* of their siblings 45 days after entry into care. Performance does not meet the final targets, and represents a slight decline from the prior monitoring period, as shown in Figure 30.

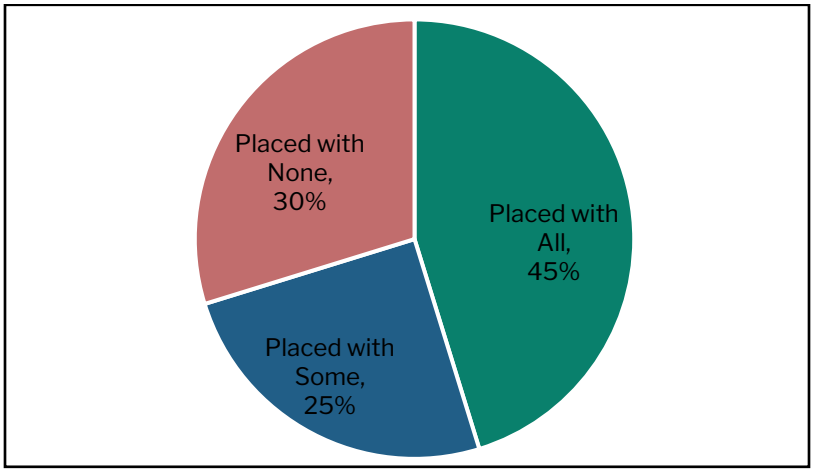
Figure 30: Sibling Placements for Children Entering Placement September 2017 – September 2021



Source: CAPSS data provided by DSS

Figure 31 further shows the breakdown of sibling placements during this monitoring period. Thirty percent of all children entering care with siblings were not placed with *any* siblings 45 days after entry, which is a slight decline in performance from the prior monitoring period, when only 25 percent of children were not placed with any siblings.

Figure 31: Sibling Placements for Children Entering Placement
April – September 2021
N=692



Source: CAPSS data provided by DSS

Therapeutic Placements

The FSA includes a requirement that DSS identify "enforceable interim benchmarks with specific timelines, subject to consent by the Plaintiffs and approval by the Co-Monitors, to measure progress," with respect to the placement of children in therapeutic placements when determined to be needed (FSA IV.B.I.2.).[167] These benchmarks and timelines were to be established as part of the Placement Implementation Plan (FSA IV.B.I.2.).

At the time of finalization of the Placement Implementation Plan, the Co-Monitors and Parties determined that, because the process of assessing and identifying the need for more intensive supports and placements would likely be modified as DSS began to implement its Placement Implementation Plan and develop new assessment, decision-making, and placement processes, DSS would wait to propose benchmarks and timelines until implementation began. DSS and the Co-Monitors anticipated that there might be a need for the initial FSA requirements in this area to be amended, and expected that any proposed updates, benchmarks, and timelines would be submitted by no later than July 2019. DSS has not proposed updated requirements. Benchmarks and timelines for performance of the initial FSA

[167] "Therapeutic Level of Care" refers to the leveling system used by DSS within the therapeutic placement and services array, including but not limited to Level 1, 2, 3 foster care placements and Psychiatric Residential Treatment Facilities, as described in the Human Services Policy and Procedures Manual and The State of South Carolina, Fixed Price Bid No. 5400002885 (FSA II.S.).

requirements have also not been proposed, and DSS has reported that it is not able to collect or report data in this area.

The initial FSA requirements are as follows:
All Class Members that are identified by a Worker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified. This requirement shall not apply if the Worker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days. (FSA IV.B.I.3)

All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members. (FSA IV.B.I.4)

At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. (FSA IV.B.I.5)

IX. Family Time: Visits with Parents and Siblings

Regular and substantive contact between children in foster care and their parents helps to facilitate reunification and reduce the trauma of family separation. When children are separated and in different placements, it is crucial that they maintain contact and a relationship with their siblings. Children in foster care also benefit from ongoing, supportive relationships with other family members.

As the COVID-19 pandemic continues, DSS encourages in-person contact between children and their parents and between siblings in foster care not residing together, but with precautions, such as inquiring about a person's exposure to COVID-19 and their health status. Data for this period reflect some children are having in-person contact with family members through visiting at DSS offices; local parks; homes of kin foster parents; and restaurants. Others are communicating via video, as allowed by DSS policy when responses to COVID-19-related questions reveal in-person contact should not occur.

Most children, however, are not spending the *minimum* time required by DSS policy and the FSA each month with their family. DSS, USC CCFS, and Co-Monitor staff conduct twice-yearly case record reviews to determine performance on DSS's minimum twice-monthly standard for children's contacts with their parents and minimum once-monthly contact for siblings in foster care and living apart.[168] Results from these reviews continue to show that performance remains far below policy and practice expectations.

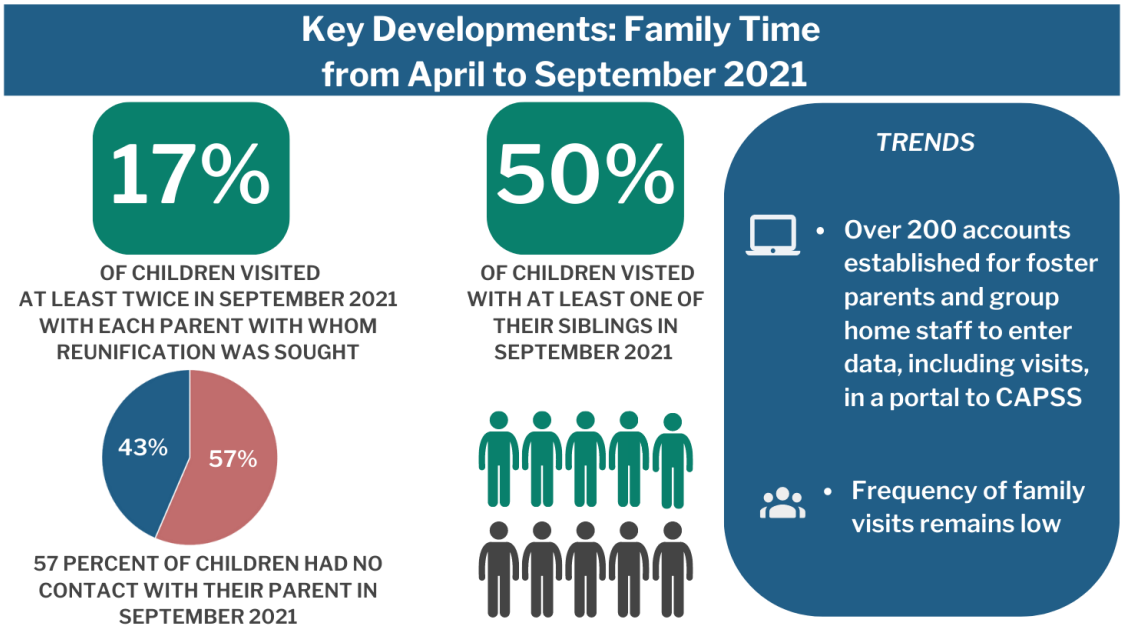
During September 2021, 17 percent of children visited twice with the parent(s) with whom they are to reunify, as required by DSS policy. The records of almost two-thirds (57%) of the children reflected *no* documented contact, either in person, by video, or by phone with the parent(s) with whom the child is to reunify. Only half (50%) of siblings in foster care and living apart during the entire month of September 2021 saw each other at least one time. These continued poor results for meeting the minimum standards for children's contact with their parents and siblings are unacceptable.

DSS has distributed policy and practice resources about the importance of children in foster care spending time with their parents, siblings, and other family members. Additionally, the agency requires that staff participate in training focused on

[168] Data from the last month, March and September, of each monitoring period is used to measure and report performance.

increasing awareness of the importance of the time children spend with their family. CAPSS has also been updated for case managers to better capture planned and completed visits. Caregivers from both foster and group homes can provide information to be entered into a child's case record electronically, including about time children spend with their parents and siblings. DSS reports that community organizations, centers, and churches across the state have continued to make both indoor and outdoor spaces for families to visit.[169] A private provider assists DSS in scheduling and supporting visits in Greenville County as part of a voluntary partnership.

Performance on the required minimum time children spend with their parents and siblings is not improving despite these efforts. As DSS continues to address staffing and caseload concerns, the agency, along with partners, must continue to identify root causes of this practice failure and work to reduce all barriers to increasing the time children spend with their family members. This is especially true when the plan is for a child to return home.



[169] DSS reports partnering with churches and other community organizations in Greenville, Anderson, Cherokee, Pickens, Union, Richland, Aiken, Kershaw, Lexington, Florence, Jasper, Hampton, Dorchester, Charleston, Orangeburg, and Colleton counties to provide spaces for children to visit with family members.

Family Time: Progress and Implementation Updates

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

The adequate staffing, manageable caseloads, and placement challenges with which DSS has been faced also impact outcomes for visits or family time. Placement near home, near parents, with siblings, and/or with a family member all help to increase family time and are also areas which DSS continues to address for improvement.

Policy and Practice Guidance and Tool

On September 29, 2021, DSS published its revised Foster Care Visitation Policy, addressing children's visits with their parents and siblings. This revision references the DSS's GPS Practice Model, including partnering with families and other team members to plan and support visits. It also contains a section on documentation and clarifies the role of the supervisor in ensuring the standards for the number of visits are met and their role in supporting the quality of visits. DSS reports updates to the policy continue to be made and another updated version is forthcoming.

One of the updates to the next iteration of the Foster Care Visitation Policy will be references and a link to a Quality Visitation Guide, an effort to meet the goal of increasing the quality of visits between parents and children. DSS reports that as of the writing of this report, the Quality Visitation Guide has been drafted, reviewed by executive leadership, and is awaiting finalization.

DSS has updated CAPSS so that a child and family's Visitation Plan, which should be created in partnership with families, populates in the Family Permanency Plan. Since the Family Permanency Plan is a document encompassing all plans to support family members, it contains the agreements and arrangements for children's time with their family with streamlined data entry for case managers and supervisors.

Training

In late October 2021, DSS began to outline a training on Quality Visitation, using the draft Quality Visitation Guide as a foundation. DSS anticipates beginning to offer training sessions in the Spring of 2022.

Visitation Awareness training for case managers, supervisors, and foster parents is one of DSS's core strategies to communicate the importance of increasing the amount of time children spend with their family members. Visitation Awareness training and documentation training are requirements for all new child welfare staff within one year of employment and is offered for existing child welfare staff on a quarterly basis. Visitation Awareness. From April to September 2021, an additional 19 case managers, two supervisors, and 142 foster parents participated in Visitation Awareness Training.

Sibling Connections training sessions are also available throughout the calendar year for all foster parents. Co-Monitor staff have observed Visitation Awareness training to become familiar with the presentation but have not yet reviewed or observed the Sibling Connection training.

Data

Additions and modifications to CAPSS to capture data on visits and a new Visitation Plan document are not yet in uniform use. DSS reports continuing to amend the Visitation Tab in CAPSS to make it more user friendly for data entry. Updates were made in early November 2021 and staff were sent a link to a recorded demonstration of how to use it. Management reports, for use by regional and county-level management, with data from the Visitation Tab were also updated, and can be used to track progress on the use of the Visitation Tab and outcomes for children's visits with their parents and siblings.

In March 2021, DSS launched a Child and Adult Information Portal (CAIP), a method by which authorized users affiliated with a private provider can send data to DSS via a smartphone, tablet, laptop, or desktop computer to a child's record. Case managers receive notification by email of new CAIP entries. A Spanish language version of the CAIP was released in May 2021. As of September 30, 2021, 220 CAIP accounts had been assigned. Foster parents and group home provider staff have been able to enter information about children's visits with their parents and siblings, as well as appointments with health care providers, since the launch of CAIP in March 2021.

Performance Data

Sibling Visits

Section IV.J.2. of the FSA requires that *'[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed."*[170] DSS committed to achieving this target by March 2021.

DSS requires, at minimum, once-monthly face-to-face, intentional, interaction between siblings in foster care who do not reside together, and more frequent contact when possible.[171] The expectation is that case managers and caregivers arrange for ongoing, frequent interaction between siblings, unless one of the approved exceptions applies and is documented in CAPSS. Children should meet in-person, and interact via video and/or phone calls, and texts.

USC CCFS, DSS, and Co-Monitor staff conducted a case record review using a structured tool to collect data on visits between children in foster care living apart from a sibling who is also in foster care. Reviewers examined a sample of 298 records, representing 202 families, for required sibling visits in September 2021.[172]

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

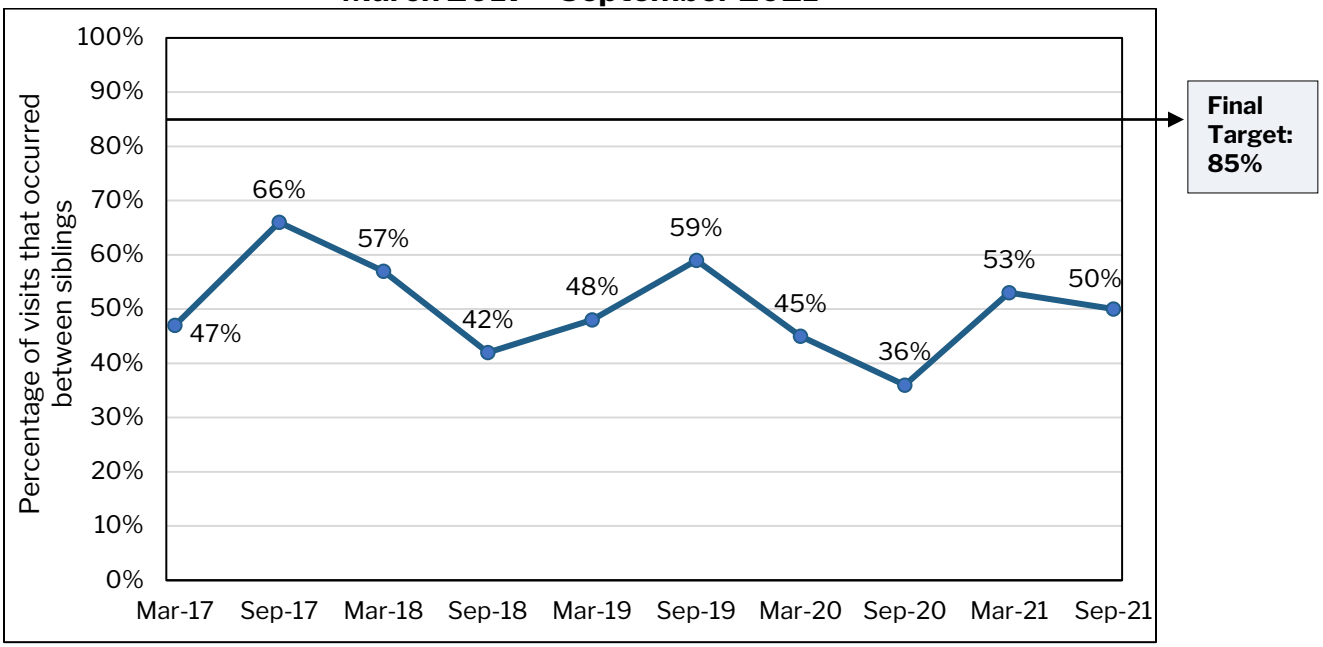
[171] DSS Child Welfare Policies and Procedures: Chapter 5 Foster Care, Family Visitation, 510.3 (September 29, 2021).

[172] A statistically valid sample of 298 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

Documentation in 10 of the 298 records reflected an applicable exception to a sibling visit.[173]

Of the remaining 288 records, half (145 or 50%) contained documentation that at least one sibling visit had occurred.[174] Although some (13) siblings were only in contact virtually, most (126) spent time together in-person.[175] Current performance data continues to fall short of the agreed-upon performance standard and is a slight decrease from March 2021, when 53 percent of children participated in at least one required sibling visit.

Figure 32: Visits Between Siblings Placed Apart
March 2017 – September 2021



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

[173] These exceptions include that a court order prohibited a visit, a child could not be located despite attempts, or that a child was in a facility and visitors were not allowed.
[174] The 288 applicable records represent 202 families; records with documentation of a sibling visit represent 103 families.
[175] For 4 visits, the reviewer was unable to determine the mode of visit, and 2 children had contact by telephone only.

Parent-Child Visits

The FSA requires that *'[a]t least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought […]"* (FSA IV.J.3.).[176] DSS committed to achieving this target by March 2021.

DSS Family Visitation policy states that within 30 days of a child entering foster care, their case manager must create a plan for visits with input from the child, parents/guardians, other significant persons, foster parent or congregate care provider, guardian ad litem, and, if applicable, the child's therapist or behavioral health provider. Visits with parents must be at least twice a month, unless limited by a court order. The policy also states that safety and risk factors do not determine whether children spend time with their parents but influence the level of supervision for[177], location of, and level of support the child, parent(s) and sibling(s) will need before, during, and after the visit.

USC CCFS, DSS, and Co-Monitor staff use a structured instrument to collect data on visits between children in foster care and the parent(s) with whom reunification is sought. Reviewers examined a sample of 327 records for documentation of contacts between a child and their parent(s) during September 2021.[178,179]

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

[177] According to DSS policy and practice, levels of supervision for visits from most to least restrictive are: therapeutic, supervised, monitored, and unsupervised.

[178] As of September 30, 2021, there were 2,147 children who had been in foster care for at least 30 days with a permanency goal of "return to home" or "not yet established." A statistically valid sample of 327 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

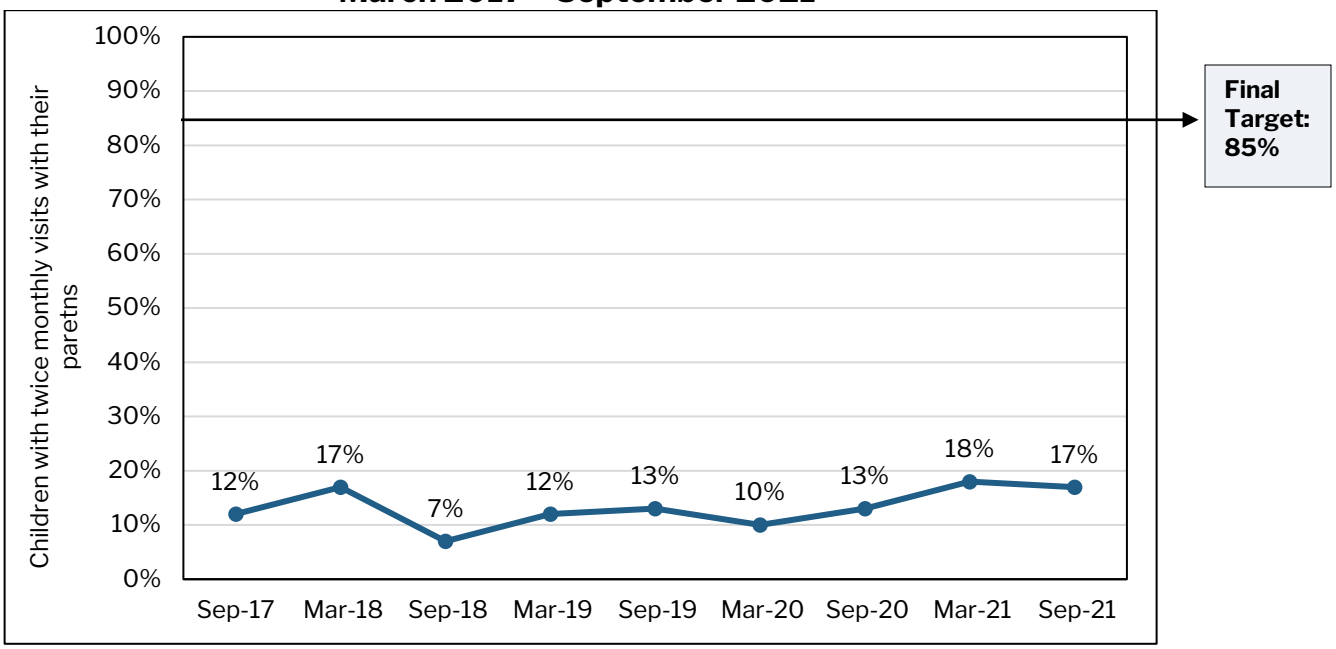
[179] Permanency goals were identified using data in the CAPSS field in which case managers are expected to update case goals in accordance with the most current determination in legal proceedings.

In 58 of the 327 records, there was documentation of an applicable exception to the requirement of the child visiting with their parent(s) during September 2021.[180] Of the remaining 269 records, 152 (57%) had no documentation of the child having any contact with the parent(s) with whom they are to be reunited, either in person, by video, or by phone. In 46 (17%) of the 269 records, documentation reflected one contact between the child and their parent during September 2021.

About a quarter, 71 (26%) of the 269 records showed the required minimum standard of two contacts with each parent with whom reunification is sought.[181] The final performance target is 85 percent.

Figure 33 shows consistently poor performance for at least twice monthly visits between parents and children when the permanency goal for the child is reunification, ranging from seven to 18 percent since September 2017. This is not acceptable practice.

Figure 33: Children with Twice Monthly Visits with Their Parents
March 2017 – September 2021



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

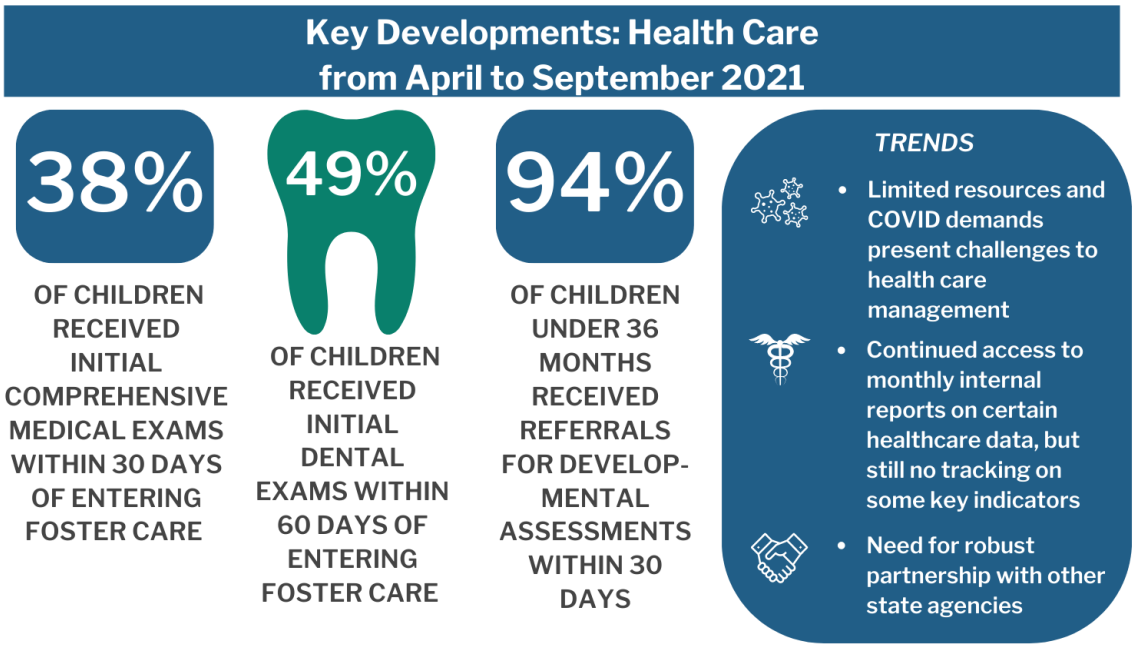
[180] These exceptions include that the parent did not visit despite attempts to arrange and conduct a visit; a court order prohibited visits; and the child refused to participate in a visit.
[181] Reviewers identified and sought documentation of visits with a second parent for 95 children. However, documentation in CAPSS does not always specify the reunification resource when parents live apart. Thus, this number is likely an overcount of reunification resources.

X. Health Care

Child welfare systems must be able to quickly identify children's physical and behavioral health needs, provide high quality preventative and acute care, track care delivery, and communicate health care information to families, caregivers, and partner agencies. This area of work has been a key aspect of DSS's reform efforts. During this monitoring period, DSS continued to build on the work of its Office of Child Health and Well-Being, though progress has been limited by a lack of adequate staffing and funding, and the demands of the COVID-19 pandemic.

DSS's small team of Regional Nurses, overseen by a Statewide Nurse Manager, continue to receive praise, and have been valued across the state as important resources in ensuring children's needs are met. DSS has done what it has been able to in the context of existing resources and increasing demands, to improve documentation and coordination of medical and dental visits. Despite these efforts, however, the percentage of children receiving initial and periodic well-child visits in a timely manner has not improved significantly. Fewer than half of children who entered foster care during the monitoring period received initial comprehensive medical exams within 30 days of entering foster care. Similarly, fewer than half received an initial dental exam within 60 days of entering foster care. Without sufficient funding and additional nurses and support staff to do this important work, progress has and will continue to be limited. This is particularly true given the strains that the COVID-19 pandemic has placed on the medical and behavioral health care system – making access to care challenging – and on families – making health care needs even greater.

As is the case in all states, and as explicitly designed and reflected in DSS's Health Care Improvement Plan, the responsibility of delivering health care to children in foster care does not rest with DSS alone. As has been consistently reiterated throughout this report, it continues to be critical that DSS work with its state agency and community partners – as well as its private Managed Care Organization (MCO) partner – to develop robust, accessible community-based services and supports across the state for children and families. DSS also must work with urgency to maximize all funding sources available to provide for children's health and behavioral health care needs, including Medicaid and other federal funding streams.



Health Care: Progress and Implementation Updates

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

(a) *Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;*
(b) *Assessing the accessibility of health care screening and treatment services throughout the state, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and*
(c) *Identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment services"* (FSA IV.K.1.(a-c)).

On August 23, 2018, the Co-Monitors approved DSS's Health Care Improvement Plan.[182] A Plan addendum (the "Health Care Addendum") was approved by the Co-Monitors on February 25, 2019, establishing commitments by Select Health, the MCO for the majority of children in foster care, and DHHS to a framework for care coordination involving distinct, interrelated roles for the DSS Office of Health and Well-Being, DSS case managers, Select Health Care Coordinators, and foster and biological families.[183] Although a general delineation of roles was included in the Addendum, the Plan was approved with the understanding that additional detail would be determined during implementation, and the efficacy and adequacy of the model would be assessed each year to see if it requires changes or additions.

During the monitoring period, DSS's Office of Child Health and Well-Being, under the leadership of Gwynne Goodlett, maintained its commitment to the Health Care Improvement Plan. Staffing shortages and the ongoing demands of the COVID-19 pandemic presented significant barriers to progress, however, as the focus of the already over-taxed Well-Being staff shifted away from forward planning to day-to-day triage.

Internal Capacity Building

The Child Health and Well-Being nurse infrastructure and regional Well-Being Teams continue to operate throughout the state, though a high number of staff vacancies has made the workload even greater for these staff. The teams are overseen by Regional Well-Being Managers, and are designed to each be staffed by Regional Nurses, Regional Clinical Specialists, and other members – including a Therapeutic Services Coordinator, a Community Liaison Coordinator, an Assessment and Planning Coordinator, a Well-Being Data Coordinator, and Health Care Data Coordinator. Based on a model utilized effectively in Tennessee's child welfare system, the Well-Being Teams function in coordination with state Office of Child Health and Well-Being staff, and are charged with supporting case managers in assessing and managing the well-being needs of children in foster care.

As has been consistently reported, even when fully staffed, Regional Nurses have had to serve in a data management function rather than using their clinical skills to manage the significant task of ensuring that the health care needs of children in care

[182] To see the Health Care Improvement Plan, go to: https://dss.sc.gov/media/1980/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf
[183] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

are adequately addressed. Unfortunately, as February 2021, three of the five Regional Nurse positions had become vacant, and three of four Health Care Data Coordinator positions were no longer filled.

Defining a Managed Care Organization Partnership

South Carolina's system for health care delivery to children and families that utilize Medicaid gives a significant role to private MCOs. Select Health is the designated MCO for many children and families who have Medicaid and for nearly all children in foster care in the state, which means that it is contractually obligated to ensure children's health care needs are being met. It is also charged with approving or denying payment for medical and behavioral health services. In so doing, Select Health plays many roles: it is a point of contact, a collector of essential data, a resource in identifying providers, a determiner of allowable services, and a payor of claims. DSS's Health Care Plan and Addendum formalizes a partnership with Select Health in an integrated model of health care case management and care coordination for children in foster care.

Select Health has 19 staff in its Foster Care Unit (including eight clinical nurses, two social workers, and one Foster Care Liaison), along with a medical director. It has continued to partner with DSS on a weekly Foster Care Grand Rounds process through which cases of concern are discussed. DSS reports that it has continued to engage Select Health as a partner in devising real-time solutions as health care challenges have arisen during the course of the COVID-19 pandemic.

There remains significant work to be done in operationalizing Select Health's role in the day-to-day management of children's health care, beyond denying or approving claims and offering a roster of in-network providers. More than three years since the entry of both the Health Care Improvement Plan and the Health Care Addendum, there remains a lack of clarity around many of the role definition issues that were to be resolved in early implementation, leaving DSS with all the tasks of managing children's health care, but without a sufficient infrastructure to do so. This is not a sustainable model, nor is it consistent with the one conceptualized during development of the Plan and Addendum. Given the resources provided by the state to Select Health for the management of children's health care, and the lack of real improvement in ensuring that children's health care needs are being met, this work is urgent.

Coordination and Collaboration with DHHS

DSS reports continued work with the new DHHS leadership team, led by Director Robbie Kerr, who was confirmed in April 2021. Given the need to improve access to quality services for all South Carolina children, particularly those in foster care, it is essential that DSS continue to foster this collaboration with DHHS as its leadership team sets priorities, and that the agencies actively pursue ways to maximize federal Medicaid funding to meet the needs of children in foster care throughout the state. As mentioned above, the federal government recently issued guidance that vastly increases the reimbursement rate for state expenditures on qualifying community-based mobile crisis intervention, so that states can receive an 85 percent federal match for these services for the first three years.[184] Mobile crisis intervention, also referred to as "mobile response," provides on-site, real-time intervention for families when a child experiences a behavioral health crisis, allowing for immediate de-escalation of the situation. This service can be used to stabilize children in their placements and prevent placement disruptions, prevent hospitalizations, and quickly connects families to services. South Carolina has not indicated an intent to utilize this option.

Network Sufficiency

As has been reiterated throughout this report, foundational to both the Health Care Improvement Plan and the Placement Implementation Plan (discussed in Section VIII. *Placements*) is the need for an array of robust, community-based services, including intensive in-home supports, so that children will no longer be subject to frequent moves to higher level placement settings to access services. At the time of Health Care Improvement Plan development, DSS expected to assess and build out this capacity in coordination with both Select Health and DHHS. In 2018, Select Health represented that it had the capacity for real-time tracking of network adequacy throughout the state, and committed to being a partner with DSS to ensuring the sufficiency of this network to children in care, but this has been slow to come to fruition. There is widespread understanding in the community of the inadequacies of the network of services available to children and families in South Carolina. Additionally, while the Foster Health Advisory Committee (FHAC) had been a useful body for collaborating on health care issues for this population, that group did not meet between August 2021 and February 2022.

[184] To see the December 28, 2021 Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, go to: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

Performance Data

As noted in previous monitoring reports, the Co-Monitors and DSS have been engaged in discussions about re-assessing the approved data methodologies for health care measures given the shared goal of efficiently and effectively producing understandable, timely performance data that can be used both for public and court accountability purposes, and for day-to-day management and quality improvement. The Co-Monitors have included in this report a combination of data from internal DSS management methodologies as well as the approved methodologies in the Health Care Addendum. These data have been collected by DSS's Regional Nurses, and are derived from a combination of CAPSS data, Medicaid claims data, and Select Health records. They have not been independently validated by the Co-Monitors. DSS still does not have the capacity to produce health care data related to initial health screens, behavioral health assessments (following a screening which identified need), and follow-up care.

Comprehensive Medical Assessments

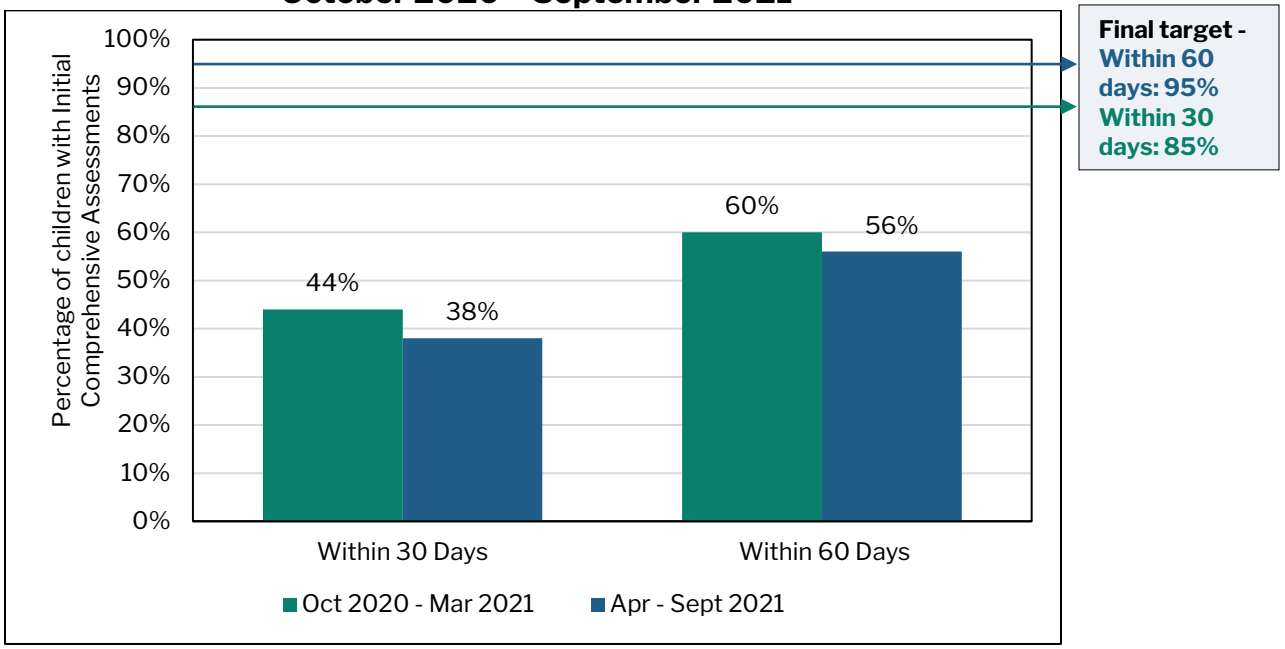
In accordance with American Academy of Pediatrics (AAP) guidelines for health care delivery to children in foster care, comprehensive medical assessments are to be performed for the purpose of "reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and behavioral health conditions requiring immediate attention; and developing an "individualized treatment plan."[185]

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, based on AAP guidelines, DSS committed that '*At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care; at least 95% will receive a comprehensive medical assessment within 60 days of entering care*."[186] DSS committed to achieving these targets by March 2021.[187]

[185] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003)), p. 22.
[186] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[187] The baseline performance data that were used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.

DSS reports that 38 percent (474 of 1,244) of children who entered care between April and September 2021 and were in care for at least 30 days received an initial comprehensive medical assessment within 30 days of entry, and 56 percent (513 of 920) of children who entered care this period and were in care for at least 60 days received an initial comprehensive medical assessment within 60 days of entry (see Figure 34. This performance remains below the final targets of 85 percent, and 95 percent, respectively, and represents a decline from the prior monitoring period.

Figure 34: Initial Comprehensive Medical Assessments within 30 and 60 Days October 2020 – September 2021



Source: Medicaid claims data provided by DSS

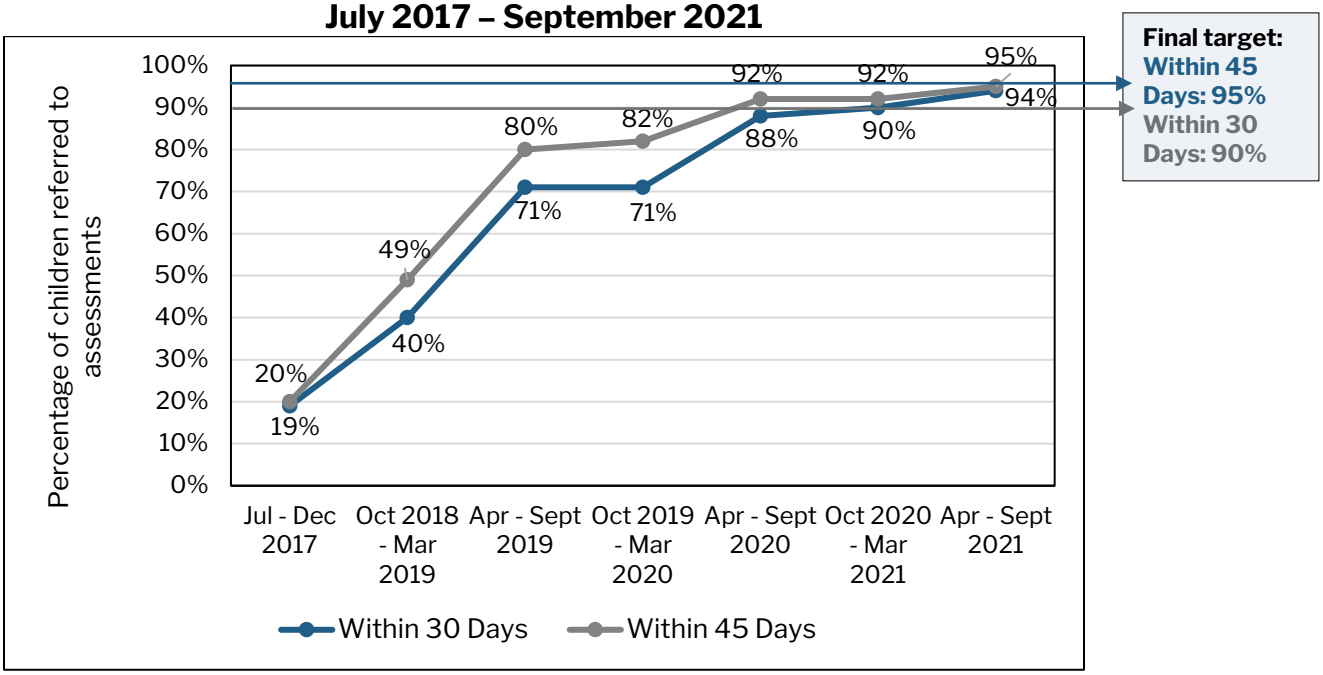
Developmental Assessments

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

DSS reports that 94 percent (321 of 343) of children under 36 months of age who entered care between April and September 2021 and were in care for at least 30 days were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days of their entry into care; and 95 percent (312 of 329) of children who were in care for at least 45 days were referred to BabyNet within 45 days. Current performance meets the final targets for this measure (see Figure 35).

It is important to note that these data only measure whether a child was *referred* for a developmental assessment and do not capture whether an assessment *occurred*. As reported previously, DSS is working to improve its system for tracking completion of these assessments and any recommended follow-up care.

Figure 35: Referrals for Developmental Assessments within 30 and 45 Days July 2017 – September 2021



Source: CAPSS data provided by DSS

Initial Dental Examinations

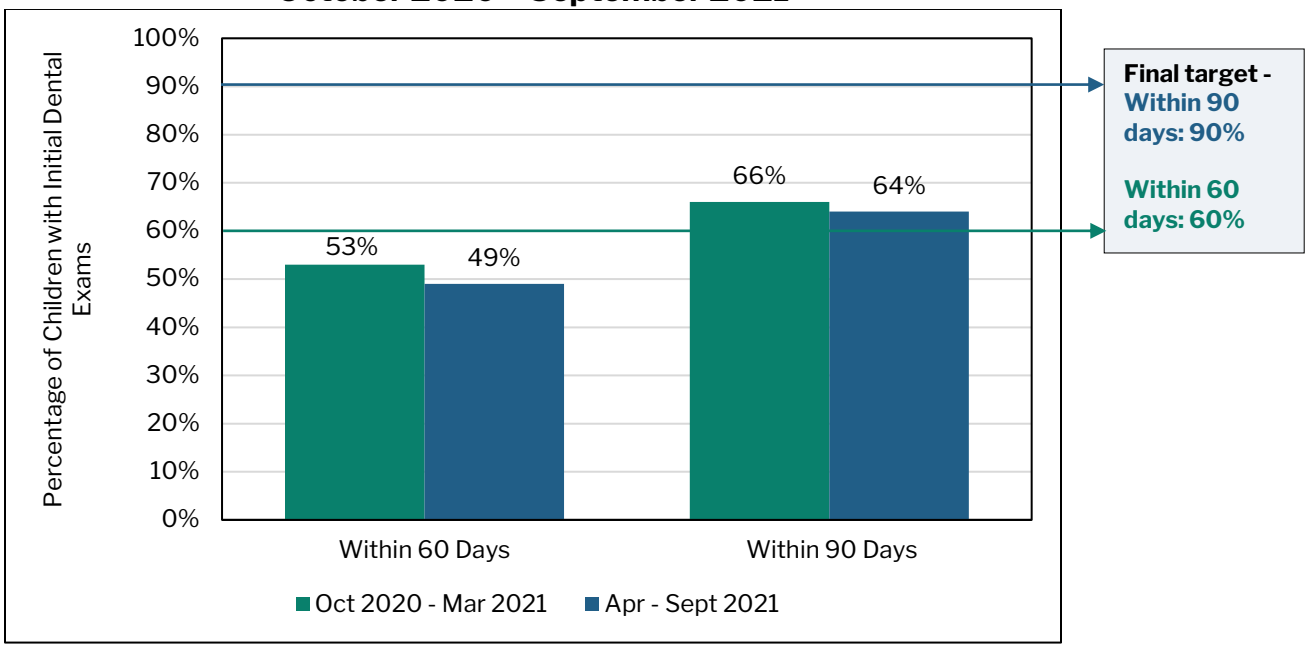
In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that *'At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care; at least 90% will receive a dental examination within 90 days of entering care.*" DSS committed to achieving these targets by March 2021.[188]

DSS reports that 49 percent (314 of 640) of children ages two and older who entered foster care between April and September 2021 and were in foster care for at least 60 days had a dental exam within 60 days, and 64 percent (301 of 470) of children ages

[188] The baseline performance data that was used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.

two and older who remained in care for at least 90 days had a dental exam within 90 days.[189] This performance represents a slight decline from the prior monitoring period, and does not meet the target for either requirement, as shown in Figure 36.

Figure 36: Initial Dental Exams within 60 and 90 Days
October 2020 – September 2021



Source: Medicaid claims data provided by DSS

Periodic Well-Child Visits

In accordance with AAP guidelines for ongoing health care delivery for children in foster care, periodic preventative well-child visits should be performed for the purpose of promoting "overall wellness by fostering healthy growth and development," as well as "regularly assess[ing] for success of foster care placement," and "identify[ing] significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings."[190] Based on these guidelines, DSS committed in its Health Care Outcomes that, *'At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American*

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

Academy of Pediatrics periodicity guidelines;[191] *at least 98% will receive a periodic preventative visit semi-annually. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually; at least 98% will receive a periodic preventative visit annually."*[192] DSS committed to achieving these targets by March 2021.

As explained above, the Co-Monitors have continued to work with DSS to modify the methodologies used for measuring periodic preventative well-child visits by incorporating data collected and validated by DSS nurses.[193] Regional Nurses review CAPSS records for each child in foster care and estimate the date for the next required well-child visit based on the child's age and date of the most recent visit.

DSS reported that of all children under 18 years of age who were in foster care for at least 30 days on November 15, 2021, 56 percent (2,083 of 3,729) were up to date on their well-child visits.[194] Of the remaining children, 176 (5%) children did not have a well-child visit indicated in the DSS record or in DHHS and Select Health data systems. This is a slight improvement from the last monitoring period, in which 53 percent of children were up to date on their well-child visits as of April 12, 2021, but is still significantly below the targets for compliance. As depicted in Figure 37, 39 percent (1,470 of 3,729) of children were past due on their well-child visit according to the periodicity schedule.

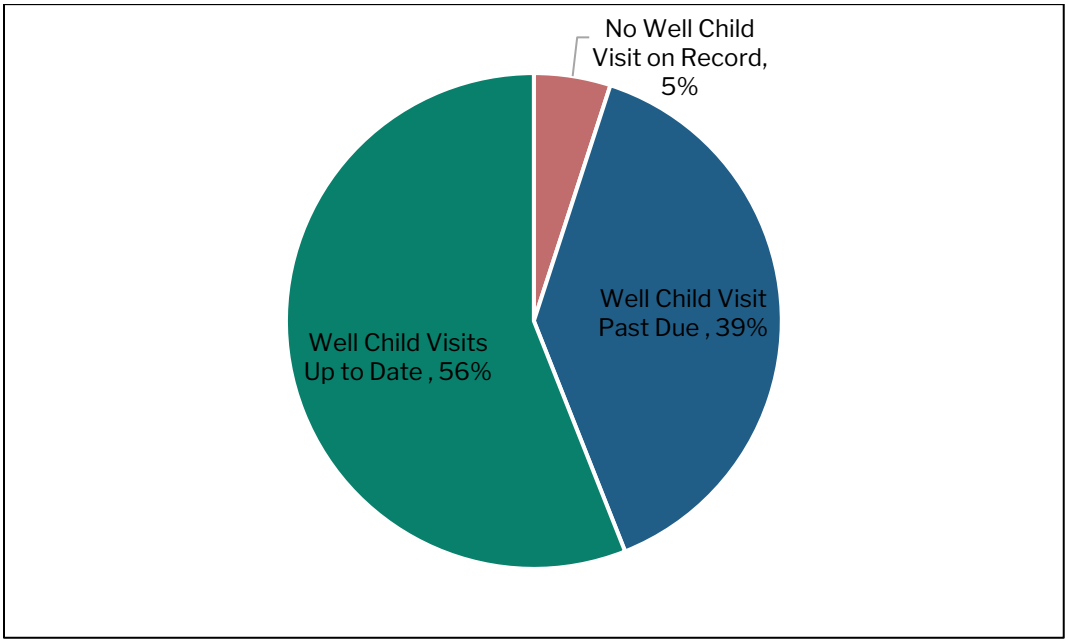
[191] See AAP Recommendations for Preventative Pediatric Health Care, which can be found at https://www.aap.org/enus/Documents/periodicity_schedule.pdf

[192] These guidelines are based on AAP's recommendations for children in foster care as described in *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003).

[193] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than those later approved in the Health Care Addendum.

[194] Detailed data for periodic preventative visits and periodic dental exams by age were not provided for the month of September 2021, so data as of November 15, 2021 are used herein.

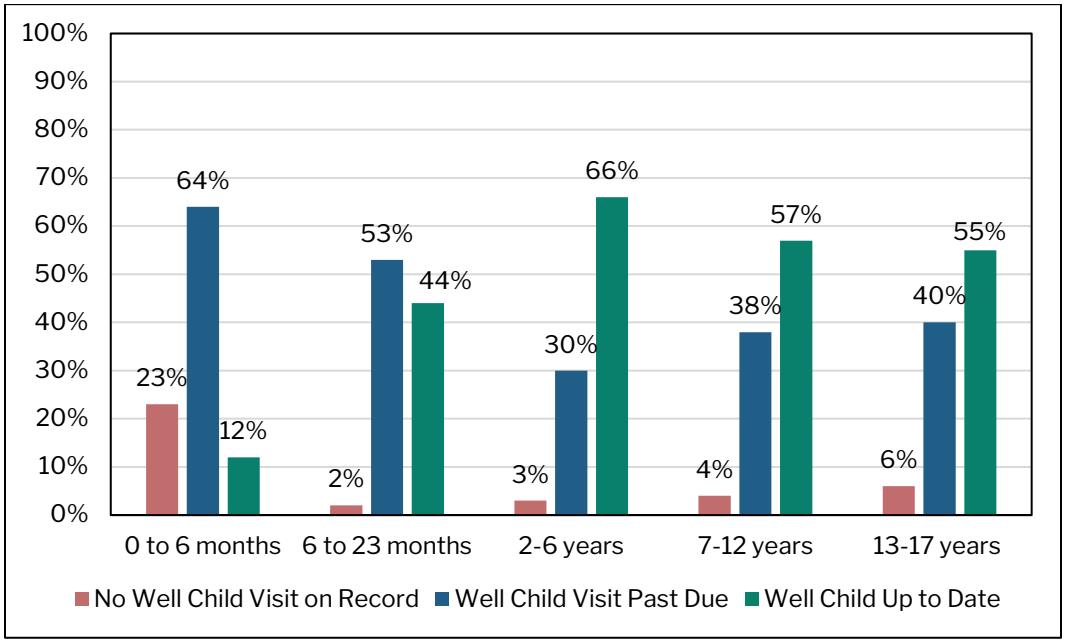
Figure 37: Well-Child Visits as of November 15, 2021 N=3,729



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

For this monitoring period, DSS also provided their internal management data by age group. For November 2021, these data indicated that 18 (23%) of the 76 infants, ages birth to six months, had no well-child visit on record; 49 (64%) young children were past due; and only nine (12%) young children either were up to date or had an upcoming appointment scheduled, as seen in Figure 38. The highest compliance was seen for children ages two to six-years-old (66%), followed by ages seven to 12-years-old (57%).

Figure 38: Well-Child Visits By Age
as of November 15 ,2021
N=3,729



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

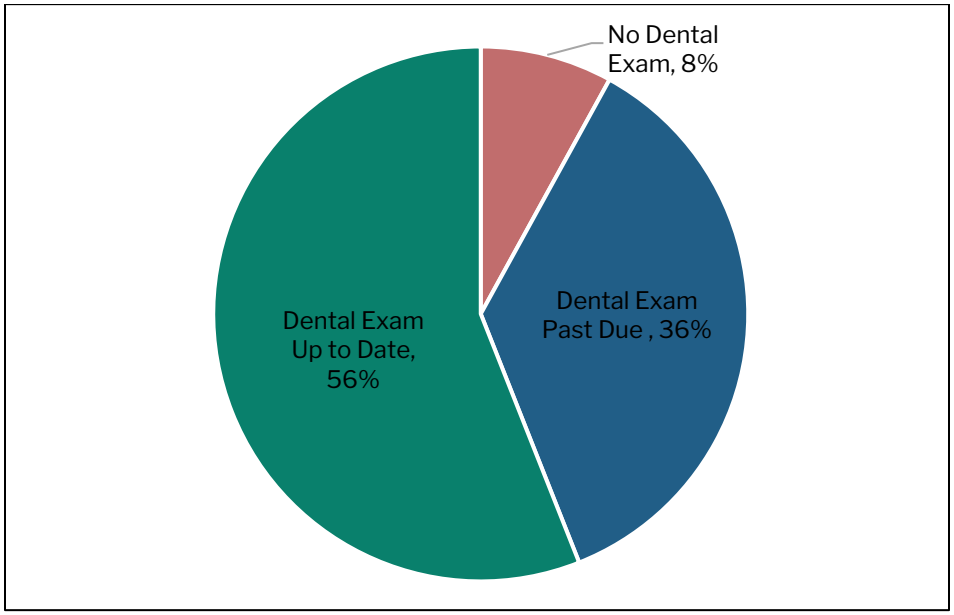
Periodic Dental Examinations

In the DSS Health Care Outcomes, DSS also committed that "*At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually; at least 90% will receive a dental examination annually.*" DSS committed to achieving these outcomes by March 2021.

Given the methodologies now used internally at DSS for dental care management, as well as the limitations for DHHS data extraction, the Co-Monitors agreed to report DSS's internal data for this measure this monitoring period. DSS reports that of the 3,286 children between two and 17-years-old who were in care for at least 30 days on November 15, 2021, 56 percent (1,830) were up to date on their semi-annual dental examination. As shown in Figure 39, 36 percent (1,177) were past due for their dental exam and eight percent of children (279) had no dental examination on record.[195] This is approximately the same level of performance as the prior monitoring period, and is below the final target of 75 percent for semi-annual dental exams.

[195] These data were collected and analyzed by DSS staff utilizing different methodologies than those later approved in the Health Care Addendum.

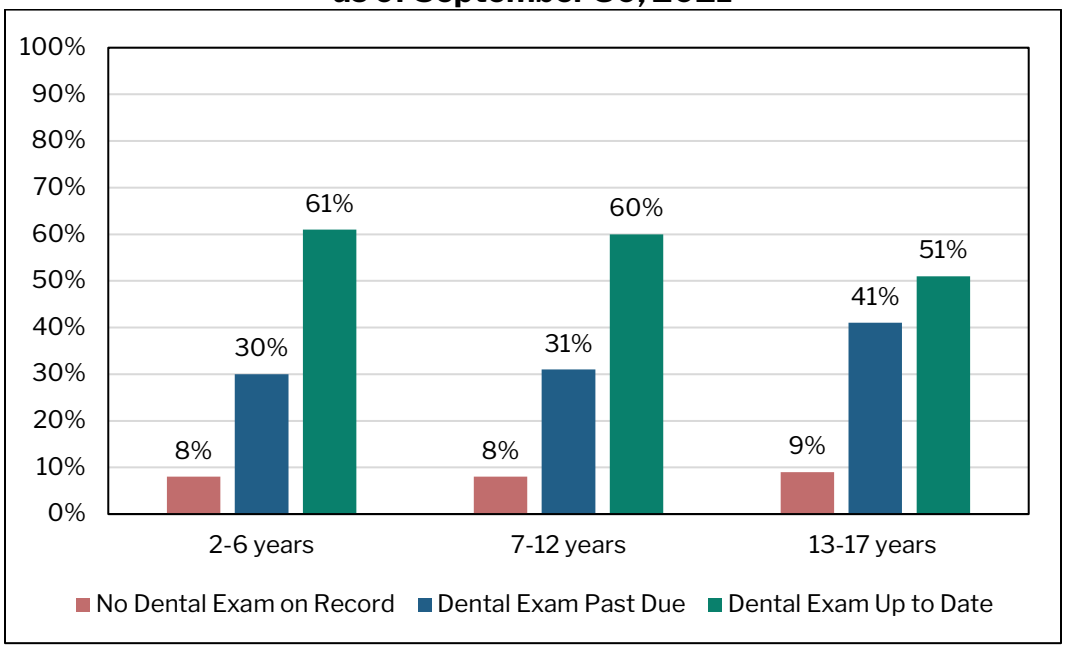
Figure 39: Periodic Dental Examinations as of November 15, 2021 N=3,286



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

There is less variation in the breakdown for up-to-date dental exams by age than there was for periodic medical visits, as seen in Figure 40. In both cases, the age group of two to six-years-old was most likely to have up-to-date medical visits and dental exams. For periodic dental exams, only about half children ages 13 to 17 were up to date on dental exams.

Figure 40: Periodic Dental Examinations By Age as of September 30, 2021



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

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ADR: Accountability, Data, and Research
APS: Adult Protective Services
ARPA: American Rescue Plan Act
CAC: Child Advocacy Center
CANS: Child and Adolescent Needs and Strengths Tool
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CARES: Coronavirus Aid, Relief, and Economic Security Act
CFT: Child and Family Team/Teaming
CPA: Child Placing Agency
CPS: Child Protective Services
CQI: Continuous Quality Improvement
CY: Calendar Year
DHHS: Department of Health and Human Services
DJJ: Department of Juvenile Justice
DMH: Department of Mental Health
DSS: Department of Social Services
EPM: Expedited Placement Meeting
FAST: Family Advocacy and Support Tools
FES: Family Engagement Specialist
FFCRA: Families First Coronavirus Response Act
FFPSA: Family First Prevention Services Act
FHAC: Foster Health Advisory Committee
FMAP: Federal Medical Assistance Percentage
FSA: Final Settlement Agreement
FTE: Full-Time Equivalent
GPS: Guiding Principles and Standards Case Practice Model
ICPC: Interstate Compact on the Placement of Children
IFCCS: Intensive Foster Care and Clinical Services
ILT: Instructor Led Training
IO: Interim Order
LPHA: Licensed Practitioner of the Healing Arts
MCO: Managed Care Organization
MOU: Memorandum of Understanding
OHAN: Out-of-Home Abuse and Neglect Unit

OJT: On-the-Job Training
PIP: Performance Improvement Plan
SACWIS: State Automated Child Welfare Information System
SLRF: Coronavirus State and Local Fiscal Recovery Fund
SNAP: Supplemental Nutrition Assistance Program
TANF: Temporary Assistance for Needy Families
TFC: Therapeutic Foster Care
USC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B – Monitoring Activities

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

Given the COVID-19 pandemic, the Co-Monitors were unable to complete site visits in person to discuss the reform efforts with staff and providers on the ground. During the monitoring period, in July 2021, the Co-Monitors engaged in video interviews with case managers and supervisors from three counties. Also in July 2021, the Co-Monitors held individual calls with a number of foster parents to learn about their experiences. Thematic information gathered from these sessions will be shared with DSS leadership for system improvement purposes. Throughout the monitoring period, the Co-Monitors continued regular check-ins with other stakeholders, and community partners.

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

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

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

- Review of all OHAN investigation case records in CAPSS involving Class Members as an alleged victim accepted in September 2021, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care 30 days or more on September 30, 2021, to assess whether documentation of a case manager's contact with a child in September 2021 addressed each of the agreed upon expected practices or elements which collectively meet the definition of a visit (FSA IV.B.2&3.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care for 30 days or more on September 30, 2021 and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in September 2021 (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, 2021, to assess whether the child had visited with the parent(s) with whom reunification was sought during September 2021 (FSA IV.J.3.);

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

- Review of case files of Class Members ages six and under who were placed in a congregate care setting from April to September 2021 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office overnight from April to September 2021 (FSA IV.D.3.); and

- Participation in regular meetings between DSS and its partners to review data and plan for implementation of the Placement and Health Care improvement plans.

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Workload Limits for Foster Care: 1a. At least 90% of caseworkers[196] shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c)) Approved Workload Limits:[197,198]	OHAN investigators: 0% within required limit (September 2017) 100% had more than 125% of the limit (September 2017)	OHAN investigators: 19% within the required limit Monthly range within the required limit: 14 - 73% 56% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 7 - 86%	OHAN investigators: 0% within the required limit Monthly range within the required limit: 0 – 13% 92% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 69 – 92%	OHAN investigators: [201] 41% within the required limit Monthly range within the required limit: 8 – 41% 35% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 35 – 86%

[196] The FSA utilizes the term "caseworker" to refer to DSS case carrying staff. As part of its Case Practice Model development and outlining enhanced job expectations, DSS now utilizes the term "case manager." Where appropriate and for consistency with practice, this report will utilize the term case manager.
[197] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[198] Caseload limits and methodologies to calculate performance for case managers with mixed caseloads, both Class and Non-Class Members, were approved in December 2017. Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, APS cases, families involved in child protective service assessments, and children placed by ICPC. Performance for foster care case managers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the case manager serves to the total number of families (cases) of Non-Class Members the case manager also serves; the total number should not exceed 15 children and cases.
[201] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and supervisor. These random dates are as follows: April 15, 2021; May 21, 2021; June 16, 2021; July 7, 2021; August 23, 2021; September 30, 2021.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
• *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoption worker* – 15 children[199] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training	<u>Foster Care case managers:</u> 28% within the required limit (September 2017) 59% had more than 125% of the limit (September 2017). <u>IFCCS case managers:</u>[200] 10% within the required limit (September 2017) 77% had more than 125% of the limit (September 2017) <u>Adoption case managers:</u> 23% within the required limit (September 2017)	<u>Foster Care case managers:</u> 59% within the required limit Monthly range within the required limit: 50 - 59% 26% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 26 - 36% <u>Adoption case managers:</u> 15% within the required limit	<u>Foster Care case managers:</u> 49% within the required limit Monthly range within the required limit: 48 – 58% 34% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 27 – 36% <u>Adoption case managers:</u> 19% within the required limit	<u>Foster Care case managers:</u> 44% within the required limit Monthly range within the required limit: 44 – 54% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 31 – 37% <u>Adoption case managers:</u> 25% within the required limit

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

[200] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
	62% had more than 125% of limit (September 2017).	Monthly range within the required limit: 15 - 28% 50% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 50 - 61%	Monthly range within the required limit: 13 – 19% 61% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 51 – 74%	Monthly range within the required limit: 14 – 25% 62% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 61 – 65%
Workload Limits for Foster Care: 2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c)) Approved Supervisor Limits: • *OHAN supervisors* – 6 investigators	OHAN Supervisors: 100% within the required limit (March 2018) None were more than 125% of the limit (March 2018) Foster Care Supervisors: 42% within the required limit (March 2018)	OHAN Supervisors: 0% within the required limit each month this period 50% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 50% Foster Care Supervisors: 79% within the required limit	OHAN Supervisors: 100% within the required limit each month this period 0% had more than 125% of the limit. Foster Care Supervisors: 86% within the required limit	OHAN Supervisors: 75% within the required limit Monthly range within required limit: 67 – 100% 0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 33% Foster Care Supervisors: 81% within the required limit

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
• *Foster Care*, *IFCCS*,[202] and *Adoption* supervisors – 5 case managers	36% had more than 125% of the limit (March 2018)	Monthly range within the required limit: 76 - 82% 5% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 5 - 15%	Monthly range within the required limit: 77 – 86% 8% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 5 – 8%	Monthly range within the required limit: 81 – 83% 8% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 7 – 11%
	<u>Adoption Supervisors:</u> 38% within the required limit (March 2018) 19% had more than 125% of the limit (March 2018)	<u>Adoption Supervisors:</u> 75% within the required limit Monthly range within the required limit: 70 - 81% 5% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 5%	<u>Adoption Supervisors</u>: 86% within the required limit Monthly range within the required limit: 75 – 86% 0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 – 5%	<u>Adoption Supervisors</u>: 74% within the required limit Monthly range within the required limit: 73 – 91% 9% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 5 – 9%

[202] The IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads between September and December 2019.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
	IFCCS Supervisors:[203] 57% within required limit (March 2018) 29% had more than 125% of the limit (March 2018)			
Visits Between Case Managers and Children: 3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place. (FSA IV.B.2.)	24% of cases reviewed had all agreed-upon elements of a visit (September 2019)	30% of cases reviewed had documentation of all agreed-upon elements of a visit.	38% of cases reviewed had documentation of all agreed-upon elements of a visit.	34% of cases reviewed had documentation of all agreed-upon elements of a visit.[204,205]

[203] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.
[204] DSS, USC CCFS, and the Co-Monitors worked together to develop an instrument and reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2021. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.
[205] A sample of 345 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed. Documentation from a statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all (345 of 345, or 100%) of the children reviewed.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Visits Between Case Managers and Children: 4. At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child. (FSA IV.B.3.)	22% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence. (September 2019) 92% of face-to-face contacts took place in the child's residence. (September 2019)	30% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence. 84% of face-to-face contacts took place while the child was in their own residence or placement.	34% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence. 79% of face-to-face contacts took place while the child was in their own residence or placement.	26% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence.[206,207] 80% of face-to-face contacts took place while the child was in their own residence or placement.
Investigations - Intake: 5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy.	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between April and September 2020, 93% of screening decisions not to investigate were determined to be appropriate.	Between October 2020 and March 2021, 97% of screening decisions not to investigate were determined to be appropriate.	Between April and September 2021, 91% of screening decisions not to investigate were determined to be appropriate.

[206] DSS, USC CCFS, and the Co-Monitors reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2021. Reviewers assessed documentation for the elements which define a visit.
[207] A sample of 345 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed. Documentation from a statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all (345 of 345, or 100%) of the children reviewed.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
(FSA IV.C.2.)				
Investigations - Case Decisions: 6. At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. (FSA IV.C.3.)	47% of applicable investigation decisions to unfound were determined to be appropriate (March 2017).	66% (39) of 59 applicable investigation decisions to unfound were determined to be appropriate.	74% (37) of 50 applicable investigation decisions to unfound were determined to be appropriate.	72% (36) of 50 applicable investigation decisions to unfound were determined to be appropriate.
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance	78% of applicable investigations were timely initiated. (March 2017)	78% (52) of 67 applicable investigations were timely initiated.	87% (48) of 55 applicable investigations were timely initiated.	92% (49) of 53 applicable investigations were timely initiated.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
with South Carolina law in at least 95% of the investigations. *Investigations - Contact with Alleged Child Victim:* 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[208] (FSA IV.C.4.((a)&(b))				
Investigations - Contact with Core Witnesses:	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	27% (18) of 67 applicable investigations included contact with all necessary core witnesses.	67% (37) of 55 applicable investigations included contact with all necessary core witnesses.	50% (27) of 54 applicable investigations included contact with all necessary core witnesses. [209]

[208] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes – the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[209] Completion of contact with core witnesses by type, as applicable, for the 54 investigations reviewed is as follows: alleged victim child(ren), 94%; reporter, 75%; alleged perpetrator(s), 94%; law enforcement, 70%; alleged victim child(ren)'s case manager, 76%; other adults in home or facility, 52%; other children in home or facility, 79%; and additional core witnesses as identified for the investigation, 78%.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c))				
Investigations - Timely Completion: 10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[210]	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	97% of investigations reviewed were appropriately closed within 45 days.	96% of investigations reviewed were appropriately closed within 45 days.	96% of investigations reviewed were appropriately closed within 45 days. [211]

[210] For the purposes of this measure, an investigation is not completed if DSS determines the report is unfounded because the deadline to complete the investigation has passed.

[211] Reviewers determined that 1 of the investigations that was closed within 45 days was closed prematurely in an effort to meet the 45-day requirement, which is not considered compliant under the FSA. This investigation was closed on the 45th day after intake even though there were documented incomplete tasks. Although closed in DSS's system, this investigation is not included in the numerator as compliant for any of the timely closure measures.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
(FSA IV.C.4.(d)) ***Final target by March 2021: 95% closure in 45 days***				
<u>*Investigations - Timely Completion:*</u> 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[212] (FSA IV.C.4.(e))	96% of investigations reviewed were closed within 60 days. (March 2017)	99% of investigations reviewed were closed within 60 days.	98% of investigations reviewed were closed within 60 days.	98% of investigations reviewed were closed within 60 days.

[212] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Final target by March 2021: 95% closure in 60 days				
Investigations - Timely Completion: 10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days.[213] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	99% of investigations reviewed were closed within 90 days.	98% of investigations reviewed were closed within 90 days.	98% of investigations reviewed were closed within 90 days.
Family Placements for Children Ages Six and Under: 11. No child age six and under shall be placed in a congregate	Baseline data for this measure are not available.	The circumstances of all but 6 children met an agreed upon exception. A total of 34 Class Members ages six and under were placed in congregate care.	The circumstances of all but 3 children met an agreed upon exception. A total of 32 Class Members ages six and under were placed in congregate care.	The circumstances of all but 4 children met an agreed upon exception.[214] A total of 25 Class Members ages six and

[213] Ibid.

[214] In validating data for this measure, the Co-Monitors identified 4 situations that did not meet an agreed-upon exception. In 1 case, DSS reported that the child was placed with their mother, but Co-Monitor staff could not validate this claim. In another, a 6-year-old was placed at a residential treatment facility after being hospitalized but did not meet the threshold of a medical necessity exception. The remaining 2 cases were sibling groups who remained in group homes beyond 90 days without documented efforts to move the children to a family-based placement. While it is important that siblings not be separated to meet the terms of this measure, it is essential that ongoing efforts be made to secure a less restrictive placement in which the children can remain together.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
care setting except with approved exceptions. (FSA IV.D.2.)				under were placed in congregate care.[215]
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there was 1 overnight placement in a hotel, but it was for the purpose of safely quarantining a child who had tested positive for COVID-19.	DSS reports there were 5 overnight placements in a DSS office.	DSS reports there were 68 overnight placements in a DSS office (for 34 unique children).
Congregate Care Placements: 13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. (FSA IV.E.2.)	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	84% of children in foster care were placed outside of a congregate care setting.	85% of children in foster care were placed outside of a congregate care setting.	86% of children in foster care were placed outside of a congregate care setting.[216]

[215] This includes 15 children residing in a facility or group care with their mothers, 9 children who were part of large sibling groups for whom DSS reported a single, family-based placement could not be located despite efforts, and 1 child who had been hospitalized.
[216] This does not include 24 children who were hospitalized (11) or in a correctional/juvenile justice facility (13).

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Congregate Care Placements - Children Ages 12 and Under: 14. At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. (FSA IV.E.3.)	92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018)	97% of children ages 12 and under in foster care were placed outside of a congregate care setting.	98% of children ages 12 and under in foster care were placed outside of a congregate care setting.	99%[217] of children ages 12 and under in foster care were placed outside of a congregate care setting.[218,219]

[217] This includes 10 children ages 6 and under who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[218] The Co-Monitors have approved exceptions for placing children ages 7 to 12 in a congregate care facility and built a process for submitting documentation and approval for exceptions during this monitoring period. For those children placed between April and September 2021, DSS did not submit any exceptions.
[219] This does not include 6 children who were hospitalized on the last day of the monitoring period.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Emergency or Temporary Placements for More than 30 Days: 15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. (FSA IV.E.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[220]
Emergency or Temporary Placements for More than Seven Days: 16. Class Members experiencing more than one Emergency or Temporary Placement within	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[221]

[220] DSS recently began tracking the use of emergency placements in CAPSS. Co-Monitors will review these data for inclusion in the next monitoring report. As discussed in Section VIII. *Placements*, DSS continues to provide the Co-Monitors with data regarding emergency "incentive" payments made to providers to accept placement of a child overnight.
[221] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. (FSA IV.E.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
<u>*Placement Instability:*</u> 17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37. (FSA IV.F.1.)	3.55 moves per 1,000 days (October 1, 2016 to September 30, 2017).	4.17 moves per 1,000 days (October 1, 2019 to September 30, 2020).	Data for this measure are produced on an annual basis.	Data for this measure are not available.[222]
<u>*Sibling Placements:*</u>	63% of children entering foster care with siblings were placed with at least one of their	73% of children entering foster care with siblings were placed with at least	75% of children entering foster care with siblings were placed with at least	70% of children entering foster care with siblings were placed with at least

[222] Shortly before publication of this report, DSS discovered errors in its placement instability data that led it to conclude that these data, which had been collected, analyzed, and provided to the Co-Monitors, were not valid. As a result, accurate and validated performance data with respect to this measure for the period October 2020 through September 2021 could not be included in this report.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.2.&3.)	siblings on the 45th day after entry. (March 2018)	one of their siblings on the 45th day after entry.	one of their siblings on the 45th day after entry.	one of their siblings on the 45th day after entry.[223]
<u>*Sibling Placements:*</u> 19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless an exception applies.	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry (March 2018).	46% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	48% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	45% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[224]

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
<u>*Youth Exiting the Juvenile Justice System:*</u> 20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or DJJ that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period	Data are not available for this period.[225]

[225] The Co-Monitors do not believe the current system captures all violations of this provision and are currently undergoing a comprehensive review, jointly with DSS and in collaboration with DJJ, of youth involved with both the juvenile justice and child welfare systems. Findings will be published in a subsequent report. As discussed in Section VIII. *Placements,* DSS is in the process of developing a reliable system for tracking youth involved with both the juvenile justice and child welfare systems who are subject to this provision. The Co-Monitors reviewed a number of cases reported by stakeholders in which youth spent time in DJJ facilities due, in part, to DSS's failure to appropriately meet their needs.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
provide for their appropriate placement. (FSA IV.H.1.)				
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: 21. All Class Members that are identified by a Caseworker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[226]

[226] At the time of finalization of the Placement Implementation Plan, the Co-Monitors and Parties determined that, because the process of assessing and identifying the need for more intensive supports and placements would likely be modified as DSS began to implement its Placement Implementation Plan, DSS would wait to propose benchmarks and timelines until implementation began. DSS and the Co-Monitors anticipated that there might be a need for the initial FSA requirements in this area to be amended, and that any proposed updates, benchmarks, and timelines would be submitted by no later than July 2019. As discussed in Section VIII. *Placements*, DSS has not yet implemented many core strategies of the Placement Implementation Plan, and has not proposed updated requirements. Benchmarks and timelines for performance of the initial FSA requirements have also not been proposed, and DSS has reported that it is not able to collect or report data in this area.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
(FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: 22. All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. (FSA IV.I.3.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[227]

[227] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Therapeutic Foster Care Placements - Level of Care Placement: 23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.4.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period. [228]

[228] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Therapeutic Foster Care Placements - Level of Care Placement: 23.b. At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period. [229]

[229] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Family Visitation - Siblings 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	36% of all required visits between siblings occurred for those who were not placed together.	53% of all required visits between siblings occurred for those who were not placed together.	50% of all required visits between siblings occurred for those who were not placed together.[230]
Family Visitation - Parents: 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies.	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	13% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	18% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	17% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. [231]

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
(FSA IV.J.3.)				
Health Care - Immediate Treatment Needs: 26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[232]
Health Care - Initial Medical Screens	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. ***Dates to reach final target and interim benchmarks to be added once approved.[233]***				Data for this measure are not available.[234]
<u>*Health Care - Initial Comprehensive Assessments*</u> 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care.	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	See Section X. *Health Care*	44% of children received a comprehensive medical assessment within 30 days.	38% of children received a comprehensive medical assessment within 30 days.[235]

[233] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks for Initial Medical Screens and Initial Mental Health Assessments to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.
[234] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020. DSS reports that it will be able to reliably collect and report these data once the CANS is fully implemented and available in CAPSS.
[235] As discussed in Section X. *Health Care*, the Co-Monitors have not independently validated these data.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	See Section X. *Health Care*	60% of children received a comprehensive medical assessment within 60 days.	56% of children received a comprehensive medical assessment within 60 days.[236]
Health Care - Initial Mental Health Assessments 30. At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[237]

[236] Ibid.

[237] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020. While DSS has shared data regarding the total number of children who received mental health assessments, DSS remains unable to produce data related to children who received mental health assessments based on identified needs, as required by the agreed-upon measure.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***				
<u>*Health Care - Initial Mental Health Assessments*</u> 31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[238]

[238] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Health Care –Referral to Developmental Assessments 32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care.	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	88% of children under 36 months of age were referred within 30 days.	87% of children under 36 months of age were referred within 30 days.	94% of children under 36 months of age were referred within 30 days.
Health Care –Referral to Developmental Assessments 33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care.	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	92% of children under 36 months of age were referred within 45 days.	92% of children under 36 months of age were referred within 45 days.	95% of children under 36 months of age were referred within 45 days.
Health Care – Initial Dental Examinations	35% of children age one and above received a dental exam within 60 days. (March 2018)	See Section X. *Health Care*	53% of children ages two and above received a	49% of children ages two and above received a

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care.			dental exam within 60 days.	dental exam within 60 days.[239]
Health Care – Initial Dental Examinations 35. At least 90% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care.	48% of applicable children age one and above received a dental exam within 90 days. (March 2018)	See Section X. *Health Care*	66% of applicable children ages two and above received a dental exam within 90 days.	64% of applicable children ages two and above received a dental exam within 90 days.[240]
Health Care – Periodic Preventative Care (Well visits)	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

[239] As discussed in Section X. *Health Care*, the Co-Monitors have not independently validated these data.
[240] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly.	30% (42) of 137 children under the age of six months who entered care between October 1, 2018 and March 31, 2019 received a periodic preventative visit monthly.			
Health Care - Periodic Preventative Care (Well visits) 37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.	38% of children between the ages of six and 36 months received periodic preventative visits in accordance with the periodicity schedule. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Preventative Care (Well visits) 38. At least 98% of Class Members between the ages of six months and 36 months in	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
care for one month or more will receive a periodic preventative visit semi-annually.				
Health Care – Periodic Preventative Care (Well visits) 39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually.	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Preventative Care (Well visits) 40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.	58% of children ages three years and older received an annual preventative visit. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
Health Care – Periodic Dental Care 41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.	54% of children ages two years or older received a dental exam semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Dental Care 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.	81% of children ages two years or older received an annual dental examination. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care - Follow-Up Care 43. At least 90% of Class Members will receive timely accessible and appropriate	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**	**April – September 2021 Performance**
follow-up care and treatment to meet their health needs. ***Dates to reach final target and interim benchmarks to be added once approved.***[241]				

[241] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019. DSS has not yet established a reliable mechanism for measuring baseline performance in this area.