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

October 1, 2020 - March 31, 2021

CO-MONITORS

JUDITH MELTZER
PAUL VINCENT

CO-MONITOR STAFF

RACHEL PALETTA
ELISSA GELBER
GAYLE SAMUELS
ALI JAWETZ

Published October 6, 2021

Michelle H., et al. v. McMaster and Leach Progress Report for the Period October 1, 2020 - March 31, 2021

Table of Contents

List of Tables

List of Figures

Michelle H., et al. v. McMaster and Leach
Progress Report for the Period October 1, 2020 - March 31, 2021

I. Introduction

This is the ninth six-month report on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) entered in *Michelle H., et al. v. McMaster and Leach*.[1] Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the approximately 4,000 children in foster care in South Carolina (SC)[2] and incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3] This report covers DSS performance during the period October 1, 2020 through March 31, 2021, and has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Elissa Gelber, Rachel Paletta, Gayle Samuels, and Ali Jawetz. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs); and the public.

The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the custody of their parent(s) or guardian(s) and placed in DSS's custody. The FSA reflects DSS's agreement to address long-standing problems in the operation of its child welfare system. It was crafted by state leaders and Plaintiffs to guide a multi-year reform effort on behalf of children in DSS's custody. The FSA includes a wide range of specific provisions governing: the workloads of case managers and supervisors; visits between children in foster care and their case managers; family time, or visits between children in foster care and their parents and siblings; investigations of 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

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

2019, leading to the development of Implementation Plans approved and ordered by the Court.[4] The intention was that these Plans – 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 multiple subsequent Orders. 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 FY2019-2020 budget, while it awaited the FY2020-2021 appropriation from the South Carolina General Assembly.[5] 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 Parties regarding what steps DSS was required to take before July 2021.[6]

The Co-Monitors and their staff utilize a range of sources and activities to collect information for inclusion in this report and to inform the overall assessment of the State's progress. These include, among other things, review of records in DSS's Child and Adult Protective Service System (CAPSS);[7] analysis and validation of data 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, private providers, and other stakeholders; and meetings with DSS leaders and staff. Appendix B includes a list of specific activities used to assess DSS's progress during 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.[8,9] In order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about key developments beyond March 31, 2021 (the end of the monitoring period), where applicable.

---

[4] *See* Court orders approving Workload, Placement, and Health Care Plans (February 27, 2019, Dkt. 109) and Visitation Plan (April 3, 2019, Dkt. 115).
[5] Joint Report of Plaintiffs and Defendants to the Honorable Richard Gergel (July 22, 2019, Dkt. 145).
[6] COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[7] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).
[8] 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)."
[9] 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, South Carolina DSS continued to navigate the demands and challenges caused by the COVID-19 pandemic, as well as continuing to push forward on long term priorities of the reform effort. The pandemic also placed a large burden on the children, families, and community providers with whom DSS works, who have had to transition to reduced access to some community services, as well as virtual visits and virtual service delivery. For families with children in foster care, despite significant effort by DSS leaders and staff, this has often meant less face-to-face time with loved ones, limited access to needed supports, and additional barriers to family reunification.

DSS has struggled to juggle priorities and meet the many *Michelle H*. obligations without receiving needed additional appropriations from the South Carolina General Assembly. Despite some notable areas of progress, described below, many of the barriers to improved outcomes and system transformation that existed at the beginning of the lawsuit remain – notably, a lack of resources, an inadequate placement system and service array, and the need to infuse a changed approach to case practice that more fully engages children, families, and providers.

Almost five years after entry of the Final Settlement Agreement, South Carolina DSS has made gradual but steady progress to reduce congregate care placements, build capacity to provide and track health care delivery for children and youth, and increase placements and support for kinship caregivers. Young children under the age of six now rarely stay in group home facilities, and increasingly, DSS staff reach out to identify and place children in their custody with their kin. The Department has also reported rolling out and training on the Child and Family Teaming process, which is a core element of its Guiding Practices and Standards (GPS) Case Practice Model. It has also worked with a consultant to develop an approach to assessing child and youth strengths and needs with two new assessment tools that it will use to support the case planning process.[10]

However, much of the way that children and their family members experience encounters with DSS has not changed, and DSS staff remain overburdened and underpaid.[11] There remain an inadequate number of family-based foster placements

[10]These are the Family Advocacy and Support Tool (FAST) and the Child and Adolescent Needs and Strengths tool (CANS), described further in Section IV. *Placements*.

[11] Effective July 1, 2021, case managers and supervisors began receiving salary raises, 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

and of accessible, high-quality community-based services, particularly for children with specialized needs. And while the aspirations and expectations are beginning to shift, team-based planning with families, children, caregivers, and providers is not yet standard practice. Just under half of case managers have caseloads within required standards, and staff turnover has remained stubbornly high, impacting case managers' ability to maintain connections between children and their families, with visitation between siblings and between children and the parents with whom they plan to reunify remaining low. Too many children remain in foster care for long periods of time and children with complex needs experience a high degree of instability.

These underlying problems threaten the improvements DSS has made and is actively pursuing, and are now revealing themselves in a placement crisis that has led to an increasing number of children spending days and nights in DSS offices and moving through multiple temporary or emergency foster placements. Thus, though we want to acknowledge and celebrate that DSS is reducing its reliance on congregate care placement and increasing its use of licensed kin, at the same time too many children and youth are placed far from their home and community, including an increasing number placed out-of-state. Placements for specific populations, particularly older youth, children with behavioral health concerns or disabilities, and LGBTQ+ youth, remain in woefully short supply. Many congregate care facilities that remain in use are restrictive and sometimes unsafe, do not provide services on-site, and at times do not have the staffing and resources to meet children's needs. Until these problems are addressed, the transition to building more therapeutic settings will be impossible.

The upcoming monitoring period presents significant opportunity for DSS. In July 2021, staff began receiving salary raises, the two new tools for family assessment that capture strengths and needs were implemented, and there is opportunity for further partnership with the new leadership team at the South Carolina Department of Health and Human Services (DHHS). Additionally, significant new federal COVID-19 recovery funds may become available to DSS if they are allocated by the Governor and General Assembly. DSS has also been working on revising its Placement Implementation Plan which comprises the primary framework for restructuring the Department's placement array and processes. As part of this revision, DSS staff have reached out to youth who have experienced foster care and are incorporating their vital feedback into their plans. In the interim, the current Court-ordered plan is in

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).

place and while aspects of it have been implemented successfully, some key elements have not. Key elements not yet implemented include commitments for 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; developing wraparound crisis intervention services particularly for kin caregivers; maximizing the use of Medicaid-funded services to fill gaps in the current service array; determining activities that would meet the needs of dually-involved youth with DSS and the Department of Juvenile Justice (DJJ); and piloting and refining a system that incorporates most of these reforms in several geographic areas of the State. DSS is at a moment where it can build on its work to date and use opportunities from recovery from the COVID-19 pandemic to make significant progress toward meeting more of the terms of the FSA and Implementation Plans.

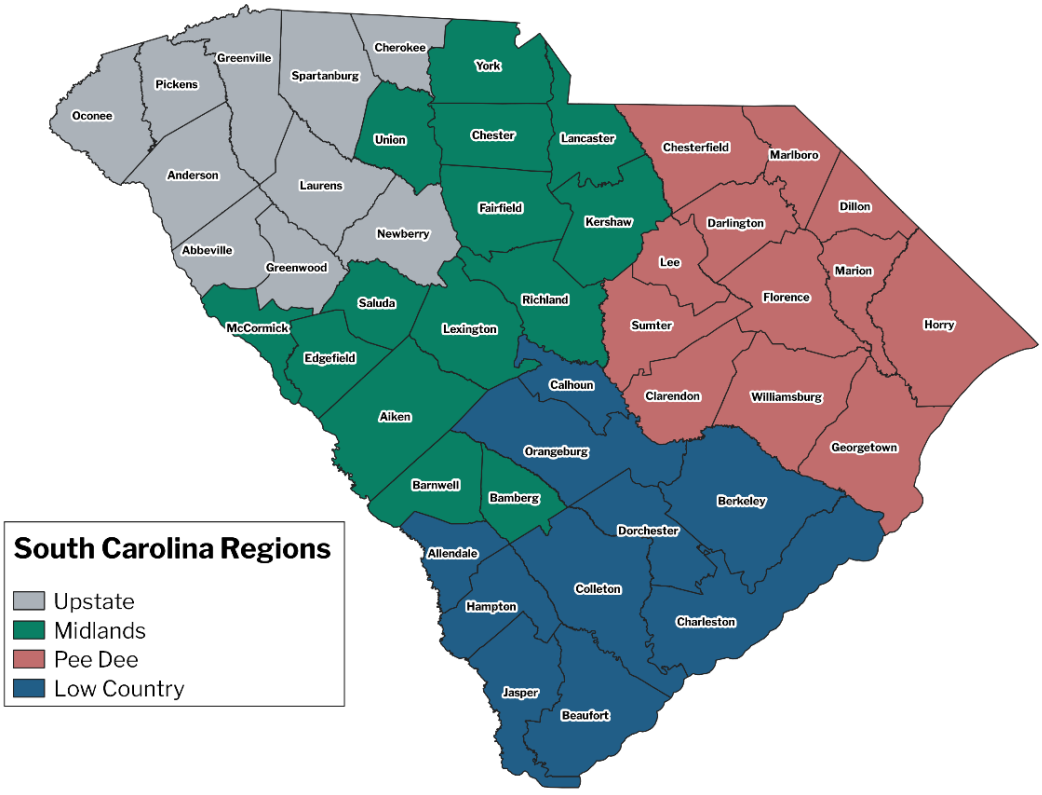
It continues to be the Co-Monitors' belief that, even before the infusion of the full complement of additional financial resources that the Department has acknowledged it needs, there remain some urgent needs with respect to children in out-of-state placements and office and night-to-night placements that must be tackled now. In addition, DSS leaders should continue to move forward with the foundational capacity building efforts with its staff and with the private provider community so that the system as a whole can effectively capitalize on the expansion of budgetary resources when provided.

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."[12] 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).

Figure 1: South Carolina Counties by Region

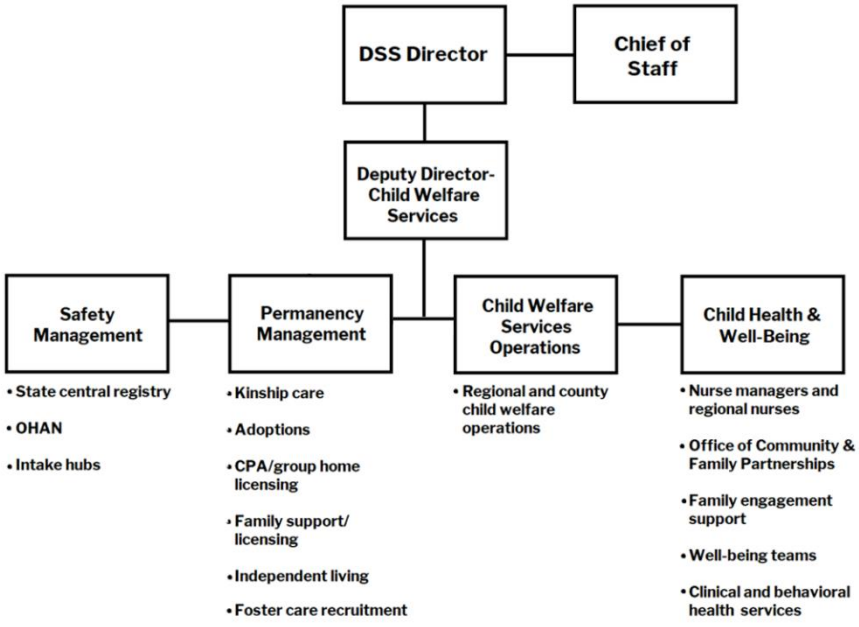


[12] To see DSS's mission, visit: https://dss.sc.gov/about/

The FSA pertains specifically to children who have been involuntarily removed from the custody of their parents or guardians and taken into the custody of DSS. These children reside in foster care or "out-of-home" care. DSS, 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 a family member or someone known to their family, while working to address safety issues so they can return home to their parents or guardians. When reunification is not possible, DSS must work towards another permanent, long-term plan, such as guardianship or adoption.

DSS's foster care work is part of its Child Welfare Services Division, overseen by Deputy Director of Child Welfare, Karen Bryant. The Child Welfare Services Division is organized into four primary areas of focus: Safety Management, Permanency Management, Operations, and Child Health and Well-Being.[13] Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.[14]

Figure 2: DSS Child Welfare Services Division Organizational Chart



[13] 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.

[14] As is true of many systems across the country, some private organizations are licensed as Child Placing Agencies (CPAs), which receive funding to provide foster care through group facilities or by recruiting, training, and licensing foster parents. Coordinating with CPAs falls under Permanency Management in Figure 2. Approximately 30 percent of children in DSS custody were placed through CPAs as of the end of the monitoring period.

Foster Care Budget and Financing

The federal government provides legal mandates and financial support through a number of significant sources and has shown "long-standing interest in helping states improve their services to children and families."[15] Specifically, the federal Children's Bureau, within the Administration for Children and Families, distributes funds to states through mandatory spending programs authorized through the Social Security Act. The largest of these programs is authorized under Title IV-E of the Social Security Act and operated 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.[16] Eligibility depends on the income level of the parent(s) from whose custody the child was removed. Even if a child's case is found to be Title IV-E eligible, reimbursement is allowed only for specific portions of certain eligible expenses. 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.[17] In South Carolina, approximately 46 percent of children in foster care meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[18,19]

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.[20] 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

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

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

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

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

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

[20] 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/

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.[21] Medicaid can be used to cover non-direct health care services, such as behavioral health services, and services as part of therapeutic foster care. Many states have also used Medicaid to support health care case management for children in foster care. South Carolina is largely not currently utilizing the options for reimbursement of these costs for children in foster care. Though DSS and DHHS leaders have stated interest in exploring ways of tapping into this funding, the progress has been very slow. DSS is currently pursuing a Medicaid waiver to improve access to mental health services, which will be reported in the following monitoring period.

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.[22] South Carolina's budget process begins in July or August of the year preceding the start of the new fiscal year when the Governor sends budget instructions to state agencies. In typical circumstances, agencies submit their budget requests to the Governor between September and November, detailing every new and recurring dollar they plan to spend in the following year, and 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

[21] 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#/

[22] 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.

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.

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 is 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.[23,24] Despite this increase, however, the allocation remained $23,594,857 short of DSS's request, based upon the funding estimated needed for compliance with all outstanding obligations in the FSA. DSS reports that the General Assembly plans to reconvene this fall to begin discussions regarding the allocation of the approximately $2.1B of the American Rescue Plan's State Recovery Fund.

Population and Demographics of Children in Foster Care

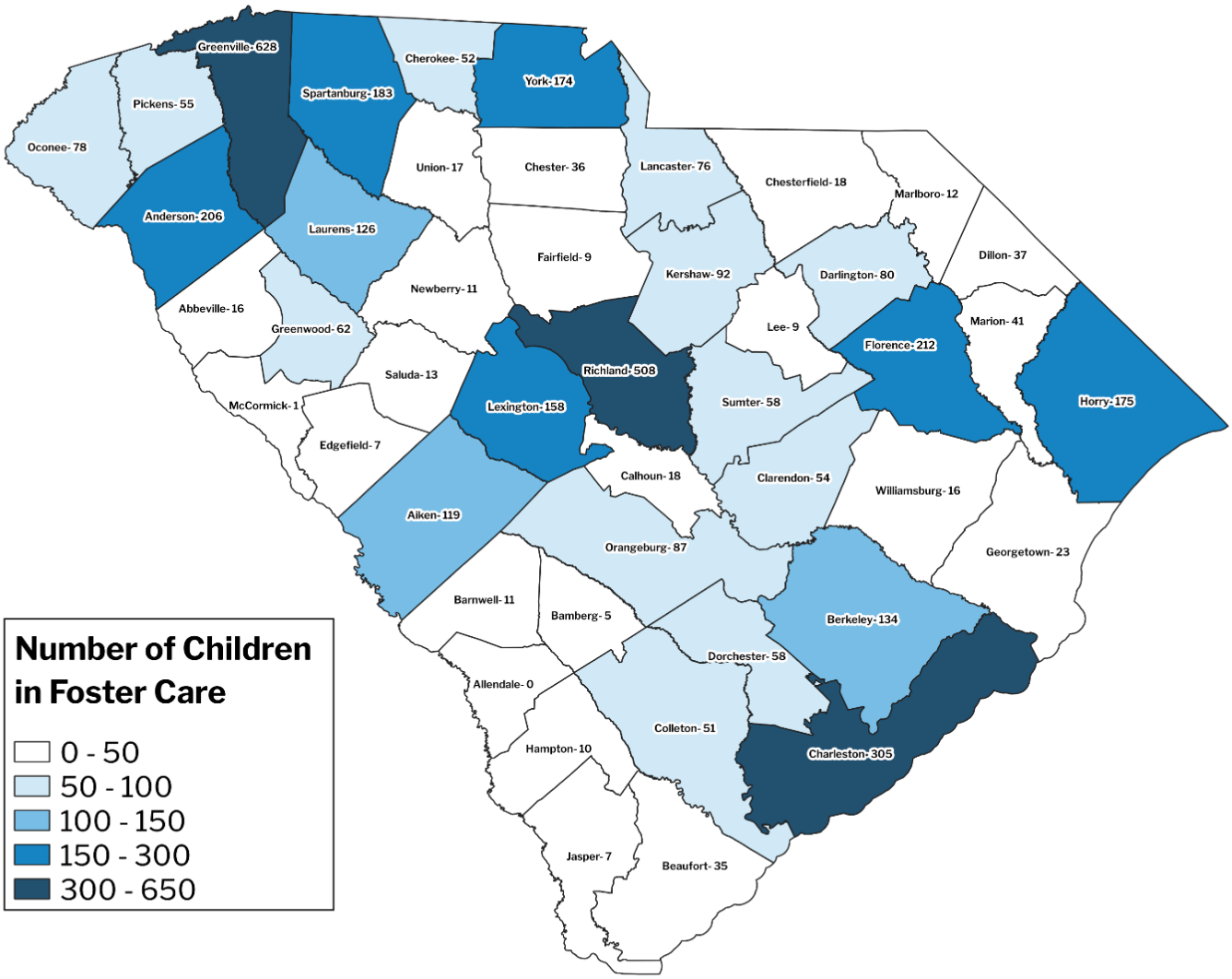
Over 1.1 million children under the age of 18 resided in South Carolina in 2019; during the monitoring period, 5,169 children were in foster care at some point.[25,26] DSS now regularly publishes real-time data about children in out-of-home care on its public website.[27] Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care. On June 29, 2021, for example, 4,083 children were in DSS's custody, and 1,372 (34%) 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 June 29, 2021, ranging from none to 628. 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 508. 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 June 29, 2021. Differences among counties

[23] In May 2020, DSS utilized funding available as a result of COVID-related legislation to temporarily increase foster home board rates through to the USDA-based rates of $20.03, $23.41, and $24.72 per day for foster family homes including kinship foster homes. DSS has since made this change permanent.
[24] See Table 4 for new salary schedule.
[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/

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.

Figure 3: Number of Children in DSS Custody by County as of June 29, 2021[28]



Source: Data from DSS website, 6/29/21

Though the foster care population remains lower than it was at the end of the prior monitoring period (when there were 4,072 children in foster care on September 30, 2020), there was an increase in the foster care population since January 2021 when

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

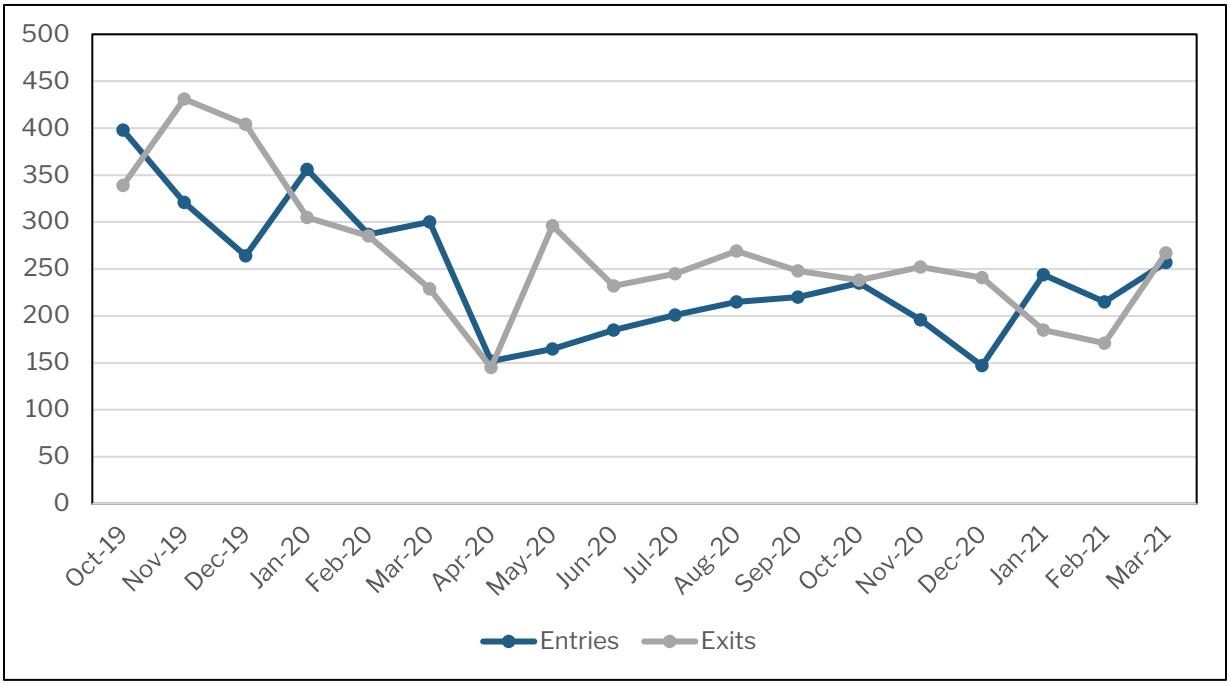
the number of children entering care began exceeding the number of children exiting. As seen in Table 1 and Figure 4, 1,294 children entered foster care and 1,354 children exited foster care during this monitoring period. Compared to the prior monitoring period (April to September 2020), there have been slightly more entries and slightly fewer exits.

Table 1: Foster Care Entries and Exits
October 2020 – March 2021

Category	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
Children Served	4,277	4,235	4,130	4,133	4,163	4,249
Entries into Care	235	196	147	244	215	257
Exits from Care	238	252	241	185	171	267
Children in Care on Last Day of Month	4,039	3,983	3,889	3,948	3,992	3,982[29]

Source: CAPSS data provided by DSS

Figure 4: Foster Care Entries and Exits
October 2019 - March 2021

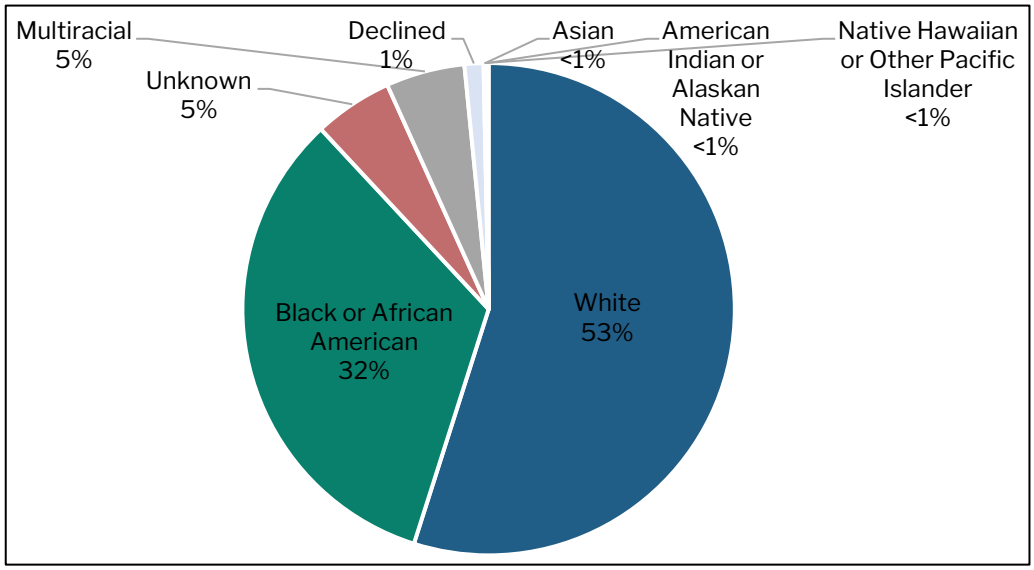


Source: CAPSS data provided by DSS

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

As it does throughout the United States, the legacy of disproportionate removal of Black children from their families persists in South Carolina, though at lower rates than in years past. When comparing race and ethnicity of children in DSS custody, as shown in Figure 5, to that of the total child population in the state, representation appears slightly disproportionate: 53 percent of children in foster care are identified as White compared to 57 percent of all children in the state; 32 percent of children in foster care are identified as Black compared to 31 percent of all children in the state.[30]

Figure 5: Population of Children in DSS Custody by Race as of June 29, 2021 N=4,083



Source: Data from DSS website, 6/29/21[31,32]

When these data are analyzed by county, certain areas show a larger disproportionality for Black children, while others seem to have eliminated this racial disproportionality. These data provide DSS with the opportunity to examine if inequities or practice issues are the cause of data disparities. This information also can help DSS identify where disproportionalities have changed over time. Table 2 depicts specific data from the six largest counties in the state:

[30] Categories included herein reflect data provided by DSS. DSS does not record Hispanic or Latinx as a category in their race data.
[31] Data were rounded to whole numbers. The population of Asian, American Indian or Alaskan Native, and Native Hawaiian or Other Pacific Islander children was each 0.1%.
[32] 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
Aiken County	30%	N/A	38%
Charleston County	32%	49%	32%
Greenville County	21%	24%	21%
Horry County	19%	24%	28%
Richland County	56%	62%	59%
Spartanburg County	24%	N/A	25%

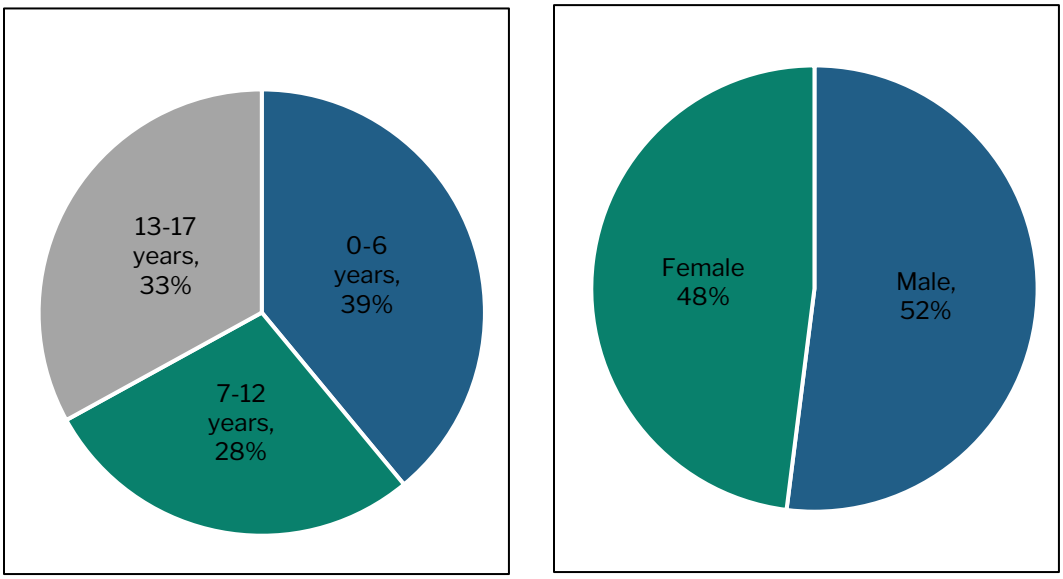
Source: Data from DSS website, 6/26/20 and 7/22/21 and Kids Count Data Center, 2019

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

In terms of age and gender, Figure 6 shows that about one-third (33%) of the foster care population are adolescents (ages 13 to 17), and 39 percent of children in care are ages six and under. Slightly less than half of children in foster care are reported to be female (48%).[33]

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

Figure 6: Children in DSS Custody by Age and Reported Gender as of June 29, 2021
N=4,083



Source: Data from DSS Website, 6/29/21

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

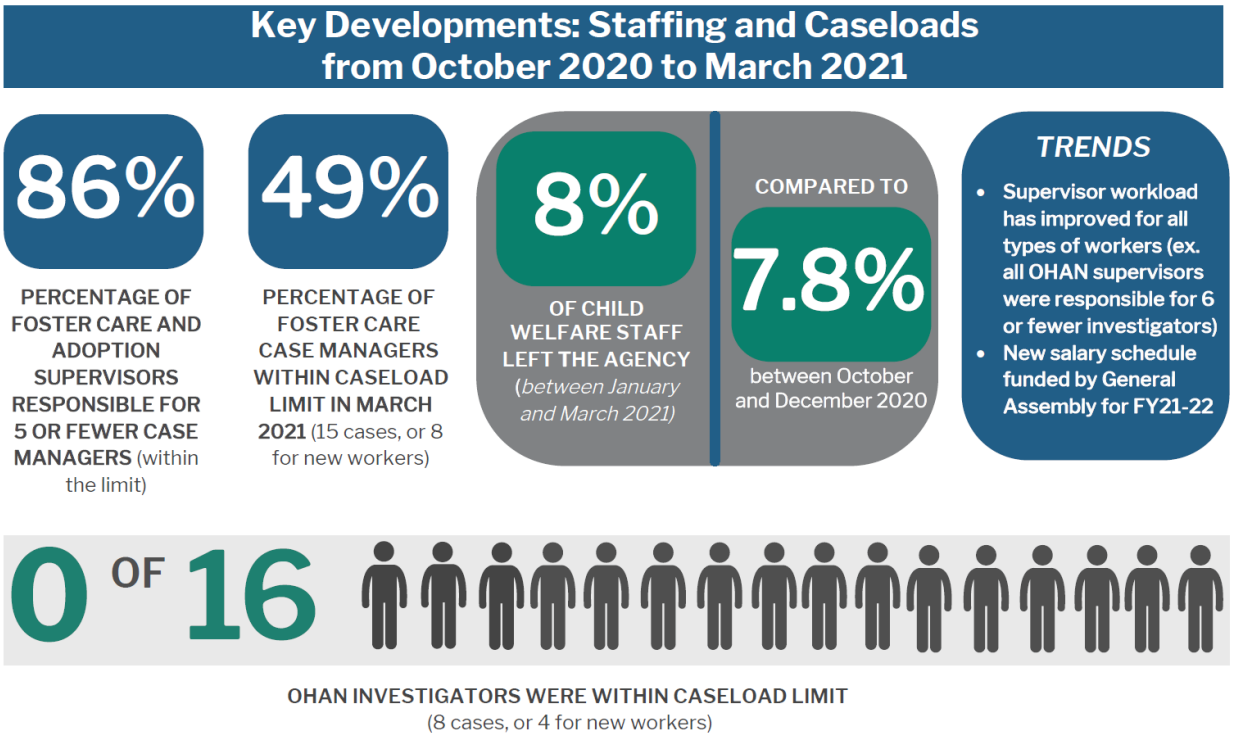
IV. Caseloads

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system and has been a focus of DSS's reform. Case managers must have the resources and supports needed to engage families and providers in creating meaningful plans and monitor progress towards individualized case goals, among many other important tasks.[34] 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 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.

Caseload size continued to be a problem during this monitoring period and levels of compliance for both Out-of-Home Abuse and Neglect (OHAN) investigators and foster care case managers declined. As of March 31, 2021, no OHAN case manager was responsible for a caseload within the required limit (a drop in performance from 19% in compliance as of September 30, 2020), and caseload compliance for foster care case managers fell from 59 percent as of September 30, 2020, to 49 percent as of March 31, 2021.

Workload compliance did increase for supervisors in foster care, adoption, and Out-of-Home abuse and neglect (OHAN) during this monitoring period. More detailed data on caseloads over time can be found in the Performance Data section beginning on page 25.

[34] 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.[35] The Plan's strategies primarily focus on improvements to infrastructure and hiring, training, and retention of case managers and supervisors. The discussion below includes implementation updates for select Implementation Plan, and Joint Report, and Mediation Agreement strategies during this period.

[35] 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. Using a standard of 12 children to one case manager, DSS estimated a need for 213 new case manager positions, and 43 supervisors to meet caseload standards. The court-ordered Workload Implementation Plan included adding these staff as a required action. Although these positions and the requisite $18 million in funding to pay for them have been requested during the last two state budget cycles, no new positions were approved by the General Assembly in the FY 2021-2022 budget.[36]

In CY2020, DSS had an average of 1,851 filled positions within adoptions, family preservation, foster care, intake, investigations, licensing, and OHAN; during the year, 424 (22.9%) employees left their positions,[37] with the highest quarterly percentage (7.6%) of separations occurring between October and December 2020.[38] This trend has continued and increased in the first quarter of CY2021. Between January and March 2021, eight percent of staff left their positions, a rate that would, if continued, bring annual turnover to 32 percent of staff. The highest percentage of staff separations were within foster care (10%), followed by family preservation (8.6%), and investigations (8.4%).[39] The most frequently cited reasons by staff for leaving during the first quarter of CY2021 were personal (83%), employee movement within the agency (7%), and dismissal for conduct of unsatisfactory performance (5%).

DSS provided separate data on the average length of time positions had been vacant as of March 31, 2021. For the 73 vacant foster care case manager positions on that date, the statewide average for length of time they had been vacant was 2.33 months. The average vacancy time for the 19 adoption case manager positions was 2.58 months, and 1.57 months for the seven foster care supervisor vacancies.

DSS's 2020 Child Welfare Workforce Report (Appendix D) includes more detailed data and analysis on the DSS workforce, including demographics of staff; number of vacant positions, separations, and hires during the year; and findings from DSS' "stay"

[36] 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.
[37] This includes staff who remained employed within DSS but accepted a new role.
[38] The position types experiencing the most turnover in CY2020 were investigations (28%), and foster care (27%).
[39] The pace of separations in the first quarter of CY2021 is higher than in prior years (2018 was 6.8%; 2019 was 7.6%; and 2020 was 5.7%).

surveys and exit interviews with staff.[40] Some highlights from this report are bulleted below:

- In CY2020, DSS hired 664 new child welfare staff. In the first quarter of 2020, DSS reports that hiring for child welfare staff outpaced staff separations from the agency.
- Between April and September 2020, hiring surpassed separations some months – primarily in the third quarter – however, by October 2020 and through the remainder of the year, child welfare staff were leaving their positions at a higher rate than hiring was occurring.
- As of December 31, 2020, DSS reports of the 2,021 funded child welfare services staff positions, 1,749 positions were filled and 272 (13%) were vacant. Ninety-eight of the vacant funded positions were foster care and adoption case managers, OHAN investigators, and foster care case manager assistants.
- In 2020, of the staff who responded to a "stay" survey, 58 percent reported that a job in child welfare was not their first career choice, and 85 percent responded this was their first full-time job in child welfare.
- Slightly less than half (47%) of survey respondents who had been employed for nine months indicated they were "very unlikely" or "unlikely" to leave their job within the next six months. Almost one in five staff (17%) reported they were "very likely" or "likely" to leave their job within the next six months. The remaining 35 percent of staff responded they were "neither likely nor unlikely" to leave within six months.

Most respondents (64%) indicated salary as the primary reason that would contribute to leaving their employment. Table 3 includes other reasons commonly identified.

[40] As one retention strategy, beginning in September 2019, DSS implemented "stay" interviews or surveys with new staff following their 30-day, six-month, and nine-month from hire anniversary dates.

Table 3: Reasons Staff Cited during 9-Month Stay Interviews that Would Contribute to Leaving DSS Employment
N=76

Reason	Percentage of Survey Respondents
Salary	64%
Burnout	58%
Job Stress	55%
Excessive Workload	50%
Pursue Another Job Opportunity Outside of DSS	41%
Personal Safety	29%
Lack of Appreciation	26%
Relocation	26%
Lack of Promotional Opportunities	25%
Job Expectations	21%
Pursue Another Child Welfare Position Outside of DSS	21%
Health	21%

Source: DSS's 2020 Child Welfare Workforce Report

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 applied to child welfare case managers and supervisors, and will be implemented in two phases. In the first phase, beginning 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 4). In addition, the new salary schedule provides supervisors with a 10 percent higher starting salary than the baseline salary for case managers ($40,000 starting salary for case managers without a BSW or MSW, and $44,000 starting salary for supervisors).

Table 4: 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**[41]	**Salary Range for >1 year of Service** (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[42]	$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[43]	$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: Appendix D, DSS Workload Implementation Plan (February 2019)

Beginning in January 2022, DSS will implement the guidance and process for Child Welfare case managers and supervisors to qualify for the second phase of the plan that provides increases based upon level 2 and 3 classifications in the salary schedule. Quarterly thereafter, these staff can submit documentation and request an evaluation for ascension to the next level. Qualifications for advancement to the next level include advanced training, and a practice evaluation to assess a case manager's demonstration of 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

[41] Or case managers who have not yet completed Child Welfare Services Certification.
[42] In 2019, when the Workload Implementation Plan was approved, approximately 14% of DSS case managers had earned a BSW.
[43] In 2019, when the Workload Implementation Plan was approved, approximately 3% of DSS case managers had earned a MSW.

manager will conduct training – and will have the opportunity to serve as mentors to new case managers.[44]

Pre-Service Training Redesign

DSS reports that beginning in September 2021, they will pilot a new Child Welfare Certification curriculum in the Upstate region, including a component for supervisors. Supervisors received an introductory overview of the new training in August and September 2020. DSS plans to use lessons learned and feedback from pilot participants to make necessary adjustments before rolling out the training in other regions of the state.

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).[45] The approved caseload standards are included in Table 5.

[44] For example, the Department reports case managers can become certified to conduct ACES training, or be certified as a CFSR reviewer or CFTM facilitator, 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 CFTMs each year to maintain certification.

[45] 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 5: 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[46]
Adoption Case Manager[47]	One case manager to 15 children (1:15)	No more than 8 children (1:8)	More than 18 children
OHAN Case Manager	One case manager 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)[48]	N/A	More than 7 case managers

Source: Approved DSS Workload implementation Plan (February 2019)

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

To assist in assessing progress over time, Figure 7 and Figure 8 show performance data on caseloads by case manager and supervisor type for prior and current monitoring periods. Compared to six months prior, the percentage of workers with caseloads within required limits has declined for foster care and OHAN case managers and improved for adoption case managers. Caseloads for all types of case

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

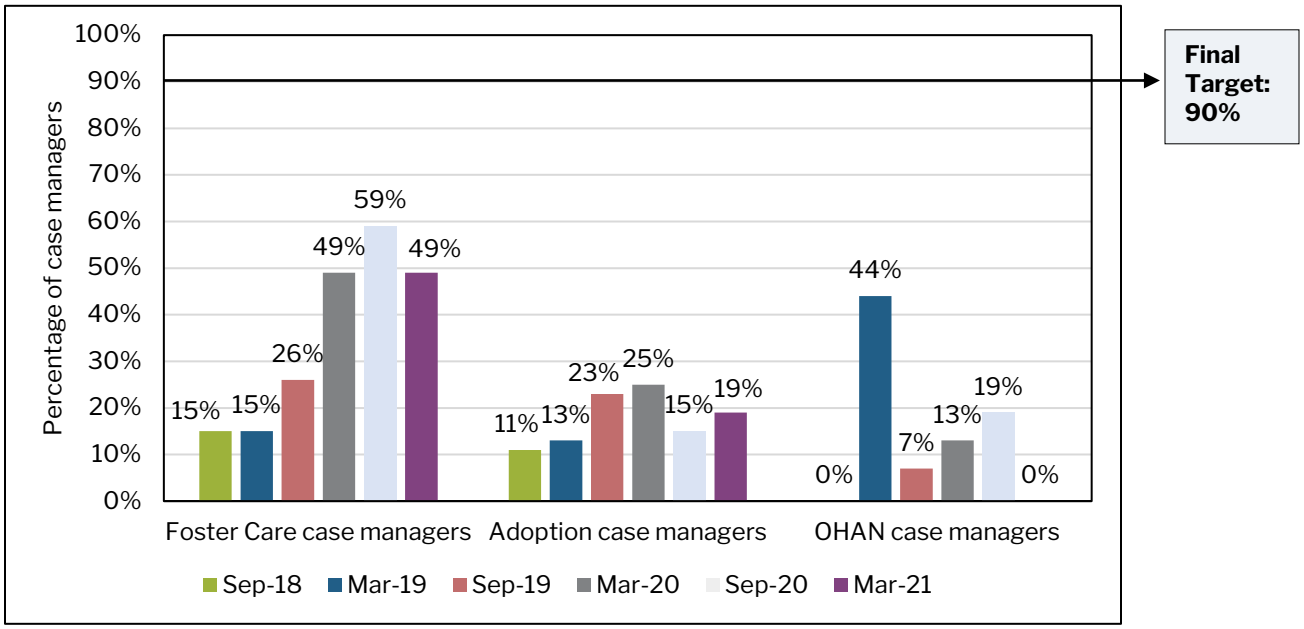
[46] Ibid.

[47] 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.

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

managers are far from meeting the required FSA target. Workloads for supervisors have improved for all supervisor types.

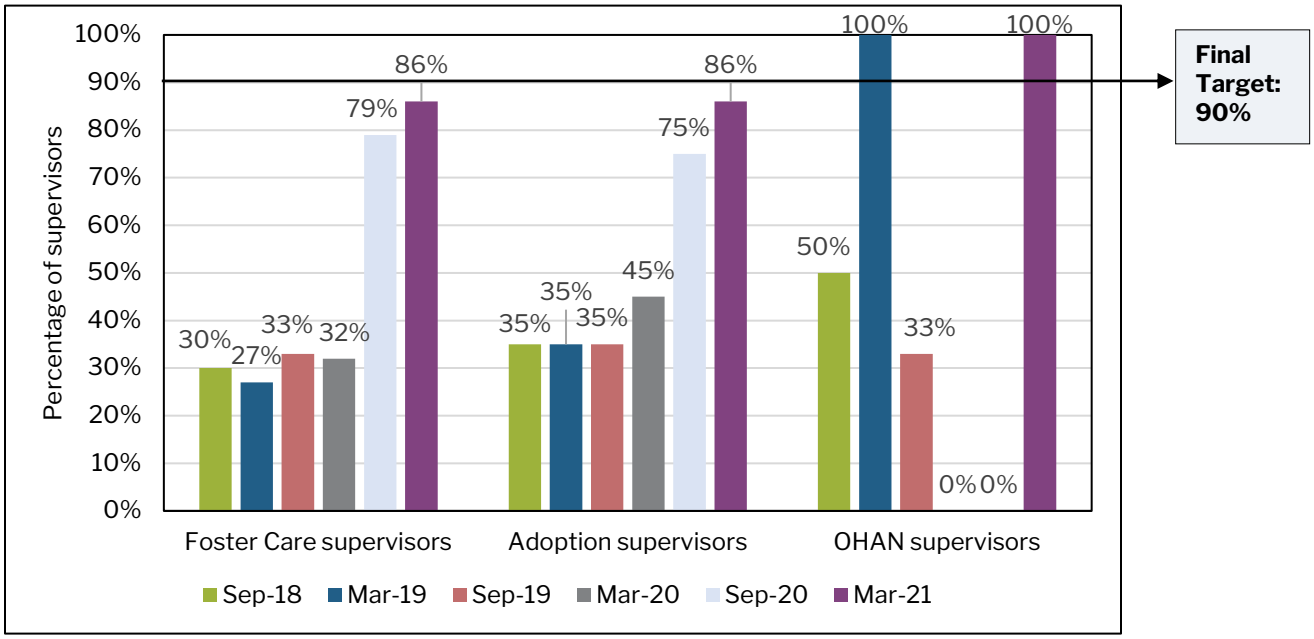
Figure 7: Percentage of Case Managers With Caseloads Within the Required Limits, by Case Manager Type September 2018 - March 2021[49]



Source: CAPSS data provided by DSS

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

Figure 8: Percentage of Supervisors With Workloads Within the Required Limits, by Supervisor Type September 2018 – March 2021



Source: CAPSS data provided by DSS

Foster Care Case Managers

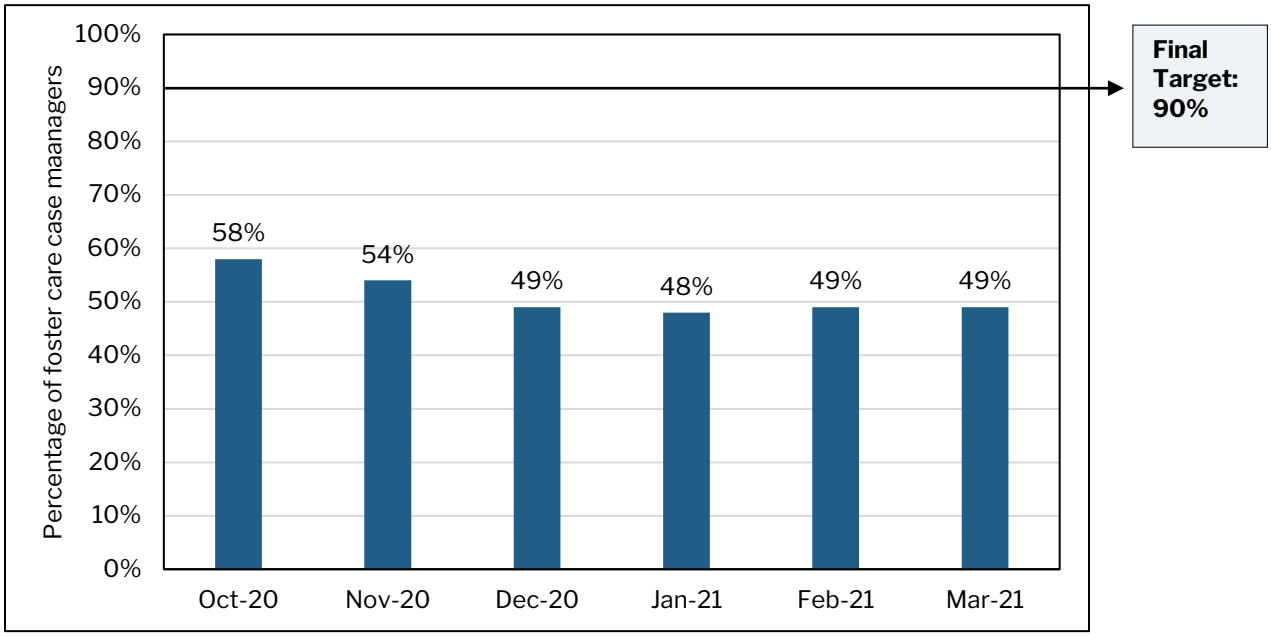
On March 31, 2021, there were 283 foster care case managers with at least one child in foster care on their caseload.[50] Of these case managers, 49 percent (138) had caseloads within the required limit of 15 cases (8 cases for new case managers), and 34 percent (97) of case managers had caseloads more than 125 percent of the caseload limit, meaning they were responsible for more than 18 cases (more than 10 cases for new case managers).[51] Additionally, as of March 31, 2021, of those case managers with caseloads exceeding the required limit, 47 (17% overall) foster care case managers had caseloads of more than 160 percent of the standard (more than 24 cases).

Point in time data for each month between October 2020 and March 2021[52] show that between 48 and 58 percent of foster care case managers, including new case managers, had caseloads within the required limit (see Figure 9); and 27 to 36 percent

[50] This includes 61 newly hired foster care case managers.
[51] The remaining 48 (17%) 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).
[52] 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: October 9, 2020; November 18, 2020; December 29, 2020; January 5, 2021; February 11, 2021; March 31, 2021.

of foster care case managers had caseloads that were more than 125 percent of the caseload limit (see Figure 10).[53] The percentage of foster care case managers with caseloads more than 160 percent over the caseload limit rose from five percent in October 2020 to 17 percent in March 2021.

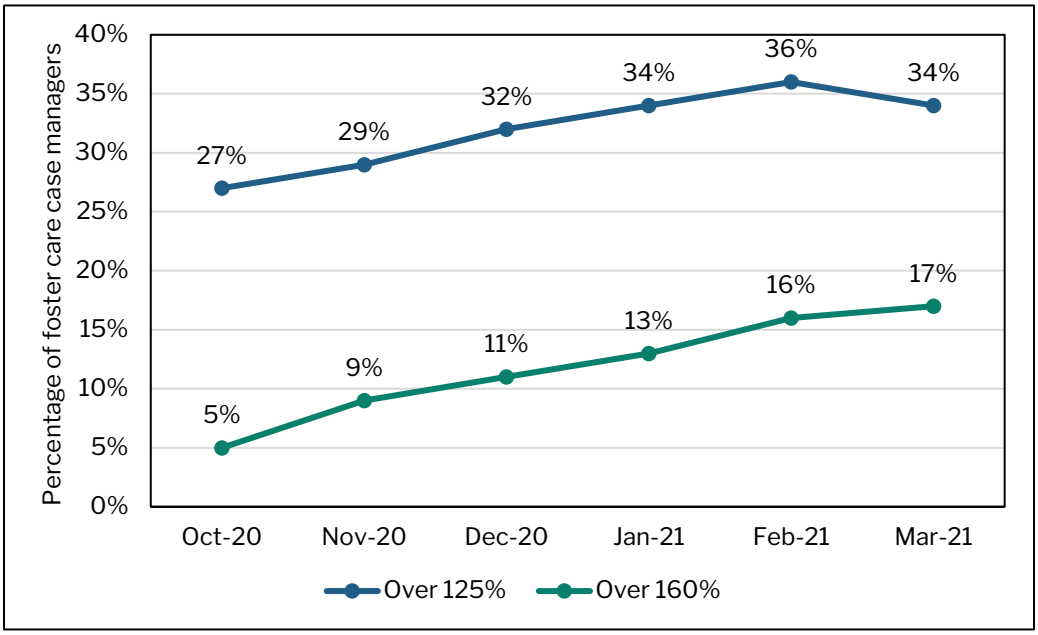
Figure 9: Foster Care Case Managers With Caseloads Within the Required Limits October 2020 – March 2021



Source: CAPSS data provided by DSS

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

Figure 10: Foster Care Case Managers With Caseloads over 125% and 160% of Required Limits October 2020 – March 2021[54]



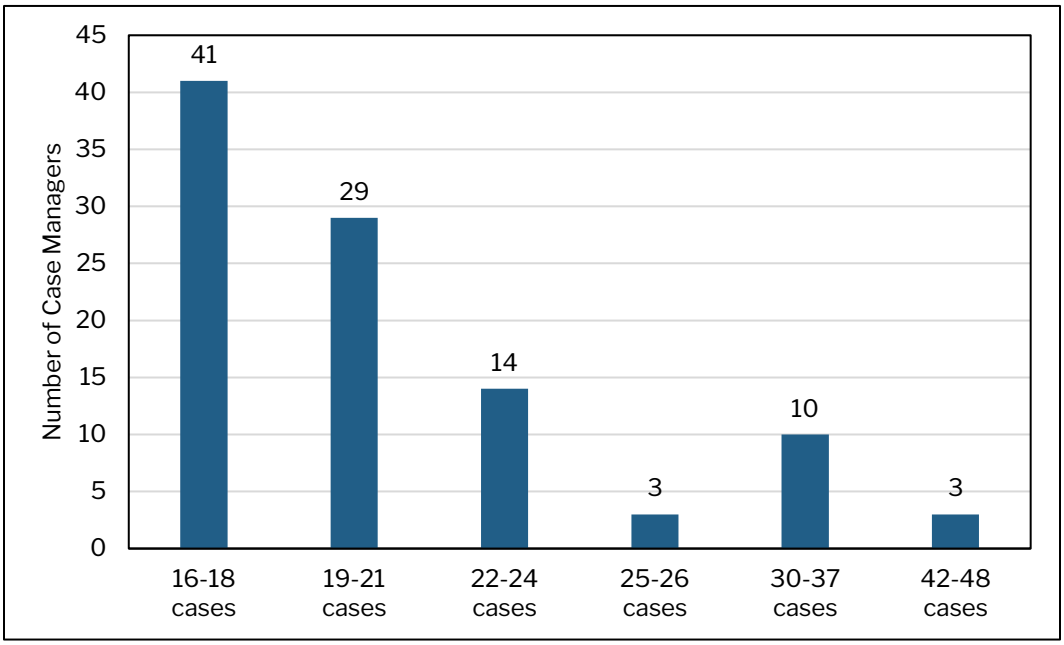
Source: CAPSS data provided by DSS

Figure 9 and Figure 10 above merge data for all foster care case managers – those newly hired as well as those hired more than six months prior. Figure 11 reflects the number of cases carried specifically by the 100 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 March 31, 2021. As of September 30, 2020, only two case managers were responsible for more than 30 cases (double the caseload standard), however this has risen steeply over the last six months, with 13 (13%) case managers responsible for 30 or more cases, including three case managers with caseloads in the range of 42 to 48 cases on March 31, 2021.[55]

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

[55] Two of the case managers with the highest caseloads (42 and 48 cases) work in Kershaw County, and are the only 2 case managers with caseloads that include Class Members within the county. The third case manager – with a caseload of 42 – is in York County. Data provided by DSS reflect as of March 31, 2021, there were 12 case managers in York County with caseloads that include Class Members, and 4 of these case managers are new staff (3 finished Child Welfare Certification Training the month prior in February 2021).

Figure 11: Number of Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago With Caseloads that Exceeded the Limit March 31, 2021 N = 100



Source: CAPSS data provided by DSS

As discussed above, 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 March 31, 2021, are shown in Table 6. Although performance for foster care case manager caseloads within the standards continues to be lower than the final target in every region, performance is particularly low in the Midlands region (27%), and there has been a significant decline in performance in the Upstate (from 73% in September 2020 to 55% in March 2021) and Low Country (from 63% in September 2020 to 50% in March 2021) regions. There has been an improvement over the past six months in the Pee Dee region, from 36 percent compliance in September 2020 to 68 percent in March 2021.

Table 6: Percentage of Foster Care Case Managers with Caseloads Within the Required Limit by Region

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
Low Country	63% N=62	50% N=50
Midlands	30% N=83	27% N=78
Pee Dee	36% N=52	68% N=50
Upstate	73% N=114	55% N=105

Source: CAPSS data provided by DSS

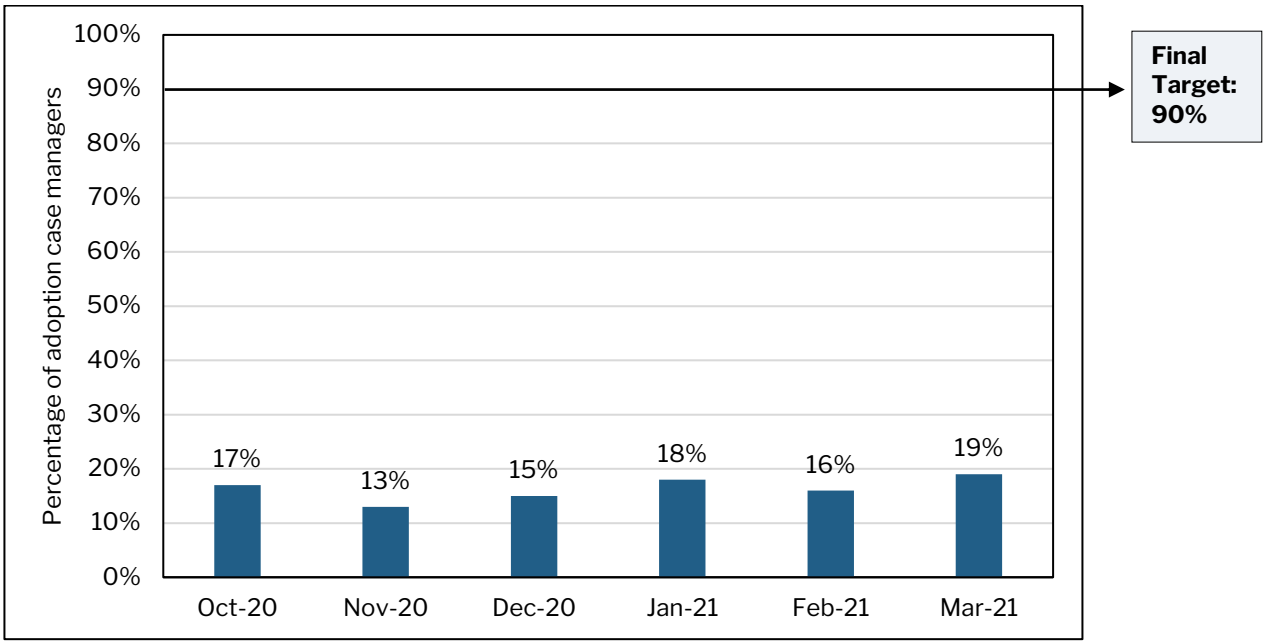
Adoption Case Managers

On March 31, 2021, there were 75 adoption case managers serving at least one Class Member[56]; 14 (19%) case managers had caseloads within the caseload requirement (1:15, or 1:8 for new case managers), and 46 (61%) case managers had caseloads that exceeded 125 percent of the limit (more than 18 children, or more than 10 children for new case managers).[57] Additionally, 10 (13%) adoption case managers had caseloads of more than 160 percent of the standard (more than 24 cases).

Between October 2020 and March 2021, a monthly range of 13 to 19 percent of adoption case managers had caseloads within the required limit (see Figure 12); 51 to 74 percent of adoption case managers had caseloads that exceeded 125 percent of the required limit; and 13 to 26 percent had caseloads over 160 percent of the limit (see Figure 13).

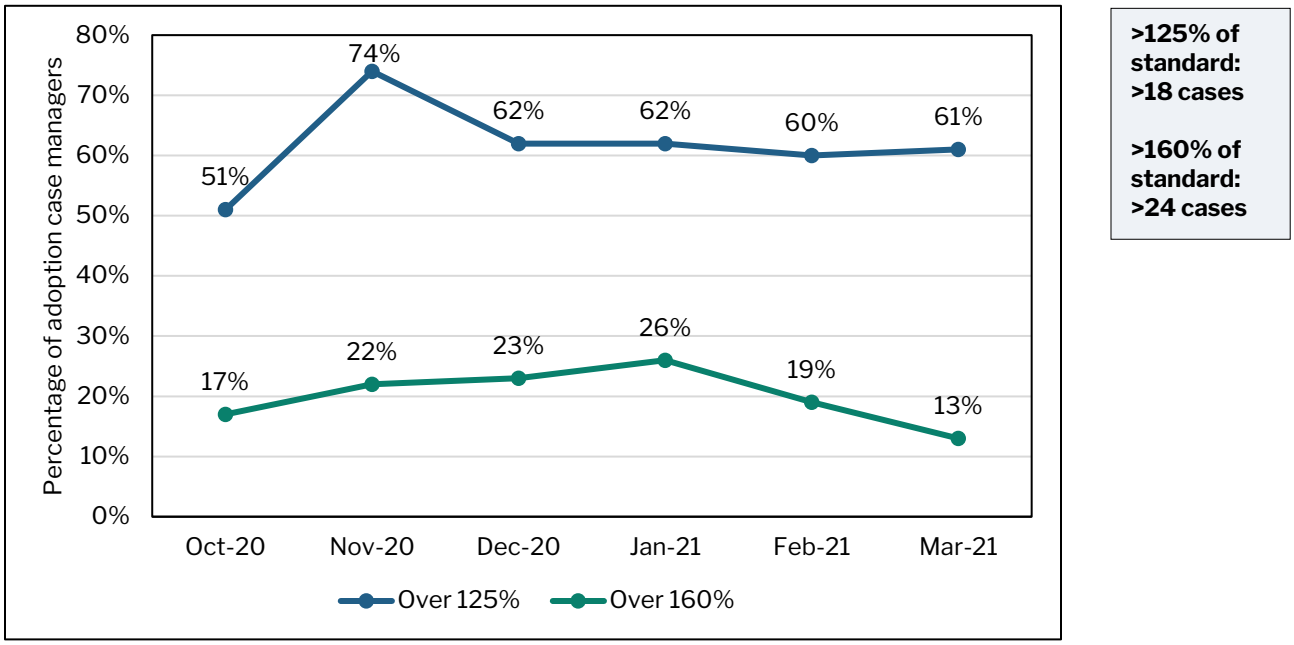
[56] This includes 11 newly hired adoption case managers.
[57] The remaining 15 (20%) case managers had caseloads greater than 100 percent, but less than 125 percent (i.e., between 16 and 18 cases).

Figure 12: Adoption Case Managers with Caseloads Within the Required Limits
October 2020 – March 2021



Source: CAPSS data provided by DSS

Figure 13: Adoption Case Managers with Caseloads over 125% and 160% of Required Limits
October 2020 – March 2021



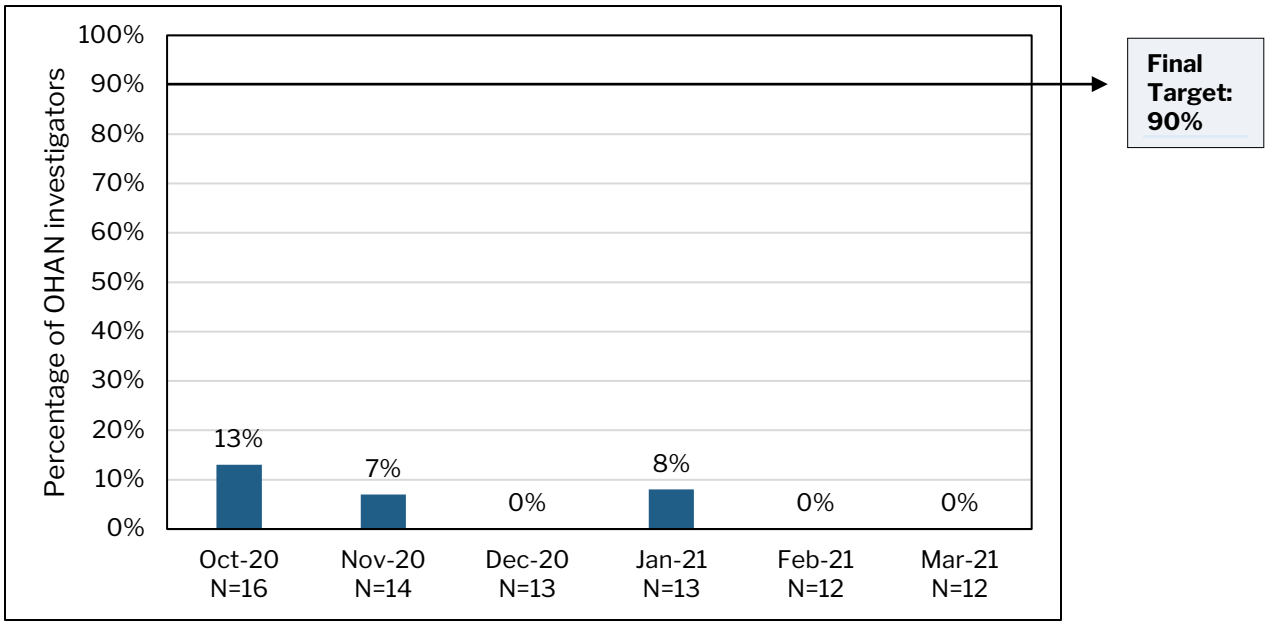
Source: CAPSS data provided by DSS

Out-of-Home Abuse and Neglect Case Managers

In March 2021, OHAN had 12 assigned investigators, and all had been employed for longer than six months; no (0%) investigator had a caseload within the required standard (1:8), and 11 (92%) investigators had caseloads over 125 percent of the required limit (more than 10 investigations).[58] Seven (58%) OHAN investigators had caseloads of more than 160 percent of the standard (more than 13 investigations).

Between October 2020 and March 2021, the number of OHAN investigators declined from 16 in October 2020 to 12 by March 2021. A monthly range of zero to 13 percent of OHAN case managers had caseloads within the required limits (see Figure 14), 69 to 92 percent of case managers had caseloads that exceeded 125 percent of the required limit, and 42 to 86 percent had caseloads that exceeded 160 percent of the standard (see Figure 15).[59]

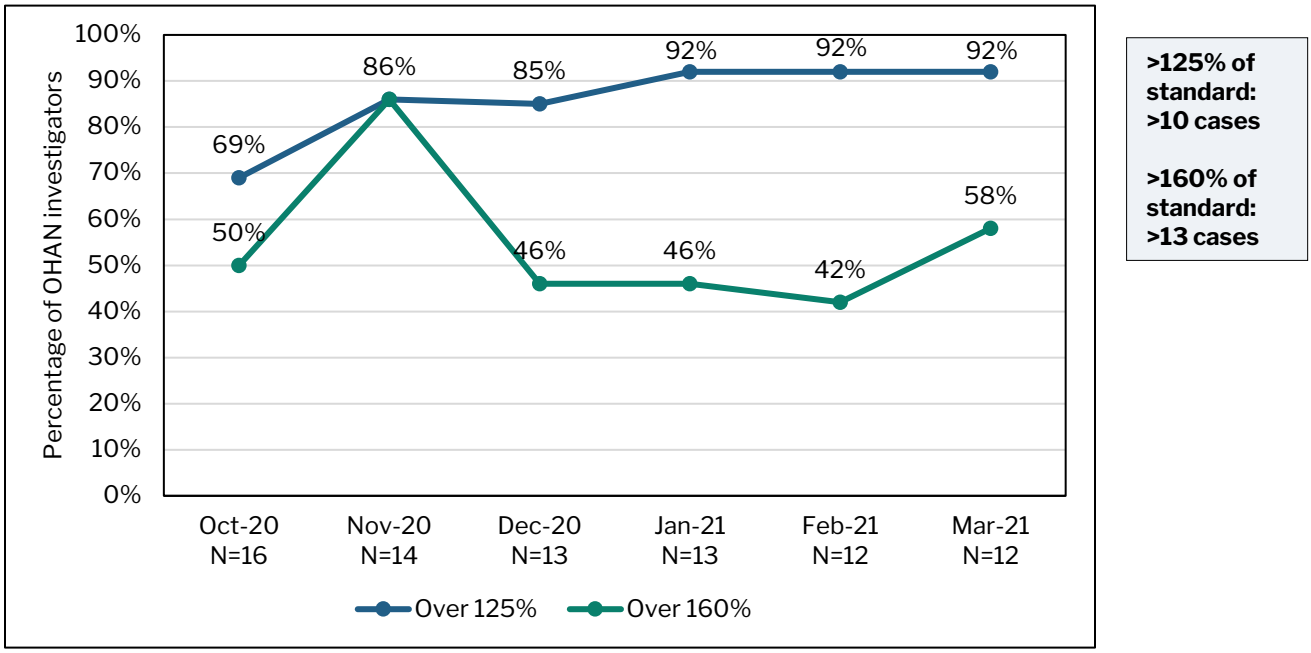
Figure 14: OHAN Investigators with Caseloads Within the Required Limits October 2020 – March 2021



Source: CAPSS data provided by DSS

[58] The remaining 1 OHAN case manager had a caseload of 10 investigations.
[59] Large fluctuations in performance are due to the small number of OHAN investigators.

Figure 15: OHAN Investigators with Caseloads over 125% and 160% of Required Limits October 2020 – March 2021[60]



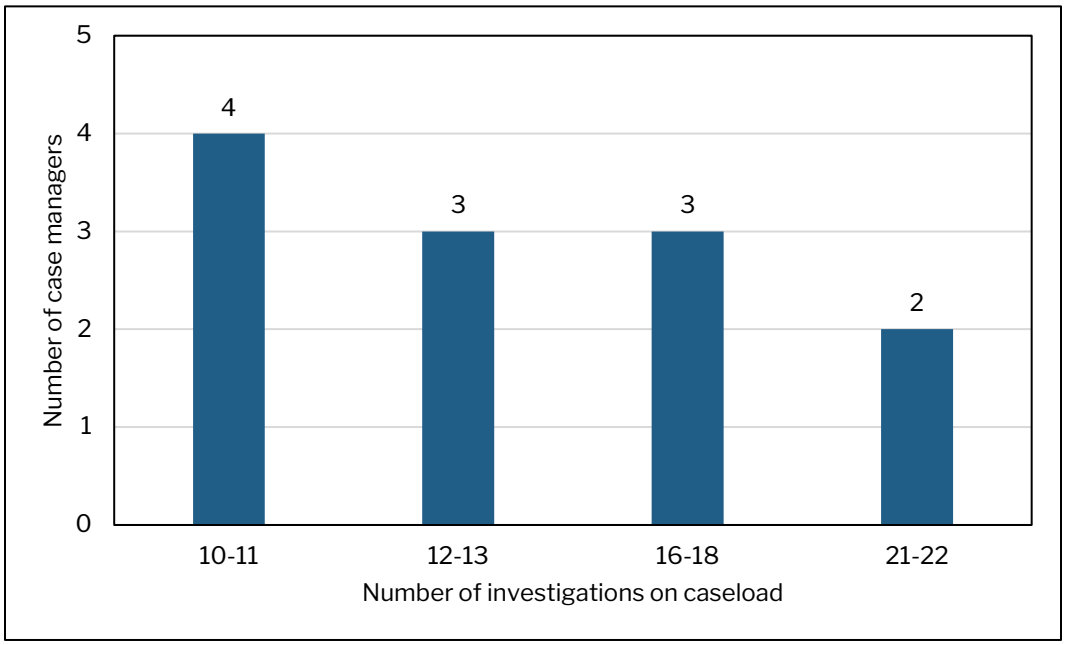
Source: CAPSS data provided by DSS

Figure 16 includes the caseload size of the 12 OHAN investigators who had caseloads exceeding the limit on March 31, 2021. Caseload sizes have increased in the last six months. Specifically, on September 30, 2020, the highest number of investigations held by one case manager was 16, and as of March 31, 2021, nearly half (42%) of the case managers had been assigned 16 or more investigations, over double the required standard.[61]

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

[61] After this monitoring report, DSS reports 7 new investigator positions and 2 new supervisor positions have been allocated to OHAN, bringing the total number of allocated investigator positions to 26 in September 2021. As of September 30, 2021, 17 positions were filled, 2 were vacant, and the 7 new positions were posted for hire since earlier that month.

Figure 16: Number of OHAN Investigators with Caseloads that Exceeded the Limit March 31, 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.[62]

[62] DSS has identified occasional situations in which supervisors may be directly responsible for a case for a short period of time. These include circumstances in which a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is nearing closure; there are complexities regarding the case that need to be addressed; or an important legal event will occur within the timeframe. While the supervisor is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child: monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent, as applicable; and other activities, as necessary. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving supervisor for up to five days until the supervisor assigns the case to the receiving case manager. After reviewing data on supervisors carrying cases for several monitoring periods, DSS has identified additional circumstances which result in supervisors carrying cases. These include when a case manager leaves the agency and creates a vacancy that takes some time to fill (including onboarding new staff with required training and limiting their caseload to half the required limit during the first 6 months after

Foster Care Supervisors

Between October 2020 and March 2021, a monthly range of 77 to 86 percent of foster care supervisors supervised five or fewer case managers, and five to eight percent of supervisors supervised seven or more case managers (or 125 percent of the required limit).[63,64] Specifically, on March 31, 2021, of the 92 supervisors supervising foster care case managers, 79 (86%) supervised five or fewer case managers, and seven (8%) supervisors supervised seven or more case managers. Current performance is below the final target of 90 percent.

Adoption Supervisors

Between October 2020 and March 2021, a monthly range of 75 to 86 percent of adoption supervisors supervised five or fewer case managers; one supervisor supervised seven or more case managers, or 125 percent of the required limit, during the months of October 2020, January 2021, and February 2021.[65] On March 31, 2021, of the 21 supervisors supervising adoption case managers, 18 (86%) supervisors supervised five or fewer case managers. Current performance is below the final target of 90 percent.

OHAN Supervisors

Between October 2020 and March 2021, OHAN had three supervisors each month responsible for the 12 to 16 investigators who were accepting investigations. Every month, all (100%) OHAN supervisors supervised six or fewer case managers. Current performance exceeds the final target.

---

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. These data will be included in the next monitoring report.

[63] Monthly performance for foster care supervisors supervising 5 or fewer case managers are as follows: October 2020, 81%; November 2020, 83%; December 2020, 77%; January 2021, 79%; February 2021, 83%; March 2021, 86%.

[64] Monthly performance for foster care supervisors supervising 7 or more case managers are as follows: October 2020, 6%; November 2020, 7%; December 2020, 6%; January 2021, 5%; February 2021, 6%; March 2021, 8%.

[65] Monthly performance for adoption supervisors supervising 5 or fewer case managers are as follows: October 2020, 75%; November 2020, 75%; December 2020, 76%; January 2021, 76%; February 2021, 75%; March 2021, 86%.

V. Visits Between Case Managers and Children

DSS case managers are expected to have face-to-face visits with children in foster care and their caregivers at least once a month.[66] At least 50 percent of those visits must be in the "residence of the child," or the child's placement.[67] The purposes of these visits are to assess the child's status in multiple areas including safety, physical and emotional health, and to ensure that the child's needs are being met. Depending upon the needs of the child, the DSS case manager may see children and their caregivers more often. Case managers are also expected to assess the status of any services being provided to the child and/or caregiver to meet the child's needs and support placement stability; discuss updates on achieving permanency for the child; and continue to strengthen the relationship with the child and their caregivers during these contacts.

The *Michelle H.* requirement that at least 90 percent of children must receive face-face visits by their case managers during a 12-month period can be reported with quantitative data from CAPSS. However, monitoring staff found it difficult to verify reported quantitative data upon review of documentation. At times, documentation was repeated over several months or was minimal to establish that there was indeed contact 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. Co-Monitors and DSS rely on case managers' documentation of contacts to report on progress in this area towards reliance on a quantitative report of case managers' contacts with children for the measure.

A case record review from one month of the monitoring period provides 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. Documentation from a statistically valid sample of DSS records from March 2021 shows contact between case managers and children occurred in nearly all (97%) cases reviewed.[68] Case managers had contact with more than three-quarters (269 of 345, or 78%) of children in-person. As allowed by DSS

[66] FSA IV.B.2.
[67] FSA IV.B.3.
[68] The sample was derived from a universe of 3,336 cases of children in placement for 30 days or more as of March 31, 2021, with a 95% confidence interval and 5% margin of error.

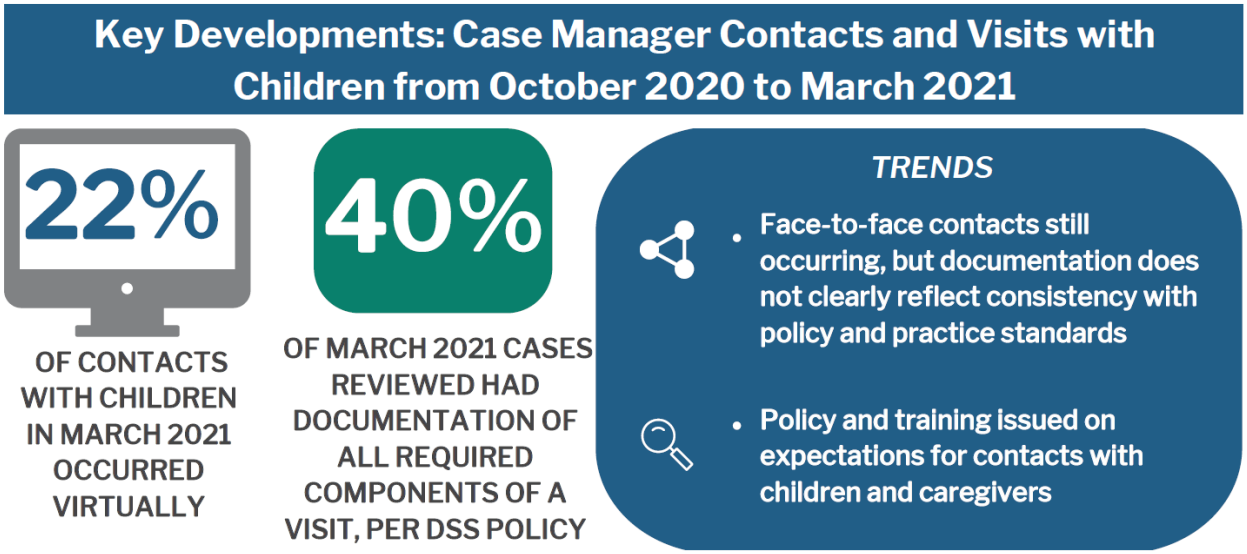
leadership during the COVID-19 pandemic, after posing several questions to screen for risk of exposure to the COVID-19 virus, some case managers had contact with children via video (65 of 345, or 19%).

Documentation for March 2021 does not reflect that *contacts* are being made – either in-person, by video, or by telephone – in accordance with each of the *visit* expectations.[69] Although performance in this area improved from the September 2020 case record review, reviewers found documented practices consistent with every required component of a visit pursuant to DSS policy and the FSA in 40 percent (139 of 345) of records. Also, as discussed in more detail below, case managers' documentation of contacts with children does not consistently reflect assessments of safety. More detailed data on case manager visits with children over time can be found in the Performance Data section beginning on page 41.

Improved performance for case managers' visits with children may be addressed with enhanced documentation, but the Co-Monitors continue to believe that reducing the demands on case managers through manageable caseloads, placing children closer to their home communities so that case managers spend more time with children, their caregivers, and others who reside with the child would positively impact performance in this area.

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

[69] During this monitoring period, the Co-Monitors and DSS worked to clarify documentation representative of a case manager's discussion of permanency with a child or caregiver. Discussion of a child moving to be placed with a sibling(s); discussion of visiting with parents; and discussion of visiting with family members are included in the clarification.



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.[70] 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.

While DSS develops training and a coaching plan for statewide implementation of the GPS Case Practice Model, DSS is simultaneously 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. The training also aims to improve supervisors' ability to coach case managers to improve documentation.

DSS reports that County/Regional leadership has been reviewing documentation of case managers' contacts with children since February 2021 and that in May 2021, DSS implemented a Child Contact Review quality assurance tool for use by County

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

leadership. The tool guides the user to respond to questions and provide comments upon the review of documentation of visits. There is also a process for providing feedback to case managers and their supervisors on findings.

In May 2021, DSS issued supplemental Policy (Work Aid 5.5 Case Manager Contacts with Children, Youth, and Young Adults and Work Aid 5.6 Case Manager Contacts with A Caregiver) as additional guidance on preparing for, conducting, and documenting contacts, a supplement to Chapter 5 policy published in October 2020.

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 number of monthly visits between children and a case manager refers to a federal requirement of a minimum of one visit per month.[71]

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

- An interview with the child alone, away from both the caregiver and other children in the home;
- Substantive inquiry as to the child's safety, permanency, and well-being. "Substantive inquiry" means focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the child;
- 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.

[71] Social Security Act - Section 422(b)(17)

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 gather data on whether the record reflects that: the child was seen alone; there was a summary of the conversation; there were assessments of safety, permanency, and well-being; there was discussion of the status of services being delivered; and there was a discussion of the status of the case plan, each as required by DSS policy.

Reviewers assessed a statistically valid sample of 345 DSS case records for children in foster care during the entirety of March 2021 to understand the practices of case managers relative to the expectations for their visits with children.[72] During March 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 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 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 multiple contacts during a month and the case manager being shown multiple rooms in a child's placement via video.

Reviewers identified documentation of a contact – either in-person or virtual – between a DSS case manager and a child in 344 of 345 (close to 100%) records.[73] There was documentation that the DSS case managers' contact with 272 (79%) of the children occurred while the child was in their placement. Some contacts between case managers and children also took place while children were at a daycare, a location in the community, or a DSS office.

[72] The sample was derived from a universe of 3,336 cases of children in placement for 30 days or more as of March 31, 2021, with a 95% confidence interval and 5% margin of error.
[73] In 1 record, the case manager's documentation of a contact with a child was taken from contact between the child and the child's guardian ad litem. This is not allowed by DSS policy and this record was flagged and addressed by DSS.

Most (78%, or 269 of 345) of the contacts case managers had with children were in-person. Only 19 percent (65 of 345) of the contacts with children were virtual; one contact was by phone; and in 10 instances (3%), documentation was unclear about the case manager's mode of contact with the child.

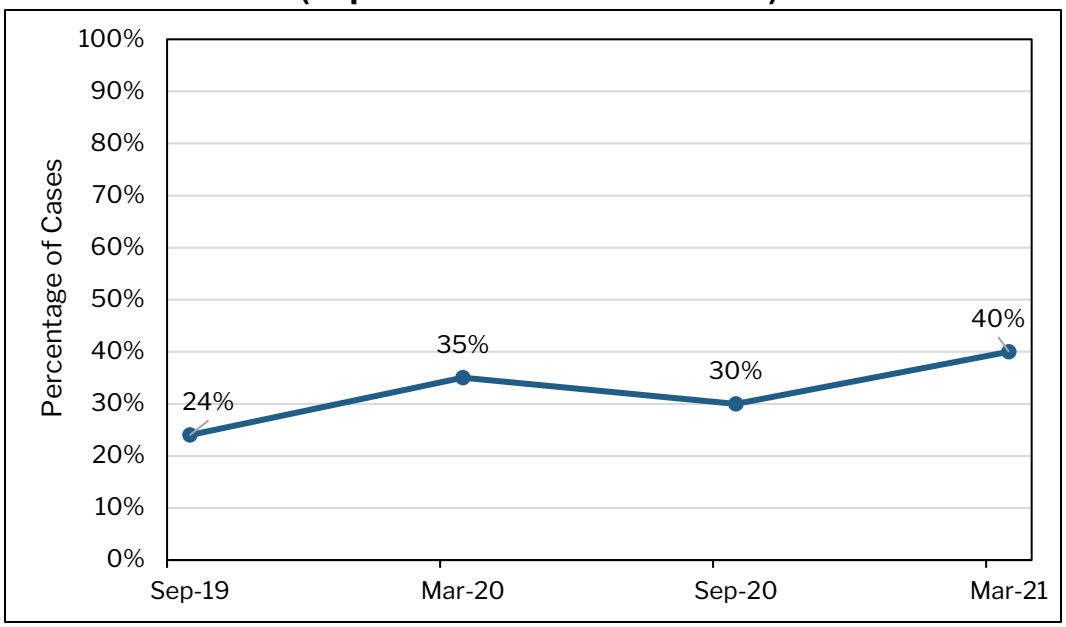
These data once again support the reliability of CAPSS data as an indication of whether a contact between a case manager and a child occurred. Documentation of practices during these contacts, however, shows that the interactions do not routinely meet the agreed upon standard for a visit. Specifically:

- Reviewers found documented practices consistent with each required component of a visit pursuant to DSS policy and the FSA in 40 percent (139 of 345) of records.[74] In an additional 76 (22%) cases, only one of the required components of a visit was missing from documentation.
- Reviewers found documentation that case managers were able to speak with the child alone in 213 (62%) cases, though virtual contacts created a challenge to private conversations in some cases.
- For 145 (42%) of the cases, reviewers determined that the documentation of the contact did not reflect an adequate safety assessment.[75] 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.[76]

Figure 17 shows results of case record reviews for all components of a case manager's contact with a child between September 2019 and March 2021.

[74] In most (111 or 80%) of the 139 cases in which documentation reflected all required components of a case manager's visit with a child, the visit was in-person; 27 were via video; and for 1 case, the reviewer was unable to determine the mode of the case manager's visit.
[75] In 67 cases, documentation did not clearly reflect whether the child was alone during the contact with the case manager.
[76] 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 17: Percentage of Reviewed Cases with All Required Components of a Visit Between Case Managers and Children (September 2019-March 2021)

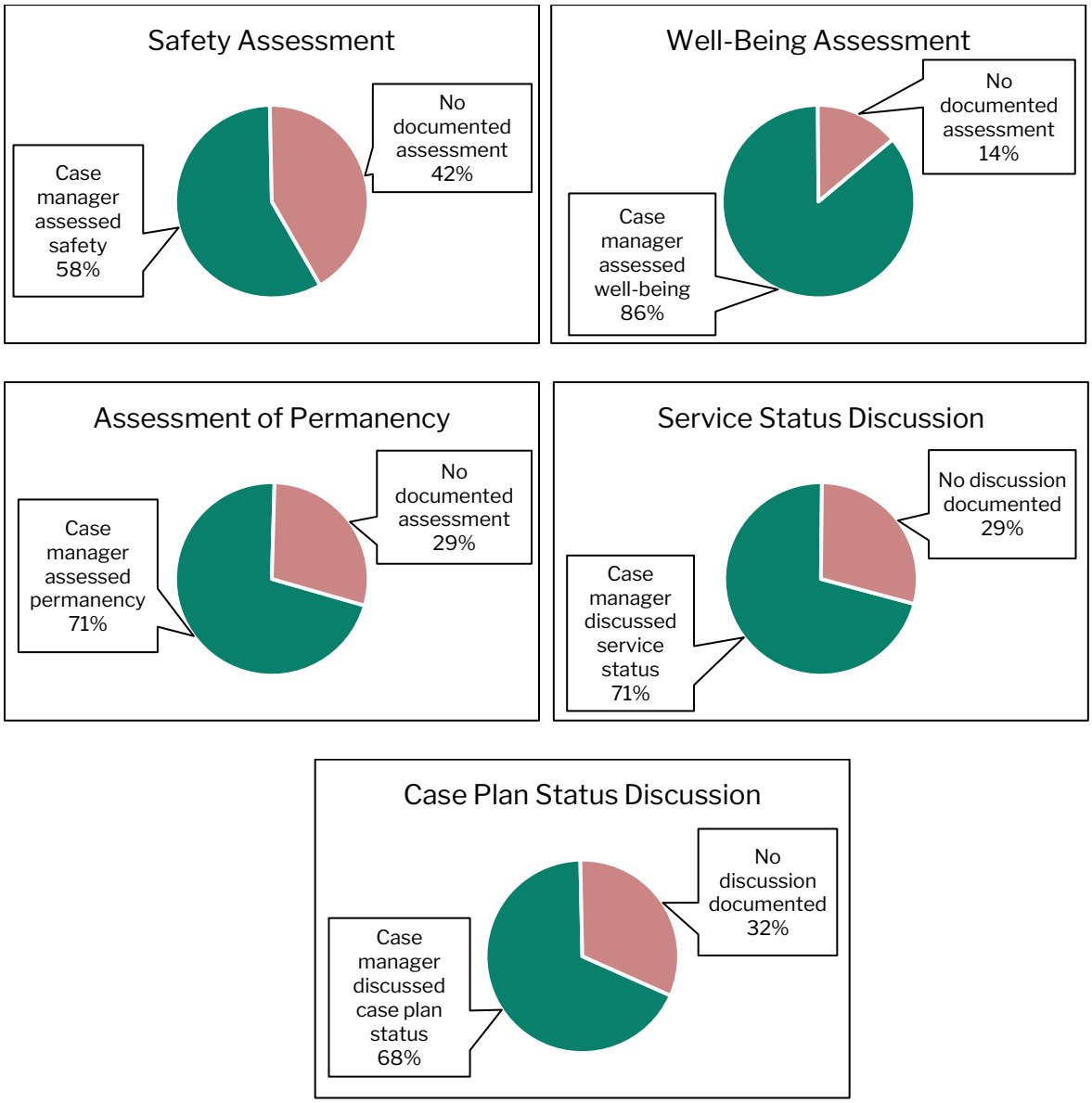


Source: Case Record Review conducted by USC CCFS, DSS, and Co-Monitor staff

More results from the March 2021 review show the need for improved practices as well as more complete documentation in CAPSS (see Figure 18). Specifically:

- 91 percent (313 of 345) of the records contained a *summary of conversations and observations*.
- 86 percent (297 of 345) of the records contained documentation that the case manager discussed the topics of *well-being* with the child and/or caregiver.
- 71 percent (245 of 345) of the records contained documentation that the case manager discussed the child's *permanency* status with the child and/or caregiver.
- 71 percent (245 of 345) of the records contained documentation that the case manager discussed the *status of services* being delivered with the child and/or caregiver.
- 68 percent (233 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 18: Documented Practices during Case Manager Contacts with Children and Caregivers (March 2021) N=345



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

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

The work of screening and investigating allegations of abuse and neglect of children in foster care – completed by DSS's Intake Hubs[77] 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 on a determination that they have been abused or neglected by their caregivers and are not safe with their families – ensuring their safety and well-being while in state custody is a primary obligation. OHAN unit staff must be prepared to quickly respond to all allegations that meet the criteria for possible abuse or neglect in foster homes and group homes, and have the tools, skills, and supervision necessary to complete investigative tasks with quality and timeliness to determine if abuse or neglect occurred.

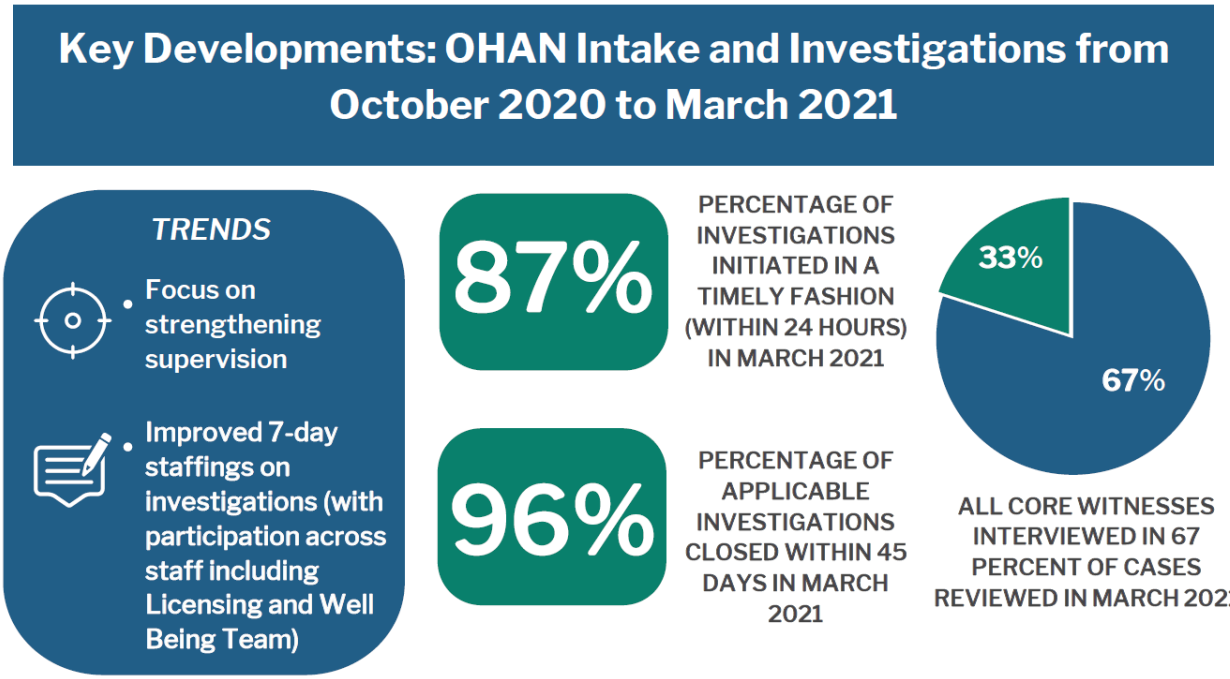
Performance data for the current monitoring period show improvement in practice toward all required FSA measures, and DSS met the final target for appropriateness of screening decisions and timely closure of investigations. The Co-Monitors review of documentation of practice and discussions with OHAN staff reflect that reinforcement of practice expectations, use of critical thinking skills, and frequent supervision has strengthened the quality of OHAN's work. Unfortunately, caseloads continue to be too high to allow staff to consistently perform to practice and policy expectations. In March 2021, OHAN had 12 assigned investigators, and all (100%) had caseloads over the required standard of eight investigations. Five investigators (42%) had caseloads higher than double the required limit, with one worker responsible for 22 investigations (nearly three times that required limit).[78] More detailed data on OHAN intake and investigations over time can be found in the Performance Data section beginning on page 48.

In the third and fourth quarter of CY2020, OHAN had three staff leave (15% of the FTE OHAN investigator positions), and one additional staff left in February 2021. Filling vacant positions – along with hiring for the new positions that have been

[77] 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.

[78] After this monitoring report, DSS reports 7 new investigator positions and 2 new supervisor positions have been allocated to OHAN, bringing the total number of allocated investigator positions to 26 in September 2021. As of September 30, 2021, 17 positions were filled, 2 were vacant, and the 7 new positions were posted for hire since earlier that month.

allocated to OHAN – is time consuming for OHAN leadership who have other responsibilities, and often results in a limited selection of candidates who do not reliably follow through with the interview and selection process.



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.[79]

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

[79] 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.

The OHAN unit, under the direction of Louise Cooper, has found that focusing on and strengthening supervision has been one of the most impactful and useful strategies to improve practice, particularly in identifying and ensuring contact with core witnesses. Currently, there are a minimum of three supervisory staffings held during each investigation, and new in recent months, the 7-day staffing includes participation by county case managers and supervisors, and staff from Licensing, the Well-Being Team, Adoptions, and Kinship Care, as applicable. This increased participation ensures information sharing across DSS divisions, and allows OHAN to hear directly from the assigned case manager and licensing staff on their interactions with the child and placement provider.

DSS recognizes that more staff are needed to reduce caseloads, and allow investigators the time needed to complete each assigned investigation in accordance with policy and practice expectations. As of March 31, 2021, OHAN had three vacant OHAN 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 has estimated that 11 new OHAN staff positions are necessary. Funding for these positions was included in DSS's FY2020-2021 budget request, which was not passed by the General Assembly due to the COVID-19 pandemic. This request was again included in DSS's FY2021-2022 budget request, but funding was not allocated by the General Assembly.

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.[80] 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.[81] 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.[82] 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 October 2020 and March 2021 were reviewed by Co-Monitor staff to determine appropriateness of the screening decision.[83,84,85]

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

[81] SC Code § 63-7-20.

[82] This includes a foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).

[83] This review includes examining information entered into CAPSS, and listening to recordings of referrals, when available.

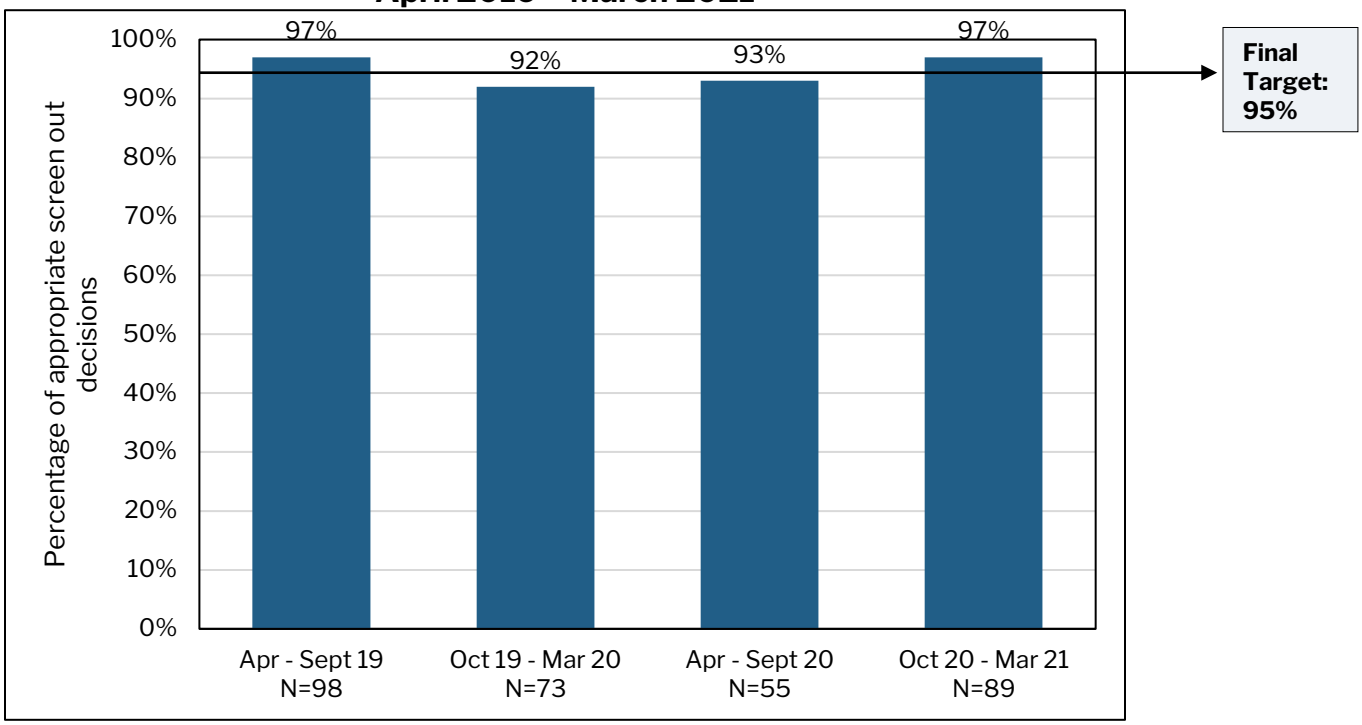
[84] Some referrals were found not to be applicable for review because the alleged victim child was not a Class Member (i.e., the child was voluntarily placed by the legal guardian in the congregate care setting or through ICPC from another state, or was the biological or adopted child of the caregiver), or the referral was screened out as a duplicate to a prior report that was under investigation or had previously been investigated.

[85] 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.

Between October 2020 and March 2021, a total of 89 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.[86] The Co-Monitors determined that 86 (97%) of these decisions not to investigate were appropriate. In two of the three 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 third referral, although the allegations met the SDM definition for sexual abuse, intake staff incorrectly screened the referral out due to the alleged incident occurring several years prior.[87]

As reflected in Figure 19, performance has improved since the prior period, and DSS met the final target of 95 percent.

Figure 19: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect April 2019 – March 2021



Source: Monthly review data, Co-Monitor staff

[86] Due to fluctuations in the number of applicable screening decisions each month, the Co-Monitors assess performance aggregated across the monitoring period.
[87] DSS confirmed that this was not an appropriate screen out reason.

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.[88,89] 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.[90] 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.[91] All of these activities are critical components of a thorough OHAN investigation that results in accurate safety assessments and findings.

There are seven FSA measures that relate to investigations – timely initiation (two measures),[92] 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 June 2021 which examined 55 investigations involving Class Members that were accepted for investigation in March 2021.

Demographics of Alleged Victim Children

Table 7 includes demographic information for the 99 alleged victim children identified in the 55 investigations reviewed. Almost half (49%, or 27 of 55) of the investigations involved one alleged victim child; 21 (38%) investigations involved two

[88] SC Code § 63-7-1210; Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018); SC DSS Directive Memo, April 26, 2016.
[89] 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.
[90] Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).
[91] Ibid.
[92] 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.

children, and three (5%) involved three children.[93] Over half (55%, or 54 of 99) of the identified alleged victim children were between the ages of 10 and 17, and nearly one-third (31%) 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 White (66%), followed by Black or African American (22%), multi-racial (11%), and one Native Hawaiian or other Pacific Islander.[94]

Table 7: Demographics of Alleged Victim Children
March 2021
N= 55 investigations, 99 alleged victim children

Number of alleged victim children per investigation	
1 child	27 (49%)
2 children	21 (38%)
3 children	3 (5%)
4 or more children	4 (7%)
Age of alleged victim children	
Birth to 2	5 (5%)
3 to 4	9 (9%)
5 to 9	31 (31%)
10 to 13	23 (23%)
14 to 17	31 (31%)
Race of alleged victim children	
White	65 (66%)
Black or African American	22 (22%)
Multiracial	11 (11%)
Native Hawaiian or other Pacific Islander	1 (1%)
Placement at time of alleged incident	
Outside home county	68 (69%)
Within home county	31 (31%)

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

[93] For the remaining 4 investigations, 1 identified 4 alleged victim children, 1 identified 5 alleged victim children, and 2 identified 6 alleged victim children.
[94] As of June 29, 2021, of all children in foster care, 53% were White, 32% were Black, 5% were Multi-racial, <1% were Native Hawaiian or Pacific Islander, and <1% were American Indian or Alaskan Native. For the remaining 9%, the race of 8% was unknown, and 1% declined to provide their race.

Placement Providers

Three-quarters (75%) of the 55 investigations involved foster homes, with the remaining 25 percent investigating allegations in group homes or other congregate care facilities. 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, and approximately one-third of children were placed outside of their home region.

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

Region and County	Number of Foster Homes and Facilities with Investigations N=55	Percent of Children Placed Within Home County N=99
Upstate	*14*	41%
Anderson	3	50%
Greenville	6	44%
Laurens	1	100%
Pickens	3	17%
Spartanburg	1	0%
Midlands	*17*	23%
Aiken	2	66%
Chester	1	100%
Fairfield	5	0%
Lancaster	2	0%
Lexington	3	0%
Richland	4	29%
Low Country	*10*	20%
Berkeley	1	0%
Charleston	5	25%
Colleton	1	100%
Dorchester	2	0%
Orangeburg	1	0%
Pee Dee	*14*	36%
Dillon	1	100%
Florence	2	80%
Georgetown	1	0%
Horry	5	50%
Marion	2	0%
Sumter	2	0%
Williamsburg	1	0%

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

Three congregate care facilities had more than one investigation accepted in March 2021, [95]and one foster home had two investigations.

Reporter Type

In one-quarter of the investigations reviewed, the identified reporter was DSS staff (14 of 55 or 25%), 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 school staff (9%), and foster parent or provider facility staff (16%) who either witnessed alleged abuse or neglect or were informed of an incident that necessitated reporting.

Allegation Type and Finding[96]

The most frequently identified allegations within the 55 investigations reviewed were physical abuse (51%, or 28 of 55), and physical neglect (49%, or 27 of 55).[97] As shown in Table 8, 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.

[95] 2 facilities had 3 investigations, and 1 facility had 2 investigations accepted in March 2021.
[96] For state statutory definitions of types of abuse and neglect, see SC Code § 63-7-20.
[97] Investigations can include more than 1 allegation type.

Table 9: Allegation Types[98] against Alleged Victim Children by Age
March 2021

	Birth-2 years	3-4 years	5-9 years	10-13 years	14-17 years	Number of Children within each Allegation Type
Physical Abuse	4 (9%)	6 (13%)	14 (31%)	12 (27%)	9 (20%)	45
Sexual Abuse	-	-	-	1 (25%)	3 (75%)	4
Mental Injury	-	-	1 (9%)	7 (64%)	3 (27%)	11
Physical Neglect	2 (3%)	5 (8%)	16 (27%)	14 (24%)	22 (37%)	59
Contributing to the Delinquency of a Minor	-	-	-	-	1 (100%)	1
Abandonment	-	-	1 (100%)	-	-	1

Source: Case Record Review completed in June 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 March 2021, most involved foster homes (41 of 55); within foster homes, there was a relatively even number of physical abuse (22) and physical neglect (21) allegations. Similarly, of all investigations in congregate care facilities, there was an even number of physical abuse (6), and physical neglect (6) allegations.

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

	Foster Home	Congregate Care Facility
Physical Abuse	22	6
Sexual Abuse	0	4
Mental Injury	6	1
Physical Neglect	21	6
Contributing to the Delinquency of a Minor	1	0
Abandonment	1	0

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

[98] Ibid.

In five of the 55 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. Two investigations were indicated for physical abuse, two were indicated for sexual abuse, and one indicated investigation included allegations of both mental injury 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.[99] DSS committed to achieving these targets by March 2021.

Of the 55 applicable investigations accepted in March 2021, contact was made with all alleged victim child(ren) within 24 hours in 44 (78%) investigations,[100] and in an additional four (7%) investigations, all applicable good faith efforts were made to make contact with the alleged victim children;[101] thus, total compliance toward this measure is 87 percent. Of the seven investigations in which DSS did not make

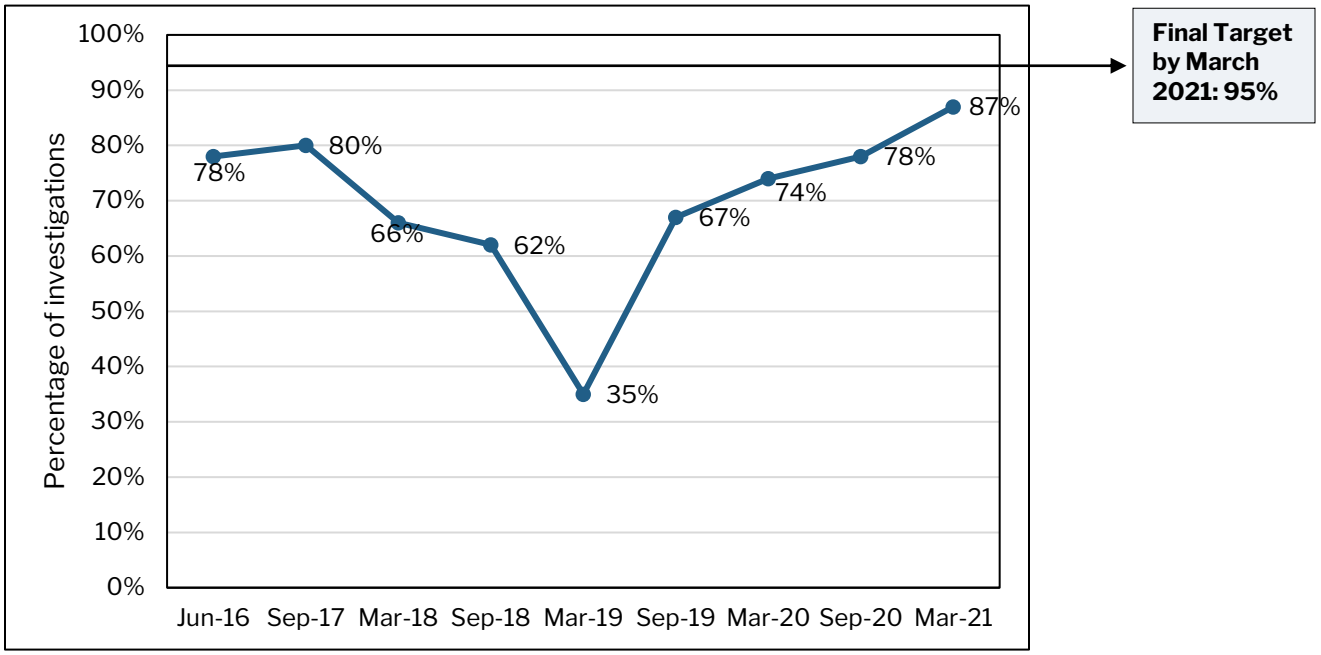
[99] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to contact with an alleged victim child(ren) within 24 hours: investigator attempted to see child(ren) at school or child care facility; investigator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

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

[101] Specifically, in 2 investigations, contact was made with some of the alleged victim children within 24 hours, and the remaining alleged victim children were in runaway status and were unable to be found despite efforts to locate. In the other 2 investigations, the alleged victim children were placed in facilities which prohibited contact for medical reasons.

contact with all alleged victim children within 24 hours, the investigator made contact with some but not all alleged victim children within 24 hours in two investigations. Current performance shows continued improvement since September 2019 but remains below the final target of 95 percent (see Figure 20).

Figure 20: Timely Initiation of OHAN Investigations
June 2016 – March 2021



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

Data were analyzed by county and region to determine if timely contact was made more frequently in some areas over others. As reflected in Table 11, investigations involving children placed in the Upstate and Low Country were more consistent in having contact within 24 hours of the report.

Table 11: Timely Contact with Alleged Victim Children by Region
March 2021

Region	Contact with all alleged victim children made within 24 hours
Upstate	86% (12/14)
Midlands	76% (13/17)
Low Country	90% (9/10)
Pee Dee	71% (10/14)

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

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.[102,103]

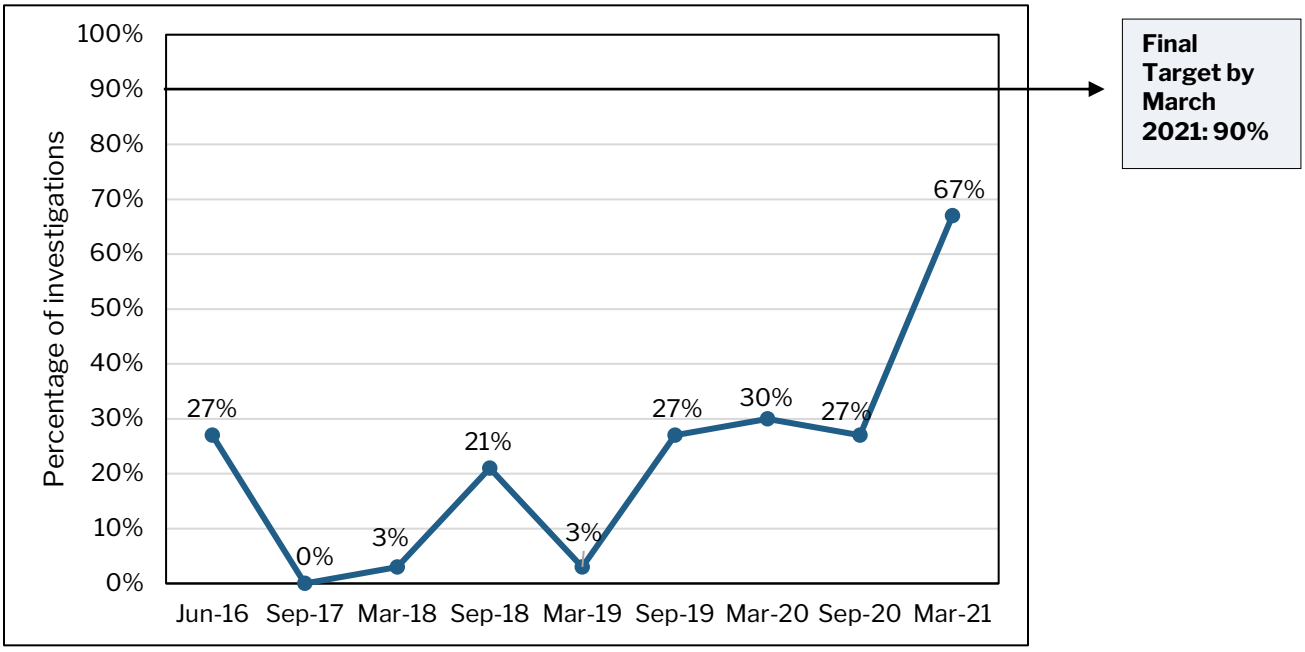
DSS made substantial progress in performance toward this measure this period. In reviewing investigative records, Co-Monitor staff found increased examples of documentation reflecting frequent consultations between OHAN investigators and their supervisors to discuss the information collected thus far, and to identify what additional core witnesses should be interviewed prior to case closure.

Of the 55 applicable investigations involving Class Members accepted in March 2021, 37 (67%) reflected contact with all necessary core contacts during the investigation. Current performance is a significant improvement over all prior periods, but does not yet meet the final target of 90 percent (see Figure 21).

[102] 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.

[103] 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.

Figure 21: Contact with All Necessary Core Witnesses during OHAN Investigations June 2016 – March 2021



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

Data presented in Table 12 shows the frequency of OHAN investigator contact with each type of core witness in the 55 investigations reviewed.

Table 12: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness March 2021 N=55

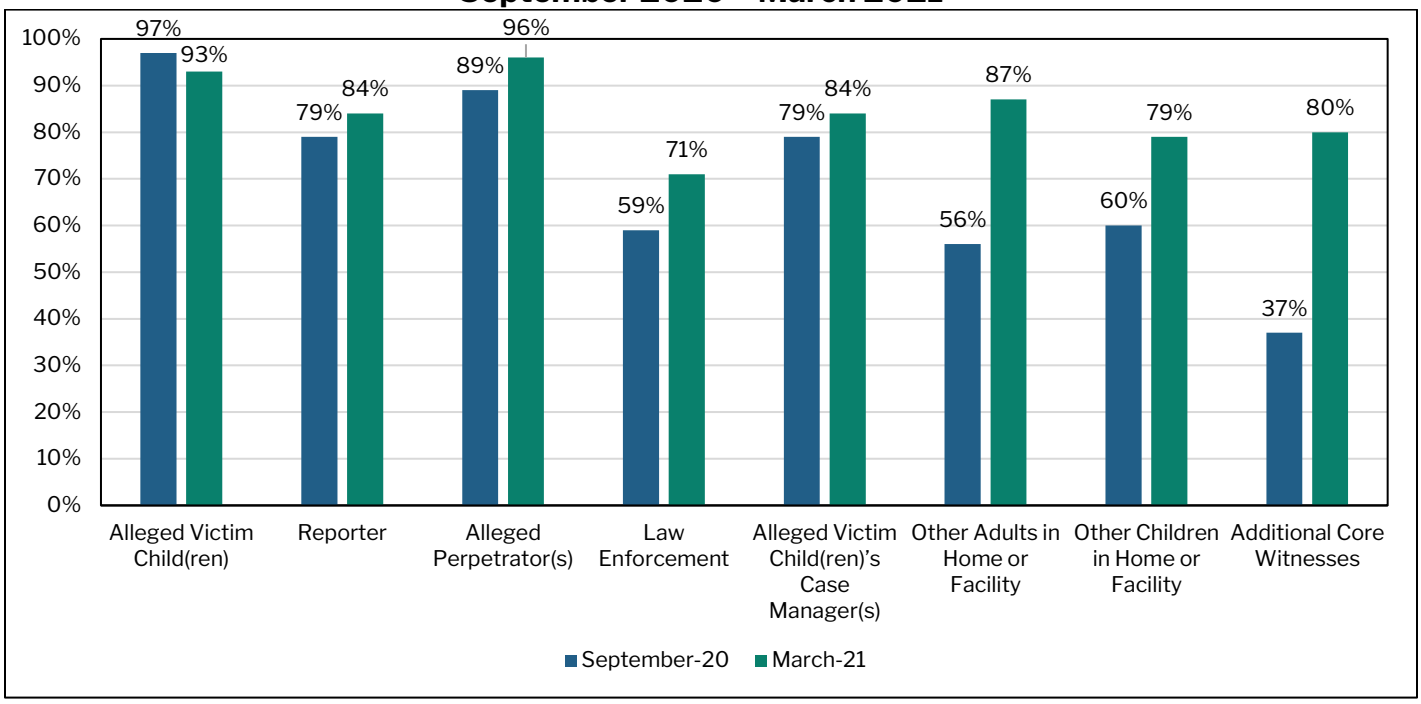
Core Witness	Number of Applicable Investigations	Contact/Interview with All	Contact/Interview with Some	Contact/Interview with None
Alleged Victim Child(ren)	55	51 (93%)[104]	2 (4%)	2 (4%)
Reporter	49[105]	41 (84%)	-	8 (16%)
Alleged Perpetrator(s)	54[106]	52 (96%)[107]	1 (2%)	1 (2%)
Law Enforcement	17	12 (71%)	-	5 (29%)
Alleged Victim Child(ren)'s Case Manager(s)	55	46 (84%)	1 (2%)	8 (15%)
Other Adults in Home or Facility[108]	30	26 (87%)[109]	2 (7%)	2 (7%)
Other Children in Home or Facility[110]	29[111]	23 (79%)	5 (17%)	1 (3%)
Additional Core Witnesses	49[112]	39 (80%)[113]	8 (16%)	2 (4%)

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

[104] Performance includes 2 investigations 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 investigation, and efforts were made to locate them.
[105] The reporter in 5 investigations was anonymous. In 1 investigation, the investigator was unable to locate or contact the reporter despite attempts.
[106] An exception to contact with alleged perpetrator was applicable in 1 investigation, as law enforcement prevented contact.
[107] In 1 investigation, the investigator spoke with some perpetrators, and was unable to contact the remaining perpetrator despite numerous attempts.
[108] 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.
[109] Performance includes 3 investigations in which contact was made with some adults in the household, but the other adults in the household could not be interviewed due to a medical condition (1) or refusal to cooperate (2).
[110] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other children in foster care and biological or adopted children in the home. For investigations involving institutions, as most facilities have many children placed, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[111] Exceptions to contact with other children in the home or facility were applicable in 2 investigations as the legal guardian for the children refused to allow the OHAN investigator to conduct interviews with them.
[112] Additional core witnesses identified by reviewers in 49 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).
[113] Performance includes 3 investigations in which contact was made with some additional core witnesses, and the other additional core witnesses either refused to cooperate or the investigator was unable to locate or contact them despite attempts.

Data in Figure 22 show that the frequency of contact with almost all categories of core witnesses have improved as compared to performance from the prior review period in September 2020. The one area of slight decline is contact with the alleged victim children.

Figure 22: Contact with Necessary Core Witnesses During OHAN Investigations September 2020 – March 2021



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

Investigation Case Decisions

At the conclusion of an investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[114]

Section IV.C.3. of the FSA requires that *'[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected."* DSS committed to achieving these targets by March 2021.

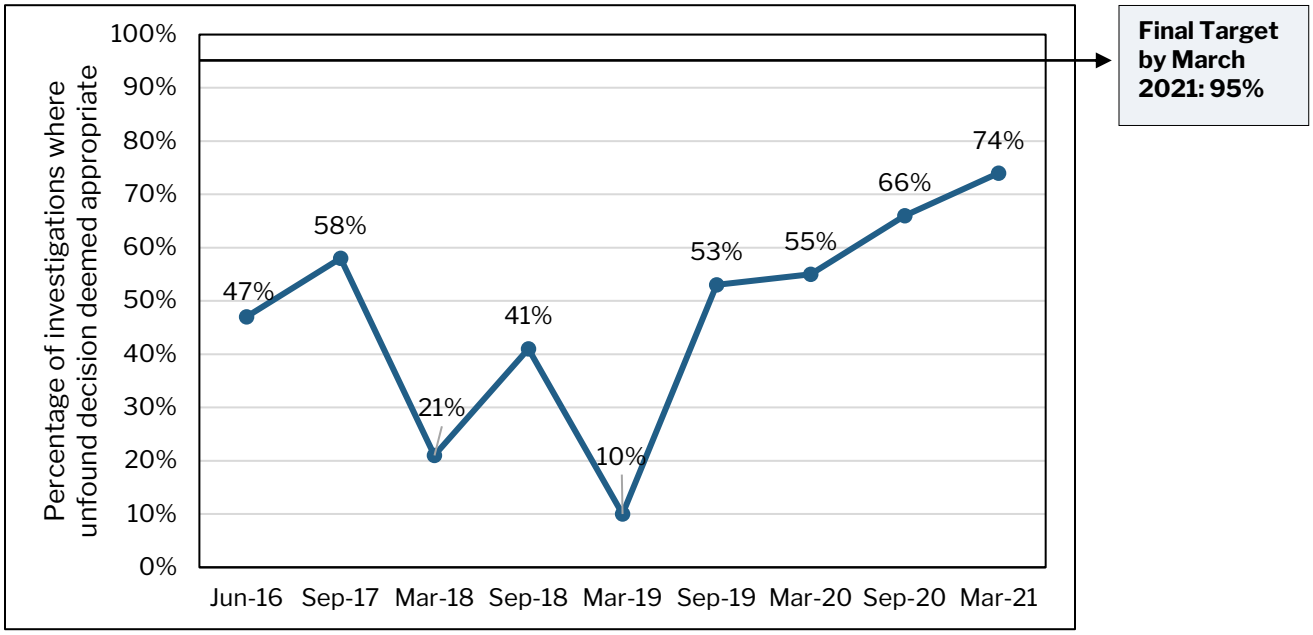
Of the 55 applicable investigations reviewed for March 2021, the final case decision was to *unfound* the allegations in 50 investigations. Reviewers agreed that the case

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

decision to *unfound* the investigation was appropriate in 37 (74%) of the investigations.[115] In 11 (85%) of the 13 investigations in which the reviewer did not agree with the decision to *unfound*, this was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the case, including, for example, not interviewing a witness with relevant information, not clarifying conflicting information, or not collecting medical/forensic reports. In two investigations in which the reviewer disagreed with the unfounded decision, the reviewer assessed that sufficient information was collected, however, there was evidence that the alleged incident had in fact occurred. One of these investigations involved physical neglect in a foster home, and the other involved physical abuse in a congregate care facility.

Performance has continued to improve since September 2019 but is below the final target of 95 percent.

Figure 23: Decision to Unfound OHAN Investigations Deemed Appropriate June 2016 – March 2021



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

[115] 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.[116] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision.[117]

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

[117] 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 55 investigations reviewed, in 10 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.[118] 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-four (98%) of the 55 investigations were completed within 60 days of opening.[119] Performance meets the final benchmark and target for closure within 60 days.

Completed within 90 Days

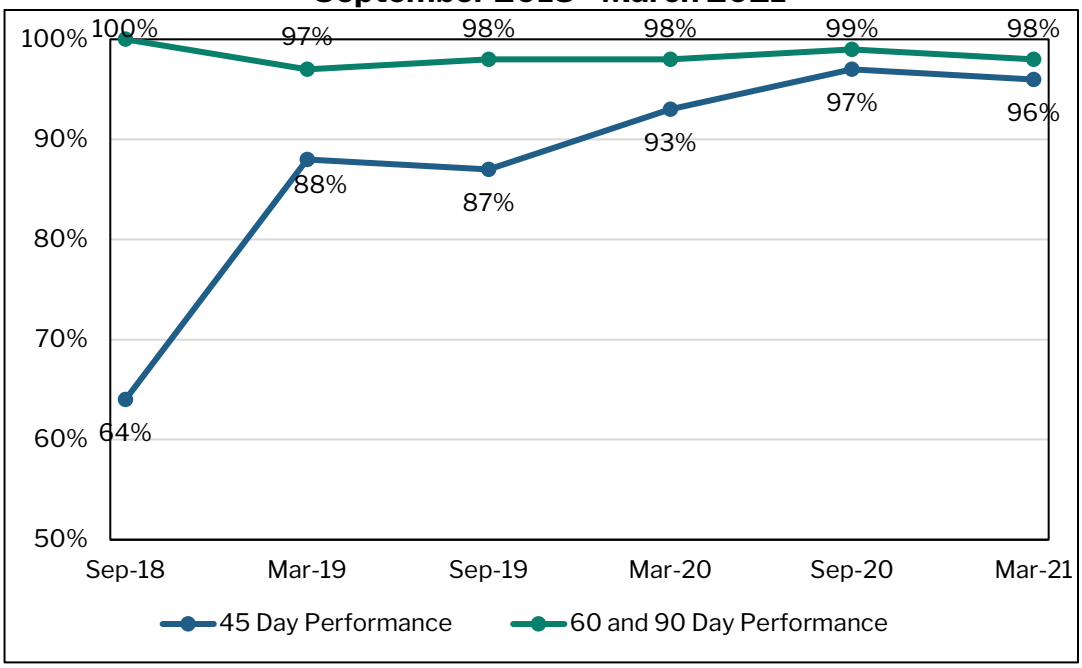
All investigations were closed within 60 days; therefore, performance toward 90-day closure is also 98 percent, and performance meets the final benchmark and target for this measure.

Figure 24 reflects performance for timely closure from September 2018 to March 2021.

[118] In this investigation, most core witness contacts did not occur, and no follow up was completed by the investigator as directed in supervisory meetings. The investigation was closed on the 45th day after intake. Although closed in DSS's system, this investigation is not included in the numerator as compliant for any of the timely closure measures.

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

Figure 24: Timely Completion of OHAN Investigations
September 2018 - March 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.[120]

[120] 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, and April 16, 2021 monitoring reports.

VII. Placements

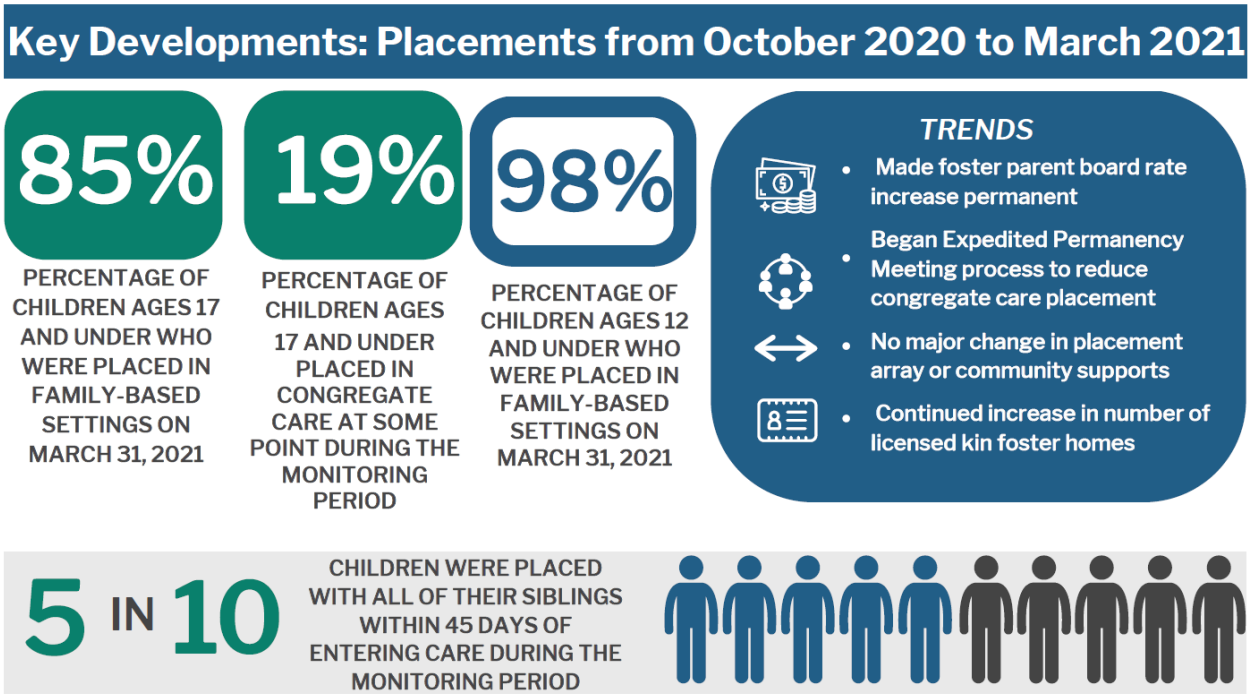
Child welfare policy and best practice requires that children in foster care be in family-like environments, in or close to their home communities, and with kin caregivers and siblings whenever possible. This expectation requires that child welfare systems identify and support kin and family-based caregivers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

The availability of appropriate placements and supports for children throughout South Carolina remains a significant challenge for DSS – one that has only been exacerbated by the COVID-19 pandemic. Although DSS has continued to emphasize the importance of reducing congregate placements and has made progress in this area, and increasing reliance on kin caregivers, the shortage of appropriate foster homes and quality services to support children and families in the community remains. As DSS staff acknowledges and has been consistently reported in all prior monitoring reports, placement decisions are often made based on availability, rather than on the unique needs of children and their families. In addition, the lack of community-based services and other supports places further pressure on the ability for children to remain with kin and in family-based placements. More detailed data on placement over time can be found in the Performance Data section beginning on page 76.

As the COVID-19 pandemic has drawn on, and South Carolina's under-funded child welfare system has continued to operate with severe resource deficits, the impact of this reality has only deepened. The instances of children staying overnight in DSS offices because no placement could be found began to increase at the end of the monitoring period. Though there were only five overnight stays during the monitoring period, however, between April and July 2021, there had been a total of more than 50 overnight stays in DSS offices.[121] Many more children are moved multiple times during their stay in foster care – sometimes through a series of emergency or short-term placements until a more stable setting can be found. Many children continue to be placed far from their home communities and schools, and separated from their siblings, family members, and other important people in their lives. This is destabilizing for both children and their families who have been separated, at a time when what is needed most is support and connection. In addition, the use of out-of-state placements in residential treatment facilities has increased, further separating children from their families and increasing the financial burden on the state.

[121] This number represents 21 unique children.

Though DSS reports having completed many of the discrete tasks outlined in its Placement Implementation Plan, it has yet to move forward on many of the most important elements of the Plan, in part due to a lack of funding and the competing demands of the COVID-19 pandemic. These include 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;[122] developing a robust safety monitoring process to address inappropriate placements for children; developing wraparound crisis intervention services particularly for kin caregivers; maximizing the use of Medicaid-funded services to fill gaps in the current service array; determining activities that would meet the need of youth dually-involved with DSS and DJJ; and recruiting and retaining more foster parents, particularly kin caregivers to better address placement needs of Class Members.[123] DSS's ability to access federal and state resources, and commitment to aligning the core strategies included in this Plan with the key strategies of the reform effort overall, will be essential to improving the experience and outcomes of the children in its care.



[122] As mentioned in Section III. *Background Information*, 31% of children were placed through private agencies as of March 31, 2021.
[123] DSS has developed and submitted to Children's Bureau a diligent 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.[124] The Plan incorporates Placement Needs Assessment recommendations and reflects a new reliance on children's family members and a strong preference for keeping children, with appropriate supports, in family-based settings in their own communities, and with kin or fictive kin whenever possible.[125] The Plan also includes commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making, and to closer strategic partnerships with private providers to develop a placement and service array to meet the needs of children and families. These are 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 service providers. DSS remains delayed in implementing its approved Placement Implementation Plan.

In early 2020, DSS leadership sought to amend some aspects of the Placement Plan to both account for unanticipated delays due to funding inadequacies and to accord with the (then, new) leadership team's reform vision. The Co-Monitors expressed willingness to work with them as they sought to modify the Plan and a completion date for Plan modifications was set at September 30, 2020 in the Mediation Agreement.[126] DSS leadership then reported they anticipated sending an updated proposal by June 2021, a deadline that has since passed.[127] The Co-Monitors have continued to emphasize the critical nature of many of the currently unimplemented

[124] The Placement Implementation Plan is available at: https://dss.sc.gov/media/1950/dss-placement-implementation-plan.pdf
[125] 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.
[126] COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201)
[127] DSS Letter to Court (February 1, 2021, Dkt. 207, p.15).

parts of the Plan in addressing current systemic challenges and failures. On several occasions, the Co-Monitors shared their expectation that any acceptable Plan modification must maintain the comprehensiveness and robustness of the approved Plan, and adhere to the FSA directive that it address the issues explored in the Placement Needs Assessment.[128] These include "the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs" (FSA IV.D.1).

DSS has acknowledged that it has struggled, in the midst of the COVID-19 pandemic and as it tries to move forward with other important reform priorities, to operationalize many of the strategies that are critical for restructuring its placement processes. After engaging in an assessment process with a national child welfare consultant in recent months, DSS reports that it is continuing to work with private providers and stakeholders with lived experience in foster care in an effort to move forward on improvements to the Plan. Many private providers have consistently echoed their desire to be engaged in this transformation as primary partners and their concerns about the pace of reform in this area. DSS leaders are increasingly clear about their goals for the work, but need to demonstrate that DSS can translate those aspirations into different experiences for children and families.

Until a Plan modification is completed, approved, and entered by the Court, the current plan is enforceable, and the Co-Monitors have continued focus on the approved Placement Implementation Plan. Included below is a summary of progress in key areas in which DSS attempted to move forward during this period. DSS leadership has expressed its continued commitment to these strategies, both as core elements of the Placement Plan, and as fundamental elements of their vision for the Department. We will review elements of the Plan under three headers – ensuring an adequate supply of placement resources, ensuring the safety of placements, and achieving the kind of individualized, team-based planning needed to give every child and family a chance to succeed.

[128] To see the Placement Needs Assessment, go to: https://dss.sc.gov/media/1986/appendix-usc-placement-needs-analysis-baseline-study.pdf. After reviewing these initial findings on August 31, 2017, the Co-Monitors shared additional recommendations based on assessment findings and requested additional work be completed on placement projections. Given the delays in completing the Placement Needs Assessment, the decision was made to incorporate these data and recommendations directly into the Placement Implementation Plan instead of producing a final version of the Placement Needs Assessment.

Ensuring an adequate supply of placement resources

Kin Placement

During this monitoring period, DSS continued its work to prioritize the placement of children with kin. DSS policy now requires case managers to make "concerted efforts" to identify and place children with kinship caregivers "throughout the life of a case," and case managers need to obtain supervisory approval to place a child with an unrelated caregiver when placement with kin is not possible.[129] This all represents an important policy and culture shift. DSS has sought to provide kin with the information and assistance needed to become licensed caregivers, and reports that it is building an understanding among staff, community partners, and court officials of this approach to kinship foster care. A DSS Kinship Advisory Panel – which includes five kin caregivers, a DSS kinship care manager, six 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.

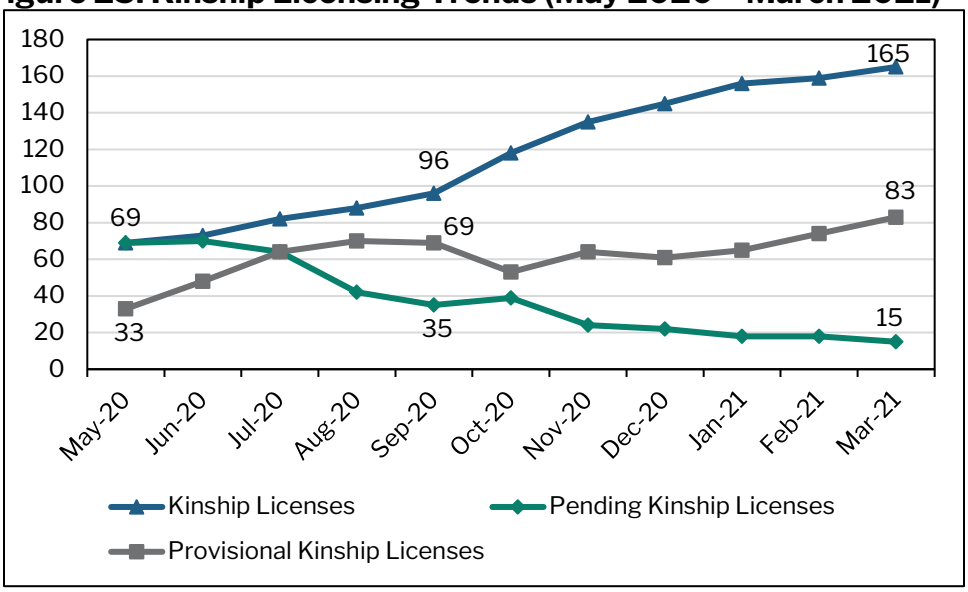
DSS has been working to increase the number of kin caregivers applying to be licensed foster placements, which allows those caregivers to access a financial stipend and DSS support. The number of licensed kin homes has increased to 181 as of June 2021 from 145 in December 2020.[130] Also as of June 30, 2021, there were 53 provisional kinship home licenses issued.[131,132] The number of children placed with kin caregivers, combining licensed and unlicensed, has remained largely the same, but more previously unlicensed kin, who were recently provisionally licensed, are now receiving financial support for their care. Though there is a long way to go, DSS' recent work has demonstrated progress. DSS hopes to be one of a growing number of child welfare systems nationally that now place many or even most children in foster care with kin and is taking important beginning steps.[133]

The engagement of private CPAs as partners in the licensing process over the last year has been helpful in freeing up limited internal DSS licensing staff to focus exclusively on the licensing of kin homes, since DSS did not receive funding to

[129] Child Welfare Policies and Procedures Manual, Chapter 5, Section 510.2.1 (effective October 2020)
[130] DSS Letter to Judge Gergel, July 7, 2021. (Dkt. No 217).
[131] Provisional Licensure enables kin to host the child in their home before the full foster parent licensure process has been completed. This enables a child to be placed in the home of their relative or person with whom they are familiar, as quickly as possible, while full licensure is pursued.
[132] As per DSS's Joint Report commitments, a permanent regulation to support provisional licensure of kin was published on May 13, 2020.
[133] At the end of FY 2017, nationally, one-third of children in foster care were in a relative foster home. https://www.childtrends.org/blog/the-share-of-children-in-foster-care-living-with-relatives-is-growing

support new kin licensing positions. Since July 2020, all potential non-kin foster home providers have been referred to CPAs for licensing. Figure 25 shows the improvement in kin licensing from the prior two monitoring periods.

Figure 25: Kinship Licensing Trends (May 2020 – March 2021)



Source: Data provided by DSS

DSS received a new round of funding in October 2020 from the Administration for Children and Families for capacity-building for kinship navigation services, a new *Caring for Our Own* kinship caregiver training, and one-time kinship care supports. Each cohort for the nine-hour virtual *Caring for Our Own* training has had between 10 and 20 participants, and by June 2021, 47 kinship caregivers had participated. DSS hired a Kinship Navigator Grant Coordinator in June 2020 to provide grant management and oversight. DSS has not fully implemented its plans for a robust Kinship Navigator program but has taken interim steps – DSS requested additional federal funding to continue to expand Kinship Navigation Services. Though these efforts are short of the full-scale Kinship Navigator program DSS envisions, they also represent important steps towards the Department's goal of increasing and sustaining placement of children with kin.

Foster Parent Board Rates

Another cause of South Carolina's placement challenges has been the low rates paid to foster parents. Although budgetary decisions were delayed due to the COVID-19 pandemic, DSS utilized additional funding, available as a result of temporary pandemic-related adjustments to federal Medicaid match rates under the Families

First Coronavirus Response Act (FFCRA)[134] to move ahead with a rate adjustment to foster parents for board payments on a temporary basis.[135] DSS continued to provide an enhanced "COVID" rate to all licensed or provisionally licensed kin, and licensed non-kin, and has committed to continue funding this increase, up to the USDA level,[136] through at least September 2021. Based on the now approved FY2021-2022 budget, DSS is able to make the enhanced rates permanent as of July 1, 2021. DSS is also hoping that as it is successful in moving children from congregate care placements (which are costly to the state) into family-based settings, additional savings may be realized that can be repurposed for increases in payments to family-based providers and development of necessary community supports.

Ensuring the safety 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 seclusion and restraint."[137] Stakeholders, OHAN investigations, and the notifications of overnight stays in local DSS offices continue to reveal startling stories about the cases of young people who reside in these facilities. In accordance with the Placement Needs Assessment recommendations, DSS has begun work to improve the quality and safety of such facilities.

Safety and Quality Response

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

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

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

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

[137] 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*.

facilities throughout the state.[138] It has continued to utilize the Safety and Quality Response Review Protocol, developed in accordance with the Placement Implementation Plan, to review family foster or group care providers who receive multiple abuse and/or neglect referrals within a specified timeframe.

DSS reports that bi-monthly meetings have been scheduled to occur since September 2020, but it remains unclear whether the work of the review teams alone, without robust integration into Continuous Quality Improvement processes, has the capacity or authority to fundamentally transform safety issues in these facilities. Between December 2020 and April 2021, three foster homes and 11 congregate care facilities were reviewed within this forum. During the monitoring period, corrective action plans were issued and completed for three congregate care facilities to address a broad range of concerns, including: staff's inability to de-escalate incidents among residents; excessive use of seclusion and restraint; deficiencies in maintenance of buildings; and inadequate provision of food. Though all facilities met the terms of their corrective action plans, DSS expressed concern about the sustainability of implementing change, and thus has chosen not to place any more children at one of these facilities. DSS has reported that the loss of beds from this facility is one driver of its placement crisis, resulting in children staying overnight in the office. According to DSS, identified trends from the bi-monthly meetings include the need for more training opportunities for staff on the topic of sex trafficking, staff shortages leading to a decrease in bed capacity, and a lack of supervision for children placed in congregate care facilities.

Congregate Care Reduction

As described below in the Performance Data section, DSS has significantly reduced the number of children placed in congregate care. Continuing a sustainable and successful congregate care reduction strategy will ultimately depend upon the accessibility of high-quality formal and informal supports to prevent the separation of families at the front end of the system, and support reunification when it is determined that children must temporarily be taken into the custody of the state. In acknowledgement of the importance of family-based placements, and the heightened risk of harm to children and staff during the COVID-19 pandemic, DSS has continued to move ahead with the comprehensive case review process to which it committed to in the Mediation Agreement in July 2020.

[138] 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*.

As of June 2021, the cases of 97 children 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. The initial focus has been on children in Level 1 and 2 group care. Of the first cohort of 37 children, there were 30 EPMs, and 26 children were stepped down to family-based settings either before or after the meeting occurred. According to data provided by DSS, 45 of the second cohort of 109 children were moved to a family-based setting before the EPM occurred, and six were stepped down after the meeting occurred. Among the 146 children between the first two cohorts, this means 67 (46%) were stepped down to family-based placements, and 58 remained in congregate care.[139] DSS reports that there is evidence that as County Directors become champions of the EPM process, appropriate family-based placements are more readily identified and are better suited for a child's transition from congregate care. The process has affirmed the hypothesis that many children in Level 1 and 2 group care possibly could have avoided placement in congregate settings with appropriate planning. DSS and Co-Monitors agree that attention to tracking the data on the durability of placements post-transition from group care will be essential.

As the Co-Monitors have discussed with DSS, 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 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 DSS's efforts to partner with congregate care providers in planning for the smooth transition of children from group care to family-based settings. As discussed, children are still being moved frequently through multiple placements, and transitions out of congregate care do not necessarily result in long-term family-based placements.

Achieving individualized, team-based planning

Even a sufficient array of services and placements would not be enough to meet the needs of children and families without 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 Teaming (CFT) model. In early 2020, DSS Director Leach decided to transition from its former model

[139] 5 youth (of 146) whose cases were reviewed in the initial 2 cohorts have since returned to congregate care since the review process began in October 2020.

that outsourced teaming facilitation to a contracted provider to a model based in building the capacity of DSS staff to incorporate CFTs in their practice. As of March 2021, DSS had completed hiring and onboarding for all four family engagement coach positions, all four supervisor positions, all six administrative assistant positions, and 23 of 24 facilitator positions.

As of March 2021, the CFT model had been introduced to staff in all the state's 46 counties. The focus is on building workforce capacity to implement the model by having trained CFT coaches in every region and supporting CFT coaches in training and certifying frontline supervisors in this practice. In the state's data system of record, workers will fill out the Family Permanency Plan, a replacement for what was known as a treatment plan, during and after a team meeting. The Family Permanency Plan will also be informed by two assessment tools – the Family Advocacy and Support Tool (FAST), and the Child and Adolescent Needs and Strengths tool (CANS). These tools are intended to maximize communication and assessment around family needs and will support the teaming and planning process. Training on FAST and CANS began in select counties in July 2021. Training modules around CFT have been added to the Child Welfare Certification Training to build the foundational engagement and teaming skills that new case managers will need into their pre-service training.

The shift from conceptualizing family engagement as an ancillary service to an understanding that case managers need the skills and knowledge for effective engagement is foundational to other aspects of DSS's placement work, because it will allow for assessment, planning, and decision-making through collaborative teams with families. The success of this model will ultimately depend not only on the capacity of a team of dedicated family engagement staff, but also on the ability of *all* DSS case managers to facilitate CFTs and practice in a way that is consistent with these values. 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.

Performance Data

Placement of Children in Congregate Care

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

DSS has been evaluating the needs of children placed in congregate care during the COVID-19 pandemic to assess whether their needs can be met in more family-like settings that carry a lower risk of exposure to the virus. This process, combined with a focus on kin placement and the overall reduction in the number of children in foster care, has led to improved performance in this area. As of March 31, 2021, 85 percent (3,344 of 3,915) of Class Members were placed outside of a congregate care placement (see Table 13). Twenty-one children resided in other institutional settings outside of DSS's control due to an acute medical need or incarceration.[140] As shown in Figure 276, this performance comes very close but does not meet the March 2021 final benchmark. DSS has continued to gradually reduce the percentage of children placed in congregate care over the last several years.

Table 13: Types of Placements for Children
March 31, 2021

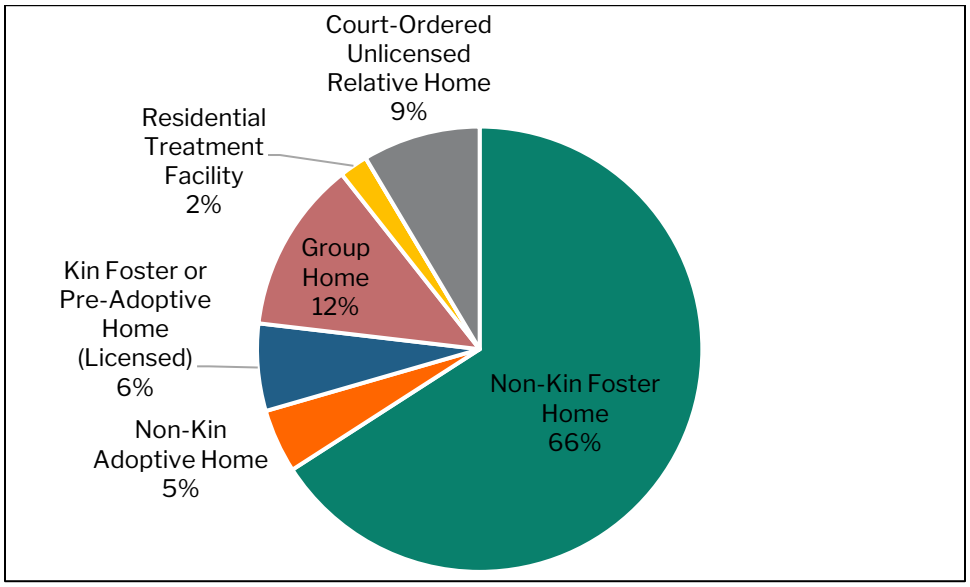
Children in Foster Care	
3,915 (100%)[141]	
Type of Placement	**Number (%) of Children**
Family-Based Setting	3,344 (85%)
Congregate Care	571 (15%)

Source: CAPSS data provided by DSS

[140] Specifically, DSS reports that 12 children were incarcerated in correctional or juvenile detention facilities, 8 children were hospitalized, and 1 resided in a Department of Disabilities and Special Needs (DDSN) training home.
[141] This does not include 21 children who resided in other institutional settings on the last day of the monitoring period.

Figure 26 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 (66%, or 2,580 of 3,195) were placed in unrelated foster homes; 248 children (6%) resided in licensed relative foster homes; and 81 children (2%) were placed in residential treatment facilities. As described earlier, the percentage of children placed in licensed kin homes has increased, but South Carolina still has more than 10 times as many children placed with non-relative foster parents than with kin.

Figure 26: Percentage of Children in Family-Based and Congregate Care Placements on March 31, 2021
N=3,195



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 14, as of March 31, 2021, 2,562 of 2,629 Class Members ages 12 and under resided outside of a congregate care placement, and 9 children ages six and under resided in congregate care pursuant to a valid exception, resulting in

performance of 98 percent. As shown in Figure 27, performance in this area has improved steadily since March 2018 and meets the March 2021 final target of 98 percent for the first time.[142]

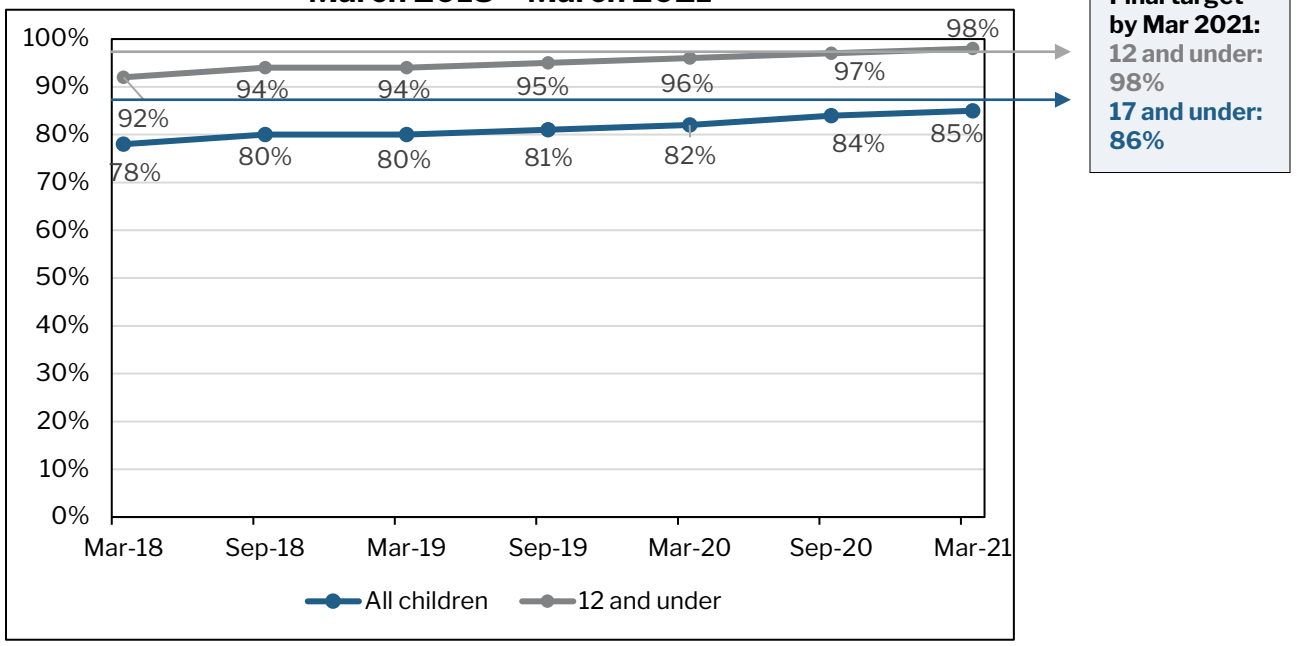
Table 14: Types of Placements for Children Ages 12 and Under
March 31, 2021

All Children in Foster Care Ages 12 and Under	
2,629 (100%)	
Type of Placement	**Amount of Children**
Family-Based Setting	2,571 (98%)[143]
Congregate Care	58 (2%)[144]
Breakdown of Type of Congregate Care	
Group Home	40 (2%)
Residential Treatment Facility	18 (<1%)

Source: CAPSS data provided by DSS

[142] The Co-Monitors have approved exceptions for placing children ages 7 to 12 in a congregate care facility, thus actual performance may be higher than reported. DSS provided data on 15 children to which they believe exceptions apply that have not yet been validated. The Co-Monitors and DSS will develop a process for review of applicable exceptions in future monitoring periods.
[143] This includes 9 children ages 6 and under who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[144] This does not include 2 children who were hospitalized on the last day of the monitoring period.

Figure 27: Trends in Placement of Children Outside of Congregate Care March 2018 – March 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 four percent (150 of 3,525) of Class Members in care at any time during the monitoring period and between the ages of 12 and under were placed in congregate care at some point between October 2020 and March 2021.[145] For children between the ages of seven and 12, eight percent (115 of 1,473) were placed in a congregate care setting at some point between October 2020 and March 2021.[146] This represents improvement from the prior monitoring period, when 10 percent of Class Members between the ages of seven and 12 were placed in congregate care at some point. As of March 31, 2021, 95 percent (1,039 of 1,095) of children between the ages of seven and 12 were placed outside of congregate care. This reflects an improvement since September 2020, when 93 percent of children ages seven to 12 were placed outside of congregate care on the last day of the period.

The vast majority (86%, or 490 of 571) 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

[145] This percentage does not include children who were placed in other institutional settings at some point during the monitoring period, such as children who were hospitalized. The Co-Monitors have not independently validated these categorizations.
[146] Ibid.

support they are expected to provide to a child (either Level 1, 2, or 3). As has been previously reported, the facilities vary a great deal in terms of available supports, programming, and level of restriction, and none offer formal clinical services onsite.

The data in Figure 27 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 has also been reduced over time. Data show that almost one-fifth (19%, or 958 of 5,169) of all children in foster care during this monitoring period were placed in a congregate care setting *at some point* between October 2020 and March 2021.

Children Ages 13 to 17

Children ages 13 to 17 are more likely than younger children to spend time in congregate care. On March 31, 2021, 504 (39%) of 1,286 children ages 13 to 17 resided in congregate care. This is a reduction and improvement from September 30, 2020, when 42 percent of children in this age group resided in congregate care, and from the prior March, when 49 percent of teenagers resided in congregate care. For the first time, slightly less than the majority (49%, or 808 of 1,644) of children ages 13 to 17 in foster care at any time between October 2020 and March 2021 were placed in a congregate care setting at some point during that time. This is an improvement from prior monitoring periods; for example, 57 percent of adolescents resided in congregate care at some point between April and September 2020.

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),[147] and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure currently requires approval of a Regional Director prior to the placement of any child in a non-family-based setting.

Most children ages six and under who resided in congregate care placements during the monitoring period were placed pursuant to an agreed upon exception. Of the 32 young children who resided at a congregate facility at some point during the period, 10 resided in a treatment facility or group care with their mothers and 22 were part of a large sibling group for whom DSS reported a single, family-based placement could not be located. Three children were part of sibling groups who remained at group homes beyond 90 days without documented efforts to move the sibling group to a family-based placement, and therefore did not meet an exception. While the Co-Monitors do not recommend sibling groups be separated in order to meet the terms of this measure, it is essential that efforts be made to secure less restrictive placements that can accommodate all siblings.

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.).

[147] 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.

During this monitoring period, the Co-Monitors were notified of five instances of a child staying overnight at a DSS office or hotel.[148] However, as previously noted, there has been a subsequent, substantial increase, with 21 children having 50 episodes of overnight placements during the period April through July 2021. In addition to these 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 late at night on an emergency basis and picked up early in the morning to avoid violation of this measure.

Until a modified Placement Plan has been developed and approved, which should account for the development of community-based services and a continuum of care to meet the needs of children, DSS must establish an interim practice of dealing with this problem of overnight stays. While children remain in the office overnight, they may not have a safe or appropriate place to sleep, may not attend school, may not have activities to occupy them if they remain in the office throughout the day, and require case managers to supervise them, which inhibits their abilities to complete regular case management duties for other families.

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.).

[148] In October 2020, a 15-year-old in Oconee County stayed overnight in the office after being released from DJJ detention and staying in multiple emergency placements, but DSS could not identify a long-term placement that was appropriate for the child's needs. In December 2020, a 14-year-old in Clarendon County stayed overnight in the office after being placed in emergency protective custody. Placement was identified the following day. In January 2021, a 17-year-old in Richland County stayed overnight in the office multiple nights over the course of a weeklong period (interspersed with emergency placements) when a stable placement could not be found after the child was discharged from a group home. The child had been restrained at prior group home placements and put into solitary confinement, denied medical care, and there were no documented visits with the child's family members in two years of being in care, which contributed to escalated behaviors and moving from placement to placement. In March 2021, a 17-year-old in Spartanburg County stayed overnight in the office after returning from running away from a prior placement. In the coming months, the child would stay overnight in DSS offices nine times. Also in March 2021, a 16-year-old in Clarendon County stayed overnight in the DSS office after returning from running away from a foster parent with the child's younger sibling.

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

DSS reports that as of August 2021, the Department is tracking the use of emergency placements, both paid and unpaid, although these data have not yet been validated by the Co-Monitors.[149] The anecdotally reported frequent use of emergency placements, and lack of data surrounding the practice, continues to be a significant concern, particularly given the depth of DSS's placement instability issue. During the monitoring period, DSS began tracking emergency placements manually, and identified 37 emergency placements between October 2020 and March 2021. The tracker is not reflective of the amount of time that youth spent in emergency placement foster homes. Based on conversations with DSS frontline staff, the Co-Monitors believe this manual tracking system understates the extent of the problem. The Co-Monitors will meet with DSS to clarify the definition of emergency placement, night-to-night placement, and the use of this tracker.

As reported previously, DSS also reports paying foster care providers an "enhanced rate" as an incentive to house children overnight while longer-term placement is being sought. Between October 2020 and March 2021, DSS reported 31 unique children were placed with foster home providers and 52 children were placed with group home providers under an enhanced rate based on payment data. Neither the Co-Monitors nor DSS believe that all emergency placements are reflected in this enhanced rate payment data or through the manual tracker.

Right outside of the monitoring period, DSS began updating CAPSS, the data system of record, so that emergency placements, both paid and unpaid, can be captured in the Placement tab. DSS reports that data entry began in August 2021, by only a select

[149] 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 or young person returns to the prior long-term placement (temporary placements include respite care, hospitalizations for less than 30 days, or transitional visits with caregivers).

few staff to increase consistency and accuracy. The Co-Monitors have not yet validated the use of this system.

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.).

The Co-Monitors continue to be concerned about Class Members who are also involved with the South Carolina Department of Juvenile Justice (DJJ). DJJ involvement includes pre-adjudication detention, a prescribed sentence at one of the state's secure evaluation centers, and/or post-adjudication placement at a secure facility or one of many group homes, as well as being on probation. Class Members become involved with DJJ for several reasons, including because of actions that involve little or no harm to others (such as truancy, "incorrigibility," or, in many cases, running away from a DSS placement, which are often known as "status offenses").

As previously reported, designated DSS liaisons throughout the state have access to a DJJ data system portal, which provides limited information about children with open DJJ cases. Members of the regional Well-Being Teams, known as Community Liaison Coordinators, are responsible for finding services for this population, and sometimes enter information about DJJ involvement directly into CAPSS so that it can be accessible to DSS case managers. In some but not all parts of the state, DSS-identified liaisons and Regional DJJ liaisons have built closer working relationships, allowing for more informal collaboration and information sharing. In January 2021, DSS was able to share a match list of all children with an open foster care service line on December 31, 2020, which showed that 161 children also had an open DJJ service line in the month of December. Both DSS and the Co-Monitors continue to have questions about these data, because the information about this population in the systems of record of both DSS and DJJ lack clarity and specificity about the reasons for involvement, status of charges, and placements.

At any given time, DSS reports between 10 and 20 young people are incarcerated in secure DJJ facilities. The Co-Monitors rely on both DSS reports and anecdotal reports by stakeholders to assess DSS performance with respect to the FSA in this area of practice. The Co-Monitors are regularly made aware of cases that reflect the frequency and fluidity of movement between DSS and DJJ, with decisions made largely based on the availability of placement rather than a child's unique needs. Children often come to the attention of DJJ because they choose to leave DSS placements in which they feel unsafe, or in which their needs are not being met, leading to law enforcement involvement and delinquency charges. For example:

- In January 2021, a 16-year-old in Richland County was detained after running away, which was a probation violation for pending charges. The child was subsequently taken to an adult correctional facility, where the child remained incarcerated for a probation violation for almost two months, because DSS did not move toward assessment or finding placement. DSS reports a lack of communication with DJJ on this case.
- In March 2021, a 15-year-old in Richland County was picked up by law enforcement after running away from a DSS foster home and was placed at an adult detention center on a probation violation for five days, and then moved to a DJJ detention center. The court ordered that the child be immediately released to DSS as soon as placement was secured, but the child remained in the detention center for almost a full month.
- In March 2021, a 17-year-old in York County was detained at a juvenile justice facility when there were concerns the child might be a victim of sex trafficking. The child remained in the DJJ facility for two days after the DSS case was opened, at which point the child was placed at a congregate care facility that specializes in working with youth victims of sex trafficking.

Children who encounter both DSS and DJJ often bear the highest burden posed by the lack of community-based supports and appropriate placement options. These children often develop escalating behaviors as a result of system failures, frequent placement instability, lack of services, and trauma of separation from their families, and thus the lack of appropriate placements becomes a self-reinforcing problem.

The Co-Monitors and DSS are planning for a joint review by the end of 2021 to better understand the systemic inadequacies that contribute to children's DJJ involvement and/or time in detention, secure evaluation facilities, or DJJ group homes. The goal of the upcoming review is to develop a deeper understanding of the factors driving DJJ

involvement in order to aid DSS's efforts to improve the experiences of and supports for dually involved youth. Ideally the results will also inform the work to develop appropriate community supports and placement options in collaboration with other state agencies, an integral part of the Placement Implementation Plan.

Sibling Placements

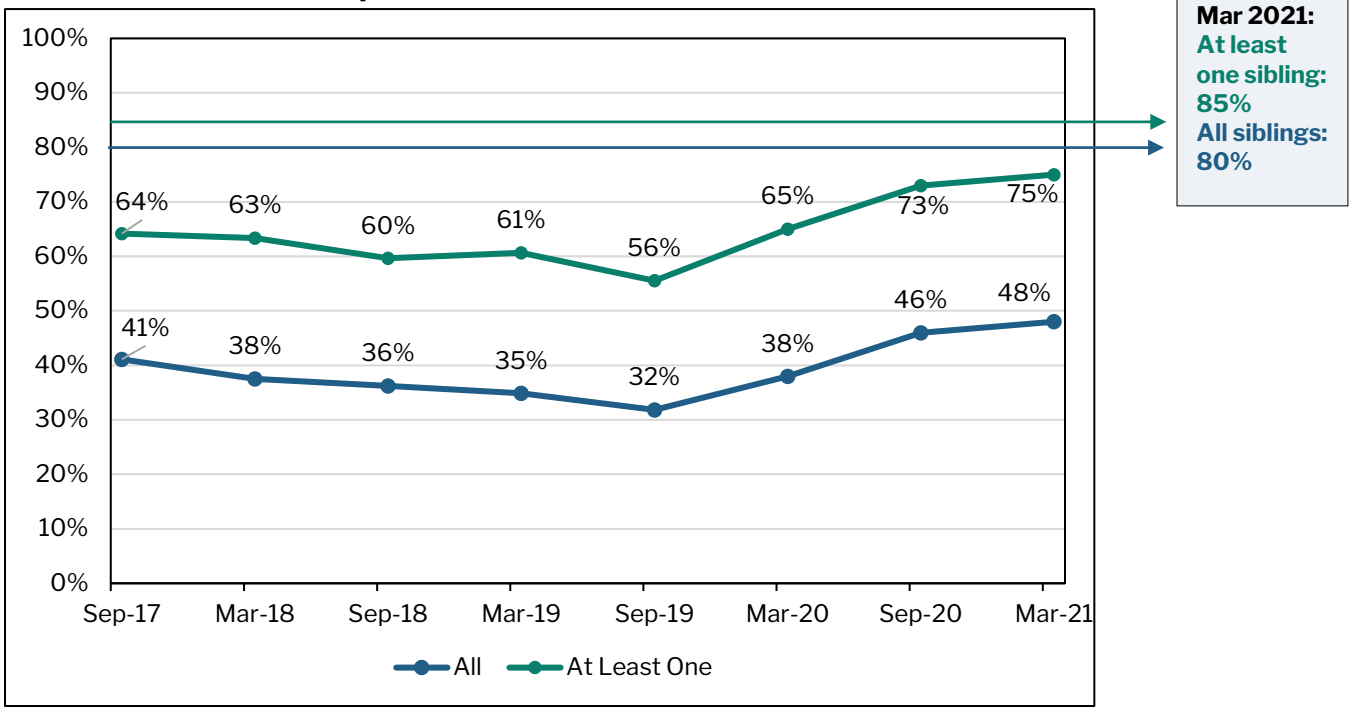
The FSA recognizes the importance of the lifelong and supportive relationship between children and their siblings and *requires that 'at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings"* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).[150] DSS committed to achieving these targets by March 2021.

DSS provided data for 632 children who entered foster care between October 2020 and March 2021 with a sibling or within 30 days of a sibling's entry to foster care.[151] For this cohort, 75 percent (476 of 632) of children were placed with at least *one* of their siblings, and 48 percent (303 of 632) of children were placed with *all* of their siblings 45 days after entry into care. Performance does not meet the March 2021 final targets, but represents a slight improvement from the prior monitoring period, as shown in Figure 28.

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

[151] Because performance for this measure is assessed on the 45th day after children enter foster care, the number of applicable children included in the measure is impacted by the decrease in children entering care in each month of the COVID-19 pandemic. As represented in the data herein, whereas 813 children were included in the universe in the October 2019 to March 2020 monitoring period, only 632 children were included this period.

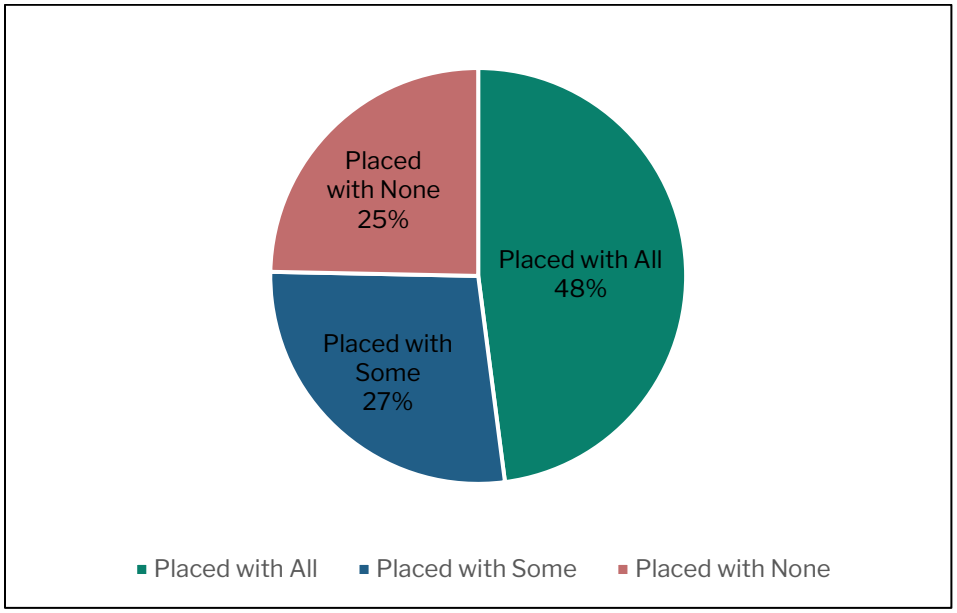
Figure 28: Sibling Placements for Children Entering Placement September 2017 – March 2021



Source: CAPSS data provided by DSS

Figure 29 further shows the breakdown of sibling placements during this monitoring period. One quarter of all children entering care with siblings were not placed with *any* siblings, which is approximately the same performance as the prior monitoring period, but a significant improvement from March 2020, when 35 percent of children were not placed with any siblings.

Figure 29: Sibling Placements for Children Entering Placement
October 2020 – March 2021
N=632



Source: CAPSS data provided by DSS

VIII. Family Time: Visits with Parents and Siblings

Most children in foster care benefit from an ongoing relationship with their parents, siblings, and other family members.[152,153] This is regardless of the child's permanency goal. When children and their parents and/or their siblings are separated, regular and multiple forms of contact maintain and strengthen attachments that are fundamental for the health and well-being of both children and adults.

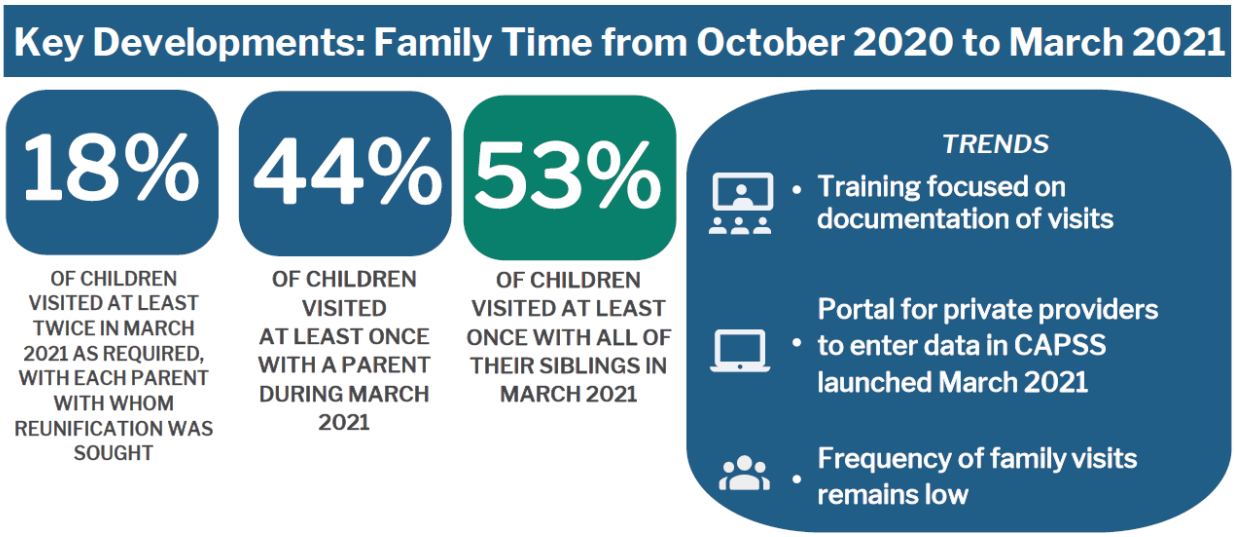
Results from twice-yearly record reviews to determine performance on DSS's minimum twice-monthly standard for children's contacts with their parents and minimum monthly contact for siblings in foster care living apart continue to remain far below expectations. During March 2021, 18 percent of children visited twice with the parent(s) with whom they are to reunify, as required by DSS policy. In the records of more than half (51%) of the children there was no documented contact, either in person, by video, or by phone with the parent(s) with whom the child is to reunify.

Just over half (53%) of separated siblings saw each other once during March 2021. While improving, these results for the minimum standards for children's contact with their parents and siblings, one or two hours per month, cannot be accepted as the norm. The time children in foster care spend with their family members must be respected, valued, and expanded. Also, more creative ways for facilitating children's time with their family must be used, and documented for accountability, by DSS and its partners. More detailed data on family visits over time can be found in the Performance Data section beginning on page 93.

Continued guidance from DSS encourages in-person contact between siblings in foster care not residing together and between children and their parents with precautions related to the COVID-19 pandemic. Data from recent reviews show some children are having in-person contact with family members, and others are communicating via video with family members, as allowed by DSS when responses to a series of questions reveal in-person contact is not possible. DSS reports exploring ways to expand visitation services in the provider community, building on the existence of two private providers operating visitation centers and another

[152] Lenore M. McWey, Alan Acock, Breanne E. Porter. The impact of continued contact with biological parents upon the mental health of children in foster care. Children and Youth Services Review, Volume 32, Issue 10, 2010, Pages 1338-1345.
[153] Armeda Stevenson Wojciak, Lenore M. McWey, Christine M. Helfrich. Sibling relationships and internalizing symptoms of youth in foster care. Children and Youth Services Review, Volume 35, Issue 7, 2013, Pages 1071-1077.

focusing on sibling visitation. Community centers and churches have made both indoor and outdoor spaces for families to visit. Efforts to support safe, in-person contacts among family members must continue and expand.



Family Time: Progress and Implementation Updates

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

DSS's Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and by the Court on April 3, 2019.[154] Meeting the important goals of children spending time with their parents and siblings is related to staffing, as case managers need time to assist in planning and facilitating visits and work closely with parents towards reunification. Children should be placed with or closer to family members and their siblings. DSS' placement challenges also impact performance in this area.

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

Although actions are delayed, DSS continues to make progress towards developing and implementing strategies, as described below.

Policy and Practice Guidance

DSS reports that its Visitation work group is continuing to work on amendments to the visitation policy issued in June 2019 and has recently received feedback on a draft shared with leadership. The amendments, which include a "Quality Visitation Guide" are expected to align with the agency's GPS Case Practice Model. As a step in achieving the goal of cultivating a shared understanding of the importance and critical function of parent-child and sibling visits, DSS continues to develop and disseminate a newsletter entitled *Visitation Matters* to case managers, supervisors, program coordinators, and provider staff. *Visitation Matters* was disseminated in December 2020 and July 2021.

To meet the goal of increasing the quality of visits between parents and children, DSS planned to seek technical assistance for defining quality parent-child visits and develop a model in line with the agency's practice model. DSS previously reported considering two models and partnered with a technical assistance provider to incorporate a coaching model in a Visitation Guide. DSS also reports that a training curriculum on the guide is in development. The timeline for completion of the Guide and curriculum, as well as the development of the training schedule are pending.

Training

Visitation Awareness training for case managers, supervisors, and foster parents is one of DSS's core strategies to communicate the importance of increasing the amount of time children spend with their family members. The Visitation Awareness training reiterates that policy references a *minimum* expectation for the time children spend with their parents and siblings: one hour, twice monthly with parents, and one hour monthly with siblings not placed together. The expectation, however, is for much more time. Supporting and encouraging multiple forms of children's contact with family members, including in-person visits, is expected of DSS staff, foster parents, and private partners. DSS case managers, case manager assistants, case manager supervisors, and program coordinators are expected to participate in Visitation Awareness training to reinforce these principles. New staff are expected to do so within their first year of employment. Legal staff are invited to participate in the training. In addition to the staff previously trained, DSS reports that since January 1, 2021, 27 case managers, four supervisors, 24 foster parents, and two legal staff

have participated in Visitation Awareness. An additional 26 supervisors participated in Visitation Awareness training targeted to supervisors.

To meet the goal of increasing the frequency of children's visits with their parents and siblings, DSS planned to adopt a foster parent training and support model in line with the shared parenting model. DSS has adopted PRIDE as the training model for foster parents but has not yet implemented the training due to budget constraints. DSS reports that since child placing agencies are completing the licensing process for non-relative caregivers, further collaboration is needed regarding the foster parent training model.

Data

Additions and modifications to CAPSS to capture data on visits and a new Visitation Plan document – which is expected to be completed by a child's case manager – are not yet in uniform use. DSS has continued to work on making this CAPSS capability more user-friendly. Data from this CAPSS update are presented in reports to Regional and County management leadership, to be used for tracking and improving results for family visits.

DSS developed 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. Appropriate data relates to education, physical and behavioral health, and visits or maintaining connections with family members. Training on the use of CAIP began in early 2021, and the portal launched on March 15, 2021. DSS reports that since then, 437 foster care providers have created training accounts and 72 percent (316) of them have completed training on how to use the portal. Participants in training also receive a manual and tip sheet on the use of CAIP. As of June 4, 2021, DSS reports that data for 75 visits had been entered by providers, and by September 8, 2021, 183 visits had been entered.

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

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

USC CCFS, DSS, and Co-Monitor staff conducted a case record review using a structured 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 302 records, representing 191 families, for required sibling visits in March 2021.[156] Documentation in 13 of the 302 records reflected an applicable exception to a sibling visit.[157]

[155] 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).

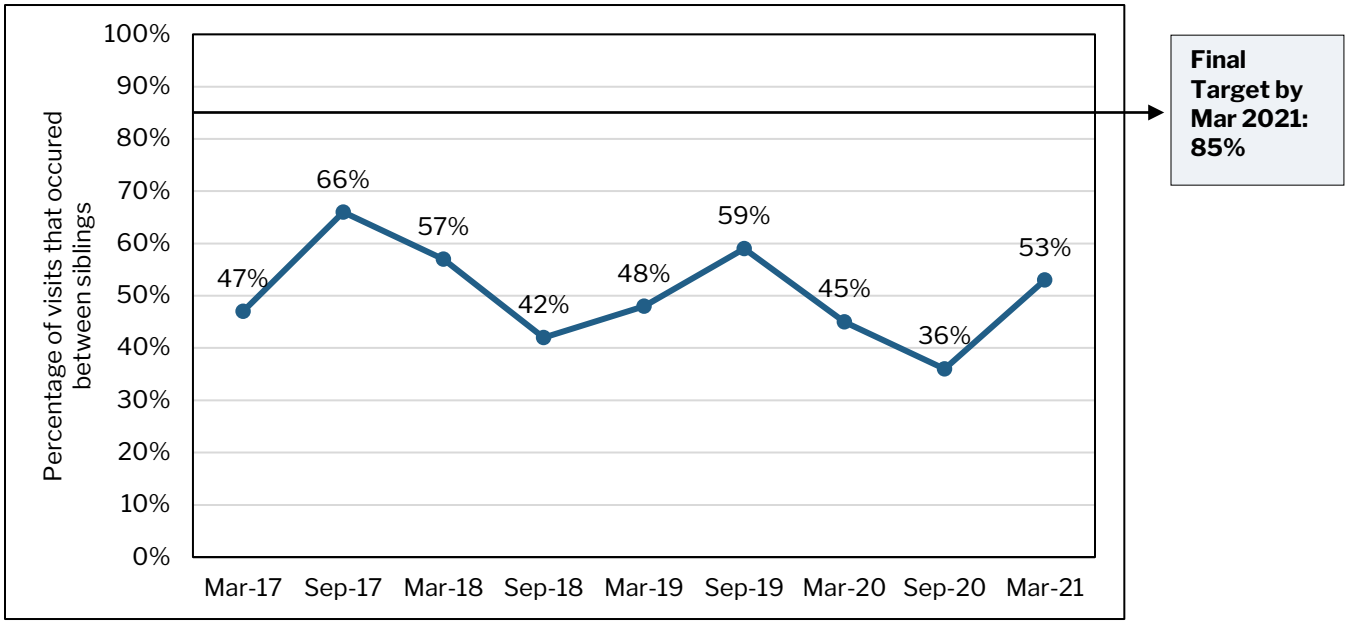
[156] A statistically valid sample of 302 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

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

Of the remaining 289 records, slightly more than half, (152 (53%)) had documentation that a sibling visit had occurred.[158] This is a significant improvement from the prior monitoring period (36% in September 2020) but still falls short of the agreed-upon performance standard. As the threat of the COVID-19 pandemic continues to be mitigated, and as case managers continue to better utilize technology, such as video, for sibling visits, the instances of sibling visits have increased significantly since the prior monitoring period (April to September 2020). This monitoring period also demonstrated higher rates of contact than the monitoring period prior to the pandemic (October 2019 to March 2020), at which point sibling visits took place in 133 (45%) of records.

Of the completed visits, 12 percent (18 of 152) were by video; 89 percent (136 of 152) were in-person; and there was one instance of a voice-only call. For too many children, not visiting with their sibling is a missed opportunity to form and maintain crucial connections during a time of uncertainty. For many children this compounds the losses felt with virtual or hybrid schooling and limited social interactions with peers. The performance does not meet the final target of 85 percent, as shown in Figure 30.

Figure 30: Visits Between Siblings Placed Apart
March 2017 - March 2021



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

[158] The 302 applicable records represent 191 families; records with documentation of a sibling visit represent 84 families.

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.).[159] DSS committed to achieving these targets by March 2021.

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

In addition to the minimum twice monthly, in-person time between children and their parents, DSS has continued to engage frontline staff in training and other messaging about the importance of children having ongoing contact with their parents.

In November 2020, DSS provided guidance to staff for transitioning back to in-person family visits by January 30, 2021, for those families not already visiting in-person. Guidance included a reminder to follow COVID-19 safety guidance of the Center for Disease Control, including but not limited to using personal protective equipment and distancing practices, sanitizing the visitation area, and holding visits in lower-risk settings such as outdoors or in open spaces when feasible. DSS also allowed the child's guardian ad litem to provide their position on in-person visits. If there was disagreement with in-person contact, an alternate contact plan was to be developed. Any parent or caregiver who did not have access to needed technology

[159] 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.

was to be offered access at a DSS office. DSS directed that, at minimum, frequent phone calls between the child and parent should be facilitated.

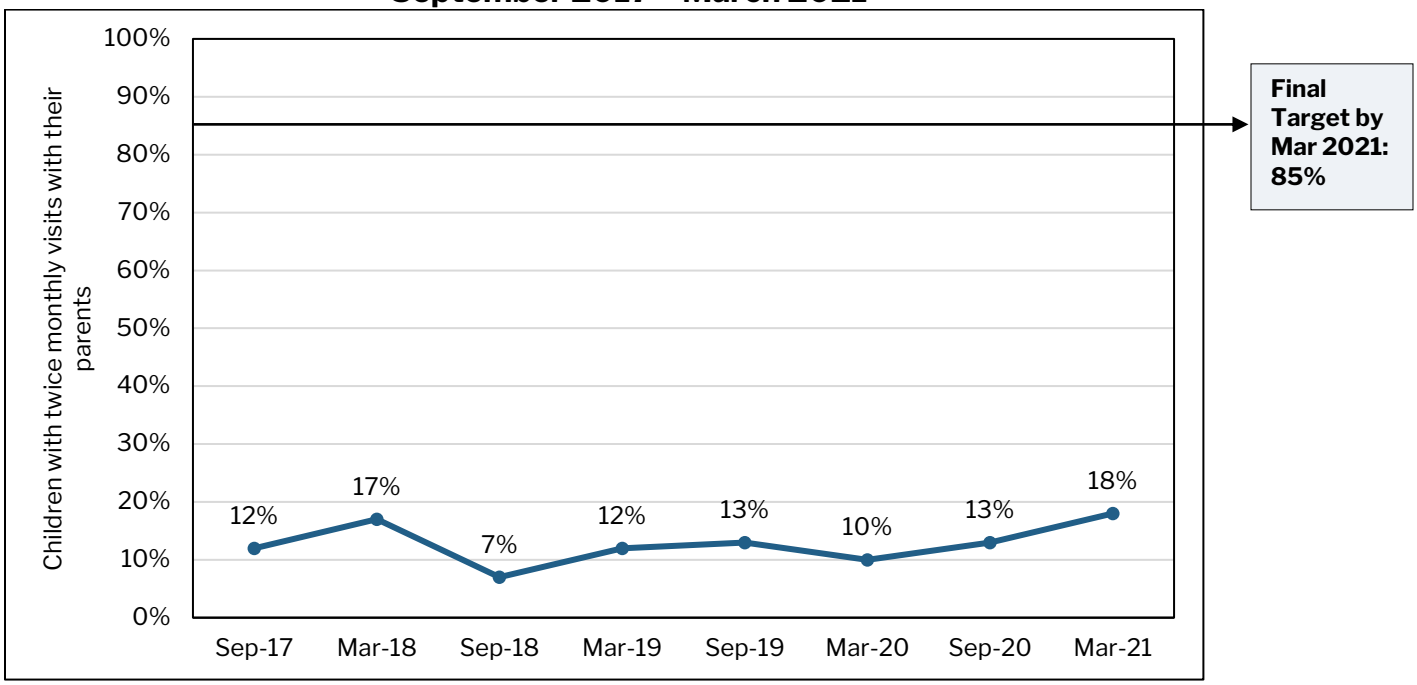
USC CCFS, DSS, and Co-Monitor staff use a structured instrument to collect data on visits between children in foster care and the parent(s) with whom reunification is sought. Reviewers examined a sample of 325 records for documentation of contacts between a child and their parent(s) during March 2021.[160,161]

In 47 of the 325 records, there was documentation of an applicable exception to the requirement of the child visiting with their parent(s) during March 2021.[162] Of the remaining 278 records, 141 (51%) showed no documentation of the child having contact with the parent(s) with whom they are to be reunited, either in person, by video, or by phone; 87 (31%) showed one contact, which is below the standard; 50 (18%) showed two contacts with each parent with whom reunification is sought, which meets the required minimum standard; and no case showed more than two contacts during March 2021.[163]

The final performance target for March 2021 is 85 percent. Figure 31 shows consistently poor performance for at least twice monthly visits between parents and children, ranging from seven to 18 percent since September 2017. This low level of performance for children's contact with their parent(s) continues to be troubling and unacceptable.

[160] As of March 31, 2021, there were 2,099 children who had been in foster care for at least 30 days with a permanency goal of "return to home" or "not yet established." A statistically valid sample of 325 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.
[161] 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.
[162] 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.
[163] Reviewers identified and sought documentation of visits with a second parent for 108 children. However, documentation in CAPSS does not always clarify the reunification resource when parents live apart. This number is likely an overcount of reunification resources.

Figure 31: Children with Twice Monthly Visits with Their Parents September 2017 – March 2021



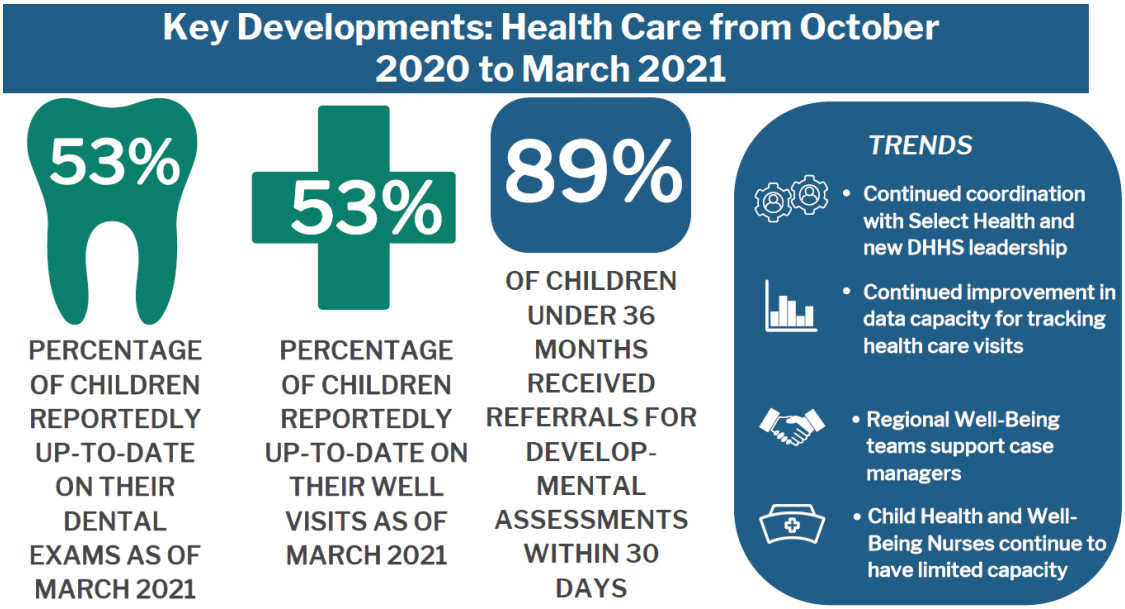
Source: Case Record Review conducted by USC CCFS, DSS, and Co-Monitor staff

IX. Health Care

DSS must provide for the health care of the children in its custody, which requires the ability to quickly identify children's physical and behavioral health needs, provide high quality preventative and acute care, track care delivery, and communicate key health care information to patients and partner agencies. DSS has continued to build on the work its Office of Child Health and Well-Being, and its progress with respect to building internal capacity is notable.

DSS has continued to take steps toward improving the number of children who receive initial and periodic well child visits in a timely manner, both through improved documentation in CAPSS and the coordination between case managers, regional nurses, and the Well-Being teams. Between 50 and 60 percent of children are receiving their initial medical assessments and initial dental examinations within 60 days, as well as their well child visits in accordance with the periodicity schedule. South Carolina has entered a federal affinity group of 12 states seeking to improve health care outcomes in accordance with state requirements, and thus has a goal of increasing performance by 10 percentage points within 12 months. DSS has progressed from relying on delayed six-month data to timely monthly information that it uses for internal management. More detailed data on health care over time can be found in the Performance Data section beginning on page 103.

It continues to be critical that DSS work with its agency and community partners to develop robust, accessible community-based services and supports across the state for children and families. The additional challenges posed by the COVID-19 pandemic have only served to exacerbate this need. It is also critical that DSS continues to work 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, after many months of review and input from the Co-Monitors and Plaintiffs, and the support of health care consultants, DSS obtained Co-Monitor approval for its Health Care Improvement Plan.[164] A Plan addendum (the "Health Care Addendum") was approved by the Co-Monitors on February 25, 2019, establishing commitments by Select Health, the Managed Care Organization (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.[165] 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 making progress on the Health Care Improvement Plan. In collaboration with DHHS, Select Health, and community partners, DSS continued to collect data, define its partnerships, and build capacity among staff.

Data Development

DSS continued to make progress this period in developing systems for collecting, sharing, and analyzing health care data at both the administrative and case levels. This has involved combining retrospective, administrative data from DHHS and Select Health with real-time, reliable case manager documentation. DSS has reported continued progress with respect to the collection of comprehensive information on the provision of follow-up medical and behavioral health care to children.[166]

---

[164] 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

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

[166] FSA IV.K.4.(b)). required that by August 31, 2016, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue." Though initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS has lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into a Joint Agreement on the Immediate Treatment Needs of Class Members, (Dkt. 162) which set out a timeline for specific action steps DSS would take to comply with, and ultimately measure performance with respect to, a new set of standards that would replace the initial FSA IV.K.4(b) requirements. While DSS has moved forward in establishing systems for the collection of data on the delivery of care necessary to address identified treatment needs, it does not yet have the capability to produce data in accordance with the specific obligations outlined therein. DSS reports that it is taking steps to improve the reliability and availability of these data in coordination with Select Health, foster parents, and providers, and is in the process of developing a proposed case review process to track the delivery of health care services. Additional updates will be provided in the next monitoring report.

Internal Capacity Building

The Child Health and Well-Being nurse infrastructure and regional Well-Being Teams now operate throughout the state. The teams are overseen by Regional Well-Being Managers, and staffed by Regional Nurses, Regional Clinical Specialists, and other members – including a Therapeutic Services Coordinator, a Community Liaison 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 serving in a supportive role with case managers in assessing and managing the well-being needs of children in foster care. Frontline staff have continued to report that the Well-Being Teams have been very useful supports in terms of identifying services for and answering medical questions about children and youth.

Given limited staff resources, Regional Nurses have largely served 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 are adequately addressed. DSS has acknowledged the need for additional nurses and more support staff. Nursing staff should have the time and capacity to provide clinical support on individual cases to ensure that all children, including those with complex needs or chronic medical issues, are getting consistent, high quality care. Ideally, support staff would also serve as resources for biological and foster families, providers, and DSS case managers, and could help arrange physical and behavioral health preventative, routine, and follow-up care. DSS requested, but did not receive, funding it requested for administrative staff support for its nurses in the FY2021-2022 budget.

Defining a Managed Care Organization Partnership

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

DSS reports that the infrastructure put in place with the Health Care Improvement Plan and Addendum has remained essential during the COVID-19 pandemic. During a time that has demanded constant, real-time assessment and modification of process such as prior approval requirements, payment guidelines, and provider accessibility, DSS has continued to engage Select Health as a partner in devising real-time solutions as health care challenges have arisen.

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 for intensive review. There is still significant work to be done in clarifying 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. This has been a priority for some time. Given the significant budgetary constraints within which DSS currently struggles and the resources expended to Select Health for the management of children's health care, this work is urgent.

Coordination and Collaboration with DHHS

The announcement in January 2021 – on the heels of a newly forged, productive partnership between DSS and DHHS – that DHHS's current leadership team would be stepping down from their roles was a setback to DSS. However, DSS has been building a relationship 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 new leadership team sets priorities, and that the agencies continue to pursue ways of maximizing federal Medicaid funding to meet the needs of children in foster care throughout the state.

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 VII. *Placements*) is the need for an array of robust, community-based services, including intensive in-home supports, so that children will no longer be subject to frequent moves to higher level placement settings to access services. At the time of Health Care Plan development, DSS hoped to assess and build out this capacity in coordination with both Select Health and DHHS. There was much enthusiasm about

the vast quantity of data that Select Health and DHHS collect through their gaps-in-care analyses and provider "heat maps," but this work has not yet come to fruition. DSS reports that network adequacy will be the focus of the quarterly meeting between DSS, DHHS, and Select Health in Fall 2021.

The Co-Monitors continue to believe that this is a key area of work, and one that must be done with expediency and in close partnership with DHHS, Select Health, the Department of Mental Health, and community partners throughout the state. As discussed in Section VII. *Placements* of this report, though DSS has committed to seeking resources to expand community-based services and supports for family placements, particularly for children moved out of congregate care settings, the agency did not receive the funding requested of the General Assembly in the FY2021-2022 budget. This reality makes the work ahead with DHHS to pursue funding for these supports through Medicaid even more pressing.

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.

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

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

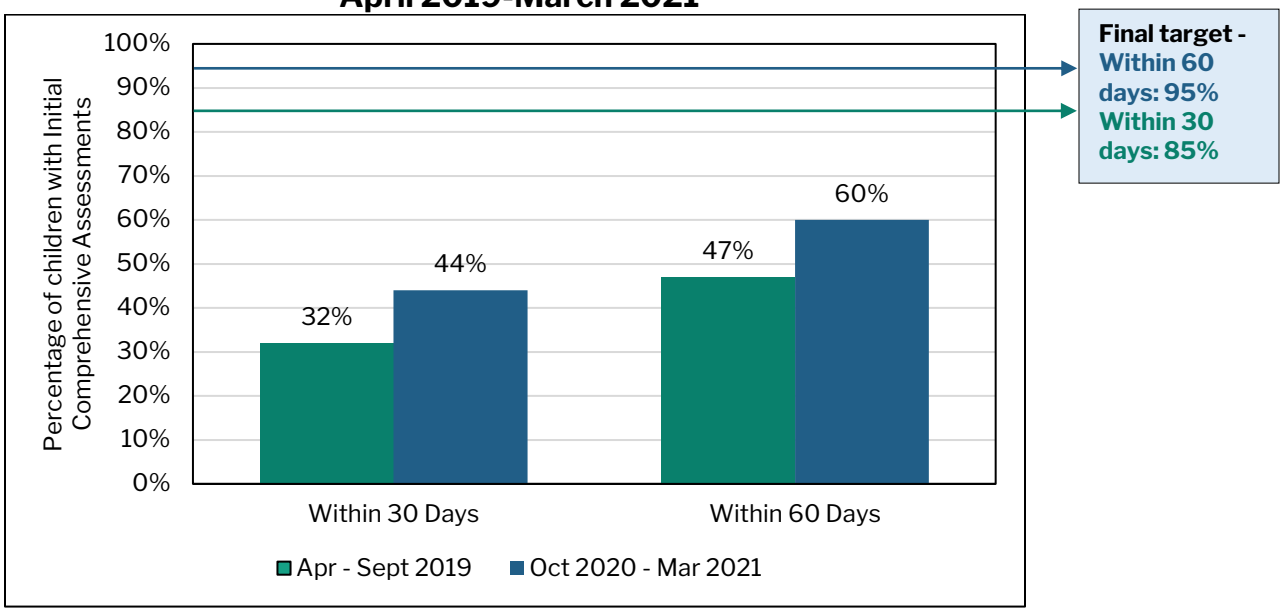
performed for the purpose of "reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and behavioral health conditions requiring immediate attention; and developing an "individualized treatment plan."[167]

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*."[168] DSS committed to achieving these targets by March 2021, though 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 44 percent (467 of 1,060) of children who entered care between October 2020 and March 2021 and were in care for at least 30 days received an initial comprehensive medical assessment within 30 days, and 60 percent (465 of 779) 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 (see Figure 32).[169] This performance is below the March 2021 final targets of 85 percent, and 95 percent, respectively, though improved from the prior monitoring period from which these data were collected.

[167] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003)), p. 22.
[168] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[169] While the Co-Monitors have not independently validated these data, Co-Monitor staff have reviewed the data for internal consistency and have interviewed DSS nursing and data staff to verify the process for collecting and reporting these data.

Figure 32: Initial Comprehensive Assessments within 30 and 60 Days April 2019-March 2021[170]



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.

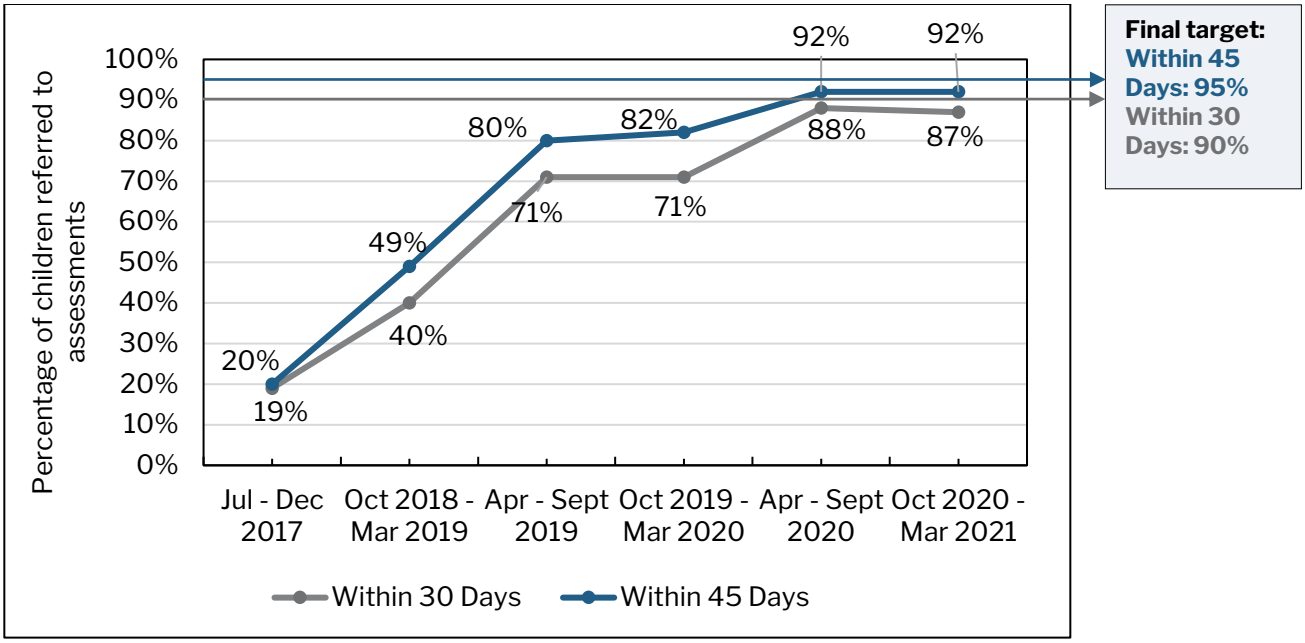
DSS reports that 87 percent (264 of 305) of children under 36 months of age who entered care between October 2020 and March 2021 were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days; and 92 percent (266 of 288) of children were referred within 45 days. Current performance is within three percentage points of the final targets for this measure (see Figure 33)[171].

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*.

[170] As mentioned above, in the prior two monitoring periods, DSS produced internal management data for up to date health care visits rather than the approved methodology for Initial Comprehensive Medical Assessments, which explains the missing data between October 2019 and September 2020.
[171] While the Co-Monitors have not independently validated these data, Co-Monitor staff have reviewed the data for internal consistency and have interviewed DSS nursing and data staff to verify the process for collecting and reporting these data.

As reported previously, DSS is working to improve its system for tracking completion of these assessments and any recommended follow-up care.

Figure 33: Referrals for Developmental Assessments within 30 and 45 Days July 2017 – March 2021



Source: CAPSS data provided by DSS

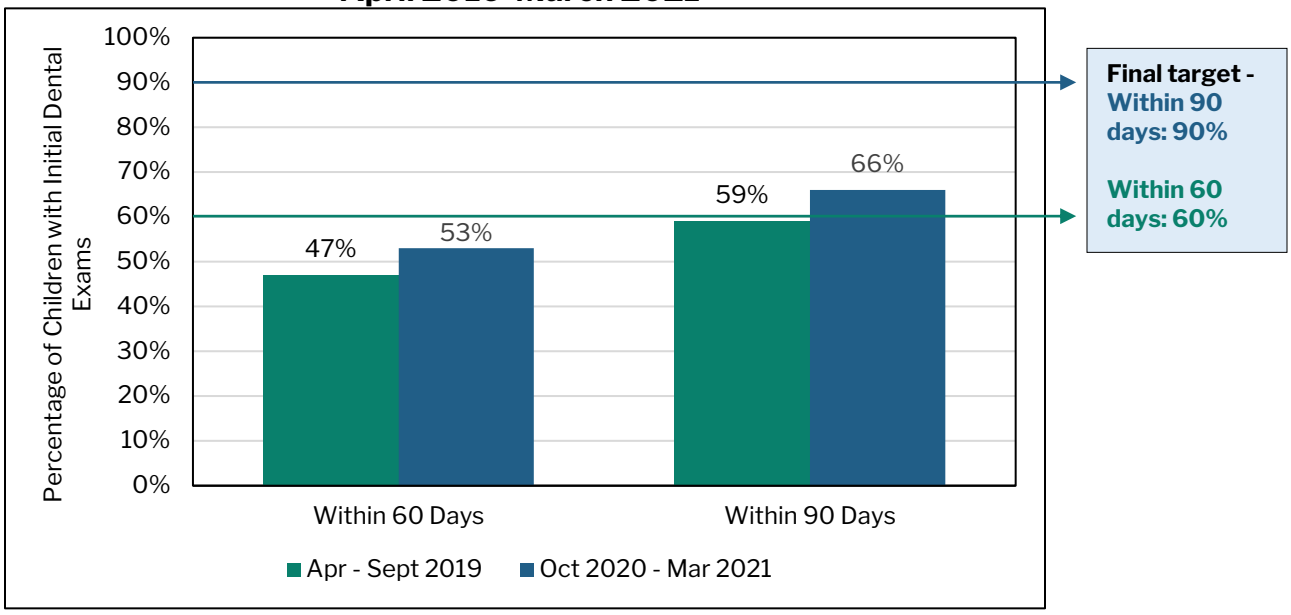
Initial Dental Examinations

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, though the baseline performance data that was used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those since approved by the Co-Monitors.

DSS reports that 53 percent (303 of 577) of children ages two years and over who entered care between October 2020 and March 2021 had a dental exam within 60

days, and that 66 percent (282 of 427) had a dental exam within 90 days.[172,173] This performance falls short of the final targets, as shown in Figure 34.

Figure 34: Initial Dental Exams within 60 and 90 Days
April 2019-March 2021[174]



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 are to be performed for the purpose of promoting "overall wellness by fostering healthy growth and development," as well as "regularly assess[ing] for success of foster care placement," and "identify[ing] significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings."[175] 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*

[172] This excludes children who had a visit within six months of entering care.
[173] While the Co-Monitors have not independently validated these data, Co-Monitor staff have reviewed the data for internal consistency and have interviewed DSS nursing and data staff to verify the process for collecting and reporting these data.
[174] As mentioned above, in the prior two monitoring periods, DSS produced internal management data for up to date health care visits rather than the approved methodology for Initial Dental Exams, which explains the missing data between October 2019 and September 2020.
[175] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.

more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines;[176] *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."*[177] DSS committed to achieving these targets by March 2021.

As explained above, given the methodologies being used internally at DSS for health care management, as well as the limitations for DHHS data extraction during the COVID-19 pandemic, the Co-Monitors have been in discussion with DSS about modifying the approved methodologies for periodic preventative well-child visits performance by using data collected by DSS nurses.[178] Regional Nurses reviewed CAPSS records for each child in foster care and estimated the date for the next required well-child visit based on the child's age and most recent visit. For validation purposes, nurses collected documentation of visits from providers and pulled data from DHHS and/or Select Health to determine when the most recent visit occurred.

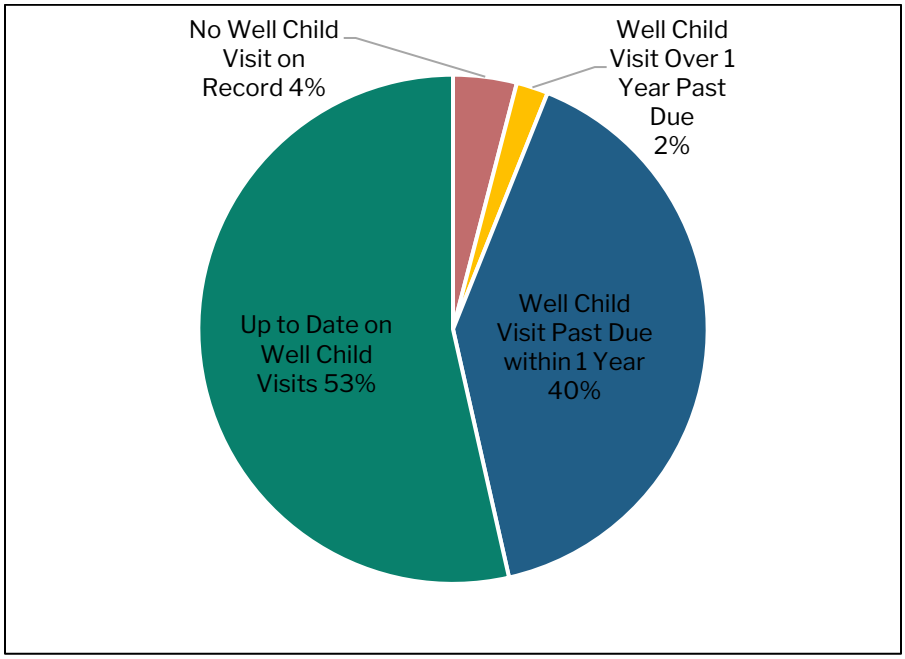
DSS reported that of all children under 18 years of age who were in foster care on April 12, 2021, for at least 30 days, 53 percent (1,956 of 3,714) were up to date on their well-child visits. Of the remaining children, 135 (4%) did not have a well-child visit indicated in the DSS record or in DHHS and Select Health data systems. This is a slight reduction from the last monitoring period, in which 60 percent of children were up to date on their well-child visits. As depicted in Figure 35, 40 percent (1,482 of 3,714) of children were past due on their well-child visit according to the periodicity schedule, but were within 12 months of the estimated follow-up visit date. DSS reports that their methodology accounts for reviewing past required visits, not only the most recent required visit.

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

[177] 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).

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

Figure 35: Well-Child Visits Recorded as of April 12, 2021 N=3,714



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

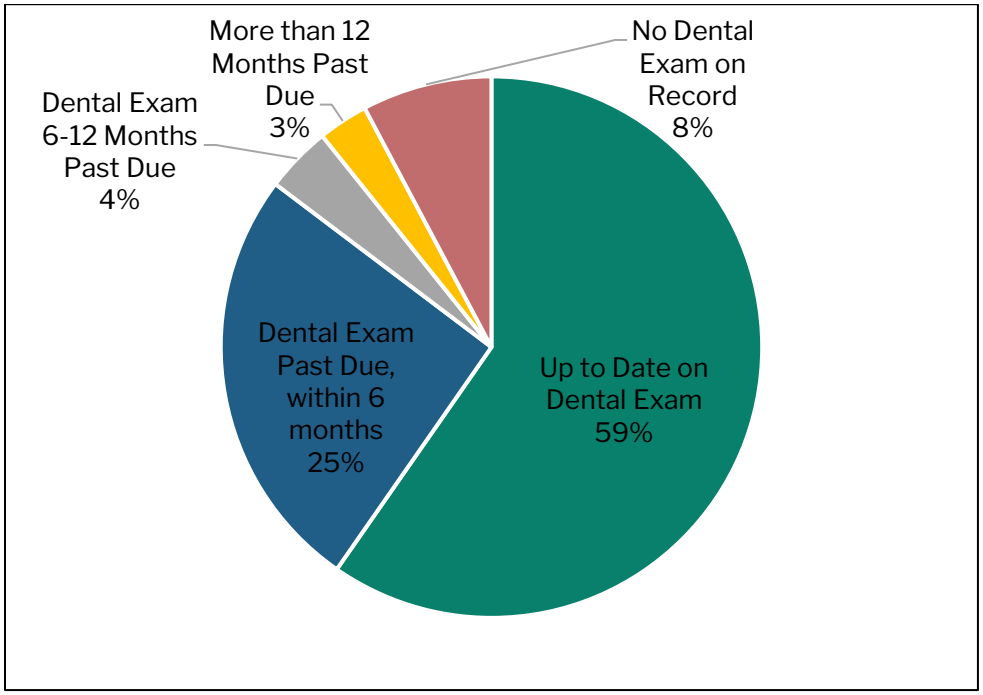
Periodic Dental Examinations

In the DSS Health Care Outcomes, DSS committed that *'At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care; at least 90% will receive a dental examination within 90 days of entering care.*" DSS also committed that "*At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually; at least 90% will receive a dental examination annually."*

As explained above, given the methodologies now used internally at DSS for dental care management, as well as the delays and limitations for DHHS data extraction during the COVID-19 pandemic, the Co-Monitors agreed to report DSS's internal data for this measure this monitoring period. DSS reports that of all children between two and 17 years old who were in care on March 31, 2021, for at least 30 days, 59 percent (1,976 of 3,342) were up to date on their dental examination. An additional 25 percent (848 of 3,342) were overdue, but within six months of their estimated dental follow-up date. As shown in Figure 36, seven percent of children (230 of 3,342) were more

than six months past their estimated dental follow-up date, and eight percent of children (257 of 3,342) had no dental examination on record.[179] This is approximately the same level of performance as the prior monitoring period.

Figure 36: Dental Examinations Recorded as of March 31, 2021 N=3,342



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

[179] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than those approved in the Health Care Addendum. These data are comparable to that reported in the prior monitoring period. DSS and the Co-Monitors are in discussion about how these data relate to the FSA target for periodic well-child visits.

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ADR: Accountability, Data, and Research
APS: Adult Protective Services
CAC: Child Advocacy Center
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CARES: Coronavirus Aid, Relief, and Economic Security Act
CFT: Child and Family Teaming
CPA: Child Placing Agency
CPS: Child Protective Services
CQI: Continuous Quality Improvement
CY: Calendar Year
DHHS: Department of Health and Human Services
DJJ: Department of Juvenile Justice
DMH: Department of Mental Health
DSS: Department of Social Services
EPM: Emergency Placement Meeting
FFCRA: Families First Coronavirus Response Act
FFPSA: Family First Prevention Services Act
FSA: Final Settlement Agreement
FTE: Full-Time Equivalent
GPS: Guiding Principles and Standards Case Practice Model
ICPC: Interstate Compact on the Placement of Children
IFCCS: Intensive Foster Care and Clinical Services
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
PIP: Performance Improvement Plan
SC: South Carolina
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. However, the Co-Monitors engaged in video interviews with case managers and supervisors from three counties, foster parents, and other community partners. Thematic information gathered from these sessions will be shared with DSS leadership for system improvement purposes.

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

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

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

- Review of all OHAN investigation case records in CAPSS involving Class Members as an alleged victim accepted in March 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 March 31, 2021, to assess whether

dictation/documentation of a case manager's face-to-face contact with a child in March 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 March 31, 2021 and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in March 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 March 31, 2021, to assess whether the child had visited with the parent(s) with whom reunification was sought during March 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 October 2020 to March 2021 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office overnight from October 2020 to March 2021 (FSA IV.D.3.); and

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

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

Table: Summary Performance on Settlement Agreement Requirements

Final Settlement Agreement (FSA) Requirements	Baseline Performance	October 2019 – March 2020 Performance	April - September 2020 Performance	October 2020 - March 2021 Performance
Workload Limits for Foster Care: 1a. At least 90% of caseworkers[180] shall have a workload within the applicable Workload Limit. ***Final target by March 2021: 90% within required limit*** 1b. No caseworker shall have more than 125% of the applicable Workload Limit. ***Final target by March 2021: No more than 0% have more than 125% of the required limit*** (FSA IV.A.2.(b)&(c))	OHAN case managers: 0% within required limit (September 2017) 100% had more than 125% of the limit (September 2017)	OHAN case managers: 13% within the required limit Monthly range within the required limit: 0 - 13% 87% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 86 - 100%	OHAN case managers: 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 case managers:[185] 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%

[180] 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.
[185] 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: October 9, 2020; November 18, 2020; December 29, 2020; January 5, 2021; February 11, 2021; March 31, 2021.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Approved Workload Limits:[181,182] • *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoption worker* – 15 children[183] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training	Foster Care case managers: 28% within the required limit (September 2017) 59% had more than 125% of the limit (September 2017). IFCCS case managers:[184] 10% within the required limit (September 2017) 77% had more than 125% of the limit (September 2017)	Foster Care case managers: 49% within the required limit January – March 2020 range within the required limit: 47 - 49% 35% had more than 125% of the limit. January – March 2020 range with caseloads more than 125% of the limit: 34 - 36%	Foster Care case managers: 59% within 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%	Foster Care case managers: 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%

[181] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[182] 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.
[183] 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.
[184] 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
	Adoption case managers: 23% within the required limit (September 2017) 62% had more than 125% of limit (September 2017).	Adoption case managers: 25% within the required limit January – March 2020 range within the required limit: 24 - 25% 51% had more than 125% of the limit. January – March 2020 range with caseloads more than 125% of the limit: 51 - 64%	Adoption case managers: 15% within the required limit 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%	Adoption case managers: 19% within the required limit 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%
Workload Limits for Foster Care: 2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. ***Final target by September 2020: 90% within required limit***	OHAN Supervisors: 100% within the required limit (March 2018) None were more than 125% of the limit (March 2018)	OHAN Supervisors: 0% within the required limit Monthly range within the required limit: 0 – 67% 50% had more than 125% of the limit.	OHAN Supervisors: 0% within the required limit each month this period 50% had more than 125% of the limit.	OHAN Supervisors: 100% within the required limit each month this period 0% had more than 125% of the limit.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
2b. No supervisor shall have more than 125% of the applicable Workload Limit. ***Final Target by September 2020: No more than 0% have more than 125% of the required limit*** (FSA IV.A.2.(b)&(c)) <u>Approved Supervisor Limits:</u> • *OHAN supervisors* – 6 investigators • *Foster Care*, *IFCCS*,[186] and *Adoption* supervisors – 5 case managers	<u>Foster Care Supervisors:</u> 42% within the required limit (March 2018) 36% had more than 125% of the limit (March 2018)	Monthly range supervising more than 125% of the limit: 0 - 50% <u>Foster Care Supervisors</u>:[188] 32% within the required limit 41% had more than 125% of the limit.	Monthly range supervising more than 125% of the limit: 0 - 50% <u>Foster Care Supervisors:</u> 79% within the required limit Monthly range within the required limit: 76 - 82% 5% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 5 - 15%	<u>Foster Care Supervisors:</u> 86% within the required limit 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%

[186] 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.
[188] DSS provided for the first time this period details on supervisors carrying cases in addition to supervising case carrying case managers during February and March 2020. Co-Monitor staff analyzed these data for March 2020, and are including performance for only this month.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
	Adoption Supervisors: 38% within the required limit (March 2018) 19% had more than 125% of the limit (March 2018) IFCCS Supervisors:[187] 57% within required limit (March 2018) 29% had more than 125% of the limit (March 2018)	Adoption Supervisors: 45% within the required limit Monthly range within the required limit: 44 - 50% 34% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 25 - 37%	Adoption Supervisors: 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%	Adoption Supervisors: 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%

[187] 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
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)	35% of cases reviewed had documentation of all agreed-upon elements of a visit.	30% of cases reviewed had documentation of all agreed-upon elements of a visit.	38% of cases reviewed had documentation of all agreed-upon elements of a visit.[189,190]
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	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)	35% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence.[191,192] (March 2020)	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. (September 2020)	34% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's

[189] 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 March 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.
[190] A sample of 345 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed.
[191] DSS, USC CCFS, and the Co-Monitors reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2020. Reviewers assessed documentation for the elements which define a visit.
[192] A sample of 348 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
taken place in the residence of the child. (FSA IV.B.3.)	92% of face-to-face contacts took place in the child's residence. (September 2019)	83% of face-to-face contacts took place while the child was in their own residence.	84% of face-to-face contacts took place while the child was in their own residence or placement.	residence.[193,194] (March 2021) 79% 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. (FSA IV.C.2.)	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between October 2019 and March 2020, 92% of screening decisions not to investigate were determined to be appropriate.[195]	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.

[193] 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 March 2021. Reviewers assessed documentation for the elements which define a visit.
[194] A sample of 348 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed.
[195] Performance data for this measure were previously reported on a monthly basis. Due to the small number of applicable screening decisions each month, for the April through September 2020 monitoring period, the Co-Monitors have changed the methodology in reporting performance for this measure. Instead of calculating performance based upon screening decisions made in each individual month, performance will be determined by examining all screening decisions made during the monitoring period. For comparison purposes, data for prior monitoring periods were recalculated using the updated methodology and are provided within this Table.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Investigations - Case Decisions: 6. At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. (FSA IV.C.3.) ***Final target by March 2021: 95% of decisions deemed appropriate***	47% of applicable investigation decisions to unfound were determined to be appropriate (March 2017).	55% (28) of 51 applicable investigation decisions to unfound were determined to be appropriate.	66% (39) of 59 applicable investigation decisions to unfound were determined to be appropriate.	74% (37) 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)	74% (40) of 54 applicable investigations were timely initiated.	78% (52) of 67 applicable investigations were timely initiated.	87% (48) of 55 applicable investigations were timely initiated.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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.[196] (FSA IV.C.4.((a)&(b)) ***Final target by March 2021: 95% timely initiated***				

[196] 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.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Investigations - Contact with Core Witnesses: 9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c)) ***Final target by March 2021: 90% contact with all core witnesses***	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	30% (16) of 54 applicable investigations included contact with all necessary core witnesses.	27% (18) of 67 applicable investigations included contact with all necessary core witnesses.	67% (37) of 55 applicable investigations included contact with all necessary core witnesses.[197]

[197] Completion of contact with core witnesses by type, as applicable, for the 55 investigations reviewed is as follows: alleged victim child(ren), 93%; reporter, 84%; alleged perpetrator(s), 96%; law enforcement, 71%; alleged victim child(ren)'s case manager, 84%; other adults in home or facility, 87%; other children in home or facility, 79%; and additional core witnesses as identified for the investigation, 80%.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Investigations - Timely Completion: 10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[198] (FSA IV.C.4.(d)) ***Final target by March 2021: 95% closure in 45 days***	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	93% of investigations reviewed were appropriately closed within 45 days.	97% of investigations reviewed were appropriately closed within 45 days.	96% of investigations reviewed were appropriately closed within 45 days. [199]

[198] 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.

[199] Reviewers determined that 1 of the investigations that was closed within 45 days was closed prematurely in an effort to meet the 45-day requirement, which is not considered compliant under the FSA. In this investigation, the majority of core witness contacts did not occur, and no follow up was completed by the investigator as directed in supervisory meetings. The investigation was closed on the 45th day after intake. 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Investigations - Timely Completion: 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[200] (FSA IV.C.4.(e)) ***Final target by March 2021: 95% closure in 60 days***	96% of investigations reviewed were closed within 60 days. (March 2017)	98% of investigations reviewed were closed within 60 days.	99% of investigations reviewed were closed within 60 days.	98% of investigations reviewed were closed within 60 days.

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Investigations - Timely Completion: 10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days.[201] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	98% of investigations reviewed were closed within 90 days.	99% 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 care setting except with approved exceptions. (FSA IV.D.2.)	Baseline data for this measure are not available.	The circumstances of all but 1 child met an agreed upon exception. A total of 37 Class Members ages six and under were placed in congregate care.	The circumstances of all but 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.[202] A total of 32 Class Members ages six and under were placed in congregate care.[203]

[201] Ibid.
[202] In validating data for this measure, the Co-Monitors identified 3 situations that did not meet an agreed-upon exception, all of which described sibling groups who remained at group homes beyond 90 days without documented efforts to move the children to a family-based placement. While the Co-Monitors do not want sibling groups to be separated in order to meet the terms of this measure, it is essential that efforts be made to secure less restrictive placement that can accommodate the siblings so they reside together in foster care.
[203] This includes 10 children residing in a facility or group care with their mothers, and 22 who were part of large sibling groups for whom DSS reported a single, family-based placement could not be located.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there were 5 overnight placements in a DSS office.	DSS reports there was 1 overnight placement in a hotel, but it was for the purpose of safely quarantining a child who had tested positive for COVID-19.	DSS reports there were 5 overnight placements in a DSS office.
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.) ***Final target by March 2021: 86% family-based settings***	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	82% of children in foster care were placed outside of a congregate care setting.	84% of children in foster care were placed outside of a congregate care setting.	85% of children in foster care were placed outside of a congregate care setting.[204]

[204] This does not include 21 children who were hospitalized (8), in a Department of Disabilities and Special Needs (DDSN) training home (1), or in a correctional/juvenile justice facility (12).

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Congregate Care Placements - Children Ages 12 and Under:*</u> 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.) ***Final target by March 2021: 98% family-based settings***	92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018)	96%of children ages 12 and under in foster care were placed outside of a congregate care setting.	97% of children ages 12 and under in foster care were placed outside of a congregate care setting.	98%[205] of children ages 12 and under in foster care were placed outside of a congregate care setting.[206,207]

[205] This includes 9 children ages 6 and under who resided in a congregate care placement on the last day of the monitoring period pursuant to a valid exception.
[206] Exceptions have been approved, though not applied during this monitoring period for children ages 7 to 12; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in future monitoring periods.
[207] This does not include 2 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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.[208]
Emergency or Temporary Placements for More than Seven Days:	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[209]

[208] DSS recently began tracking the use of emergency placements. DSS continues to provide the Co-Monitors with data regarding emergency "incentive" payments made to providers to accept placement of a child overnight. In Section VII. *Placements*, DSS reports 31 children were placed with foster home providers and 52 children were placed with group home providers with an enhanced rate. Neither DSS nor the Co-Monitors believe these enhanced rate payment data are an accurate proxy for all emergency placements and the actual number is likely higher. The Co-Monitors will report data for this measure when it is available.

[209] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. (FSA IV.E.5.) ***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).	Data for this measure are produced on an annual basis.	4.17 moves per 1,000 days (October 1, 2019 to September 30, 2020).[210]	Data for this measure are produced on an annual basis.

[210] Specifically, there were a total of 6,566 moves across 1,572,980 days.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Sibling Placements:*</u> 18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.2.&3.) ***Final target by March 2021: 85% placed with at least one sibling***	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	65% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	73% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	75% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.[211]
<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)	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry (March 2018).	38% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	46% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	48% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[212]

[211] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for exception review and approval in future monitoring periods.
[212] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
days of their siblings shall be placed with all their siblings, unless an exception applies. ***Final target by March 2021: 80% placed with all siblings***				
<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.	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.[213]

[213] As discussed in Section VII. *Placements,* DSS is in the process of developing a reliable real-time system for tracking youth involved with both the juvenile justice and child welfare systems in CAPSS. DSS reported three violations of this provision during the monitoring period. 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
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.)				
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. [214]

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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. [215]

[215] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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. [216]

[216] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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. [217]

[217] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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.) ***Final target by March 2021: 85% visits with siblings***	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	45% of all required visits between siblings occurred for those who were not placed together.	36% of all required visits between siblings occurred for those who were not placed together.	53% of all required visits between siblings occurred for those who were not placed together.[218]
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	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	10% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	13% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	18% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. [219]

[218] 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.
[219] 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
reunification is sought, unless an exception applies. (FSA IV.J.3.) ***Final target by March 2021: 85% parent visits***				
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.[220]

[220] 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**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Health Care - Initial Medical Screens*</u> 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.***[221]	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.[222]
<u>*Health Care - Initial Comprehensive Assessments*</u> 28. At least 85% of Class Members will receive a comprehensive medical	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	44% of children received a comprehensive medical assessment within 30 days.[223]

[221] 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.

[222] 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.

[223] While the Co-Monitors have not independently validated these data, Co-Monitor staff have reviewed the data for internal consistency and have interviewed DSS nursing and data staff to verify the process for collecting and reporting these data.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
assessment within 30 days of entering care. ***Final target by March 2021: 85%***				
<u>*Health Care - Initial Comprehensive Assessments*</u> 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care. ***Final target by March 2021: 95%***	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	60% of children received a comprehensive medical assessment within 60 days.[224]

[224] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Health Care - Initial Mental Health Assessments 30. At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[225]

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

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Health Care - Initial Mental Health Assessments 31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available. [226]

[226] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 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. ***Final target by March 2021: 90% referred within 30 days***	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	71% of children under 36 months of age were referred within 30 days.	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.
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. ***Final target by March 2021: 95% referred within 45 days***	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	82% of children under 36 months of age were referred within 45 days.	92% of children under 36 months of age were referred within 45 days.	92% of children under 36 months of age were referred within 45 days.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Health Care – Initial Dental Examinations 34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care. ***Final target by September 2020: 60%***	35% of children age one and above received a dental exam within 60 days. (March 2018)	See Section IX. *Health Care*	See Section IX. *Health Care*	53% of children ages two and above received a dental exam within 60 days.[227]

[227] While the Co-Monitors have not independently validated these data, Co-Monitor staff have reviewed the data for internal consistency and have interviewed DSS nursing and data staff to verify the process for collecting and reporting these data.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Health Care – Initial Dental Examinations*</u> 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. ***Final target by March 2021: 90%***	48% of applicable children age one and above received a dental exam within 90 days. (March 2018)	See Section IX. *Health Care*	See Section IX. *Health Care*	66% of applicable children ages two and above received a dental exam within 90 days.[228]
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 36. At least 90% of Class Members under the age of six	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly.[229] (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[230]

[228] Ibid.
[229] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS agreed to utilize 2 methodologies to capture the occurrence of required monthly medical visits for children under the age of 6 months: the first applies to children under the age of 6 months who are *in care on the last day of the reporting period*, and the second to children under the age of 6 months *entering care* in a given period.
[230] As discussed in Section IX. *Health Care*, lags in data collection, production, and analysis related to the COVID-19 pandemic, and internal improvements in mechanisms for the collection of health care data, resulted in a decision to utilize data used for internal management purposes rather than the approved methodology. As a result, data do not directly align with FSA measure.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
months in care for one month or more will receive a periodic preventative visit monthly. ***Final target by March 2021: 90%***	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.			
<u>*Health Care - Periodic Preventative Care (Well visits)*</u> 37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines. ***Final target by March 2021: 90%***	38% of children between the ages of six and 36 months received periodic preventative visits. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[231]

[231] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually. ***Final target by March 2021: 98%***	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[232]
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually. ***Final target by March 2021: 90%***	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[233]

[232] Ibid.
[233] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually. ***Final target by March 2021: 98%***	58% of children ages three years and older received an annual preventative visit. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[234]
<u>*Health Care – Periodic Dental Care*</u> 41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.	54% of children ages two years or older received a dental visit semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[235]

[234] Ibid.
[235] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
<u>*Health Care – Periodic Dental Care*</u> 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually. ***Final target by March 2021: 90%***	81% of children ages two years or older received an annual dental examination. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*[236]
<u>*Health Care - Follow-Up Care*</u> 43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.	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.

[236] Ibid.

Table: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**	**October 2020 - March 2021 Performance**
Dates to reach final target and interim benchmarks to be added once approved.[237]				

[237] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019. Due to data limitations and priorities set for Plan implementation, DSS has not yet been able to propose these benchmarks. Benchmarks will be set once there is a reliable mechanism in place for measuring baseline performance in this area.

DSS SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

CHILD WELFARE SERVICES
2020 WORKFORCE REPORT

Child Welfare Services Data - January 1, 2020 through December 31, 2020

WORKFORCE

1,749 Total current Child Welfare Services (CWS) front-line workforce, including CWS Case Manager Assistants, CWS Case Managers, CWS Case Manager Supervisors, and OHAN Investigators and Investigative Supervisors

545 Number of CWS front-line Adoptions Case Managers, Foster Care Case Manager Assistants, Case Managers, and Case Manager Supervisors, and OHAN Investigators and investigative Supervisors

The majority of the front-line Foster Care Case Managers, Adoptions Case Managers, and OHAN Investigators are Women - 91%.

- Average age – 35 years old.
- Women in these positions earn an average $36,286 annually.
- 31.5% describe themselves as Married.
- 66% describe themselves as Black or African-American.
- 31% describe themselves as White.

Accordingly, Men make up 9% of the Foster Care Case Managers, Adoptions Case Managers, and OHAN Investigators.

- Average age – 38 years old.
- Men in these positions earn an average $36,428 annually.
- 33.5% describe themselves as Married.
- 58.8% describe themselves as Black or African-American.
- 39% describe themselves as White.

ORGANIZATIONAL UNIT	(Multiple Items)					
POSITION VACANT?	N					
GENDER	CLASS CODE	INTERNAL POSITION TITLE	POSNR	Count of PERNR	Average of AGE	Average of ANNUAL SALARY
Female				497.00	34.50	$36,181.96
	AH35			12.00	37.42	$38,824.08
		OHAN INVESTIGATOR		12.00	37.42	$38,824.08
	AH40			3.00	37.33	$42,134.33
		OHAN INVESTIGATIVE SUPERVISOR		3.00	37.33	$42,134.33
	GA30			14.00	34.57	$23,109.71
		CWS CASE MANAGER ASSISTANT FC		14.00	34.57	$23,109.71
	GA40			357.00	32.20	$35,534.48
		CWS CASE MANAGER AD		99.00	35.10	$35,523.29
		CWS CASE MANAGER FC		258.00	31.09	$35,538.77
	GA50			111.00	41.49	$39,466.66
		CWS CASE MANAGER AD		4.00	44.25	$39,547.75
		CWS CASE MANAGER FC		34.00	43.26	$37,552.06
		CWS CASE MANAGER SUPERVISOR AD		19.00	42.89	$40,094.95
		CWS CASE MANAGER SUPERVISOR FC		54.00	39.67	$40,445.07
Male				48.00	38.60	$36,428.13
	AH35			3.00	44.67	$37,703.00
		OHAN INVESTIGATOR		3.00	44.67	$37,703.00
	GA30			1.00	67.00	$22,625.00
		CWS CASE MANAGER ASSISTANT FC		1.00	67.00	$22,625.00
	GA40			33.00	34.24	$35,692.27
		CWS CASE MANAGER AD		4.00	44.75	$36,818.75
		CWS CASE MANAGER FC		29.00	32.79	$35,536.90
	GA50			11.00	47.45	$39,542.82
		CWS CASE MANAGER FC		5.00	50.80	$36,844.00
		CWS CASE MANAGER SUPERVISOR FC		6.00	44.67	$41,791.83
Grand Total				545.00	34.86	$36,203.64

VACANCIES

272 Total number of vacant FTE CWS front-line case manager and supervisor positions, and OHAN Investigator positions as of December 31, 2020

98 Number of vacant Foster Care Case Manager Assistants, Foster Care and Adoptions Case Managers and Case Manager Supervisors, and OHAN Investigators

ORGANIZATIONAL UNIT	(Multiple Items)
POSITION VACANT?	Y
Row Labels	Count of POSNR
AH35	2.00
OHAN INVESTIGATOR	2.00
GA30	4.00
CWS CASE MANAGER ASSISTANT FC	4.00
GA40	83.00
CWS CASE MANAGER AD	22.00
CWS CASE MANAGER FC	61.00
GA50	9.00
CWS CASE MANAGER FC	3.00
CWS CASE MANAGER SUPERVISOR AD	1.00
CWS CASE MANAGER SUPERVISOR FC	5.00
Grand Total	98.00

HIRES

486 Total number of front-line CWS positions filled in 2020, including CWS Case Manager Assistants, CWS Case Managers, CWS Case Manager Supervisors, and OHAN Investigators

178 Number of CWS Foster Care Case Manager Assistants, and Adoptions Case Managers, Case Manager Supervisors, and OHAN Investigators hired in 2020.

CWS CASE MANAGER HIRES	PERNR COUNT	Average Annual Salary	Sum of Annual Salary
2020			
Qtr1	**46**	**$35,396.30**	**$1,628,230.00**
GA40	42	$35,427.00	$1,487,934.00
CWS CASE MANAGER AD	**4**	**$35,427.00**	**$141,708.00**
CWS CASE MANAGER FC	**38**	**$35,427.00**	**$1,346,226.00**
GA50	3	$36,371.67	$109,115.00
CWS CASE MANAGER FC	**1**	**$35,427.00**	**$35,427.00**
CWS CASE MANAGER SUPERVISOR AD	**1**	**$36,844.00**	**$36,844.00**
CWS CASE MANAGER SUPERVISOR FC	**1**	**$36,844.00**	**$36,844.00**
UZ01	1	$31,181.00	$31,181.00
CWS CASE MANAGER AD	**1**	**$31,181.00**	**$31,181.00**
Qtr2	**47**	**$35,139.85**	**$1,651,573.00**
AH35	1	$36,843.00	$36,843.00
OHAN INVESTIGATOR	**1**	**$36,843.00**	**$36,843.00**
GA30	1	$23,756.00	$23,756.00
CWS CASE MANAGER ASSISTANT FC	**1**	**$23,756.00**	**$23,756.00**
GA40	44	$35,463.59	$1,560,398.00
CWS CASE MANAGER AD	**5**	**$35,427.00**	**$177,135.00**
CWS CASE MANAGER FC	**39**	**$35,468.28**	**$1,383,263.00**
UZ01	1	$30,576.00	$30,576.00
CWS CASE MANAGER AD	**1**	**$30,576.00**	**$30,576.00**
Qtr3	**47**	**$35,188.87**	**$1,653,877.00**
GA30	1	$22,625.00	$22,625.00
CWS CASE MANAGER ASSISTANT FC	**1**	**$22,625.00**	**$22,625.00**
GA40	46	$35,462.00	$1,631,252.00
CWS CASE MANAGER AD	**6**	**$35,427.00**	**$212,562.00**
CWS CASE MANAGER FC	**40**	**$35,467.25**	**$1,418,690.00**
Qtr4	**38**	**$34,446.08**	**$1,308,951.00**
GA30	3	$23,002.00	$69,006.00
CWS CASE MANAGER ASSISTANT FC	**3**	**$23,002.00**	**$69,006.00**
GA40	34	$35,427.00	$1,204,518.00
CWS CASE MANAGER AD	**6**	**$35,427.00**	**$212,562.00**
CWS CASE MANAGER FC	**28**	**$35,427.00**	**$991,956.00**
GA50	1	$35,427.00	$35,427.00
CWS CASE MANAGER FC	**1**	**$35,427.00**	**$35,427.00**
Grand Total	**178**	**$35,070.96**	**$6,242,631.00**

STAY SURVEYS

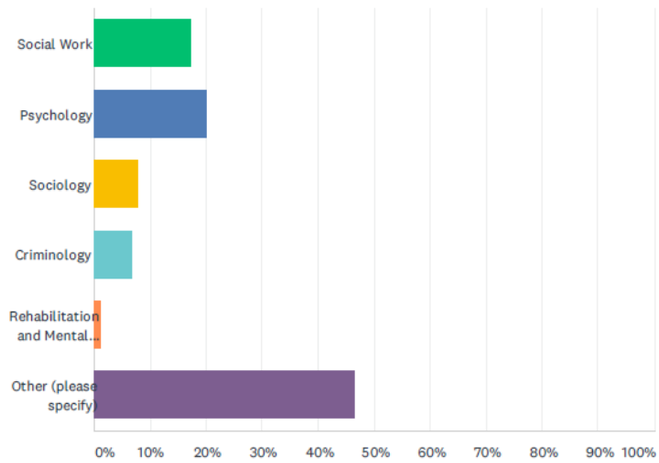
Newly hired CWS front-line employees receive "Stay Surveys" during their first year of employment. These occur at thirty days, six months, and nine months. Stay Survey responses are used to gauge new employee satisfaction and support retention efforts.

Stay Survey Data:
Respondents are between 25 and 34 years old, and 85% report this being their first full-time job in Child Welfare.

- 47% report having a Bachelor's or Master's degree in a major that is not Social Work, Sociology or Psychology. Examples include Criminal Justice, Human Services, Child and Family Studies and Religious Studies
- 58% report that a job in Child Welfare was not their first career choice

Q9 Your Degree

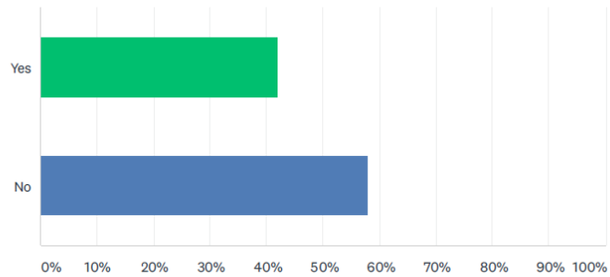
Answered: 75 Skipped: 1



ANSWER CHOICES	RESPONSES	
Social Work	17.33%	13
Psychology	20.00%	15
Sociology	8.00%	6
Criminology	6.67%	5
Rehabilitation and Mental Health Counseling	1.33%	1
Other (please specify)	46.67%	35
TOTAL		75

Q11 Was Child Welfare your first career choice?

Answered: 76 Skipped: 0

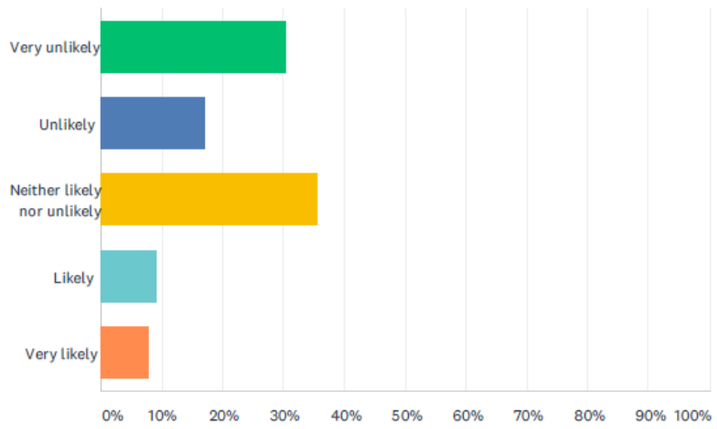


ANSWER CHOICES	RESPONSES	
Yes	42.11%	32
No	57.89%	44
TOTAL		76

- 36% of respondents to the 9-month survey, say they're "neither likely nor unlikely" to leave their CWS job in the next six months.
- 30% say they're "very unlikely" to leave their CWS job in the next months.

Q26 How likely are you to leave your Child Welfare job in the next 6 months?

Answered: 76 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very unlikely	30.26%	23
Unlikely	17.11%	13
Neither likely nor unlikely	35.53%	27
Likely	9.21%	7
Very likely	7.89%	6
TOTAL		76

- 64% of Stay Survey respondents note “Salary” as the primary variable that would contribute to their leaving employment.

Child Welfare Stay Survey - 9 Month

ANSWER CHOICES	RESPONSES	
Salary	64.47%	49
Benefits	18.42%	14
Pursue Another Child Welfare Position outside of DSS	21.05%	16
Pursue Another Job Opportunity outside of DSS	40.79%	31
Pursue Further Education	18.42%	14
Lack of Promotional Opportunities	25.00%	19
Job Expectations	21.05%	16
Job Security	6.58%	5
Job Stress	55.26%	42
Personal Safety	28.95%	22
Relationship with co-workers	1.32%	1
Relationship with supervisor(s)	10.53%	8
Shift Work	6.58%	5
Excessive Workload	50.00%	38
Burnout	57.89%	44
Organizational Climate	9.21%	7
Lack of Appreciation	26.32%	20
Maternity/Child care	7.89%	6
Health	21.05%	16
Work/Family Conflict	18.42%	14
Relocation	26.32%	20
Transportation/Commute	7.89%	6
Retirement	6.58%	5
Military Service	0.00%	0
Other (please specify)	7.89%	6
Total Respondents: 76		

SEPARATIONS

435 Total number of front-line CWS separations in 2020, including CWS Case Manager Assistants, CWS Case Managers, and CWS Case Manager Supervisors, and OHAN Investigators

158 Number of CWS Foster Care Case Manager Assistants, and Adoptions and Foster Care Case Managers and Case Manager Supervisors, and OHAN Investigators.

In the first quarter of 2020, hiring outpaced separations. In April, shortly after the COVID-19 Pandemic became a reality, hiring decreased and separations began to increase. By May, hires and separations were virtually equal. Hiring surpassed separations again in the third quarter; but the trend ended thereafter. By October, employee separations swung up, surpassed hiring, and the pattern continued through December 2020. (See tables under Turnover.)

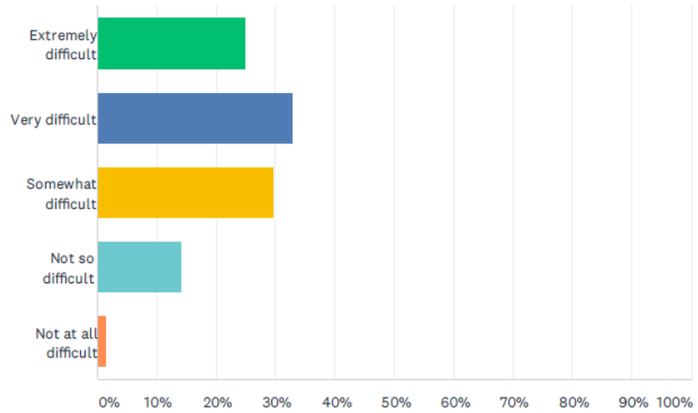
Exit Survey Data:
The CWS front-line employees who responded to the exit survey had been employed for less than two (2) years.

- 32% found it "very difficult" and 25% found it "extremely difficult" to balance their work and personal lives while working for DSS.
- 61% reported that there was nothing DSS could have done to prevent their leaving.

EMPLOYEE EXIT SURVEY

Q11 How difficult was it for you to balance your work and personal life while working here?

Answered: 64 Skipped: 0



ANSWER CHOICES	RESPONSES	
Extremely difficult	25.00%	16
Very difficult	32.81%	21
Somewhat difficult	29.69%	19
Not so difficult	14.06%	9
Not at all difficult	1.56%	1
Total Respondents: 64		

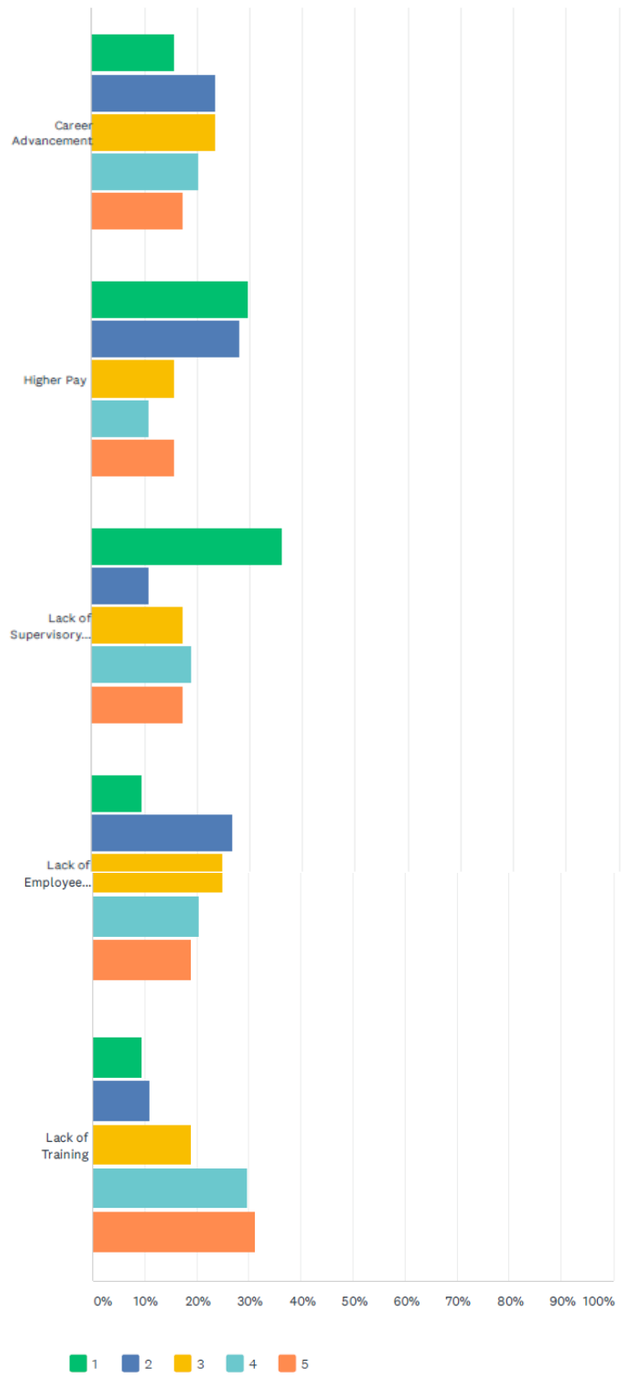
Separation Reasons:

Below are the reasons recorded for the CWS front-line case manager separations. These are "true" separations, meaning the employee left DSS employment. The highest ranked reason employees left employment (36%) was recorded as "Lack of Supervisory Support."

EMPLOYEE EXIT SURVEY

Q17 We want to know why you chose to leave employment with DSS. Please rank the following attributes in order of importance with 1 being the most important to you.

Answered: 64 Skipped: 0



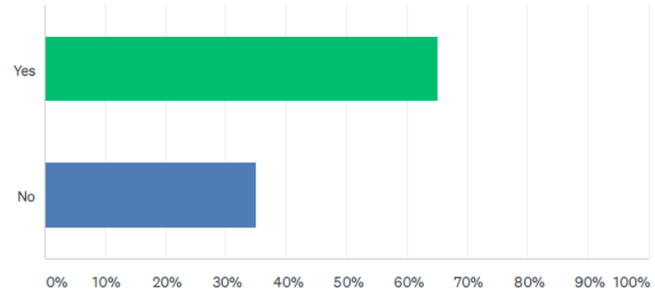
	1	2	3	4	5	TOTAL	SCORE
Career Advancement	15.63% 10	23.44% 15	23.44% 15	20.31% 13	17.19% 11	64	3.00
Higher Pay	29.69% 19	28.13% 18	15.63% 10	10.94% 7	15.63% 10	64	3.45
Lack of Supervisory Support	35.94% 23	10.94% 7	17.19% 11	18.75% 12	17.19% 11	64	3.30
Lack of Employee Recognition	9.38% 6	26.56% 17	25.00% 16	20.31% 13	18.75% 12	64	2.88
Lack of Training	9.38% 6	10.94% 7	18.75% 12	29.69% 19	31.25% 20	64	2.38

- 65% of respondents would consider returning to work for DSS, and about half (52%) of them are "somewhat likely" to recommend DSS employment to a friend.

EMPLOYEE EXIT SURVEY

Q18 Would you consider returning to work at DSS?

Answered: 63 Skipped: 1

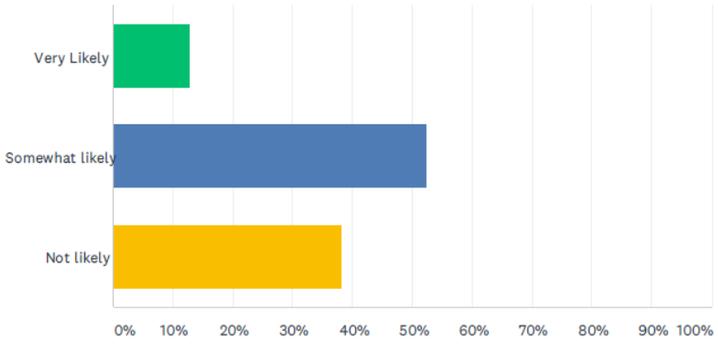


ANSWER CHOICES	RESPONSES	
Yes	65.08%	41
No	34.92%	22
TOTAL		63

EMPLOYEE EXIT SURVEY

Q19 How likely are you to recommend a friend work at DSS?

Answered: 63 Skipped: 1



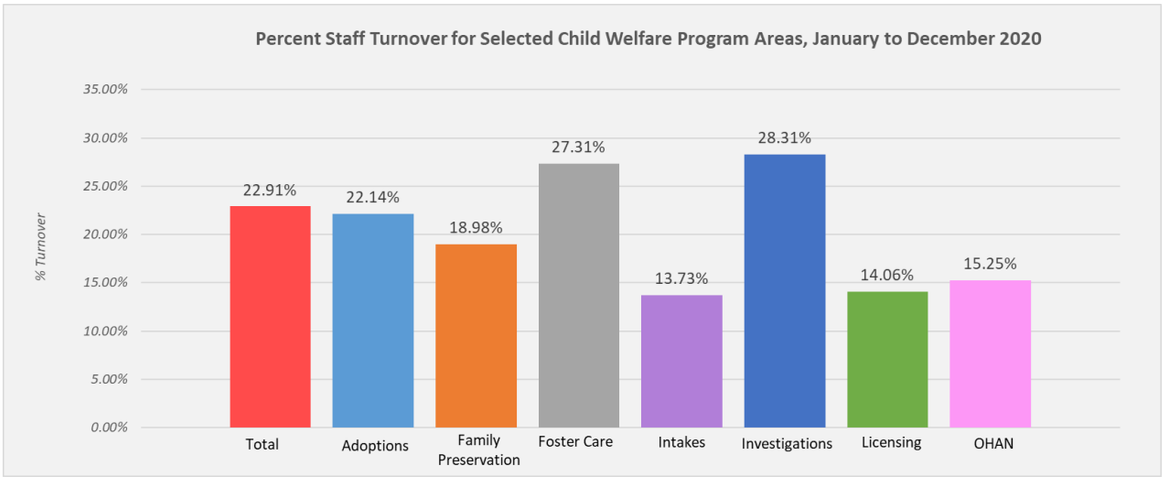
ANSWER CHOICES	RESPONSES	
Very Likely	12.70%	8
Somewhat likely	52.38%	33
Not likely	38.10%	24
Total Respondents: 63		

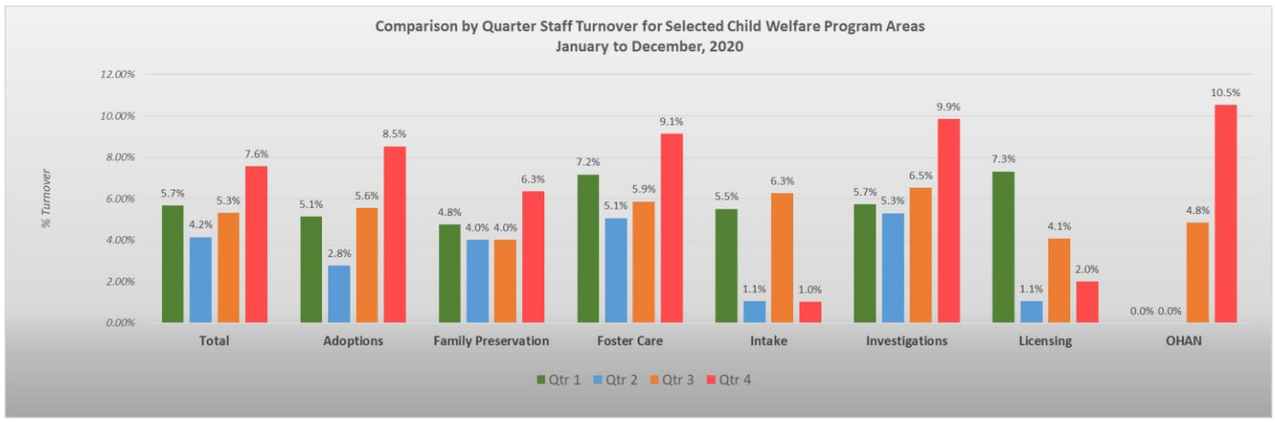
- Not everyone who separates from DSS opts to complete an exit survey. However, below are the separation reasons recorded in the State's enterprise information system (SCEIS). Note: "ZL/99" is a code used by SCEIS to indicate an employee movement to another State entity.

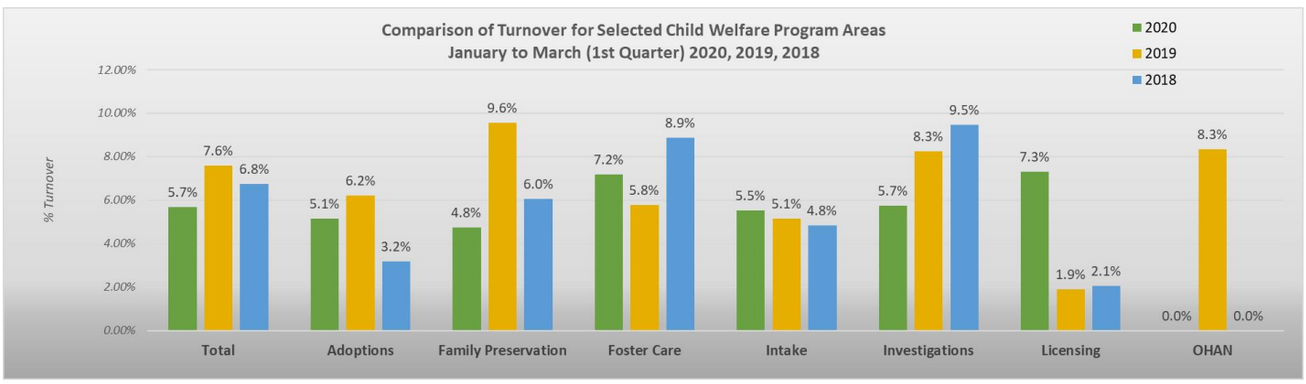
CWS CASE MANAGER SEPARATIONS	Employee Count	Average Age	Average SVC YRS	Average Annual Salary
2020	**158**	**31.03**	**2.62**	**$35,688.56**
Qtr1	**40**	**31.60**	**3.57**	**$36,327.58**
Dismissal- Conduct	1	28.00	0.98	$36,844.00
CWS CASE MANAGER FC	**1**	**28.00**	**0.98**	**$36,844.00**
Employed Outside State Gov	1	34.00	11.30	$35,427.00
CWS CASE MANAGER AD	**1**	**34.00**	**11.30**	**$35,427.00**
Personal	35	31.03	2.89	$36,082.94
CWS CASE MANAGER AD	**5**	**29.00**	**2.74**	**$35,427.00**
CWS CASE MANAGER FC	**30**	**31.37**	**2.91**	**$36,192.27**
Retirement	1	61.00	24.40	$47,075.00
CWS CASE MANAGER SUPERVISOR FC	**1**	**61.00**	**24.40**	**$47,075.00**
ZL/99	2	27.50	2.59	$35,427.00
CWS CASE MANAGER AD	**1**	**28.00**	**0.82**	**$35,427.00**
CWS CASE MANAGER FC	**1**	**27.00**	**4.37**	**$35,427.00**
Qtr2	**25**	**33.32**	**2.80**	**$35,727.32**
Dismissal- Unsatisfactory Perf	2	25.50	0.79	$35,427.00
CWS CASE MANAGER FC	**2**	**25.50**	**0.79**	**$35,427.00**
Job Abandonment	1	63.00	4.88	$36,844.00
CWS CASE MANAGER FC	**1**	**63.00**	**4.88**	**$36,844.00**
Personal	20	32.55	2.41	$35,568.70
CWS CASE MANAGER AD	**4**	**31.50**	**5.70**	**$35,427.00**
CWS CASE MANAGER FC	**16**	**32.81**	**1.59**	**$35,604.13**
ZL/99	2	34.00	7.61	$37,055.50
CWS CASE MANAGER FC	**2**	**34.00**	**7.61**	**$37,055.50**
Qtr3	**36**	**28.28**	**2.06**	**$35,133.89**
Dismissal- Conduct	1	22.00	0.66	$35,427.00
CWS CASE MANAGER FC	**1**	**22.00**	**0.66**	**$35,427.00**
Dismissal- Unsatisfactory Perf	1	26.00	0.16	$35,427.00
CWS CASE MANAGER AD	**1**	**26.00**	**0.16**	**$35,427.00**
Personal	31	28.90	2.23	$35,086.61
CWS CASE MANAGER AD	**7**	**27.00**	**2.73**	**$35,427.00**
CWS CASE MANAGER ASSISTANT FC	**2**	**30.50**	**2.28**	**$22,625.00**
CWS CASE MANAGER FC	**20**	**29.15**	**1.66**	**$35,649.20**
CWS CASE MANAGER SUPERVISOR FC	**1**	**28.00**	**6.20**	**$38,686.00**
OHAN INVESTIGATOR	**1**	**35.00**	**6.04**	**$42,776.00**
ZL/99	3	24.67	1.44	$35,427.00
CWS CASE MANAGER FC	**3**	**24.67**	**1.44**	**$35,427.00**
Qtr4	**57**	**31.37**	**2.22**	**$35,573.44**
Diff Job/Diff State Agency	1	35.00	0.24	$35,427.00
CWS CASE MANAGER FC	**1**	**35.00**	**0.24**	**$35,427.00**
Dismissal- Unsatisfactory Perf	1	30.00	0.76	$35,427.00
CWS CASE MANAGER FC	**1**	**30.00**	**0.76**	**$35,427.00**
Employed Outside State Gov	3	29.67	2.53	$35,427.00
CWS CASE MANAGER AD	**2**	**29.50**	**3.41**	**$35,427.00**
CWS CASE MANAGER FC	**1**	**30.00**	**0.77**	**$35,427.00**
Personal	47	30.15	1.37	$35,447.49
CWS CASE MANAGER AD	**8**	**27.88**	**1.68**	**$35,604.13**
CWS CASE MANAGER ASSISTANT FC	**1**	**39.00**	**0.05**	**$22,625.00**
CWS CASE MANAGER FC	**35**	**30.06**	**1.29**	**$35,599.97**
CWS CASE MANAGER SUPERVISOR AD	**1**	**46.00**	**0.75**	**$36,844.00**
OHAN INVESTIGATOR	**2**	**28.50**	**2.54**	**$37,865.50**
Retirement	2	60.00	24.28	$38,410.50
CWS CASE MANAGER AD	**1**	**58.00**	**32.30**	**$39,977.00**
CWS CASE MANAGER FC	**1**	**62.00**	**16.25**	**$36,844.00**
SAP Agency to Non-SAP Agency	1	37.00	0.55	$35,427.00
CWS CASE MANAGER FC	**1**	**37.00**	**0.55**	**$35,427.00**
ZL/99	2	30.00	2.31	$36,135.50
CWS CASE MANAGER AD	**1**	**36.00**	**2.74**	**$36,844.00**
CWS CASE MANAGER FC	**1**	**24.00**	**1.87**	**$35,427.00**
Grand Total	**158**	**31.03**	**2.62**	**$35,688.56**

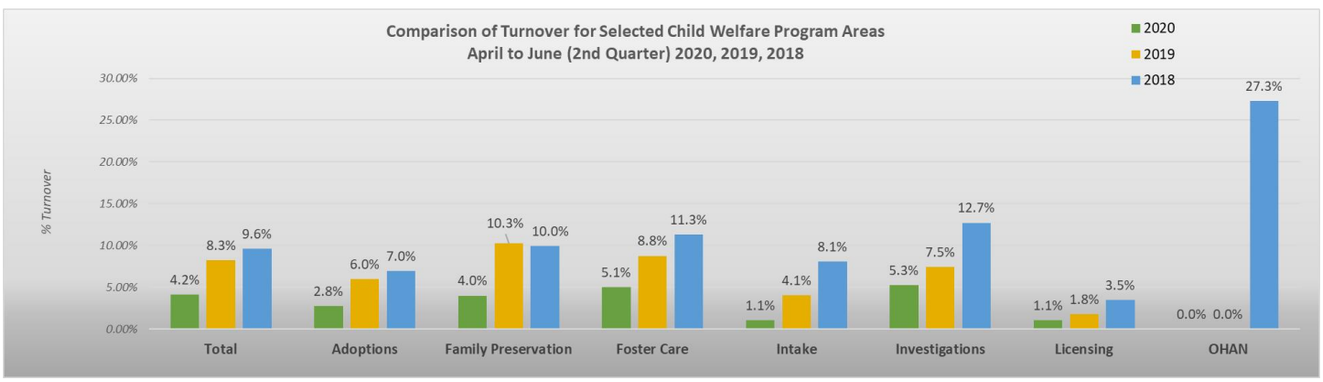
TURNOVER

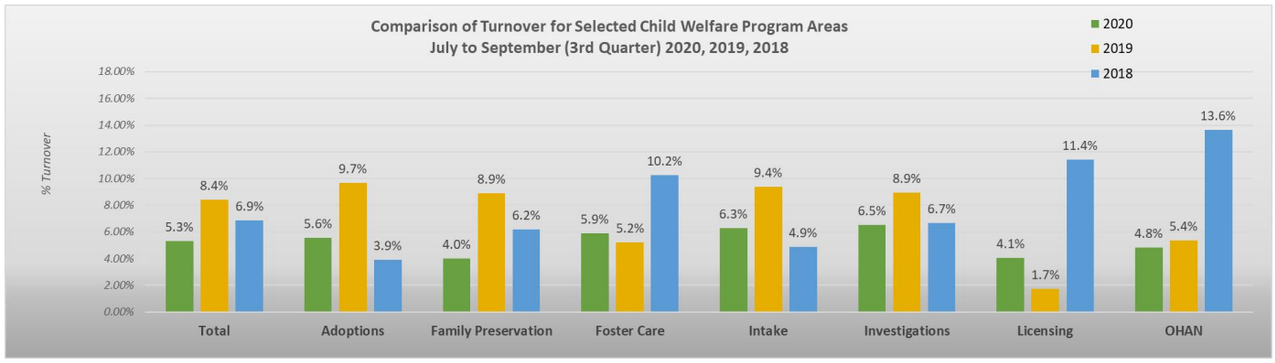
2020 January to December Annual Staff Turnover Charts
Adoptions, Family Preservation, Foster Care, Intakes, Investigations, Licensing, and OHAN

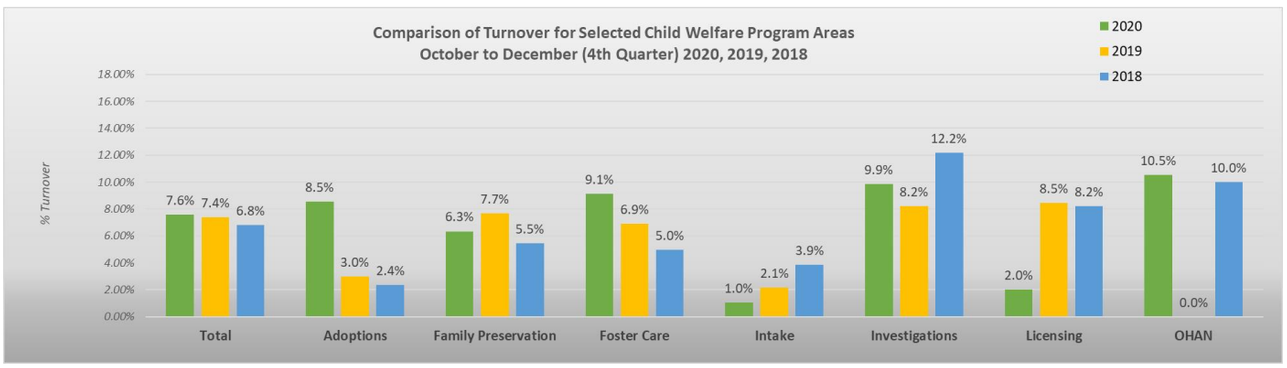












***Source**: DSS Human Resources, January 2021*

***Prepared By**: Accountability, Data and Research Division, SC Department of Social Services 03/05/2021*