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, 2019-March 31, 2020

**CO-MONITORS**

JUDITH MELTZER
PAUL VINCENT

**CO-MONITOR STAFF**

RACHEL PALETTA
ELISSA GELBER
GAYLE SAMUELS

Published October 6, 2020

# Michelle H., et al. v. McMaster and Leach Progress Report for the Period October 1, 2019 - March 31, 2020

## Table of Contents

## List of Tables



## List of Figures

# Michelle H., et al. v. McMaster and Leach
# Progress Report for the Period October 1, 2019 - March 31, 2020

## I. Introduction

This is the seventh six-month report[1] on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) entered in *Michelle H., et al. v. McMaster and Leach*. Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the approximately 4,300 children in foster care in South Carolina (SC)[2] and incorporates provisions that had been ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] This report covers DSS performance during the period October 1, 2019 through March 31, 2020, and has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Co-Monitor staff Elissa Gelber, Rachel Paletta, Gayle Samuels, Ali Jawetz, and Nicole Kim. It is presented to The Honorable Richard Gergel, U.S. District Court Judge, Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs), and the public.

The FSA outlines the state's obligations to significantly improve the experiences and outcomes of children removed from the custody of their parent(s) or guardian(s) and placed in foster care, and reflects DSS's agreement to address long-standing problems in the operation of its child welfare system. The FSA was crafted by state leaders and Plaintiffs to guide a multi-year reform effort. It includes a wide range of specific provisions governing: case manager and supervisor caseloads; visits between children in foster care and their case managers; family time with parents and siblings; investigations of allegations of abuse and neglect of children in foster care; appropriate foster care and therapeutic placements; and access to physical and behavioral health care for children in DSS custody. It also includes provisions which required DSS to complete assessment work before designating and incorporating specific performance outcomes, benchmarks, and timelines. In the context of this structure, the Co-Monitors have worked closely with DSS leaders and Plaintiffs to identify and develop phased Implementation Plans to guide much of the needed reform work.

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

The Co-Monitors and their staff utilized a range of sources to collect information for inclusion in this report and to inform their overall assessment of progress. These include, among other things, review of records in DSS's Child and Adult Protective Service System (CAPSS);[5] analysis and validation of data collected by DSS through structured reviews; group interviews with case managers, private providers, and other stakeholders; and meetings with DSS leaders and staff. Appendix B includes a listing of specific activities used to assess DSS's progress during this monitoring period.

Included in this report is a summary of the Co-Monitors' general findings, followed by a detailed discussion of DSS's performance with respect to the FSA requirements, as well as updates on the implementation of strategies contained in each of the court-ordered Implementation Plans.[6,7] In light of the COVID-19 pandemic, and in order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about key developments beyond March 31, 2020 (the end of the monitoring period).

## II. Summary of Performance

This monitoring period began with a sense of promise and possibility. Though performance had not yet significantly improved in many areas measured by the FSA – largely due to historical resource deficiencies and an inadequate FY2019-2020 budget allocation – work was progressing to position the Department to proceed with broadscale reform when new funding became available. Perhaps for the first time since entry into the FSA, DSS conveyed a sense of urgency in identifying and addressing the root causes of the system failures that have long impacted children in foster care and their families. Under the leadership of Director Michael Leach, there was keen focus and cautious optimism as all involved hoped for a FY2020-2021 DSS fiscal appropriation that would enable the Department to more fully implement its FSA commitments and move the important work of reform forward.

By early March 2020 – almost one year into Director Leach's tenure – DSS had made headway in laying the groundwork for reform. It re-established relationships with key private, government, and community partners, and formally launched its Guiding Principles and Standards ("GPS") Case Practice Model, with the goal of shifting agency culture towards a more strength-based model of practice grounded in authentic engagement with families. DSS continued filling positions that had long remained vacant, and staff expressed enthusiasm about the new direction of the

[5] CAPSS, Child and Adult Protective Services System, is DSS's State Automated Child Welfare Information System (SACWIS).
[6] 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)."
[7] To see all Implementation Plans and Addendums for the Michelle H. Final Settlement Agreement, go to: https://dss.sc.gov/child-welfare-reform/

Department. Dedicated family engagement staff were put in place, charged with implementing a model focused on teaming with parents, youth, and those who support them for case planning and decision making throughout the state, and additional capacity was added to support youth leaving foster care between the ages of 18 and 21. After many months of struggling to retrieve and understand health care data, Nurse Care Coordinators began working in each one of DSS's four regions across the state, sifting through children's health histories and following up with case managers and practitioners to assemble information and schedule overdue appointments. Newly constituted Well-Being Teams, based on a model used effectively in Tennessee, were put in place to serve as resources to DSS staff in managing the physical and behavioral health needs of children in foster care. Though the number of licensed kin foster families had not meaningfully increased, there was a beginning understanding of a newly available licensure process for kin and an expectation that efforts to communicate a strong preference for placing children with family members would yield a substantial increase once adequate staff were available to move applications for licensure forward at a faster pace.

On March 13, 2020, with the new fiscal year in sight, Governor McMaster declared a state of emergency in South Carolina based on the imminent threat to public health posed by the COVID-19 pandemic.[8] The pandemic has dealt a severe blow to states across the nation, including South Carolina, and to an agency that was finally positioned to intensify its reform efforts. It has demanded even more of DSS leadership, staff, providers, partners, and community members, as many children and families have depended more than ever on DSS supports. In the midst of leading a large social services agency, and managing a court-ordered overhaul of its child welfare division, DSS leadership and staff have spent hours searching for protective equipment for staff, adjusting protocols for case manager visits with children and families, organizing intensive cleaning of offices, distributing computers and ensuring computer network connections for staff to work from home, processing thousands of Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) applications, coordinating health care and testing, and quelling provider concerns. Perhaps most critically, the pandemic has delayed the state's budget process, making the prospect of much-needed FY2020-2021 resources far less certain.

DSS leadership has emphasized that they continue to be committed to the Department's long-term strategic priorities and are hopeful they can proceed with key aspects of the reform in the coming year. While this commitment is commendable, DSS's historical failure to meet the needs of children and families is a reminder that the hope of change can be just that in the absence of a strong

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

foundation. The DSS child welfare system remains woefully under-resourced, lacking an adequate network of supports for children and families.

As covered in more detail throughout this report, this has meant that DSS performance and outcomes remain troubling.[9] Though fewer young children are being placed in congregate care, the array of placements and services in the state are wholly insufficient to meet children's needs. There has been much progress in developing infrastructure for collaboration and data collection in the area of healthcare, but sparse DSS resources dedicated to managing children's health and mental health needs has left too many children without the care and stability they need. Children are not being afforded even minimally required time with family members, including their parents with whom they are supposed to be reunified. Caseloads for many case managers and supervisors remain unmanageably high, and the unit responsible for investigating allegations of abuse and neglect of children in foster care placements is still not resourced appropriately to consistently and thoroughly carry out its work. It is difficult to imagine that, in the absence of ample supports, a system that was performing at this level prior to the pandemic will be able to deliver on the promise of reform at a time when even the most well-resourced systems in the nation are struggling to meet the needs of children and families.

This is a moment that demands a vision and framework for living out DSS's stated values – of being family- and community-centered, trauma-informed, strengths-based, and culturally responsive – and for defining DSS's role and purpose in the lives of South Carolina's children and families. More than ever, DSS needs to deepen its ability to oversee the safety of children in foster care placements, to support children in their home communities, to ensure ongoing connections with loved ones, and to engage and strengthen families in ways that allow them to thrive. As DSS moves forward with its reform in the months ahead, the Co-Monitors recommend that attention be paid to the following foundational action steps. These recommendations have been highlighted as key priorities since the inception of this lawsuit, and are based on years of experience with other systems that have been engaged in meaningful system transformation:[10]

- **Expedite plan for thorough and intensive training of all staff in DSS's model of case practice:** System transformation requires a shared vision of what is expected in order to meet the safety, well-being, and permanency needs of the

[9] Unless otherwise indicated, data included throughout this report is for the period October 1, 2019 through March 31, 2020. Governor McMaster declared a State of Emergency in South Carolina on March 13, 2020, so the impact of the COVID-19 pandemic on FSA performance data is likely to be reflected in data reported for the next monitoring period, April 1, 2020 through September 30, 2020.

[10] In June 2020, at the direction of the Court, Parties engaged in a mediation process with the goal of identifying priorities that DSS could immediately act upon through currently available funding sources. The DSS commitments that resulted from this process – which are more short-term and specific to particular areas of practice – were memorialized in the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201). These commitments are referenced in more detail in Appendices D-H, which outline the action steps to which DSS is committed in each area of practice.

children and families served by DSS. Though DSS has worked to develop a model of case practice – referred to as its Guiding Principles and Standards ("GPS") – the implementation of a strategy for helping new and existing staff to build the skills needed to practice in accordance with this model is long overdue. Beyond the training that orients staff to the procedural changes required by GPS, additional training must include robust coaching, mentoring, and ongoing support to build the skills necessary to meaningfully engage families, assess underlying strengths and needs, craft individualized safety and permanency plans, and track and adjust as case plans proceed. GPS training needs to extend to supervisors, foster parents, and providers so that the entire system has the skills and confidence needed to realize the goals and expectations of the practice model. In addition, GPS principles need to be integrated into quality assurance processes so that they are aligned with and designed to measure fidelity to the model. DSS reports that its GPS implementation workgroups have been tasked with integrating the model into policy and practice. The quality and robustness of this work will be critical in the months ahead.

- **Leverage private agency partnerships through contractual relationships that foster meaningful collaboration:** Many private providers have expressed willingness to work with DSS to find new ways of supporting children and families. Funding currently devoted to more restrictive congregate care placements and other outsourced functions can be re-directed to a full array of community-based resources and other supports. Given the productive working relationship that has taken root over the past year, DSS and its private sector partners should work together to provide children and families with the supports they need to thrive. This will require mutual accountability, action-oriented planning, evaluation and adjustment of contracting models, and the availability of flexible funds that can be used when crafting individualized service and support plans for children and families.

- **Work with public agency partners to increase availability of and access to high-quality community-based services:** It is important that DSS work closely across agencies – now and on an ongoing basis – to develop more robust and accountable systems of care to serve children and families who come to the attention of DSS. This includes the Department of Health and Human Services (DHHS), the Department of Mental Health (DMH), and the Department of Juvenile Justice (DJJ) among others. A key part of this collaboration should be the assessment and enhancement of available community-based services throughout the state, and building a shared understanding of the types of underlying needs that can be met through partner agencies, without the need for DSS intervention. This area of work is also fundamental to the state's efforts to bolster its prevention continuum in accordance with the Family First Prevention Services Act (FFPSA).

- **Continue to focus on building a strong infrastructure:** As DSS works to best position itself for full implementation of its FSA commitments, and moves ahead with specific short-term action steps, leadership must continue to shore up the infrastructure necessary to support and sustain change. Despite significant improvements in systems for collecting and utilizing data, DSS's data capacity remains limited in some key areas, and additional data staff are still needed. Human resources and administrative capacity to recruit, hire, train, and retain new case managers and supervisors continues to be sub-optimal, at times causing delays in filling much-needed positions. The Department continues to need to build a robust Continuous Quality Improvement (CQI) process that is closely tied to agency management and that can easily and routinely provide quantitative and qualitative information for managers, supervisors, and case managers on the effectiveness of their work. The CQI process should specifically gather information about DSS's fidelity to key practice principles and include face-to-face interviews with children, families, DSS staff, and external stakeholders about their experiences with DSS.

- **Consider piloting new strategies in particular areas of the state:** It is difficult, if not impossible, to predict exactly how even very well-conceived, carefully planned strategies will play out in practice. Implementation generally involves some amount of testing and refining in response to early results and community and stakeholder feedback. It has been, and continues to be, our recommendation that DSS consider a phased approach to implementing some of the more ambitious strategies to which it has committed. This will allow adaptations to be made, and necessary resources to be engaged, prior to full state implementation. Such an approach – which must entail support for local innovation and flexible access to a full range of resources – would be especially useful in implementing strategies such as Child and Family Teaming (CFT) that require a significant re-orientation of values, a considerable shift in practice, and the availability of an entirely new and much broader array of community resources.

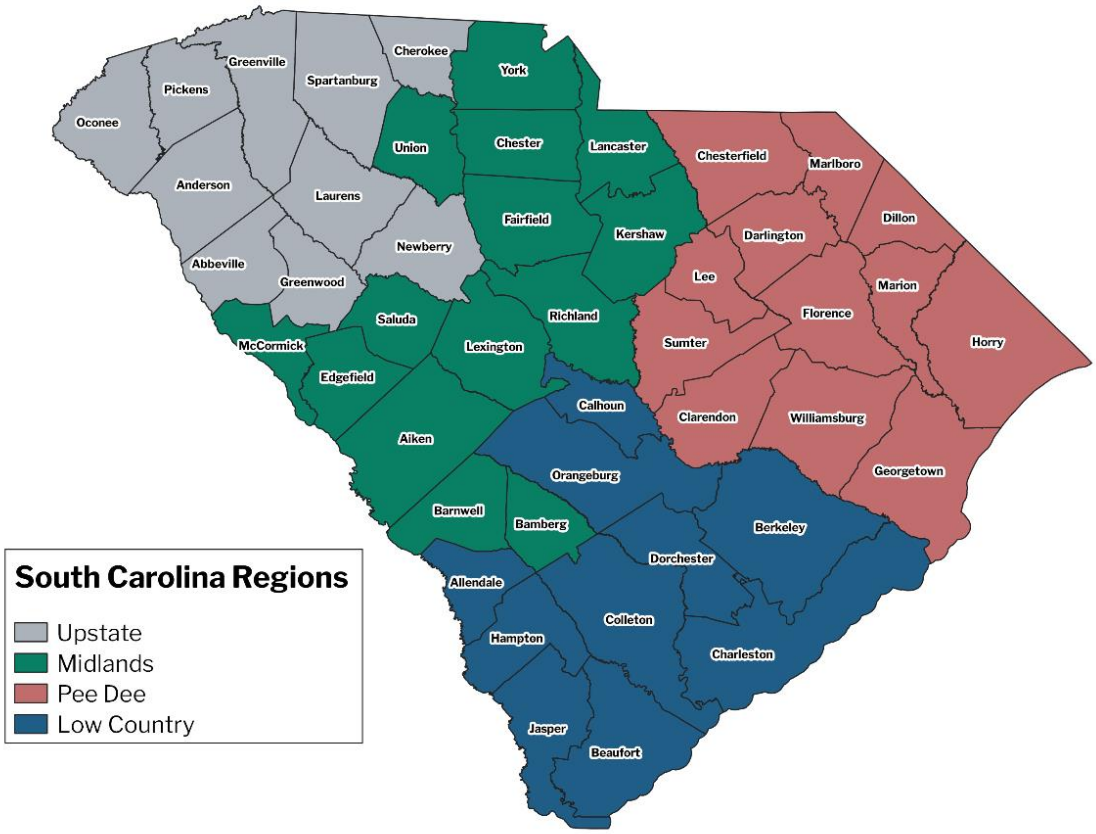
- **Maximize the use of all available sources of funding:** DSS should act expeditiously and ardently to ensure it is making use of all state and federal revenue sources, especially now that the state as a whole is expected to have a revenue shortfall as a result of the COVID-19 pandemic. Though adequate funding is not a magic bullet for all necessary system improvements, securing and sustaining sufficient fiscal resources will increase DSS's ability to implement the critically necessary actions to which it is committed, and to deliver on the system reforms for which South Carolina children and families have long been waiting.

# III. Background Information

## South Carolina Department of Social Services: Structure and Mission

DSS, directed by Michael Leach, 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."[11] The agency oversees investigations of child abuse and neglect, preventative services for families, foster care, adoptions, child care, child support, Adult Protective Services (APS) and economic assistance programs such as TANF, which provides financial assistance to families experiencing poverty and programs to support employment, and SNAP, which provides nutrition benefits to families earning low wages to purchase food. DSS is structured to deliver services through regional and county offices; the state's 46 counties are each part of one of four regions – Midlands, Upstate, Pee Dee, and Low Country (see Figure 1).

**Figure 1: South Carolina DSS Counties by Region**

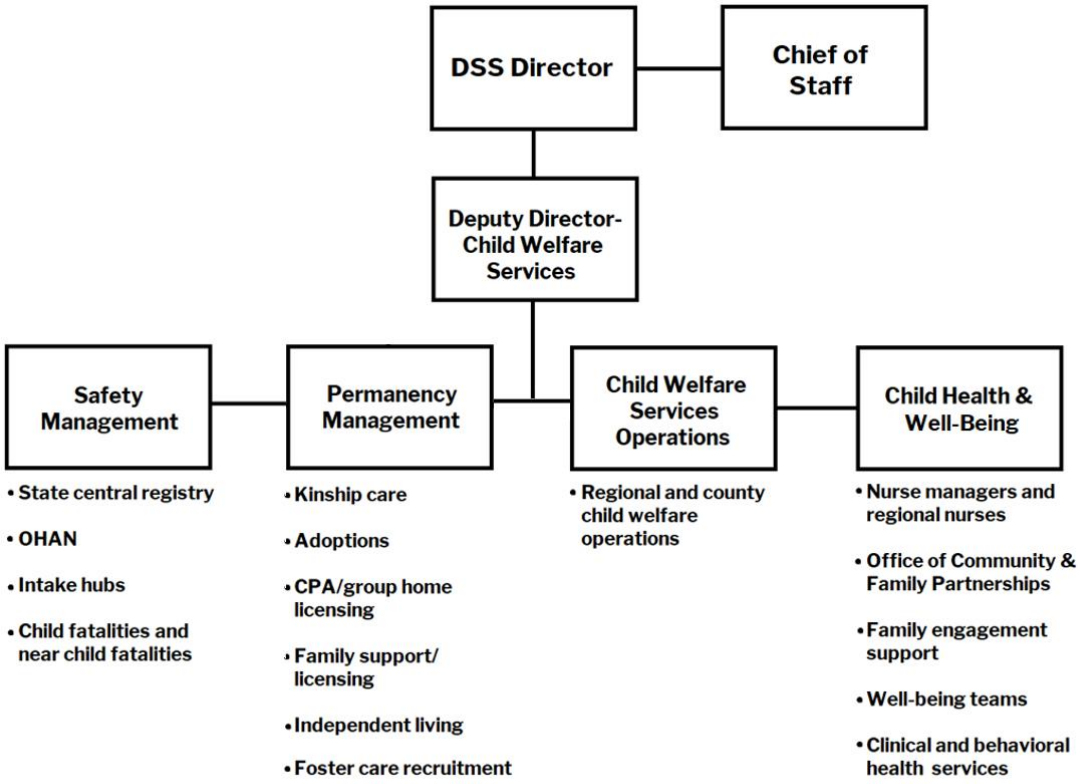



[11] To see DSS's mission, visit: https://dss.sc.gov/about/

The FSA pertains specifically to children who have been involuntarily removed from their parents or guardians and taken into the custody of DSS. Referred to as "foster care" or "out-of-home care," DSS is responsible in these cases for caring for children on a temporary basis while engaging families and providing them with the services and supports needed for the children to safely return home. When reunification is not possible, DSS must work towards another permanent, long-term plan for the child, such as guardianship or adoption.

DSS's foster care work is part of its Child Welfare Division, overseen by Deputy Director of Child Welfare Karen Bryant. The Child Welfare Division is organized into four primary areas of focus: Safety Management, Permanency Management, Operations, and Child Health and Well-Being.[12] Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

**Figure 2: DSS Child Welfare Division Organizational Chart**




[12] A fifth area of focus – Performance Management and Accountability – was recently moved out of the Child Welfare Division. This function has been incorporated into the work of the Department's Policy and Continuous Quality Improvement Division.

## Foster Care Budget and Financing

Although states have primary responsibility for ensuring the welfare of children and their families, the federal government has shown "long-standing interest in helping states improve their services to children and families," and provides financial support through a number of significant sources.[13] Specifically, the federal Children's Bureau, within the Administration for Children and Families, distributes funds to states through mandatory spending programs authorized through the Social Security Act. The largest of these programs is authorized under Title IV-E of the Social Security Act, and operated on an "open-ended" basis, meaning states are entitled to receive reimbursement for a portion of every dollar spent on behalf of an "eligible" child.[14] 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.[15] In South Carolina, approximately 47 percent of children in foster care meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[16,17]

Because nearly all children in foster care are eligible for Medicaid, this is another important source of revenue for state child welfare systems. States paying for Medicaid services receive funds at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate is currently 70.63 percent.[18] This is both a considerably higher rate than the reimbursement rate for most expenditures under Title IV-E, and one that can be applied broadly to *all* children in foster care. Medicaid reimbursement is not limited to services for children who meet the Title IV-E eligibility requirement. States that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – even vastly – funding

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

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

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

[16] 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)

[17] 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.

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

available for the support of children in foster care.[19] Medicaid can be used to cover non-direct health care services, such as mental health services, and therapeutic foster care. Many states have also used Medicaid to support health care case management for children in foster care. South Carolina is not currently utilizing the option for reimbursement of these costs for children in foster care but is exploring it.

State funding for foster care in South Carolina is allocated on an annual basis through the General Assembly agency appropriation process. The state fiscal year in South Carolina is from July to June, spanning two calendar years. Throughout this report and in accordance with state practice, fiscal year designations reference the July year in which funding is allocated, and the June year in which the fiscal period ends. For example, FY2019-2020 references the period from July 2019 through June 2020. South Carolina's budget process begins in July or August of the year preceding the start of the new fiscal year when the governor sends budget instructions to state agencies. In typical circumstances (prior to the COVID-19 pandemic), agencies submit their budget requests to the governor between September and November, detailing every new and recurring dollar they plan to spend in the following year, and the items that will require state funding. Agencies are also required to estimate anticipated federal funding, and related conditions. In November, upon instruction from the governor, the state Board of Economic Advisors issues an initial forecast of economic conditions to give the governor and lawmakers a sense of how much revenue will be available for expenditure in the coming year. In early January, the governor submits the executive budget to the General Assembly. Both houses of the state legislature review the budget, initially in committee (the House Ways and Means and Senate Finance Committee), and ultimately pass budgets through full floor votes. If the House and Senate versions of the budget do not match, a conference committee consisting of both House and Senate members is assembled to reconcile differences. The legislature must pass a budget with a simple majority by the beginning of the fiscal year, July 1. The governor may exercise line item veto power on the enacted budget.

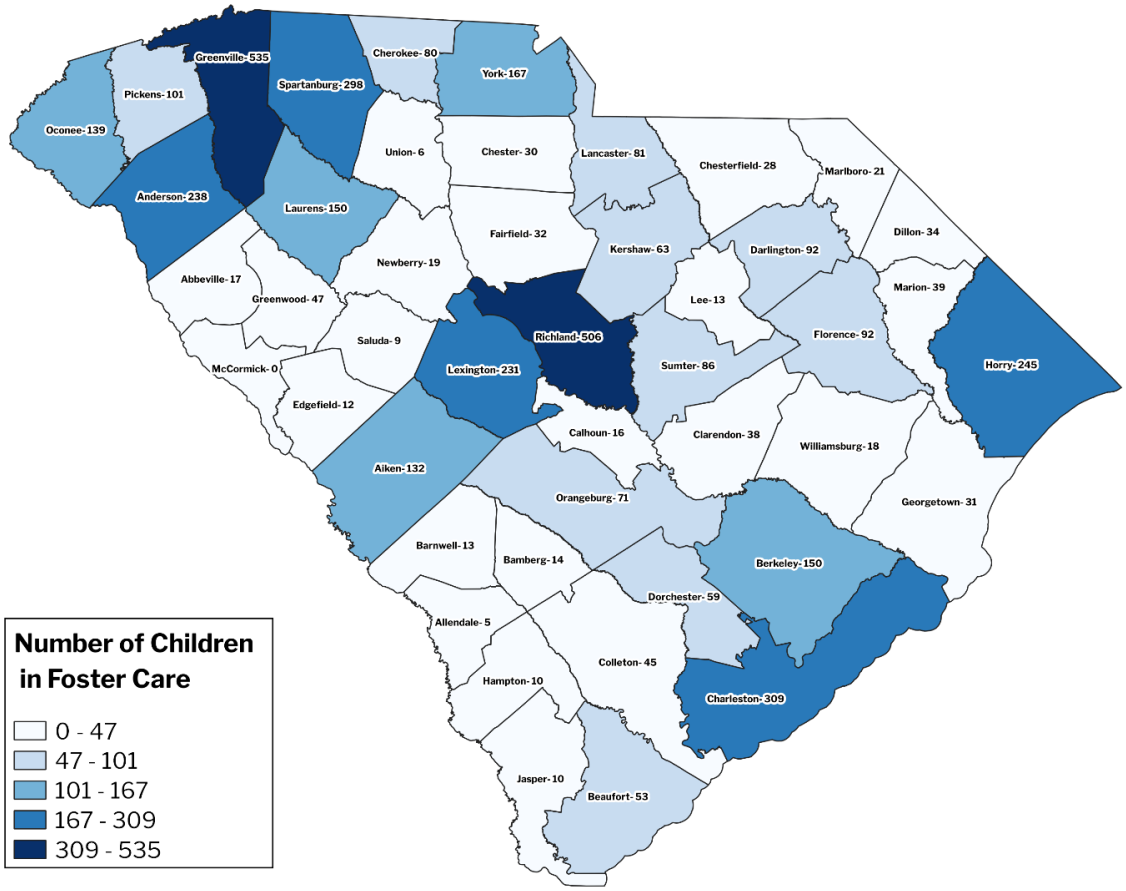
The regular budget cycle was disrupted this year due to the COVID-19 pandemic. Because the General Assembly was unable to convene to agree upon a final FY2020-2021 appropriation, it passed a continuing resolution as a temporary measure. The resolution, passed on May 12, 2020, directed continued funding of the "ordinary" expenses of state government at the levels authorized for FY2019-2020, beginning July 1, 2020, until the legislature reconvenes to pass a FY2020-2021 appropriation.[20]

[19] 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#/
[20] To see the bill, go to: https://www.scstatehouse.gov/sess123_2019-2020/bills/3411.htm

## Population and Demographics of Children in Foster Care

In FY2018-2019, 1,111,183 children under the age of 18 resided in South Carolina; 8,225 of these children were placed in foster care at some point during the year.[21,22] In an effort to build accountability and transparency, DSS now regularly publishes real-time data about children in out-of-home care on its public website.[23] 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 26, 2020, for example, 4,237 children were in DSS's custody, and 1,267 (30%) of these children had been in foster care for 24 months or longer.

**Figure 3: Number of Children in DSS Custody by County as of April 1, 2020[24]**




Source: Data from DSS, 4/1/20

[21]To see child population data from Kids Count Data Center, go to: https://datacenter.kidscount.org/data#SC/2/0/char/0

[22] To see children placed during FY 2018-2019 by county, go to: https://dss.sc.gov/media/2133/total-children-served-during-sfy-19.pdf

[23] To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

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

The map in Figure 3 shows a varied number of children from each county in foster care at the end of the monitoring period, ranging from none to 535. As expected, counties with larger numbers of children in foster care typically correspond to a higher overall population of children within the county. For example, Richland County (total child population 88,924), where Columbia, the state's capital and largest city, is based, had the second-highest number of children in foster care in the state, at 506. Allendale County, a primarily rural county and the least populous in the state (total child population 1,655), had only five children in foster care on April 1, 2020. Differences among counties contribute to a variation in accessibility of services and programs, distances that case managers, families, and children in placement must travel to spend time in person with one another, receive treatment, or attend appointments.

As seen in Table 1, 1,926 children entered foster care and 1,993 children exited foster care during this monitoring period. This is a decrease of 106 entries and increase of 109 exits as compared to the last monitoring period (April to September 2019).

**Table 1: Foster Care Entries and Exits**
**October 2019 – March 2020**

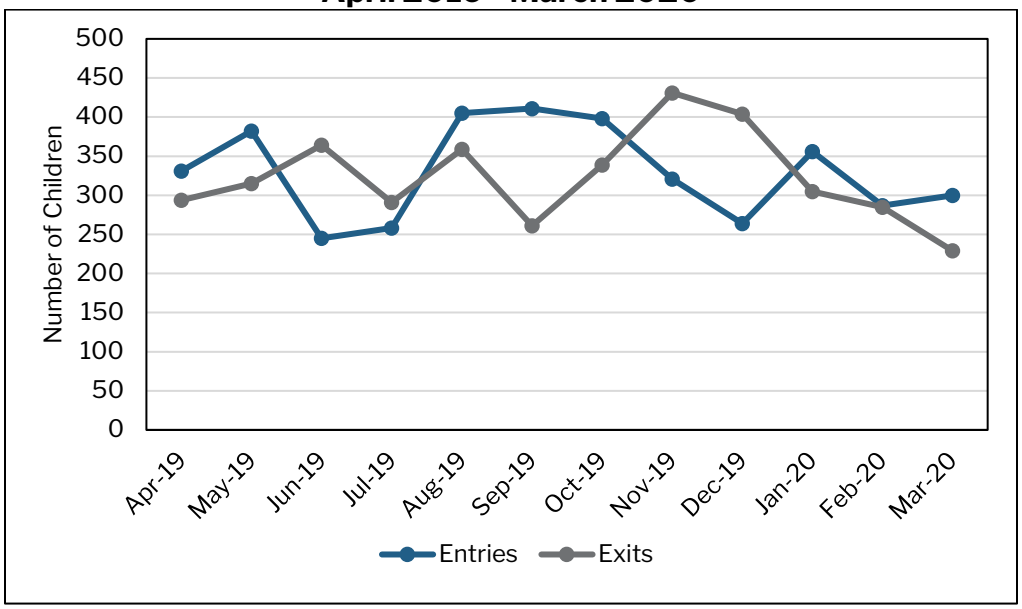
| Category | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 |
|---|---|---|---|---|---|---|
| **Children Served** | 4,910 | 4,884 | 4,710 | 4,656 | 4,625 | 4,623 |
| **Entries into Care** | 398 | 321 | 264 | 356 | 287 | 300 |
| **Exits from Care** | 339 | 431 | 404 | 305 | 285 | 229 |
| **Children in Care on Last Day of Period** | - | - | - | - | - | 4,385[25] |

Source: CAPSS data provided by DSS

Figure 4 displays the entries and exits into foster care during the monitoring period, from October 2019 to March 2020. The data reflect a consistent overall foster care population throughout recent monitoring periods. As shown by the "Entries into Care" line, fewer children tend to enter foster care during the summer and winter months, while more children enter foster care in the fall months when the school year begins. These patterns have been disrupted by the COVID-19 pandemic in South Carolina and across the nation, as schools ceased physical operations in the spring.

[25] 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.

**Figure 4: Foster Care Entries and Exits**
**April 2019 - March 2020**



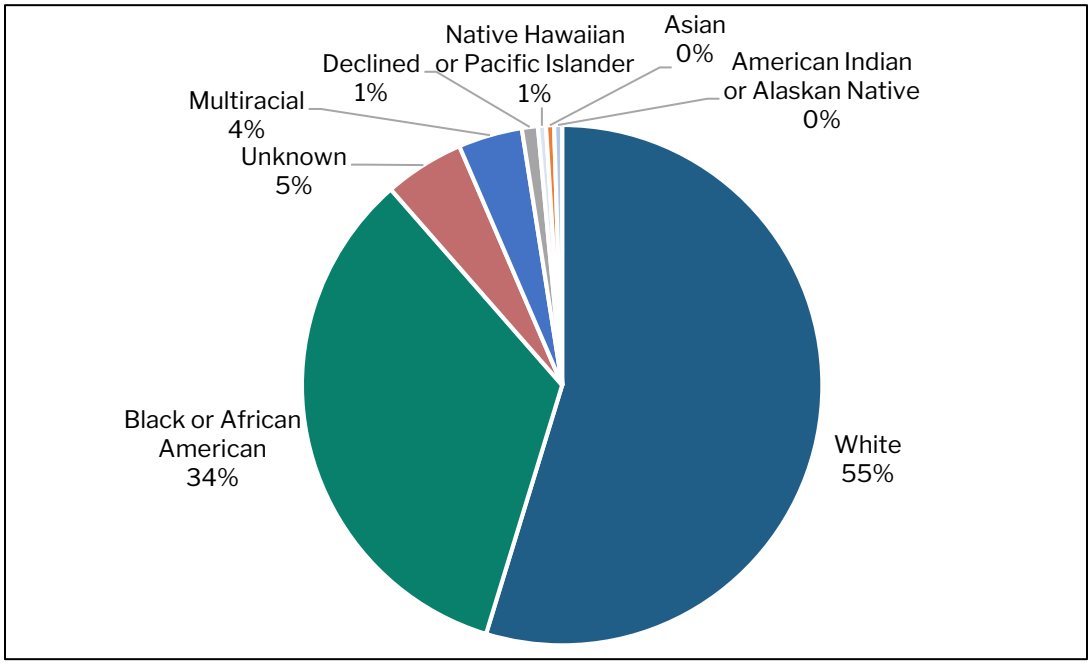

Source: CAPSS data provided by DSS

As in child welfare systems across the country, DSS has observed a significant decline in the number of child abuse and neglect reports received since mid-March 2020 when schools closed for in-person education in response to the COVID-19 pandemic. Because data throughout this report relate primarily to the period ending in March 2020, the impact of this decline may not yet be reflected. The Co-Monitors, however, are following this trend closely, and will be reporting on data for April to September 2020 in the next monitoring report.

The legacy of disproportionate removal of children of color from their parent(s) or guardians, particularly Black children, persists in South Carolina, as it does in every state child welfare agency in the United States. When comparing race and ethnicity of children in DSS custody, as shown in Figure 5, to that of the total child population in the state, representation appears slightly disproportionate: 55 percent of children in foster care are identified as White compared to 57 percent of all children in the state; 34 percent of children in foster care are identified as Black compared to 31 percent of all children in the state.[26]

[26] Categories included herein reflect data provided by DSS. DSS does not record Hispanic or Latinx as a category in their race data.

**Figure 5: Population of Children in DSS Custody by Race as of June 26, 2020 N=4,237**




Source: Data from DSS website, 6/26/20[27]

When these data are analyzed by county, however, further inequities for Black children emerge.

For example, Richland, Greenville, Charleston, and Horry counties have the largest numbers of children in foster care in their respective regions, and in all four of these counties, the percentage of Black children in foster care is significantly greater than the percentage of all Black children within the counties. Table 2 depicts the specifics:

**Table 2: Disproportionality of Black Children in Largest County in Each Region**

| | Percentage of Black children in foster care | Percentage of Black children in county population |
|---|---|---|
| **Richland County** | 62% | 56% |
| **Greenville County** | 24% | 21% |
| **Charleston County** | 49% | 32% |
| **Horry County** | 24% | 19% |

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

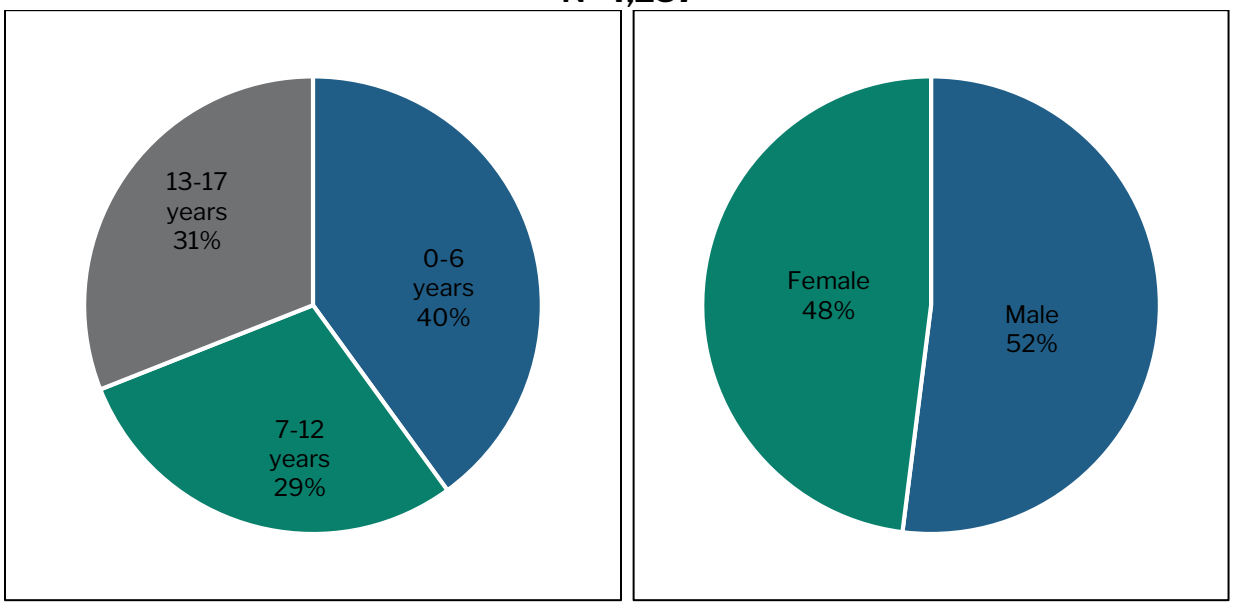
DSS has reported that it is working with community and law enforcement partners throughout the state to encourage careful exercise of discretion when

[27] To see DSS' updated race data, go to: http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

determinations are made about taking children into DSS custody, and to jointly confront racial bias by building awareness around decisions that may be influenced by racial bias.[28] DSS must continue to be attuned to what these data indicate about families, their needs, and the structures in place to meet those needs – close to home and with family – as it proceeds with reform.

In terms of age and gender, Figure 6 shows that about a third of the foster care population are adolescents (ages 13 to 17), and 40 percent are ages six and under. Slightly less than half of children in foster care are reported to be female.[29]

**Figure 6: Children in DSS Custody by Age and Gender as of June 26, 2020 N=4,237**




Source: Data from DSS Website, 6/26/20

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

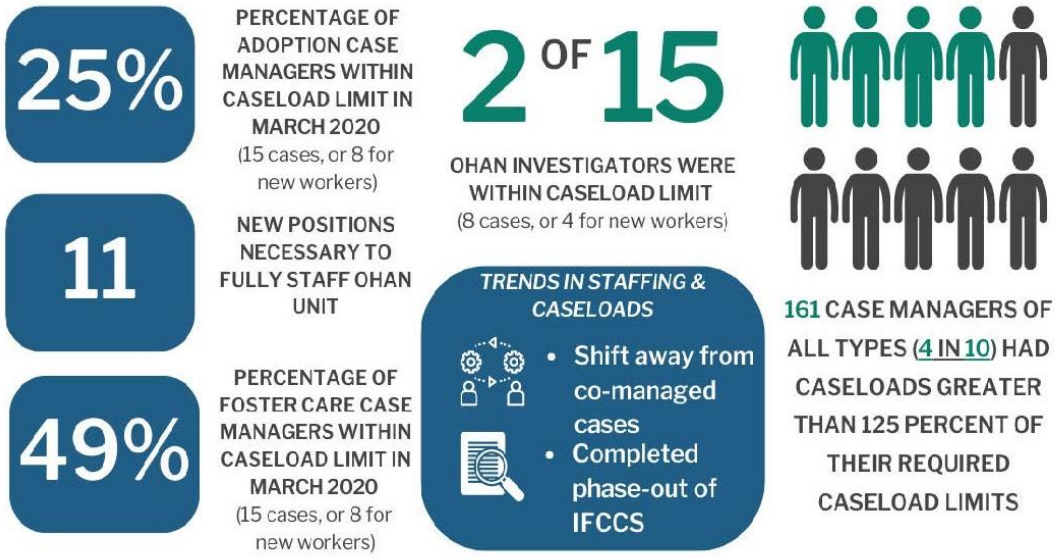
[28] Leach, Michael. Letter to South Carolina Sheriffs and Chiefs of Police. South Carolina Department of Social Services. July 24, 2020.
[29] DSS does not collect data on children who identify as gender neutral or non-binary.

## IV. Caseloads

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system and has been a focus of DSS's reform. Case managers must have the resources and supports needed to engage families and providers in creating meaningful plans and monitor progress towards individualized case goals, among many other important tasks.[30] Child welfare agencies must ensure that the appropriate number and types of positions – including case managers, supervisors, and support staff – are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled with trained staff with as little disruption as possible to families and staff. Case managers also need training and supervision to ensure they have the skills required to effectively carry out their roles, and must be compensated with salaries and benefits that equate to a professional living wage so they can invest in and pursue their work as a career.

As discussed below, DSS moved forward this monitoring period with important structural changes to improve the efficiency of its workforce. Caseloads have been reduced for all types of case managers – foster care, adoptions, and Out-of-Home Abuse and Neglect (OHAN) investigators – although not to the degree required to meet FSA interim benchmarks.

**Key Developments: Staffing and Caseloads, March 2020**




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

## *Workload Progress and Implementation Updates*

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

The Workload Implementation Plan was approved by the Co-Monitors on February 20, 2019, and approved by the Court on February 27, 2019.[31] The strategies within the Plan focus primarily on improvements to infrastructure and hiring, training, and retention of case managers and supervisors. The strategies are sequenced for short-term implementation (due January 2019 through January 2020), intermediate implementation (due July 2019 through July 2020), and longer-term implementation (due July 2020 through 2023). The discussion below includes implementation updates for select short-term and intermediate strategies due during this period.

*Hiring, Training, and Onboarding of New Case Managers and Supervisors*
Obtaining and filling new case manager positions is a strategy that can have a significant impact on the current caseload size of staff. Historically, DSS has not had enough case manager positions to ensure caseloads are within the required limits, and even when positions become available, there have been challenges in hiring and retaining staff. For example, in CY2019, the turnover rate for DSS staff was 32 percent.[32,33] The adoption staff turnover rate was 25 percent (increase from 17% in CY2018), and within foster care staff, 27 percent left in CY2019 (decrease from 35% in CY2018).

In its FY2018-2019 budget, DSS received funding for 182 case manager positions and 37 supervisor positions; some of this funding was to create new positions, and some was to provide funding for previously unfunded positions. As of July 2019, when the Joint Report was developed,[34] 29 previously funded case manager positions and six supervisor positions remained unfilled. DSS committed to filling these positions

[31] The Workload Implementation Plan is available at: https://dss.sc.gov/media/1948/dss-workload-implementation-plan.pdf
[32] This includes staff in adoptions, family preservation, foster care, Intensive Foster Care and Clinical Services (IFCCS), intake, investigations, licensing, and OHAN.
[33] The highest turnover rate was with Intensive Foster Care and Clinical Services (IFCCS) case managers (43%), with over half leaving in the third and fourth quarter of CY2019, which is when a decision was made to eliminate the position by the end of the year.
[34] DSS identified a number of limited action items on which it could move forward without the resources it had requested from the legislature in its FY2019-2020 budget, memorialized in a Joint Report of Plaintiffs and Defendants (the "Joint Report") (July 22, 2019, Dkt. 145). These commitments have been implementation priorities over the course of the monitoring period and are referenced throughout each section of this report.

by October 31, 2019, and as of June 24, 2020, DSS reports 220 of 223[35] positions allocated in FY2018-2019 have been filled; candidates for the two case manager positions have been selected, and their applications sent to Human Resources for processing, and the remaining supervisor position was scheduled to be posted in late June 2020.

DSS continues to make annual, updated projections on the number of additional case manager and supervisors needed to achieve caseload targets. Using a standard of assigning no more than 12 children to one case manager, DSS estimated a need for 213 additional case manager and 43 supervisor positions over previously funded positions in FY2020-2021. The agency sought the requisite resources to fund these positions (cost of approximately $23 million) in its FY2020-2021 budget request. As of the writing of this report, it is not yet known if this funding will be approved and included in the final state FY2020-2021 budget.

*Increased Salaries for Staff with BSW and MSW Degrees*

One of the foundational strategies in the Workload Implementation Plan includes steps to stabilize and professionalize the workforce including the adoption of a new salary schedule for case managers and supervisors that will raise entry level salaries significantly, and provide for structured increases based on education, training, and longevity.[36] The salary schedule in the approved Plan provides greater parity with case manager salaries in states with similar demographic characteristics, and ensures staff receive a living wage upon hiring or no later than within two to three years of employment. To implement this strategy, DSS included a request for the necessary funds (approximately $23.3 million in state general funds) within its FY2020-2021 budget, for implementation to begin in July 2020. As of the writing of this report, it is not yet known if this funding will be approved and included in the final state FY2020-2021 budget.

*Case Assignment and Worker Categories*

During this monitoring period, DSS completed two Implementation Plan strategies that have had a significant impact on how its workforce is structured, and are intended to positively impact its ability to achieve and maintain caseloads within the required limits.[37] First, between September and December 2019, DSS phased out use of Intensive Foster Care and Clinical Services (IFCCS) as a separate workload and

[35] This includes four additional OHAN investigator positions that have a different classification than county case manager positions.

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

[37] Historically, DSS organized its case carrying workers for Class Members into several types: (1) foster care case managers who are located and supervised through county offices; (2) adoption case managers who are frequently secondary case managers for children in foster care with permanency goals of adoption but who are not yet legally eligible for adoption; and (3) IFCCS case managers who are assigned to children with significant mental or behavioral health needs, and are located and supervised through 1 of the state's 4 regional DSS offices.

staffing category, and all IFCCS case managers and supervisors transitioned into foster care units in county offices. This change was recommended – and adopted by DSS – following the assessment of an expert workforce consultant who determined that, in most instances, IFCCS staff did not possess a higher level of training or skill than other foster care case managers, and that assigning case management solely based on the needs of the child as determined at one point in time, diminishes the focus on case and permanency planning with families. This change occurred in several phases.[38] In September 2019, DSS conducted regional informational meetings regarding the restructure, and by October 30, 2019, Human Resources updated position descriptions, location changes, and supervisor changes, as needed. By November 30, 2019, DSS conducted regional training on South Carolina's Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) process, and new Well-Being Team members received training on new job tasks.[39] Finally, as discussed in more detail in Section IX. *Health Care*, in December 2019, DSS repurposed many IFCCS positions as key members of new DSS Well-Being Teams. By the end of the month, DSS completed the transfer of IFCCS case managers and supervisors, and all associated cases, to the county structure.

The second change was the discontinuation of the practice of assigning the cases of children legally eligible for adoption to both adoption and foster care case managers, ensuring instead that children and families have one point of contact for communication and case planning. This transition began in February 2019 with children who already placed with a family that intended to adopt them, and continued through the end of the year for all children who were legally eligible for adoption.[40] Of the original cohort of children identified as legally free and not case managed by an adoption worker when the transition began, 85 percent (289 of 339 children) had been transferred for full case management by an adoption worker by June 2020.[41] DSS reports some cases are being transitioned more slowly due to the high caseload size of adoptions staff; the data presented later in this section reflect only 25 percent of adoption case managers had caseloads within the required standard of 1:15 as of the end of March 2020.

Finally, in response to specific concerns about the caseloads of case managers responsible for investigating allegations of abuse and/or neglect of children in foster

[38] The Implementation Plan requires DSS to develop an IFCCS transition plan by August 30, 2019. The Joint Report modified this commitment, and requires DSS to finalize the transition plan for phasing out IFCCS case managers and determine staffing and fiscal impact by September 30, 2019.
[39] Ibid.
[40] See Appendix B for a detailed explanation of each phase and timeline for transfers to adoption case managers.
[41] Of the 50 children who are legally eligible for adoption and continue to be managed by county offices, 10 children have a permanency goal of APPLA, 10 children are over age 18, 9 children are age 17, and 14 children are age 16. DSS reports that 16-year old children who are legally free will transfer to case management by an adoption worker unless there are extenuating circumstances (e.g., children who are medically fragile and the county case manager is most familiar with the child's diagnosis, case needs, etc.); and that decisions to transfer 17-year olds to case management by an adoption worker are made on a case-by-case basis, taking into consideration the desires of the youth and other factors related to their permanency plans.

care – DSS's OHAN unit – the Workload Implementation Plan requires that by September 2019, DSS assess OHAN caseloads and determine how many additional staff may be needed to bring staff to the required caseload standards. DSS has determined to meet the caseload requirements, 11 new positions are necessary. DSS's FY2020-2021 budget request includes these new positions for OHAN; as of the writing of this report, the status of this request has not been determined.

Multiple changes occurred during the first three months of this monitoring period, October through December 2019. DSS staff transitioned to new caseload categories, there were delays in filing vacancies in anticipation of transfers; adoption case managers took on increased case management responsibility for cases already on their caseload; leading up to change in caseload standards as of January 2020. As of January 2020, both foster care case managers (now inclusive of prior IFCCS positions), and adoption case managers are assessed at the 1:15 (one worker to 15 cases) caseload standard. In acknowledgement of these transitions, performance data for foster care and adoption case managers included below are only for the months of January through March 2020. OHAN case managers continue to have a caseload standard of 1:8 (one worker to eight investigations); caseload data for OHAN staff are assessed for all six months this period.

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

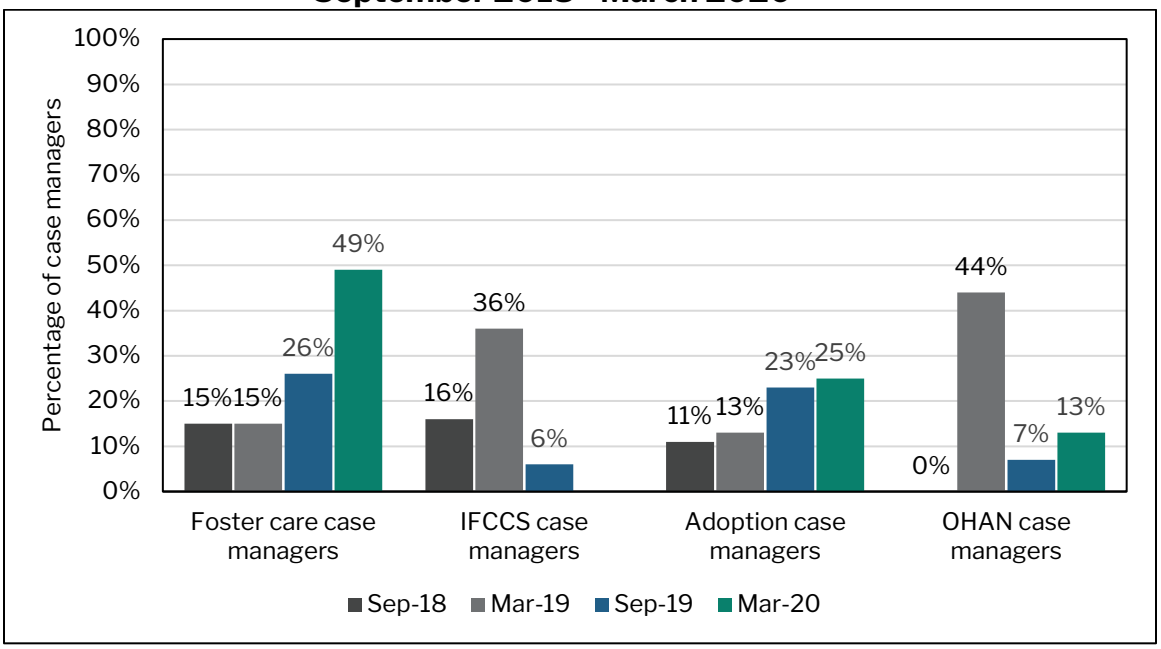
## *Performance Data*

The FSA requires *'[a]t least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit"* (FSA IV.A.2.(b)) and that *'[n]o Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit"* (FSA IV.A.2.(c)). The interim benchmark for this monitoring period is for at least 65 percent of all case managers to have caseloads within the required limits, and no more than 25 percent of all case managers to have caseloads more than 125 percent of the required limits. As referenced earlier, there are different caseload standards dependent upon the types of cases a case manager manages – specifically foster care and adoption, and investigations of allegations of abuse and neglect of children in foster care (OHAN).[42]

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

To assist in assessing progress over time, Figure 7 and Figure 8 show performance data on caseloads by case manager and supervisor type for prior and current monitoring periods. As of March 31, 2020, caseload levels had improved since the last period for all types of case managers,[43] however, performance for supervisor workload is mixed.

**Figure 7: Performance Trends for Percentage of Case Managers Within the Required Caseload Limits, by Case Manager Type September 2018 - March 2020[44,45]**




Source: CAPSS data provided by DSS

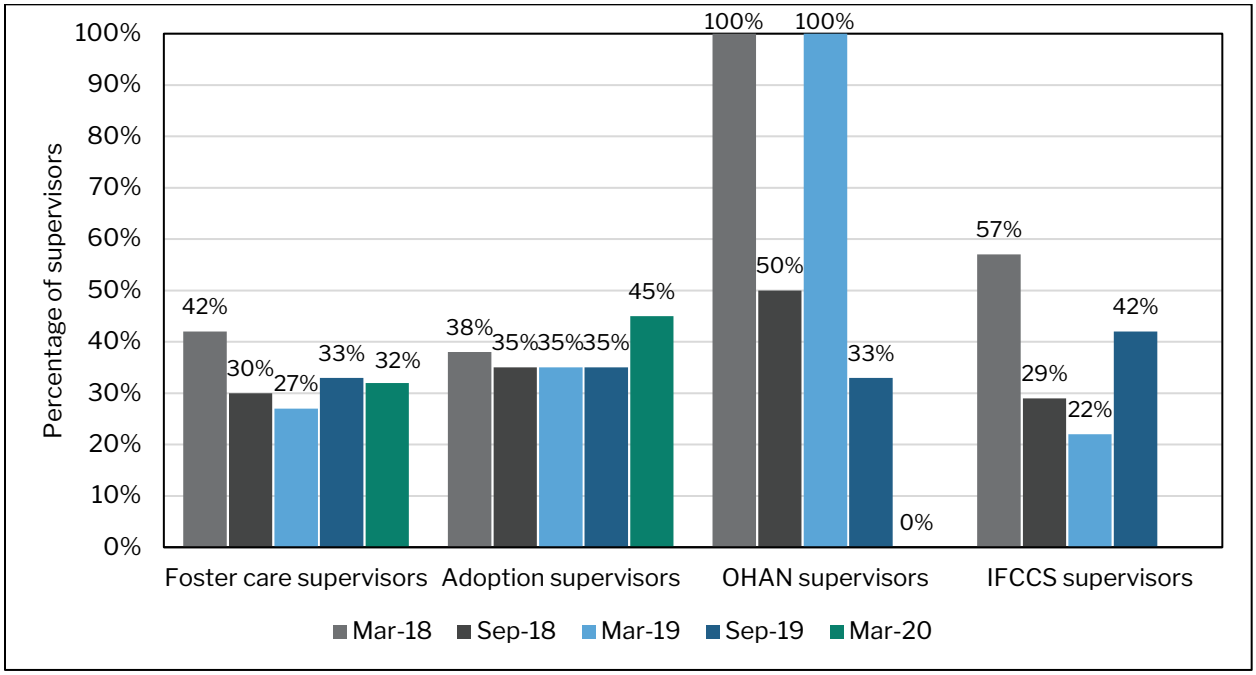
case manager assignment to several family preservation cases involving families with multiple children. DSS has indicated that supervisors and office managers are continually assessing assignments to case managers with mixed caseloads to ensure balanced and manageable workloads. Because approval of this methodology is "provisional," DSS and the Co-Monitors will assess it in practice as it is implemented, reserving the right to modify the standard at any time if it is determined that the best interests of children are not being served. The following types of cases are counted by family (case): Child Protective Services (CPS) assessment; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on Placement of Children (ICPC). This methodology is only applied to foster care case managers with mixed caseloads and is not applied to adoption case managers.

[43] The Co-Monitors selected a random day in each month during this period to measure caseload compliance for each type of case manager. These random dates are as follows: October 23, 2019; November 18, 2019; December 9, 2019; January 14, 2020; February 29, 2020; March 31, 2020.

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

[45] IFCCS caseload performance data were assessed between September 2018 and September 2019. This position was eliminated in late-2019, and staff transitioned into county offices as foster care case managers.

**Figure 8: Performance Trends for Percentage of Supervisors Within the Required Workload Limits, by Supervisor Type March 2018 – March 2020[46,47]**




Source: CAPSS data provided by DSS

## Foster Care Case Managers

*The caseload standard for case managers who are responsible for providing case management for foster care cases is one case manager to 15 children (1:15).* Newly hired foster care case managers are expected to have reduced caseloads as they build skills for this work and should have no more than eight (1:8) cases on their caseload for six months after they complete Child Welfare Certification training.

The March 2020 interim benchmark for this measure is 65 percent of case managers will not exceed 15 children on their caseloads and no more than 25 percent of case managers will have more than 18 cases (125% of the required caseload standard). The standard also requires that no case manager has a caseload of more than 170 percent (no more than 25 cases, or 13 for new case managers) of the standard by March 2020.

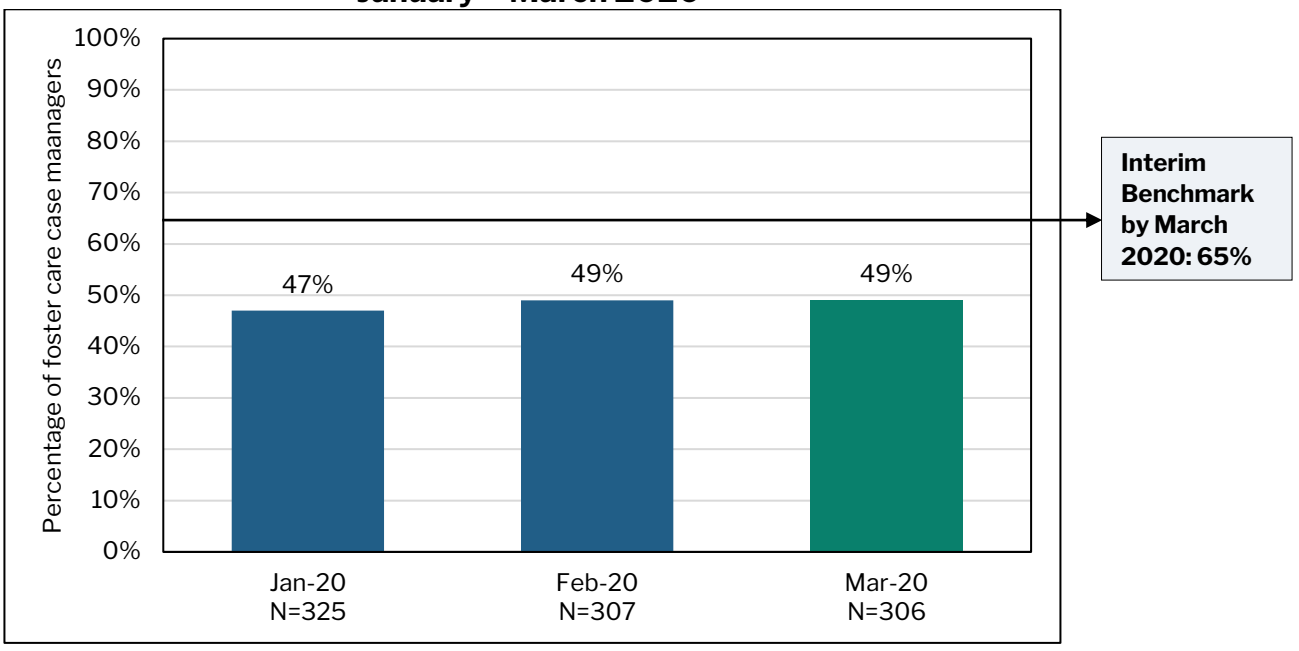
On March 31, 2020, there were 306 foster care case managers with at least one child in foster care on their caseload.[48] Of these case managers, slightly less than half (49%, or 151 of 306) of the total foster care case managers had caseloads within the

[46] Workload limits for supervisors are as follows: foster care, and adoption supervisors, 1 supervisor to 5 case managers; OHAN supervisors, 1 supervisor to 6 investigators. The final target for this measure is 90%.
[47] IFCCS supervisor workload performance was assessed between September 2018 until September 2019. This position was eliminated in late-2019, and staff transitioning into county offices as foster care supervisors.
[48] This includes 68 newly hired foster care case managers.

required limit of 15 cases (eight cases for new case managers), and 106 (35%) case managers' caseloads were more than 125 percent of the caseload limit, meaning they were responsible for at least 18 cases (at least 10 cases for new case managers). Additionally, as of March 31, 2020, 42 (14%) foster care case managers had a caseload of more than 170 percent of the standard.

Point-in-time data for each month between January and March 2020 show that between 47 and 49 percent of foster care case managers, including new case managers, had caseloads within the required limit (see Figure 9); 34 to 36 percent of foster care case managers had caseloads that were more than 125 percent of the caseload limit; and 14 to 16 percent had caseloads that were more than 170 percent of the caseload limit (see Figure 10).[49] Performance has improved since the prior period (between April and September 2019, 15 to 26% of foster care case managers had caseloads within the standard), but does not reach the interim benchmark of 65 percent.

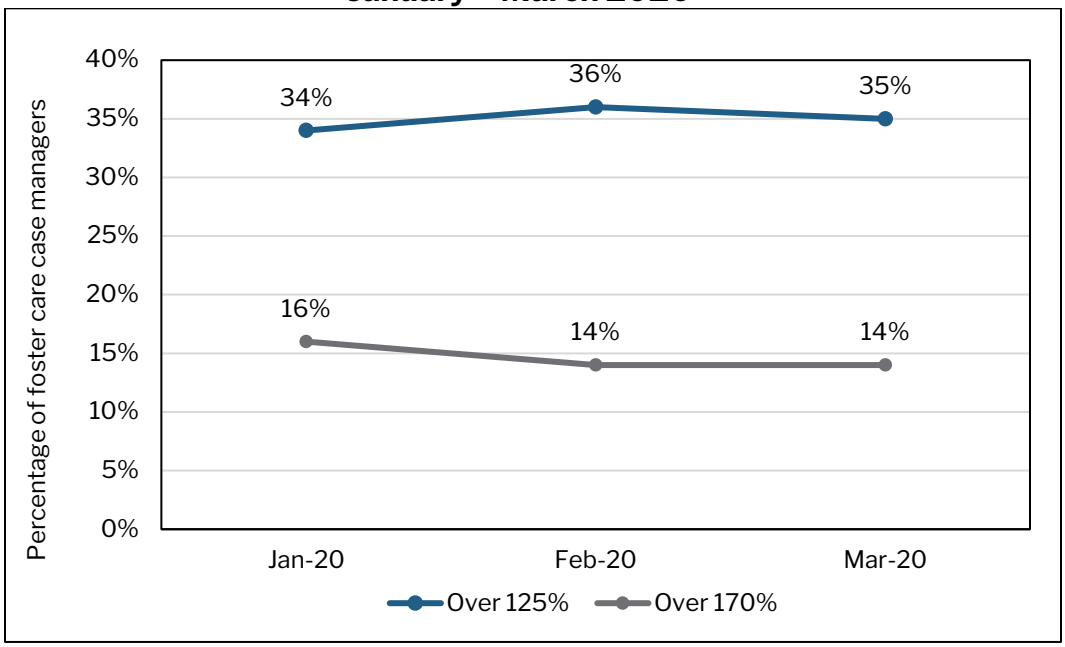
**Figure 9: Foster Care Case Managers Within the Required Caseload Limits January – March 2020**




Source: CAPSS data provided by DSS

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

**Figure 10: Foster Care Case Managers over 125% and 170% of Required Caseload Limits January – March 2020[50]**

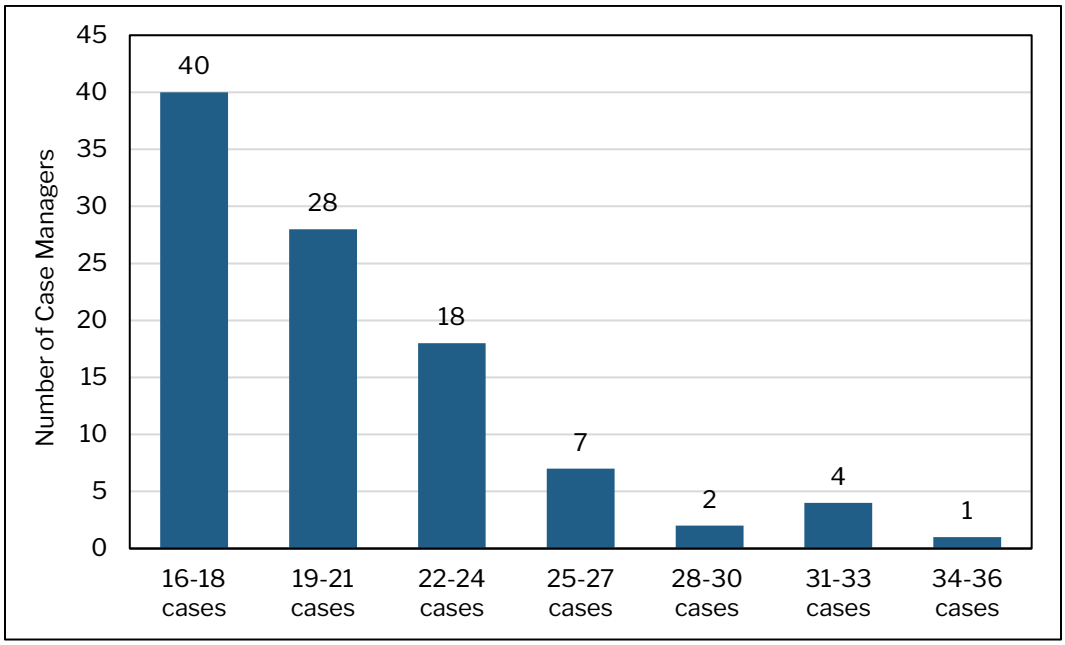



Source: CAPSS data provided by DSS

Figure 9 and Figure 10 merge data for all foster care case managers – those newly hired as well as those hired more than six months prior. Figure 11 reflects the number of cases carried specifically by the 100 foster care case managers who had completed Child Welfare Certification more than six months prior and had responsibility for more than 15 children on March 31, 2020. Over half (68%) of these case managers had caseloads between 16 and 21 cases, and almost 20 percent managed caseloads between 22 and 24 cases.

[50] The interim benchmark for case managers with over 125% of the limit is no more than 25% by March 2020. Additionally, by March 2020, no (0%) case manager should have a caseload more than 170% of the limit.

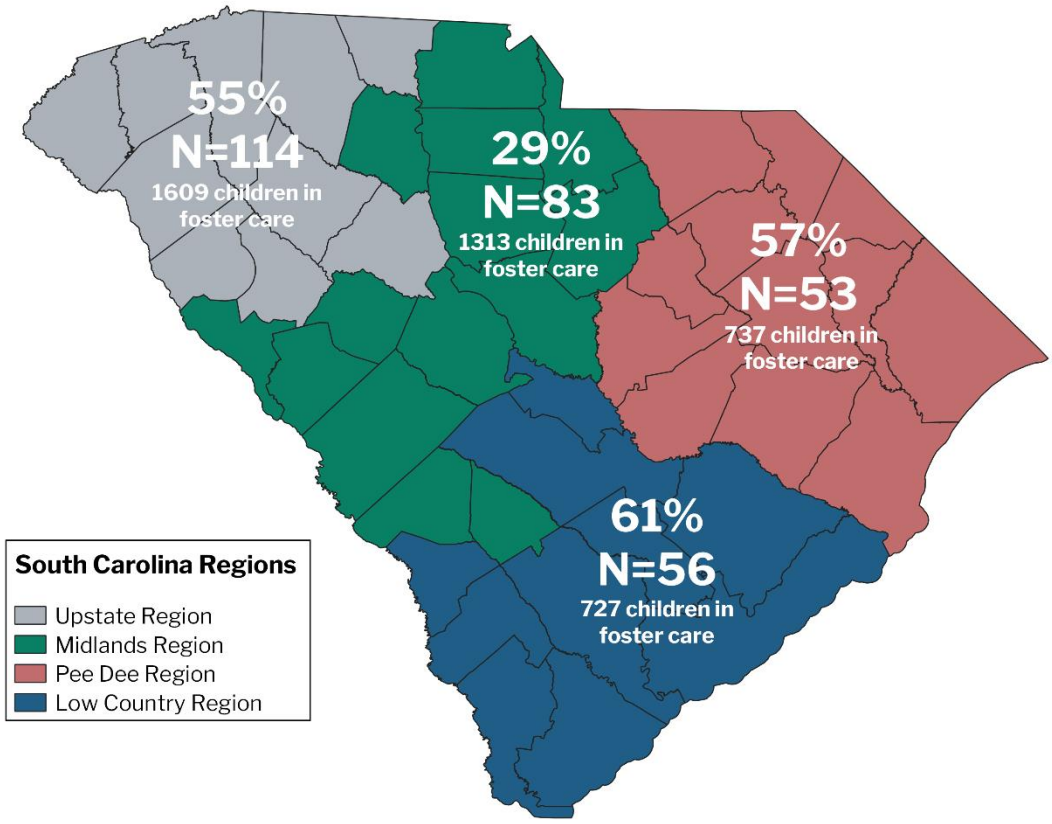
**Figure 11: Number of Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago and Were Over the Caseload Limit**
**March 31, 2020**
**N=100**




Source: CAPSS data provided by DSS

DSS offices are divided among four regions, and each differs in terms of geographical size, the number of children and families served, and the number of assigned and onboarded case managers. Data on foster care case manager caseloads by region as of March 31, 2020, are shown in Figure 12. Although regional performance for foster care case manager caseloads is lower than the interim benchmark in every region, the Low Country has the highest performance (61%). In the Midlands, less than one in three case managers (29%) had a caseload within required limits.

**Figure 12: Percentage of Foster Care Case Managers Within the Required Caseload Limit by Region March 31, 2020**




Source: CAPSS data provided by DSS

## Adoption Case Managers

*The caseload standard for case managers providing adoption support to children with a goal of adoption is one case manager to 15 children (1:15).*[51] Newly hired adoption case managers should have no more than nine children on their caseload for six months after they complete Child Welfare Certification training. The March 2020 interim benchmark for this measure is 65 percent of case managers with no more than 15 cases, no more than 25 percent of case managers with more than 18 cases

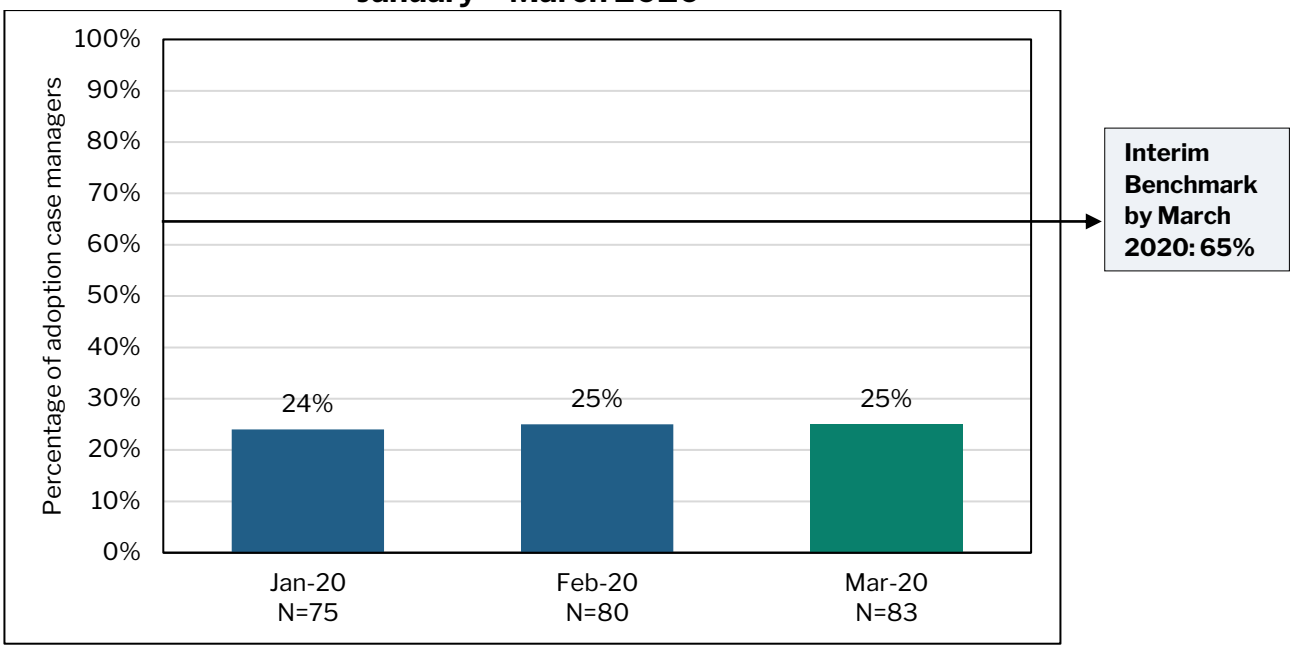
[51] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager, even when an adoption case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for adoption workers was 1:17. In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

(125% of the required caseload standard), and also requires that no case manager has a caseload of more than 170 percent (no more than 25 cases, or 13 for new case managers) of the standard by March 2020.

On March 31, 2020, there were 83 adoption case managers serving at least one Class Member.[52] Of these 83 case managers, 21 (25%) case managers had caseloads within the caseload requirement, and 42 (51%) case managers had caseloads that exceeded 125 percent of the limit. Additionally, 11 (13%) adoption case managers had a caseload of more than 170 percent of the standard.

Between January and March 2020, a monthly range of 24 to 25 percent of adoption case managers had caseloads within the required limit (see Figure 13); 51 to 64 percent of adoption case managers had caseloads that exceeded 125 percent of the required limit; and 13 to 39 percent had caseloads over 170 percent of the limit (see Figure 14). As with foster care case manager caseloads, adoption case manager caseloads have improved from the prior period (between April and September 2019, 10 to 23% of adoption case managers had caseloads within the standard) but does not reach the interim benchmark of 65 percent.

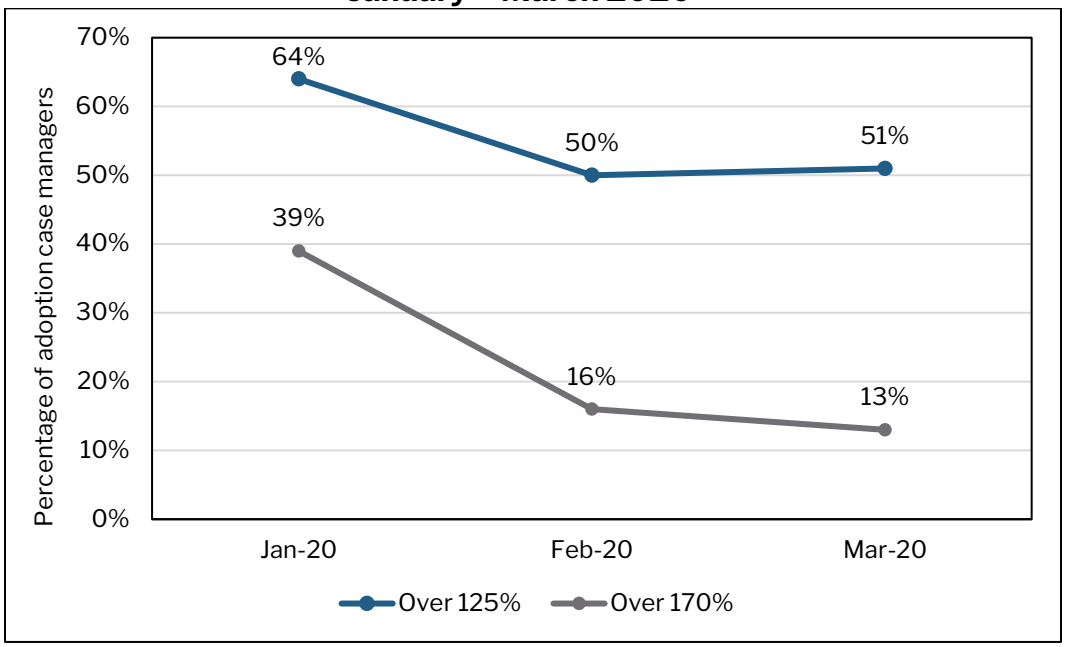
**Figure 13: Adoption Case Managers Within the Required Caseload Limits January – March 2020**




Source: CAPSS data provided by DSS

[52] This includes 8 newly hired adoption case managers.

**Figure 14: Adoption Case Managers over 125% and 170% of Required Caseload Limits January – March 2020[53]**




Source: CAPSS data provided by DSS

## Out-of-Home Abuse and Neglect Case Managers

*The caseload standard for case managers conducting investigations involving allegations of abuse and/or neglect of a child in foster care is one case manager per eight investigations (1:8).* Newly hired OHAN case managers should have no more than four investigations on their caseload for six months after they complete Child Welfare Certification training. The March 2020 interim benchmark for this measure is 65 percent, no more than 25 percent of case managers with more than 10 investigations (125% of the required caseload standard), and also requires that no case manager has a caseload of more than 170 percent of the standard (no more than 13 cases or 7 for new case managers) by March 2020.

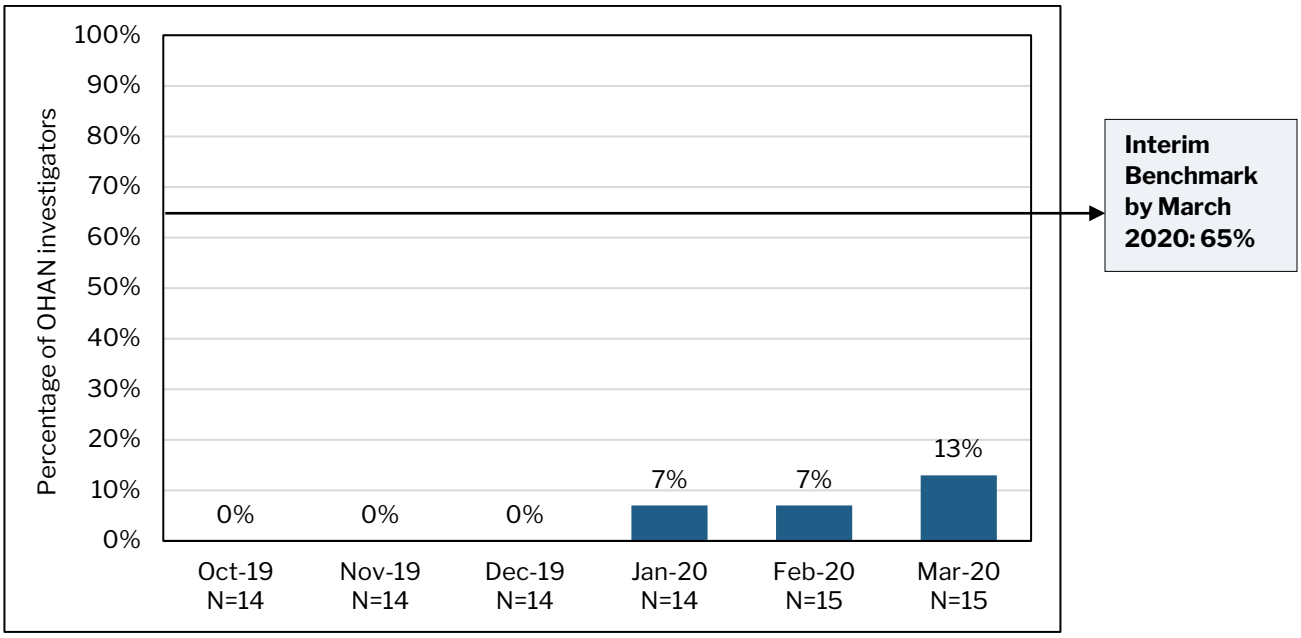
In March 2020, OHAN had 15 assigned investigators; one was a new case manager who had started in February 2020. On March 31, 2020, of the 15 OHAN investigators, two (13%) investigators had a caseload within the required standard, and 13 (87%) investigators had caseloads over 125 percent of the required limit. Additionally, eight (53%) OHAN investigators had caseloads of more than 170 percent of the standard.

Between October 2019 and March 2020, a monthly range of zero to 13 percent of OHAN case managers had caseloads within the required limits (see Figure 15), and 86

[53] The interim benchmark for case managers with over 125% of the limit is no more than 25% by March 2020. Additionally, by March 2020, no (0%) case manager should have a caseload more than 170% of the limit.

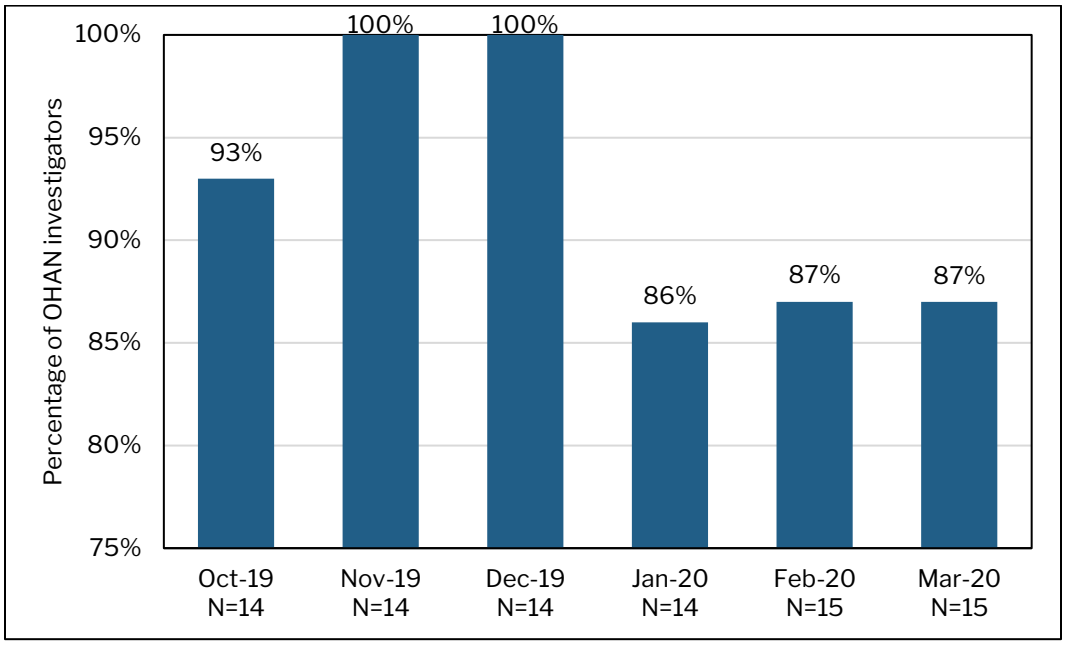
to 100 percent of case managers had caseloads that exceeded 125 percent of the required limit each month (see Figure 16).

**Figure 15: OHAN Investigators Within the Required Caseload Limits October 2019 – March 2020**




Source: CAPSS data provided by DSS

**Figure 16: OHAN Investigators over 125% of Required Caseload Limits October 2019 – March 2020[54]**

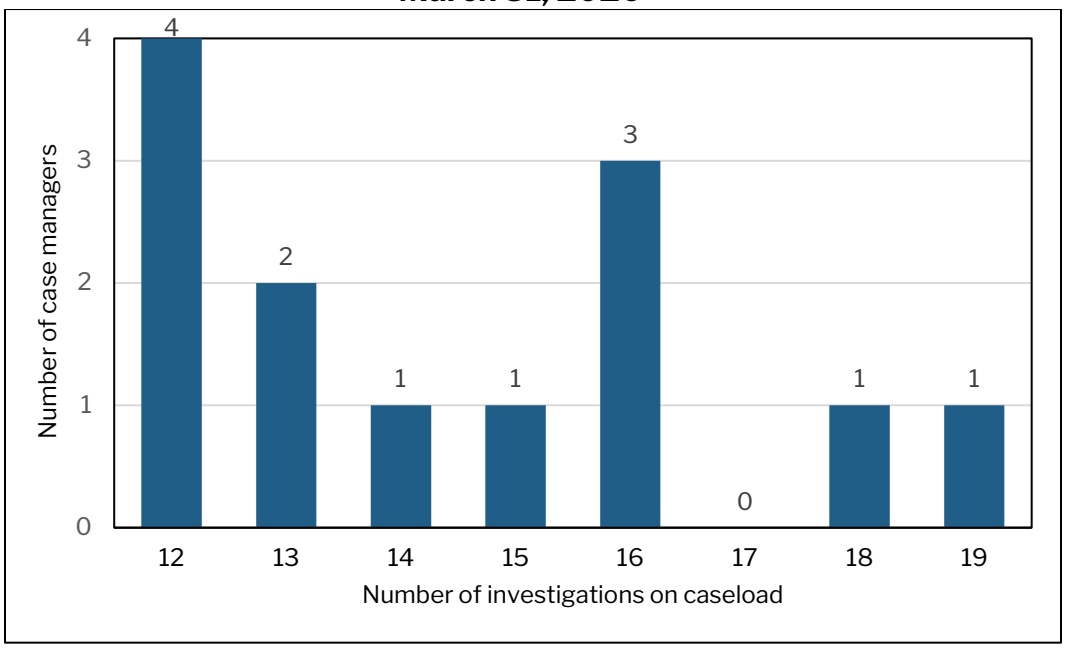



Source: CAPSS data provided by DSS

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

Figure 17 includes the caseload size of the 13 OHAN investigators who had caseloads exceeding the limit on March 31, 2020. Nearly half (46%) of investigators had caseloads that were double or greater than twice the standard, including the new OHAN investigator who started in February 2020 and was assigned 12 investigations by the end of March.

**Figure 17: Caseload Size for OHAN Case Managers that Exceeded the Limit March 31, 2020[55]**

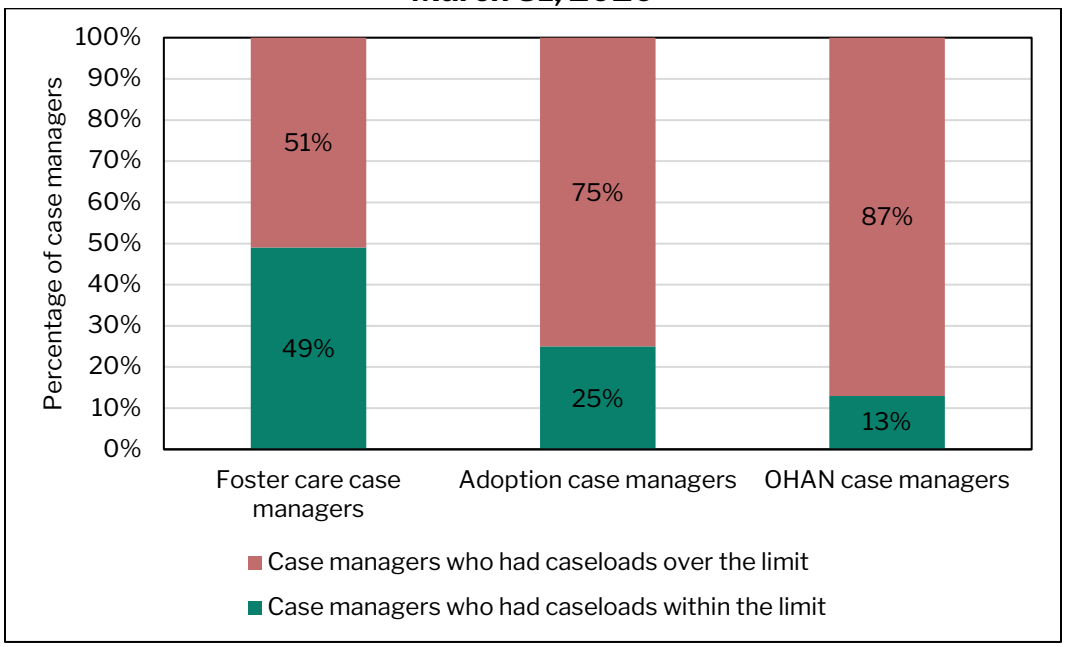



Source: CAPSS data provided by DSS

In summary, Figure 18 reflects the percentage of foster care, adoption, and OHAN case managers within and over the required caseload limits on March 31, 2020.

[55] One OHAN case manager with a caseload size of 12 was the new worker who had started in February 2020. As a new worker, the caseload limit is 4 investigations.

**Figure 18: Foster Care, Adoption, and OHAN Case Managers that were Within and Over the Required Caseload Limits March 31, 2020**




Source: CAPSS data provided by DSS

## Supervisor Workloads

The Workload Implementation Plan includes separate timelines and interim benchmarks for supervisors. The final target is that at least 90 percent of supervisors will supervise the number of case managers within the limit, and no supervisor will be assigned more than 125 percent of the standard. By March 2020, the interim benchmark is that 80 percent of foster care and adoption supervisors will supervise no more than five workers, and OHAN supervisors will be responsible for no more than six investigators. Additionally, no more than 10 percent of supervisors will be responsible for more than 125 percent of the required standard (or 7 case managers for foster care and adoption supervisors, and 8 investigators for OHAN supervisors).

DSS has also identified occasional situations in which supervisors may be directly responsible for a case for a short period of time. These include when a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is nearing closure, if there are complexities regarding the case that need to be addressed, or if an important legal event will occur within the timeframe. While the supervisor is 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. For the first time this period, DSS provided detailed data for some months during the period, identifying which supervisors are carrying cases, for how long they have been assigned to the cases, and the type of cases (e.g., foster care, child protective services, or children subject to the Interstate Compact on the Placement of Children because they are placed in South Carolina from a different state). The data reflect that 126 supervisors were responsible for at least one Class Member on their caseload as of March 31, 2020. Of those, 26 supervisors (21%) were responsible for at least one case for over five days. Most (73%, or 19 of 26) of these supervisors were responsible for one to five cases, however, six supervisors were responsible for directly managing between 10 and 17 cases. The Co-Monitors were not able to identify any assignments among these 126 supervisors that were made according to the limited situations DSS has identified as being acceptable.[56] Co-Monitor staff have discussed these data with DSS staff, who will follow-up to make adjustments as needed.

**Foster Care and Adoption Supervisors**

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

As referenced earlier, DSS provided for the first time this period details on supervisors carrying cases in addition to their supervision of case managers during February and March 2020. Co-Monitor staff analyzed these data for March 2020, and are including performance for only this month. On March 31, 2020, of the 117 supervisors supervising foster care case managers, 37 (32%) supervised five or fewer case managers, and 48 (41%) supervisors supervised more than six case managers.[57]

Between October 2019 and March 2020, a monthly range of 44 to 50 percent of adoption supervisors supervised five or fewer case managers, and 25 to 37 percent of supervisors supervised more than six case managers, or 125 percent of the

[56] In more closely reviewing these situations, DSS identified several themes. These include: supervisors in adoptions keeping cases to finalization of the adoption for continuity; issues with supervisors in small counties with limited staff to reassign cases to; errors in data entry and management where services were not closed but should have been; and turnover and timing issues in some cases where the service closed or transferred with the hiring of new staff.

[57] The Co-Monitors identified 3 foster care supervisors who were assigned 13 or more cases as of March 31, 2020 in addition to supervising 3 or 4 staff. None of these case assignments were determined to meet one of the appropriate situations in which a supervisor may be responsible for carrying a case for a limited period of time. The Co-Monitors assessed these supervisors as out of compliance with the workload limit.

required limit.[58,59] Specifically, on March 31, 2020, of the 29 supervisors supervising adoption case managers, 13 (45%) supervisors supervised five or fewer case managers, and 10 (34%) supervisors supervised more than six case managers. Current performance is below the interim benchmark of 80 percent.

*The workload standard for supervisors providing supervision to case managers conducting OHAN investigations is one supervisor to six investigators (1:6).*[60]

Between October 2019 and March 2020, OHAN had two to three supervisors each month responsible for the 14 to 15 investigators who were accepting investigations. A monthly range of zero to 67 percent of OHAN supervisors supervised six or fewer case managers, and in the last three months of the period, one (50%) supervisor supervised more than seven case managers, or 125 percent of the required limit.[61,62,63] In March 2020, there were two OHAN supervisors, and neither (0%) supervisor was responsible for six or fewer case managers.

[58] Monthly performance for adoption supervisors supervising 5 or fewer case managers are as follows: October 2019, 44%; November 2019, 45%; December 2019, 50%; January 2020, 50%; February 2020, 48%; March 2020, 45%.
[59] Monthly performance for adoption supervisors supervising more than 6 case managers are as follows: October 2019, 25%; November 2019, 25%; December 2019, 25%; January 2020, 27%; February 2020, 37%; March 2020, 34%.
[60] 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.
[61] Large fluctuations in performance are due to the small number of supervisors each month.
[62] Monthly performance for OHAN supervisors supervising 6 or fewer case managers are as follows: October 2019, 67%; November 2019, 67%; December 2019, 67%; January 2020, 0%; February 2020, 0%; March 2020, 0%.
[63] Monthly performance for OHAN supervisors supervising more than 7 case managers are as follows: October 2019, 0%; November 2019, 0%; December 2019, 0%; January 2020, 50%; February 2020, 50%; March 2020, 50%.

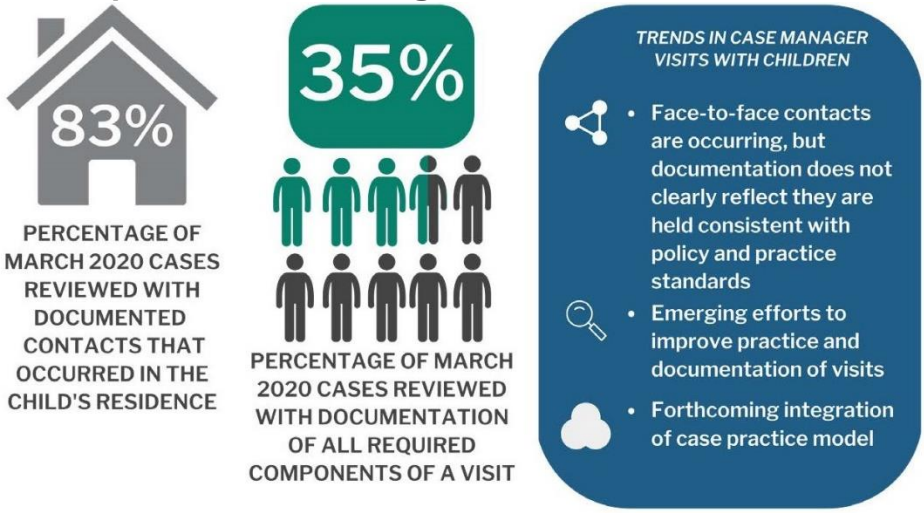
## V. Visits Between Case Managers and Children

DSS case managers are expected to have face-to-face contact with children in foster care and their caregivers on a monthly basis, and more often depending on the needs of the child or foster family. These visits allow case managers to assess whether a child is safe and well in areas such as physical and emotional health, and to ensure that their needs are being met in their foster home. The visits also provide an opportunity for case managers to assess the status of any services being provided to the child and/or foster parent, to share updates on progress towards permanency, and to build relationships with the child and their caregivers.

Monthly contacts between case managers and children are occurring in nearly all cases. However, documentation has not consistently reflected that practice during these contacts aligns with DSS's policy and practice expectations for visits between case managers and children. DSS has continued to promote visits between case managers and children that focus on assessing the status of children and foster families, and on identifying progress and challenges. DSS has also worked to build an understanding amongst case managers and supervisors of the importance of complete, timely documentation in CAPSS.

Improving performance in this critical area will ultimately depend upon DSS's ability to implement its GPS Case Practice Model and support staff in meeting new practice expectations with efforts such as continuing to reduce caseloads to a manageable level and placing children closer to their home communities so that their case managers spend more time with them than traveling to see them. Case managers and supervisors will also need to focus on documenting their interactions with children and families, as required, so there is a clear record of engagement.

**Key Developments: Case Manager Visits with Children, March 2020**



## *Visits Between Case Managers and Children: Progress and Implementation Updates*

The Co-Monitors approved DSS's Visitation Implementation Plan on March 28, 2019.[64] The Plan includes strategies to clarify the role and function of case manager contacts with children through GPS Case Practice Model implementation; increase the quality of these contacts by developing and delivering training; improve the quality of documentation of visits; and implement quality improvement processes.

As DSS continues work with Chapin Hall[65] to implement its GPS Case Practice Model – which includes a focus on the importance of collaborative relationships with children and their caregivers, conducting formal and informal assessments, and creating and tracking plans with children, parents, and caregivers – the agency is also drafting policy and procedures to further guide case manager practice during visits with children and their caregivers. DSS reports that consultation with the federally funded Capacity Building Center for States to develop curriculum on contacts and documentation has resulted in an outline for a curriculum that is expected to be completed by September 30, 2020. Practice guidance was distributed in November 2019. Collectively, if properly implemented, these activities are intended to have a positive impact on outcomes for children in DSS custody and their families.

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

## *Performance Data*

The FSA requires "*at least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place,"* and "*at least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child"* (FSA IV.B.2.&3.). The total minimum number of monthly visits between children and a case manager refers to a federal requirement of a minimum of one visit per month.[66]

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

[64] The Visitation Implementation Plan is available at: https://dss.sc.gov/media/1956/3-28-2019-final-dss-visitation-implementation-plan.pdf
[65] https://www.chapinhall.org/
[66] Social Security Act - Section 422(b)(17)

DSS Policy and Procedure (Chapter 5, Foster Care Visitation, effective June 1, 2019),[67] for purposes of compliance with the FSA.[68]

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

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

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

Although quantitative data on case manager contacts with children is available through CAPSS, a closer review of individual case records is required to assess documentation related to the content of those contacts. Applying a survey instrument, reviewers assessed documentation of case manager contacts with children for the agreed-upon elements of a visit, as described above. Specifically, reviewers gather data on whether the record reflected that: the child was seen alone; there was a summary of the conversation; there were assessments of safety, permanency, and well-being; there was discussion of the status of services being delivered; and there was a discussion of the status of the case plan, as required by DSS policy.

The ability of DSS case managers to see children in their homes was impacted by the COVID-19 pandemic towards the end of this monitoring period. Although case managers were still able to have contact with children in person under the Governor's directive,[69] DSS encouraged case managers to ask a series of screening questions about possible exposure to COVID-19 and symptoms of the illness, travel to certain

[67] Human Services Policy and Procedural Manual, Chapter 5, Section 510.7.300 can be accessed at: https://dss.sc.gov/media/2070/additionalupdatedpolicy_2019-06-07.pdf

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

[69] As discussed above, in continued response to the COVID-19 pandemic, Governor McMaster issued a subsequent Executive Order on March 13, 2020, directing all non-essential State employees to not report to work in-person, effective March 20, 2020. Child welfare county directors and intake staff are considered essential but case managers were expected to work from home. DSS directed case managers to work remotely, with the expectation that all work-related activities would continue. On March 25, 2020, DSS issued a letter to foster parents that explicitly allowed in-person contacts with case managers and service providers, if the foster parent was comfortable, and facilitating other forms of contact with children.

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

Despite the impact of the COVID-19 pandemic and implications for practice in the month of March, DSS leadership supported the plan to move forward with an assessment of case manager contacts with children for this time period. In collaboration with University of South Carolina's Center for Child and Family Studies (USC CCFS) and the Co-Monitors, DSS reviewed a statistically valid sample of 350 DSS case records for children in foster care during March 2020 to understand the practices of case managers relative to the expectations for the time spent with children.[70] Reviewers identified documentation of a face-to-face contact between the case manager and child in 347 of the 350 records.[71] The record for one child, who was in "runaway" status and for whom the case manager made efforts to locate during the month, was removed from the universe of cases. Reviewers further identified documentation of case manager contact with 288 (83%) of 349 children in the child's own residence. Contacts also took place at a DSS office, the child's school or daycare setting, and other locations in the community.[72] Most (204 of 288, or 71%) of the contacts case managers had with children in their residence were in person. Almost a quarter, 24 percent (64 of 288), of the contacts with children in their residence were virtual; and six percent (17 of 288) were by phone. There was also documentation that 93 percent (323 of 349) of the children were seen alone.

This finding supports the reliability of CAPSS data as an indication of whether a contact between a case manager and a child occurred. The review also concluded, however, that documentation still does not consistently reflect that practice during these contacts meet the agreed upon standard for an acceptable visit. Reviewers identified documented practices consistent with each required component of a visit pursuant to the FSA in only 35 percent (123 of 349) of records.[73] While improved from the 24 percent (80 of 338) result of a review documentation of face-to-face contacts in September 2019, these results remain well below the standard of 90 percent, showing both the need for improved practices and improved documentation in CAPSS.[74] Specifically:

- 91 percent (319 of 349) of the records contained a summary of conversations and observations;

[70] The sample was derived from a universe of 3,832 cases active for 30 days or more as of March 30, 2020, with a 95% confidence interval and 5% margin of error.
[71] In 2 cases, there was an unsuccessful attempt to see a child and in 1 case there was no documentation of an attempt or contact during the month.
[72] Case managers had 65 contacts via video and 19 via telephone due to restrictions on face-to-face contact related to the COVID-19 pandemic.
[73] Due to shifting protocols in response to the COVID-19 pandemic, 32 of the 123 cases in which documentation reflected all required components of a visit involved virtual visits (31 were held via video and 1 via phone).
[74] DSS is in the process of developing interim benchmarks for case manager visits with children. Draft proposed benchmarks were produced to the Co-Monitors on September 10, 2020.

- 62 percent (218 of 349) of the records contained evidence that the case manager assessed the child's safety;[75]

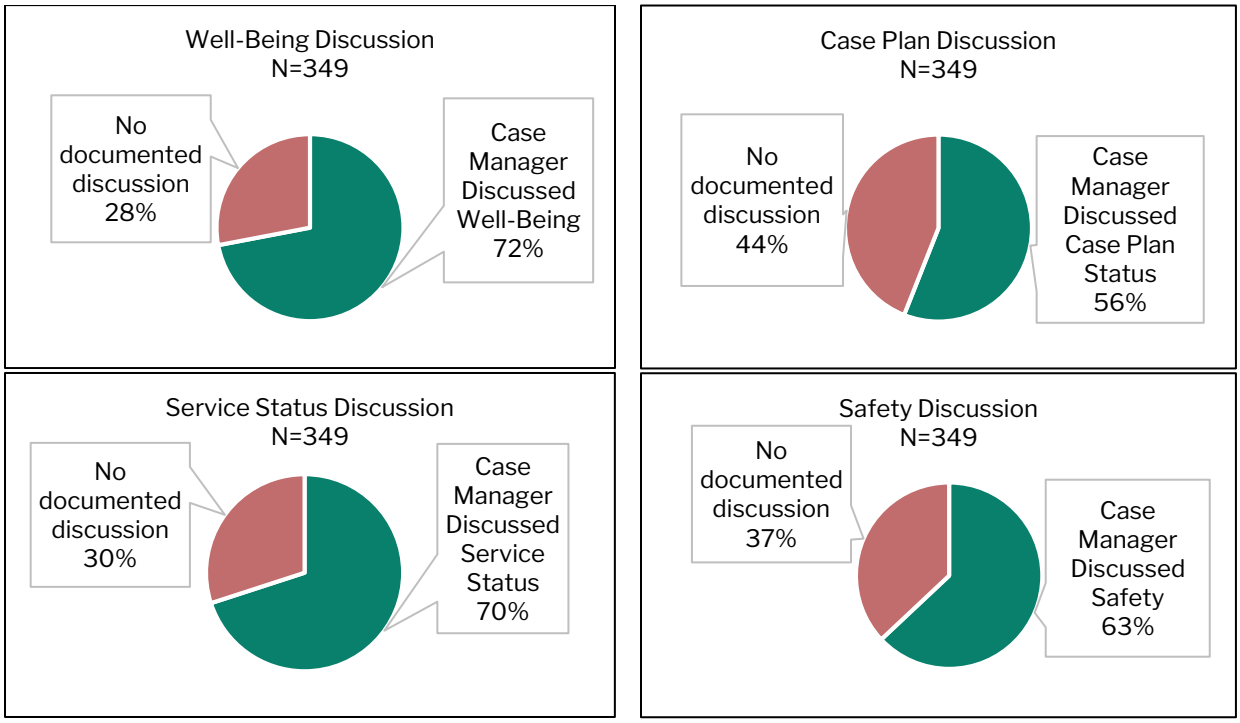
- 72 percent (251 of 349) of the records contained documentation that the case manager discussed the topics of well-being with the child and/or caregiver;

- 70 percent (243 of 349) of the records contained documentation that the case manager discussed the status of services being delivered with the child and/or caregiver; and

- 56 percent (196 of 349) of the cases contained documentation that the case manager discussed the status of a case plan with the child and/or caregiver.

Figure 19 depicts findings from the review of documentation of the DSS case manager's contacts with children and their caregivers.

**Figure 19: Documented Practices during Case Manager Contacts with Children and Caregivers March 2020**




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

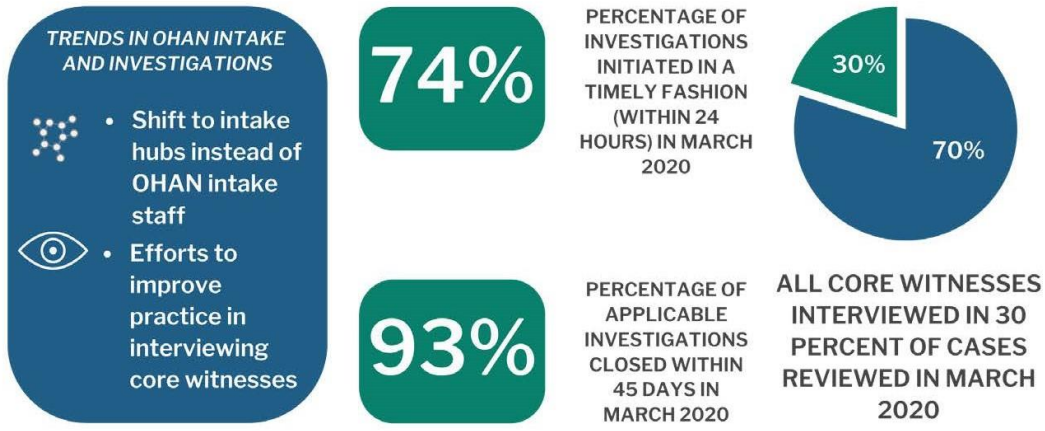
[75] In reviewing documentation regarding assessment of the child's safety, reviewers also applied the requirement that children be interviewed in private, as developmentally appropriate. In general, the expectation is that infants, toddlers, and children under the age of 4 can be seen in the presence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

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

The work of screening and investigating allegations of abuse and/or neglect of children in foster care – completed by DSS's OHAN program – is a critical function of any child welfare system. This program 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 determine if abuse or neglect occurred. Children are separated from their families and taken in foster care based on a determination that they have been abused or neglected by their caregivers - ensuring their safety and well-being while in state custody is a primary obligation.

Even during the COVID-19 pandemic, when many other DSS employees are teleworking, OHAN investigators have continued to do their work in person, and have been recognized as providing a critical role in ensuring children in DSS custody are safe. Performance data for the current monitoring period reflect improvement in timely initiation of investigations – which includes contacting all alleged victim children within 24 hours of the referral – and timely closure of investigations. Some progress has also been shown in contacting all necessary core witnesses during an investigation, but performance is still substantially below the interim benchmark. As previously reported, despite best efforts, progress in this area is likely to be limited until DSS has the resources available to add the significant additional staff positions needed to meet OHAN caseload requirements and ensure consistent high-quality practice including assessments of children's safety.

**Key Developments: OHAN Intake and Investigations**
**October 2019 - March 2020**



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

The FSA required that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to OHAN intake and investigations. The Implementation Plan must have *'enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets [...]"* (FSA IV.C.1.). On September 11, 2017, the Co-Monitors approved DSS's OHAN Implementation Plan and Plaintiffs provided their consent to the Plan on November 7, 2017.[76]

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

Work this period has centered on developing user-friendly CAPSS reports for staff to monitor timely contact with children involved in investigations and contacting all necessary core witnesses. OHAN has implemented some new practices to assist staff in identifying core witnesses for each investigation, but as the data below reflect, additional focus is needed for performance to improve. Ultimately, to implement the new skills staff have been taught in the updated OHAN investigation training curriculum, and to fully follow through on guidance investigators receive from supervisors, OHAN caseloads must more manageable. In March 2020, OHAN had 15 assigned investigators, and two (13%) of these investigators had a caseload within the required standard. Almost all investigators (87%, or 13 of 15) had caseloads over 125 percent of the required limit, and eight (53%) OHAN investigators had caseloads of more than 170 percent of the standard.

DSS has recognized that more staff are needed to reduce caseloads. As of March 31, 2020, OHAN had 15 investigator positions filled, as well as two supervisors. There was one vacant investigator position, and one vacancy for a supervisor. To meet caseload requirements, 11 new OHAN staff positions are necessary. Funding these

[76] 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

positions was included in DSS's FY2020-2021 budget request; as of the writing of this report, the status of this request has not been determined.

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

*Performance Data*

**OHAN Intake**

Beginning in November 2019, DSS's Intake Hubs began screening all referrals alleging abuse and neglect of children, including allegations involving Class Members in foster homes and institutions.[77] Screening decisions are made utilizing a Structured Decision Making® (SDM) intake tool.[78] Before this transition, OHAN intake staff were responsible for screening all referrals involving Class Members, and a less structured instrument was used. On July 27, 2020, the Intake Hubs began providing 24-hour coverage to receive and screen abuse and neglects referrals during weekdays, and OHAN staff continue to receive and screen referrals on weekends until the Hubs are staffed to provide full weekend coverage. DSS was planning for this to occur in June 2020, however due to disruptions caused by the COVID-19 pandemic, adjusted the schedule to October 15, 2020.

Intake Hub and OHAN staff make decisions to either accept a referral for investigation or take no further action on the referral ("screen out") based upon information collected from reporters to determine if the allegations meet the state's statutory definition of abuse or neglect.[79] 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.[80] All screening decisions are reviewed and approved by a supervisor prior to being finalized.

[77] Intake Hubs are regionally-based call centers responsible for receiving reports of alleged abuse and/or 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] For more information on SDM, see https://www.nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare
[79] SC Code § 63-7-20.
[80] This includes a foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012).

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

All applicable referrals of abuse and/or neglect received and not investigated by DSS's OHAN unit between October 2019 and March 2020 were reviewed by Co-Monitor staff to determine appropriateness of the screening decision.[81,82] Performance data were collected and are reported separately for each month.

Between October 2019 and March 2020, the Co-Monitors determined a monthly range of 75 to 100 percent of decisions not to investigate a referral of abuse and/or neglect were appropriate (see Figure 20). During March 2020, nine (90%) of the 10 applicable decisions to screen out a referral were deemed appropriate.

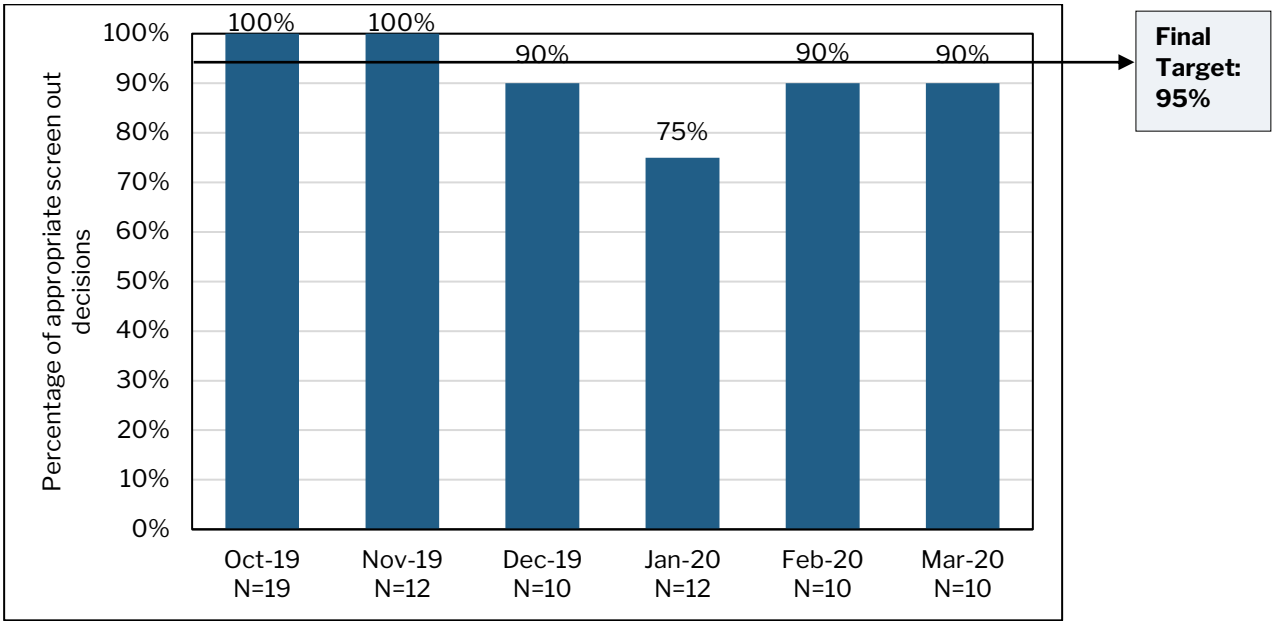
As reflected in the figure, DSS met the final target of 95 percent during the first two months this period. Large fluctuations in performance can be attributed to the small number of applicable screening decisions each month.[83] In January 2020, when DSS's performance was the lowest for the period, only 12 intakes were applicable.

[81] 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.

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

[83] The number of applicable decisions each month are as follows: October 2019, 19; November 2019, 12; December 2019, 10; January 2020, 12; February 2020, 10; March 2020, 10.

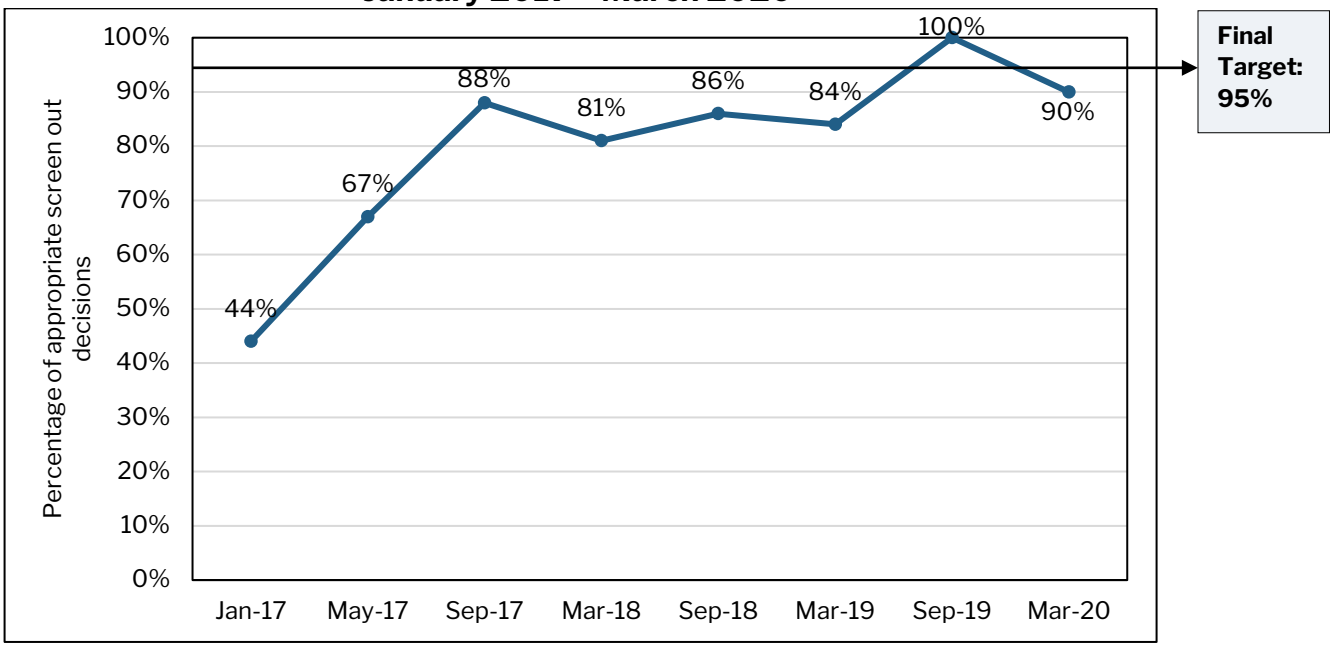
**Figure 20: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect October 2019 – March 2020**




Source: Monthly review data, Co-Monitor staff

In all instances in which the Co-Monitors disagreed with a screening decision, there was insufficient information being collected and documented by the intake worker; for example, only a few sentences listed in the intake report, or a lack of clarifying questions asked and documented by the intake worker when necessary to assess the information shared. Figure 21 includes performance trends for appropriateness of decisions not to investigate referrals between January 2017 and March 2020. Since DSS's implementation of the Intake Training Curriculum for staff in 2017, and adoption of the SDM® intake tool in late-2019, the Co-Monitors have seen improved consistency in appropriate decision-making.

**Figure 21: Performance Trends for Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect January 2017 – March 2020**




Source: January 2017 performance collected during review of 128 referrals received by DSS between August 1, 2016 and January 31, 2017 and not accepted for investigation. Performance data for May 2017, September 2017, March 2018, September 2018, March 2019, September 2019, and March 2020 reflect findings from monthly reviews completed by Co-Monitor staff.

## OHAN Investigations

Allegations of abuse or neglect of children in DSS custody – in settings including licensed foster homes, residential facilities, and group homes – screened by DSS's Intake Hub or OHAN for investigation are assigned to OHAN staff.[84,85] 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.[86] 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

[84] SC Code § 63-7-1210; Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012); SC DSS Directive Memo, April 26, 2016.
[85] 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. During a review of investigations accepted in March 2020, the Co-Monitors identified 1 case in which this did not occur, and the OHAN investigator assessed both the child in foster care and the caregiver's adopted child as alleged victims.
[86] Human Service Policy and Procedural Manual, Chapter 7-721. p. 6, 12 (effective date 11/29/2012).

children within that setting.[87] All of these activities are critical components of a quality OHAN investigation that results in accurate assessments and findings.

There are seven FSA measures that relate to investigations – timely initiation (two measures),[88] 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, USC CCFS, and DSS staff in June 2020 which examined 54 investigations involving Class Members that were accepted in March 2020. In recognition of a State of Emergency declared by Governor McMaster on March 13, 2020 and its potential impact on OHAN practice, where relevant, additional data analysis are provided within certain measures to reflect how performance may or may not have been impacted by the COVID-19 pandemic.

*Timely Initiation of Investigations*

The FSA requires *'[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations"* (FSA IV.C.4.(a)). Additionally, FSA Section IV.C.4.(b) requires *'[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors."* The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of referral by OHAN and face-to-face contact with the alleged child victim must be within 24 hours.[89] The March 2020 interim benchmark is that 90 percent of investigations will include face-to-face contact with the alleged victim child(ren) within 24 hours.

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

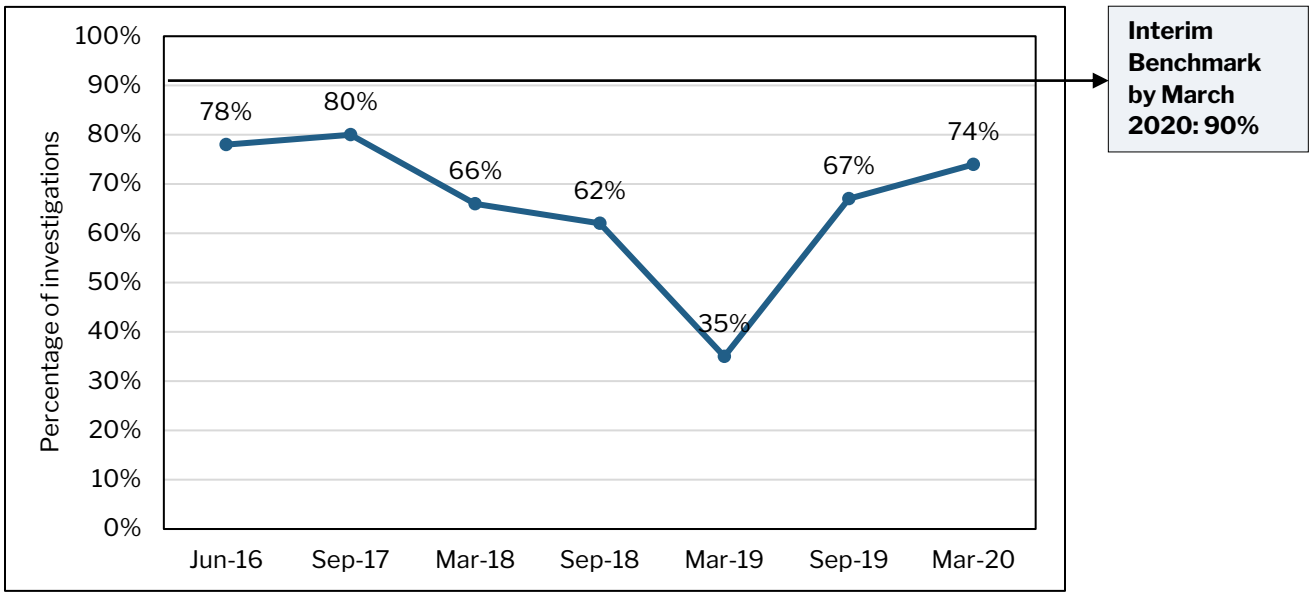
[88] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). 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.

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

Of the 54 applicable investigations accepted in March 2020, contact was made with all alleged victim child(ren) within 24 hours in 39 (72%) investigations, and all applicable good faith efforts to contact the alleged victim child(ren) were made in an additional one (2%) investigation, for a total of 74 percent of investigations timely initiated. Of the 14 investigations in which DSS did not contact all alleged victim children within 24 hours, the investigator did make contact with some, but not all, alleged victim children within 24 hours in four investigations.

Current performance shows improvement since March 2018, but is below the interim benchmark of 90 percent (see Figure 22).

**Figure 22: Timely Initiation of Investigations**
**June 2016 – March 2020**




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

As discussed earlier in this report, on March 13, 2020, Governor McMaster declared a State of Emergency in South Carolina based on a determination that the COVID-19 pandemic posed an imminent public health emergency. Despite this declaration, DSS staff continued to work, and OHAN investigators sought to respond to investigations within 24 hours. Analysis of timely initiation data by date the investigation was opened reflect that the pandemic minimally impacted the percentage of investigations in which alleged victim children were timely seen by OHAN investigators.[90] Of the 25 investigations accepted between March 1 and March 12, 2020, 18 investigations were timely initiated, and in one investigation, good faith efforts were made, resulting in 76% performance. By comparison, of the 29 investigations accepted between March 13 and 31, 2020, 21 (72%) investigations were timely initiated.

[90] The number of investigations is small, thus meaningful comparisons are difficult to make.

*Contact with Core Witnesses during Investigation*

The FSA requires *'[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors"* (FSA IV.C.4.(c)). The March 2020 interim benchmark is 70 percent of investigations include contact with all core witnesses.

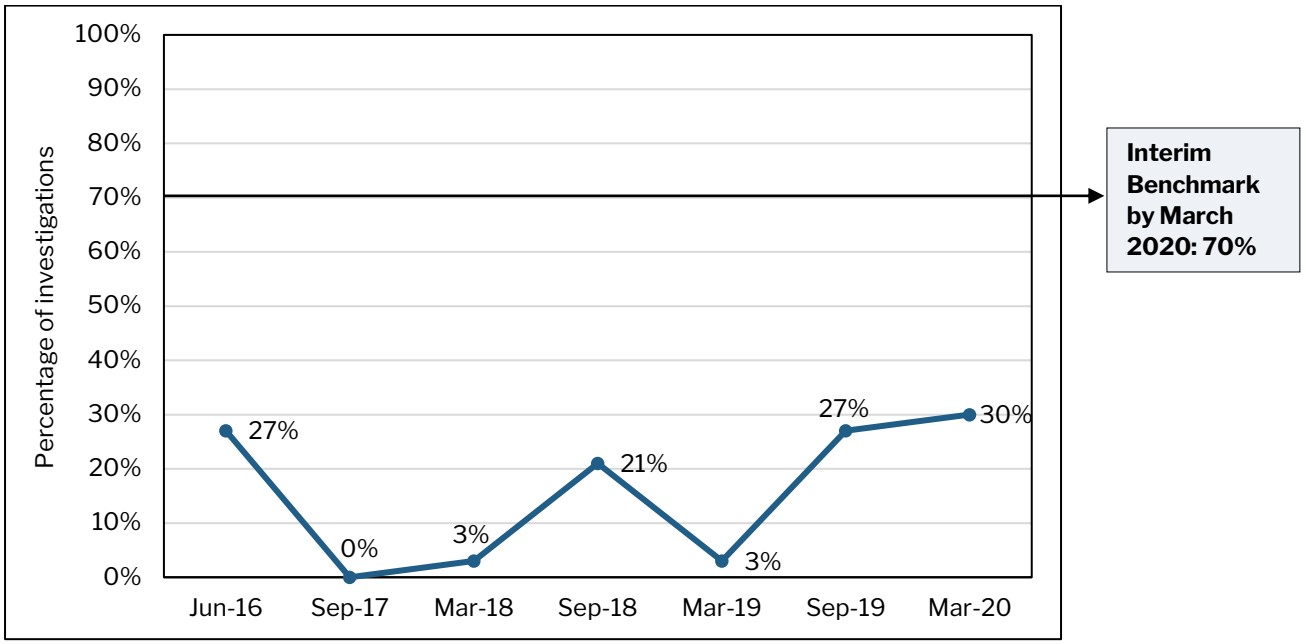
A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS case manager, other child(ren) and/or adult(s) in the home, and, when involved, law enforcement. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses.[91,92]

Performance data for this period were collected during a case record review of investigations involving Class Members accepted in March 2020. Sixteen (30%) of the 54 applicable investigations reflected contact with all necessary core contacts during the investigation. Current performance reflects an improvement since the same month in 2019, however, continues to be significantly below the interim benchmark of 70 percent (see Figure 23).

[91] 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.

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

**Figure 23: Contact with All Necessary Core Witnesses during Investigations June 2016 – March 2020**




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

Data presented in Table 3 shows the frequency of OHAN investigator contact with each type of core witness in the 54 investigations reviewed.

**Table 3: Interviews with Necessary Core Witnesses during Investigations by Type of Core Witness March 2020 N=54**

| Core Witness | Number of Applicable Investigations | Contact/Interview with All | Contact/Interview with Some | Contact/Interview with None |
|---|---|---|---|---|
| **Alleged Victim Child(ren)** | 53[93] | 52 (98%) | - | 1 (2%)[94] |
| **Reporter** | 46[95] | 42 (91%) | - | 4 (9%) |
| **Alleged Perpetrator(s)** | 51[96] | 47 (92%) | 2 (4%) | 2 (4%) |
| **Law Enforcement** | 16 | 10 (63%) | - | 6 (38%) |
| **Alleged Victim Child(ren)'s Case Manager(s)** | 54 | 50 (93%) | - | 4 (7%) |
| **Other Adults in Home or Facility[97]** | 31 | 15 (48%) | 6 (19%) | 10 (32%) |
| **Other Children in Home or Facility[98]** | 36[99] | 20 (56%) | 4 (11%) | 12 (33%) |
| **Additional Core Witnesses** | 49[100] | 25 (51%) | 14 (29%) | 10 (20%) |

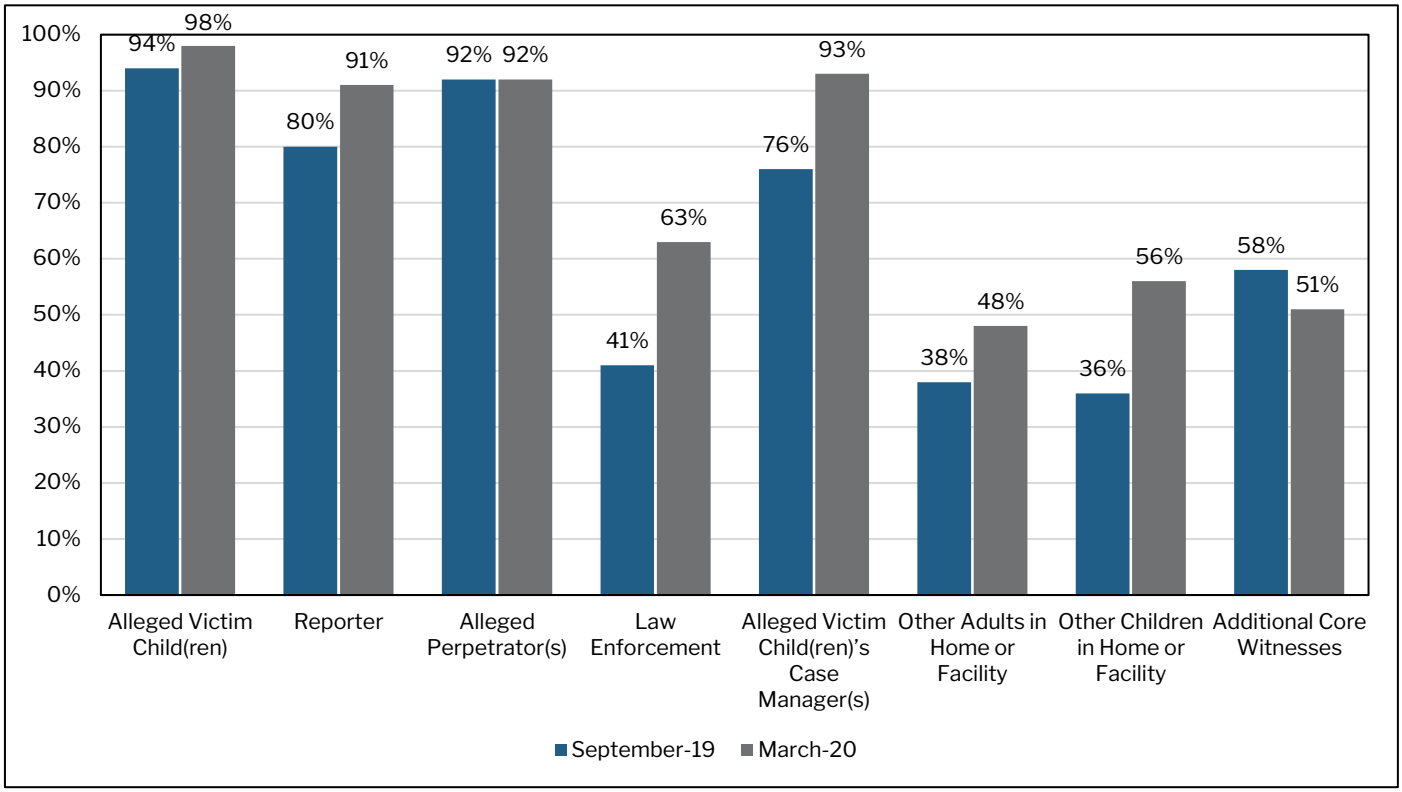
Source: Case Record Review completed in June 2020 by USC CCFS, DSS, and Co-Monitor staff
*Totals may not equal 100% due to rounding

Figure 24 reflects improved – in some instances, substantially improved – performance from the prior review period in September 2019. Frequency of interviews with law enforcement rose from 41 percent in September 2019 to 63

[93] In 1 investigation, the alleged victim child was on runaway status beginning in February 2020, and throughout the course of the investigation. The investigator had ongoing contact with both law enforcement and the alleged victim child's case manager to verify the child's status and to try to interview the alleged victim child if located.
[94] In this investigation, the investigator observed the alleged victim child, but the child did not want to speak to the investigator. Documentation does not reflect that the investigator attempted to engage or develop rapport with the alleged victim child and did not make additional attempts to interview the child during the course of the investigation.
[95] The reporter in 6 investigations was anonymous. In 2 investigations, the investigator was unable to locate or contact the reporter despite attempts.
[96] Exceptions to contact with alleged perpetrator(s) were applicable in 3 investigations, as the alleged perpetrator refused to cooperate or could not be located or identified despite efforts.
[97] 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.
[98] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other children in foster care and biological or adopted children in the home. For investigations involving institutions, as most facilities have many children placed there, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[99] Exceptions to contact with other children in home or facility were applicable to 1 investigation, as 1 of the children who may have had information about the incident did not want to speak with the investigator despite multiple efforts.
[100] Additional core witnesses identified by reviewers in 49 investigations included family members, school or day care personnel, mental health or medical providers, foster home licensing workers, GALs, adoptions specialist, supervisors, previous or current placement provider, and staff from the Department of Juvenile Justice (DJJ).

percent in March 2020; interviews with the child's case manager increased from 76 percent to 93 percent; and interviews with other children in the home or facility rose from 36 percent to 56 percent. Additional progress is needed, but performance is trending in the right direction.

**Figure 24: Contact with Necessary Core Witnesses**
**September 2019 – March 2020**




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

All investigations assessed during this review were conducted while the state was under a State of Emergency due to the COVID-19 pandemic. Documentation from investigative files reflects that in many investigations, the bulk of investigative activities occur in the first few weeks after the investigation is accepted. Co-Monitor staff analyzed data to assess if there was a difference in completion of core contacts based upon if the investigation was accepted between March 1 and 12, 2020, versus later in the month when a State of Emergency had been declared. Data reflect a very slight difference – with performance lower for investigations accepted later in the month – although the number of investigations during each two-week period was small.[101]

[101] Of the 25 investigations accepted between March 1 and 12, 2020, all core contacts were made in 8 (32%) investigations. Of the 29 investigations accepted between March 13 and 31, 2020, all core contacts were made in 8 (28%) investigations.

*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.[102]

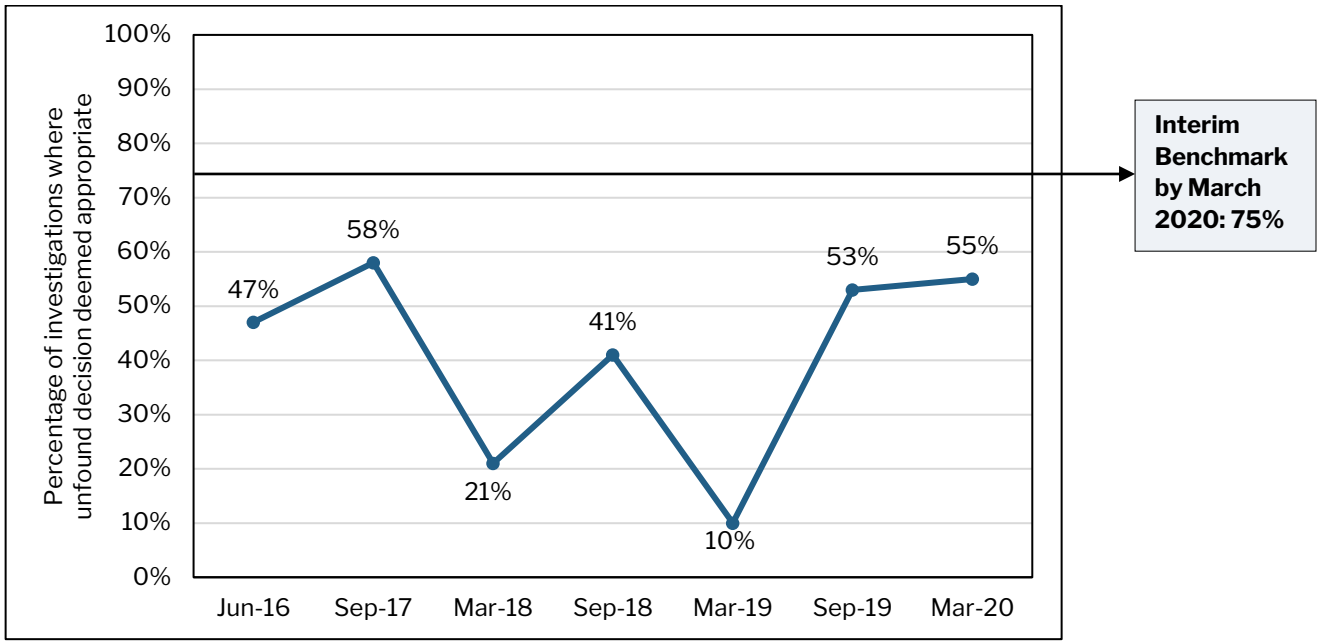
Section IV.C.3. of the FSA requires *'[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected."* The March 2020 interim benchmark is 75 percent of case decisions to unfound determined to be appropriate.

Performance data for this period were collected during the previously referenced case record review of investigations accepted in March 2020. Of the 54 applicable investigations reviewed, the final case decision was to *unfound* the allegations in 51 investigations. Reviewers agreed that the case decision to *unfound* the investigation was appropriate in 28 (55%) of the 51 investigations (see Figure 25).[103] In all instances in which a reviewer did not agree with the decision to *unfound*, this was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the case, including, for example, not interviewing a witness with relevant information, not clarifying conflicting information, or not collecting medical/forensic reports.

Current performance has improved since the same month in 2019 but is below the interim benchmark of 75 percent.

[102] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 3 (effective date 11/29/2012).
[103] As part of the Co-Monitors protocol for all case reviews that are conducted, if during the course of a case review a safety concern is identified that was not addressed, DSS is immediately notified for appropriate follow-up.

**Figure 25: Decision to Unfound Investigations Deemed Appropriate June 2016 – March 2020**




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

*Timely Investigation Completion*

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

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

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

- *'At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA IV.C.4.(f)). The March 2020 interim benchmark for this measure is 95 percent.

The FSA and OHAN policy provide that the DSS Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[104] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision.[105]

Performance data on investigation closures were collected during the case record review of investigations that were accepted in March 2020.

*Completed within 45 Days*
Of the 54 investigations reviewed, 44 investigations were completed within 45 days, however, reviewers determined that one of these investigations was prematurely closed as unfounded in an effort to meet the 45 day requirement, which is not considered compliant under the FSA.[106] Of the 10 investigations that were closed between 46 and 60 days, nine (90%) had documentation reflecting the investigator requested an extension beyond 45 days to allow additional time to either receive forensic interview results or await law enforcement action; eight (80%) of these requests were approved by the OHAN Director. Of the 46 investigations assessed for the 45-day closure measure, 43 (93%) investigations were timely completed within 45 days (see Figure 26). Current performance meets the interim benchmark and final target for this measure.

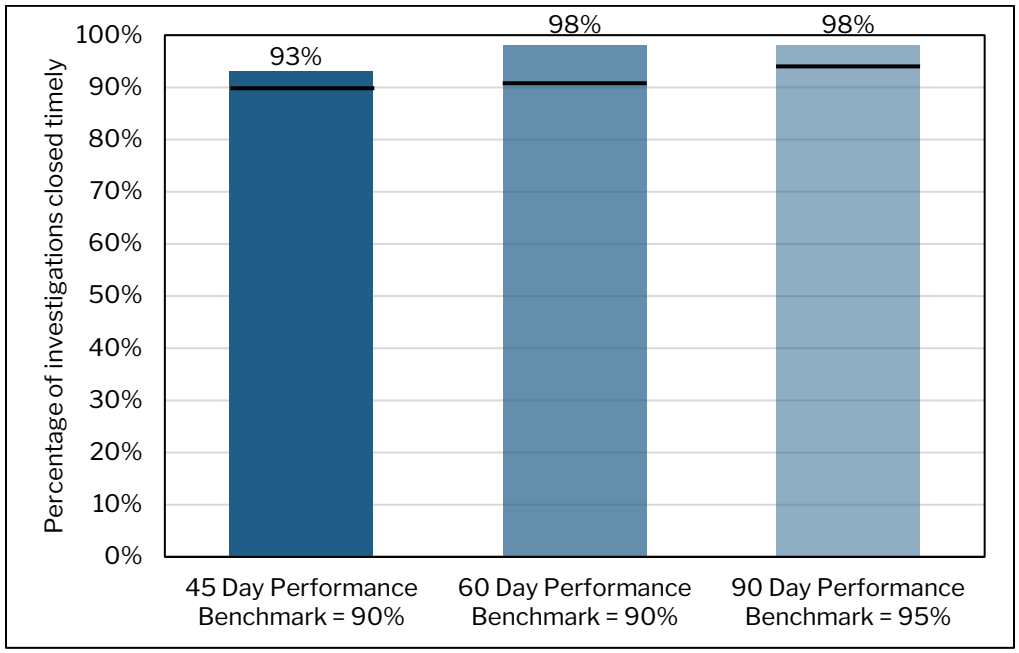
*Completed within 60 Days*
Fifty-three (98%) of the 54 investigations were completed within 60 days of opening.[107] Performance meets the interim benchmark and final target for closure within 60 days.

[104] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 12 (effective date 11/29/2012).
[105] 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; and child has been too ill or traumatized to speak with investigator.
[106] In this investigation, a supervisory staffing was held approximately 1 month prior to closure and the supervisor instructed the investigator to interview the DJJ worker, DSS licensing worker, foster father/alleged perpetrator, and make a law enforcement referral. Additionally, the investigator made a referral for a CAC interview on the same day as the supervisory staffing, and this was not completed prior to closure; no extension request was made to ensure this occurred. The investigation was closed on the 44th day after intake.
[107] This does not include the 1 investigation that was assessed as closed prematurely to meet the required timeframe.

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

Figure 26 reflects performance for timely closure in March 2020.

**Figure 26: Timely Completion of Investigations**
**March 2020**
**N=54**




Source: Case Record Review completed in June 2020 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.[108]

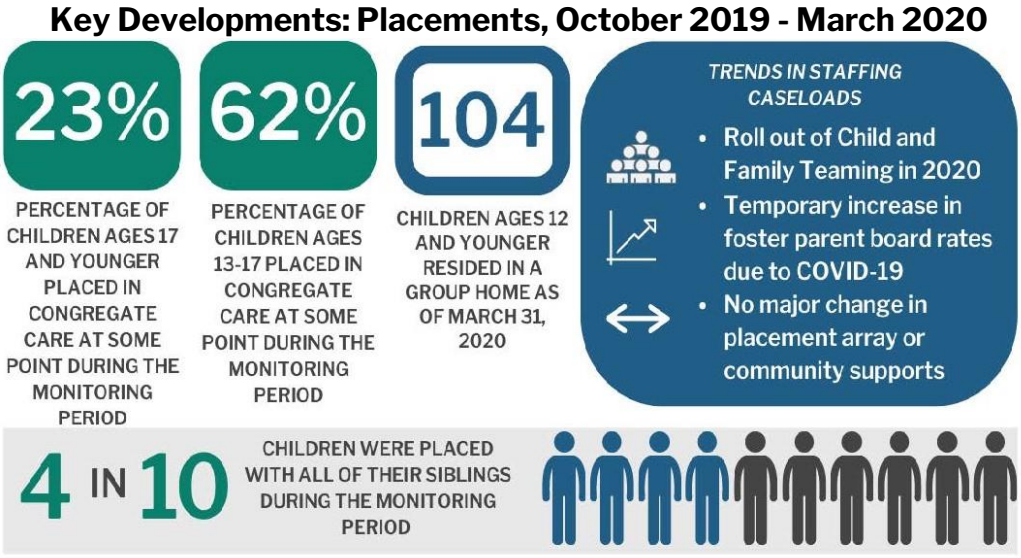
[108] Pursuant to FSA V.E.1-3, the Co-Monitors identify these provisions may be eligible for "Maintenance of Effort" designation by the Court. Defendants have previously achieved compliance with the obligations set forth in FSA IV.C.4.(d), (e), and (f), as reflected in the April 24, 2019, September 16,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

## VII. Placements

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

The availability of appropriate, stable placements for children throughout South Carolina continues to be a significant challenge for DSS. As DSS acknowledges, placement decisions are often made based on availability, rather than on the unique needs of children and their families. Many children are still placed far from their home communities and schools, and separated from their siblings, family members, and other important people in their lives. Although there is a shared understanding that congregate placement should be minimized, the shortage of appropriate foster homes and quality, community-based supports has meant that children often experience multiple moves and are placed in less than ideal settings, at times on only a temporary or emergency basis until a more stable or longer-term placement can be found. For children and families, this can also mean fear, uncertainty, and isolation at a time when what is needed most is healing, support, and connection.

DSS's Placement Implementation Plan presents a roadmap for fundamentally shifting the way the needs of children in foster care are identified and met. Through a focus on building the supports and services necessary to keep children in their communities, with family members whenever possible, and on decision-making in the context of child and family teams, the Placement Implementation Plan reflects DSS's commitment to a set of values to underlie all of its work. Although DSS has endeavored to implement the Plan where possible, a lack of funding has prevented the Department from moving forward in a timely manner with many strategies that are critical for establishing the foundation for reform. This has meant that action steps have sometimes been disjointed from more ambitious, overarching reform goals. The COVID-19 pandemic has only complicated this landscape, straining an already vastly under-resourced placement and services infrastructure and further delaying the possibility of funding increases. At the same time, the pandemic has only increased the risks of placement in congregate settings, particularly for children with underlying health conditions. DSS's ability to access resources and move forward with Plan implementation in the coming months will be essential to improving the experience and outcomes of the children in its care.




## *Placements: Progress and Implementation Updates*

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

On February 20, 2019, DSS obtained approval of its Placement Implementation Plan.[109] The Plan incorporates Placement Needs Assessment recommendations, and reflects a new reliance on children's family members and a strong preference for keeping children, with appropriate supports, in family-based settings in their own communities, with kin or fictive kin whenever possible. The Plan also includes commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making, and to closer strategic partnerships with private providers to develop a placement and service array to meet the needs of children and families. These are tremendous undertakings, which require not only significant resources, but re-orientation of the workforce and extensive engagement with key partners, such as foster parents, family members, and service providers. As contemplated in the Plan, initial implementation requires the use of technical assistance.

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

The transition in agency leadership last year, and lack of funding in the FY2019-2020 budget, led to significant delays in DSS's implementation of the approved Placement Implementation Plan. In many areas, key deadlines passed without meaningful progress. Given the importance of this work, DSS leadership has focused on advocating for needed funding in the FY2020-2021 budget and was hopeful the Department would be able to proceed with implementation in many areas beginning July 1, 2020. However, the disruption in the budget process caused by the COVID-19 pandemic has made the availability of resources for this work only more uncertain. This has meant that progress with respect to many Placement Plan strategies remains elusive.

DSS has shared that, given these circumstances, it believes some aspects of the Placement Plan should be amended. On August 27, 2020, the Department submitted proposed Plan modifications to the Co-Monitors. DSS and the Co-Monitors have been engaging in discussions about this proposal in the weeks since, and the Co-Monitors have emphasized 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,[110] including "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).

Until a Plan modification is completed, approved, and entered by the Court, the Co-Monitors are continuing to monitor progress with respect to the Placement Implementation Plan to which DSS remains committed.[111] Included below is a summary of progress in key areas in which DSS has attempted to move forward this period. DSS leadership has expressed its continued commitment to these strategies, both as core elements of the Placement Plan, and as fundamental to their vision for the Department.

*Child and Family Teaming*

DSS has worked on the establishment of an internal structure to support the rollout of the Child and Family Teaming (CFT) model statewide. After years of delivering "family engagement programming" through a contracted provider, DSS leadership

[110] 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.

[111] The updated version of the Placement Plan was supposed to be completed by September 30, 2020 according to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201, p. 6), but is still in process. Updated timelines will be included and discussed in future monitoring reports.

decided to build internal capacity to engage families and community partners. As of January 2020, a newly designated Family Engagement Program Manager oversees 34 regional staff responsible for facilitating and supporting CFTs.[112] Four of these staff serve as family engagement "coaches," to train facilitators and ensure that team meetings are being held in a manner consistent with DSS's goals, values and intended processes and timelines for FTMs in the life a case. Though the Placement Implementation Plan included initial CFT rollout in two to three pilot counties to allow for the testing and refining of approaches, DSS has moved forward with its plan to implement the CFT model, beginning in June 2020, first in the 10 counties that were selected for its federal Program Improvement Plan (PIP), with the goal of full implementation statewide by February 2021.[113,114]

The shift from conceptualizing family engagement as an ancillary, outsourced service to understanding it as central to DSS's mission is one that foundational to all other aspects of DSS's placement work. If integrated and understood at all levels of the Department, it will set the context in which the CFT model can be fully implemented, allowing for assessment, planning, and decision-making through collaborative teams. DSS will need significant ongoing support in carrying out this new vision, including the type of intensive, on-site coaching described and incorporated in the Placement Implementation Plan.[115] As the Co-Monitors have shared with DSS, the success of this model will ultimately depend not only on the capacity of a team of dedicated family engagement staff, but on the ability of *all* DSS case managers to facilitate CFT meetings and practice in a way that is consistent with these values. Case managers are the primary means of connection with families, and drive case plan development and implementation. Without the ability of staff to genuinely engage with, consistently assess, and work in a collaborative way to support the dynamic needs of families, meaningful and sustainable improvements in practice will not be possible.

Building this capacity in a stable workforce will require significant resources, and purposeful, ongoing training, coaching, and follow through. DSS has integrated this feedback into its plans, and has begun including case managers in its rollout counties in trainings as well, but more work will be needed to encourage these staff and help them to build the mindset and skills needed to effectively engage families. A strategy

[112] As of September 2020, DSS had completed hiring and onboarding for all 4 family engagement coach positions, all 4 supervisor positions, 4 of 6 administrative assistant positions, and 10 of 24 facilitator positions (an additional 5 new hires are pending approval by human resources).
[113] South Carolina Child and Family Services Review Round 3 Program Improvement Plan (PIP). Approved September 19, 2019; Revised October 28, 2019.
[114] The 10 "innovation counties" chosen for implementation of South Carolina's Program Improvement Plan (PIP) are: Greenville, Pickens, Aiken, Newberry, York, Fairfield, Chesterfield, Horry, Berkeley, and Jasper. Initial implementation in these counties was phased: rollout in Greenville and Horry began on June 1, 2020, rollout in Pickens, York, Chesterfield, Berkeley, and Jasper on July 1, 2020, and rollout in the remaining 3 counties following on August 10, 2020.
[115] DSS has been working with Chapin Hall at the University of Chicago on a plan for CFT implementation and training curriculum development. DSS reports that on March 6, 2020, an official "kickoff" meeting was held, and that DSS has since worked with Chapin Hall to finalize the Advanced Facilitator training curriculum.

to retrain the existing workforce in the competencies necessary to fully implement CFT (and the GPS case practice model as a whole) will be essential part of this work.

DSS leadership and family engagement staff visited Utah in March 2020 to learn about their CFT practice firsthand. The experience offered DSS the opportunity to see how transformational the model can be when fully implemented, and DSS reported being inspired by what they observed.

*Safety and Quality Response*

DSS reports that it has continued its work to improve collaboration and communication about safety concerns between OHAN, Contract Monitoring, Licensing, and Regional Clinical staff, all of whom have roles in provider oversight. With the initial support of a technical assistance provider, DSS developed a formal process referred to as the Safety and Quality Response Review Protocol, currently being utilized to review family foster or group providers who receive multiple abuse and/or neglect referrals within a specified timeframe. As of July 17, 2020, the process is overseen by DSS's new Quality and Safety Response Coordinator. DSS is hopeful that this new position will serve as a single point of contact to coordinate data, analyze trends and areas needing improvement amongst providers, act as a liaison for providers and staff in regard to reporting critical incidents, and manage a help line for children in foster care. Original timelines for this work have been modified and DSS reports that this protocol, including joint staffings between Licensing, OHAN, and Contracts, as well as state-level meetings with providers to address concerns, will now be fully implemented by December 31, 2020.

*Kin Placement*

South Carolina's policies and practices have historically been out of sync with national policy guidance and best practices which have recognized the importance of identifying, engaging, and supporting kin as caregivers. In accordance with the Placement Implementation Plan, DSS has continued its work to prioritize the placement of children with kin or fictive kin. It has also taken some foundational steps to provide kin and fictive kin with the information and assistance needed to consider becoming licensed caregivers.[116] DSS reports that it is building an understanding among staff, community partners, and court officials of its new approach to kinship foster care through the distribution of tip sheets and brochures. The Kinship Advisory Panel has continued to convene monthly, which includes five kin caregivers, the kinship care manager, six kinship coordinators, and two representatives from advocacy groups, all of whom address and discuss issues of relevance to the kin care community.

DSS formally updated its placement policies in July 2020 to reflect its commitment to kinship care. DSS case managers are now required to make "concerted efforts" to

[116] "Fictive kin" refers an individual who is not related by birth, adoption, or marriage to a child, but who has an emotionally significant relationship with the child.

identify and place children with kinship caregivers "throughout the life of a case," and must obtain supervisory approval to place a child in with an unrelated caregiver when placement with kin is not possible.[117]

Though DSS has seen a small increase in the number of kin caregivers applying to be licensed foster parents, the lack of capacity to quickly process these applications – even with DSS's policy amendments that allow for waiver of some licensing requirements that do not relate to safety – has limited DSS's ability to enhance the number of provisionally or fully licensed kinship homes in any significant way.[118] DSS reports that as of September 8, 2020, there were 86 licensed kinship homes, 40 pending applications for kinship home licenses, and 83 provisional kinship home licenses had been issued.[119] The addition of eight licensing staff in December 2019 to assist with processing kin licensure applications is not enough staff to support a transition to a significant reliance on kin caregivers. DSS has requested funding for this purpose in the FY2020-2021 budget. DSS has also committed to transitioning current licensing staff to focus solely on kin licensing, and securing the assistance of partner Child Placing Agencies (CPAs) to license the non-kin families currently engaged in the licensing process. Between July and December 2020, all new potential non-kin foster home resources, as well as the 225 non-kin foster families in the licensing process as of June 2020, will be licensed through CPAs.

DSS reports that with a small grant awarded by a national child welfare organization and the help of a Charleston-based advocacy group, it has begun rolling out kin support services in a limited area of the state. Though far short of the full-scale Kinship Navigator program DSS envisions – one that would provide a wide range of supports and connections to community resources, including concrete supports, peer support groups, assistance with completing benefit applications and legal issues, and guidance with licensure – it is a start. DSS recognizes the Kinship Navigator program as critical to the sustainability of a successful kin care program and hopes to receive funding to expand to all regions in the state in FY2021-2022.

*Supports for Foster Parents*

The Placement Implementation Plan required DSS to provide an initial increase in foster care board rates, effective July 1, 2019, to be followed by a more significant increase in July 2020. In May 2019, the General Assembly approved a proviso allowing for an incremental rate increase, and DSS began paying this rate to all kin and non-kin foster parents licensed directly through DSS or through private CPAs. DSS requested funding for an additional increase in the FY2020-2021 budget, at which point it committed to adjust rates further to more fully account for the costs of

[117] Child Welfare Policies and Procedures Manual, Chapter 5, Section 510.2

[118] Provisional Licensure enables a family member or other adult who has a relationship with a child 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 as quickly as possible, while full licensure is pursued.

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

caring for a child in foster care, and make them more comparable to those paid in many other southern states.

As discussed, although budgetary decisions have been delayed due to the COVID-19 pandemic, DSS has been able to utilize additional funding available as a result of temporary adjustments to federal Medicaid match rates under the Families First Coronavirus Response Act (FFCRA) to move ahead with the rate adjustment on a temporary basis.[120,121] As of August 16, 2020, DSS has provided an enhanced "COVID" rate to all licensed kin, non-kin, and provisionally licensed foster families, and has committed to continue funding this increase, up to the USDA level, through at least December 2020.[122] DSS plans to make the rates permanent if the General Assembly approves the agency's budget request, and will continue to assess the adequacy of the rates annually. DSS also anticipates that as it moves children out of congregate care placements (which are costly to the state) and into family-based settings, savings may be realized that can be repurposed for increases in maintenance payments to family-based providers and necessary community supports.

*Congregate Care Reduction*

Any sustainable and successful congregate care reduction strategy will ultimately depend upon the availability of high-quality community services and supports, and on DSS's ability to implement its CFT model with fidelity. DSS also acknowledges that congregate care placement presents a particularly heightened risk of harm during the pandemic. In light of this, DSS has committed to a comprehensive case-by-case review of all children in congregate care beginning in October 2020. The review will be done through 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. Initial focus will be on children in level one and two group care, before continuing with cases of children with more significant therapeutic needs. As the Co-Monitors have discussed with DSS, the success of this strategy will ultimately depend upon the expansion of the type of community-based supports necessary to place and maintain children in family-based settings.

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

---

[120] 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)).

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

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

*Performance Data*

**Placement of Children in Congregate Care**

The FSA contains several provisions related to the placement of children in the most family-like, least restrictive environments necessary to meet their needs. Overall, the FSA requires that *at least 86 percent of Class Members be placed outside of congregate care on the last day of the reporting period* (FSA IV.E.2.). The interim target is that by March 2020, at least 82 percent of children must be placed outside of congregate care on the last day of the monitoring period.

DSS acknowledges that the risks of institutional placement may be especially concerning during the COVID-19 pandemic, given the possibility of rapid spread of the virus through contained spaces, and the difficulty of isolating sick or exposed children or staff. As discussed above, this has provided additional impetus for expeditiously evaluating the needs of all children currently placed in congregate care, and the possibility of meeting their needs in lower risk, more family-like settings.

As of March 31, 2020, 82 percent (3,579 of 4,357) of Class Members were placed outside of a congregate care placement (see Table 4). Twenty-five children resided in other institutional settings outside of DSS's control due to acute medical need or incarceration.[123] This performance meets the March 2020 interim benchmark, and is relatively unchanged from the prior monitoring period in which 81 percent of Class Members were placed outside of congregate care.

**Table 4: Types of Placements for Children**
**March 31, 2020**

| **Children in Foster Care** | |
|---|---|
| 4,357 (100%) | |
| **Type of Placement** | **Amount of Children** |
| Family-Based Setting | 3,579 (82%) |
| Congregate Care | 778 (18%)[124] |

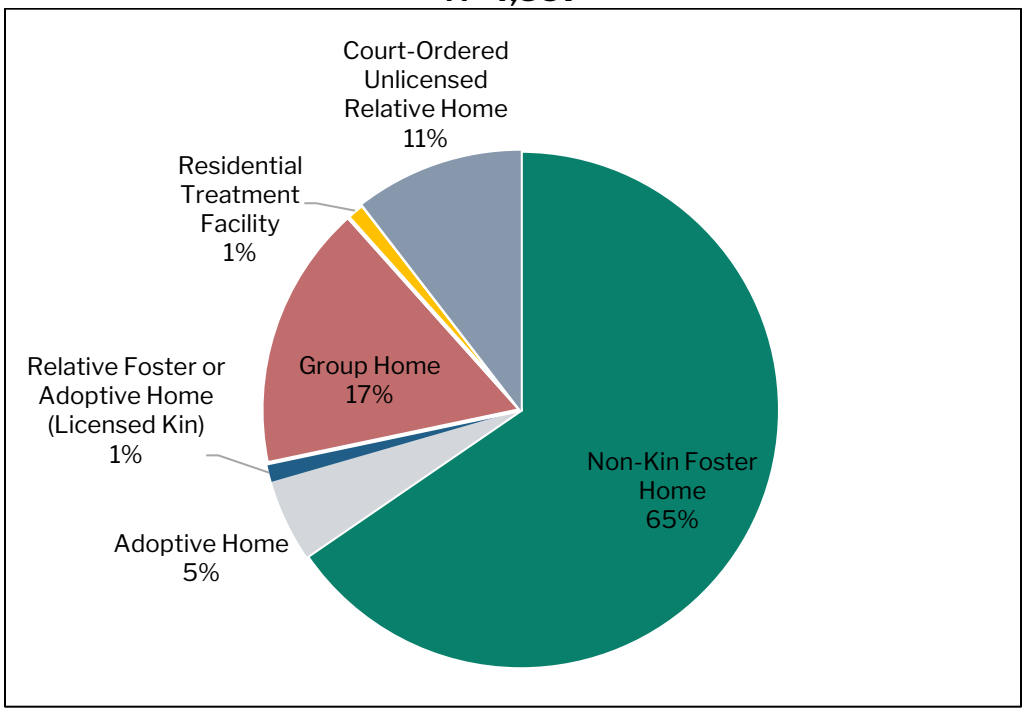
Source: CAPSS data provided by DSS

Figure 27 depicts the breakdown of placements for all children in foster care, both family-based and congregate care. The majority of children (65%, or 2,851 of 4,357)

[123] Specifically, DSS reports that 21 youth were incarcerated in correctional or juvenile justice detention facilities, and 4 youth were hospitalized.
[124] This does not include 25 youth who resided in other institutional settings on the last day of the monitoring period.

are placed in unrelated foster care placements, while very few children are placed in a licensed relative home (1%) or adoptive home (5%).

**Figure 27: Percentage of Children in Family-Based and Congregate Care Placements on March 31, 2020**
**N=4,357**




Source: CAPSS Data provided by DSS

As shown in Figure 27, almost all (93%, or 727 of 778) of the children placed in congregate care, meaning a group home, residential treatment facility, or emergency shelter, reside in group homes. These facilities are categorized and funded based on the level of support they are expected to provide (either Level 1, 2, or 3). The facilities vary a great deal in terms of available supports, programming, and level of restriction, though none offer formal clinical services onsite. As reported by placement consultants engaged by the Co-Monitors in 2018, many facilities, particularly at higher levels of care, offer restrictive environments with inflexible rules that can be arbitrary and punitive, with "little indication of individualization of assessment and case planning, cramped interpersonal settings, often contained in locked or fenced settings, excessive reliance on seclusion and restraint."[125] These facilities tend to preclude connection with friends and family members more so than family foster homes.

The data in Figure 27 reflect the percentage of children in each type of placement at a single point in time – March 31, 2020. They do not capture children's experiences

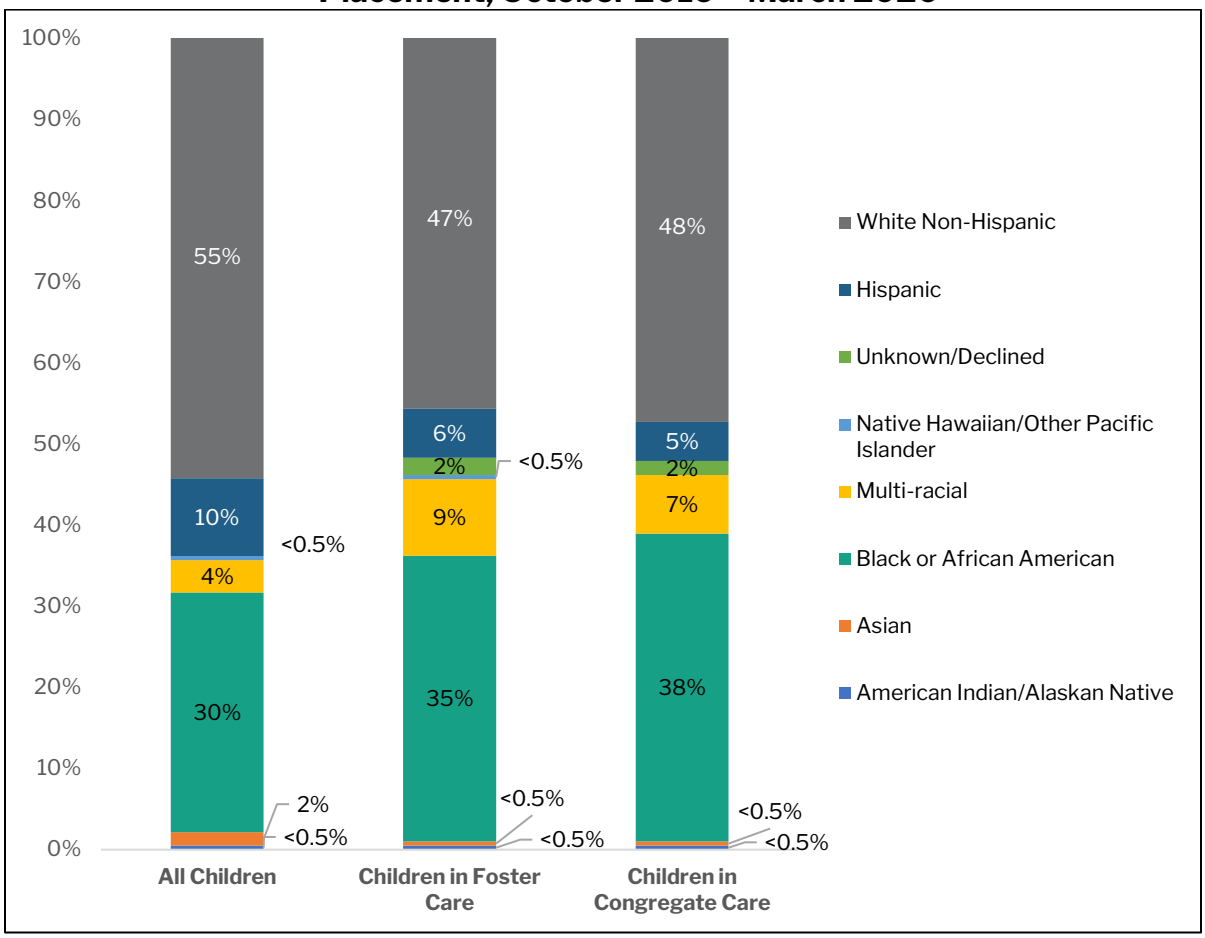
[125] Taylor, George, and White, Marci. (December 21, 2018). Review of South Carolina Residential Treatment Facilities and Group Homes Utilized by DSS. *Technical Assistance to the Michelle H. vs. McMaster Co-Monitors*.

over the entirety of their time in foster care. Available data on children who experience congregate care at *any* time during the monitoring period show a significantly greater incidence of congregate care placements, particularly amongst older youth. Data show that almost one-fourth (23%, or 1,428 of 6,323) of all children in foster care during this monitoring period were placed in a congregate care setting *at some point* between October 1, 2019 and March 31, 2020.[126]

The placement of children in institutional settings – especially children whose needs could be met in a family setting with appropriate supports – is a particularly concerning practice when representation by race is considered. Figure 28 shows the placement of children in congregate care placements over the course of the monitoring period, broken down by race. As depicted, Black or African American children represent a greater percentage of the congregate care population, than of the total child population and the population of children in foster care in the state.

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

**Figure 28: Racial Disproportionality in Foster Care and Congregate Care Placement, October 2019 – March 2020**




Source: Kids Count Data Center, 2019 and CAPSS data provided by DSS[127]

*Children Ages 13 to 17*

As mentioned above, youth ages 13 to 17 are most likely to spend time in congregate care. On March 31, 2020, 649 (49%) of 1,315 youth ages 13 to 17 resided in a congregate care placement. This is a slight reduction and improvement from September 30, 2019 when 52 percent of youth in this age group resided in a congregate care placement. Sixty-two percent (1,160 of 1,858) of youth ages 13 to 17 in care at any time between October 2019 and March 2020 were placed in a congregate care setting at some point. This is an area of concern and one in which performance is relatively unchanged from prior monitoring periods; for instance, 64 percent of youth in this age group resided in congregate care at some point between April and September 2019.

[127] DSS collects data on Hispanic children as an ethnicity rather than a racial group, meaning that children of multiple racial groups may also identify as Hispanic. In this breakdown, Co-Monitor staff made adjustments so that those who identified as Hispanic and Black, Hispanic and Native, or Hispanic and Asian are included in the 'Multiracial' category.

*Children Ages 12 and Under*

The FSA includes placement standards specific to certain age groups of children, and requires that *'[a]t least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file"* (FSA IV.E.3.). The interim benchmark is that by March 2020, 95 percent of children ages 12 and under must be placed outside of congregate care on the last day of the monitoring period.

As reflected in Table 5, as of March 31, 2020, 2,914 of 3,043 Class Members ages 12 and under resided outside of a congregate care placement, and 14 children ages six and under resided in congregate care pursuant to a valid exception, resulting in performance of 96 percent. Performance in this area has improved slightly in the last year, from 94 percent in March 2019, and 95 percent in September 2019. DSS performance this monitoring period meets the March 2020 interim benchmark and is close to the final target of 98 percent.[128]

**Table 5: Types of Placements for Children Ages 12 and Under March 31, 2020**

| **All Children in Foster Care Ages 12 and Under** | |
|---|---|
| 3,043 (100%) | |
| **Type of Placement** | **Amount of Children** |
| Family-Based Setting | 2,928 (96%)[129] |
| Congregate Care | 115 (4%)[130] |
| **Breakdown of Type of Congregate Care** | |
| Group Home | 104 (4%) |
| Residential Treatment Facility | 11 (1%)[131] |

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 (pursuant to the FSA), and most children in congregate care are in group homes. Data show that six percent (268 of 4,465) of Class Members

[128] The Co-Monitors have approved, but not applied, exceptions for placing children ages 7 to 12 in a congregate care facility. DSS has not yet developed the capacity to track the use of these exceptions on a regular basis, so performance may be higher than reported. DSS will develop a process for review and approval of applicable exceptions in future monitoring periods.

[129] This includes 14 children ages 6 and under who resided in congregate care placements pursuant to a valid exception.

[130] This does not include 2 children who were hospitalized (1) or incarcerated (1) on the last day of the monitoring period.

[131] This includes 1 child in a non-DMH psychiatric hospital.

ages 12 and under were placed in congregate care at some point between October 1, 2019 and March 31, 2020.[132]

As of March 31, 2020, 91 percent (1,169 of 1,284) of children specifically between the ages of seven and 12 were placed outside of congregate care. This reflects an improvement since March 2019, when 85 percent of children ages seven to 12 were placed outside of a congregate care setting on the last day of the period. The incidence of congregate care placement for children ages seven to 12 at some point over the course of the monitoring period has also improved. Between October 1, 2019 and March 31, 2020, 12 percent (231 of 1,868) of Class Members ages seven to 12 were placed in a congregate care setting at some point, compared to 16 percent from April 1 to September 30, 2019.[133]

*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),[134] 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 Regional Director approval prior to the placement of any child ages six and under in a non-family-based setting.

In all but one case, children ages six and under who resided in congregate care placements at some point during the monitoring period were placed consistent with

[132] 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.

[133] Ibid.

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

an agreed upon exception. Of the 37 children who reportedly resided at a congregate facility at some point during the period, 27 resided in a treatment facility or group care with their mothers, and nine were part of a large sibling group for whom DSS reported a single, family-based placement could not be located.

**Placement in DSS Offices and Hotels**

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

During this monitoring period, the Co-Monitors were notified of five instances of a child staying overnight at a DSS office in violation of this provision. In October 2019, a 14-year old in Anderson County was moved from the DSS office to various emergency temporary foster homes over the course of two weeks. Also in October 2019, a 17-year old in Richland County spent the night at the DSS office after being asked to leave a group home; the youth was taken to the hospital, did not meet criteria for an acute stay, remained at the DSS office before being moved to a temporary emergency foster home for two days, then placed in a group home. In October 2019, a 16-year old in Charleston County spent the night at the DSS office after entering foster care and awaiting an initial placement in a group home. In November 2019, a 16-year old in Richland County spent the night in the DSS office after a hearing for a parole violation, before being moved to a temporary emergency foster home for two days, followed by placement in a group home. In March 2020, in Greenville County, a 10-year old diagnosed with autism was moved between four temporary foster homes and the DSS office within eight days, before being placed in a therapeutic foster home.

**Emergency or Temporary Placements**

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

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

DSS remains unable to track its use of emergency placements. This continues to be a significant concern, particularly given DSS's poor placement instability performance in the last period,[135] and the frequent stakeholder reports received by the Co-Monitors regarding the use of "enhanced rates" to providers to house children on a one-night, emergency basis, while DSS seeks appropriate longer term placement. According to accounting records shared by DSS, 171 children were subject to this practice between October 2019 and March 2020 alone.[136] Of these 171 children, 118 were in a group home on an emergency basis for an average number of 11 days each. The numbers likely underestimate the practice of night-to-night and short-term emergency placements as neither the Co-Monitors nor DSS believe that all emergency placements are reflected in this enhanced rate payment data.[137] The Co-Monitors have asked DSS to expeditiously address mechanisms for tracking the use of emergency placements so that data can be used in future periods to assess FSA performance and help inform practice. [138]

DSS committed in its Placement Implementation Plan to use CFTs to make more informed individualized placement decisions for children, and develop and provide quality services and supports to meet children's needs. If effectively implemented, this approach has the potential to reduce reliance on emergency and temporary placements, which remains an essential need.

---

[135] Placement instability data are reported on an annual basis. For the period October 1, 2018 to September 30, 2019, DSS data indicated that 45 percent of children experienced 2 or more placement moves, indicating 3 or more total placements, within 12 months. Data for the period October 1, 2019 to September 30, 2020 will be included in the next report.

[136] 35 of these children were moved to 2 placements during the monitoring period that received this enhanced emergency rate; and 17 children were placed in between 3 and 5 placements that received this enhanced emergency rate.

[137] The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

[138] DSS produced data regarding the use of temporary placements for the first time during the last period (for August and September 2019). Upon review and discussion of these data, it was agreed that these data did not capture the types of placements intended under the FSA and, instead, largely included those short-term placements important to any well-functioning child welfare system (such as hospitalizations, respite placements, and transitional visits back to a child's family).

**Juvenile Justice Placements**

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

The Co-Monitors continue to be concerned about Class Members who are also involved with the South Carolina Department of Juvenile Justice (DJJ). DJJ involvement includes pre-adjudication detention; a prescribed sentence at one of the state's secure evaluation centers; and/or post-adjudication placement at a secure facility or one of many group homes with restrictive rules. 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). As of March 31, 2020, DSS reports that 185 of the children in its care also had active cases with DJJ.[139]

DSS has continued to work on data-sharing protocols with DJJ. A protocol has been in place since December 2019 to allow designated liaisons at both DSS and DJJ to confirm whether a youth that they serve is currently also being served by, or has been engaged in the past with, the other agency, and DSS now collects information about a child's history of involvement with DJJ at the time of intake. As of May 2020, DJJ can also use the portal to report placements it believes are made in violation of the FSA. With the help of members of its regional Well-Being Teams, DSS also continued its work this period to enter information about DJJ involvement directly into CAPSS. Though not yet comprehensive, DSS does now, for the first time, have the functionality to run reports that list children in DSS care who have open cases with DJJ. These are important steps, and DSS reports encouraging the sharing of information between DSS and DJJ at the local level, but DSS still has relatively limited access to information about the reason for DJJ detention or placement for the children in its care.

The lack of readily available, comprehensive information about children in DSS custody who may be residing in DJJ placement in violation of the FSA has meant that the Co-Monitors have had to continue to rely on anecdotal reports by stakeholders to assess DSS performance with respect to the FSA in this area of practice. The Co-Monitors are regularly made aware of cases that reflect the frequency and fluidity of movement between DSS and DJJ, with decisions made, at least in part, based on the

[139] DJJ defines active involvement as any case open for intake, diversion, evaluation, parole, probation, or commitment.

availability of placement resources and the willingness or ability of a caregiver (DSS or otherwise) to maintain the youth in the community. Children often come to the attention of DJJ because they choose to leave placements in which they feel unsafe, or in which their needs are not being met, leading to law enforcement involvement and delinquency charges. For example:

- In October 2019, a 17-year old in Spartanburg County was held at a juvenile justice facility after a case manager told a judge that DSS would not be able to find placement. The child was moved to a group home by DSS two days later.

- In November 2019, a 16-year old in Richland County requested to remain in secure DJJ placement to finish a GED program, which the judge allowed, but made clear that appropriate placement had to be identified at the following hearing. DSS closed the child's case prior to the next hearing, and the child returned home with a relative with none of the requested services in place.

- In February 2020, a 14-year old in Greenville County remained in secure detention because DSS did not have an available placement.

- In February 2020, a 13-year old in Greenwood County remained in secure detention over the weekend before DSS received approval to move the child to a residential treatment facility.

The Co-Monitors continue to encourage DSS leadership to review, understand, and address the systemic inadequacies that drive children's DJJ involvement or unnecessary time in detention, secure evaluation facilities, or DJJ group homes. Though the lack of appropriate placement options or community supports is not the fault of any individual DSS case manager or attorney, decisions made in precincts or courtrooms across the state are at times leaving children who rely on DSS as their caregiver to bear the burden of system failures as they are left in facilities that are ill-equipped to provide them with the care and support they need and deserve.

The Co-Monitors and DSS agree that even when fully implemented, technological solutions are unlikely to sufficiently address the significant practice and systems issues apparent in the cases of youth involved with both DSS and DJJ. Similarly, the impact of procedural requirements (such as the requirement that Interagency Staffings be held at key decision points) are likely to be limited in the absence of robust community supports and a shift in the way DSS case managers engage with youth. The work to address these system inadequacies on a deeper level, and to develop appropriate community supports and placement options in collaboration with other state agencies, is an integral part of the Placement Implementation Plan. DSS has acknowledged that planning for youth involved with these systems must be based in a teaming model that reflects the shared goal of keeping youth out of

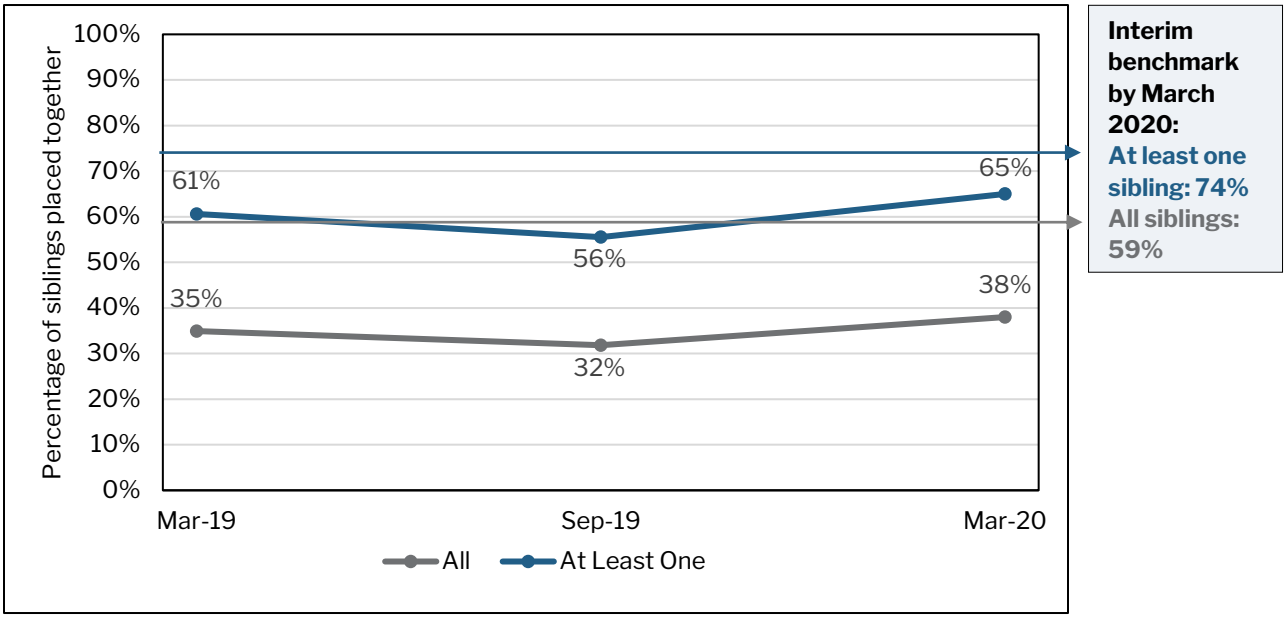
restrictive settings whenever possible, and within a context in which high-quality community-based services to address youth's underlying needs are available.

**Sibling Placement**

The FSA recognizes the importance of the relationship between children and their siblings and *requires that at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings* (FSA IV.G.2. & 3.). The FSA 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).[140] The interim benchmark is that 74 percent of children should be placed with at least one sibling, and 59 percent of children should be placed with all siblings.

DSS provided data for 813 children who entered foster care between October 1, 2019 and March 31, 2020, with a sibling or within 30 days of a sibling's entry to foster care. For this cohort, 65 percent (530 of 813) of children were placed with at least *one* of their siblings, and 38 percent (310 of 813) of children were placed with *all* of their siblings 45 days after entry into care (see Figure 29). This is an improvement in performance from the prior monitoring period, but still falls significantly short of the March 2020 interim benchmarks.

**Figure 29: Sibling Placements for Children Entering Placement March 2019 – March 2020**

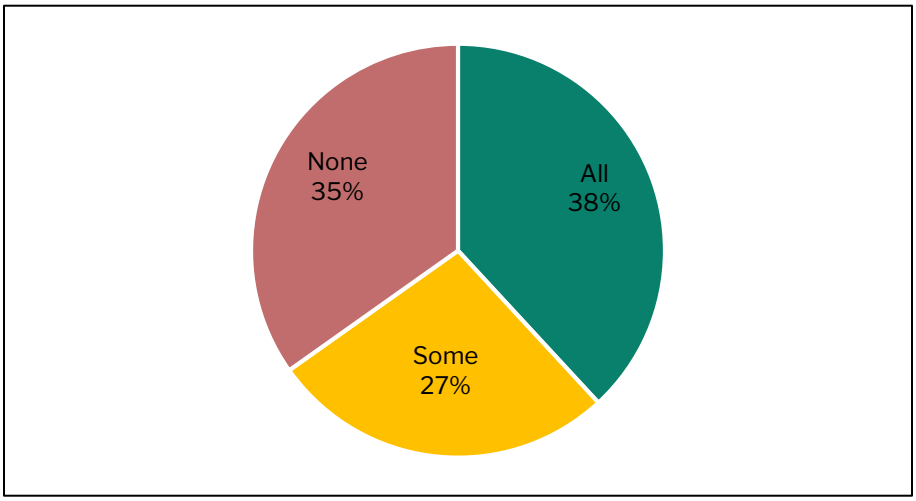



Source: CAPSS data provided by DSS

[140] 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.

Figure 30 further shows the breakdown of sibling placements during this monitoring period. Of the 530 (65%) children who were placed with at least one of their siblings, 220 (27%) were placed with some but not all. Performance with respect to the percentage of children not placed with *any* siblings also slightly improved from 39 percent in March 2019 to 35 percent in March 2020.

**Figure 30: Sibling Placements for Children Entering Placement**
**October 1, 2019 – March 31, 2020**
**N=813**




Source: CAPSS data provided by DSS

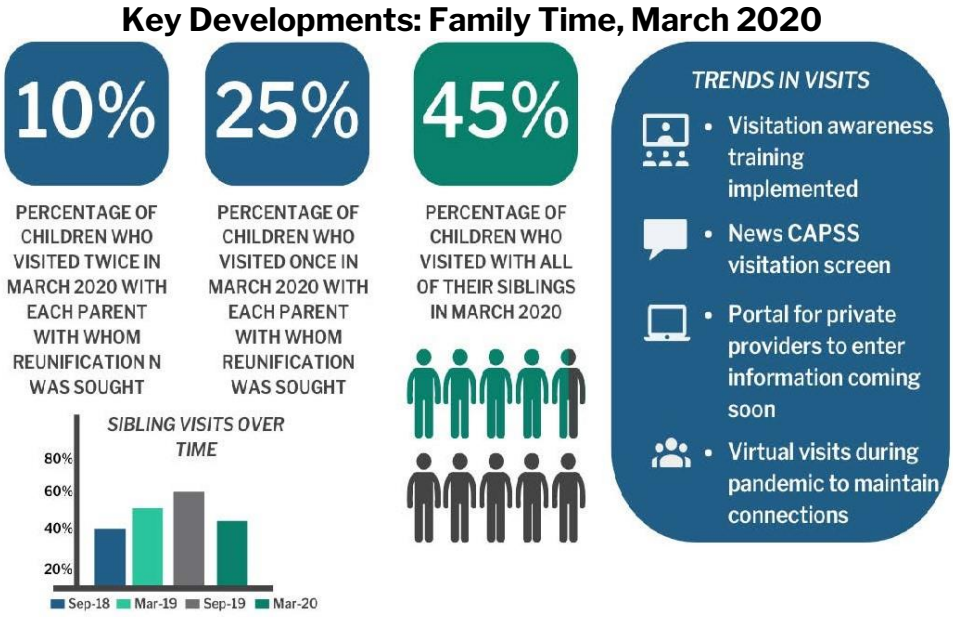
## VIII. Family Time: Visits with Parents and Siblings

It is important that children in foster care maintain meaningful connections with siblings with whom they are not placed and with parents and other family members with whom they are to reunify. DSS policy has set minimal requirements for contact between children and their siblings and parents, but the expectation is for more frequent and varied contact.

DSS continued its work this period to emphasize the importance of time with family and communicate its goal of moving away from the historical practice of limiting time together to formal, one-hour monthly visits among siblings and twice monthly visits between children and their parents. This shift will support not only increased contact between children and their family members, but, ideally, opportunities for families to connect in settings that are less restrictive than a DSS office. DSS has begun to build an understanding that unless there is a safety reason for supervised visits, children's contacts with their family members are to occur in more normalized settings and circumstances – at playgrounds, restaurants, or a family member's homes – and that these and other forms of contact may be facilitated by case managers or foster parents. DSS continued its Visitation Awareness Training this period and has made ongoing efforts to train and communicate with staff about the importance of children's contact with family members.

This shift in expectations is not yet reflected in practice, however. Fewer than half of the children whose cases were recently reviewed by DSS, USC CCFS, and Co-Monitor staff had spent time with their sibling(s) with whom they do not reside. Similarly, the majority of children with a permanency goal of reunification, or without a permanency goal yet established by the Court, had no contact at all with their parent(s).

Given the additional challenges the COVID-19 pandemic has presented for ongoing contact between children and their families, DSS has begun to use technology as a way of helping to maintain communication. Though not a substitute for in-person contact, these virtual and telephone contacts reflect possibilities and opportunities, in addition to time spent in-person, for children to maintain and build relationships which are central to their healing and well-being.




## *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, approved by the Co-Monitors on March 28, 2019, includes strategies to achieve visitation targets. Although delayed, DSS continues to make progress towards developing and implementing strategies, as described below.

Visitation Awareness training is one of DSS's core strategies to communicate the importance of visits and other forms of contact between children and their family members. The training was developed and is delivered to set a foundation for case managers, supervisors, and foster parents, with the goal of shifting agency practices.[141] All staff are expected to participate in the training and new staff are

[141] In addition to previously reported participant data, DSS reports that between October 2019 and March 2020 149 staff, including 139 supervisors, participated in a Visitation Awareness training session. 70 foster parents have been trained to deliver the training and 217 foster parents have participated in the training.

expected to do so within 90 days of their Child Welfare certification. The Learning Management System, the platform used for training registration, now allows DSS to more accurately track training participation. DSS attorneys are also invited to participate in the training, which is offered on a quarterly basis.

Enhancements to DSS's June 2019 visitation policy, aimed to align with the agency's practice model, are delayed but reportedly underway with drafts being reviewed and revised internally. In August and November 2019 and March 2020, DSS released practice tips for family visits for both DSS and private provider staff in the form of a newsletter. The document continues to highlight the importance of the time children spend with family members and focuses on improving performance on and documentation of visits.

Additions to CAPSS were also made to better capture data on visits. This update, as well as a new Visitation Plan document, which is expected to be completed by a child's case manager, are not yet uniformly in use. Anecdotally, there are reports that some case managers experience these new data entry fields as onerous and duplicative. These data entry requirements are related to management reports which DSS planned to develop and train managers to use to track and improve results on family visits. DSS reports these management tools are in testing phase. DSS is also preparing to roll out a new Child and Adult Information Portal that will enable foster parents and group home providers to directly enter visit information in CAPSS. Training is being coordinated between DSS and USC, with an estimated implementation date of November 2020.

While efforts to improve performance on family and sibling visits are recent, there has been little to no improvement in the quantity of visits between children and their family members. These results are likely related to the caseloads and workloads of case managers, where children are placed, relative to their sibling(s) and home, and the engagement of and planning with parents and other family members. As DSS works to decrease caseloads, increase placements for children within their home communities, and implement CFT meetings and its GPS Case Practice Model, it expects a positive impact on the opportunities children will have to spend time with their family.

Appendix E of this report includes a list of all strategies related to visits with family due this period, as well as related Joint Report commitments.[142]

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

*Performance Data*

**Sibling Visits**

Section IV.J.2. of the FSA requires *'[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed."*[143] The March 2020 interim benchmark for monthly sibling visits is 70 percent.

DSS requires, at minimum, 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 and Co-Monitor staff conducted a case record review using a structured instrument to collect data on visits between children in foster care living apart from a sibling who is also in foster care. Reviewers examined a sample of 310 records for required sibling visits in March 2020.[144] Documentation in 17 of the 310 records reflected an applicable exception to a sibling visit.[145] Of the remaining 293 records, 133 (45%) had documentation reflecting a sibling visit occurred.[146] This represents a reduction in performance from September 2019, as shown in Figure 31, possibly

[143] 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).

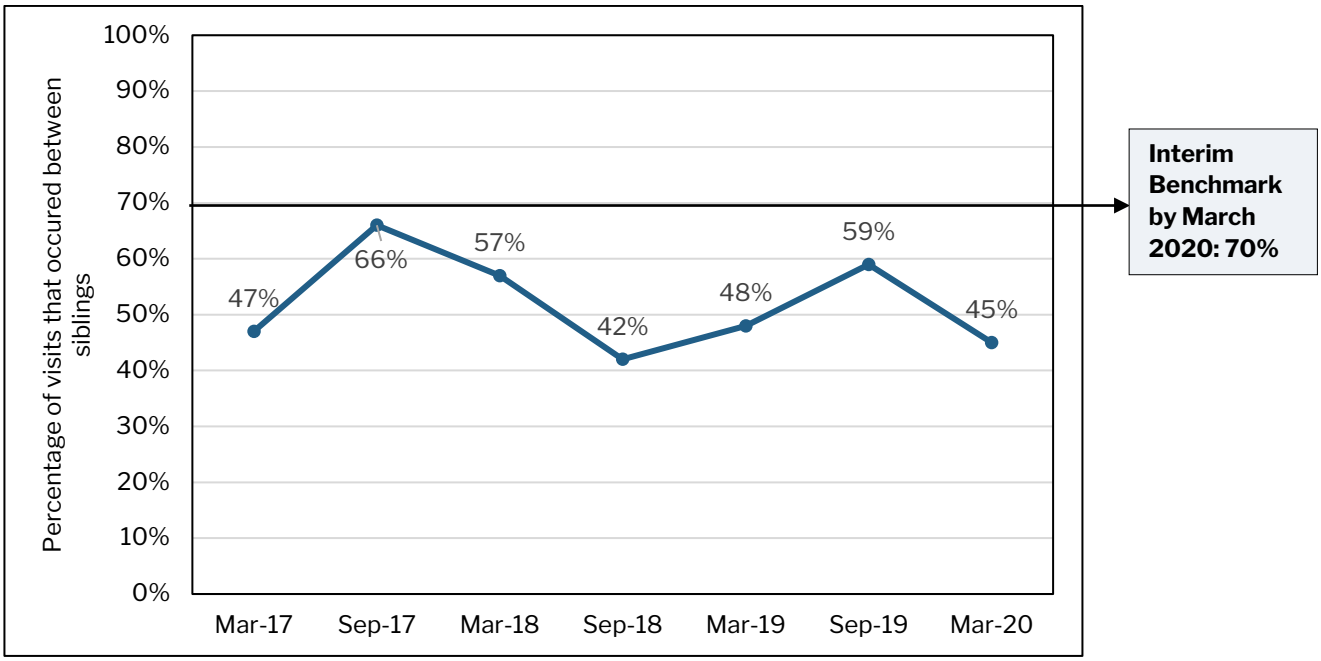
[144] During March 2020, there were 1,601 visits required between siblings who had been in foster care for at least 30 days and living apart. A statistically valid sample of 310 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

[145] In 9 of the cases, it was determined that visitation would be psychologically harmful for the child; in 3 cases, a child refused to participate in a visit; in 3 cases a child was on "runaway status"; in 1 case a child was in a facility in which visits was not possible; and in 1 case there was a court order prohibiting visits.

[146] The majority (114 of 133) of visits were in-person. As allowed, due to the COVID-19 pandemic, 14 visits were via video calls; and 1 was a phone call. For 1 contact the record did not clearly indicate the mode of contact.

impacted by the COVID-19 pandemic. Performance does not meet the March 2020 interim benchmark of 70 percent.

**Figure 31: Visits that Occurred between Siblings Placed Apart March 2017 - March 2020**




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

## Parent-Child Visits

The FSA requires *'[a]t least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought […]"* (FSA IV.J.3.).[147] The interim benchmark for at least twice monthly visits between children and their parent(s) is 60 percent.

[147] 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.

According to DSS policy, unless prohibited by court order, a child's case manager is expected to arrange for a child to spend time with their parent(s) within one week of the child's placement.[148] The policy also states that within 30 days of a child entering foster care, the case manager must create a plan for visits with input from the child, the parents/guardians, other significant persons, foster parent or congregate care provider, the guardian ad litem, and, if applicable, the child's therapist or behavioral health provider.[149] 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 communicated the importance of children and their parents maintaining other forms of contacts, to include video and phone calls, text messages, and emails, unless contrary to the child's safety or well-being, as determined by a clinician or court order. Neither DSS staff nor placement providers can limit or prohibit family contact as a disciplinary measure.

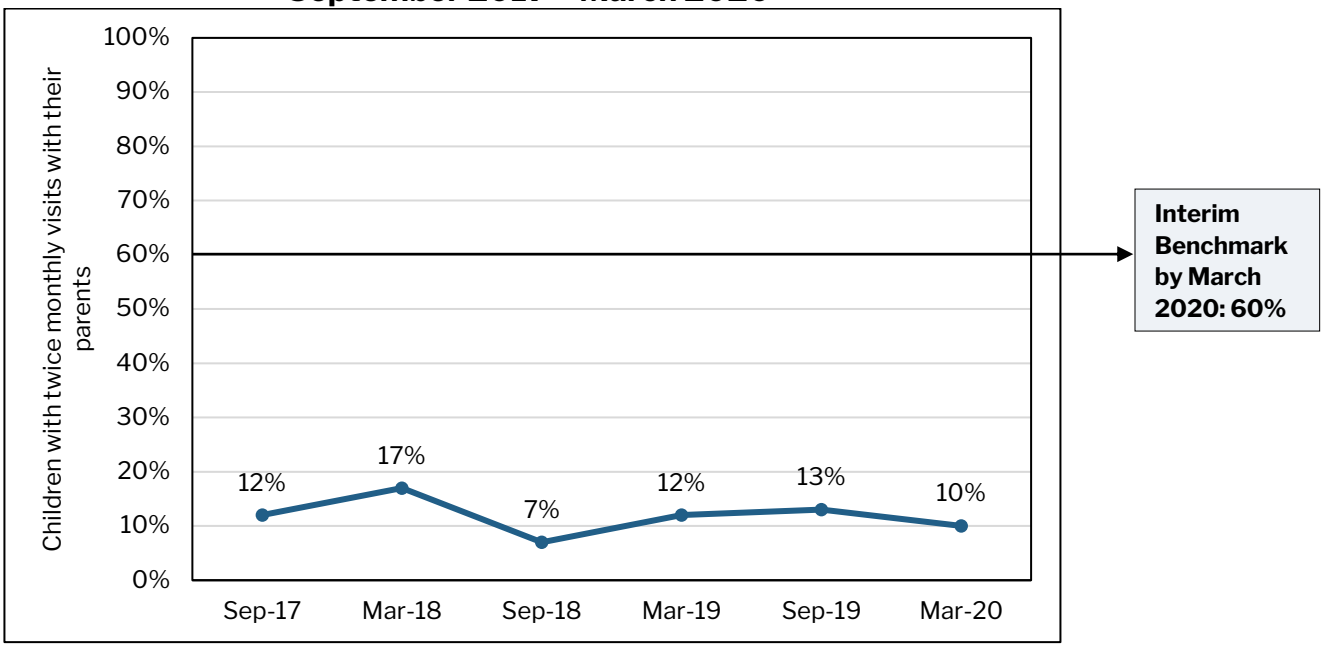
On March 25, 2020, in response to the COVID-19 pandemic, DSS directed case managers to ask both children's caregivers and parents a set of screening questions to determine COVID-19 infection symptoms, possible exposure, and comfort with the parent and child spending time together in a "thoroughly sanitized"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

USC CCFS, DSS, and Co-Monitor staff apply a structured instrument to collect data on visits between children in foster care and the parent(s) with whom reunification is sought. Reviewers examined a sample of 328 records for visits between a child and their parent(s) that were required in March 2020.[150,151] In 21 of the 328 records, there was documentation of an applicable exception to this requirement.[152]

[148] Human Services Policy and Procedural Manual, Chapter 5, Section 510.7.300.
[149] Ibid.
[150] As of March 31, 2020, there were 2,212 children who had been in foster care for at least 30 days with a goal of "return to home" or "not yet established." A statistically valid sample of 328 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.
[151] 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.
[152] 21 cases were removed from the sample because case circumstances reflected a valid exception to the visit requirement. In 11 cases, the parent did not visit despite attempts to arrange and conduct a visit; in 3 cases the child was on "runaway status"; in 3 cases a court order prohibited visits; in 2 cases the parent was missing with best efforts to locate; and in 2 cases the child refused to participate in a visit.

Of the remaining 307 records, 25 percent (78 of 307) reflected that the child had one visit in March 2020 with each parent with whom the child is to reunify.[153,154] Forty-two records (14%) reflected that twice during March 2020, the child spent time with at least one parent with whom the child is to reunify. Thirty-one records (10%) contained documentation of a child visiting twice during March 2020 with both parent(s) with whom the child is to reunify. This is far below the performance benchmark of 60 percent. Figure 32 shows performance for at least twice monthly visits between parents and children, ranging from 10 to 17 percent since September 2017. The impact of the COVID-19 pandemic affected visits in the middle of March 2020, by which time children could have had at least one visit with their parent(s), which explains some, but not all, of the results. DSS has expressed that this level of performance is a critical concern, and that this is an area of practice that urgently needs improvement.

**Figure 32: Children with Twice Monthly Visits with Their Parents September 2017 – March 2020**




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

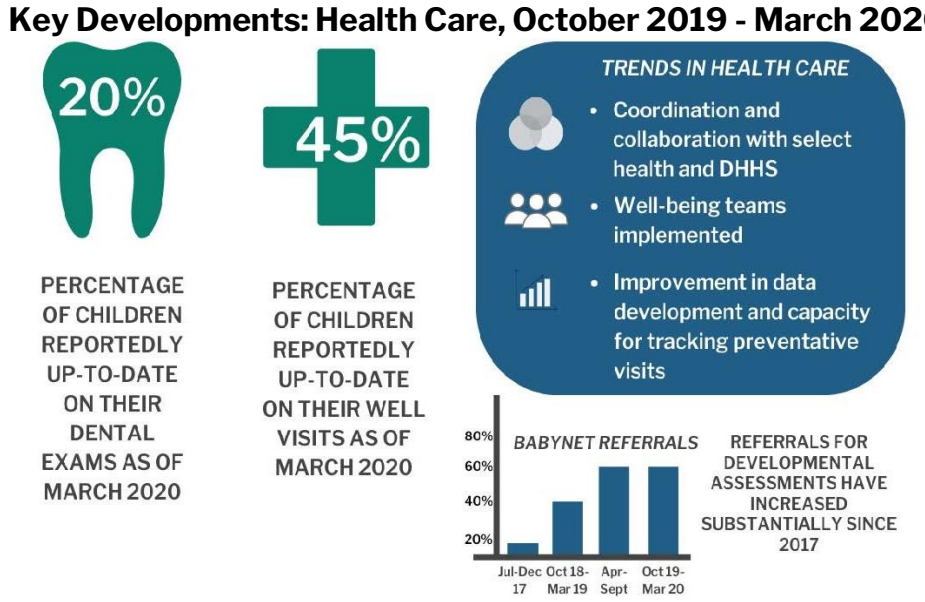
[153] Reviewers identified and sought documentation of visits with a second parent for 151 children. However, documentation is CAPSS does not clarify the reunification resource when parents live apart. This number is likely an overcount of reunification resources.
[154] Children and their parents participated in-person visits, video calls, and phone calls as allowed during the pandemic.

## IX. Health Care

States must provide children in foster care with the supports and services they need to be healthy. This requires the ability to quickly identify children's physical and behavioral health needs, to provide high quality preventative and acute care, and to track care delivery and communicate key health care information. DSS has made progress in building this capacity over recent months, and many of the key components of the health care infrastructure envisioned by leadership are now in place. Each of DSS's four regions now has a dedicated clinical nurse that is part of DSS's state-level Office of Child Health and Well-Being, as well as a Well-Being Team that serves as a clinical support and liaison to community resources. In partnership with the South Carolina Department of Health and Human Services (DHHS) and Select Health, the state's Managed Care Organization (MCO) for most children in foster care, DSS worked this period to refine its systems for collecting and analyzing health care data, and for collaborating on medically complex cases. The important work of engaging community providers and agency partners in informing policy and implementation decisions has also continued.

There is, however, still much work to be done. Nearly four years after entry into the FSA, data show that many children are not receiving required medical visits, and there remains a need throughout the state for quality community-based services and supports for children. The COVID-19 pandemic in South Carolina has only amplified this need and added to the pressures on a nascent health care infrastructure. Clinical attention to children and families with chronic health issues has been required; the stressors of the pandemic have increased behavioral health concerns; foster families and group providers have needed help in navigating exposure risks; and case managers and families have struggled with access to providers.

The next phase of DSS's care work will require continued innovation, ongoing collaboration, and an intensified focus on approaches that promote accountability. DSS recognizes that now, more than ever, it will also need additional resources to effectively manage the health and well-being of the children in its custody.




## *Health Care: Progress and Implementation Updates*

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

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

On August 23, 2018, after many months of review and input from the Co-Monitors and Plaintiffs, and the support of health care consultants, DSS obtained Co-Monitor approval for its Health Care Improvement Plan. In granting Plan approval, the Co-Monitors indicated that DSS would need to update it to include two critical components it was not yet prepared to submit: (1) baselines and interim percentage

targets (FSA IV.K.1.(c)); and (2) a proposed model of health care case management and care coordination, with updated associated budget projections.[155] A Plan addendum (the "Health Care Addendum") was approved by the Co-Monitors on February 25, 2019, establishing commitments by Select Health and DHHS to a framework for care coordination involving distinct, interrelated roles for the DSS Office of Health and Well-Being, DSS Case Managers, Select Health, and foster and biological families.[156] Though a rough delineation of roles were included in the Addendum, it was approved with the understanding that additional detail would be determined through implementation, and the efficacy and adequacy of the model would be assessed each year to see if it requires changes or additions.[157]

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

*Data Development*

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

[155] The FSA also required that within 120 days of the completion of the Health Care Improvement Plan, the Co-Monitors, with input from Parties, would "identify the final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, which Parties agree will be final and binding" (FSA IV.K.5). After consulting with Parties and the health care consultants, the Co-Monitors submitted final health care outcomes to the Court on December 21, 2018. These outcomes are intended to guide health care implementation, and to serve as measures of DSS's progress in meeting the physical health, behavioral health, and dental needs of the children in their care. In accordance with FSA K.1.(c), DSS updated its Health Care Improvement Plan to include baselines and interim percentage targets for meeting these final health care outcomes. The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf

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

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

significant accomplishment. DSS has reported that its focus over the coming months will be on the review and development of data on follow-up care.[158]

*Internal Capacity Building*

Since March 2020, the Child Health and Well-Being nurse infrastructure has been in place, including a state-level Nurse Care Manager and Dental Nurse, and one Nurse Care Coordinator and Data Coordinator in each region. In addition, DSS has also now implemented regional Well-Being Teams, overseen by Regional Well-Being Managers, and staffed by Regional Nurse Care Coordinators, Regional Clinical Specialists, and other members – including a Therapeutic Services Coordinator, a Community Liaison, an Assessment and Planning Coordinator, a Well-Being Data Coordinator, and Health care Data Coordinator. Many of these positions were formerly part of the IFCCS structure that was eliminated in December 2019. Based on a model utilized effectively in Tennessee, the Well-Being Teams operate in coordination with state Office of Child Health and Well-Being staff, and are charged with serving in a supportive role with case managers in assessing and managing the well-being needs of children in foster care.

As previously reported, DSS and the Co-Monitors have been concerned that, even with the support of regional Well-Being Teams, six nurses are not sufficient to manage the significant task of ensuring that the health care needs of all children in care are adequately addressed, particularly given the complexity of, and attention required by, each individual child. Now that the Office of Child Health and Well-Being is considered by DSS to be fully staffed, it has become clear that this work cannot be effectively done without the addition of more nurses and support staff. The day-to-day management of provider data alone has required the full-time support of virtually all clinical nurse staff and, even so, nurses report they have only been able to keep up with tracking basic well-child visits. Ensuring that all children, including those with complex needs or chronic medical issues, are getting consistent, high quality care requires nursing staff who have the time to provide clinical support on cases; serve as resources for biological and foster families, providers, and DSS case managers; and arrange physical and behavioral preventative, routine, and follow-up care. Nurses have reported that they want to take on these roles, but will need more support in

[158] 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 recent months to establish 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 obligations outlined therein. DSS reports that it is taking a number of steps to improve the reliability and availability of these data in coordination with Select Health, foster parents, and providers, and the Co-Monitors will provide a progress update in the next report.

order to do so. DSS recognizes the need to expand its Office of Child Health and Well-Being staff, and is in the process of trying to obtain funding for 12 additional positions, including two additional clinical nurses.

In recognition of the insufficiency of current staff capacity under the circumstances of the COVID-19 pandemic, DSS is in the process of determining whether two nurses can be hired through CARES Act funding to work with children most vulnerable to the impact of the COVID-19 pandemic: children with underlying medical conditions and children residing in congregate care facilities.[159]

*Defining a Managed Care Organization Partnership*

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

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

Select Health also continues to be in communication with DSS about the intricacies of the care coordination model. Select Health reports that it now has 21 staff in its new Foster Care Unit (including eight clinical nurses, two social workers, and a Foster Care Liaison) and a new medical director and has partnered with DSS to implement a weekly Foster Care Grand Rounds process through which cases of concern are chosen for intensive review. There is still significant work to be done, however, in clarifying the Select Health role in the day-to-day management of children's care, beyond denying or approving claims and offering a roster of in-network providers. This has been a priority for some time. Given the significant budgetary constraints

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

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

*Coordination and Collaboration with DHHS*

DSS has also continued to work closely with DHHS to improve access to quality health care for children in foster care. As a result of feedback received from providers throughout the state, work over recent months has focused, on adjusting the funding platform utilized to bill for Medicaid eligible services for children placed in therapeutic foster homes throughout the state. As of July 1, 2020, TFC providers no longer have to bill Medicaid incrementally for services provided to the children in their care – a practice that has been crippling to many therapeutic providers throughout the state. This has been a much needed and celebrated change in the provider community. DSS reports that this change has been welcomed by therapeutic providers who have long been overburdened by the administrative requirements of supporting children in foster care with higher levels of need.[160]

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

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 work in close partnership with DHHS to explore ways of maximizing federal Medicaid funding.

*Network Sufficiency*

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

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

DSS began to collect anecdotal information from its case managers and supervisors in a database about the service needs of children and families throughout the state, and expects that by June 30, 2021, it will be prepared to implement "mitigation plans" for areas in which service or provider capacity is limited. As discussed in Section VII. *Placements*, DSS has also committed to seeking resources through CARES or its FY2020-2021 budget request to expand services and supports for family placements for children moved out of congregate care settings. The Co-Monitors continue to believe that this is a key area of work, and one that must be done with expediency and in close partnership with DHHS, Select Health, the Department of Mental Health, and community partners throughout the state.

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

## *Performance Data*

After many months of collecting and producing data to assess compliance with FSA health care measures, DSS has determined that the methodology currently being used does not result in information that is useful for DSS leadership, or for staff in the field. The Co-Monitors have discussed with DSS the possibility of re-assessing these approved methodologies in the next monitoring period given the shared goal of efficiently, effectively producing understandable, timely performance data that can be used both for public and court accountability purposes, and for day-to-day management and quality improvement.

Given this, and the delays that DSS encountered in acquiring updated DHHS Medicaid claims data during the COVID-19 pandemic, the Co-Monitors agreed to include in this report a limited set of health care data already available to DSS for its own internal management purposes. These data have been collected and validated by DSS's Regional Nurse Care Managers, and are derived from a combination of CAPSS data, Medicaid claims data, and Select Health records. They have not been independently validated by the Co-Monitors.

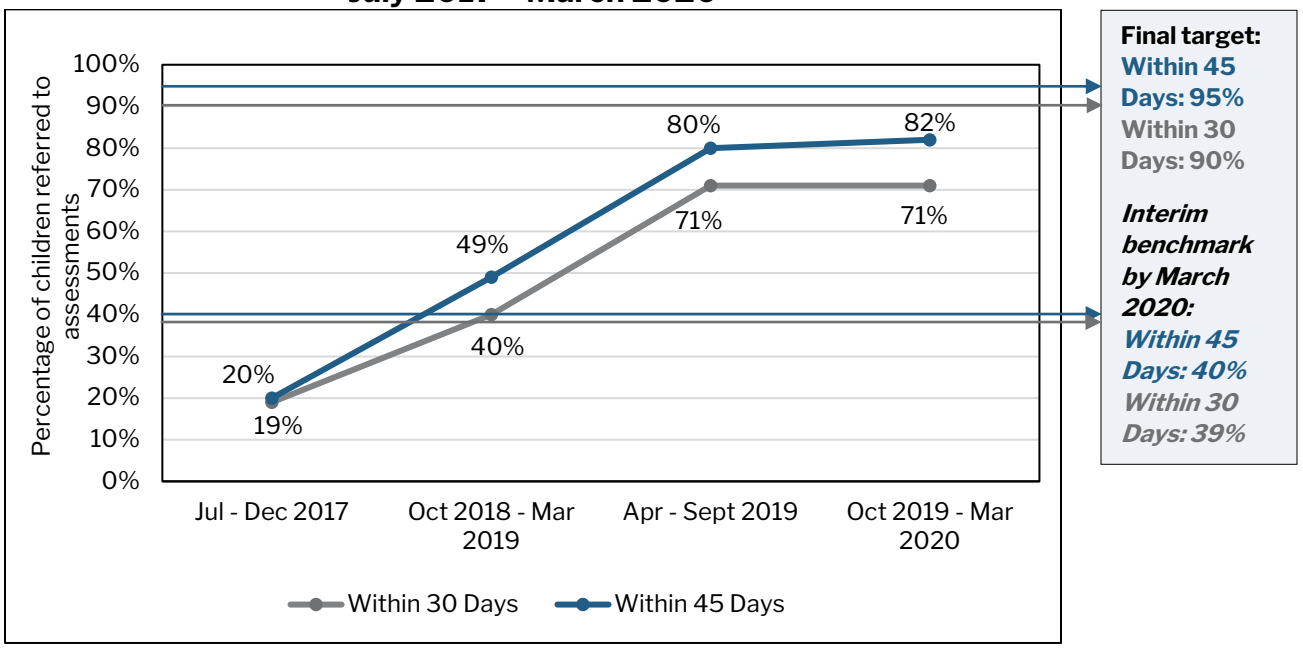
In addition, data lags related to the COVID-19 pandemic made it difficult for DSS to access, analyze, and share health care data in some areas (initial health screens, behavioral health assessments, and follow-up care) this reporting period. The Co-Monitors agreed that, given the impact of the pandemic and resulting resource constraints, focusing on producing these data for the next monitoring period would yield more reliable results.

**Developmental Assessments**

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that "*At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care; at least 95% shall be referred within 45 days.*" The interim benchmark is that 39 percent of children under 36 months will be referred to BabyNet within 30 days, and 40 percent will be referred within 45 days.

DSS continued to put a particular focus this reporting period on ensuring that all children under 36 months of age are referred for developmental assessments to determine if early intervention services are needed, and maintained its significant progress both in documenting referrals that had been made and making new referrals where needed. DSS reports that 71 percent (291 of 412) of children under 36 months of age who entered care between October 1, 2019 and March 31, 2020 were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days. Eighty-two percent (312 of 381) of children were referred within 45 days. These data significantly exceed the interim benchmark, and are consistent with performance in the prior monitoring period (see Figure 33). It is important to note that these data only measure whether a child was *referred* for a developmental assessment and do not capture whether an assessment *occurred*. DSS reports that it is also working to improve its system for tracking completion of these assessments and any recommended follow-up care, and that this will be essential work.

**Figure 33: Developmental Assessments within 30 and 45 Days**
**July 2017 – March 2020**




Source: CAPSS data provided by DSS

**Well-Child Visits**

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed, based on AAP guidelines, that *'At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care; at least 95% will receive a comprehensive medical assessment within 60 days of entering care*."[161]

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."[162] Based on these guidelines, DSS committed in its Health care Outcomes that, "*At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines;*[163]*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."*[164]

As explained above, given the methodologies now used internally at DSS for health care management, as well as the delays and limitations expected in a new DHHS data extraction during the pandemic, the Co-Monitors agreed to report initial comprehensive medical assessments and periodic preventative well-child visits performance using data collected by DSS nurses during this monitoring period.[165] Nurse care coordinators reviewed CAPSS records for each child in foster care and estimated the date for the next required well-child visit based on the child's age and most recent assessment. For validation purposes, nurses collected documentation of visits from providers and pulled data from DHHS and/or Select Health in order to determine when the most recent assessment occurred.

---

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

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

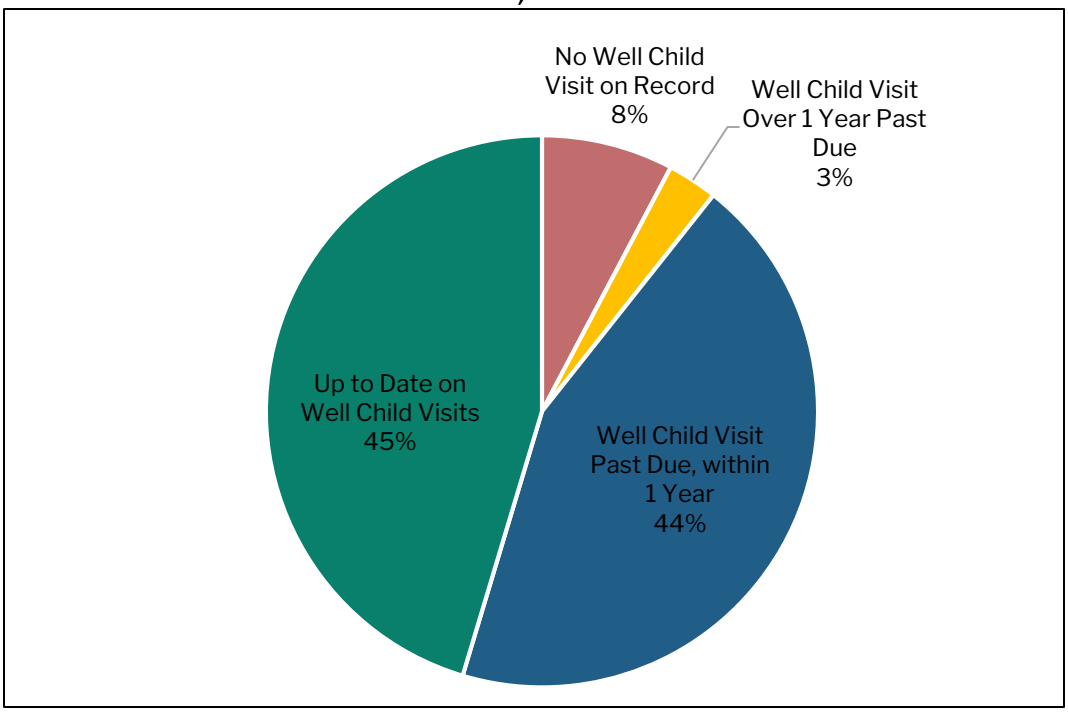
[163] See AAP Recommendations for Preventative Pediatric Health Care, which can be found at https://www.aap.org/enus/Documents/periodicity_schedule.pdf

[164] 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).

[165] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than were used by the Co-Monitors for reporting purposes in prior periods. Data are, therefore, incomparable to prior performance and are not meant to indicate performance relative to the FSA target.

DSS reported that of all children under 18 years of age who were in foster care on April 6, 2020 for at least 30 days, 45 percent (1,866 of 4,114) were up to date on their well-child visits. Of the remaining children, 318 (8%) did not have a well-child visit indicated in the DSS record or DHHS and Select Health data systems. As depicted in Figure 34, 44 percent of children were past due on their well-child visit according to the periodicity schedule, but were within 12 months of the estimated follow-up visit date.

**Figure 34: Well-Child Visits Recorded as of April 6, 2020 N=4,114**



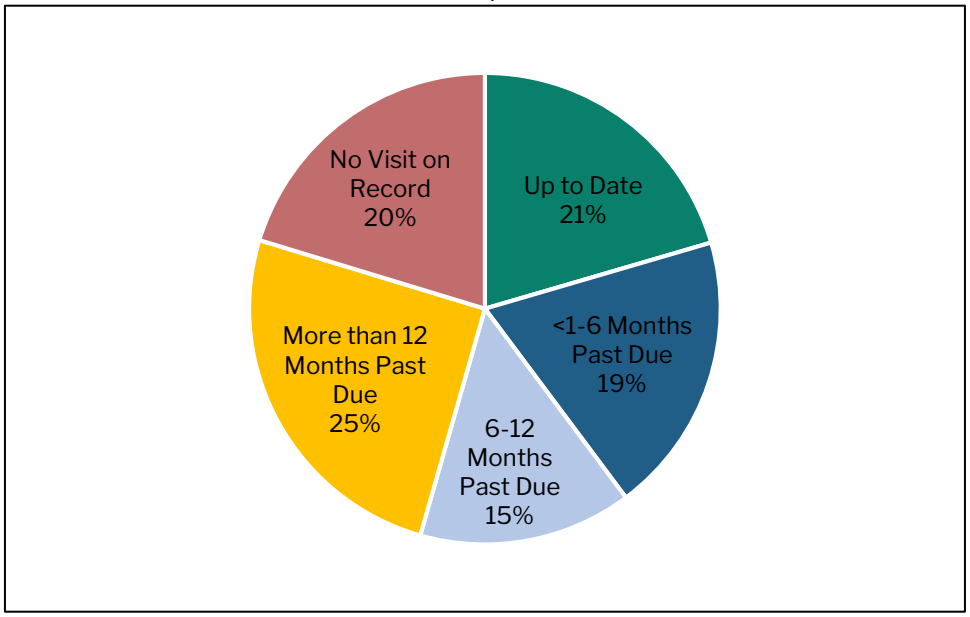

Source: CAPSS, DHHS, and Select Health data provided by DSS

## Dental Examinations

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

As explained above, given the methodologies now used internally at DSS for dental care management, as well as the delays and limitations expected in a new DHHS data pull during the pandemic, the Co-Monitors agreed to report only DSS's management internal data this reporting period. DSS reports that of all children between two and 17 years old who were in care on April 6, 2020 and at that point had been in care for at least 30 days, 20 percent (729 of 3,561) of them were up to date on their dental examination. An additional 19 percent (688 of 3,561) were within six months of their estimated dental follow-up date. One quarter of children (900 of 3,561) were more than 12 months past their estimated dental follow-up date, and one fifth of children (723 of 3,561) had no dental examination on record.[166]

**Figure 35: Dental Examinations Recorded as of April 6, 2020 N=3,561**




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

[166] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than were used by the Co-Monitors for reporting purposes in prior periods. Data are, therefore, incomparable to prior performance and are not meant to indicate performance relative to the FSA target.

## Appendix A - Glossary of Acronyms

**AAP:** American Academy of Pediatrics
**APS:** Adult Protective Services
**CAC:** Child Advocacy Center
**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
**DHHS:** Department of Health and Human Services
**DJJ:** Department of Juvenile Justice
**DMH:** Department of Mental Health
**DSS:** Department of Social Services
**FFCRA:** Families First Coronavirus Response Act
**FFPSA:** Family First Prevention Services Act
**FSA:** Final Settlement Agreement
**FTE:** Full-Time Equivalent
**GPS:** Guiding Principles and Standards Case Practice Model
**ICPC:** Interstate Compact on the Placement of Children
**ISCEDC:** Interagency System for Caring for Emotionally Disturbed Children
**IFCCS:** Intensive Foster Care and Clinical Services
**IO:** Interim Order
**MCO:** Managed Care Organization
**MOU:** Memorandum of Understanding
**NCCD:** National Council on Crime & Delinquency
**OHAN:** Out-of-Home Abuse and Neglect Unit
**PCG:** Public Consulting Group
**PIP:** Performance Improvement Plan
**SC:** South Carolina
**TFC:** Therapeutic Foster Care
**USC CCFS:** University of South Carolina's Center for Child and Family Studies

## Appendix B - Monitoring Activities

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

Given the COVID-19 pandemic, the Co-Monitors were unable to complete site visits in person to discuss the reform efforts with staff and providers on the ground. However, the Co-Monitors engaged in video interviews with several groups of staff across the state: nurses, well-being team members, family engagement staff, kinship licensing staff, Chafee transition specialists, and members of the visitation work group. Thematic information gathered from these sessions have been shared with DSS leadership for system improvement purposes.

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

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

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

- Review of a statistically valid sample of OHAN investigations involving Class Members as an alleged victim accepted in March 2020, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care 30 days or more on March 31, 2020, to assess whether dictation/documentation of a case manager's face-to-face contact with a child in March 2020 addressed each of the agreed upon expected practices or elements which collectively meet the definition of a visit (FSA IV.B.2&3.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care for 30 days or more on March 31, 2020 and living apart from a sibling also in foster care, to assess whether a sibling visit had occurred in March 2020 (FSA IV.J.2.);

- Review of a statistically valid sample of case records in CAPSS for Class Members with a permanency goal of reunification, or with a permanency goal which had not yet been established in Family Court, and in foster care for 30 days or more on March 31, 2020, to assess whether the child had visited with the parent(s) with whom reunification was sought during March 2020 (FSA IV.J.3.);

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

- Review of case files of Class Members ages six and under who were placed in a congregate care setting from October 2019 to March 2020 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office overnight from October 2019 to March 2020 (FSA IV.D.3.); and

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

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

**Table 6: Summary Performance on Settlement Agreement Requirements**

| Final Settlement Agreement (FSA) Requirements | Baseline Performance | October 2018 - March 2019 Performance | April - September 2019 Performance | October 2019 – March 2020 Performance |
|---|---|---|---|---|
| *Workload Limits for Foster Care:*<br><br>1a. At least 90% of caseworkers[167] shall have a workload within the applicable Workload Limit.<br><br>***Interim benchmark by March 2020: 65% within required limit***<br><br>1b. No caseworker shall have more than 125% of the applicable Workload Limit.<br><br>***Interim benchmark by March 2020: No more than 25% have more than 125% of the required limit***<br><br>(FSA IV.A.2.(b)&(c)) | OHAN case managers:<br>0% within required limit (September 2017)<br><br>100% had more than 125% of limit (September 2017) | OHAN case managers:<br>44% within required limit<br><br>Monthly range within the required limit: 0 - 44%<br><br>56% had more than 125% of limit.<br><br>Monthly range with caseloads more than 125% of limit: 56 - 86% | OHAN case managers:<br>7% within required limit<br><br>Monthly range within the required limit: 0 - 50%<br><br>93% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of limit: 50 - 100% | OHAN case managers:[173]<br>13% within required limit<br><br>Monthly range within the required limit: 0 - 13%[174]<br><br>87% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of limit: 86 - 100%[175] |

[167] 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.
[173] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager. These random dates are as follows: October 23, 2019; November 18, 2019; December 9, 2019; January 14, 2020; February 29, 2020; March 31, 2020.
[174] Monthly performance for OHAN case manager caseloads within the required limit is as follows: October 2019, 0%; November 2019, 0%; December 2019, 0%; January 2020, 7%; February 2020, 7%; March 2020, 13%.
[175] Monthly performance for OHAN case manager caseloads more than 125% over the limit is as follows: October 2019, 93%; November 2019, 100%; December 2019, 100%; January 2020, 86%; February 2020, 87%; March 2020, 87%.

**Table 6: Summary Performance on Settlement Agreement Requirements**

| Final Settlement Agreement (FSA) Requirements | Baseline Performance | October 2018 - March 2019 Performance | April - September 2019 Performance | October 2019 – March 2020 Performance |
|---|---|---|---|---|
| Approved Workload Limits:[168,169]<br>• *OHAN worker* - 8 investigations<br>• *Foster care worker* – 15 children<br>• *Adoption worker* – 15 children[170]<br>• *IFCCS worker* – 9 children[171]<br>• *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training | Foster Care case managers:<br>28% within required limit (September 2017)<br><br>59% had more than 125% of limit (September 2017). | Foster Care case managers:<br>15% within required limit<br><br>Monthly range within required limit: 14 - 20%<br><br>76% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of the limit: 67 - 76% | Foster Care case managers:<br>26% within required limit<br><br>Monthly range within required limit: 15 - 26%<br><br>57% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of the limit: 57 - 75% | Foster Care case managers:[176]<br>49% within required limit<br><br>January – March 2020 range within required limit: 47 - 49%<br><br>35% had more than 125% of the limit.<br><br>January – March 2020 range with caseloads more than 125% of the limit: 34 - 36% |

[168] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[169] 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.
[170] As described in Section IV. *Caseloads*, between October and December 2019 of this monitoring period, the previously approved adoption caseload standard was 1:17. Beginning January 2020, the adoption caseload standard was modified to 1:15, the same standard applied to foster care case managers.
[171] As described in Section IV. *Caseloads*, the IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.
[176] During this monitoring period, DSS implemented significant changes to how its workforce is structured. Between September and December 2019, DSS phased out use of its Intensive Foster Care and Clinical Services (IFCCS) position as a separate workload and staffing category, and all IFCCS case managers and supervisors transitioned into foster care units in county offices. Additionally, beginning in February 2019, DSS discontinued the practice of assigning children's cases to both adoption and foster care case managers when a child is legally eligible for adoption. Due to multiple factors impacting caseloads in the first three months of this monitoring period – October through December 2019 – caseload performance for foster care and adoption workers is only reported for January through March 2020. See Section IV. *Caseloads* for further discussion of these changes.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | <u>Adoption case managers:</u><br>23% within required limit (September 2017)<br><br>62% had more than 125% of limit (September 2017).<br><br><u>IFCCS case managers:</u><br>10% within required limit (September 2017)<br><br>77% had more than 125% of limit (September 2017). | <u>Adoption case managers:</u><br>13% within required limit<br><br>Monthly range within required limit: 10 - 14%<br><br>75% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of the limit: 75 - 83%<br><br><u>IFCCS case managers:</u><br>36% within required limit<br><br>Monthly range within required limit: 15-36%<br><br>44% had more than 125% of the limit<br><br>Monthly range with caseloads more than 125% of the limit: 44-65% | <u>Adoption case managers:</u><br>23% within required limit<br><br>Monthly range within required limit: 10 - 23%<br><br>69% had more than 125% of the limit.<br><br>Monthly range with caseloads more than 125% of the limit: 66 - 71%<br><br><u>IFCCS case managers</u>:[172]<br>6% within required limit<br><br>Monthly range within required limit: 6-32%<br><br>78% had more than 125% of the limit<br><br>Monthly range with caseloads more than 125% of the limit: 45-78% | <u>Adoption case managers:</u><br>25% within required limit<br><br>January – March 2020 range within required limit: 24 - 25%<br><br>51% had more than 125% of the limit.<br><br>January – March 2020 range with caseloads more than 125% of the limit: 51 - 64% |

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

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | | | | |
| *Workload Limits for Foster Care:*<br><br>2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit.<br><br>***Interim benchmark by March 2020: 80% within required limit***<br><br>2b. No supervisor shall have more than 125% of the applicable Workload Limit.<br><br>***Interim benchmark by March 2020: No more than 10% have more than 125% of the required limit***<br><br>(FSA IV.A.2.(b)&(c))<br><br>Approved Supervisor Limits:<br>• *OHAN supervisors* – 6 investigators | OHAN Supervisors:<br>100% within required limit (March 2018)<br><br>None were more than 125% of the limit (March 2018)<br><br>Foster Care Supervisors:<br>42% within required limit (March 2018)<br><br>36% had more than 125% of the limit (March 2018) | OHAN Supervisors:<br>100% within required limit (in each month)<br><br>None were more than 125% of the limit.<br><br>Foster Care Supervisors:<br>27% within required limit<br><br>Monthly range within the required limit: 22 - 35%<br><br>63% had more than 125% of the limit.<br><br>Monthly range supervising more than 125% of the limit: 49 - 64% | OHAN Supervisors:<br>33% within required limit<br><br>Monthly range within the required limit: 33 - 67%<br><br>33% were more than 125% of the limit (in each month)<br><br>Foster Care Supervisors:<br>33% within required limit<br><br>Monthly range within the required limit: 33 - 42%<br><br>50% had more than 125% of the limit.<br><br>Monthly range supervising more than 125% of the limit: 45 - 53% | OHAN Supervisors:<br>0% within required limit<br><br>Monthly range within the required limit: 0 – 67%[179]<br><br>50% had more than 125% of the limit<br><br>Monthly range supervising more than 125% of the limit: 0 - 50%<br><br>Foster Care Supervisors:[180]<br>32% within the required limit<br><br>41% had more than 125% of the limit. |

[179] Large fluctuations in performance are due to the small number of supervisors each month.
[180] 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 6: Summary Performance on Settlement Agreement Requirements**

| Final Settlement Agreement (FSA) Requirements | Baseline Performance | October 2018 - March 2019 Performance | April - September 2019 Performance | October 2019 – March 2020 Performance |
|---|---|---|---|---|
| • *Foster Care*, *IFCCS*,[177] and *Adoption* supervisors – 5 case managers | <u>Adoption Supervisors:</u><br>38% within required limit (March 2018)<br><br>19% had more than 125% of the limit (March 2018)<br><br><u>IFCCS Supervisors:</u><br>57% within required limit (March 2018)<br><br>29% had more than 125% of the limit (March 2018) | <u>Adoption Supervisors:</u><br>35% within required limit<br><br>Monthly range within the required limit: 21 - 35%<br><br>20% had more than 125% of the limit.<br><br>Monthly range supervising more than 125% of the limit: 14 - 41%<br><br><u>IFCCS Supervisors:</u><br>22% within required limit<br><br>Monthly range within the required limit: 22-30%<br><br>63% had more than 125% of the limit<br><br>Monthly range supervising more than 125% of the limit: 59-63% | <u>Adoption Supervisors:</u><br>35% within required limit<br><br>Monthly range within the required limit: 35 - 55%<br><br>26% had more than 125% of the limit.<br><br>Monthly range supervising more than 125% of the limit: 0 - 31%<br><br><u>IFCCS Supervisors</u>:[178]<br>42% within required limit<br><br>Monthly range within the required limit: 37-46%<br><br>42% had more than 125% of the limit<br><br>Monthly range supervising more than 125% of the limit: 37-42% | <u>Adoption Supervisors:</u><br>45% within required limit<br><br>Monthly range within the required limit: 44 - 50%<br><br>34% had more than 125% of the limit.<br><br>Monthly range supervising more than 125% of the limit: 25 - 37% |

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

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | | | | |
| *Visits Between Case Managers and Children:*<br><br>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.<br><br>(FSA IV.B.2.) | 24% of cases reviewed had all agreed-upon elements of a visit (September 2019) | Data are not available for this period. | 24% of cases reviewed had documentation of all agreed-upon elements of a visit (Baseline/September 2019) | 35% of cases reviewed had documentation of all agreed-upon elements of a visit.[181,182] |
| *Visits Between Case Managers and Children:*<br><br>4. At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child. | 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)<br><br>92% of face-to-face contacts took place in the child's residence. (September 2019) | Data are not available for this period. | 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. (Baseline)<br><br>92% of face-to-face contacts took place in the child's residence. (Baseline) | 33% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence.[183,184] (March 2020)<br><br>83% of face-to-face contacts took place while |

[181] 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 2020. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.
[182] A sample of 350 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed.
[183] 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 2020. Reviewers assessed documentation for the elements which define a visit.
[184] A sample of 350 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed.

**Table 6: Summary Performance on Settlement Agreement Requirements**

| Final Settlement Agreement (FSA) Requirements | Baseline Performance | October 2018 - March 2019 Performance | April - September 2019 Performance | October 2019 – March 2020 Performance |
|---|---|---|---|---|
| (FSA IV.B.3.) | | | | the child was in their own residence. |
| *Investigations - Intake:*<br><br>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.<br><br>(FSA IV.C.2.) | 44% of screening decisions to not investigate were determined to be appropriate. (March 2017) | Monthly performance for screening decisions not to investigate determined to be appropriate:<br><br>October 2018: 94%<br>November 2018: 94%<br>December 2018: 100%<br>January 2019: 100%<br>February 2019: 88%<br>March 2019: 84% | Monthly performance for screening decisions not to investigate determined to be appropriate:<br><br>April 2019: 87%<br>May 2019: 100%<br>June 2019: 93%<br>July 2019: 100%<br>August 2019: 100%<br>September 2019: 100% | Monthly performance for screening decisions not to investigate determined to be appropriate:[185]<br><br>October 2019: 100%<br>November 2019: 100%<br>December 2019: 90%<br>January 2020: 75%<br>February 2020: 90%<br>March 2020: 90% |
| *Investigations - Case Decisions:*<br><br>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. | 47% of applicable investigation decisions to unfound were determined to be appropriate (March 2017). | 10% (3) of 31 applicable investigation decisions to unfound were determined to be appropriate. | 53% (31) of 59 applicable investigation decisions to unfound were determined to be appropriate. | 55% (28) of 51 applicable investigation decisions to unfound were determined to be appropriate. |

[185] Fluctuations in performance can be attributed to the small number of applicable screening decisions each month. The number of applicable decisions each month are as follows: October 2019, 19; November 2019, 12; December 2019, 10; January 2020, 12; February 2020, 10; March 2020, 10.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| (FSA IV.C.3.)<br><br>***Interim benchmark by March 2020: 75% of decisions deemed appropriate*** | | | | |
| <u>*Investigations - Timely Initiation:*</u><br><br>7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations.<br><br><u>*Investigations - Contact with Alleged Child Victim:*</u><br><br>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.[186] | 78% of applicable investigations were timely initiated. (March 2017) | 35% (12) of 34 applicable investigations were timely initiated. | 67% (42) of 63 applicable investigations were timely initiated. | 74% (40) of 54 applicable investigations were timely initiated. |

[186] 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 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| (FSA IV.C.4.((a)&(b))<br><br>***Interim benchmark by March 2020: 90% timely initiated*** | | | | |
| <u>*Investigations - Contact with Core Witnesses:*</u><br><br>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.<br><br>(FSA IV.C.4.(c))<br><br>***Interim benchmark by March 2020: 70% contact with all core witnesses*** | 27% of applicable investigations included contact with all necessary core witnesses. (March 2017) | 3% (1) of 34 applicable investigations included contact with all necessary core witnesses. | 27% (17) of 63 applicable investigations included contact with all necessary core witnesses. | 30% (16) of 54 applicable investigations included contact with all necessary core witnesses.[187] |
| <u>*Investigations - Timely Completion:*</u> | 95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017) | 88% of applicable investigations reviewed were appropriately closed within 45 days. | 87% of investigations reviewed were appropriately closed within 45 days. | 93% of investigations reviewed were appropriately closed within 45 days.[189] |

[187] Completion of contact with core witnesses by type, as applicable, for the 54 investigations reviewed is as follows: alleged victim child(ren), 98%; reporter, 91%; alleged perpetrator(s), 92%; law enforcement, 63%; alleged victim child(ren)'s case manager, 93%; other adults in home or facility, 48%; other children in home or facility, 56%; and additional core witnesses as identified for the investigation, 51%.

[189] Reviewers determined that 1 of the investigations that was closed within 45 days was closed prematurely in an effort to meet the 45-day requirement, which is not considered compliant under the FSA. In this investigation, a supervisory staffing was held approximately 1 month prior to closure and instructed

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 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.[188]<br><br>(FSA IV.C.4.(d))<br><br>***Interim benchmark by March 2020: 90% closure in 45 days*** | | | | |
| <u>*Investigations - Timely Completion:*</u><br><br>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 | 96% of investigations reviewed were closed within 60 days. (March 2017) | 97% of investigations reviewed were closed within 60 days. | 98% of investigations reviewed were closed within 60 days. | 98% of investigations reviewed were closed within 60 days. |

the investigator to interview the DJJ worker, DSS licensing worker, foster father/alleged perpetrator, and make a law enforcement referral. Additionally, the investigator made a referral for a CAC interview on the same day as the supervisory staffing, and this was not completed prior to closure; no extension request was made to ensure this occurred. The investigation was closed on the 44th 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.

[188] 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 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 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.[190]<br><br>(FSA IV.C.4.(e))<br><br>***Interim benchmark by March 2020: 90% closure in 60 days*** | | | | |
| *Investigations - Timely Completion:*<br><br>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.[191]<br><br>(FSA IV.C.4.(f)) | 93% of investigations reviewed were closed within 90 days. (September 2017) | 97% of investigations reviewed were closed within 90 days. | 98% of investigations reviewed were closed within 90 days. | 98% of investigations reviewed were closed within 90 days. |

[190] 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.
[191] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | | | | |
| *Family Placements for Children Ages Six and Under:*<br><br>11. No child age six and under shall be placed in a congregate care setting except with approved exceptions.<br><br>(FSA IV.D.2.) | Baseline data for this measure are not available. | The circumstances of all but 3 children met an agreed upon exception. A total of 19 Class Members ages six and under were placed in congregate care. | The circumstances of all but 2 children met an agreed upon exception. A total of 32 Class Members ages six and under were placed in congregate care. | The circumstances of all but 1 child met an agreed upon exception.[192] A total of 37 Class Members ages six and under were placed in congregate care.[193] |
| *Phasing-Out Use of DSS Offices and Hotels:*<br><br>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 that there were 6 overnight placements in a DSS office (4 of which related to the same child). | DSS reports that there were 4 overnight placements in a DSS office. | DSS reports that there were 5 overnight placements in a DSS office. |
| *Congregate Care Placements:*<br><br>13. At least 86% of the Class Members shall be placed outside | 78% of children in foster care were placed outside of a congregate care setting. (March 2018) | 80% of children in foster care were placed outside of a congregate care setting. | 81% of children in foster care were placed outside of a congregate care setting. | 82% of children in foster care were placed outside of |

[192] In validating data for this measure, the Co-Monitors identified 1 situation that did not meet an agreed-upon exception. The instance involved a 6-year old who was placed in a group home without evidence that the placement setting was necessary to meet the child's specific needs.
[193] Although the number of children ages 6 and under in congregate care has increased, this is largely due to the fact that DSS has successfully placed a greater number of children with their families who are residing in these facilities. Of the 37 children, 27 children were residing in a facility or group care with their mothers and 9 were part of a large sibling group for whom DSS reported a single, family-based placement could not be located.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| of Congregate Care Placements on the last day of the Reporting Period.<br><br>(FSA IV.E.2.)<br><br>***Interim benchmark by March 2020: 82% family-based settings*** | | | | a congregate care setting.[194] |
| <u>*Congregate Care Placements - Children Ages 12 and Under:*</u><br><br>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.<br><br>(FSA IV.E.3.) | 92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018) | 94% of children ages 12 and under in foster care were placed outside of a congregate care setting. | 95% of children ages 12 and under in foster care were placed outside of a congregate care setting. | 96%[195] of children ages 12 and under in foster care were placed outside of a congregate care setting.[196,197] |

[194] This does not include 25 children who were hospitalized (4), or in a correctional/juvenile justice facility (21).
[195] This includes 14 children ages 6 and under who resided in a congregate care placement pursuant to a valid exception.
[196] 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.
[197] This does not include 2 children who were hospitalized (1) or incarcerated (1) on the last day of the monitoring period.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| ***Interim benchmark by March 2020: 95% family-based settings*** | | | | |
| <u>*Emergency or Temporary Placements for More than 30 Days:*</u><br><br>15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days.<br><br>(FSA IV.E.4.)<br><br>***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.[198,199] |
| <u>*Emergency or Temporary Placements for More than Seven Days:*</u> | Baseline data for this measure are not available. | Data are not available for this period. | Data are not available for this period. | |

[198] As discussed in more detail in Section VII. *Placements*, DSS produced data with respect to temporary placements for the first time during the last period (for August and September 2019), but after discussion with DSS it was agreed that these data did not capture the types of placements intended under the FSA. The Co-Monitors have asked DSS to revise the way it is tracking the use of temporary placements so that data produced in future periods can assess FSA performance and help inform practice.

[199] Although DSS does not yet formally track the use of emergency placements, DSS continues to provide the Co-Monitors with data regarding emergency "incentive" payments made to providers to accept placement of a child overnight. In Section VII. *Placements*, the Co-Monitors report that 171 children were subject to this practice. Neither DSS nor the Co-Monitors believe that all emergency placements are reflected in this enhanced rate payment data. The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 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.)<br><br>***Dates to reach final target and interim benchmarks to be added once approved***. | | | | Data are not available for this period.[200] |
| <u>*Placement Instability:*</u><br><br>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.<br><br>(FSA IV.F.1.) | 3.55 moves per 1,000 days (October 1, 2016 to September 30, 2017). | 3.92 moves per 1,000 days (October 1, 2017 to September 30, 2018).[201] | 4.30 moves per 1,000 days (October 1, 2018 to September 30, 2019).[202] | Data for this measure are produced on an annual basis. |

[200] As discussed in more detail in Section VII. *Placements*, DSS produced data with respect to temporary placements for the first time during the last period (for August and September 2019), but after discussion with DSS it was agreed that these data did not capture the types of placements intended under the FSA. The Co-Monitors have asked DSS to revise the way it is tracking the use of temporary placements so that data produced in future periods can assess FSA performance and help inform practice.
[201] Data for this measure are reported on an annual basis and calculates the rate of placement moves per 1,000 days of foster care among Class Members. See FSA II.O. for further description of methodology.
[202] Specifically, there were a total of 6,936 moves across 1,614,117 days.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | | | | |
| <u>Sibling Placements:</u><br><br>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<br><br>(FSA IV.G.2.&3.)<br><br>***Interim benchmark by March 2020: 74% 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) | 61% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. | 56% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. | 65% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.[203] |
| <u>Sibling Placements:</u><br><br>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). | 35% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry. | 32% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry. | 38% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[204] |

[203] 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.
[204] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| days of their siblings shall be placed with all their siblings, unless an exception applies.<br><br>***Interim benchmark by March 2020: 59% placed with all siblings*** | | | | |
| <u>*Youth Exiting the Juvenile Justice System:*</u><br><br>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.[205] |

[205] As discussed in Section VII. *Placements,* DSS is in the process of developing a reliable real-time system for tracking youth involved with both the juvenile justice and child welfare systems. The Co-Monitors reviewed a number of cases reported by stakeholders in which youth spent time in DJJ facilities due, in part, to DSS's failure to appropriately meet their needs. In accordance with its obligations, DSS also self-reported 1 violation of this provision during this monitoring period.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 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.<br><br>(FSA IV.H.1.) | | | | |
| *Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment:*<br><br>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.<br><br>(FSA IV.I.2.) | Baseline data for this measure are not available. | Data are not available for this period. | Data are not available for this period. | Data are not available for this period. [206] |

[206] Pursuant to the Placement Implementation Plan, DSS was to propose a methodology for measuring compliance with this requirement by July 2019. DSS has reported that it will consider an appropriate methodology that aligns with placement practice in proposing an updated Placement Implementation Plans to the Co-Monitors by September 30, 2020.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| ***Dates to reach final target and interim benchmarks to be added once approved***. | | | | |
| *Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement:*<br><br>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.<br><br>(FSA IV.I.3.)<br><br>***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. [207] |
| *Therapeutic Foster Care Placements - Level of Care Placement:* | Baseline data for this measure are not available. | Data are not available for this period. | Data are not available for this period. | Data are not available for this period. [208] |

[207] Ibid.
[208] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 23.a. Within 60 Days:<br>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.<br><br>(FSA IV.I.4.)<br><br>***Dates to reach final target and interim benchmarks to be added once approved***. | | | | |
| <u>*Therapeutic Foster Care Placements - Level of Care Placement*</u>:<br><br>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 | 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] |

[209] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 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.<br><br>(FSA IV.I.5.)<br><br>***Dates to reach final target and interim benchmarks to be added once approved***. | | | | |
| <u>*Family Visitation - Siblings*</u><br><br>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.<br><br>(FSA IV.J.2.)<br><br>***Interim benchmark by March 2020: 70% visits with siblings*** | 66% of all required visits between siblings occurred for those who were not placed together. (March 2018) | 48% of all required visits between siblings occurred for those who were not placed together. | 59% of all required visits between siblings occurred for those who were not placed together. | 45% of all required visits between siblings occurred for those who were not placed together.[210] |
| <u>*Family Visitation - Parents:*</u> | 12% of children with a permanency goal of reunification visited twice with | 12% of children with a permanency goal of reunification visited twice | 13% of children with a permanency goal of reunification visited twice | 10% of children with a permanency goal of reunification visited twice |

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

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies.<br><br>(FSA IV.J.3.)<br><br>***Interim benchmark by March 2020: 60% parent visits*** | the parent(s) with whom reunification was sought. (March 2018) | with the parent(s) with whom reunification was sought. | with the parent(s) with whom reunification was sought. | with the parent(s) with whom reunification was sought. [211] |
| <u>*Health Care - Immediate Treatment Needs:*</u><br><br>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 | Baseline data for this measure are not available. | Data for this measure are not available. | Data for this measure are not available. | Data for this measure are not available.[212] |

[211] 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.

[212] 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. Performance with respect to this Agreement is discussed in Section IX. *Health Care*.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| mental health) for which treatment is overdue.<br><br>(FSA IV.K.4.(b)) | | | | |
| <u>*Health Care - Initial Medical Screens*</u><br><br>27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care.<br><br>***Dates to reach final target and interim benchmarks to be added once approved.***[213] | 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.[214] |
| <u>*Health Care - Initial Comprehensive Assessments*</u><br><br>28. At least 85% of Class Members will receive a | 36% of children received a comprehensive medical assessment within 30 days. (March 2019) | 36% of children received a comprehensive medical assessment within 30 days. (Baseline) | 32% of children received a comprehensive medical assessment within 30 days. | See Section IX. *Health Care*[215] |

[213] 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 May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.
[214] 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 beginning in this monitoring period. DSS is in the process of evaluating whether its multiple screening and assessments processes can be streamlined by replacing the screening tool with CANS. DSS reports that once this determination is made, necessary CAPSS updates will be made and data will be collected for this measure. Initial data is expected to be available in December 2020.
[215] 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 determination to utilize data collecting utilizing different methodologies for this reporting period. As a result, data do not directly align with FSA measure and are incomparable to prior performance.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| comprehensive medical assessment within 30 days of entering care.<br><br>***Interim benchmark by March 2020, 76%*** | | | | |
| <u>*Health Care - Initial Comprehensive Assessments*</u><br><br>29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.<br><br>***Interim benchmark by March 2020: 90%*** | 52% of children received a comprehensive medical assessment within 60 days. (March 2019) | 52% of children received a comprehensive medical assessment within 60 days. (Baseline) | 47% of children received a comprehensive medical assessment within 60 days. | See Section IX. *Health Care*[216] |
| <u>*Health Care - Initial Mental Health Assessments*</u> | 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.[218] |

[216] Ibid.
[218] 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 beginning in this monitoring period.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 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.<br><br>***Dates to reach final target and interim benchmarks to be added once approved.***[217] | | | | |
| *Health Care - Initial Mental Health Assessments*<br><br>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 | 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] |

[217] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.
[220] 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 beginning in this monitoring period.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| the comprehensive medical assessment.<br><br>***Dates to reach final target and interim benchmarks to be added once approved.***[219] | | | | |
| *Health Care –Referral to Developmental Assessments*<br><br>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.<br><br>***Interim benchmark by March 2020: 39% referred within 30 days*** | 19% of children under 36 months were referred within 30 days. (July-December 2017) | 40% of children under 36 months were referred within 30 days. | 71% of children under 36 months were referred within 30 days. | 71% of children under 36 months were referred within 30 days. |
| *Health Care –Referral to Developmental Assessments* | 20% of children under 36 months of age were referred within 45 days. (July to December 2017) | 49% of children under 36 months were referred within 45 days. | 80% of children under 36 months were referred within 45 days. | 82% of children under 36 months were referred within 45 days. |

[219] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care.<br><br>***Interim benchmark by March 2020: 40% referred within 45 days*** | | | | |
| <u>*Health Care – Initial Dental Examinations*</u><br><br>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.<br><br>***Interim benchmark by March 2020: 54%*** | 35% of children age one and above received a dental exam within 60 days. (March 2018) | 56% of applicable children ages two and above received a dental exam within 60 days. | 47% of applicable children ages two and above received a dental exam within 60 days. | See Section IX. *Health Care*[221] |

[221] 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 determination to utilize data collecting utilizing different methodologies for this reporting period. As a result, data do not directly align with FSA measure and are incomparable to prior performance.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| | | | | |
| <u>*Health Care – Initial Dental Examinations*</u><br><br>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.<br><br>***Interim benchmark by March 2020: 75%*** | 48% of applicable children age one and above received a dental exam within 90 days. (March 2018) | 67% of applicable children ages two and above received a dental exam within 90 days. | 59% of applicable children ages two and above received a dental exam within 90 days. | See Section IX. *Health Care*[222] |
| <u>*Health Care – Periodic Preventative Care (Well visits)*</u><br><br>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.[223] (March 2019) | 49% (40) of 82 children under the age of six months received a periodic preventative visit monthly. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[224] |

[222] Ibid.
[223] 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.
[224] 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 determination to utilize data collecting utilizing different methodologies for this reporting period. As a result, data do not directly align with FSA measure and are incomparable to prior performance.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| months in care for one month or more will receive a periodic preventative visit monthly.<br><br>***Interim benchmark by March 2020: 83%*** | 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. | 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. (Baseline) | | |
| <u>*Health Care - Periodic Preventative Care (Well visits)*</u><br><br>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.<br><br>***Interim benchmark by March 2020: 81%*** | 38% of children between the ages of six and 36 months received periodic preventative visits. (March 2019) | 38% of children between the ages of six and 36 months received periodic preventative visits. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[225] |
| <u>*Health Care – Periodic Preventative Care (Well visits)*</u> | 62% of children between the ages of six and 36 months | 62% of children between the ages of six and 36 | Data for this measure are not available. | See Section IX. *Health Care*[226] |

[225] Ibid.
[226] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 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.<br><br>***Interim benchmark by March 2020: 88%*** | received a periodic preventative visit semi-annually. (March 2019) | months received a periodic preventative visit semi-annually. (Baseline) | | |
| <u>*Health Care – Periodic Preventative Care (Well visits)*</u><br><br>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.<br><br>***Interim benchmark by March 2020: 63%*** | 12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019) | 12% of children ages three years and older received a periodic preventative visit semi-annually. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[227] |
| <u>*Health Care – Periodic Preventative Care (Well visits)*</u> | 58% of children ages three years and older received an annual preventative visit. (March 2019) | 58% of children ages three years and older received an annual preventative visit. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[228] |

[227] Ibid.
[228] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| 40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.<br><br>***Interim benchmark by March 2020: 88%*** | | | | |
| <u>*Health Care – Periodic Dental Care*</u><br><br>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) | 54% of children ages two years or older received a dental visit semi-annually. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[229] |
| <u>*Health Care – Periodic Dental Care*</u><br><br>42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually. | 81% of children ages two years or older received an annual dental examination. (March 2019) | 81% of children ages two years or older received an annual dental examination. (Baseline) | Data for this measure are not available. | See Section IX. *Health Care*[230] |

[229] Ibid.
[230] Ibid.

| Table 6: Summary Performance on Settlement Agreement Requirements | | | | |
|---|---|---|---|---|
| **Final Settlement Agreement (FSA) Requirements** | **Baseline Performance** | **October 2018 - March 2019 Performance** | **April - September 2019 Performance** | **October 2019 – March 2020 Performance** |
| ***Interim benchmark by March 2020: 87%*** | | | | |
| <u>*Health Care - Follow-Up Care*</u><br><br>43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.<br><br>***Dates to reach final target and interim benchmarks to be added once approved.***[231] | 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. |

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

## Appendix D - Workload Implementation Plan Strategy Updates as of April 30, 2020[232,233]

**Strategies towards Achieving Targets:**

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| **Short-Term Strategies (January 2019 - January 2020)** | | |
| 1. The Agency will make updated projection of the number of additional caseworkers needed to achieve caseload compliance. | June 30, 2019; date amended by the Joint Report to August 31, 2019 | Completed. As part of its FY2020-2021 budgeting process, using a standard of 12 children to one case manager, DSS estimated a need for 213 additional case manager and 43 supervisor positions. The agency requested the requisite resources to fund these positions in its FY2020-2021 budget request. It is not yet known if this funding will be approved and included in the final state FY2020-2021 budget.<br><br>The Joint Report included five steps for DSS to take in order to re-evaluate the fiscal impact of hiring new staff, and increasing case manager salaries. The action steps were due either August 31, 2019, or September 18, 2019, and included: identify where each current case manager and supervisor fits within the updated salary scheduled; determine the number of case managers and supervisors with BSW and MSW degrees; forecast new hires to meet interim caseload benchmarks, based on Class size; identify funds needed based on fiscal impact analysis; and establish eligibility criteria (specific training requirements and practice competencies) for moving staff to levels II and III. DSS reports most of these steps were completed in order to estimate the |

[232] Not all strategies included and required in the Workload Implementation Plan are included in this Table. Strategies identified as intermediate or long-term were not yet due during this period, and will be included and discussed in future monitoring reports.
[233] Commitments included herein are based upon the Workload Implementation Plan (February 20, 2019, Dkt. 119), the Joint Report (October 30, 2019, Dkt. 145), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[234] In some instances, in an effort to provide relevant context and available information, this Table reflects the status of actions after April 30, 2020.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| | | number of new staff and funds necessary to include in the FY2020-2021 budget request.<br><br>DSS has not yet completed the last step, which requires establishing eligibility criteria for moving staff to levels II and III of the new salary schedule. DSS reports a workgroup has completed the competencies for case managers, and the training department is working with technical assistance to develop new certification training. Different training tracks will be built to enhance staff's knowledge and skills beyond the foundational certification course. DSS anticipates this work will be complete by December 31, 2020. |
| 2. The Agency will hire, train, and onboard new case managers and supervisors in accordance with the hiring schedule in the Workload Implementation Plan. | Ongoing | Partially completed.<br><br>The Joint Report detailed action steps within this commitment to occur between June 2019 and July 2020 in preparation for receipt of funding to hire new staff, and to fill positions previously allocated in prior fiscal years. DSS has completed most of these steps, including adding caseworker funding needs as an agenda item for meetings with legislators. One outstanding commitment required DSS to make offers to candidates to fill the remaining 29 of 182 case manager positions funded in FY2018-2019 budget, and six of 37 remaining supervisor positions funded in FY2018-2019 by October 31, 2019.[235] As of June 24, 2020, DSS reports 220 of 223[236] positions allocated in FY2018-2019 have been filled; candidates for the two case manager positions have been selected, and sent to Human Resources for processing, and the remaining supervisor position was scheduled to be posted in late June 2020. |

[235] This deadline was adjusted to August 31, 2020 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[236] The additional four positions are OHAN investigator positions that have a different classification than county case manager positions.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| 2. More fully use caseworkers assigned to the custody programs by eliminating the current practice of assigning two caseworkers, one in the foster care program and one in adoptions, to children who are legally eligible for adoption. | End of January 2020 | |
| 2.a. Phase 1: Cases of all children with a permanency plan of adoption who are free for adoption and are placed with a family that intends to adopt and has signed an adoption agreement or a pre-adoption agreement will be assigned solely to an adoption worker. | Implementing as of February 2019 | See Section IV. *Caseloads* for a more detailed discussion of strategy implementation. |
| 2.b. Phase 2: Cases of children with a permanency plan of adoption who are free for adoption, and who are siblings of children case managed by Adoptions pursuant to Phase 1 but are not placed with a family that intends to adopt will be assigned solely to an adoption worker. | Implementing as of February 2019 | |
| 2.c. Phase 3: Cases of children case managed by county DSS foster care case managers who have a permanency plan of adoption and are free for adoption, but do not have an identified adoptive resource will be assigned solely to an adoption worker. | DSS will begin implementation by July 2019 | |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| 2.d. Phase 4: Cases of children case managed by IFCCS service coordinators who have a permanency plan of adoption and are free for adoption, and who are siblings of children case managed by Adoptions pursuant to Phase 3, but do not have an identified adoptive resource will be assigned solely to an adoption worker. | DSS will begin implementation by September 2019 | |
| 2.e. Phase 5: Cases of all other children who have a permanency plan of adoption, are free for adoption and case managed by IFCCS service coordinators, but do not have an identified adoptive resource will be assigned solely to an adoption worker. | DSS will begin implementation by November 2019 | |
| 3. By May 31, 2019, the Department will complete the necessary research and decide whether to move forward or not with eliminating IFCCS as a separate caseload category. If IFCCS is eliminated as a workload category, a transition plan will be completed by August 30, 2019. | DSS will make decision by May 31, 2019, and develop transition plan by August 30, 2019; date amended by the Joint Report to September 30, 2019 | Completed. On May 31, 2019, DSS decided to eliminate IFCCS as a separate workload and staffing category.[237] In September 2019,[238] DSS developed a transition plan with the following schedule:<br>- By September 31, 2019, DSS will conduct regional informational meetings regarding the restructure<br>- By October 30, 2019, Human Resources will update position descriptions, location changes, and supervisor changes, as needed. Additionally, DSS will coordinate staffings within county offices to shift siblings that are currently being managed by two case managers to one case manager. |

[237] This change was recommended following the assessment of an expert workforce consultant who determined that, in most instances, IFCCS staff did not possess a higher level of training or skill than other foster care case managers, and that assigning case management solely on the needs of the child diminishes the focus on case and permanency planning with families.
[238] The Implementation Plan requires DSS to develop a transition plan by August 30, 2019. The Joint Report modified this Implementation Plan strategy, and requires DSS to finalize the transition plan for phasing out IFCCS case managers and determine staffing and fiscal impact by September 30, 2019.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| | | - By November 30, 2019, DSS will conduct regional training on the ISCEDC process, and new Well-Being Team members will receive training on new job tasks.<br>- By December 1, 2019, DSS will complete realignment of Well-Being Team job tasks.<br>- By December 31, 2019, DSS will transfer IFCCS case managers and supervisors to the county structure, and transfer cases as needed.<br><br>The transition plan was completed on schedule. |
| 4. Implement "Stay" interviews conducted by managers for staff at regular intervals (e.g., 60, 90, 180, 260 days) through their first year of work and develop and implement a process for follow-up on needs expressed by interviewees. The process also includes county office Directors' documentation of individual follow-up with interviewed caseworkers to address more immediate non-systemic needs. | A formal process to record and aggregate results of "Stay" interviews is being developed and will be implemented by June 30, 2019. | Delayed and ongoing. DSS reports that surveys are sent to new staff following their 30-day, 90-day, six month, and nine month anniversary dates. When issues are identified that require follow-up, they are reported to the county director, regional director, and Human Resources employee relations for follow-up.<br><br>The first round of surveys were used with new hires in September 2019, and the most recent surveys were sent to new hires in April 2020. |
| 5. Increase salaries for staff having BSW or MSW degrees and revise caseworker and supervisor job descriptions to indicate a clear preference for social work degrees as per the attached salary plan. | End of January 2020 | Partially completed. DSS requested necessary funding in its FY2020-2021 budget request. It is not yet known if this funding will be approved and included in the final state FY2020-2021 budget. |
| 6. Engage South Carolina public university departments of social work in developing a partnership using provisions for federal funding available under Title IV-E of the Social Security Act. This partnership will be directed toward recruitment of BSW students who, in return for tuition support and DSS-based internship opportunities, will commit to at least two years of work | End of January 2020 | Updates on specific steps discussed below. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| for DSS upon graduation. Ideally, this partnership will also be developed to include at least two courses with specific child welfare content that will lead, along with the agency internship, to allowing these students to become qualified as caseworkers without having to go through the pre-service training currently required of all new hires. The focus of student education should be direct practice rather than administrative. | | |
| 6.a. Within 90 days of plan finalization, hire a Child Welfare Workforce Developer. Once this person is in place, he/she will be responsible for implementing items b – d. below by June 30, 2019. | June 30, 2019; date amended by the Joint Report to October 31, 2019 | Completed. DSS reports that a Workforce Developer was hired and started employment on November 4, 2019. |
| 6.b. Contact the Georgia Department of Family and Children's Services agency-university consortium, and possibly with those in other states (e.g., Louisiana, New Jersey, Pennsylvania, etc.) known to have long standing, successful agency-university partnerships, to obtain information about design and other key considerations in establishing and supporting agency-university agreements. | June 30, 2019; date amended by the Joint Report to November 30, 2019 | On June 17, 2019, DSS staff spoke with university consortium contacts in Georgia's Division of Family and Children's Services (DFCS) to learn more about the opportunities and challenges in implementing this strategy.<br><br>The Joint Report requires DSS to contact other states such as Louisiana, New Jersey, and Pennsylvania regarding their university partnership programs by November 30, 2019. DSS reports that since her hire, the new Workforce Developer has contacted child welfare staff in Tennessee, Louisiana, and New Jersey. |
| 6.c. Conduct outreach to South Carolina universities to ascertain interest and establish a planning group. | June 30, 2019; date amended by Joint Report to November 30, 2019 | Delayed and ongoing. On December 11, 2019, DSS convened a meeting with representatives from USC (Columbia and Upstate Campuses), Winthrop, and SC State to learn more about their social work programs and determine interest in forming partnerships. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| | | The Joint Report requires DSS to draft foundation MOUs to be utilized for University Partnerships by December 31, 2020. DSS reports a MOU which establishes the work of the "University Partnership Planning Team" was drafted and finalized with input from universities. In March 2020, interest MOUs were secured with four SC University partners.<br><br>The Joint Report also requires by January 31, 2020, DSS will seek commitments from state-funded universities, and to form a planning group. DSS reports a planning team has been formed with members from each university partner. The DSS Workforce Developer was collaborating with each planning team on the structure of the program, but work was interrupted due to the COVID-19 pandemic. DSS reports a meeting with university partners is scheduled for mid-September 2020. |
| 6.d. Consult with Public Consulting Group, the Region 4 office of the federal Administration for Children, Youth, and Families, and/or other technical assistance resource(s) to explore opportunities for accessing IV-E funding to support a university partnership or multi-university consortium. | June 30, 2019; date amended by the Joint Report to October 31, 2019 | Delayed. DSS reports an initial conversation was held with Public Consulting Group (PCG) to explore opportunities for IV-E funding in June 2019. As DSS is no longer working with PCG, in the alternative, DSS is utilizing the experience of one of its university partners who worked with IV-E funding in another state.<br><br>The Joint Report added three additional commitments in developing the university partnership: by February 28, 2020, DSS would request scopes of work and identify technical assistance (TA) for developing the university partnerships program; by May 31, 2020, DSS would complete the contract preparation process for TA; and, by July 31, 2020, DSS would work with the planning group, including university partners) to develop the program structure.[239] DSS reports that TA has not been sought or secured, but it will identify additional technical assistance to move this work forward, as needed. |

[239] This deadline was adjusted to October 31, 2020 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| 7. Advance the proposal already initiated to provide repayment of student loans for staff employed for at least one year who have degrees in social work and, possibly, in very closely related fields. Work to assess the cost of this strategy will be completed during the current fiscal year to allow for this to be included in the agency's budget request for 2020-21 which will be made in September 2019. Once approved, payment can be made retroactively to staff who qualify. | September 2019 | Completed. DSS included in its FY2020-2021 budget request funding for a Title-IV E Stipend Training Program. It is not yet known if this funding will be approved and included in the final state FY2020-2021 budget. |
| 8. Create a realistic job preview video or a virtual reality demonstration or, alternatively, enter into an agreement with an existing jurisdiction to adapt an existing one, for posting on the state human resources website with required viewing by those wishing to submit an online application for a child welfare caseworker position. | August 2019 | Delayed, subsequently completed. DSS worked with USC to develop a job preview video similar to the one utilized by Georgia's child welfare system. The video was provided to DSS on February 13, 2020, and on April 23, 2020, DSS received approval for the use of 30-second Public Service Announcements for social media messaging and for mass media broadcast time. A video is available on DSS's website, under the Career page.[240]<br><br>DSS reports the video will be incorporated into the interview process starting in June 2020. |
| 9. With the Office of Human Resources, review current procedures for approving requests for authorizations of salary above the minimum and for salary increases within pay band and make any changes needed to ensure that they are based upon clear, objective, and consistently applied criteria. | DSS communication of procedures and criteria in writing to all staff by June 30, 2019. | Delayed, subsequently completed. DSS reports a communication memo was distributed to staff on October 14, 2019. DSS reviewed its Human Resources Policy and Procedure Manual, Chapter 3: Classification and Pay, and determined updates were not necessary to fulfill this commitment. |

[240] See https://dss.sc.gov/about/careers/

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| 10. DSS will make offers of employment for the nine new OHAN investigative positions to begin by March 17, 2019. The staff that accept an offer of employment and who have completed child welfare certification will be trained utilizing the new OHAN Investigation Training curriculum and accepting cases no later than April 30, 2019. The staff that accept an offer of employment and who have not completed child welfare certification will complete child welfare certification, will be trained utilizing the new OHAN Investigation Training and will be accepting cases no later than July 15, 2019. By September 30, 2019, DSS will determine how many additional staff are needed to bring OHAN staff to the required caseload standards and begin the process for allocation of additional positions. | Make offers of employment by March 17, 2019.<br><br>Ensure all staff are trained and accepting cases no later than July 15, 2019.<br><br>By September 30, 2019, DSS will determine how many additional staff are needed; date amended by the Joint Report to August 30, 2019 for DSS to identify (assess and evaluate) staffing needs and resources based on current workload and trend analysis, and identify future resources as indicated. | Completed. Offers of employment were made to nine new OHAN investigative candidates by March 27, 2019 and all candidates accepted. Most of the new hires had already completed Child Welfare Certification training, and completed the newly developed Investigation training curriculum shortly after hire. The newly hired staffed who had not completed Child Welfare Certification training were enrolled and completed the training in mid-June 2019.<br><br>As of March 31, 2020, OHAN had 15 investigator positions filled, as well as two supervisors. There was one vacant investigator position, and one vacancy for a supervisor. DSS has determined to meet caseload requirements, 11 new OHAN staff positions are necessary. Funding these positions was included in DSS's FY2020-2021 budget request; as of the writing of this report, the status of this request has not been determined.<br><br>Other than efforts to improve supervision, DSS has not developed specific retention strategies for OHAN staff. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| **Intermediate Strategies (July 2019 - July 2020)** | | |
| 12. DSS will seek funding in September 2019 to raise the salaries of all child welfare frontline staff (i.e., caseworkers and supervisors) consistent with the salary plan. Where such raises for caseworkers and supervisors result in caseworkers being paid more or within 10% less than child welfare supervisors or managers to whom they report, budget shall also be requested to raise salaries of those positions to the next highest step consistent with the salary plan so that salaries are higher than those in the highest subordinate position level. | September 2019 | Completed. DSS included in its FY2020-2021 budget request funding to implement the new salary plan to bring case manager and supervisor salaries to the SC living wage amount. It is not yet known if this funding will be approved and included in the final state FY2020-2021 budget. |
| 13. DSS will design, and request both budget and administrative authorization to implement, a career path for child welfare caseworkers that consists of a trainee entry level position and provides two to three levels beyond trainee with increasing qualifications related to education, experience, and skill demonstration and ascending pay grades, preferably with opportunities for pay advancement to a maximum salary within each grade. This new set of positions is viewed as necessary (a) to maintain personnel in providing direct services to families and children as they grow in work related knowledge and skill and (b) to reduce turnover by affording employees opportunities for career advancement. That new salary structure and career path, as prepared by DSS, the Public Consulting Group (PCG) and Sue Steib, a workforce development consultant is included as a separate attachment (Appendix A). | Initiate in July 2019, and complete by July 2020 | DSS reports final edits to this process are underway, and Chapin Hall has reviewed the competencies to ensure alignment with the practice model. DSS anticipates finalizing the process and developing the training by November 2020. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| 14. Identify counties with caseloads consistently over 125% of standard, allocate additional positions to achieve under 125% of standard across programs (taking into consideration current vacancies), and deem positions approved to fill. This will require undertaking a process to validate the size of caseloads with at least one class member, particularly those in the non-custody programs, to ensure that counts represent only those that need to be open. To make this determination, DSS will need to establish criteria and direction for review of caseloads to include processes and protocols that include supervisory oversight and QA. In child protection assessments, for example, agency policy calls for a determination to be made within 45 days of a report with the possibility of one 15-day exception. Thus, any case open longer than 60 days, should be screened for closure, if no safety concerns exist and all necessary information has been collected to make a determination on the allegations. In Family Preservation, cases open longer than three months may call for updated safety assessments and plans for disposition and closure within 60 days unless there are clear reasons related to child safety and risk for maintaining a case for a specified length of time. | Initiate in July 2019, and complete by July 2020 | DSS reports a weekly report is provided to the field on workers with caseloads that are 125% or more above standard, and that management continues to monitor and right size positions to equalize caseloads when vacancies occur. As part of the budget preparation process, DSS reviewed caseload and staff data and estimated needed case managers and worked with Operations on a rightsizing exercise. If DSS is provided with the funding requested for additional positions, there will be increased capacity to further address caseload sizes. |
| 15. Implement measures to support selection of staff more likely to remain in child welfare by taking the following actions by January 2020:<br>a. Design or adopt a research-informed protocol for selection of applicants (e.g., the *Staying Power* toolkit developed in North Carolina) that includes assessment of competencies, standardized interviewing procedures, and exercises such as | January 2020; date amended by the Joint Report to July 31, 2020. | Not yet completed. The Joint Report required DSS to adopt a competency-based model for interviewing and hiring, and update position descriptions and performance documents to reflect this new model. DSS reports case manager competencies have been selected, and position descriptions are being updated and standardized by describing each job's Purpose, Functions, Minimum Training, Education, and Competencies. Supervisor competencies are under review by a workgroup. DSS reports this commitment is scheduled for completion by July 31, 2020. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| use of questions and writing of reports based on typical child welfare case scenarios.<br>b. Train personnel involved in hiring in the new selection process. | | |
| 16. Determine a ratio of allocation of support staff positions to foster care caseloads using current data on workload, miles traveled by caseworkers, and number of children placed farther than 30 miles away. Based on ratio, determine the number of new support positions needed statewide and by county. In addition, determine a base number of support positions for each county to meet transportation needs as Placement Implementation Plan efforts reduce the number of children placed out of county. The agency currently has 62 support positions statewide. Consider position need by county as a basis for adjusting current assignments and requesting budget in September 2019 for additional allocations in FY '20-21. Such positions can be used for routine agency-required transportation of parents of children in out-of-home care and for children themselves in selected situations which do not involve transporting children to appointments or events that are likely to be emotionally charged or to require that the child be accompanied by someone with direct knowledge of or responsibility for the child's day to day functioning and well-being (e.g., medical or psychotherapy appointments). The goal of using these positions for support services would be to relieve foster care caseworkers of some of their transportation responsibilities and to eliminate the use of contracted transportation services for children in favor of selectively using trained support personnel with consistency in their individual assignment to specific children in the situations described above. Such personnel might also be assigned other administrative | September 2019 | DSS requested 36 positions in its last budget request. It is not yet known if this funding will be approved and included in the final state FY2020-2021 budget. DSS reports staff are working to create a standardized methodology to determine support staff need and allocation. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[234] |
|---|---|---|
| duties otherwise handled by caseworkers such as handling payment related questions from providers or resource families and scheduling of appointments. | | |
| 17. Design and implement measures to support high quality supervision as the cornerstone of workforce stability and performance. This will include:<br><br>b. Ensure that supervisors are the initial recipients of training in new knowledge and skills. DSS will utilize the Learning Management System to incorporate new training content into the supervisor training track. Training tracks are currently under development with assistance from our Chapin Hall partners and will be completed in conjunction with the Case Practice Model.<br>c. Acknowledge the unique positions of supervisors at the midpoint of the organization (i.e., "touching" both front line staff and management) by creating a structure for them to regularly provide input and feedback to leadership regarding program policy, workforce development, internal and external messaging, and any other barriers to the attainment of positive outcomes for families.<br>d. Create policy that prioritizes supervisors in all professional development opportunities such as stipends to obtain MSWs, additional training/certification in specialty areas, and incentivize through higher pay grades, formal acknowledgment of expertise, appointment to special committees and task forces, etc. | March 2020<br><br>January 2020<br><br>January 2020 | DSS reports that the requirement for supervisors to be the initial recipients of training in new knowledge and skills has been incorporated into Human Resources policy. A supervisor training track is being developed, and is estimated for completion by March 2021.<br><br>DSS has created a Supervisor Advisory Board to provide a forum for them to provide input and feedback to leadership. The first meeting will be convened on September 9, 2020.<br><br>The Joint Report also required by July 31, 2020, DSS to work with USC to develop an overview of pre-service training content that all supervisors who entered the agency prior to 2019 must complete as part of their in-service training requirement. DSS is working with a technical assistance provider – Christina Fly – to sequence, map, and develop supervisor training. DSS reports efforts are underway to align child welfare training with the practice model, and to ensure supervisors are trained first. A new Child Welfare Certification curriculum is being developed, which will include a component for supervisors; DSS reports supervisors will be included in the roll-out of the new curriculum, with trainings occurring between August 31 and September 17, 2020. |

## Appendix E - Visitation Implementation Plan Strategy Updates as of April 30, 2020[241]

**Strategies towards Achieving Targets:**

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| **Parent-Child & Sibling Visitation: Data Collection and Interim Benchmarks** | | |
| 1. Baseline data for parent-child and sibling visitation requirements (J.2 and J.3) will be determined using case reviews with a confidence level of 95% and a confidence interval of 5%. These case reviews will be contracted out to the University of SC who will build, test, and use two instruments to capture the data. | | Completed. |
| 2. Interim benchmarks to be determined following analysis and aggregation of baseline data. Benchmarks will be monitored for compliance through case review samples until ongoing reports for compliance have been developed, validated and methodologies approved. | | Completed. |
| **Parent-Child & Sibling Visitation: Increase the Quality of Parent-Child Visitation** | | |
| 3. Seek technical assistance for defining quality parent-child visitation and develop a model that is in line with the agency's practice model. | March 2019 | Delayed. DSS has adapted the documentation portion of Quality Matters training for all forms of visits including parent-child and sibling visits, and developed a curriculum. The roll-out schedule was delayed due to the COVID-19 pandemic but an online portion of the training is being offered. As of May 1, 2020, 270 supervisors have been trained. The agency has also adapted |

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

[242] In some instances, in an effort to provide relevant context and available information, this Table reflects the status of actions after April 30, 2020.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| | | elements of Strive and Visit Coaching models to include in training, and the second half of the training will run from September 9, 2020 through October 26, 2020. |
| **Parent-Child & Sibling Visitation: Cultivate a Shared Understanding of the Importance and Critical Function of Parent-Child and Sibling Visitation, and an Understanding of Related Policy, Procedures, and Responsibilities** | | |
| 4. Develop and implement a consistent and comprehensive visitation policy that is aligned with the agency practice model and incorporates the core practice skills of engagement, teaming, assessment, planning, intervening, tracking and adapting. Additional policy enhancements will be made once the practice model is finalized and the quality visitation model is developed. | April 2019 | Delayed. DSS released policy and procedures on children's visits and other contact with their siblings and parents, effective June 1, 2019. Additional policy enhancements and work aids regarding contacts between case managers and parents, children, and caregivers have been completed and presented to a committee for finalization. Other visitation related policies and work aids pertaining to quality documentation and parent/child and sibling visits are in draft form. Each policy takes the DSS Practice Model into consideration and includes these values. |
| 5. Develop and deliver a visitation awareness training to casework assistants, caseworkers, supervisors, and Program Coordinators that is integrated with the practice model framework. Training will address the importance of visitation, how to engage the family in visitation planning and integrating visitation into the case plan; new policy to include roles and responsibilities; and CAPSS changes. This training will be an introductory step to build on as the quality visitation model is developed. | May 2019 | Completed and ongoing. Between October 2019 and March 2020, additional staff and foster parents, as reported below, have participated in Visitation Awareness training.<br>• 10 case managers<br>• 139 supervisors<br>• 217 foster parents<br>• 70 foster parents trained as trainers |
| 6. Develop and disseminate practice tips to casework assistants, caseworkers, supervisors, and program coordinators. | June 2019 | Completed and ongoing. Practice Tips were disseminated in November 2019 and March 2020. |
| 7. Invite legal staff to visitation training to begin aligning legal practices with visitation best practices. | May 2019 | |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| | | Completed and ongoing. During this monitoring period, an additional two staff attorneys and one paralegal have participated in Visitation Awareness training. |
| 8. Incorporate initial training and refreshers into staff training plans. | May 2019 & ongoing | Completed and ongoing. New staff are expected to complete Visitation Awareness training within 90 days of their Child Welfare certification. Visitation Awareness training is part of staff training plans and now includes classroom and virtual training. |
| **Parent-Child & Sibling Visitation: Increase the Frequency of Parent-Child and Sibling Visitation** | | |
| 9. Engage the leadership of provider organizations (Foster Parent Association Palmetto Association for Children and Families and Child Placing Agencies) in defining their role and setting the expectations for foster care providers. | April 2019 | Completed and ongoing. DSS facilitates a provider visitation workgroup to help providers define their role and set expectations in supporting visits. This group has been able to address safety concerns and improve communication. DSS also shares the Visitation Matters quarterly newsletter for distribution to provider agency staff. |
| 10. Develop and deliver Foster Care provider training on the importance and function of parent-child and sibling visitation and their role in visitation. | June 2019 | Completed and ongoing. Visitation Awareness training geared to foster parents has been developed and delivered to 217 foster parents. Additionally, 70 foster parents trained as trainers of the curriculum. |
| 11. Reinforce expectations through contract monitoring. Specifically, monitor compliance with the regulation prohibiting the deprival of family visits as a form of punishment. | Ongoing | Completed and ongoing. Contract Monitoring and Licensing staff are interviewing children during visits to congregate care facilities to determine if there are instances of deprivation of family visits. DSS expects issues to be addressed immediately with the provider and reports that no concerns have been reported during this monitoring period. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| 12. Develop and implement a process for ongoing budget request for state fleet vehicles that accounts for additional allocated casework assistant positions as proposed in the Caseload Implementation Plan. | Ongoing | Completed. This resource is factored into the DSS's budget request for new positions. |
| 13. DSS will fill all (10) current vacancies for transportation aides and make deliberate efforts to keep those positions filled. | June 30, 2019 | Not yet completed. As of May 4, 2020, there are three vacancies: one is pending an offer; one has been reposted; and one is awaiting posting. |
| 14. Develop and implement a Foster Care Provider Portal for foster parents and group home providers to directly input visitation information into CAPSS. | May 2019 | Not yet completed. The Child and Adult Information Portal is in testing phase. Estimated implementation is now October 2020. |
| 15. Provide supervisor training on responsibilities and procedures for monitoring the frequency and quality of family visits | June 2019 | Completed and ongoing. Visitation Awareness training provided to supervisors contains these responsibilities and procedures. |
| 16. Develop user-friendly, actionable management reports in CAPSS. | June 2019 | Delayed. Reports are in testing phase. |
| 17. Provide training on management reports. | June 2019 & ongoing | Delayed. Reports are in testing phase and will be followed by training for management. |
| 18. Determine a ratio of allocation of support staff positions to foster care caseloads using current data on workload, miles traveled by caseworkers, and number of children placed farther than 30 miles away. Based on ratio, determine the number of new support positions needed statewide and by county. In addition, determine | September 2019 | Completed. DSS did not receive funding for this additional (36) staff allocation. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| a base number of support positions for each county to meet transportation needs as Placement Implementation Plan efforts to reduce the number of children placed out of county. The agency currently has 62 support positions statewide. Consider position need by county as a basis for adjusting current assignments and requesting budget in September 2019 for additional allocations in FY2020-2021. | | |
| **Parent-Child & Sibling Visitation: Increase the Quality of Data and Documentation of Parent-Child and Sibling Visits** | | |
| 19. Develop and implement CAPSS enhancements to increase the capacity for documenting parent-child and sibling visitation information. | March 2019; amended by the Joint Report to August 15, 2019 | Completed. As of August 2019, CAPSS included a visitation tab for entry of scheduled visits and documentation of facilitated visits. |
| 20. Provide training on CAPSS enhancements. | May 2019 | Completed. A webinar and manual on the use of the CAPSS Visitation tab are available to staff. |
| 21. Develop user-friendly, actionable management reports in CAPSS. | June 2019 | Delayed and ongoing. The capability to pull family visits reports has been available in CAPSS since August 2020. DSS is in the process of adjusting and refining these reports to improve reliability so that they are usable by staff. |
| 22. Provide training on management reports. | June 2019 | Delayed. To be implemented upon completion of testing phase. An overview of the reports was provided to leadership during county meetings held on August 27, 28 and 31 and September 2, 2020. |
| 23. Develop and implement standards for quality documentation. | June 2019 | Delayed. DSS worked with the Center for State to develop quality documentation standards through workgroup sessions. Policy |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| | | has been updated to include documentation expectations for parent-child visitation, sibling visitation, and case manager-child contacts, and is awaiting final approval for publication. Visitation Awareness training includes basic documentation expectations for visitation occurrences. A documentation guide will be finalized and linked as a resource to the policy. |
| **Case Manager-Child Visitation: Clarify the Role and Function of Case Manager-Child Contacts** | | |
| 24. Practice Model Implementation:<br>• Utilization of practice guidance related to caseworker-child contacts<br>• Supervision, modeling and coaching related to caseworker-child contacts | May 2019 | Not yet completed. DSS is working to contract with Chapin Hall to assist with full Practice Model implementation. Practice model implementation is scheduled to begin in 2021. |
| 25. Visitation Awareness Training delivered to Casework Assistants, caseworkers, supervisors, and Program Coordinators. | April 2019 | Completed. |
| 26. Draft and implement policy revisions that align caseworker-child contact policy and procedure with the agency practice model. | June 2019 | Not yet completed. Policies have been drafted and are undergoing finalization processes. |
| 27. Develop and disseminate practice tips to casework assistants, caseworkers, supervisors, and program coordinators that reinforce practice model values, guiding principles and practice skills related to caseworker-child visits. | June 2019 | Completed and ongoing. Practice Tips have been disseminated in November 2019, March 2020, and July 2020. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[242] |
|---|---|---|
| **Case Manager-Child Visitation: Increase the Quality of Case Manager-Child Contacts** | | |
| 28. Adopt and adapt quality contact training developed by the Capacity Building Center for States. | May 2019 | Not yet completed. The curriculum outline has been drafted. Curriculum development is underway with completion expected by October 31, 2020. |
| **Case Manager-Child Visitation: Improve the Quality of the Dictation Capturing the Case Manager-Child Visit** | | |
| 29. Deliver training to casework assistants, caseworkers, supervisors, and program coordinators. | June 2019 | Not yet completed. |
| 30. Develop and implement standards for visitation and quality documentation. | June 2019 | Not yet completed. This is related to curriculum and policy development. |

## Appendix F - OHAN Implementation Plan Strategy Updates as of April 30, 2020[243,244]

**Strategies towards Achieving Targets:**

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| **Intake and Investigations** | | |
| 1. Institute investigative caseworker office day for case management activities | Complete by September 2017 | Delayed, subsequently completed. DSS reports that implementation began in February 2019. Since that time, DSS reports that OHAN staff continue to have office days for case management activities and this schedule works well. |
| 2. Develop a user-friendly report to track and monitor face-to-face contact and case initiation within 24 hours | To be determined after Data Workgroup prioritizes CAPSS and data work (see Core Foundational and Capacity Building section above - 3.b). Some development has already occurred. | Delayed, subsequently completed.<br><br>The Joint Report required by August 31, 2019, DSS rebuild the timeliness reports using queries to remove Non-Class Members. In August 2019, DSS reports CAPSS IT finished development of a report to track timely initiation of investigations involving only Class Members, however, with changes in CAPSS, the base data used in this report was changed and DSS had to rebuild the query. The Co-Monitors have requested these data from DSS to validate, and will provide feedback to DSS, as needed. |
| 3. Revise the intake referral sheet to gather updated placement and caseworker information | Complete by March 2017 | Completed. OHAN previously revised the intake referral sheet used by OHAN intake workers. When intake screening |

[243] Not all strategies included and required in the OHAN Implementation Plan are included in this Table. Strategies identified as intermediate or long-term were not yet due during this period, and will be included and discussed in future monitoring reports.
[244] Commitments included herein are based upon the OHAN Implementation Plan (August 9, 2017, Dkt. 223) and the Joint Report (October 30, 2019, Dkt. 145).
[245] In some instances, in an effort to provide relevant context and available information, this Table reflects the status of actions after April 30, 2020.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| | | responsibility transferred to the Intake Hubs in November 2019, DSS began using a standardized form within CAPSS in addition to Structured Decision-Making® (SDM)[246] intake tool. OHAN investigators have reported to Co-Monitor staff that in investigations in which an alleged victim child has been moved, the new placement information is not always available, which can delay timely contact with the alleged victim child. This issue was also observed by reviewers when reviewing records of investigations that were accepted in March 2020. DSS reports that strategies are being developed to address intakes with incomplete information, and to bolster the interview and information gathering techniques of intake staff. |
| 4. Revise existing checklist to expand core witness list | Complete by April 2017 | Completed, and ongoing. DSS has developed a form which lists core witness categories that is used by OHAN staff to identify core witnesses in each investigation. When an investigation is received, an OHAN staff member reviews the information provided, and identifies core witnesses for the investigator to interview.<br><br>Current performance data reflect that additional work is needed to emphasize the definition of core witness, and to ensure it is consistently applied. |
| 5. Develop tracking system for documenting core witness contacts and provide additional guidance and training to caseworkers on identifying core witnesses | Complete by December 2017 | Not yet completed. DSS reports that updates to CAPSS to track core witnesses were delayed due to a lack of resources and the volume of work within OHAN.<br><br>The Joint Report required by July 29, 2019, DSS to identify core witnesses for each case during supervision using the core witness checklist and when cases are completed, utilize the |

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| | | checklist to determine whether all identified core witnesses were contacted. The Joint Report also required by August 15, 2019, the new core witness screens in CAPSS should be completed and reports should begin to be generated; additionally, DSS was to implement a quality assurance process to verify that entered data are complete and accurate.<br><br>During a recent case record review of investigations accepted in March 2020, Co-Monitor staff saw investigations in which core witnesses are identified during periodic reviews between the supervisor and investigator (for example, 10-day reviews, 20-30 day reviews).<br><br>The CAPSS updates were completed, and the new screens were launched in August 2019. DSS reports that CAPSS reports have been developed and are being refined to capture necessary data. A meeting was held on May 12, 2020 to discuss the process of identifying and capturing data on core witnesses, and modifications were recommended and completed to eliminate duplication of core witnesses, and make the reports easier to read and understand. |
| 6. Research and adopt a screening and assessment tool to help guide decision-making for OHAN intake | Complete by May 2017 | Delayed, subsequently completed. During this monitoring period, with the assistance of NCCD,[247] DSS completed the process of developing a SDM process and instrument for use at the Intake Hubs. Implementation began in November 2019. |
| 7. Develop and conduct specialized OHAN training to include findings from OHAN baseline reviews (including clarifying practice standards around "collateral" contact prior to making a hotline decision), CAPSS documentation training, interview and investigative | OHAN basic intake training to occur for existing case managers and supervisors | *Intake training* – Completed. Training sessions on a newly developed intake training curriculum began in September 2017.<br><br>*Investigation training* – Delayed, subsequently completed.. The investigation training curriculum was finalized, and the first week |

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| techniques, restraint training, assessing for safety and risk, and critical decision-making | beginning September 2017. OHAN basic investigative training to occur for existing case managers and supervisors by December 2017. All new case managers and supervisors will be required to complete training going forward. | of the two-week training was initially delivered to three OHAN case managers and one supervisor in early January 2019. The second week of the training was held in mid-April 2019. Newly hired staff completed investigation training in July 2019.<br><br>Moving forward, due to the small number of new staff joining OHAN at one time, DSS is considering converting training to a virtual format which would allow new staff to be trained immediately, and provide existing OHAN staff access the training as a refresher course. The training also needs to be updated to incorporate intake changes, inclusion of GPS model, and policy changes. Once training is available virtually, DSS will require all staff to take the training as a refresher. |
| 8. Develop a Provider History report in CAPSS to provide an easy to access and consistent history on providers for use by OHAN caseworkers, supervisors, and reviewers<br><br>- Preliminary report is currently being tested<br>- Once finalized, report will be automated in CAPSS.<br>- OHAN intake caseworkers will be trained to access, read, and summarize the previous allegations for the past two years and consider the previous history as a factor in determining preponderance of evidence for case | Work has begun. Preliminary report has been created and is being pretested with staff, supervisors, and reviewers. Based on feedback, report will be finalized and automated in CAPSS. Until automation, ad hoc reports will continue to be extracted. Work complete by September 2017. | Completed. DSS reports a provider history report has been developed in CAPSS and was incorporated into standard practice in September 2017. The report includes the past five years of OHAN intakes and investigations, allowing case managers to identify possible trends. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| 9. Develop a coordinated process with Licensing that may include the following:<br><br>- Create a new policy to establish clear guidelines for revocation of foster home and facility licenses for multiple allegations of policy violations that do not constitute abuse or neglect but that are detrimental to child well-being | Development of policies to be completed by July 2017. Implementation of policies and training of existing staff on new policies completed by November 2017 by Licensing and OHAN. | Delayed, subsequently completed. DSS reports that OHAN policy has been updated, to include a provision that a foster parent's license may be revoked if a provider is found to have violated the signed discipline agreement, including the prohibition against corporal punishment. The policy was published on May 31, 2019. |
| **Supervisor Review** | | |
| 10. Determine ways to increase guided supervision staffing, critical thinking, monitoring-accountability system by supervisor | | Completed. DSS reports the Guided Supervision Tool was finalized in May 2017 and is currently in use. |
| 11. Revise the Guided Supervision Tool to be specific to OHAN performance measures and for case reviews and system for utilization in practice. After implementation, this tool will be used at every supervisory review to guide the critical thinking of staff in investigatory work. | Complete by May 2017 | |
| 12. Train OHAN Supervisors on use of the Guided Supervision tool (see above for additional training of supervisors on information from OHAN baseline reviews) | Complete by June 2017 | |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[245] |
|---|---|---|
| 13. Implement Guided Supervision in OHAN by training staff on the expectations and begin use of the Guided Supervision process | Complete by June 2017 | |
| 14. Implement standardized supervisory case review prior to case decision | Complete by April 2017 | Completed. DSS reports this strategy is being implemented. This case review is typically completed with the investigator, and provides the forum in which the case decision is made. |
| 15. Refine case closure supervisory review to include CAPSS and paper file (thorough review) | Complete by April 2017 | Completed. DSS reports this strategy is currently being implemented. The recent case review conducted by Co-Monitor staff was virtual due to travel and physical distancing restrictions in place due to the COVID-19 pandemic, and paper files were not accessible. DSS has stated that OHAN staff are instructed to upload everything from the paper file into CAPSS. |
| 16. Develop methodology for caseload distribution | Complete by September 2017 | Delayed, subsequently completed. Beginning in late-2018, OHAN staff are allocated to and physically located within the DSS regions to assist in travel responsibilities and increase familiarity with foster parents, congregate care facilities, and local DSS staff. Cases are distributed based on geographic location. DSS reports a review of the distribution methodology was completed in November 2019, and DSS reports that although cases are typically assigned by region, distribution also includes an assessment of case proximity to adjoining regions as an investigator in the adjoining region may be physically closer or equal in distances to the case location that the investigator in the region, and may also have fewer cases. |

## Appendix G - Placement Improvement Plan Strategy Updates as of April 30, 2020[248,249]

**Strategies towards Achieving Targets:**
The Department identified a number of strategies to achieving the placement targets:

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| **A. Case Planning and Placement Processes** | | |
| A.1. With TA assistance, DSS will develop a protocol, guidance and timeframes for the field about the new Child and Family Teaming model (including Administrative Issuances to pilot the approach), assessment tool(s), availability of case-specific information from DSS partners and administrative data, the frequency of child and family team meetings and family group conferences, documentation requirements in CAPSS and other documentation requirements. | June 30, 2019 | Delayed and ongoing. DSS held a "kickoff" meeting on March 6, 2020 with Chapin Hall and CFTM workgroups. Sub-groups related to communication and implementation are meeting weekly. The newly named Family Permanency Plan has been developed and will be built into CAPSS with a December 2020 target date for completion. |
| A.1. (cont.) DSS will, with TA assistance as necessary, develop and implement training and coaching plan for CFT process for new and existing caseworkers and will secure a TA provider, if necessary, to shadow FE Liaisons and DSS staff in implementing the new CFT process. | Develop training and coaching plan in consultation with the Co-Monitors – August 30, 2019<br><br>Implement training and coaching plan for caseworkers and supervisors in pilot counties by September 30, 2019. | Delayed and ongoing. DSS is currently working with Chapin Hall to finalize an advanced facilitation curriculum, manual, and training/coaching plan. Once complete, the plan will be reviewed by the Co-Monitors.<br><br>Delayed and ongoing. DSS began training and implementation, beginning with its PIP counties |

[248] Not all strategies included and required in the Placement Implementation Plan are included in this Table. Due to delays in implementation and resource constraints, DSS is in the process of proposing an updated implementation timeline that maintains core commitments but adjusts timelines (due to the Co-Monitors by September 30, 2020). Updated timelines and strategies identified as not yet due during this period will be included and discussed in future monitoring reports.
[249] Commitments included herein are based upon the Placement Implementation Plan (February 20, 2019, Dkt. 117), the Joint Report (October 30, 2019, Dkt. 145), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[250] In some instances, in an effort to provide relevant context and available information, this Table reflects the status of actions after April 30, 2020.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| | | in June 2020. DSS is not currently moving forward with a placement pilot. |
| A. 1. (cont.) DSS will determine whether contract modifications are necessary to the Family Engagement contract and, if necessary, make contract modifications to align with the Placement Plan. | Determine whether contract modifications are needed – June 30, 2019 | Delayed and ongoing. DSS determined that it would develop an internal Family Engagement team. As of September 2020, DSS had completed hiring and onboarding for all 4 family engagement coach positions, all 4 supervisor positions, 4 of 6 administrative assistant positions, and 10 of 24 facilitator positions (an additional 5 new hires are pending approval by human resources). |
| A. 2. FE Coordinators and DSS, with TA assistance if necessary, will work to develop processes for including clinical input and distance participation in ways that preserve the primacy of the CFT. | To be done in conjunction with development of protocol and guidance of new CFT model – June 30, 2019 | Delayed and ongoing. DSS's CFT model envisions the inclusion of clinicians working with the family as well as DSS Regional Clinical Specialists and other Well Being Team members as needed. |
| A.2. (cont.) Design YE program, propose draft budget and launch YE program within DSS. | Design YE program and propose draft budget – September 1, 2019 | Completed. DSS hired and onboarded a Youth Engagement Coordinator in January 2020 and has engaged technical assistance in this area. |
| A.4. DSS will use Family Engagement Liaisons to develop coaching and training plan for DSS case managers and supervisors within regions that will pilot the new approach. | Develop training and coaching plan – August 30, 2019. | Delayed and ongoing. DSS began implementation of its coaching and training plan in June 2020 with a series of 3-day facilitator trainings and 1-day case manager and supervisor trainings in alignment with its CFTM rollout schedule. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| A.4. (cont.) Family Engagement Liaisons to provide training to supervisors and case managers in pilot counties. | Implement training and coaching plan in pilot counties by September 30, 2019 | Not yet completed. DSS has not moved forward with a placement pilot. |
| A.5. (cont.) Develop roll-out plan for training, certification and use of the revised Universal Application (UA) as standardized assessment tool pending procurement of new evidence-informed assessment tool. | Deadline of August 30, 2019 to modify the UA | Delayed and ongoing. The UA has been updated and reviewed by both legal staff and regional directors. CAPSS integration is scheduled for June 2020, and there is a process underway for considering CAPSS interfacing with the health and education passports. A Placement Decisions and Universal Application webinar was held on July 21, 2020. An additional Placement Policy training is scheduled for September 24 and 25, 2020. |
| **B. Restructured Partnership with Private Providers and Continuum Development** | | |
| B. 1 In consultation with the Co-Monitors, the Department will engage a TA provider with experience designing and implementing performance-based continuum contracting in other jurisdictions and the private provider community in developing and implementing performance based continuum contracts. | April 2019 | Not yet completed. DSS has requested scopes of work from potential providers and requested funding for TA support in its budget request for FY2020-2021. |
| B.1 (cont.) Work with internal and external stakeholders, including, private providers to gather information to support development of the care continuum model. | June 30, 2019 | Not yet completed. DSS reports that it has met with internal and external stakeholders to discuss the need to expand its placement and service array, but needs TA support and additional work to further develop its model. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| B.1 (cont.) Offer incentives for care continuum transition resource development. | July 2019 | Not yet completed. |
| B.1 (cont.) Hold regular information exchange meetings. | August 30, 2019 and ongoing | Ongoing. DSS The continues to host the Private Provider Advisory Committee meeting monthly. The August 2020 meeting was cancelled due to a training conflict. The next meeting is scheduled for September 22, 2020. |
| B. 2 Develop a safety monitoring plan for congregate care placements, including but not limited to, developing policy and practice updates and reminders to caseworkers on what should occur during visits with children and refresher training to caseworkers on how to assess children's safety at every visit and explore issues which have already been identified at congregate care facilities (and other placements). | July 2019 – July 2020 (Joint Report)[251] | Ongoing. DSS reports that OHAN, contract monitoring, and licensing have been collaborating to review providers with multiple referrals in a specified timeframe. With the support of a TA provider, New Allies, an initial process was developed, referred to as the Safety and Quality Response Protocol. Staffings utilizing this protocol began in March 2020, and work is underway to refine it and coordinate it with incident reporting in partnership with providers.<br><br>The Joint Report also required DSS to meet with providers to discuss contract revisions related to a foster home placement oversight and QA system and execute a change order for revisions by August 30, 2019.[252] |
| B.2 (cont.) Identify and select technical assistance provider, in consultation with the Co-Monitors, | June 30, 2019; date amended by the Joint Report to August 31, 2019. | Completed. DSS requested and received TA assistance from New Allies. |

[251] This deadline was adjusted to December 31, 2020 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[252] This deadline was adjusted to November 30, 2020 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| possessing expertise in maltreatment, protection from harm issues (e.g. isolation/restraints, behavior management, psychotropics) and continuous quality improvement. | | |
| Identify FTE and hire Safety Monitoring Coordinator | October 31, 2019 (Joint Report) | Delayed, subsequently completed as of July 17, 2020. |
| Identify specific strategies to engage private provider support consistent with Placement Implementation Plan. | August 30, 2019 and ongoing[253] | Not yet completed. This action step will be addressed in the context of DSS's work to revise its Placement Implementation Plan, expected to be completed by September 30, 2020. |
| **C. Utilization and Support of Kin and Fictive Kin as Kinship Foster Care Providers** | | |
| C.1 (cont.) Develop new protocols for kinship care coordinators to support the field in engaging kin as a placement resource. | August 2019 | Delayed and ongoing. Quarterly Kinship Care trainings are being held, and DSS is continuing to provide materials to the field DSS is also working with a TA provider a one-page document that explains the different options for kinship caregiving, so caregivers can see at a glance what the differences are with each option. |
| C.2 (cont.) Establish and convene relative caregiver and kinship foster care policy and practice advisory group. | May 2019; convened in June 2019. | Completed and ongoing. The Kinship Advisory Panel continues to meet monthly. |

[253] This deadline was adjusted to September 30, 2020 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| C.2 (cont.) DSS will explore possibility of promulgating an emergency regulation to allow for a provisional license. Also, Senate Bill S.191 currently pending before the Legislature would, if passed, make some of these changes. | August 2019.<br><br>Pursuant to the Joint Report development of permanent regulation as follows: July 31, 2019 for notice of drafting; September 30, 2019 for contact with the Administrative Law Court to schedule a public hearing; March 31, 2020 for submission of a proposed permanent regulation to the Legislature; and May 31, 2020 for publishing of a permanent regulation. | Completed. DSS now has a permanent regulation in place to allow provisional licensure of kin who meet specified requirements. |
| C.2 (cont.) Develop and implement administrative issuance/policies for presumptive case plan that relative caregiver will become a licensed foster home; four months relative caregiver retains right to seek to become licensed or unlicensed foster home; safety plan of prevention case for 6 months. | May 2019 | Delayed and ongoing. The Kinship Policy has been drafted indicating that kinship caregivers can become licensed at any point in time when the child is in foster care. Written information is currently being provided to all kinship caregivers to explain the procedures of licensure and what services are offered. |
| C.2 (cont.) Develop protocols and scripts and outreach materials for informing and discussing with families the relative caregiver options, and develop and make available written materials that clearly communicate those options in ways that families and those working with them can understand. | April 2019 | Ongoing. DSS engaged USC to develop relevant materials, and has now published and distributed many of these materials to counties and partners to share with staff and kinship caregivers, including a "Where to Go Resource Cheat Sheet"(June 2019), Kinship Care Poster and Brochure (October 2019), and a Prospective Kinship Placement Acknowledgement (March 2020). |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| C.2 (cont.) Develop and deliver training to all relevant DSS staff and community partners and judges so that they understand the new approach to kinship foster care. | May 2019 and ongoing | Completed and ongoing. Training to prepare DSS staff to deliver Caring For Our Own training began on August 24, 2020. Provisional Licensure training was held on September 4, 2020 for DSS staff and 569 staff members attended. |
| C.3 Establish scope of work to ensure that relatives can effectively access the services of the Kinship Navigator Program | June 2019; date amended by the Joint Report to January 31, 2020 for RFP development; May 31, 2020 for selection and contracting; and July 1, 2020 for contract commencement. | Delayed and ongoing. An RFP has been awarded for a small kinship navigator program which provides resources to a limited area in the state. DSS is awaiting funding to roll out the program statewide to ensure relatives can effectively access services in all counties. |
| C.3 (cont.) Convene meetings with relative caregiver and kinship foster care policy and practice advisory group to advise on programming and to later meet with kinship navigator contractor to establish ongoing advice and support role to program. | May 2019 and ongoing | Completed and ongoing. The Kinship Advisory Panel continues to meet on a monthly basis. |
| C.4 Develop new criteria for the screening and approval of kinship foster homes. | July 2019 | Completed and ongoing. Prospective kinship caregivers are eligible for issuance of a provisional license, pending issuance of a standard license. Kinship foster home applicants are referred to the regional licensing team for further action where an application, background (and other safety checks), a home visit, and abbreviated assessment are completed, for issuance of a provisional license, valid for up to 90 days. As of July 1, 2020, the family is then eligible for the full board reimbursement rate. Non-safety items are |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| | | waived and do not restrict issuance of the license. |
| C.4. (cont.) Develop "tip sheet" and protocols for use and updating. | July 2019 | Completed. |
| C.4 (cont.) Develop and implement expedited placement process. | July 2019; date amended by the Joint Report to August 31, 2019, for DSS to develop expedited licensure process to include non-safety waivers and apply to current kin families in process and new applicants. | Completed and ongoing. The non-safety waiver form has been developed to support kinship families throughout this process to include provisional licensing regulations. Kinship Care Coordinators are providing support on the front-end to explain the process to kinship caregivers. SCDSS is currently working with a technical assistance provider (AECF) to refine the process. |
| C.4 (cont.) Hire additional staff or contract with providers if necessary, to have capacity to complete expedited approval within timelines. | July 2019; date amended in the Joint Report to November 30, 2019.[254] | Ongoing. As of July 2020, DSS has repurposed existing positions to hire eight licensing workers (one licensing worker and one support worker for each region), and has requested additional support in its FY2020-2021 budget. |
| **D. Recruitment, Retention, and Utilization of Non-Relative Foster Parents** | | |
| D.1 (cont.) DSS will request funds to support an adjusted foster home board rate applicable to licensed kinship, private provider and DSS approved foster homes, adjusted on an established periodic basis, that meets or exceeds USDA guidelines and | Request in Fall 2019 with anticipated funding in July 2020 and ongoing. | Completed and ongoing. In May 2020, DSS utilized funding available as a result of COVID-19 pandemic related legislation to temporarily increase foster home board rates through December 31, 2020 to the USDA-based rates |

[254] The COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) includes additional commitments with the goal of increasing the capacity for licensure of kin, fictive kin, and nonrelated foster parents. The Co-Monitors will report on these commitments in the next monitoring report.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| develop a process for periodically reviewing these rates. | | of $20.03, $23.41, and $24.72 per day, depending upon the age of the child, for foster family homes including kinship foster homes. Payments were made beginning August 16, 2020 and were retroactive to July 1, 2020. Funding to maintain this rate increase was requested in the FY2020-2021 budget. |
| D.2 DSS will utilize an emergency procurement to expeditiously contract to provide support to private providers who can recruit family foster homes and provide family foster care services. | March 31, 2019 | Completed. DSS reports that it issued an emergency procurement in March 2019. There are currently 13 licensed Child Placing Agencies. |
| D.2 (cont.) Hold information and planning meetings with providers regarding private provider regular foster home RFP. | June 2019 | Completed. DSS began holding informational meetings with providers in June and July 2019, which resulted in the formation of a workgroup to address contractual changes needed. Contracts have now been updated. |
| D.2 (cont.) DSS will develop regional recruitment plans for DSS homes and will incorporate the private agency recruitment plans from agencies in their region into an overarching regional recruitment plan that has both broad recruitment strategies and targeted recruitment strategies that consider the unique needs of the children and youth in need of foster and adoptive homes. | July 30, 2019 | Not yet completed. DSS will meet Sept 17, 2020 with private agency partners to discuss foster home recruitment and development of recruitment plans. DSS ADR's team has coordinated with Permanency in the development of a new foster home needs report that incorporates characteristics of the children in care. That report is now in testing phase. The information from that report will be incorporated into recruitment plans. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| D.3 DSS will develop and begin utilizing a foster parent exit survey. | July 2019 | Completed and ongoing. DSS reports that a foster parent survey has been developed. It will be provided on a quarterly basis to families that closed within the quarter. Then, on an annual basis, surveys will be completed for licensed foster families. |
| D.3. (cont.) DSS will select an evidence and trauma informed training model for preservice foster parent training. | August 30, 2019 | Completed and ongoing. DSS identified "Caring for Our Own" training curriculum for kinship caregivers. Train the Trainer sessions were conducted August 24-28, 2020. |
| D.3 (cont.) DSS will engage and contract with private providers to enhance the training offerings and access. | July 2019 and ongoing | Completed and ongoing. Providers have been engaged to share training opportunities and collaborate with each other and DSS. Providers have been willing to include DSS foster parents in their trainings, and training opportunities have been posted on the Foster Parent Association website. DSs reports that no additional contracting is needed. |
| D.3 (cont.) DSS will build and launch online training calendar. | March 30, 2019 | Completed. The training calendar is on the Foster Parent Association website, with a link to the DSS website. |
| D.4. Hire additional staff in licensing unit. | July 2019 for pilot region | Delayed and ongoing. DSS has not moved forward with a placement pilot. As a way of addressing the backlog in applications and limiting funding for additional staff statewide, |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| | | DSS engaged private providers in July 2020 to assist with licensing of non-kin foster homes.[255] |
| D.4 (cont.) Review some calendar year 2018 "screen out" decisions and make decision about whether to Implement new screening in/out protocols with licensing staff. | June 30, 2019 | Completed. A sample of screen out decisions was reviewed in June 2019. DSS reports that, based on this review, all screen outs were determined to be appropriate and that no changes are needed at this time. |
| D.4. (cont.) DSS will communicate with training providers new data collection requirements. | March 30, 2019 | Ongoing. DSS reports that it communicated new data collection requirements via email in March 2019. After receiving feedback from providers that they wished to collaborate on the development of data collection requirements, a meeting was held on June 23, 2019. A workgroup was formed as a result of this meeting, and has been charged with finalizing how the requirements will be implemented. An internal planning meeting is scheduled for September 14, 20202, and a meeting with providers will be scheduled thereafter to discuss next steps. |
| D.5 Develop foster parent handbook and distribution plan. | Start process in Spring 2019 with anticipated distribution by December 30, 2019 | Completed. The Foster Parent Handbook is available in digital format and a link will be posted to websites for DSS, State Foster Parent Association and Care to Foster. |

[255] The COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) requires families currently engaged in the licensing process and prospective new applications to be assigned to Child Placing Agencies (CPAs) by July 2020 to allow for utilization of existing internal resources for kin licensing. By December 2020, these providers are to license 225 non-kin foster families currently in process and will continue to license prospective new families that begin the application process through December 2020.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| D.5 (cont.) Conduct foster home utilization assessment and completion of study. | This process has begun and is ongoing. A memo was issued in July 2018 regarding this. Review for the pilot counties will be complete by July 2019 and statewide by September 2019. | Delayed and ongoing. DSS reports that a policy and process are in place for a monthly review of utilization by a dedicated staff person who follows up with foster parents based on the information in the monthly report. At present, this includes the production and review of two reports indicating licensed foster homes without placement for the prior 12 months. |
| D.6. Create ombudsperson using internal capacity. | June 30, 2019 | Ongoing. DSS reports that it identified a staff member to administer a foster parent helpline, and that foster parents can send comments through a secured email address for individual responses. |
| D.6. (cont.) Develop and publicize regional schedules for foster parent retention events. | June 30, 2019 | Completed. These were posted on the Foster Parent Association website and there is a link to the DSS website. |
| D.6. (cont.) Develop and implement policy for regular foster parent survey input. | July 30, 2019 | Delayed and ongoing. Licensing policy has been updated to include requirements around the foster parent survey and is currently under review by DSS's legal department. |
| D.6. (cont.) Develop trauma-informed policy for supporting foster parents after a child is removed. | August 2019 | Delayed and ongoing. Licensing policy has been updated to include requirements around trauma- informed policy to support foster parents following the removal of a child and is currently under review by the agency's legal department. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[250] |
|---|---|---|
| **E. Conducting a Placement Pilot** | | |
| E.1 (cont.) DSS will quickly conduct a performance review of the transportation vendor to determine if they possess the necessary engagement skills to provide the necessary transportation assistance to families and other adults in a therapeutically sufficient manner. | July 2019 | Not yet completed. |
| E.1 (cont.) DSS will compare the programming and performance of the current transportation vendor options against the current utilization of DSS caseworker assistants to provide transportation assistance and make a determination whether to hire additional casework assistants or significantly increase the current transportation contract for pilot counties. If after comparing the two transportation models DSS concludes that transportation assistance services using casework assistants is more aligned with the practice model and preferable, then funds will be provided to hire staff to perform this function. | July 2019 | Delayed. DSS completed a review of transportation needs and determined that additional casework assistants would be the best option for increasing transportation capacity. DSS requested funding to hire additional these staff in the FY2020-21 budget request. |

## Appendix H - Health Care Improvement Plan Strategy Updates as of April 30, 2020[256,257]

**Strategies towards Achieving Targets:**

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| **Structures for Coordination with Health Care Partners** | | |
| 1. Weekly meetings with Select Health on data sharing and other key practices, processes, and protocols. | October 2018 - Present | Ongoing. Meetings have been occurring on a regular basis to discuss data sharing, care coordination and health care case management, and individual cases, as needed. As of February 5, 2020, a decision was made to adjust participation to key leaders of both agencies. |
| 2. Weekly meetings with DHHS on data-sharing and other key practices, processes, and protocols. | October 2018 - Present | Ongoing. These meetings have now been incorporated into the weekly call with Select Health to promote direct communication between DSS, Select Health, and DHHS on issues of concern. |
| 3. Weekly cadence call to staff cases, review progress made and resolve immediate needs. | August 2018 - Present[259] | Ongoing. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified regional liaisons. Through the process of holding these calls and becoming more familiar with available data |

[256] Not all strategies included and required in the Health Care Improvement Plan are included in this Table. Strategies identified as not yet due during this period will be included and discussed in future monitoring reports.
[257] Commitments included herein are based upon the Health Care Improvement Plan (August 23, 2018, Dkt. 120), the Health Care Addendum (February 22, 2019, Dkt. 120-1), the Joint Report (October 30, 2019, Dkt. 145), the Joint Report on Immediate Treatment Needs of Class Members (November 4, 2019, Dkt. 162), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).
[258] In some instances, in an effort to provide relevant context and available information, this Table reflects the status of actions after April 30, 2020.
[259] The *Joint Agreement on the Immediate Treatment Needs of Class Members* includes additional commitments to address these issues.

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| | | sources, information gaps, and barriers to care, DSS transitioned to a more effective "Grand Rounds" model. Since January 2020, these calls have been held weekly and are focused on the therapeutic needs of children in foster care, with coordination of recommendations between Select Health, DSS county staff, and members of the DSS Well-Being teams.<br><br>DSS nursing staff have also developed a series of questions for inclusion in the Child and Adult Information Portal (CAIP) to track and address the need for follow-up care. A case review will be conducted to determine data entry issues in this area and if the resulting date demonstrate improved follow up, changes will be considered for CAPSS. |
| 4. Continue convening Foster Care Health Advisory Committee (FCHAC), a collaboration of DSS, DHHS, and providers and community partners throughout the state. | January 2018 - Present | Ongoing. The Foster Care Health Advisory Committee (FCHAC) continues to meet regularly and has been a key body in vetting, developing, and improving plans for implementation of health care work for children in foster care. A decision was made in December 2019 to adjust meeting frequency to bi-monthly and extend the meeting time from one to two hours. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| **Selection and Development of Tools for Assessment and Planning** | | |
| 5. Explore with DHHS, Select Health, QTIP providers and the AAP (American Academy of Pediatrics SC Branch), DSS's plan to use a standard, system-wide screening and assessment tool and ways to integrate the use of this tool and other best practice guidance on delivering health and behavioral health care to children in foster care. | February 2019 | Delayed and ongoing. DSS has developed a 48-Hour Initial Health Screening Tool for completion by case managers. At this point, the tool has been designed to determine whether there are emergent medical needs that need to be addressed, make referrals for services, and gather information for a child's first medical visit. Discussions are ongoing with Praed Foundation regarding whether these functions will be part of the CANS medical assessment questions, and DSS expects a decision to be made by the end of September 2020. DSS reports that the integration of CANS into CAPSS is expected to be completed by December 2020. |
| 6. Choose validated assessment tool, train DSS staff, and roll out standardized assessment tool in accordance with the processes developed in the Placement Implementation Plan. | Tool selection by August 31, 2019; request for funding by September 2019. | Ongoing. In consultation with community partners, DSS has committed to implementation of the Child Assessment of Needs and Strengths (CANS) tool. DSS received grant funding to begin implementation work and a work group has been formed and is meeting on a monthly basis. DSS has also requested funding for this work in its FY2020-2021 budget request.<br><br>CANS Training was conducted by the Praed Foundation in late August 2020. CANS is expected to be integrated into CAPSS in December 2020. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| 7. Adapt Universal Application (UA) to include health and behavioral clinical and functional assessment questions as recommended by child welfare leadership and the Foster Care Health Advisory Committee. | Tool selection by August 31, 2019; request for funding by September 2019. | Ongoing. The Universal Application has been updated based on the recommendations of its workgroup and the FCHAC. DSS reports that the integration of the tool into CAPSS is expected to be completed by July 2020. |
| 8. Connect health/behavioral health initial assessments and comprehensive assessments to placement decision-making processes, informing the Placement Implementation Plan. | August 31, 2019 | Delayed. DSS reports the workgroup responsible for reviewing and recommending changes to the Universal Application focused on connections between medical and behavioral health assessments and placement decision-making processes, and that there has been ongoing planning with respect to the use and rollout of the CANS. Delays in the implementation of the Placement Implementation Plan, including the CFT process, have delayed the timeline for this work. |
| **Care Coordination Model Development and Staffing** | | |
| 9. Develop aligned timeframes for initial assessments, comprehensive assessments and follow-up that track AAP standards for children in foster care. Those timeframes will be clarified and operationalized for data tracking purposes. | February 2019 | Completed. DSS developed a set of health care process requirements and outcomes, approved by the Co-Monitors, that align with the FSA and best practice for children in foster care.[260] These requirements have been shared with DHHS and Select Health, and Select Health is in the process of updating its internal reporting processes to reflect the timeframes included therein. |
| 10. Produce a comprehensive care coordination and health care case | March 2019 | Ongoing. The DSS Health Care Addendum was approved by the Co-Monitors on February 25, 2019, with the |

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| management framework subject to approval of the Co-Monitors. | | understanding that it would be reviewed on an annual basis. DSS and Select Health met in February 2020 to continue to build out the details of this model, and more work will be required as implementation proceeds, particularly around clarification of the Select Health care coordination role.[261] |
| 11. Select Health will build a new Foster Care Unit through the addition of 19 new positions (6 RN Complex Care Managers; 8 Care Connectors; .5 RN Manager; 1 RN Supervisor; 2 Licensed Social Worker Care Managers; .5 Medical Director; and 1 Quality Improvement Specialist). | July 2019 and ongoing | Completed. Select Health reports that all 21 staff have been hired for its Foster Care Unit, including two pediatric nurses, a Foster Care Liaison, and a new Medical Director (hired March 30, 2020). |
| 12. DSS will hire, on board and train selected candidates for Office of Child Health and Well-Being Nurse Care Manager and Nurse Care Coordinator Positions.<br><br>12.a. DSS will hire, on board, and train selected candidates for 4 remaining Office of Child Health and Well-Being Nurse Care Coordinator Positions.<br><br>12.b. Request funding for 5 Program Coordinators, 2 Quality Improvement and Contract Managers, and 3 Data Analytics and Reporting staff for Office of Child Health and Well-Being. | October 31, 2019<br><br>January 31, 2020<br><br>September 2019 | Completed. As of March 2020, four Nurse Care Coordinator positions have been filled (three have been in place since November 2019). An offer was made for the position of Nurse Care Manager in November 2019, but the position needed to be reposted after the candidate rescinded. The Upstate Nurse Care Coordinator was promoted to Nurse Manager in December 2019, and the new Upstate Nurse Care Coordinator started in March 2020. The dental nurse began in February 2020. DSS also transitioned former IFCCS data coordinators to positions in regional Well-Being Teams from which they will support Regional Nurse Care Coordinators, in place as of December 2019. |

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

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| | | DSS has requested funding to meet this commitment in the FY2020-2021 budget, and has also requested funding for four additional nurses in accordance with its Joint Report commitment. |
| 13. DSS will determine processes and requirements for funding the Medicaid portion of new Office of Child Health and Well-Being positions. | September 2019 | Completed. DSS reports that it is using Medicaid Administrative Activities contracting and that Office of Child Health and Well-Being nurses are keeping monthly time sheets. |
| **Data Development** | | |
| 14. Develop proposed set of child health outcome benchmarks and targets similar to those in the Center for Health Care Strategies' report "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit" (Allen, 2012). | December 2018 | Completed. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018. |
| 15. Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets. | Spring and Fall annually, beginning April 2019 | Completed. The FCHAC reviewed proposed FSA Health Care Outcomes prior to finalization in December 2018, and have participated in ongoing discussions of how to operationalize these measures. |
| 16. Finalize benchmarks and targets. | December 2018 | Completed and ongoing. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018. For those measures for which data were not and are not yet available, timeframes were included for the production of baseline data and the establishment of interim benchmarks. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| 17. Review/refine annually. | Spring and Fall annually, beginning April 2019 | Ongoing. DSS, in collaboration with the Co-Monitors, is in the process of reviewing the methodologies utilized for measuring performance in this area. |
| 18. Interim benchmarks incorporated into plan. | March 1, 2019 | Completed and ongoing. Interim benchmarks were approved by the Co-Monitors for inclusion in the Health Care Improvement Plan on February 25, 2019. For those measures for which data were not yet available, timeframes were included for the production of baseline data and the establishment of interim benchmarks. Because of lags in data availability due to the COVID-19 pandemic, there have been delays in the proposal of benchmarks in some areas. |
| 19. Use gaps-in-care and other red flag reports, cadence calls and performance tracking and develop a protocol based on experience beginning in August 2018. | August 2018 - Present | Completed and ongoing. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified regional liaisons. As DSS has developed its plan and structures for tracking the delivery of health care services to children in foster care, this mechanism was adapted and became part of the Well-Being Team responsibilities.<br><br>Gaps-in-care reports are being produced by Select Health on an intermittent schedule. The team is working towards a monthly production schedule. Gaps-in-care reports continue to be used to determine well child visit dates. The DSS Nursing Team is working to create identifiers so that children and youth identified on the report with chronic conditions can be tagged in CAPSS for monitoring. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| 20. DSS will work with USC to conduct health care case review to build an understanding of available data and means of storing and accessing it through CAPSS. | November 30, 2019, with results to Plaintiffs and Co-Monitors by December 31, 2019. | Completed. In October and November 2019, DSS worked with internal staff and staff at USC CCFS to perform an initial review of the process for entering and storing health care data in CAPSS. DSS reports that the review was used to inform changes to CAPSS and provide guidance to case managers and Office of Child Health and Well-Being staff. |
| 21. DSS will perform a "data cleanup" to ensure the most recent identified well-child visit date is entered as an encounter in CAPSS for every Class Member as of December 1, 2019. | December 31, 2019 | Completed and ongoing. File reviews were completed in January 2020. Ongoing work is being done to request and enter supporting after-visit summary documentation into CAPSS. |
| 21.a. DSS will produce a report, updated monthly, that indicates the date by which each Class Member is due for their next well-child visit. | February 1, 2020 | Completed and ongoing. A CAPSS report is run weekly that indicates which children are overdue for ongoing well-child visits so that case managers and supervisors can review the files of these children and ensure that visits are scheduled. Through its Office of Accountability, Data, and Research, DSS also runs monthly matched files with DHHS and Select Health data to prioritize children who require well-child visits and track requests for after-visit summaries from providers, case managers, and foster parents. |
| 22. Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards. | February 2019 | Ongoing. A series of meetings for county directors of similarly sized counties were held in April 2020. Regional meetings for frontline staff have been held or are scheduled to be held in specific counties that requested technical assistance. Case manager training will be updated further when the health screening tool is finalized and implemented after the screening and assessment tool and Universal Application are integrated into CAPSS in May 2020. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| | | DSS also conducted Data Report Use trainings in August and September 2020, which included training in the use of internal reports on updated well-child visits and dental visits. Training on the Universal Application was provided to staff in July and August 2020. Additional training will occur after further CAPSS developments in December 2020. |
| 23. DSS will collaborate with DHHS to create a report and roster that tracks services delivered to children in foster care who are either ineligible for Medicaid or utilize services that are not covered by Select Health's per member/per month rate including dental services, Medicaid waiver services and specialty care for medically fragile children among other out-of-network services provided to children in foster care. DSS and DHHS will use the report to recommend changes or improvements needed. | December 2018 | Delayed and ongoing. DSS reports that it has an improved process in place for payment of medical, behavioral health, and dental bills for children who are not eligible for Medicaid, and that it can produce a report of children in care who are not eligible for Medicaid through CAPSS. DSS also receives a monthly list of children who are not enrolled in Select Health. Policy changes have been developed and are awaiting approval so that full implementation can begin.<br><br>DSS now has in place a monthly process for the review of Medicaid identifiers in CAPSS, and is working to repurpose a position to support case managers with children and youth who are not eligible for Medicaid. If that effort is successful, that position will provide technical assistance and support beyond what the Well-Being Teams currently provide. |
| **Select Health Enrollment, Policy and Practice Development Tailored to Needs of Children in Foster Care** | | |
| 24. Fix 30-day enrollment lag by January 2019, and in interim, develop and use an administrative work-around so that children in | August 2018 - January 2019 | Ongoing. DSS continues to work with Select Health to resolve enrollment barriers. DSS, Select Health, and DHHS now have in place a process for weekly communication |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| foster care receive necessary initial assessment, comprehensive assessment and follow-up, and the data tracks them as such. | | regarding children not yet enrolled and are continuing to monitor children who experience a longer than expected wait time.<br><br>DSS reports that its updated processes, including for advanced notice of new members via email from DHHS to Select Health, continue to function smoothly, and has been allowing Select Health to begin outreach efforts within a few days of a child or youth entering foster care. |
| 25. DSS and Select Health will work together to update the Select Health Policy and Procedure Manual to ensure guidance is specific to children in foster care. | March 2019 | Delayed and ongoing. With oversight from DHHS, work continues with Select Health on policy review and development of processes specific to members who are in foster care. Part of that work includes determining if items fall under managed care or if new policy must be developed. |
| 25. (a) Develop and implement a process to guide the review and appeal of Medicaid denials for children in foster care placed in PRTFs, when deemed appropriate, to ensure Medicaid funding is utilized over state funding, whenever possible in these situations. | November 30, 2019 and ongoing | Ongoing. A protocol for staffing and reviewing cases in which PRTF placement was denied is in place and has been utilized with the support of counsel from DSS legal staff. A dedicated staff member is assigned the responsibility of reviewing Medicaid denials and coordinating with Select Health to complete the appeals process. DSS reports that this process, which has required counsel to represent DSS in fair hearings, has resulted in numerous informal overturned denials and two formal overturned denials. One fair hearing was held on March 31, 2020, and the final decision was made in the Department's favor. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| **Availability of Quality Health Care Services for Children in Foster Care** | | |
| 26. DSS will collaborate with DHHS to develop a protocol to identify dental providers available to children in foster care. | August 2018 | Delayed and ongoing. DSS reports that it is working with the DHHS dental provider manager to develop a relevant protocol. DHHS has discussed giving DSS staff access to the DentaQuest provider database, and monthly data from this database is expected to help determine current service gaps. |
| 27. DSS will plan a behavioral health and dental services capacity study to be conducted every two years by USC using Medicaid administrative data, qualitative surveys from foster parents, birth families and youth in care and DSS regional office staff. | June 2019 | Delayed. |
| 28. DSS will collaborate with DHHS, Select Health and the Foster Care Health Advisory Committee to establish a preferred provider designation based on HEDIS parameters and provider agreement to participate in cohort learning collaboratives that meet two times a year. | June 2019 | Delayed and ongoing. The FCHAC supported DSS in the development of recommendations for both primary care and behavioral health providers. DSS has continued to work with Medical University of South Carolina (MUSC) on the development of a process that will allow providers to identify children in foster care through data, and to develop trainings for providers who serve children in foster care. As of July 1, 2020, providers were able to bill Medicaid at an enhanced rate for initial well-child visit appointments for children in foster care. DSS is exploring additional mechanisms for possible Medicaid reimbursement for primary care providers for care coordination activities for children in foster care. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| 29. DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given child psychiatry staffing and regional locations around the state. | February 2019 | Not yet complete. DSS and DHHS have determined to proceed first with work on preferred provider designations for primary care providers. |
| 30. DSS, DHHS and Select Health will collaborate to establish a protocol to assign children to a patient-centered medical home, QTIP-like or FQHC preferred provider and caregivers will have the opportunity to opt-out and exercise freedom of choice. | February 2019 | Delayed and ongoing. DSS reports that it has begun to identify patient-centered medical homes that may be willing to accept children in foster care into their practices. Decisions about next steps and whether to assign children to these practices are still pending. |
| 31. DSS will work with DHHS and the AAP to build out a learning cohort of pediatric practices who wish to work with the foster care population. | February 2019 | Delayed and ongoing. DSS has completed a contract for the establishment of learning collaboratives under the guidance of the MUSC. Two planned webinars, set to occur in March and May 2020, are bring rescheduled due to the COVID-19 pandemic. |
| 32. DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed. | June 2019 | Delayed. |
| 33. DSS will review the annual External Quality Review Reports for Select Health to determine adequacy of the provider network and quality improvement plans to improve access. | June 2019 | Partially completed. DSS reports that it reviewed the most recent EQR report, Select Health baseline assessment and supplementary report from 2018, and the 2019 provider network accountability assessment, but has determined that additional information is needed to assess provider adequacy. |

| DSS Commitments to Achieve Targets | Timeline | DSS Implementation Update as of April 30, 2020[258] |
|---|---|---|
| 34. DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues. | June 2019 | Not yet completed. |
| 35. DSS will collaborate with DHHS and Select Health to determine network sufficiency, and implement mitigation plans for areas where service or provider capacity is limited. | June 2019; date amended by the Joint Report to August 31, 2019 and ongoing for DSS to collaborate with DHHS and Select Health to identify and determine network sufficiency for Class Members and implement mitigation plans for areas where service or provider capacity is limited.[262] | Delayed. DSS reports it is in the process of rolling out a user-friendly database of available services as a resource for case managers and supervisors to match services to the needs of children and families, expected by August 31, 2020. DSS believes the information gathered will be used to inform mitigation plans in areas in which service and provider capacity is limited. |
| 36. DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly. | December 2018 | Delayed and ongoing. DSS reports that there is now a specific process in place whereby DSS case managers, in conjunction with regional clinical specialists, can seek out-of-network placements, and that these cases are also staffed during weekly Grand Rounds with Select Health and Well-Being Team Managers. |

[262] This deadline was adjusted to ongoing through June 30, 2021 pursuant to the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201).