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

Monitoring Period II
(April 1, 2017 – September 30, 2017)

Progress of the South Carolina Department of Social Services

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Center for the Study of Social Policy

Michelle H., et al. v. McMaster and Alford
Progress Report for the Period April 1, 2017 – September 30, 2017

TABLE OF CONTENTS

I. INTRODUCTION 1

II. SUMMARY OF PERFORMANCE 2

III. MONITORING ACTIVITIES 7

IV. SUMMARY TABLE OF *MICHELLE H., et al. v. McMASTER and ALFORD* FINAL SETTLEMENT AGREEMENT PERFORMANCE 8

V. CASELOADS 46

VI. CASEWORKER-CHILD VISITATION 60

VII. INVESTIGATIONS 61

VIII. PLACEMENTS 81

IX. FAMILY VISITATION 94

X. HEALTH CARE 100

XI. BUDGET 104

APPENDICES

A. Glossary of Acronyms……..……..……106

B. OHAN Implementation Plan Strategy Updates……...107

C. Health Care Consultants' Findings and Recommendations……113

LIST OF TABLES

TABLE

Table 1: Summary Performance on Settlement Agreement Requirements 8

Table 2: Status of Implementation Plans and Assessments 36

Table 3: Baseline, Timeline and Interim Benchmarks for Appropriateness of Decision Not to Investigate Referral (Alleging) Institutional Abuse (and/)or Neglect 64

Table 4: Good Faith Efforts to Contact Alleged Victim Children within 24 Hours 68

Table 5: Extraordinary Circumstance Exceptions to Contact with Alleged Victim Children within 24 Hours 68

Table 6: Baseline, Timeline and Interim Benchmarks for Timely Initiation of Investigations 69

Table 7: Exceptions to Contact with Core Witnesses During Investigations 71

Table 8: Baseline, Timeline and Interim Benchmarks for Contact with All Necessary Core Witnesses during the Investigation 72

Table 9: Contact with Necessary Core Witnesses During Investigations by Type of Core Witness 74

Table 10: Baseline, Timeline and Interim Benchmarks for Appropriate Case Decisions during Investigations 76

Table 11: Examples of Good Cause Reasons to Extend Investigation Timeframes 78

Table 12: Baseline, Timeline and Interim Benchmarks for Timely Completion of Investigations 79

Table 13: Types of Placements for Children as of September 30, 2017 86

Table 14: Types of Placements for Children Ages 12 and Under as of September 30, 2017 87

Table 15: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements 88

Table 16: Sibling Placements for Children Entering Placement between April and September 2017 as of September 30, 2017 93

Table 17: Exceptions to Sibling Visitation Requirement 95

Table 18: Exceptions to Parent and Child Visitation Requirement 98

LIST OF FIGURES

FIGURE

Figure 1: Foster Care Caseworkers within the Required Caseload Limits as of September 25, 2017 50

Figure 2: Caseloads of Foster Care Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017 51

Figure 3: Caseloads of Newly Hired Foster Care Caseworkers that were Over Limit as of September 25, 2017 52

Figure 4: IFCCS Caseworkers within the Required Caseload Limits as of September 25, 2017. 53

Figure 5: Caseloads of IFCCS Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017 54

Figure 6: Caseloads of Newly Hired IFCCS Caseworkers that were Over Limit as of September 25, 2017 55

Figure 7: Adoption Caseworkers within the Required Caseload Limits as of September 25, 2017 56

Figure 8: Caseloads of Adoption Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017 57

Figure 9: Caseloads of Newly Hired Adoption Caseworkers that were Over Limit as of September 25, 2017 58

Figure 10: Foster Care, IFCCS, Adoption and OHAN Caseworkers that were Above and Within the Required Caseload Limits as of September 25, 2017 59

Figure 11: Appropriateness of Decision Not to Investigate Referral (Alleging) Institutional Abuse (and/)or Neglect 66

Figure 12: Timely Initiation of Investigations 70

Figure 13: Contact with All Necessary Core Witnesses during Investigations 73

Figure 14: Decision to Unfound Investigations Deemed Appropriate 77

Figure 15: Timely Completion of Investigations 80

Figure 16: Children Ages Six and Under in Congregate Care 89

Figure 17: Children Who Visited With All Siblings 96

Figure 18: Visits that Occurred between Siblings 97

Figure 19: Children with Twice Monthly Visits with their Parents..... 99

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

Progress Report for the Period April 1 – September 30, 2017

I. INTRODUCTION

This is the second report on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) entered in *Michelle H., et al. v. McMaster and Alford*. Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the more than 4,000 children in foster care in South Carolina[1] and incorporates provisions that had been ordered in the previous year in a Consent Immediate Interim Relief Order (the Interim Order)[2]. This report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from monitoring staff Rachel Paletta, Elissa Gelber, Gayle Samuels and Erika Feinman, and 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 DSS's obligations to significantly improve experiences and outcomes for the children in its care. It was crafted by state leaders and Plaintiffs, who conceived it to include commitments that would guide a multi-year reform effort. The FSA reflects DSS's agreement to address long-standing problems experienced by children in foster care custody and in the operation of South Carolina's child welfare system. It includes a broad range of provisions governing: caseworker caseloads; visits between children in foster care and their caseworkers and family members; investigations of allegations of abuse and neglect of children in foster care; appropriate and timely foster care and therapeutic placements; and access to physical and mental health care for children in DSS custody.

While the FSA includes many specific agreements around policy and practice changes and outcomes to be met, some FSA provisions were crafted to be more open-ended, as the Parties agreed to add greater specificity regarding outcomes, benchmarks and timelines in collaboration with the Co-Monitors following DSS diagnostic work (including specified assessments and review of baseline information). The FSA thus established a structure in which the Co-Monitors would work closely with DSS leaders to identify phased implementation plans to guide much of the work ahead.

[1] 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.).
[2] Consent Immediate Interim Relief Order (September 28, 2015).

Included in this report is a summary of the Co-Monitors' general findings, followed by a detailed discussion of the progress made during this monitoring period with respect to each of the FSA requirements.[3]

II. SUMMARY OF PERFORMANCE

In this second six-month monitoring period, covering April 1 to September 30, 2017,[4] DSS has made ongoing efforts in the context of its existing capacity and operational framework to comply with FSA requirements. DSS continued to manage the work required by the FSA through statewide workgroups focused on specific areas of practice, with workgroup chairs and state leadership coming together on a regular basis. There is also a small but dedicated Internal Monitoring Team that is a conduit for the work of the Co-Monitors and their staff and is responsive to Co-Monitor requests for information. DSS also has plans to broaden its overall leadership team by adding two new senior positions to its Child Welfare Division; it recently hired a new Director of Permanency and is in the process of hiring a Director for its new Office of Health and Wellbeing.

During this monitoring period, DSS maintained its early success in reducing the number of children ages six and under residing in congregate care facilities, placing them instead in family foster homes. DSS performance improved in some other areas measured by the FSA as well. A greater percentage of children visited with their siblings in foster care this period, and DSS practice related to screening decisions and investigation findings of referrals alleging abuse and/or neglect in out-of-home care has improved.

Nevertheless, as the data and information included in this report show, too little has changed for the children, youth and families served by South Carolina's child welfare system in the two and half years since entry of the Interim Order. DSS has urgent work ahead to improve its performance with respect to nearly all of the FSA measures. In many areas in which reform work should be underway, there remains a need for decisive actions and for additional capacity to plan and carry out reforms. The lack of accessible and nurturing placement resources throughout the state has meant that many children who have already endured the trauma of being removed from their homes are often placed far from their families, schools and communities in settings that are neither stable nor appropriate to their needs. Persistently high caseloads, well above acceptable standards, have left children in the care of caseworkers without the time, training and resources to ensure their safety, well-being and permanency. As exemplified in DSS's Out of Home Abuse

[3] Pursuant to FSA III.K., "The Co-Monitors shall not express any conclusion as to whether the Defendants have reached legal compliance on any provision(s)."

[4] The first monitoring report covered the period October 1, 2016 to March 31, 2017. See *Michelle H. et al. v. McMaster and Alford, Progress of the South Carolina Department of Social Services, October 1, 2016 – March 31, 2017.*

and Neglect unit (OHAN), such high caseloads make it exceedingly difficult, if not impossible, for DSS to follow through on improving the quality of practice. And for the vast majority of children, entry into foster care means that they have limited or no contact with their parents, even when the goal is for them to return home.

DSS staff have devoted considerable time and effort to working on the Implementation Plans required by the FSA, but frequently with inadequate results due to capacity issues. In response to the concerns and recommendations included in the Co-Monitors' first monitoring report, DSS began work with two external consultant groups. By agreeing to the Co-Monitors' retention of outside health care consultants (Kathleen Noonan and Gail Nayowith) and an audit of Child and Adult Protective Services System (CAPSS)[5] data system by national experts, DSS leadership has demonstrated an awareness of the need for additional support in building an understanding of and addressing two key issues (health care delivery and data quality) that underlie the problems identified in the FSA. There is currently positive momentum toward finalizing a Health Care Improvement Plan based on the consultants' recommendations. Constructive work is also just beginning with Chapin Hall at the University of Chicago on a data audit, which will hopefully result in changes to CAPSS and to data entry processes within DSS to allow for the production of accurate data for management and accountability purposes.

In many critical areas, however, DSS Implementation Plans are long outstanding. DSS's Workload Implementation Plan, required to be completed by December 5, 2016, has not been fully approved due to barriers in data collection, as well as a continued lack of specificity about the content of budget requests, sequencing and strategies for resource development. The Placement Needs Implementation Plan is now estimated to be completed at the end of March 2018, two years past the original FSA deadline. This delay has left the severe inadequacies in DSS's placement capacity and placement processes largely unaddressed and has left private providers – many of whom are willing and eager to work with DSS on the transformation of the placement array – without direction or appropriate contracts. Too many children remain placed in congregate care facilities that do not offer the treatment services they need. In some cases, children remain in juvenile justice detention because there is an inadequate array of placements and services to support them in the community. In addition, DSS has not been able to finalize its Visitation Implementation Plan, to be completed under the FSA by December 5, 2016, because of data validity issues that prevented clear identification of which children in its care currently have permanency goals of reunification. Finally, though DSS has demonstrated a commitment to moving its Health Care Improvement Plan forward at an increased pace due to the technical assistance and support provided by the health care consultants, significant work remains to produce a plan and move it to implementation. Most urgently, DSS needs to partner with the

[5] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).

South Carolina Department of Health and Human Services (DHHS) and its Managed Care Organization (MCO), Select Health, to find a way to comply with the FSA provision for identifying children in need of medical care, originally intended as a short-term emergency measure to be completed immediately after the entry of the FSA.

In the Co-Monitors' view, DSS's response to children and families reflects a system driven by crisis and that fails to offer many children the stability and supports they need to promote and sustain their well-being. The deep-seeded problems that led to the entry of the FSA remain, profoundly impacting the lives of children, youth and families throughout South Carolina. As reported in the last monitoring period, these are problems that cannot be resolved without a major shift in operations, an influx of significant resources and an expansion of system capacity. The Co-Monitors are increasingly concerned that, despite what they believe to be good intentions and earnest efforts of leadership, DSS still must solidify a vision and overall strategy for the type of broad-scale reform that will move it forward in a meaningful way.

In the last monitoring report, the Co-Monitors identified some themes that emerged in their initial work with DSS, as well as recommendations for actions DSS could immediately take to address them. These themes remain relevant and outlined below is an update on DSS's progress in each of these areas.

The Need for a Broader Reform Vision

As reported previously, and consistently discussed with DSS, the work to improve performance with respect to specific FSA measures will ultimately not be successful unless it is guided by and embedded within an overarching reform vision, and framed by a model of practice that reflects DSS's values, goals and principles. This vision needs to be consistently understood, enunciated and reflected in the operations and practices of DSS staff at all levels, as well as by external partners, including parents, private providers, community-based resource providers, judges, attorneys and guardian *ad litems*, who need to be brought together to plan for and drive system transformation.

The Co-Monitors have previously emphasized the foundational importance of a case practice model. In the Co-Monitors' view, DSS is still very much in need of a fully developed model of case practice, and the work to create and implement one must be accelerated. In discussions with stakeholders, DSS caseworkers and facility staff throughout the state, the Co-Monitors have seen little evidence of a shared vision for what is expected in order to meet the permanency, well-being and, in some instances, even the safety needs of the children and families served by DSS. DSS has taken some initial steps and has reported for over a year now that a model is under development, but implementation of a practice model seems to be one of many discrete tasks to

which DSS's already overburdened state and mid-level managers have been assigned and cannot decisively pursue. Despite initial efforts, DSS's work has just scratched the surface and represents very beginning steps; there is not yet a robust and well-articulated model that structures how caseworkers understand and carry out their roles and that forms the foundation of ongoing reform work. Once developed, leadership at all levels must demonstrate commitment to the case practice model's tenets and to disciplined implementation that builds caseworker and system capacity, ensures fidelity and ultimately achieves better outcomes for children, youth and families.

DSS Capacity and Resources

DSS's Internal Monitoring Team are the primary DSS staff driving the work to meet the requirements of the FSA which often seems disconnected from a vision for overall reform in the field. The dedicated staff includes an Internal Class Action Lawsuit Monitor and a Data Coordinator, and was expanded to include a Program Improvement Consultant with extensive child welfare experience in February 2018. Recognizing the need to develop more resources focused on reform, DSS took additional steps this period to reorganize its child welfare division so that responsibilities for core areas of practice can be spread across a broader leadership base. A Director for the newly created Office of Permanency has already begun in the role, and DSS is in the process of hiring a Director for a new Office of Health and Wellbeing. The Co-Monitors are supportive of this plan.

There is still a long way to go before DSS will have the resources and internal capacity needed to intensively drive reform. With very few exceptions, the practice staff responsible for implementation of reform efforts are still also responsible for day-to-day child welfare operations and have roles that are already complex, demanding and time consuming. DSS needs to move expeditiously to define the roles and responsibilities for its new positions and to hire appropriately qualified staff. But, also – and most critically – it must be able to articulate how these new offices and positions will support a broader reform vision in the field and with external partners.

Over the past two years, DSS has received additional funding from the Governor and legislature for hiring new workers and has moved forward on a salary study to support improved salaries and ultimately staff retention. However, due to increased reports of alleged child abuse and neglect and expanded intake following statewide implementation of DSS Intake Hubs, and continued high turnover among frontline staff, caseloads that had begun to decline in late 2016 and early 2017 are now back to 2015 levels. Though DSS recognizes the need to move swiftly to hire and train additional qualified staff, the Co-Monitors have not seen a clear operational plan for recruiting, onboarding, training, supporting and retaining these caseworkers. In addition,

despite repeated requests by the Co-Monitors, and a directive by the Court, DSS reports working on but has not yet completed a detailed, cohesive overall budget plan to support the type of multi-year, broad-scale reform it needs to undertake.

Creating a Functional Data and CQI Infrastructure

DSS remains in need of a functional infrastructure to support its child welfare work. This includes systems for collecting and utilizing reliable data for management and operations. Despite the efforts by a small group of hard-working data staff, issues with the quality of documentation and the integrity of CAPSS data remain pervasive. After months of work, and although some improvement has been made, DSS still cannot accurately track health care delivery or needed follow up for the children in its care, reliably identify children's permanency goals or readily access the full history of abuse or neglect investigations by provider. Even its documentation of caseworker visits with children – an area of practice DSS has long held out as a bright spot – is tentative at best.

Though DSS has spent time and resources addressing identified issues with respect to particular data elements, progress has been limited and unsustainable given the lack of mechanisms for ongoing oversight and accountability for data entry. The Co-Monitors are pleased that DSS was receptive to its recommendation that it engage an external consultant to perform a data audit, including an assessment of CAPSS architecture and data reliability. As of late February 2018, DSS has entered into a contract with Chapin Hall at the University of Chicago (one of the two external groups recommended by the Co-Monitors) with partial support from Casey Family Programs, a national foundation that focuses on child welfare outcomes. DSS reports that it has requested additional resources in its FY2018-2019 budget request, which was approved by the Governor, including funds for information technology resources and staff to monitor data integrity.

As recommended in the prior monitoring report, it will also be essential that DSS develop a robust Continuous Quality Improvement (CQI) process that is closely tied to agency management, and that can provide quantitative and qualitative information for managers, supervisors and frontline caseworkers on the effectiveness of their work. Although DSS has long reported that work in this area is under development, its entire CQI function rests now with one DSS staff member and the University of South Carolina Center for Child and Family Studies (USC CCFS)[6], both of whom are largely disconnected from other equally siloed data accountability and quality assurance functions, and without linkage to a broader vison for reform.

[6] DSS contracts with the University of South Carolina Center for Child and Family Studies to complete all required and necessary case reviews and quality assurance activities, most not related to the FSA.

III. MONITORING ACTIVITIES

The Co-Monitors are responsible for factual investigation and verification 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; independent review of individual electronic and hardcopy case records; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external stakeholders, including youth, foster parents and community organizations. For this period, the Co-Monitors conducted site visits to five local DSS offices, where they met with managers and frontline staff, and to six congregate care facilities throughout the state where they met with staff and some youth.

The FSA gives the Co-Monitors the responsibility to review and approve plans and to set or approve interim benchmarks and outcomes in multiple areas. The Co-Monitors have worked with DSS and USC CCFS to establish review protocols to gather baseline data and assess current practice and performance. In so doing, the Co-Monitors and their staff have assumed a technical assistance role in addition to a strict monitoring function, helping to build capacity in DSS and USC CCFS staff and connect its leaders and managers with people and resources from across the country. The Co-Monitors strongly believe that this type of ongoing collaboration will be critical to DSS's ability to successfully reform its child welfare system.

Finally, the Co-Monitors have been engaged with Plaintiffs to both understand their views of the problems the FSA is designed to address and to keep them informed of DSS's progress in meeting deliverables. Where required by the FSA, the Co-Monitors have elicited feedback from Plaintiffs and have worked with them to build consensus around the commitments that require consent by all Parties. As the Co-Monitors have discussed many times with the Parties, the Co-Monitors believe that open communication between Plaintiffs, DSS and the Co-Monitors is an important element of constructive planning and implementation under the FSA. A first informal meeting between the Parties occurred in February 2018. Going forward, the Co-Monitors have offered to structure subsequent meetings with the Parties to address emergent and unresolved issues related to FSA implementation.

IV. SUMMARY TABLE OF *MICHELLE H., et al. v. McMASTER and ALFORD* FINAL SETTLEMENT AGREEMENT PERFORMANCE

Table 1: Summary Performance on Settlement Agreement Requirements

Final Settlement Agreement (FSA) Requirements[7]	Final Target	October 2016 – March 2017 or Baseline Performance	April – September 2017 Performance
Workload Limits for Foster Care: A foster care Workload Limit must apply to every Caseworker and to every Caseworker's supervisor. DSS may identify categories of Caseworker or Supervisor or both and set a different Workload Limit for each category. (FSA IV.A.2.(b)&(c)) Approved Caseworker Limits:[8, 9] • OHAN investigator: 1 caseworker: 8 investigations • Foster Care caseworker: 1 caseworker: 15 children • IFCCS caseworker: 1 caseworker: 9 children • Adoption caseworker: 1 caseworker: 17 children • New worker: ½ of the applicable standard for their first 6 months after completion of Child Welfare Basic Approved Supervisor Limits: • For Foster Care, IFCCS and Adoption supervisors: 1 supervisor: 5 caseworkers • OHAN supervisors: 1 supervisor: 6 investigators	1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	OHAN caseworkers: As of September 25, 2017, no (0%) OHAN worker had a caseload within the required limit and all (100%) caseworkers had caseloads more than 125% over the limit. Foster Care caseworkers: As of September 25, 2017, 28% of foster care caseworkers had a caseload within the required limit and 59% of caseworkers had caseloads more than 125% over the limit.[10] IFCCS caseworkers: As of September 25, 2017, 10% of IFCCS caseworkers had a caseload within the required limit and 77% of

[7] The obligations for the workload study (FSA IV.A.1.), placement needs assessment (FSA IV.D.1.) and select placement limitations (FSA IV.D.2., 3. & H.1.) became operative as of September 28, 2015, when the Consent Immediate Interim Relief Order was entered. Therefore, the Interim Relief Order requirements are incorporated into the FSA.
[8] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[9] Caseload limits and methodologies to calculate performance for caseworkers 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, Adult Protective Services cases, families involved in child protective service assessments and children placed by ICPC. Performance for foster care caseworkers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) they serve to the total number of families (cases) of Non-Class Members they also serve. The total number should not exceed 15 children and cases.
[10] Performance includes both newly hired (completed Child Welfare Basic training within six months) foster care caseworkers and foster care caseworkers who had been employed for six months or longer. A standard of seven cases is applied to newly hired foster care caseworkers. Additionally, performance is calculated by applying the mixed caseload standard to applicable staff.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
			caseworkers had caseloads more than 125% over the limit.[11] <u>Adoption caseworkers:</u> As of September 25, 2017, 23% of adoption caseworkers had a caseload within the required limit and 62% of caseworkers had caseloads more than 125% over the limit.[12] <u>Newly hired caseworker caseloads:</u> As of September 25, 2017: 9% of newly hired foster care caseworkers had a caseload within the required limit.[13] 8% of newly hired IFCCS caseworkers had a caseload within the required limit.[14] None (0%) of the newly hired adoption caseworkers had a caseload within the required limit.[15]

[11] Performance includes both newly hired IFCCS caseworkers and IFCCS caseworkers who had been employed for six months or longer. A standard of five children is applied to newly hired IFCCS caseworkers.
[12] Performance includes both newly hired adoption caseworkers and adoption caseworkers who had been employed for six months or longer. A standard of nine children is applied to newly hired adoption workers.
[13] Performance assesses 44 newly hired foster care caseworkers who had completed Child Welfare Basic training less than six months before September 25, 2017.
[14] Performance assesses 12 newly hired IFCCS caseworkers who had completed Child Welfare Basic training less than six months before September 25, 2017.
[15] Performance assesses five newly hired adoption caseworkers who had completed Child Welfare Basic training less than six months before September 25, 2017.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable Workload Limit. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved***	Data are not available for this period.	Data are not available for this period.[16]

[16] Data for this measure were not available during the previous period as DSS indicated data clean-up in CAPSS was necessary to accurately reflect all supervisors who are managing caseworkers with Class Members on their caseload. After months of effort, DSS was finally able to produce relevant data to the Co-Monitors on March 8, 2018. Given the late production date, the Co-Monitors were unable to review and validate the data for inclusion in this report. The Co-Monitors anticipate reporting data for this measure in the next monitoring report.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Caseworker-Child Visitation: (FSA IV.B.2.&3.)	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.	Based on CAPSS data, monthly performance for caseworker visits to Class Members are below.[17] October 2016: 98% November 2016: 97% December 2016: 97% January 2017: 98% February 2017: 97% March 2017: 98%	Unable to determine current performance.[18]
	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.	Based on a CAPSS data, monthly performance for caseworker visits to Class Members in their placement are below. October 2016: 71% November 2016: 68% December 2016: 69% January 2017: 69% February 2017: 67% March 2017: 70%	Unable to determine current performance.[19]

[17] Co-Monitor staff completed a limited validation of these data, assessing only for frequency and location of visits, as described in Section VI of this Report. DSS appears to be meeting the caseworker visitation measures with respect to the frequency and location of caseworker-child visits. Plaintiffs have requested that the Co-Monitors perform a more in-depth review of visitation data and documentation in the future to assess the content of caseworker visits with children, based on their reading of the applicable FSA provisions.
[18] As discussed in Section VI, the Co-Monitors reviewed a sample of cases in which caseworker visits were required in September 2017. The Co-Monitors found that documentation was often inadequate, and it was not possible to discern in some cases whether a visit had occurred. Given these findings, the Co-Monitors were not able to validate CAPSS data produced by DSS with respect to these measures this reporting period.
[19] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Investigations – Intake: (FSA IV.C.2.)	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. ***Interim benchmark requirement – By September 2017, 75%***	Between August 1, 2016 and January 31, 2017, there were 128 referrals with decisions not to investigate involving a Class Member; 44% (56) of the screening decisions were determined to be appropriate.[20]	Monthly performance for screening decisions not to investigate determined to be appropriate: May 2017: 67% June 2017: 83% July 2017: 59% August 2017: 62% September 2017: 88%
Investigations – Case Decisions: (FSA IV.C.3.)	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. ***Interim benchmark requirement – By September 2017, 48%***	Between June and November 2016, there were 94 investigations with decisions to unfound; 47% (44) of these decisions were determined to be appropriate.	In September 2017, there were 38 investigations with decisions to unfound; 58% (22) of these decisions were determined to be appropriate.

[20] Performance data reflects screening decisions made by DSS's OHAN unit. DSS has represented to the Co-Monitors that all referrals of abuse and/or neglect in licensed foster homes, residential facilities and group homes across the state involving Class Members are received by or forwarded to OHAN for screening and investigation, as appropriate, and that screening decisions are not made by local office or Intake Hub staff. Additionally, performance data do not include those referrals determined 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 or through ICPC from another state or was the biological child of the caregiver).

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Investigations – Timely Initiation: (FSA IV.C.4.(a)) *Investigations – Contact with Alleged Child Victim* (FSA IV.C.4.(b))	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. 8. The 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. ***Interim benchmark requirement – By September 2017, 78%***	Between June and November 2016, of 107 applicable investigations, 78% (83) were timely initiated or had documentation supporting completion of all applicable good faith efforts.	In September 2017, of the 40 applicable investigations, 80% (32) were timely initiated or had documentation supporting completion of all applicable good faith efforts.[21, 22]

[21] Contact was made with the alleged victim child(ren) within 24 hours in 31 investigations and in one additional investigation, documentation supported completion of all applicable good faith efforts.

[22] 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 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Investigations – Contact with Core Witnesses (FSA IV.C.4.(c))	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. Core witnesses will vary from case to case and may or may not include the victim(s), Class Members, alleged perpetrators, reporter (if identified), identified eyewitness(es), other children in the placement, facility staff, treating professionals, and foster parents or caregivers as deemed to be relevant to the investigation. ***Interim benchmark requirement – By September 2017, 35%***	Between June and November 2016, of 107 applicable investigations, contact was made with all necessary core witnesses for whom there was no approved exception in 27% (29) of cases.	In September 2017, none (0%) of the 40 applicable investigations included contact with all necessary core witnesses during the investigation.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Investigations – Timely Completion: (FSA IV.C.4.(d-f))	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. 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. ***Interim benchmark requirement – By September 2017, 75%***	95% of applicable investigations received between June and November 2016 were appropriately closed within 45 days.	79% of applicable investigations received in September 2017 were appropriately closed within 45 days.[23]

[23] Of the 40 investigations received in September 2017, one investigation was excluded from the 45 day compliance measure as an extension request for 15 days was submitted and approved by the OHAN Director. Of the remaining 39 investigations, 34 investigations were completed within 45 days, however, reviewers determined that three of the investigations closed within 45 days were closed as unfounded prematurely in an effort to meet the 45 day requirement. Therefore, 31 of the 39 applicable investigations met the FSA standard.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause. 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. ***Interim benchmark requirement – By September 2017, 80%***	96% of applicable investigations received between June and November 2016 were appropriately closed within 60 days.	88% of applicable investigations received in September 2017 were appropriately closed within 60 days.[24]

[24] Three investigations were determined to be closed prematurely in an effort to meet the deadline and are not considered compliant.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days. 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. ***Interim benchmark requirement – By September 2017, 95%***	All investigations received between June and November 2016 were completed within 60 days; therefore, this measure was not applicable this period.	93% of applicable investigations received in September 2017 were appropriately closed within 90 days.[25]

[25] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Family Placements for Children Ages 6 and Under: Within sixty (60) days, DSS shall 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). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	11. No child age 6 and under shall be placed in a congregate care setting except with approved exceptions.	In March 2017, there were six children ages six and under in DSS custody and residing in a congregate care facility. The circumstances of five of those six children met an agreed upon exception for placement in congregate care.	In September 2017, there were four Class Members ages six and under in DSS custody and residing in a congregate care facility. The circumstances of one of those children met an agreed upon exception for placement in congregate care and approval was sought prior to the child's placement as per DSS directive.[26] Between April and September 2017, a total of nine Class Members ages six and under were placed in congregate care. The circumstances of five of these young children met an agreed upon exception.[27]

[26] Two of the children who did not meet an agreed upon exception were placed in a congregate care facility prior to entering DSS custody and the family court, when issuing the emergency removal (from the parents') custody order, also ordered that the children remain where they were.
[27] One of these placements was made in accordance with the process DSS put into place, requiring prior approval by the Child Welfare Director.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Phasing-Out Use of DSS Offices and Hotels: Within sixty (60) days, 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.)	12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Between November 28, 2015 and March 31, 2017, DSS reports three children remained overnight in a DSS office.	Between April 1, 2017 and September 30, 2017, DSS reports three children remained overnight in a DSS office.[28]

[28] Although reports of children sleeping in DSS offices and hotels is limited to these instances, the Co-Monitors are concerned about reports that children are being placed on an emergency, short-term basis in foster homes as a way of avoiding these overnight stays, cycling at times through a series of one-night stays in foster homes until an appropriate placement can be located.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Congregate Care Placements: (FSA IV.E.2.)	13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. ***DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.***	In March 2017, 78% (3,223 of 4,124) of all children in foster care were placed outside of a congregate care setting.	As of September 30, 2017, 79% (3,225 of 4,079) of children in foster care were placed outside of a congregate care setting.[29, 30]

[29] DSS data reports do not indicate whether a child's placement in custody is voluntary or involuntary. Although the Co-Monitors have worked with DSS to manually correct for this coding issue with respect to a number of measures, it is possible that, in some instances, such as here and other placement measures discussed in this report, a small number of Non-Class Members are included in aggregate data. The Co-Monitors hope to be able to fully distinguish between Class and Non-Class Members in the future, as DSS develops its data capacity in this area.

[30] Thirty-six children who were hospitalized (16) or in a correctional/DJJ facility (20) were removed from the universe for this measure.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Congregate Care Placements – Children Ages 12 and Under: (FSA IV.E.3.)	14. At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. ***DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.***	In March 2017, 91% (2,630 of 2,905) of children ages 12 and under in foster care were placed outside of a congregate care setting.[31]	As of September 30, 2017, 93% (2,655 of 2,866) of children ages 12 and under in foster care were placed outside of a congregate care setting.[32]

[31] Exceptions to this standard have not yet been approved by the Co-Monitors; therefore, analysis of performance does not consider any exceptions.
[32] Exceptions were recently approved, though not applied during this monitoring period. DSS will develop a process for review and approval.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Emergency or Temporary Placements for More than 30 Days: (FSA IV.E.4.)	15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions subject to the Co-Monitors' approval, 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 under Section IV.F.1 below. ***DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.***	Data are not available for this period.	Data are not available for this period.[33]

[33] The Co-Monitors have not been provided with data for this measure. DSS has indicated that creation of a code book of definitions describing each level of foster care is needed to collect accurate data for this measure and anticipates completion of this code book by December 1, 2019.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Emergency or Temporary Placements for More than 7 Days: (FSA IV.E.5.)	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. 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 under Section IV.F.1 below. ***DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.***	Data are not available for this period.	Data are not available for this period.[34]

[34] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Placement Instability: (FSA IV.F.1.)	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.	Data are not available for this period.	Children in foster care for eight (8) days or more from October 1, 2016 to September 30, 2017, experienced instability at a rate of 3.55.[35, 36]

[35] Specifically, there were a total of 5,186 moves and 1,459,138 total applicable days.

[36] It should be noted that performance based on the FSA placement instability measure is not comparable to performance with respect to the federal Round 3 Child and Family Services Review (CFSR) permanency outcome that measures stability of foster care placement. The CFSR outcome is based on the rate of placement per day of *all* children who enter foster care in a 12-month period, which is likely to be significantly higher than the rate of placement for *all* children in foster care during that period of time. See *Data Indicators for the Child and Family Services Review*, available at https://www.acf.hhs.gov/sites/default/files/cb/data_indicators.pdf.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Sibling Placements: (FSA IV.G.2.&3.)	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 one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	As of January 1, 2017, 70% of children in care 30 days or longer were placed with at least one of their siblings.	64% (484 of 754) of children entering foster care with their siblings or within 30 days of their siblings from April 1 to September 30, 2017 were placed with at least one of their siblings.[37]

[37] Currently, the reported universe of children in foster care includes both Class Members and Non-Class Members. DSS would have to manually remove children placed voluntarily from the universe. The Co-Monitors anticipate being able to report on this measure for Class Members only in the future.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	As of January 1, 2017, 37% of children in care 30 days or longer were placed with all of their siblings.	As of September 30, 2017, 41% (310 of 754) of children entering foster care with their siblings or within thirty (30) days of their siblings from April 1 to September 30, 2017, were placed with all of their siblings.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Youth Exiting the Juvenile Justice System: (FSA IV.H.1.)	20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement.	The Interim Order requirement that prohibited the maintenance of youth in Juvenile Justice Placements took effect on September 28, 2015. Between September 28, 2015 and March 31, 2017, DSS has reported that it is aware of two youth who were held in detention awaiting an available DSS placement. DSS has acknowledged, however, that it does not yet have a reliable system in place for tracking compliance with this provision so this may be an underrepresentation of actual incidences.	Unable to determine current performance.[38]

[38] DSS has continued to represent that youth are immediately taken into the physical custody of DSS upon exit from juvenile justice placement in almost all instances, and reports no violations of the FSA provision during this monitoring period. It has, however, continued to acknowledge that there is no system in place for tracking youth moving between the juvenile justice and child welfare systems. In the absence of available data, the Co-Monitors have connected with stakeholders throughout the state who work with DSS youth who are also engaged with the Department of Juvenile Justice (DJJ). Many have described serious concerns about the lack of available placements for these youth, and the ways in which this impacts time spent in DJJ facilities. The Co-Monitors have received numerous reports of dually involved youth who have been maintained in DJJ placement after DSS represented to either DJJ or the court that it could not find them an appropriate placement, and many stakeholders describe attempts by DSS to transfer to DJJ the responsibility for youth with significant behavioral needs or youth who require a higher level of care. As a result, the Co-Monitors continue to have very serious concerns in this area and suspect that violations of the applicable FSA provision did, in fact, occur in this monitoring period.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Therapeutic Foster Care Placements –Referral for Staffing and/or Assessment: (FSA IV.I.2.)	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. This requirement shall not apply if the Caseworker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[39]

[39] DSS has informed the Co-Monitors that data for this measure are not currently available as fields need to be added to CAPSS to capture and collect necessary information. The Co-Monitors anticipate that sufficient information regarding methods to develop and implement data collection for analysis and monitoring will be included in the final Placement Implementation Plan.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Therapeutic Foster Care Placements –Receipt of Recommendations for Services or Placement: (FSA IV.I.3.)	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. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members.	Data are not available for this period.	Data are not available for this period.[40]

[40] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.		
Therapeutic Foster Care Placements – Level of Care Placement: (FSA IV.I.4.&5.)	23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[41]

[41] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
	23.b. At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[42]

[42] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Family Visitation – Siblings and Parents : (FSA IV.J.2.&3.)	24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors. ***DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.***	47% of children in foster care as of March 31, 2017, visited with all siblings with whom they were not placed in the month of March. In March 2017, 55% of all required visits between siblings occurred for siblings who were not placed together.	60% of children in foster care as of September 30, 2017, visited with all siblings with whom they were not placed in the month of September.[43] In September 2017, 66% of all required visits between siblings occurred for siblings who were not placed together.[44]

[43] Data were collected during a review conducted by USC CCFS and Co-Monitor staff of a statistically valid random sample based on a 95% confidence level and +/- 5% margin of error. Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

[44] In an effort to match measurement with the FSA methodology for this measure, data collected during the case record review referenced above were utilized for the first time this period to reflect the percentage of *required visits* between siblings that occurred in the month reviewed. Since the data sample identified for review was calculated based on the number of applicable children, these data do not have the same level of statistical validity as the data discussed above. The Co-Monitors will work with DSS and USC CCFS in the next monitoring period to determine whether a sample pull based on applicable visits is possible. For comparison purposes, performance utilizing this methodology was also calculated for the prior period (October 2016 – March 2017) and is included herein.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 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 (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	12% of children in foster care as of November 30, 2017 with a goal of reunification visited twice with the parent(s) with whom reunification was sought in the month of November.[45]

[45] Data were collected during a review conducted by USC CCFS and Co-Monitor staff of a statistically valid random sample based on a 95% confidence level and +/- 5% margin of error. Permanency goals were identified utilizing data in the CAPSS field in which caseworkers are expected to update case goals in accordance with the most current determination in legal proceedings. Although outside of this monitoring period, November 2017 data were selected for review to allow time for data clean-up efforts to occur.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Health Care Improvement Plan – Initial Health Assessment: By the end of sixty (60) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members who have been in DSS custody for more than sixty (60) days as of the date of final court approval of the Final Settlement Agreement, and who have not had initial health assessments (physical/medical, dental or mental health). (FSA IV.K.4.(a))	26. Within thirty (30) days after the identification period, Defendants shall schedule the initial health assessment for at least 85% of the identified Class Members. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Physical/medical assessment: Of the 168 children identified as needing an assessment, 10% (16 children) received the necessary assessment by January 5, 2017. Dental assessment: Of the 690 children identified as needing an assessment, 15% (102 children) received the necessary assessment by January 5, 2017. Mental Health assessment: Of the 740 children identified as needing an assessment, 6% (42 children) received the necessary assessment by January 5, 2017.[46]	Data for this measure are not available.[47]

[46] Calculation of performance data for this measure required numerous rounds of data clean-up and validation by DSS, USC CCFS and Co-Monitor staff. Reported performance reflects final analysis by DSS which was provided to the Co-Monitors on September 4, 2017.

[47] As part of their review, and in response to the Co-Monitors' ongoing concerns about the inaccuracy of DSS health care data, the health care consultants retained by the Co-Monitors evaluated DSS's systems for the collection of data relevant to this measure and concluded that the data are unlikely to be accurate. The consultants made a number of recommendations to DSS in their Findings and Recommendations Report (Appendix C), including immediate steps it believed DSS should take to access health care data already collected by DHHS and Select Health, the MCO that manages the health care of all children in foster care in South Carolina. DSS quickly began to follow up on these recommendations and has recently received an initial data production from DHHS, which captures some basic screening and assessment data for all children who were in foster care in CY2017. The consultants are working with DSS to analyze these data and to determine how this type of reporting can be used to measure progress in this area going forward.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[7]	**Final Target**	**October 2016 – March 2017 or Baseline Performance**	**April – September 2017 Performance**
Health Care Improvement Plan – Immediate Treatment Needs: By the end of ninety (90) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.) (FSA IV.K.4.(b))	27. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[48]

[48] DSS does not yet have a process for accurately tracking the immediate treatment needs of the children in its care. In their Findings and Recommendation Report (Appendix C), the Co-Monitors' health care consultants concluded that, as with data related to initial screenings and assessments, the process DSS has developed for tracking immediate treatment needs data is not likely to produce reliable data. The consultants have made recommendations for the use of data already collected by DHHS and Select Health to identify and track progress with respect to immediate treatment needs. DSS is in the process of integrating this feedback into its Healthcare Improvement Plan, and the Co-Monitors and consultants will closely monitor progress.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Workload Study for Foster Care DSS shall design, conduct and complete a foster care Workload Study that applies to every Caseworker and to every Caseworker's supervisor and adopt one or more Workload Limits for foster care within 180 days (dates and obligations became operative as of September 28, 2015). The foster care Workload Study must be approved by the Co-Monitors before it is conducted. The results of the Workload Study must also be approved by the Co-Monitors before they are adopted by DSS. Each Workload Limit must be approved by the Co-Monitors before it is adopted. (FSA IV.A.1.)	Completion of Workload Study by March 28, 2016.	DSS began work in August 2015 to address concerns with caseloads. A Workload Estimation Workgroup was chartered to research best practice and develop recommendations for reducing caseloads. DSS collaborated with Casey Family Programs[50] to develop and conduct a workload estimation study which was approved by the Co-Monitors on February 22, 2016. The study examined best practices and caseload limits in other states and conducted a time study. Based upon caseworker type, the study estimated time needed for specific activities and the amount of time caseworkers have available. An initial workload study report was submitted to the Co-Monitors on March 28, 2016 and a more complete copy of the study findings and recommendations on October 21, 2016.

[49] In some instances, information in this Table reflects the status of actions as of the date of this report.

[50] Casey Family Programs is an operating foundation, working nation-wide to influence long-lasting improvements to the safety and success of children, families and the communities where they live, focused on safely reducing the need for foster care with a mission to provide and improve – and ultimately prevent the need for – foster care. https://www.casey.org/about/

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
	Adoption of Workload Limits for Foster Care by March 28, 2016.	On December 6, 2016, the Co-Monitors approved workload limits by establishing the following caseload standards for caseworkers and supervisors: Caseworker Limits: • OHAN investigator – 1 caseworker: 8 investigations • Foster Care caseworker – 1 caseworker: 15 children • IFCCS caseworker – 1 caseworker: 9 children • Adoption caseworker – 1 caseworker: 17 children[51] • New caseworker – ½ of the applicable standard for first six months after completion of Child Welfare Basic training. Supervisor Limits: • Foster Care, IFCCS and Adoption supervisors – 1 supervisor: 5 caseworkers • OHAN supervisors – 1 supervisor: 6 investigators[52] Although the caseload limits have been approved by the Co-Monitors for over a year, the methodologies to calculate performance for these limits were not provisionally approved until December 2017. In addition to calculating performance for caseworkers servicing a single type of case, a standard and methodology was needed for caseworkers who have Class and Non-Class Members[53] on their caseload. See Section V of this report for a more detailed discussion of the approved mixed caseload standard and methodology.

[51] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption caseworkers is not within the standard proffered by the Council on Accreditation, as DSS is currently structured, case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until parental rights have been terminated. Given that DSS adoption caseworkers may therefore have less direct casework responsibilities than in some other jurisdictions, the Co-Monitors accepted the proposed caseload limit for adoption caseworkers. If DSS's structure were to change so that adoption caseworkers have more case management responsibility for assigned children, the Co-Monitors would expect a proposed modification to the caseload standard.

[52] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition that those caseworkers will have lower caseloads than other direct service caseworkers.

[53] Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, Adult Protective Services cases, families involved in child protective service assessments and children placed by ICPC.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Implementing the Workload Limits for Foster Care: Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS 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.A.2.(a))	Completion of Workload Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS submitted a draft of the Workload Implementation Plan on November 30, 2016. Since that time, the Co-Monitors and Plaintiffs have provided feedback on several drafts and DSS has submitted revisions and modifications several times in response to comments. On December 21, 2017, in provisionally approving the mixed caseload methodology, the Co-Monitors informed DSS that they are prepared to approve the Workload Implementation Plan once the following are completed: (1) DSS provides reliable data on supervisory caseloads in order to set interim benchmarks and targets and (2) DSS includes more specificity in the Workload Implementation Plan on budget sequencing, requests and strategies to develop the resources needed to meet the caseload standards within four years. DSS has proposed interim benchmarks and targets in the draft Plan but these have not yet been approved.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Caseworker-Child Visitation Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS 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 the 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.B.1.)	Completion of Caseworker and Child Visitation Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	Given their findings regarding the inadequacy of documentation of caseworker visits, the Co-Monitors were not able to utilize CAPSS data produced by DSS with respect to these measures this reporting period. The Co-Monitors have provided feedback to DSS on data clean-up that will be required and plan to re-review relevant data in the next monitoring period, at which time a determination about the need for an Implementation Plan in accordance with FSA IV.B.1 can be made.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Investigation Implementation Plan Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS 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.C.1.)	Completion of Investigations Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS's OHAN Workgroup developed a plan for improving OHAN practice and DSS submitted a draft of the Investigation Implementation Plan on November 30, 2016. Since that time, there have been revisions and modifications based upon feedback from the Co-Monitors and Plaintiffs. On August 9, 2017, DSS submitted a version of the plan which the Co-Monitors approved on September 11, 2017 and Plaintiffs provided their consent to the plan on November 7, 2017. An update on implementation of the strategies within the Plan is attached as Appendix B.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Placement Needs Assessment Within one hundred twenty (120) days, DSS, with prior input from and subject to approval by the Co-Monitors, shall perform a statewide and regional foster care Placement Needs Assessment in order to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members. The needs assessment shall include specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address 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.)	Completion of Placement Needs Assessment, which includes findings and specific recommendations by June 30, 2017.	DSS submitted a report with data and findings from the Placement Needs Assessment to the Co-Monitors on August, 31, 2017. In late September 2017, the Co-Monitors requested that additional work be completed on placement projections, including adding an assessment of county needs versus regional needs so as to understand what will be needed to place children close to their home community and avoid school changes. In October 2017, written feedback from both the Co-Monitors and Plaintiffs were provided to DSS. In December 2017, the Co-Monitors provided additional written feedback to DSS. DSS reports that county level data will be provided by March 31, 2018, as part of the updated Placement Implementation Plan.

Table 2: Status of Implementation Plans and Assessments

Final Settlement Agreement (FSA) Requirements for Study and Plan Development	Final Target	Status of Implementation Plans and Assessments (as of September 31, 2017)[49]
Placement Implementation Plan Within sixty (60) days of the completion of the needs assessment, DSS shall develop an Implementation Plan to implement the recommendations of the needs assessment within eighteen (18) months. The Implementation Plan shall 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)) Placement Implementation Plan shall include strategies to address the following areas, with accompanying interim benchmarks and specific timelines: • Congregate Care Placements (FSA IV.E.1.) • Sibling Placement (FSA IV.G.1.) • Therapeutic Foster Care Placements (FSA IV.I.1)	Completion of Placement Implementation Plan, which includes interim benchmarks with specific timelines. Originally, the Interim Order required the Placement Implementation Plan to be completed by March 28, 2016 (60 days from January 28, 2016). The IO then required implementation of the recommendations in the Plan by September 28, 2017.	As presented above, DSS completed the Placement Needs Assessment on August 31, 2017. A draft Placement Implementation Plan was completed on October 31, 2017. The Co-Monitors have not yet approved a Plan and interim benchmarks and timelines. After reviewing the Plan and visiting congregate facilities, Co-Monitors provided verbal feedback, followed by written feedback to DSS on December 20, 2017. In order to incorporate the feedback, DSS informed the Co-Monitors that the next draft of the Plan will be submitted on March 30, 2018. Concurrent with the work to finalize an approved Placement Implementation Plan, there are a number of tasks that DSS should be aggressively moving forward, such as increasing recruitment of foster homes, improving the process in which foster parents apply and licenses are processed, streamlining processes for placement matching and decisions to improve efficiency, closely reviewing poor performing and inadequate or unsafe congregate care facilities, ensuring timely and appropriate contracts and collaborating with private providers to make the reform successful.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Plan for Family Placements for Children Ages 6 and Under: Within sixty (60) days, DSS shall 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). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	Completion of Plan to prevent placement of Class Members age six (6) and under in any non-family group placement by November 28, 2015.	Data indicate that DSS's processes to prevent the placement of any Class Member ages six and under in any non-family, group placement continue to work well. There has been a substantial reduction in the number of children ages six and under in congregate care. The circumstances of slightly over half of the young children (5 of 9) in congregate care this period met an agreed upon exception; one of these placements was made in accordance with the process DSS put into place, requiring prior approval by the Child Welfare Director.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Family Visitation – Siblings and Parent - Implementation Plan: Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS 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.)	Completion of Family Visitation Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS convened a Visitation Workgroup in October 2016 to assess systemic barriers to family visitation and develop and assist with the implementation of the Visitation Implementation Plan. DSS submitted a draft of the Visitation Implementation Plan on November 30, 2016 and upon receipt of feedback from the Co-Monitors and Plaintiffs, has completed several rounds of revisions and modifications. Many of the draft strategies center around increasing supervisory skills, revising policy and procedures, educating caseworkers, increasing foster parent participation and developing plans to reduce logistical barriers. The plan has not yet been approved by the Co-Monitors.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of September 31, 2017)[49]**
Health Care Improvement Plan: Within one hundred eighty (180) days, Defendants, with prior input from and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation and 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. With approval of the Co-Monitors and based on evidence of progress toward the development of the Health Care Improvement Plan, Defendants may request an extension of an additional sixty (60) days to complete the Plan. (FSA IV.K.1.)	Completion of Health Care Improvement Plan by March 31, 2017. On April 19, 2017, the Co-Monitors approved a 60 day extension, with an expected completion date of June 2, 2017. On June 1, 2017, DSS filed a Motion for Extension of Time, which was approved and extended the deadline to September 30, 2017.	After receiving an extension for preparation of its Health Care Improvement Plan pursuant to FSA IV.K.2., DSS submitted a draft report to the Co-Monitors on September 29, 2017. The Co-Monitors provided initial feedback, and in November 2017, engaged consultants with specific expertise in child welfare health care reform to assess the sufficiency of the Plan pursuant to FSA IV.K.3. The consultants' recommendations based on the results of validation activities and extensive interviews with key DSS, DMH, DHHS, MCO and community provider staff, were submitted in a Findings and Recommendations Report on February 12, 2018, attached as Appendix C. DSS is working closely with the consultants to make recommended changes to their Plan and expect to submit an updated version to the Co-Monitors by April 13, 2018. The consultants will also assist the Co-Monitors in identifying all final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services once the Plan is complete, as per Section IV.K.5. of the FSA, and progress will be reported in a later monitoring period.

V. CASELOADS

A sufficient, qualified and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Caseworkers must be given resources and support to allow them to conduct meaningful visits with children and families, assess for safety and risk and monitor progress towards individualized case goals, among many other important tasks. As discussed in performance data below, only about one-quarter of foster care and adoption caseworkers have caseloads within the required limits, and IFCCS and OHAN caseloads are substantially higher than the standards allow.

In January 2018, the DSS Director reported to the legislature that the turnover rate among DSS workers in 2016 was 30.3 percent. In an effort to improve retention, in October 2017, DSS announced incentive pay for employees who remain with the agency for a specific number of years, including one year, three years, five years, ten years, etc. The General Assembly has also approved tuition reimbursement for designated DSS staff who need assistance with educational degrees.

In Fiscal Year (FY) 2018, DSS requested and received funding for 163 new staff positions. Data provided to the Co-Monitors reflect that between July 1 and September 25, 2017, the following number of new caseworkers were hired and began accepting cases: 18 foster care caseworkers, two IFCCS caseworkers and three adoption caseworkers. The Co-Monitors are unable to determine the net addition of new caseworkers for Class and Non-Class Members; more information is required regarding vacancies, the rate at which vacancies are filled and posting and hiring for newly created positions. In addition, DSS has reported that the anticipated decline in caseloads from the hiring of new caseworkers in prior years has been offset by increased reports alleging child abuse and neglect and expanded intake staffing assignments following statewide implementation of DSS Intake Hubs. In combination with continued high turnover among frontline staff, this has meant that caseloads that had begun to decline in late 2016 and early 2017 are now back to 2015 levels.

A. Workload Implementation Plan

The FSA requires that by December 5, 2016, DSS develop an Implementation Plan to achieve the final FSA workload requirements. The Implementation Plan must 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)).

Over a year later, DSS still does not have a final, approved Workload Implementation Plan. DSS submitted an initial draft on November 30, 2016. Since that time, DSS has completed multiple

rounds of revisions and modifications in response to feedback by the Co-Monitors and Plaintiffs, but has been unable to produce a final Plan due to difficulties in establishing baseline data. The Co-Monitors approved workload limits for caseworkers and supervisors with single type caseloads on December 6, 2016. In current DSS practice, there are also caseworkers who carry mixed caseloads with more than one type of case on their caseload (for instance, a case involving a family with children in the home and a case involving a family with children in placement); a caseload standard and methodology for measuring compliance for these caseworkers was only recently provisionally approved by the Co-Monitors on December 21, 2017. Baseline data for establishing interim benchmarks are still not fully available, and as mentioned in the prior monitoring report, DSS needs to develop a more precise method to identify children needing Intensive Foster Care and Clinical Services (IFCCS) services[54,55] as well as supervisors managing IFCSS caseworkers with Class Members on their caseload.

In November 2017, DSS assembled an IFCCS Data Integration and Level of Care Workgroup. The workgroup has been charged with integrating current IFCCS databases into the CAPSS system to allow all client, placement and related services information to be centrally maintained; standardizing all forms, policies and procedures across regions; converting IFCCS specific "administrative directives" into child welfare policy; developing a mechanism to capture and track both funding eligibility and level of care determination criteria within CAPSS; and discussing "IFCCS on-boarding training" to allow for transfer of children on Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) "other lead" list[56] to IFCCS workers.

In provisionally approving the mixed caseload methodology, the Co-Monitors informed DSS that they are prepared to approve the Workload Implementation Plan once DSS completes the following: provides reliable data on supervisory caseloads in order to set interim benchmarks and targets; and includes more specificity on budget sequencing, requests and strategies to develop the resources needed to meet the caseload standards within four years. In their draft Plan, DSS estimated that they will need to hire 670 workers over a four year period to meet caseload standards. DSS has proposed interim benchmarks and targets in the draft Plan but due to delays discussed above, these have not yet been approved.

[54] Eligibility for IFCCS services is determined following a review of a child's mental health assessment(s) and diagnosis; frequency, intensity and duration of symptoms; multi-system involvement; and exhaustion of alternative services. IFCCS services utilize funding through SC's Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) to pay for treatment costs. ISCEDC funding are pooled dollars from multiple state agencies, including DSS, the Department of Mental Health, the Department of Disabilities and Special Needs, the Department of Juvenile Justice and the Department of Education.

[55] Currently, IFCCS children are identified by the office of the caseworker who manages them and possible siblings of children needing IFCCS services may be incorrectly assumed to be categorized as IFCCS. DSS committed to developing a method to identify therapeutic children (non-regular foster care) after an assessment to be managed by IFCCS. DSS had indicated that a plan to appropriately identify children needing IFCCS services in CAPSS would be complete by December 2017.

[56] The "other lead" list include children who are ISCEDC eligible and may be receiving ISCEDC services, however, they are not currently case managed by an IFCCS worker due to high IFCCS caseload levels.

B. 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)). There are different caseload standards dependent upon the types of cases a caseworker manages – foster care, IFCCS, adoption, investigations of allegations of abuse and/or neglect of a child in foster care. There are also reduced workload standards specific to newly hired caseworkers within their first six months of completing Child Welfare Basic training.

The calculation of the baseline performance for this measure was only recently possible due to complications in measuring compliance for caseworkers who have mixed caseloads. Ultimately, DSS plans to move as many caseworkers as possible to caseloads that include only one type of case, but there will continue to be caseworkers who have mixed caseloads because it makes sense from a practice or clinical perspective. For example, it may be appropriate for a caseworker to be assigned to the case of a family in which one or more children are in foster care and other children remain at home with family preservation (treatment) services, or where non-mixed caseloads are not feasible given staffing and the number of families served in some smaller counties.

On December 21, 2017, the Co-Monitors provisionally approved DSS's November 3, 2017 proposal to calculate caseloads for caseworkers 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 they also serve. The following types of cases will be counted by family (case): Child Protective Services (CPS) assessment; family preservation; other child welfare services and those involving a child subject to the Interstate Compact on the Placement of Children (ICPC). This methodology will only be applied to foster care caseworkers with mixed caseloads and will not be applied to caseloads for IFCCS and adoption caseworkers. In approving this mixed caseload methodology, the Co-Monitors relied upon DSS's commitments to: (1) move forward with plans to move caseworkers 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 caseworker assignment to multiple family preservation cases involving families with multiple children. DSS has indicated that managers will continually assess assignments to caseworkers with mixed caseloads to ensure balanced and manageable workloads. Because approval of this methodology is "provisional," DSS and the Co-Monitors will continually 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 performance data on caseloads discussed below were provided by DSS and have not been independently validated by the Co-Monitors. The Co-Monitors plan to work with DSS and the data audit consultants over the next monitoring period to ensure the accuracy of these data.

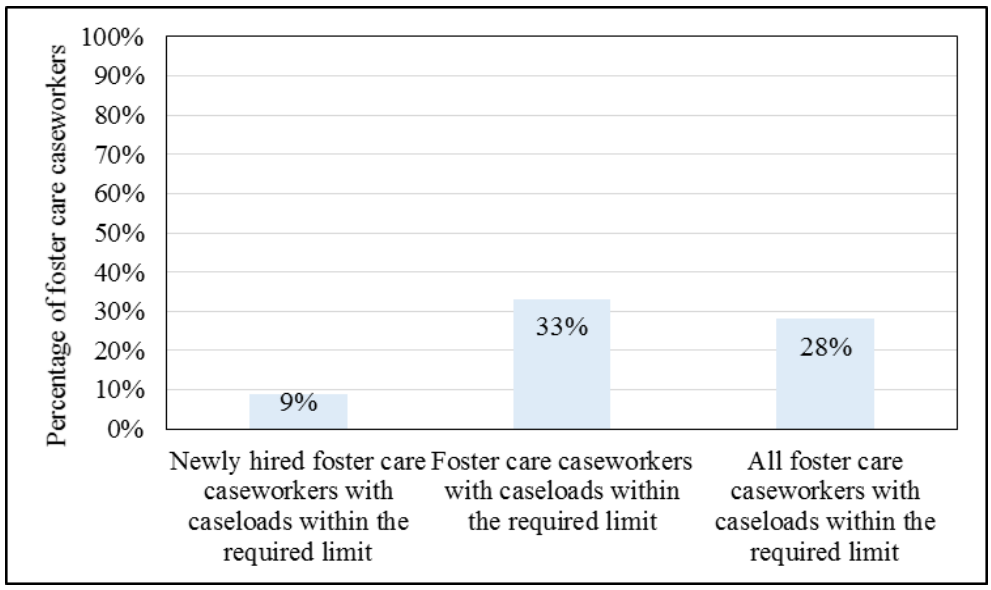
Foster Care Caseworkers

The caseload standard for caseworkers who are responsible for providing case management for foster care cases is one caseworker to 15 children (1:15). As of September 25, 2017, there were 230 foster care caseworkers with at least one foster care child on their caseload.[57] Of these 230 caseworkers, 65 (28%) foster care caseworkers had caseloads within the required limit (see Figure 1).[58] Additionally, 136 (59%) caseworkers' caseloads were more than 125 percent of the caseload limit.

Forty-four of the foster care caseworkers were newly hired workers, who had completed Child Welfare Basic training within the past six months. The caseload standard for newly hired foster care caseworkers is half of the foster care caseworker standard; therefore, newly hired foster care caseworkers should have no more seven foster care children or Non-Class families on their caseload. Of the 44 newly hired foster care caseworkers, nine percent (4 caseworkers) had seven or fewer cases as of September 25, 2017 (see Figure 1).

[57] This includes eight caseworkers designated as Adult Protective Services (APS) caseworkers who were case managing foster care children in addition to their adult clients, and 44 newly hired foster care caseworkers.
[58] In calculating performance, a standard of seven foster care children or Non-Class families is applied to newly hired caseworkers (half of the applicable caseload standard) and 15 foster care children or Non-Class families is applied to foster care or APS caseworkers.

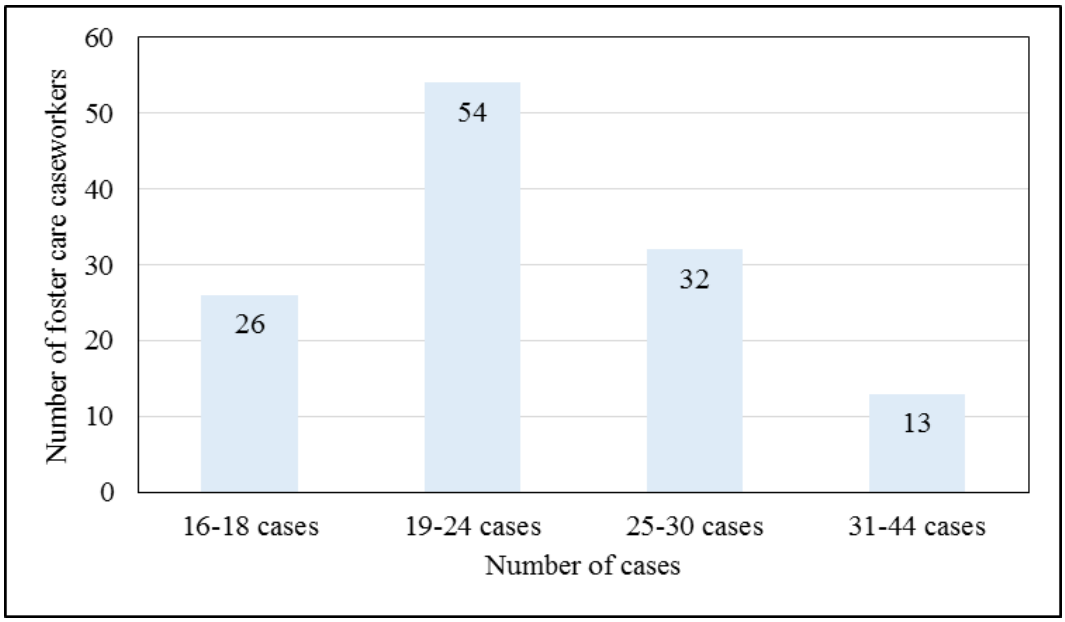
Figure 1: Foster Care Caseworkers within the Required Caseload Limits as of September 25, 2017
Newly hired caseworkers N=44
Caseworkers employed six months or longer N=186
All caseworkers N=230



Source: CAPSS Data Provided by DSS

As of September 25, 2017, the highest caseload for a foster care caseworker employed six months or longer was 44 cases. Figure 2 shows the range of caseloads for those foster care caseworkers who were over the required limit of 15 cases on that date.

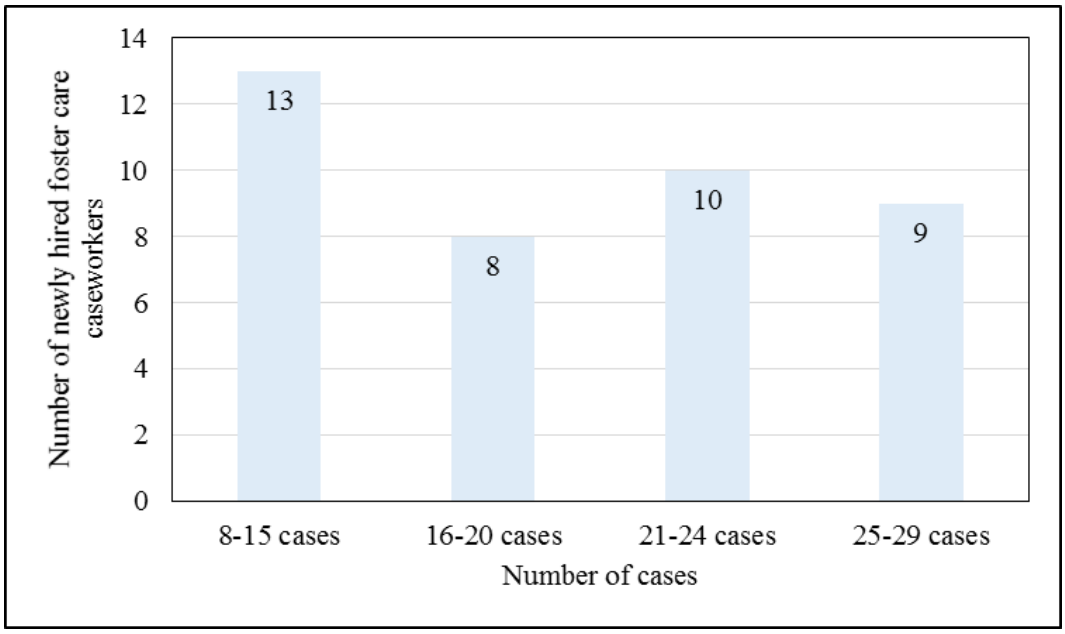
Figure 2: Caseloads of Foster Care Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017
N=125



Source: CAPSS Data Provided by DSS

The highest number of cases a newly hired foster care caseworker had on September 25, 2017 was 29 cases. The majority (68%) of newly hired foster care caseworkers had 15 or more cases. Figure 3 shows the caseload range for newly hired foster care caseworkers who were over the required limit of seven cases on that date.

Figure 3: Caseloads of Newly Hired Foster Care Caseworkers that were Over Limit as of September 25, 2017 N=40



Source: CAPSS Data Provided by DSS

IFCCS Caseworkers

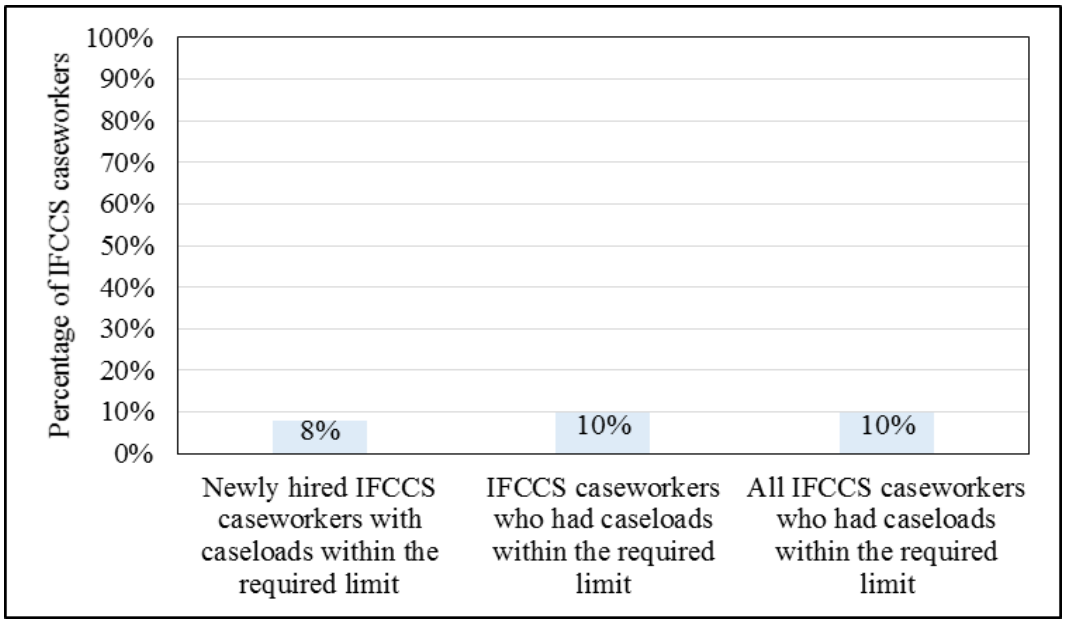
The caseload standard for caseworkers who are responsible for providing case management to children designated as needing Intensive Foster Care and Clinical Services (IFCCS) services is one caseworker to nine children (1:9). Newly hired IFCCS workers should not have more than five children on their caseload for six months after they complete Child Welfare Basic training.

As of September 25, 2017, there were 82 IFCCS caseworkers[59] serving at least one Class Member and eight (10%) of these caseworkers were within the required caseload limit (see Figure 4). Sixty-three (77%) caseworkers had caseloads more than 125 percent of the caseload limit.

Twelve of the IFCCS caseworkers were newly hired, and should have no more than five children on their caseload for six months following completion of Child Welfare Basic training. As of September 25, 2017, only one (8%) of the newly hired IFCCS caseworkers had five or fewer cases (see Figure 4).

[59] Total includes 12 newly hired IFCCS caseworkers; their caseload standard is five children.

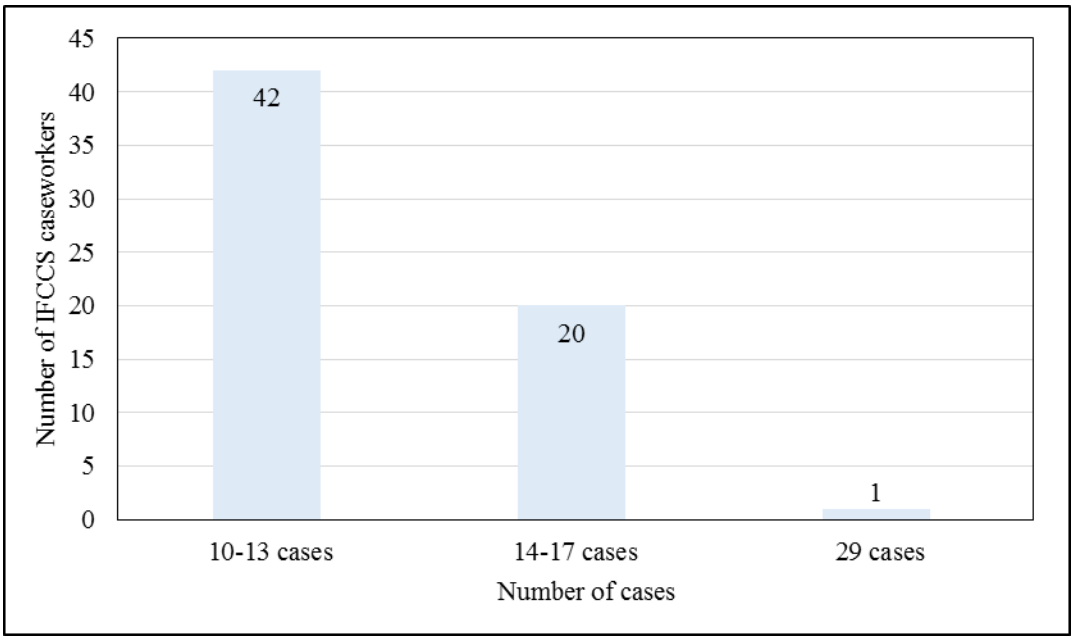
Figure 4: IFCCS Caseworkers within the Required Caseload Limits as of September 25, 2017
Newly hired IFCCS caseworkers N=12
IFCCS caseworkers employed six months or longer N=70
All IFCCS caseworkers N=82



Source: CAPSS Data Provided by DSS

As of September 25, 2017, the highest caseload for an IFCCS caseworker employed six months or longer was 29 cases. Figure 5 shows the range of caseloads for those IFCCS caseworkers who were over the required limit of nine cases on that date.

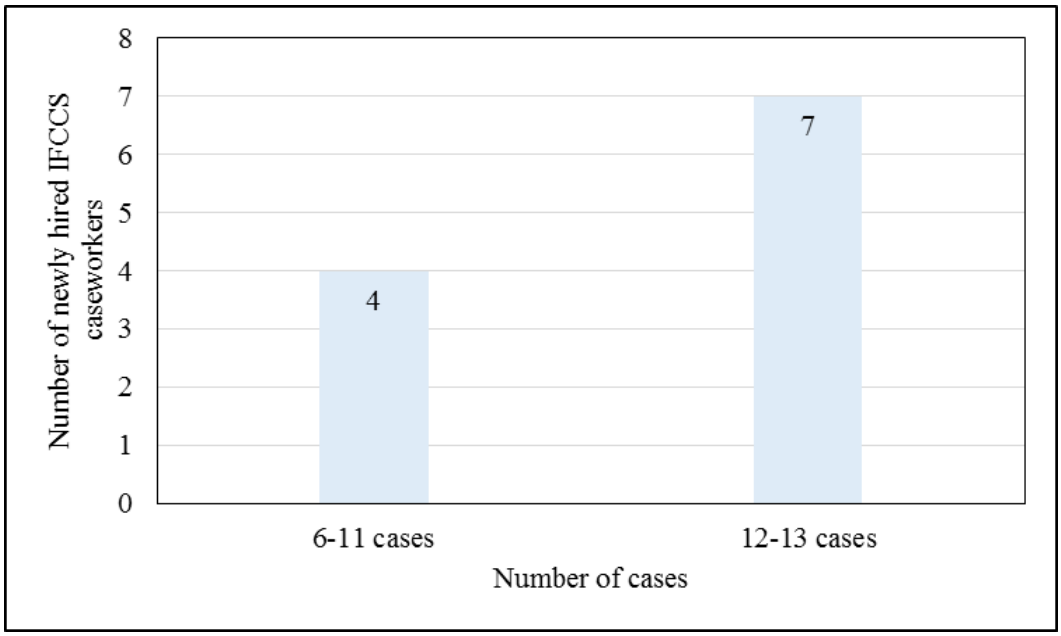
Figure 5: Caseloads of IFCCS Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017
N=63



Source: CAPSS Data Provided by DSS

The highest number of cases a newly hired IFCCS caseworker had on September 25, 2017, was 13 cases. The majority (92%) of newly hired IFCCS caseworkers had six or more cases. Figure 6 shows the caseload range for new IFCCS caseworkers who were over the required limit of five cases on that date.

Figure 6: Caseloads of Newly Hired IFCCS Caseworkers that were Over Limit as of September 25, 2017 N=11



Source: CAPSS Data Provided by DSS

Adoption Caseworkers

The caseload standard for caseworkers providing adoption support to children with a goal of adoption is one caseworker to 17 children (1:17).[60]

As of September 25, 2017, there were 73 adoption caseworkers[61] serving at least one Class Member. Of these 73 caseworkers, 17 (23%) caseworkers were within the caseload requirement and 45 (62%) caseworkers had caseloads more than 125 percent of the limit.

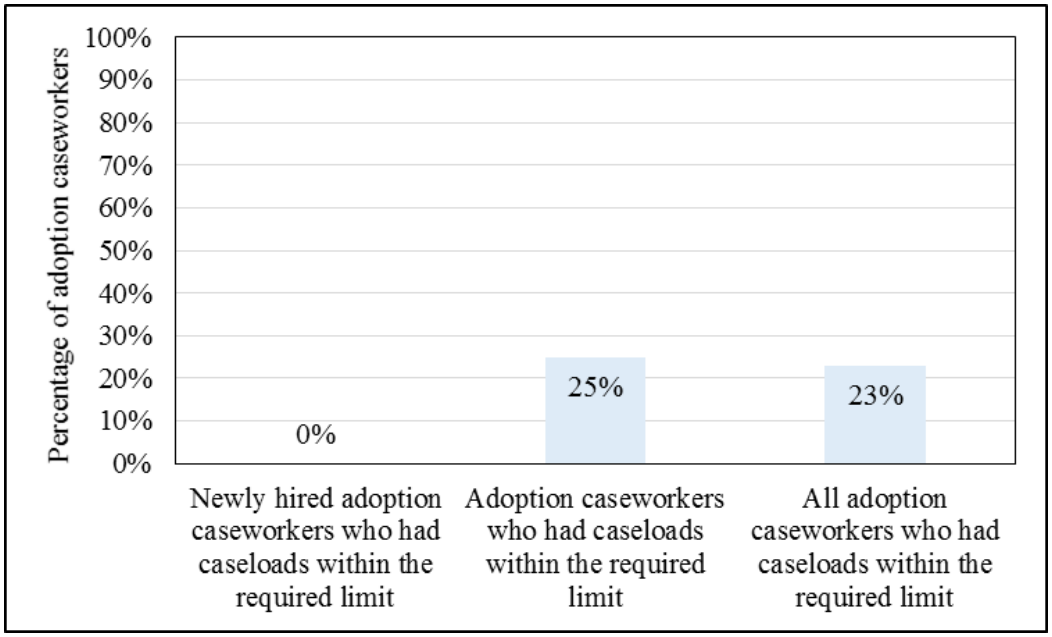
Five of the adoption caseworkers were newly hired, and should have no more than nine children on their caseload for six months following completion of Child Welfare Basic training. As of

[60] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption caseworkers is not within the standard proffered by the Council on Accreditation, as DSS is currently structured, case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until parental rights have been terminated. For example, as of September 18, 2017, of the 1,751 children who were on an adoption caseworkers' caseload, only 47 children (3%) were receiving primary case management from their adoption caseworker. Given that DSS adoption caseworkers may therefore have less direct casework responsibilities than in some other jurisdictions, the Co-Monitors accepted the proposed caseload limit for adoption caseworkers. If DSS's structure were to change so that adoption caseworkers have more case management responsibility for assigned children, the Co-Monitors would expect a proposed modification to the caseload standard.

[61] Total includes five newly hired adoption caseworkers; their caseload standard is nine children.

September 25, 2017, none (0%) of the newly hired adoption caseworkers had nine or fewer cases (see Figure 7).

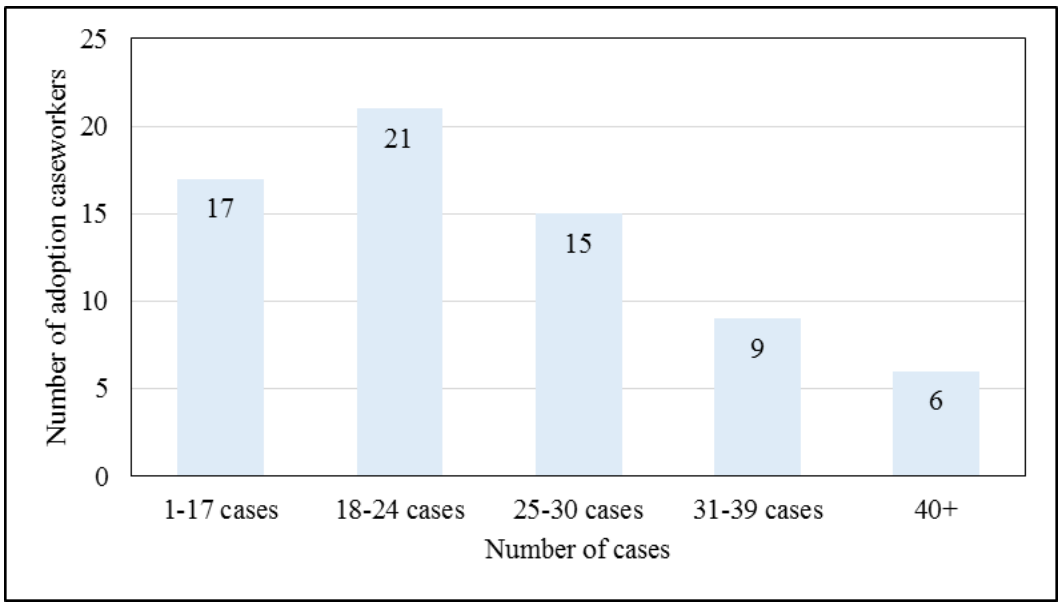
Figure 7: Adoption Caseworkers within the Required Caseload Limits as of September 25, 2017
Newly hired adoption caseworkers N=5
Caseworkers employed six months or longer N=68
All adoption caseworkers N=73



Source: CAPSS Data Provided by DSS

As of September 25, 2017, the highest caseload for an adoption caseworker employed six months or longer was 51 cases. Figure 8 shows the range of caseloads for those adoption caseworkers who were over the required limit of 17 cases on that date.

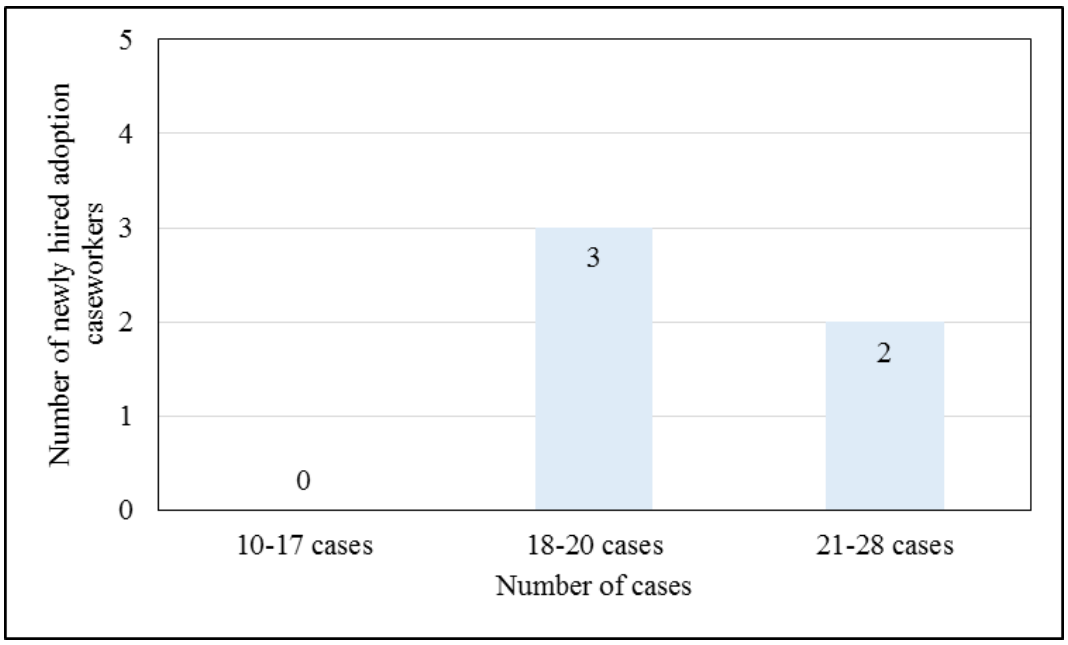
Figure 8: Caseloads of Adoption Caseworkers Employed Six Months or Longer that were Over Limit as of September 25, 2017
N=68



Source: CAPSS Data Provided by DSS

The highest number of cases a newly hired adoption caseworker had on September 25, 2017, was 28 cases. All five caseworkers had at least double the required limit. Figure 9 shows the range of caseloads for those newly hired adoption caseworkers who were over the required limit of nine cases on that date.

Figure 9: Caseloads of Newly Hired Adoption Caseworkers that were Over Limit as of September 25, 2017
N=5



Source: CAPSS Data Provided by DSS

OHAN Caseworkers

The caseload standard for caseworkers conducting investigations involving allegations of abuse and/or neglect of a child in foster care is one caseworker per eight investigations (1:8).

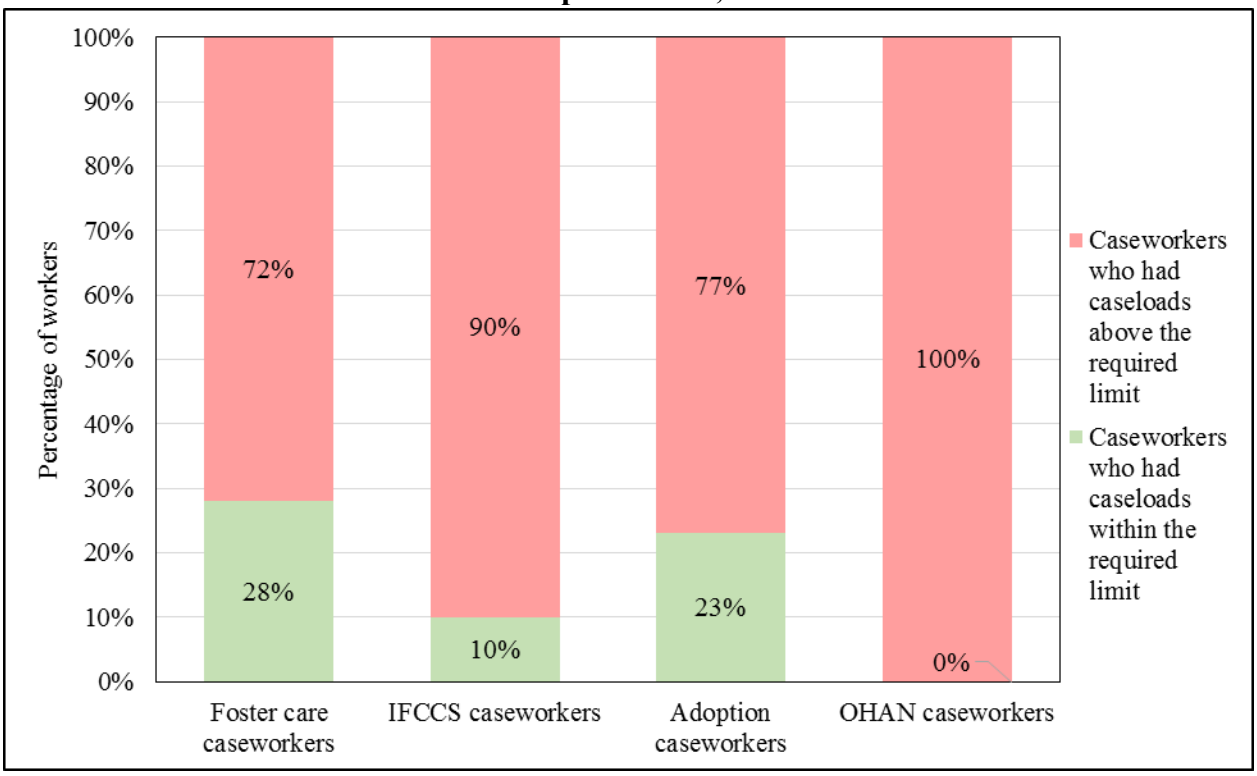
As of September 25, 2017, there were seven OHAN caseworkers investigating allegations of abuse and/or neglect. None (0%) of these caseworkers had eight or fewer investigations. As of that date, caseloads ranged from 14 to 27 investigations per worker.[62] All OHAN caseworkers' caseloads exceeded the standard by 25 percent or more. As discussed later in this report, although the data reflect that caseworkers of all types are currently overwhelmed, the Co-Monitors are particularly concerned about current OHAN caseloads given that its workers are

[62] One worker had 14 investigations, two caseworkers had 20 investigations, one worker had 21 investigations, one worker had 22 investigations, one worker had 24 investigations and one worker had 27 investigations.

responsible for ensuring the safety of children who are alleged to have been abused and/or neglected while in foster care.

In summary, Figure 10 reflects the percentage of foster care, IFCCS, adoption and OHAN caseworkers within and above the required caseload limits as of September 25, 2017.

Figure 10: Foster Care, IFCCS, Adoption and OHAN Caseworkers that were Above and Within the Required Caseload Limits as of September 25, 2017



Source: CAPSS Data Provided by DSS

Supervisors

The caseload standard for supervisors providing supervision to foster care, IFCCS and adoption caseworkers is one supervisor to five caseworkers (1:5). The standard for supervisors providing supervision to caseworkers conducting OHAN investigations is one supervisor to six investigators (1:6).[63]

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

Data for this measure were not available during the previous period as DSS indicated data clean-up in CAPSS was necessary to accurately reflect all supervisors who are managing caseworkers with Class Members on their caseload. After months of effort, DSS was finally able to produce relevant data to the Co-Monitors on March 8, 2018. Given the late production date, the Co-Monitors were unable to review and validate the data for inclusion in this report. The Co-Monitors anticipate reporting data for this measure in the next monitoring report.

VI. CASEWORKER-CHILD VISITATION

Visits between caseworkers and children in foster care are critical to a child welfare agency's ability to monitor the safety, well-being and progress of the children in its care. DSS understands these visits to be a core element of its practice and has maintained that caseworkers throughout the state visit with children on a monthly basis in nearly all cases. Although CAPSS data indicate that the visits are, in fact, occurring in accordance with the FSA requirements, the Co-Monitors were unable to validate these data this period due to significant issues with the quality of documentation.

The FSA requires "[a]t least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place" (FSA IV.B.2.) and that "[a]t least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child" (FSA IV.B.3.). The FSA further required that by December 5, 2016, DSS was to develop an Implementation Plan with "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors" (FSA IV.B.1.) to achieve the final targets related to caseworker visitation with children.

Based on review of its data, DSS reported at the time of entry into the FSA that it was already achieving the final targets related to caseworker-child visitation and therefore did not need to develop an Implementation Plan for the caseworker-child visitation measures. In the last monitoring period, it became clear to the Co-Monitors that DSS and Plaintiffs hold vastly different views of the FSA visitation requirements. DSS's interpretation of the requirements is that they are explicitly focused only on whether visits occurred and where they were held. Plaintiffs believe that the content of visits must also be examined to ensure not only that caseworkers saw children, but that they did so in a way that accords with the core purpose of visitation and that includes necessary elements as defined by practice standards and DSS policy.

Although the Co-Monitors performed a validation of CAPSS data in the first monitoring period, the review was limited. Because CAPSS documentation was not sufficient to allow for a fuller review of visit content – many notes were either sparse or substantially duplicative of those

entered in prior month – the review was done solely for the purpose of measuring the percentage of cases in which documentation indicated that a caseworker had visited the child in that month, and the location of the visit. The Co-Monitors did not assess the content of the visits nor the extent to which visits were done in accordance with DSS policy. Based on its findings, the Co-Monitors utilized CAPSS data to report performance on both FSA IV.B.2 and FSA IV.B.3, with the understanding that further validation would be necessary to assess performance on these measures in later periods.

In an effort to better understand DSS practice with respect to caseworker visits with children, the Co-Monitors again reviewed a sample of cases this reporting period.[64] Once again, documentation was inadequate in many cases, and, to a greater degree than in the last reporting period, it was not possible to discern in some cases whether a visit had even occurred.[65] Given these findings, the Co-Monitors were not able to validate CAPSS data produced by DSS with respect to these measures this reporting period. The Co-Monitors have provided feedback to DSS on data clean-up that will be required and plan to re-review relevant data in the next monitoring period, at which time a determination about the need for an Implementation Plan in accordance with FSA IV.B.1 can be made. The Co-Monitors also believe that DSS and Plaintiffs need to discuss and attempt to resolve their differences on the meaning of the FSA requirement on caseworker visitation.

Given the importance of caseworker visits in monitoring the safety, well-being and permanency of children in foster care, and how critical these visits will be to DSS's ability to meet many of the FSA measures, the Co-Monitors are increasingly concerned about the lack of reliable documentation in this area and will be closely monitoring progress over the coming months.

VII. INVESTIGATIONS

The work of investigating allegations of abuse and/or neglect of children in foster care – completed by DSS's Out of Home Abuse and Neglect (OHAN) unit – is one of the most critical functions for any child welfare system. This unit must be prepared 24 hours a day, seven days a week to receive reports, appropriately decide which reports should be screened in for investigation and, for those reports that require an investigation, make contact with the alleged victim child(ren) within 24 hours of the report to assess their safety and the allegations. Children are in foster care as a result of abuse or neglect by their caregivers, and ensuring their safety and well-being while in state custody is a primary obligation.

[64] The Co-Monitors reviewed a sample of 200 cases in which caseworker visits with children were required in September 2017.
[65] The Co-Monitors found a significant percentage of CAPSS notes reviewed were exact or near-exact replications of notes from prior or subsequent months, described other visits or activities attended by a caseworker with no evidence of interaction with the child, were cursory and non-descriptive or, in some cases, entered in error.

During the current period, data reflect improved performance in appropriateness of decisions to investigate, timely initiation of investigations and appropriate investigation decisions. However, the Co-Monitors' case review of investigations from September 2017 was not able to identify any investigation in which contact was made with all necessary core witnesses in carrying out the investigation. As referenced earlier, all OHAN workers during that month had caseloads which far exceeded the required limit, clearly impacting their ability to conduct comprehensive, quality investigations.

Following case reviews in the prior monitoring period, the Co-Monitors provided specific feedback to DSS on intake screening decisions with a focus on themes identified in decisions to inappropriately screen some referrals out. In response to this feedback, as well as other factors, DSS began screening more referrals in for investigation. The average number of referrals accepted each month for investigation between October 2016 and March 2017 was 27 investigations, and between April and September 2017 the average practically doubled to 52 investigations accepted a month with no increase in assigned staff. DSS and OHAN staff continue to be provided with specific feedback following each monthly review of intake screen-out decisions so adjustments can be made.

A. Investigation Implementation Plan

The FSA requires that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to 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.

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 worker time management; implementation of processes to track and monitor timely initiation of investigations and contact with core witnesses; development of check lists and other forms; development and completion of new OHAN trainings for caseworkers; coordination between OHAN and licensing; and improvements in supervision within OHAN. Attached as Appendix B are implementation status updates on these strategies as of September 30, 2017.

Through ongoing validation and data collection activities, Co-Monitor staff have been able to follow the implementation of several OHAN Implementation Plan strategies. Reviews of

monthly intakes have shown an increase in the use of standardized forms to assess for safety and risk during intake calls, although consistency in their application still requires improvement. In October 2017, OHAN staff participated in an intake training which was developed and conducted by staff from USC CCFS. Co-Monitor staff also participated in this training and found it to be comprehensive and beneficial. With appropriate follow-up and oversight by OHAN supervisors and management, exposure to the content and conversations during classroom sessions should improve consistency and quality of screening decisions at intake. DSS reports collaboration is underway with USC's Children's Law Center to develop a curriculum for an investigation training. Dates for completion of the curriculum and schedule for training workers have not yet been determined.

In December 2017, Co-Monitor staff conducted a group interview with OHAN caseworkers and several themes emerged. The group of experienced staff expressed dedication to their job and care for the children, foster parents and facility staff they encounter. However, as reflected in caseload data discussed earlier in this report, OHAN is significantly understaffed and caseworkers are overworked. Caseworkers reported receiving six new investigations per week, each of which require visits with children throughout the state within the required 24-hour timeframe. Due to high caseload demands, caseworkers reported that they are unable to complete all investigative tasks, and those tasks completed lack thoroughness and quality. Caseworkers also expressed that there is not sufficient time to document the work that they are able to do. The Co-Monitors have repeatedly expressed to DSS leadership their concern that this setup is untenable and unsustainable, that it is directly impacting caseworker morale and retention and that it requires immediate attention, particularly given the critical nature of OHAN's work.

B. Performance Data

Intake

Pursuant to South Carolina state statute and DSS protocol, all allegations of abuse or neglect of children in out-of-home settings – including licensed foster homes, residential facilities and group homes – received by local county offices or regional Intake Hubs must be forwarded to OHAN for screening and, if accepted, for investigation.[66, 67] 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

[66] 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.
[67] Allegations of abuse or neglect by a foster parent of their biological or adopted child are investigated by child protective service caseworkers in local county offices.

statutory definition of abuse or neglect.[68] 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.[69] OHAN staff are also directed to accept for investigation referrals which identify safety and risk factors to the child in care. All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires, "[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy" (FSA IV.C.2.). Baseline performance for this measure collected during a review of 128 referral decisions not to conduct an investigation between August 2016 and January 2017 indicated that 44 percent of the decisions were appropriate. The Table below includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 3: Baseline, Timeline and Interim Benchmarks for Appropriateness of Decision Not to Investigate Referral (Alleging) Institutional Abuse (and/)or Neglect

Baseline	
August 2016 – January 2017	44%
Timeline	**Interim Benchmark**
September 2017	75%
March 2018	90%
September 2018	95%
Final Target	**95%**

Source: OHAN Implementation Plan

In April 2017, a new safety and risk factor assessment tool was introduced to OHAN staff. This tool does not outline all considerations needed to structure consistent decision making, but instead assists workers by defining circumstances which require immediate acceptance, such as the current abuse is severe and suggests there may be present or impending danger to the child,

[68] SC Code § 63-7-20.
[69] 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).

or the child's physical living conditions are hazardous and present a situation of present or impending danger. Due to changes in practice and transitions that occurred during the month, the Co-Monitors did not review screening decisions in April 2017 and began data collection for the monitoring period in May 2017. All applicable referrals[70] of abuse and/or neglect received and not investigated by DSS's OHAN unit between May and September 2017 were reviewed.[71] Performance data were collected separately for each month.

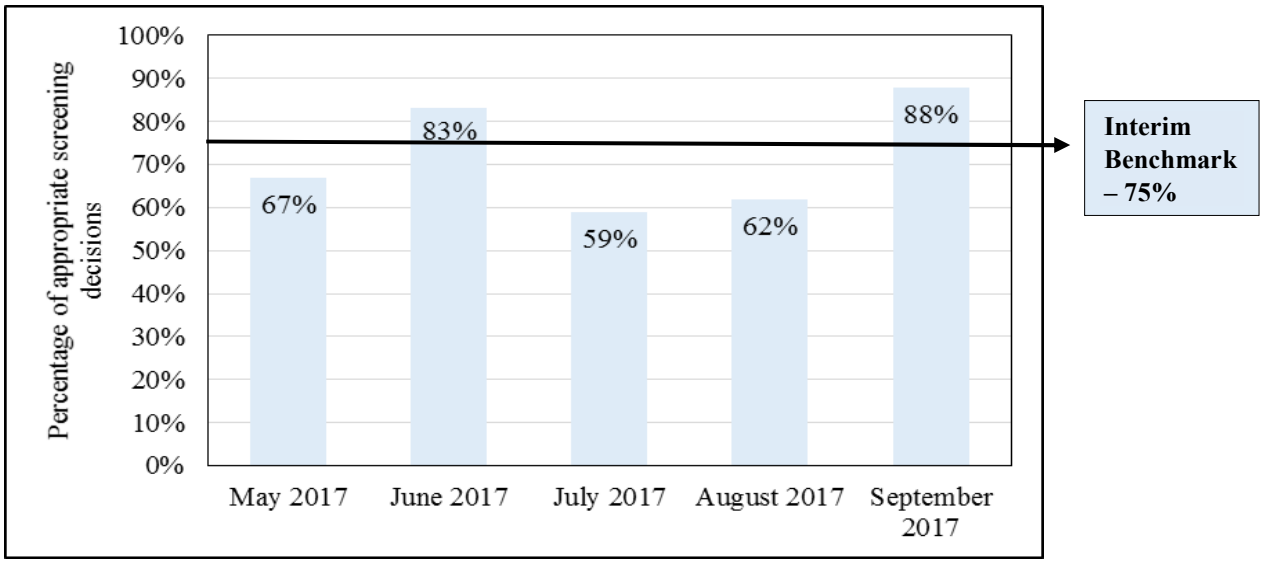
Between May and September 2017, the Co-Monitors determined a monthly range of 59 to 88 percent of decisions not to investigate a referral of abuse and/or neglect to be appropriate (see Figure 11). Specifically, in September 2017, 15 (88%) of the 17 applicable screening decisions were appropriate.[72] Performance has improved since the baseline review and exceeded the 75 percent interim benchmark target for September 2017. However, over the five months assessed, there were fluctuations in performance, demonstrating a need for more consistency in decision making to meet the next interim benchmark of 90 percent by March 2018. As discussed above, improved and consistent decision making were goals of the intake training provided to staff in October 2017.

[70] 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 or through ICPC from another state, or was the biological child of the caregiver). DSS has represented to the Co-Monitors that all referrals of abuse and/or neglect in licensed foster homes, residential facilities and group homes across the state involving Class Members are received by or forwarded to OHAN for screening and investigation, as appropriate, and screening decisions are not made by local office or Intake Hub staff.

[71] When assessing performance for this measure, reviewers considered three main criteria: (1) the allegation, if true, meets the legal definition of maltreatment; (2) the OHAN caseworker did not collect all information necessary to make an appropriate screening decision; and (3) safety or risk factors were identified within the information shared. If any of these questions were answered in the affirmative, the decision not to investigate the referral was determined to be inappropriate.

[72] Of note, of the 40 referrals that were accepted for investigation in September 2017, Co-Monitor staff assessed that 15 of the referrals should not have been accepted for investigation as there were no allegations of abuse or neglect by a caretaker.

Figure 11: Appropriateness of Decision Not to Investigate Referral (Alleging) Institutional Abuse (and/)or Neglect May – September 2017



Source: Monthly review data, USC CCFS and Co-Monitor staff

Investigations

If a referral is accepted for investigation, 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.[73] 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 caseworker or law enforcement to make arrangements for medical treatment or examinations, as needed; interview core witnesses to inform the investigation; review documents and records related to the incident; and assess the risk of further maltreatment to all children within that setting.[74] All of these activities are critical components of a quality investigation that results in accurate assessments and findings.

There are seven FSA measures pertaining to investigations – timely initiation (two measures),[75] contact with core witnesses (one measure), investigation determination decisions (one measure)

[73] Human Service Policy and Procedural Manual, Chapter 7-721. p. 6, 12 (effective date 11/29/2012).
[74] Human Services Policy and Procedural Manual, Chapter 7-721. p. 7 (effective date 11/29/2012).
[75] 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

and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted in January 2018 which examined 40 applicable investigations[76] that were accepted and initiated in September 2017. Most of the investigations involved allegations of physical neglect (20 investigations/50%) and/or physical abuse (15 investigations/38%). Twenty-three (58%) of the investigations involved allegations of abuse and/or neglect in a facility or institution and the remaining 17 (43%) investigations alleged abuse and/or neglect in a foster home. Investigations involved placements throughout the state, with 30 percent from either Charleston (5 investigations) or Richland (7 investigations) counties. The most frequent reporters alleging abuse and/or neglect were the DSS caseworker or supervisor (13 investigations) or provider/facility staff (13 investigations).

Timely Initiation

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.

The Co-Monitors approved the following efforts listed in Table 4 as "good faith efforts" for timely initiation which must be completed and documented, as applicable, for exceptions to contact with an alleged victim child(ren) within 24 hours:

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.

[76] A total of 43 reports were accepted in September 2017, however, three were found not to be applicable for this review because the alleged victim child was not a Class Member (i.e. the child was voluntarily placed by the legal guardian or through ICPC from another state) or, in one instance, the investigation involved a child fatality that was predicted, the result of severe and complicated congenital conditions.

Table 4: Good Faith Efforts to Contact Alleged Victim Children 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/CAC interview	• Investigator attempted to see child(ren) at therapist's office • Investigator contacted the assigned foster care caseworker(s) and/or supervisor(s) • Investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home • 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 (listed in Table 5) were also approved by the Co-Monitors:

Table 5: Extraordinary Circumstance Exceptions to Contact with Alleged Victim Children within 24 Hours

• 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 • Child missing despite efforts to locate (efforts should include all applicable good faith efforts listed above)

Baseline data for this measure were based on review of 107 applicable investigations[77] conducted between June and November 2016, that determined that either contact was made with the alleged victim child(ren) within 24 hours or all applicable good faith efforts to make contact were made and documented, in 78 percent of investigations. Table 6 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

[77] Some investigations 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 or through ICPC from another state, or was the biological child of the caregiver).

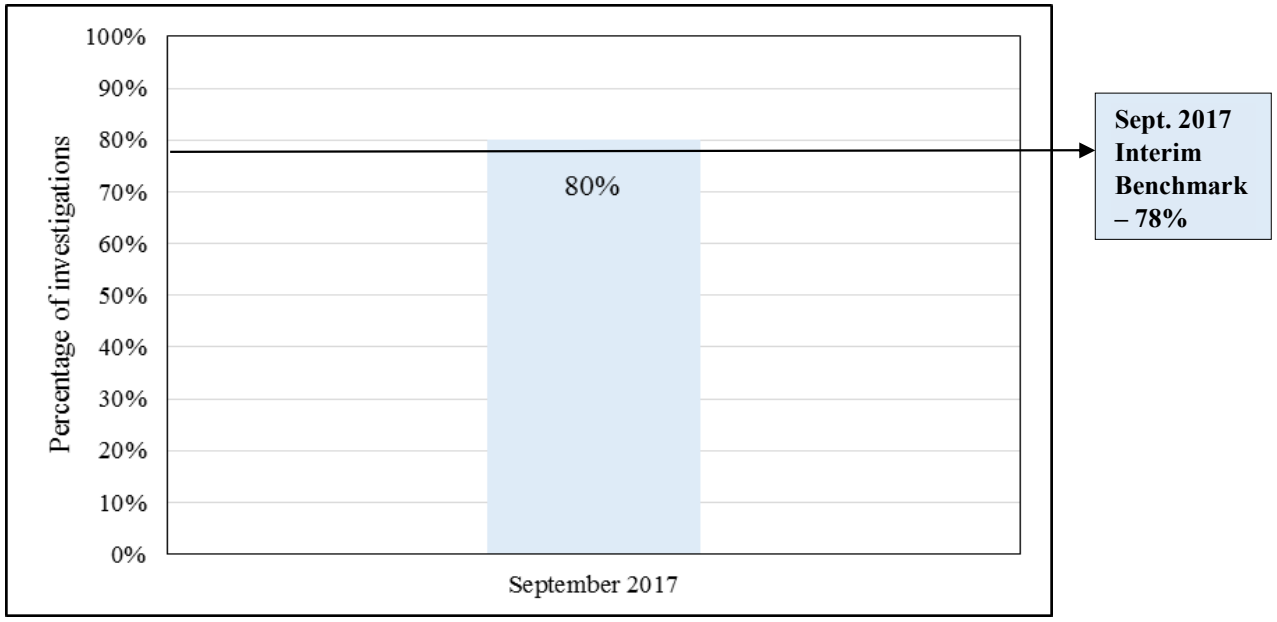
Table 6: Baseline, Timeline and Interim Benchmarks for Timely Initiation of Investigations

Baseline	
June – November 2016	78%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	78%
March 2018	80%
September 2018	80%
March 2019	85%
September 2019	85%
March 2020	90%
September 2020	90%
March 2021	95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of investigations which were received and accepted in September 2017. Of the 40 applicable investigations, contact was made with the alleged victim child(ren) within 24 hours in 31 (77.5%) investigations and in one (2.5%) additional investigation, documentation supported completion of all applicable good faith efforts; total performance for September 2017 is 80 percent, which exceeds the September 2017 interim benchmark of 78 percent (see Figure 12).

Figure 12: Timely Initiation of Investigations
September 2017
N=40



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

Although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, the Co-Monitors have determined these data cannot currently be used for reporting for two reasons. First, the CAPSS report for this measure does not distinguish between investigations involving Class and Non-Class Members which is required for reporting performance. As previously mentioned, the case record review of September 2017 investigations determined that three of the 43 investigations did not involve Class Members and should be excluded from this measure for reporting. Second, data collected during the September 2017 investigation case record review determined that all alleged victim children were not seen within 24 hours in nine of the 40 investigations reviewed. However, CAPSS data reflect that four of those nine investigations were timely initiated, indicating that the worker incorrectly entered the data. The Co-Monitors will work with DSS to improve the accuracy and reliability of these data for future reporting.

Contact with Core Witnesses

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)).

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 caseworker, 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.[78]

Listed in Table 7 are exceptions, approved by the Co-Monitors, to the requirement that the investigator make contact with a core witness during an investigation. In all instances, the exception must be supported by documentation of the exception reason and best efforts to engage:

Table 7: Exceptions to Contact with Core Witnesses During Investigations

• 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 • Medical conditions prevented witness from cooperating

Baseline data for this measure assessed 107 applicable investigations conducted between June and November 2016 and determined that the investigator made contact with all necessary core witnesses for whom there was no approved exception in 29 (27%) investigations. Table 8 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

[78] 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.

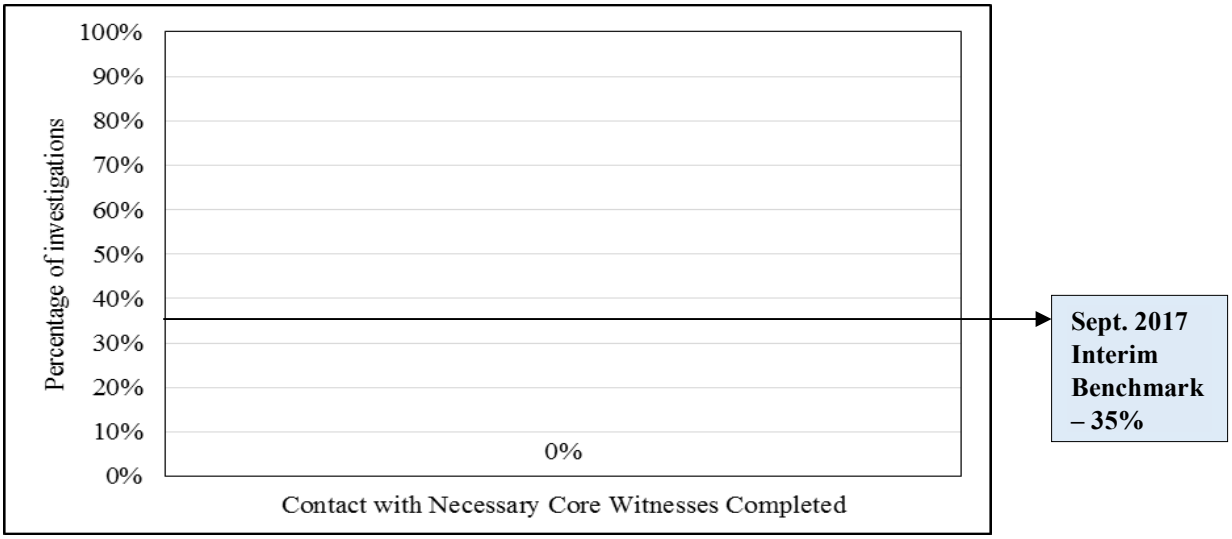
Table 8: Baseline, Timeline and Interim Benchmarks for Contact with All Necessary Core Witnesses during the Investigation

Baseline	
June – November 2016	27%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	35%
March 2018	40%
September 2018	45%
March 2019	55%
September 2019	60%
March 2020	70%
September 2020	80%
March 2021	90%
Final Target	**90%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of investigations which were received and accepted in September 2017. None (0%) of the 40 applicable investigations reflected contact with all necessary core contacts during the investigation (see Figure 13). While OHAN performance has improved with respect to other measures (i.e., intake screening decisions and timely initiation), the lack of quality with respect to contact with core witnesses is of concern and is reflective of the high workload and under-resourcing of OHAN staff and unit.

Figure 13: Contact with All Necessary Core Witnesses during Investigations September 2017 N=40



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

The following data, presented in Table 9, reflects the frequency of OHAN investigator contact with each type of core witness in the 40 investigations reviewed.

Table 9: Contact with Necessary Core Witnesses during Investigations by Type of Core Witness September 2017 N=40

Core Witness	Number of Applicable Investigations	Contact with All	Contact with Some	Contact with None
Alleged Victim Child(ren)	40	40 (100%)	-	-
Reporter	37[79]	12 (32%)	-	25 (68%)
Alleged Perpetrator(s)	40	23 (58%)	9 (23%)	8 (20%)
Law Enforcement	10	3 (30%)	-	7 (70%)
Alleged Victim Child(ren)'s Caseworker(s)	40	8 (20%)	3 (8%)	29 (73%)
Other Adults in Home or Facility[80]	22	7 (32%)	6 (27%)	9 (41%)[81]
Other Children in Home or Facility[82]	31	5 (16%)	3 (10%)	23 (74%)[83]
Additional Core Witnesses	13[84]	1 (8%)	2 (15%)	10 (77%)

Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff
*Totals may not equal 100% due to rounding

The interview with the alleged victim child(ren) is one of the most vital components of any quality investigation. Of note, although reviewers determined that the investigator met with the alleged victim child(ren) in all 40 investigations, in two investigations documentation of the interview with the child was poor and insufficient to assess the allegations and child's safety. Additionally, in nine investigations, the alleged victim child(ren) was not interviewed or observed apart from the alleged perpetrator as age and developmentally appropriate.

[79] In two investigations, the reporter was anonymous and could not be interviewed by the investigator and in one investigation, the investigator was unable to locate the reporter despite efforts.
[80] 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.
[81] All investigations in which only some or none of the other adults were interviewed involved institutions.
[82] 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 foster children 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.
[83] In the 23 investigations in which none of the other children in the home or facility were interviewed, seven involved foster homes and 16 involved institutions.
[84] Additional core witnesses identified by reviewers in 13 investigations included guardian *ad litems*, daycare staff, staff who supervise parent-child visitation, therapists and caseworker supervisors.

An alleged victim child's DSS caseworker is also a key informant during investigations of abuse and/or neglect by a caretaker while in care. The caseworker has regular contact with the child, both in their placement and in the community, and should be frequently assessing the child's safety and well-being throughout the month. For the 29 investigations in which the investigator did not interview the alleged victim child's caseworker, there was documentation in 15 investigations that some form of contact with the caseworker had occurred, but there was not documentation that information sufficient to assess the allegations and the child's safety had been shared.[85]

Case Decisions

At the conclusion of the investigation, a decision is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[86] The allegations are either founded (indicated) or unfounded.

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."

Baseline data for this measure was collected through an assessment of 94 investigations conducted between June and November 2016 in which a decision was made to unfound the allegations. Reviewers agreed that the case decision to unfound the investigation was appropriate in 44 (47%) of the 94 investigations. Table 10 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

[85] Specifically, in seven investigations, there was email correspondence between the investigator and caseworker, however, the allegations and child's safety were not sufficiently discussed – for example, an email exchange may have requested additional information and no response was received or the response did not pertain to the allegations and child's safety and no follow up occurred or the email only pertained to verifying the child's address. In five investigations, there was documentation referencing "consulting", "notifying" or "sharing information" with the caseworker, however, the documentation did not specify when and how contact occurred and if there was sufficient information shared to assess the allegations and child's safety. In three investigations, the investigator only reviewed the caseworker's CAPSS dictation and did not make independent contact with the caseworker.

[86] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 3 (effective date 11/29/2012).

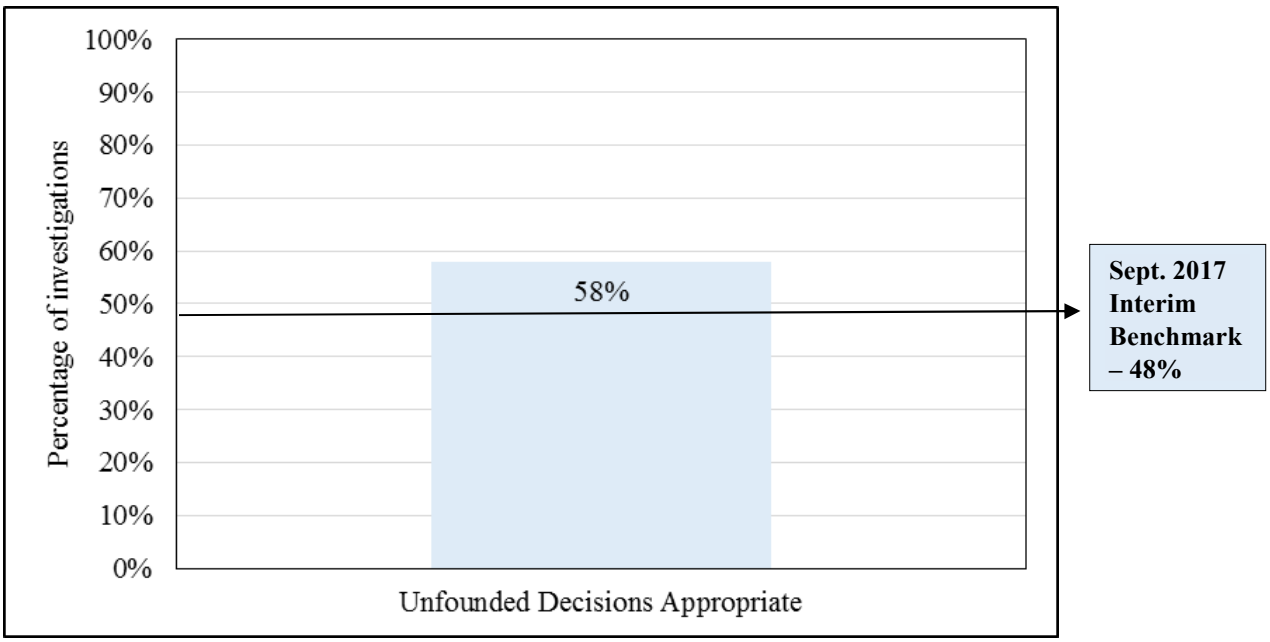
Table 10: Baseline, Timeline and Interim Benchmarks for Appropriate Case Decisions during Investigations

Baseline	
June – November 2016	47%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	48%
March 2018	50%
September 2018	55%
March 2019	60%
September 2019	65%
March 2020	75%
September 2020	85%
March 2021	95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during the previously referenced case record review of investigations received and accepted in September 2017. Of the 40 applicable investigations, 38 investigations included a case decision to unfound the allegations. Reviewers agreed that the case decision to unfound the investigation was appropriate in 22 (58%) of the 38 investigations (see Figure 14). DSS's September 2017 performance exceeds the interim benchmark of 48 percent.

Figure 14: Decision to Unfound Investigations Deemed Appropriate
September 2017
N=38



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

For those investigations in which reviewers disagreed with the unfounded decision, in most (14 investigations) the investigator did not collect all information critical to make an accurate finding and in the remaining two investigations, all necessary information was collected, but the decision to unfound was not supported by the information.

Timely 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)).

- "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)).
- "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 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.[87] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision. Examples of good cause may be one of the following listed in Table 11:

Table 11: Examples of Good Cause Reasons to Extend Investigation Timeframes

• Awaiting critical collateral information (e.g. medical report, x-rays, toxicology, video)	• Critical new information was received from witness that requires follow up
• Awaiting forensic interview/findings	• Awaiting action by law enforcement
• Awaiting critical information from another jurisdiction (e.g. central registry check)	• Child has been too ill or traumatized to speak with investigator

Baseline performance collected during a prior review of investigations conducted between June and November 2016 determined timely closure within 45 days occurred in 95 percent of investigations and timely closure within 60 days occurred in 96 percent. Table 12 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

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

Table 12: Baseline, Timeline and Interim Benchmarks for Timely Completion of Investigations

Baseline	
June – November 2016	45 days – 95%
	60 days – 96%
	90 days – N/A
Implementation Plan Timeline	**Interim Benchmark**
September 2017	45 days – 75%
	60 days – 80%
	90 days – 95%
March 2018	45 days – 75%
	60 days – 80%
	90 days – 95%
September 2018	45 days – 75%
	60 days – 80%
	90 days – 95%
March 2019	45 days – 80%
	60 days – 80%
	90 days – 95%
September 2019	45 days – 80%
	60 days – 80%
	90 days – 95%
March 2020	45 days – 90%
	60 days – 90%
	90 days – 95%
September 2020	45 days – 90%
	60 days – 90%
	90 days – 95%
March 2021	45 days – 95%
	60 days – 95%
	90 days – 95%
Final Target	**95%**

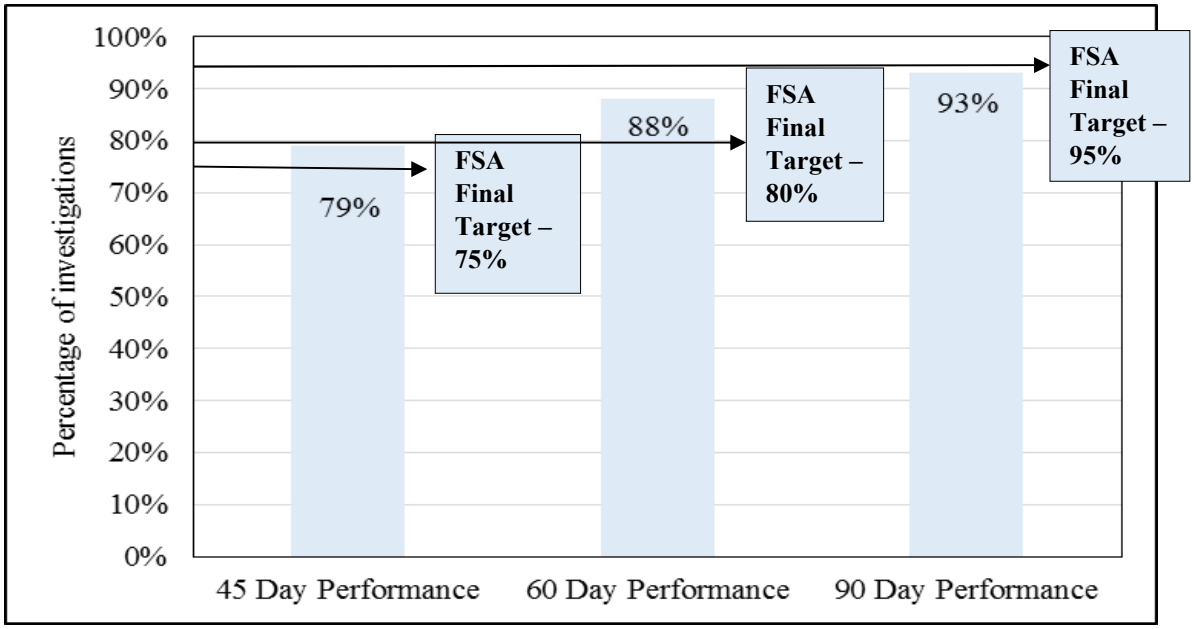
Source: OHAN Implementation Plan

Of the 40 investigations received and initiated in September 2017, one investigation was excluded from the 45 day compliance measure.[88] Of the remaining 39 investigations, 34 investigations were completed within 45 days, however, reviewers determined that three of these investigations were closed as unfounded prematurely in an effort to meet the 45 day requirement,

[88] The extension was requested and granted as the investigator was awaiting information from law enforcement.

which is not considered compliant under the FSA. Therefore, the review determined that 31 (79%) of the 39 applicable investigations were timely and appropriately closed within 45 days. Thirty-five investigations (one with an approved extension request and three without) were all closed within 60 days (this does not include those three investigations that were closed prematurely to meet required timeframes), resulting in performance of 88 percent (35 of 40) on timely completion within 60 days. The remaining two investigations were closed between 61 and 90 days, resulting in 93 percent performance for closure within 90 days. Current performance exceeds the interim benchmark level for both the 45 and 60 day requirement but not the 90 day requirement (see Figure 15).

Figure 15: Timely Completion of Investigations
September 2017
N=39 within 45 days; N=40 within 60 days; N=40 within 90 days



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

Although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, the logic within these reports does not reflect the requirements of the FSA measure so a case record review is required to collect data for reporting. Specifically, CAPSS data do not distinguish between investigations involving Class and Non-Class (i.e. the child was voluntarily placed by the legal guardian or through ICPC from another state) members which is required for reporting performance.[89] Additionally, a case record review is required to determine if an investigation is closed prematurely to meet required timeframes.

[89] The case record review of September 2017 investigations determined that three of the 43 investigations did not involve Class Members and should be excluded.

VIII. PLACEMENTS

A. Placement Needs Assessment

The FSA requires that by February 1, 2017, with prior input from and subject to approval by the Co-Monitors, DSS perform a statewide and regional foster care Placement Needs Assessment "in order to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members..." (FSA IV.D.1.). The Needs Assessment must include "specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address 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.).

In January 2016, DSS began work with the Co-Monitors to develop an approved methodology for conducting the Placement Needs Assessment. On December 27, 2016, the Co-Monitors approved DSS's methodology which identified USC CCFS as the entity to conduct the assessment. USC CCFS began the statewide Placement Needs Assessment in February 2017, with an original completion date of June 30, 2017. On June 30, 2017, DSS notified the Co-Monitors that the assessment could not be completed and that a report would be submitted instead by August 31, 2017. DSS submitted a report with data and findings to the Co-Monitors on that date and in late September 2017, the Co-Monitors requested that additional work be completed on placement projections, including adding an assessment of county needs versus regional needs so as to understand what will be needed to place children close to their home community and avoid school changes. In December 2017, the Co-Monitors provided additional written feedback to DSS. DSS reports that county level data will be provided by March 31, 2018, as part of the updated Placement Implementation Plan.

Overall, the Placement Needs Assessment identified that extensive work is necessary to expand placements, community-based services and other resources that could stabilize placements and strengthen practices that promote permanency for children in foster care. At the same time, placement processes must be streamlined, with strategic sequencing of targeted and flexible approaches to create and sustain stable placement capacity. These approaches must be manageable for all involved, especially caseworkers and supervisors.

The Co-Monitors shared with DSS that it would be important to include relevant strategies in the Placement Implementation Plan to address several themes identified through the assessment, including:

- ***There needs to be a major expansion of family foster care resources in every area of the state, including kinship placement***. Children and youth need a caretaker(s) with the skills and willingness to provide care for older adolescents, large sibling groups and for children who have experienced the level of trauma, abuse and neglect reflected in the foster care population. More foster parents should be supported in understanding child development and how to manage developmentally appropriate behaviors.

- ***There is a need for foster parents who can support legal permanency for children and youth***. Foster parents are needed who are willing to work with biological parents to assist them in reunifying with their children and, on the other end of the spectrum, foster parents who are dually licensed and willing to adopt when necessary.

- ***There are very serious consequences for children, families and the workforce that stem from the placement of so many children far from their homes and communities***. The Placement Needs Assessment identified school disruptions; difficulties maintaining parent, sibling and community connections; and significant transportations issues among these consequences, as reported in focus groups, cases reviewed and interviews with caseworkers.

- ***The placement process needs improvement***. The current process does not allow for a matching of children's needs to the skills of foster parents. The Placement Needs Assessment identified that many placements were made based solely on bed availability.

- ***The current system seems to require children to change placements, often through a move from traditional to therapeutic foster care, to access more intensive services***. One-third of the children with multiple placements whose cases were reviewed for the Placement Needs Assessment, were age six or under, and almost half of the children reviewed had placement moves that were attributed to their behaviors. Also, the criteria for levels of placement are not clear. As the Placement Needs Assessment suggests, there needs to be a reevaluation of definitions of regular and therapeutic foster care and the development of concrete, understandable criteria.

- ***The placement process seems too remote from the local offices and may lack useful input from local staff about their in-county foster homes***.

- ***Serious practice challenges are evident, including finding that there is no unifying vision of what foster care is aimed at achieving for children and families***. Specific

practice issues noted were related to: family and child engagement, family and child assessment, concurrent planning and permanency for older youth.

- ***There is a lack of mental health services for children in all levels of care***. Mental health services were most commonly identified as a necessary support in the Placement Needs Assessment. Few children reviewed received follow-up mental health services after entering care and the lack of mental health services often led to preventable placement changes.

- ***Foster care providers are in need of more DSS support and a role in case planning activities for the children in their care.***

- ***There are a range of placement data issues with respect to CAPSS that need to be addressed***.

B. Placement Implementation Plan

The FSA requires that "[w]ithin sixty (60) days of the completion of the needs assessment, DSS shall develop an Implementation Plan to implement the recommendations of the needs assessment within eighteen (18) months. The Implementation Plan shall 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)).

As presented above, DSS completed the Placement Needs Assessment on August 31, 2017. A draft of the Placement Implementation Plan was shared with the Co-Monitors on October 31, 2017, but there is not yet an approved Placement Implementation Plan. The proposed Plan highlights seven strategies:

1. Develop a comprehensive foster care recruitment and retention strategy – expand kinship care program.

2. Provide additional support for foster parents through education, training, communication and services.

3. Develop a more robust system of in-home supports for foster care children.

4. Include youth and families in service and case planning, strengthen reunification planning and supports for families, and improve permanency planning.

5. Streamline the process for assessing and documenting the needs of children, services provided, and placements.

6. Develop and implement a system of tracking availability of beds in family and therapeutic foster homes and group care providers.

7. Improve the placement process to ensure that caseworkers and youth are key partners in placement selection, processes are clear and well-coordinated and matching is based on the child's strengths and needs.

A theme from the Placement Needs Assessment, related to these strategies, is the importance of building positive working relationships with children, youth and families on an ongoing basis, not just in planning meetings to address particular tasks. This core practice function serves as the foundation for effective assessment, planning and permanency, but is not addressed in the Placement Implementation Plan.

On December 6, 2017, the Co-Monitors met with DSS leadership and provided preliminary feedback on the proposed Placement Implementation Plan. This meeting followed visits to and conversations with leadership of psychiatric residential treatment facilities and group homes designated as Levels 1, 2 and 3, as well as a group interview with OHAN staff, as discussed earlier in this report. These meetings helped to support and inform the written feedback presented to DSS on December 20, 2017.

Overall, the Co-Monitors expressed concern about the lack of clarity and concrete strategies in DSS's draft Placement Implementation Plan. Much of the Placement Implementation Plan reflects intentions to plan. For example, while there is clearly a need for restructuring the current "level of care" system – a process that will require deep work to understand current inadequacies and address a myriad of factors including child assessment processes, standards, payment structures, contracting, training and community supports and more – the Plan references only a general strategy to "streamline" the process for assessing the needs of children.

Even some of the very basic assumptions on which the Plan depend seem flawed. For example, in anticipating the number of placements, DSS assumes that an entire sibling group will be characterized as needing therapeutic foster care placement if one sibling needs such a placement. This is not the case and greatly affects the number of therapeutic beds projected by DSS. Additionally, in several areas, training is listed as something that will need to be addressed, without any more specific detail about how DSS anticipates that a transfer of learning will occur. Finally, many of the timeframes within the draft Plan are too ambitious, while others are too far out. Concurrent with the work to finalize an approved Placement Implementation Plan, there are a number of tasks that DSS should be aggressively moving forward, such as increasing

recruitment of foster homes, improving the process in which foster parents apply and licenses are processed, streamlining processes for placement matching and decisions to improve efficiency, closely reviewing poor performing and inadequate or unsafe congregate care facilities and collaborating with private providers to make the reform successful.

DSS has reported that it is in the process of reviewing the feedback the Co-Monitors provided, in consultation with USC CCFS, and that it anticipates sharing an updated draft Placement Implementation Plan at the end of March 2018.

C. Performance Data

Specific Placement Settings

Placement of Children in Congregate Care

When children cannot safely live with a parent, an alternative living arrangement with a relative or another caring adult that is stable, home and community-based, and appropriate to their needs is essential. The FSA has multiple requirements related to placing children in the most family-like, least restrictive environments and, where possible, with their siblings.

The FSA requires that at least 86 percent of Class Members be placed outside of congregate care placements on the last day of the reporting period (FSA IV.E.2.). DSS data show that as of September 30, 2017, 79 percent (3,225 of 4,079) of children in foster care were placed outside of a congregate care placement (to include residential treatment and emergency shelters) as indicated in Table 13.[90, 91]

[90] Thirty-six children who were hospitalized (N=16) or in a correctional/DJJ facility (N=20) were removed from the universe for this measure.

[91] DSS data reports do not indicate whether a child's placement in custody is voluntary or involuntary. Although the Co-Monitors have worked with DSS to manually correct for this coding issue with respect to a number of measures, it is possible that, in some instances, such as here and other placement measures discussed throughout this section, a small number of Non-Class Members are included in aggregate data. The Co-Monitors hope to be able to fully distinguish between Class and Non-Class Members in the future, as DSS develops its data capacity in this area.

Table 13: Types of Placements for Children as of September 30, 2017

Children in Foster Care	
4,079 (100%)	
Types of Placement for Children in Foster Care	**Number of Children**
Family-Based Setting	3,225 (79%)
Congregate Care, Emergency Shelter or Residential Treatment Facility	854 (21%)
Breakdown by Type of Group Care Facility	
Congregate Care	770 (19%)
Emergency Shelter	15 (<1%)
Residential Treatment Facility	69 (2%)

Source: CAPSS Data Provided by DSS
*Totals may not equal 100% due to rounding

Children Ages 12 and Under

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

DSS data in Table 14 indicate that as of September 30, 2017, 93 percent (2,655 of 2,866) of children ages 12 and under in foster care were residing in a family-based setting.

Table 14: Types of Placements for Children Ages 12 and Under as of September 30, 2017

All Children in Foster Care Ages 12 and Under	
2,866 (100%)	
Types of Placement for Children Age 12 and Under in Foster Care	**Number (Percentage) of Children**
Family-Based Setting	2,655 (93%)
Congregate Care, Emergency Shelter or Residential Treatment Facility	211 (7%)
Breakdown of Type of Facility	
Congregate Care	187 (7%)
Emergency Shelter	7 (<1%)
Residential Treatment Facility	17 (<1%)

Source: CAPSS Data Provided by DSS
*Totals may not equal 100% due to rounding

Children Ages Six and Under

The Interim Order, entered September 28, 2015, put provisions in place to immediately address the placement of children ages six and under in congregate care, requiring 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 (listed in Table 15), and DSS issued a directive outlining the procedure to be used by local and regional office staff to ensure the appropriate placement of children ages six and under in family placements. The procedure currently requires prior approval from the Deputy Director of Child

Welfare Services before any child ages six or under can be placed within a non-family-based placement.

Table 15: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements

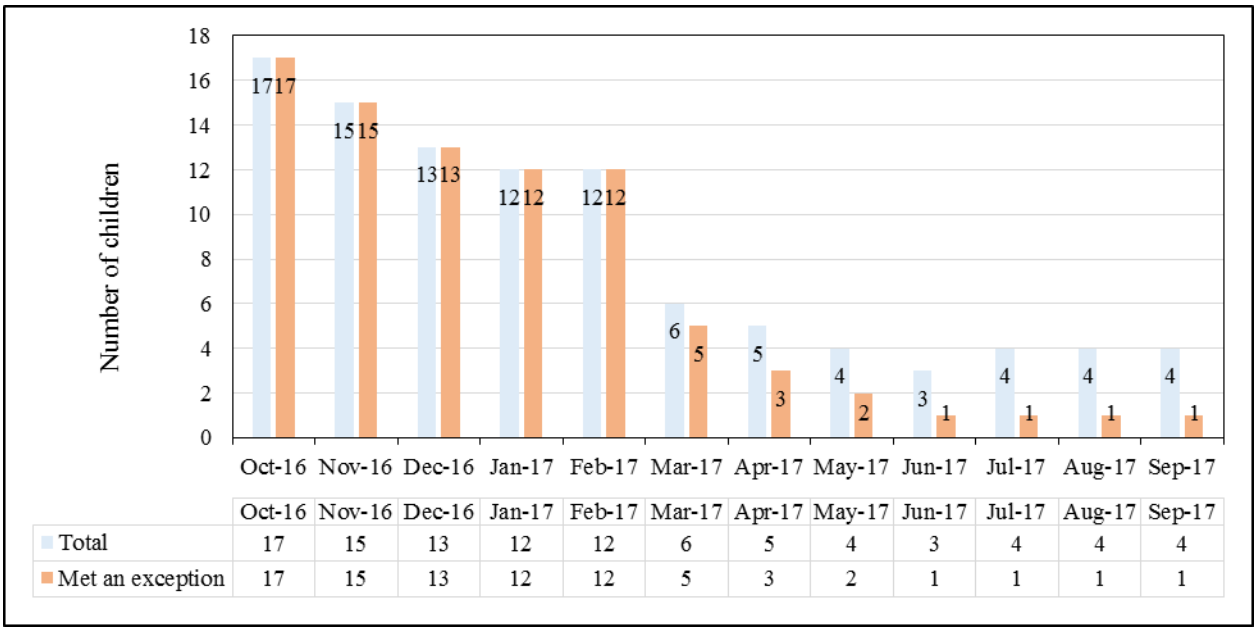
- The child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs.
- The child is the son or daughter of another child placed in a group care setting.
- The child coming into care is in a sibling group of four or larger 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.
- The child comes into care and is placed in congregate care with his or/her biological parent who is not in DSS care but who is receiving treatment at a facility.[92]
- Children who are voluntarily placed by their parent or caregiver are not subject to this requirement.

The Co-Monitors receive monthly data from DSS on all children ages six and under who were placed in congregate care during this monitoring period. These data include child-specific information regarding approved exceptions each month, with the reasons for the approval.

DSS' efforts to reduce the number of young children in congregate care, placing them instead in family-based settings, have been very successful. As illustrated in Figure 16, DSS reported that each month during this monitoring period there were four children ages six and under in congregate care placement, except for April and June 2017, when, respectively, there were five and three young children in a congregate care placement. In total, there were reportedly nine Class Members ages six and under in a congregate care facility at some point during this monitoring period. The circumstances of five of the nine children met an agreed upon exception.[93] In two of the remaining four cases, the children were in a congregate care facility and the family court, when issuing the emergency removal (from the parents') custody order, also ordered that the children remain where they were. The situations for the remaining two children did not reflect an agreed upon exception.

[92] This exception was requested and approved by the Co-Monitors in May 2017 after the initial list of exceptions was approved.
[93] The most frequent exceptions used are the child is residing with an adolescent parent in a program designed for teen mothers (for whom a family-based placement where they could be placed together could not be located) or the child is placed in congregate care with his or her/biological parent who is receiving treatment in a facility.

Figure 16: Children Ages Six and Under in Congregate Care
October 2016 - September 2017[94]



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Total	17	15	13	12	12	6	5	4	3	4	4	4
Met an exception	17	15	13	12	12	5	3	2	1	1	1	1

Source: CAPSS Data Provided by DSS

Placement in DSS Offices and Hotels

The FSA requires 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.).

Although DSS has sustained its efforts to avoid overnight stays in DSS offices and hotels during this monitoring period, the Co-Monitors were notified of two instances, involving three children, in which children stayed overnight at a DSS office in violation of this provision. DSS reports that in May 2017, two children spent the night in a DSS office while staff were seeking placement and in June 2017, another youth spent time in a DSS office overnight while transitioning from an acute visit to an emergency room. In both instances, documentation sent to the Co-Monitors and

[94] Monthly totals are not discrete, one child may be represented across several months.

reviewed in CAPSS outlined the circumstances that precipitated placement searches and how those situations were handled and resolved.

Although reports of children sleeping in DSS offices and hotels during this monitoring period is limited to these instances, the Co-Monitors are concerned about reports that children are being placed on an emergency, short-term basis in foster homes as a way of avoiding these overnight stays, cycling at times through a series of one night stays in foster homes until an appropriate placement can be located. The Co-Monitors will continue to review reports of overnight stays in DSS offices and hotels to better understand placement challenges across the state over time and will look closely at each instance to understand the circumstances and follow-up actions.

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.). Exceptions to this standard have not been approved by the Co-Monitors.

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 has been unable to provide data on the number of children in emergency and temporary placements and has not yet been able to determine if these placements are re-designated as long-term or therapeutic foster homes. DSS has indicated that creation of a code book of definitions describing each level of foster care is needed to collect accurate data for this measure and anticipates completion of this code book by December 1, 2019. Baseline data utilizing the methodology defined in the FSA are not available.

Juvenile Justice Placements

The FSA, incorporating an Interim Order provision, 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…" (FSA IV.H.1.).

DSS has acknowledged that there is no system in place for tracking youth moving between the juvenile justice and child welfare systems. After repeated requests by the Co-Monitors for a meeting with the South Carolina Department of Juvenile Justice (DJJ), a phone meeting was held with DJJ, DSS and the Co-Monitors in November 2017 during which these concerns were discussed. Although DJJ indicated during the call that information about the identities of dually involved youth might be captured in the Juvenile Justice Management System (JJMS) – its digital case database – it was not aware of any mechanisms for tracking circumstances in which youth may be put or held in juvenile justice detention or placement because of the unavailability of an appropriate DSS foster care placement. DSS has since reported that it has begun working with DJJ to develop processes to capture information related to dually-involved youth, and has shared with the Co-Monitors a recently executed Memorandum of Understanding (MOU) between the agencies that allows for basic information sharing. The MOU also provides for the designation of DSS liaisons in each county to help facilitate interagency case planning. DSS anticipates, however, that, in most counties, already overburdened county directors will serve in this role.

DSS has continued to represent that youth are immediately taken into the physical custody of DSS upon exit from juvenile justice placement in almost all instances, and reports no violations of the FSA provision during this monitoring period. In the absence of available data, the Co-Monitors have connected with stakeholders throughout the state who work with DSS youth who are also engaged with DJJ. Many have described serious concerns about the lack of available placements for these youth, and the ways in which this impacts time spent in DJJ facilities. The Co-Monitors have received numerous recent reports of dually involved youth who have been maintained in DJJ placement after DSS represented that it could not find an appropriate placement, and many stakeholders describe attempts by DSS to transfer to DJJ responsibility for youth with significant behavioral needs or who require a higher level of care. [95] As a result, the Co-Monitors continue to have very serious concerns in this area and suspect that violations of the applicable FSA provision did, in fact, occur in this monitoring period.

[95] Although some of these instances may constitute violations of the FSA, they occurred outside of the timeframe covered by this report and will therefore be considered for inclusion in the report for performance between October 2017 and March 2018.

The lack of data tracking and what seems to be a lack of understanding by DSS and DJJ about the scope and root causes of the problems in this area are particularly problematic in light of the known inadequacies of DSS's current placement array and processes. It is well understood that youth who are engaged in both the foster care and juvenile justice systems are often among the most difficult to place and support. In the absence of an infrastructure for readily identifying these youth, and purposeful steps to improve outcomes, the prospects of a smooth transition from DJJ placement to a DSS foster care placement capable of meeting youth's underlying needs become even dimmer.

Placement Stability

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

DSS utilized an external data consultant to complete analysis for this measure. DSS is planning to build capacity within DSS for future reporting. The Co-Monitors have had several conversations with DSS staff, their external data consultant and members of the external data audit team to discuss the source and coding of the underlying data for this analysis. Some potential issues have been identified, including foster care and congregate care providers with multiple provider IDs and addresses and timely data entry, which may impact the accuracy of this analysis. These issues are being explored further over the next monitoring period and will be discussed in the next progress report.

Nonetheless, utilizing the data currently available, for the period October 1, 2016 to September 30, 2017, children meeting the criteria for this measure experienced instability at a rate of 3.55, above the rate required by the FSA.[96, 97]

[96] Specifically, there were a total of 5,186 moves and 1,459,138 total applicable days.

[97] It should be noted that performance based on the FSA placement instability measure is not comparable to performance with respect to the Round 3 Child and Family Services Review (CFSR) permanency outcome that measures stability of foster care placement. The CFSR outcome is based on the rate of placement per day of *all* children who enter foster care in a 12-month period, which is likely to be significantly higher than the rate of placement for *all* children in foster care during that period of time. See *Data Indicators for the Child and Family Services Review*, available at https://www.acf.hhs.gov/sites/default/files/cb/data_indicators.pdf.

Sibling Placement

When children enter foster care, unless there are prohibitive reasons related to a child's safety or well-being, they should be placed with their siblings. Recognizing the importance of maintaining sibling connections, the FSA requires at least 80 percent of children who enter care with or within 30 days of their siblings to be placed with their siblings (FSA.IV.G.2. & 3.). 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 one or more siblings. Additional exceptions to this standard can be identified and approved by the Co-Monitors as an element of the Placement Implementation Plan, yet to be approved. The FSA sets two targets – one for placement with *at least one* of a child's siblings and the other for placement with *all* siblings. Interim benchmarks and timelines were proposed in the Placement Implementation Plan and have not been approved by the Co-Monitors.

DSS provided data for 1,288 children who entered placement between April and September 2017 who had a sibling who entered placement with or within 30 days of their entry.[98] As of September 30, 2017, 754 of those 1,288 children were still in placement. For this cohort of children, as reflected in Table 16, 41 percent (310 of 754) of children were placed with all of their siblings and 64 percent (484 of 754) of children were placed with at least one of their siblings as of September 30, 2017.

Table 16: Sibling Placements for Children Entering Placement between April and September 2017 as of September 30, 2017 N=754

Sibling Placement Status	Number	FSA Final Target
Total Number of Children Entering Placement from April 1 to September 30, 2017 Who Have a Sibling Entering Placement With or Within 30 Days	754	--
Children placed with **All Siblings**	310 (41%)	80%
Children placed with **At Least One Sibling**	484 (64%)	85%
Children **Not Placed With Any Sibling**	270 (36%)	--

Source: CAPSS Data Provided by DSS

[98] Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

IX. FAMILY VISITATION

Frequent and regular visits between children in foster care and their families are essential to maintaining family connections for children removed from their homes. The FSA includes measures specific to visits between children in foster care and their siblings and, where there is a goal of reunification, with the parent(s) with whom reunification is sought. In the last monitoring period, the Co-Monitors were unable to measure visits between children and their parents due to data issues, but were able to provide baseline data with respect to sibling visits. A second review this monitoring period reflects improved DSS performance in this area. As discussed in more detail in this section, the Co-Monitors were also able to assess baseline performance with respect to visitation between parents and children this monitoring period, finding that this is an area requiring significant work as the vast majority of children in DSS custody with a reunification goal did not visit with the parent(s) with whom reunification was sought.

A. Visitation Implementation Plan

The FSA requires "[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.).

As reported in the prior monitoring period, DSS convened staff in a Visitation Workgroup in October 2016 to assess systemic barriers to family visitation and develop and assist with the implementation of the Visitation Implementation Plan. DSS submitted a draft of the Visitation Implementation Plan on November 30, 2016, and upon receipt of feedback from the Co-Monitors and Plaintiffs, has completed several rounds of revisions and modifications. The Implementation Plan for visitation has not yet been approved by the Co-Monitors because data required to set all interim benchmarks and final targets have only recently become available.

B. 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." 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 Co-Monitors have approved the appropriate exceptions to sibling visits as listed in Table 17:

Table 17: Exceptions to 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 caseworker is to remove the child from the visit and notify the County Director afterward.
- Supervisory approval for determination that visitation would be psychologically harmful to the child.[99]

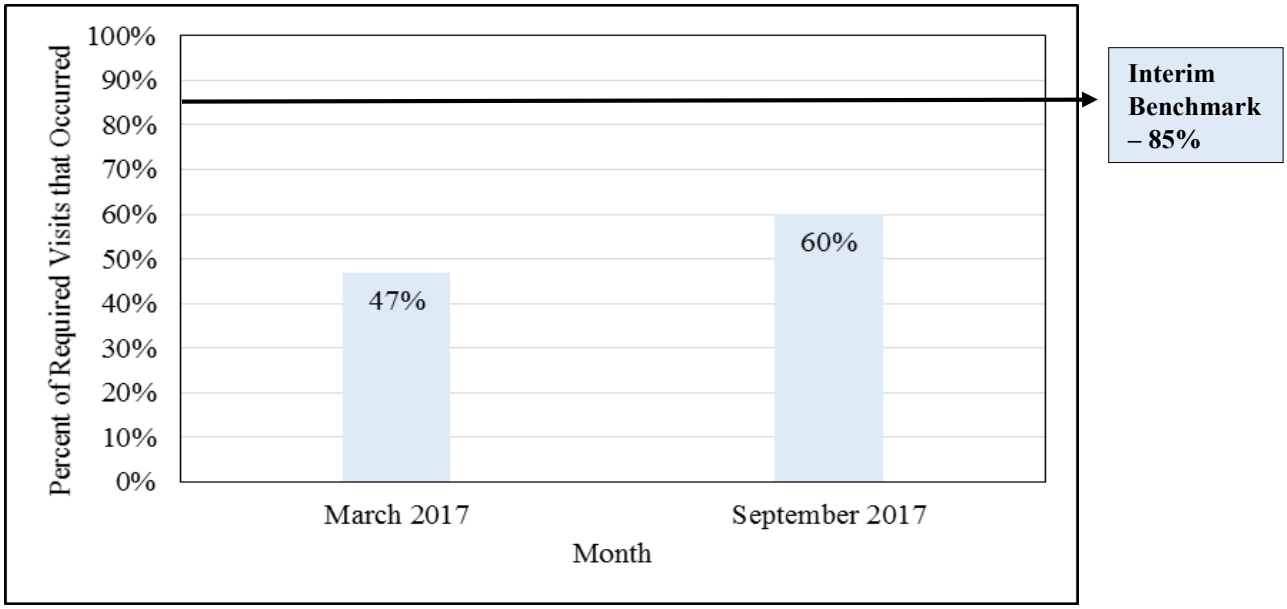
Although documentation of sibling visits is expected to be entered by caseworkers into CAPSS, the fields that capture this information were recently built and have not yet been used to extract aggregate data or in management reporting. In order to assess changes in performance for this measure, in January 2018, USC CCFS and Co-Monitor staff utilized the instrument developed in the previous monitoring period to collect data on the occurrence of visits between siblings in foster care. Reviewers looked at a sample of 310 cases for which sibling visits were required in September 2017.[100] Reviewers determined that 178 children had visited with all of their siblings during the month and that there were 15 cases to which a valid exception applied,[101] resulting in performance of 60 percent (see Figure 17). Of the 117 children who did not visit with all of their siblings, eight children visited with at least one of their siblings. Although below the FSA performance target, performance has improved since March 2017, when 47 percent of children visited with all of their siblings.

[99] 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.

[100] As of September 30, 2017, there were 1,587 children who had been in foster care for at least one month, with siblings in foster care with whom they were not placed. A statistically valid random sample of 310 cases was pulled based on a 95% confidence level and +/- 5% margin of error. Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

[101] Three cases were excluded because the child's adolescent sibling refused visitation; one case was excluded based on documentation that sibling visitation would be psychologically harmful to the child or sibling; one case was excluded because visitation was prohibited by court order; five cases were excluded because the child or sibling were residing in a medical facility in which visitation was not possible; four cases were excluded because the child or sibling was on runaway status; and one case was excluded because visits were infeasible due to geographic distance.

Figure 17: Children Who Visited With All Siblings
September 2017
N=295

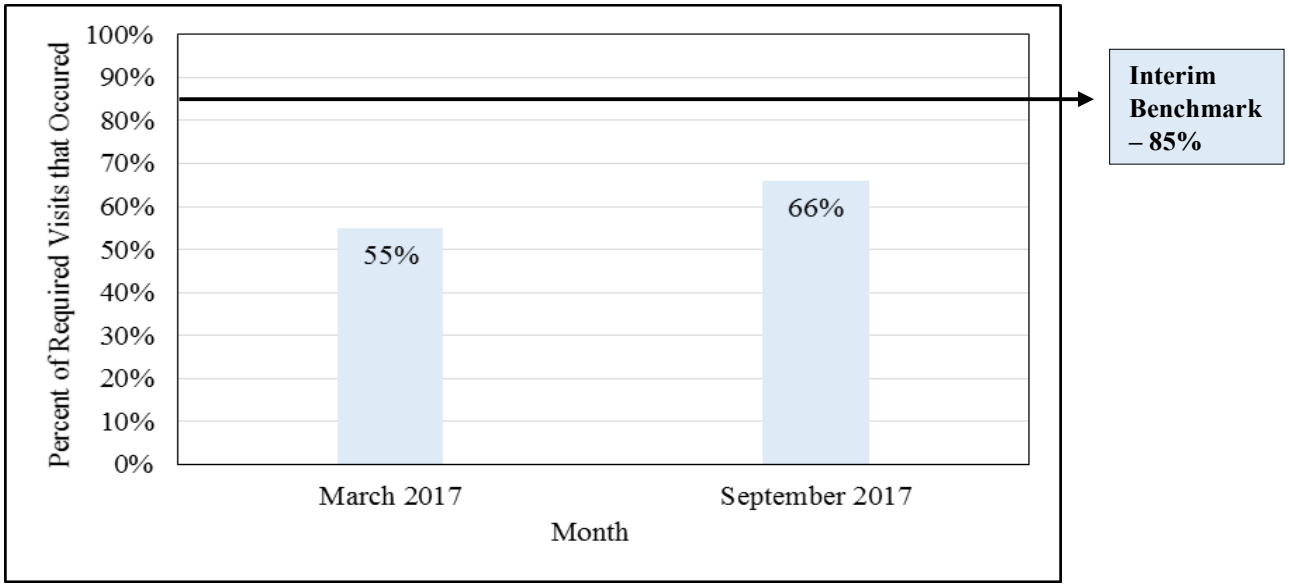


Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

Data collected during the case record review referenced above reflect the percentage of *children* who had visits with all their siblings in the month under review. In an effort to align data collection and analysis methodology with the specific FSA definitions for this measure, performance was also calculated as a percentage of all required *visits* that occurred in the month reviewed. Reviewers determined that 310 of 472 required visits[102] between children and the siblings with whom they were not placed occurred in September 2017, resulting in performance of 66 percent (see Figure 18).[103] This is an improvement in performance over the last monitoring period, when 55 percent of required visits between children and siblings occurred.

[102] Data reflect the exclusion of 18 visits for which it was determined that a valid exception applied for one of the reasons discussed above. *See, supra.,* fn 101.
[103] Because the universe of applicable visits is substantially greater than the universe of applicable children, and the data sample identified for review was calculated based on the number of applicable children, these performance data do not have the same level of statistical validity as the data discussed earlier. The Co-Monitors will work with DSS and USC CCFS in the next monitoring period to determine whether a sample pull based on applicable visits is possible.

Figure 18: Visits that Occurred between Siblings
September 2017
N=472



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

Parent 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.). The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation or with exceptions approved by the Co-Monitors listed in Table 18.

Table 18: Exceptions to Parent and 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 caseworker is to remove the child from the visit and notify the county director afterward.
- Supervisory approval for determination that visitation would be psychologically harmful to the child.[104]

Due to the Co-Monitors' concerns about the accuracy of permanency goals in CAPSS (discussed in the last monitoring report), the Co-Monitors were unable to assess baseline performance for this measure in the prior reporting period. In August 2017, DSS issued a directive to county offices regarding updated processes for capturing children's current permanency goals in CAPSS, and between September and December 2017 it tracked case-level edits to relevant CAPSS fields and reviewed a sample of cases for accuracy of data input. Although DSS has identified that there continue to be challenges with the accuracy of these data, Co-Monitor staff worked with USC CCFS to undertake a baseline record review with the understanding that there may still have been children in the sample for whom parent visits were deemed to be expected whose permanency goal may have changed from reunification. That is, in some instances, children who did not have visits with their parent(s) may actually have not done so because their permanency goal had changed from reunification to adoption or guardianship, for example, without a timely update to the goal in the relevant CAPSS field.

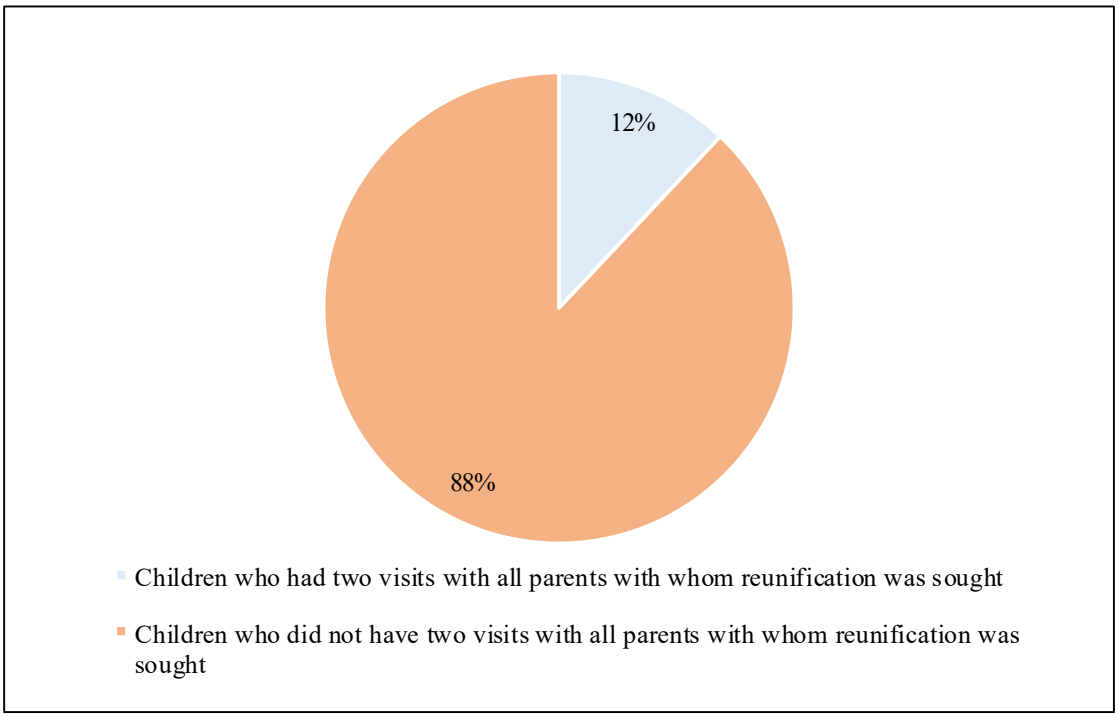
In January 2018, USC CCFS and Co-Monitor staff utilized a structured instrument to collect data on the occurrence of visits between children in foster care and their parents with whom reunification is sought. By policy and in accordance with the FSA, children are expected to visit with their parents at least twice per month. In order to assess performance, reviewers looked at a sample of 326 cases for which visits with parents were required in November 2017.[105, 106]

[104] 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.

[105] As of November 30, 2017, there were 2,124 children who had been in foster care for at least one month with a goal of "return to home," or "not yet established." A statistically valid random sample of 326 cases was pulled based on a 95% confidence level and +/- 5% margin of error.

Performance was very poor. Reviewers determined that only 39 of the 326 children visited twice during the month with all parent(s) with whom reunification was sought and that there were seven cases to which a valid exception applied,[107] resulting in performance of 12 percent, as shown in Figure 19. Almost half, 142 (45%) of the applicable children had no contact at all with any parent in the month of November.

Figure 19: Children with Twice Monthly Visits with their Parents
November 2017
N=319



Source: January 2018 Case Record Review, USC CCFS and Co-Monitor staff

[106] Although outside of this monitoring period, November 2017 data were selected for review to allow time for data clean-up efforts to occur.
[107] One case was excluded because visitation was prohibited by a court order; two cases were excluded because the parent was missing; two cases were excluded because the parent resided in a facility in which visitation was not possible; and one case was excluded because the parent refused visitation despite efforts by the caseworker.

X. HEALTH CARE

The provision of health care services to children in foster care is a fundamental obligation of child welfare systems. The ability to meet this obligation depends upon not only timely access to and follow up with high quality health care providers, but the capacity to reliably track the delivery of initial and ongoing care to children. Though DSS has made significant efforts to update case level health information so that the needs of children in foster care can be appropriately addressed, it has struggled with a plan for broader reform in this area. With the support of both DSS and Plaintiffs, the Co-Monitors engaged external health care consultants this monitoring period in hopes of moving this essential work forward with clear direction and at a faster pace. As of this report, this has been a helpful strategy. DSS has demonstrated a commitment to working closely with the Co-Monitors' consultants, and their engagement has brought new knowledge, capacity and momentum to DSS's work in this area.

A. Health Care Improvement Plan

The FSA requires 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)).

After receiving an extension for preparation of its Health Care Improvement Plan (pursuant to the FSA), DSS submitted a draft Plan to the Co-Monitors on September 29, 2017. The draft Plan describes work that DSS has undertaken – both over the past several years and more recently – to improve access to and the quality of health care for the children and youth in its care. This includes steps to develop an improved capacity to track health care delivery in CAPSS; infrastructure development through partnership with a Managed Care Organization (MCO); the appointment of a part-time child and adolescent psychiatrist for DSS; planning for a new DSS Office of Health and Wellbeing; and the reconvening of the Foster Care Advisory Committee, a

cross-agency and provider workgroup, to address issues related to the provision of health and mental health services to children in foster care statewide.

Though DSS set out a general vision for the delivery of health, mental health and dental care to children in foster care in its draft Health Care Improvement Plan, it was lacking specifics and was more a "plan to plan." The Co-Monitors strongly believe that the success of the Plan will ultimately depend upon DSS's ability to operationalize it. This will require the development of detailed timeframes, determinations regarding MCO capacity, changes to policy and practice and training of staff at all levels – including foster care, IFCCS and group home staff – as well as of foster parents and providers. It will also require that payment rates and funding structures be reexamined and that data systems and worker capacity be developed to accurately capture real-time data.

In light of these complexities and given the importance of this work, in November 2017, the Co-Monitors engaged consultants with specific expertise in child welfare health care reform (Kathleen Noonan and Gail Nayowith) to assess the sufficiency of DSS's Health Care Improvement Plan, pursuant to FSA IV.K.3. The consultants' recommendations, based on the results of validation activities and extensive interviews with key DSS, DMH, DHHS (Department of Health and Human Services), MCO and community provider staff, were submitted in a Findings and Recommendations Report on February 12, 2018 (Appendix C). In the Findings and Recommendation Report, the consultants concluded that DSS's Health Care Implementation Plan includes important conceptual and structural elements on which to build a robust health care system for children in foster care, but that it does not yet include the operational framework needed for implementation. The consultants requested that DSS develop a revised plan that includes implementation timeframes, task leads and staffing and needed resources, including a multi-year budget. They also identified five other priority action items, which they recommended DSS undertake right away. These included:

- Identify an Interim Director of the DSS Office of Health and Wellbeing: The consultants suggested that DSS prioritize hiring a permanent candidate to oversee this new office and that it draw on internal staff at partner agencies to fill the role temporarily.

- Identify and Convene a SWAT Team: The consultants suggested that DSS should quickly name a cross-agency leadership team with management authority that can meet weekly to develop a work plan and monitor Plan implementation, troubleshoot issues and provide bi-weekly progress reports to DSS and DHHS leadership, and monthly reports to the Co-Monitors.

- Obtain Gap-in-Care Reports from DHHS and its MCO: The consultants recommended that DSS immediately work with DHHS, its MCO (Select Health), and other relevant state agencies to develop a data sharing agreement that will allow DSS to access all data necessary to monitor the health care needs of the children in its care. In the interim, the consultants recommended that DSS obtain gap-in-care reports that identify children in foster care who have not received required screenings, assessments and follow up, and that the newly convened SWAT team utilize this information to monitor the procurement of this care for children who need it. They also recommended that DSS develop a protocol for notifying caseworkers about children who are missing required screening, assessment or follow up.

- Initiate Short-Term Data Workaround to Mitigate the 30-day Enrollment Gap: The consultants directed DSS to develop and implement a data workaround until DSS can create a structural solution to the 30-day enrollment lag for enrollment in the MCO, Select Health (See Appendix C).

DSS welcomed the analysis and report of the consultants and is now working closely with them to make recommended changes to their Plan and expects to submit an updated version to the Co-Monitors by April 13, 2018. They are also utilizing the consultants to guide some early actions necessary to full implementation. The Co-Monitors believe that continued engagement of the consultants will be particularly important over the next year, as DSS works to implement its Plan and believes that DSS will welcome this help. The consultants will also assist the Co-Monitors in identifying all final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, as per Section IV.K.5 of the FSA.

In addition to the Health Care Improvement Plan requirement, the FSA includes two compliance measures to address unmet health care needs of children currently in care with deadlines set shortly after initial entry into the Agreement (FSA IV.K.4.(a)&(b)), both of which are discussed below.

B. Performance Data

Initial Health Assessments

The FSA required that by December 5, 2016, DSS "identify Class Members who have been in DSS custody for more than sixty (60) days as of the date of final court approval of the Final Settlement Agreement, and who have not had initial health assessments (physical/medical, dental or mental health). Within thirty (30) days after the identification period, Defendants shall

schedule the initial health assessment for at least 85% of the identified Class Members" (FSA IV.K.4.(a)).

In the prior reporting period, the Co-Monitors reported data on children who had been in DSS custody for more than 60 days on October 4, 2016, who had not yet received initial health/medical, dental or mental health screenings entered into CAPSS. Because DSS acknowledged that the data provided were not fully accurate, the Co-Monitors worked with DSS and USC CCFS to clean-up and validate the data. In the end, the data analysis produced concerning results, and both DSS and the Co-Monitors identified actions to meet the health care needs of children in foster care as an area of high priority.

In the months since the rollout of its electronic Education and Health Passport in the last reporting period, DSS has continued to engage with the Co-Monitors about the implementation of these changes, and has made ongoing efforts to improve the reliability of its health care data. Nevertheless, the Co-Monitors have ongoing concerns about the accuracy of health care data captured in both CAPSS and paper files. As part of their review, the health care consultants retained by the Co-Monitors evaluated DSS's systems for the collection of data relevant to this measure and concluded that the data are unlikely to be accurate. The consultants made a number of recommendations to DSS in its Findings and Recommendations Report (Appendix C), including immediate steps it believes DSS should take to access health care data already collected by DHHS, and Select Health, the MCO that manages the health care of all children in foster care in South Carolina. DSS quickly began to follow up on these recommendations and has received an initial data production from DHHS, which captures some basic screening and assessment data for all children who were in foster care in CY2017. The consultants are working with DSS to analyze these data and to determine how this type of reporting can be used to identify children with unmet immediate health care needs and to measure progress in this area going forward.

Immediate Treatment Needs

The FSA requires that by January 2, 2017, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.)" (FSA IV.K.4.(b)).

Since the last reporting period, DSS's Healthcare Workgroup has spent significant time working to define "immediate treatment needs" and make CAPSS enhancements in an effort to build

capacity to capture and collect data necessary to track the provision of follow-up care to children in DSS custody. In November 2017, DSS issued a directive memo communicating the definition and importance of "immediate treatment needs" to county administrators, and requiring that all relevant medical information be entered into CAPSS by December 15, 2017. DSS reports that this process has had the benefit of focusing leadership and caseworkers on the importance of monitoring children's need for follow up health care, but does not yet have confidence in the reliability of the data it has produced.

In its Findings and Recommendation Report (Appendix C), the Co-Monitors' health care consultants concluded that, as with data related to initial screens and assessments, the process DSS has developed for tracking immediate treatment needs data is very burdensome for workers and is not likely to produce robust, reliable data. The consultants have made recommendations for the use of data already collected by DHHS and Select Health to identify and track progress with respect to immediate treatment needs. DSS is in the process of integrating this feedback into its Healthcare Improvement Plan, and the Co-Monitors and consultants will closely monitor progress.

XI. BUDGET

Reforming a foster care system with more than 4,000 children in care is not an easy task, especially if that system has been under-resourced for many years, as is true in South Carolina, and it certainly cannot be done without a significant influx of resources. The Co-Monitors have consistently discussed with DSS the need for it to muster the funding and internal capacity that will be needed to intensively drive reform of a magnitude sufficient to meet the requirements of the FSA. Throughout the Implementation Plan review process, the Co-Monitors requested that DSS provide more detailed information with respect to its plan for requesting and utilizing resources over the coming years. In the November 14, 2017 status hearing, Judge Gergel asked DSS to include in this monitoring report a specific, overarching budget that sets out the anticipated cost of the comprehensive reform called for by the FSA. DSS has not yet produced this information to the Co-Monitors, but has reported that it is in the process of compiling relevant data.

Based on a review of materials presented by Director Alford in her testimony to the House Ways and Means Healthcare Subcommittee on January 24, 2018, DSS has requested a total FY2019 budget of $20,281,214 to meet requirements that have come out of both the FSA and South Carolina's recent federal Child and Family Services Review (CFSR). The majority ($16,934,820) of this funding will be utilized to hire additional caseworkers (186), supervisors (37), trainers (6) and quality assurance (QA) staff (5); some ($1,238,064) will be used for

updates to DSS's data reporting system and make necessary modifications to CAPSS; and some ($508,330) will be dedicated to additional training, coaching, mentoring, and QA. Without information that puts these requests in the context of a multi-year budget plan – accounting also for the status of hiring of the 163 workers that were approved in the FY2018 budget – it is impossible to assess the adequacy of the requests vis-à-vis a broader reform effort. Further, when viewed without the benefit of a detailed budget plan, it is not possible to know the extent to which DSS has appropriately accounted for the myriad of factors (and expenditures) that underlie its requests. For example, the question of whether DSS will have the resources needed to meet caseload standards within four years (as it has represented it plans to do), requires a close assessment of costs related to training, office space, technology and infrastructure, and supports to retain these workers, including a boost in salaries, as well as consideration of how these expenditures will be offset by vacancies and turnover.

APPENDIX A

Glossary of Acronyms

APS: Adult Protective Services
CAPSS: Child and Adult Protective Services System
CFSR: Child and Family Services Review
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
FSA: Final Settlement Agreement
GAL: Guardian ad litem
ICPC: Interstate Compact on the Placement of Children
IFCCS: Intensive Foster Care and Clinical Services
IO: Interim Order
JJMS: Juvenile Justice Management System
MCO: Managed Care Organization
MOU: Memorandum of Understanding
OHAN: Out-of-Home Abuse and Neglect Unit
QA: Quality Assurance
SC: South Carolina
TFC: Therapeutic Foster Care
USC CCFS: University of Southern Carolina's Center for Child and Family Studies

Appendix B – OHAN Implementation Plan Strategy Updates

Strategies towards Achieving Targets:

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

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of September 30, 2017
Intake and Investigations			
a. Institute investigative worker office day for case management activities	Complete by September 2017	Plan identified that action could be completed with existing internal resources	DSS has not implemented this strategy and has indicated that it cannot be implemented with the current number of workers on the unit. No new target completion date has been set.
b. 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.	Plan identified that action could be completed with existing internal resources	DSS has not implemented this strategy. OHAN staff and management continue to use existing reports that track initial contact with children.
c. Revise the intake referral sheet to gather updated placement and caseworker information	Complete by March 2017	Plan identified that action could be completed with existing internal resources	The intake referral sheet has been updated. Co-Monitor staff have found that data input by workers is inconsistent.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of September 30, 2017
d. Revise existing checklist to expand core witness list	Complete by April 2017	Plan identified that action could be completed with existing internal resources	There have been revisions to the list of core witnesses on OHAN forms. Co-Monitor staff have found that workers and supervisors use this list inconsistently.
e. Develop tracking system for documenting core witness contacts and provide additional guidance and training to caseworkers on identifying core witnesses	Complete by December 2017	Plan identified that action could be completed with existing internal resources	DSS reports that this strategy is partially completed. The OHAN workgroup identified CAPSS updates needed to track contact with core witnesses, however, these updates have not been made. DSS has not provided an update on provision of additional guidance and training to caseworkers on identifying core witnesses.
f. Research and adopt a screening and assessment tool to help guide decision making for OHAN intake	Complete by May 2017	Plan identified that action could be completed with existing internal resources	This strategy has been partially implemented. In April 2017, OHAN began using an Intake and Investigative Safety Factors tool which provides guidance on situations that present safety and risk to a child in care to guide decisions to be accept referrals for investigation. For example, severe physical abuse, physical living conditions that are hazardous and present a situation of present or impending danger, or situations in which a child is fearful of being harmed by people living in or frequenting the home all support the acceptance of a referral for investigation. This tool was developed as a place holder until a more structured Risk and Safety Assessment tool is developed for use with both CPS and OHAN. DSS anticipated completion of the new tool in 2017.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of September 30, 2017
g. Develop and conduct specialized OHAN training to include findings from OHAN baseline reviews (including clarifying practice standards around "collateral" contact prior to making a hotline decision), CAPSS documentation training, interview and investigative techniques, restraint training, assessing for safety and risk, and critical decision making	OHAN basic intake training to occur for existing workers and supervisors beginning September 2017. OHAN basic investigative training to occur for existing workers and supervisors by December 2017. All new workers and supervisors will be required to complete training going forward	Plan identified that action could be completed with existing internal resources and USC Training Staff	This strategy is partially complete. An intake training curriculum was developed by USC and trainings were conducted between September and November 2017. DSS reports that the investigation training curriculum has not yet been developed, and a revised timeline is not available.
h. Develop a Provider History report in CAPSS to provide an easy to access and consistent history on providers for use by OHAN workers, supervisors, and reviewers - Preliminary report is currently being tested - Once finalized, report will be automated in CAPSS. - OHAN intake Workers will be trained to access, read, and summarize the previous allegations for the past 2 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, adhoc reports will continue to be extracted. Work complete by September 2017.	Plan identified that action could be completed with existing internal resources	DSS reports a provider history report has been developed and was incorporated into standard practice in September 2017. The Co-Monitors are concerned that due to instances in which providers may have multiple provider IDs within CAPSS, these reports may not always be accurate.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of September 30, 2017
i. Develop a coordinated process with Licensing that may include the following: - 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	Plan identified that action could be completed with existing internal resources	DSS reports a draft policy has been developed by the OHAN Workgroup. This policy has not been finalized.
Supervisor Review			
a. Determine ways to increase guided supervision staffing, critical thinking, monitoring-accountability system by supervisor			
- 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	Plan identified that action could be completed with existing internal resources	This strategy has been partially implemented. DSS reports the Guided Supervision Tool was finalized in May 2017 and is only in partial use as supervisors have insufficient time to work with investigators.
- 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	Plan identified that action could be completed with existing internal resources	DSS reports OHAN supervisors were trained on the Guided Supervision Tool in the summer of 2017.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of September 30, 2017
- Implement Guided Supervision in OHAN by training staff on the expectations and begin use of the Guided Supervision process	Complete by June 2017	Plan identified that action could be completed with existing internal resources	As referenced above, DSS reports that training was completed in the summer of 2017 and that the Guided Supervision Tool is in partial use by supervisors.
b. Implement standardized supervisory case review prior to case decision	Complete by April 2017	Plan identified that action could be completed with existing internal resources	DSS reports that this strategy was underway, however, due to the increase in OHAN caseworker caseload size, reviews are currently being completed too late to request an extension.
c. Refine case closure supervisory review to include CAPSS and paper file (thorough review)	Complete by April 2017	Plan identified that action could be completed with existing internal resources	OHAN supervisors are documenting case closure supervisory reviews, however, they may be completed after an investigation has been closed.
d. Develop methodology for caseload distribution	Complete by September 2017	Plan identified that action could be completed with existing internal resources	DSS reports that a regional assignment process was developed and implementation began, however, due to vacancies in the two regions with the highest caseloads, the new assignment process was ceased. DSS reports there are processes ongoing to fill current vacancies.

Appendix C – Health Care Consultants' Findings and Recommendations

Summary of Priority Actions

Submitted by Gail Nayowith and Kathleen Noonan
February 12, 2018

The Experts' full report begins on page three of this document. This summary identifies six priority actions from the full report that DSS should commence immediately.

Recognizing that full implementation of the Health Plan will roll out over a period of several years, we offer a short list of actions to help DSS jumpstart the work ahead. Work on these actions should start before a revised Health Plan is completed. We see these near-term actions as necessary in light of the scale of this effort and because the terms of the settlement require attention to the health needs of children in foster care today.

We recommend **six priority actions**, outlined below, to be undertaken right away:

1. **Produce a Revised Health Plan**
2. **Identify an Interim Director of the DSS Office of Health and Well-Being**
3. **Identify and Convene a SWAT Team**
4. **Obtain Gap in Care Reports from HHS and SH**
5. **Initiate Short-Term Data Work-Around to Mitigate the 30-Day Enrollment Gap**
6. **Initiate Short-Term Plan to Address Immediate Needs**

1. Produce a Revised Health Plan

As outlined in the report, SCDSS should develop a revised Health Plan that includes implementation timeframes, task leads and staffing, technology and other resource need, including a multi-year budget.

2. Identify an Interim Director of the DSS Office of Health and Well-Being

Name an Interim Director to fill this essential position drawing on internal staff or by detailing a staff person from another state agency, preferably SCDHHS, to take on this critical leadership role. If the job posting has not produced a sufficient candidate pool, retain a search firm to source candidates.

3. Identify and Convene a SWAT Team

Convene a SWAT Team comprised of SCDSS and SCDHHS leads, and SH staff as needed to begin meeting weekly to develop a work plan and implementation tracker and begin to monitor: progress made to implement these recommendations and other elements in the revised Health Plan, troubleshoot and resolve issues or conflicts that arise; and, provide bi-weekly progress reports to the SCDSS and SCDHHS Commissioners and monthly reports to the Co-Monitors.

4. Obtain Gap-in-Care Reports from HHS and SH

SCDSS will work with SCDHHS and other relevant state agencies, and SH if needed, to develop a data-sharing agreement to be completed in six months, as outlined earlier in the report. In the interim, SCDSS, SCDHHS, and SH as needed, can produce a Gap-in-Care Report that identifies foster children who have not received required screenings, assessments or follow up. The roster produced should be used by the SWAT Team to monitor completion of these activities for all children listed on the roster. The SCDSS can develop a protocol for notifying caseworkers about children who have missed required screening, assessment or follow-up visits and for tracking completion of all required activities.

5. Initiate Short-Term Data Work-Around to Mitigate the 30-Day Enrollment Gap

Develop and implement a data work-around until SCDSS and SCDHHS create a structural solution to the 30-day enrollment lag into SH, as described in the report. The idea is to create a 1st 30 Days Report to avoid children getting lost in the first 30 days after entry into care. To accomplish this, SCDSS can create a weekly roster of all new entrants into foster care and with assistance from SCDHHS match the roster to the child or family's Medicaid ID. The Medicaid ID can be used to pull relevant claims and encounter data for children on the roster. This information can be fed to caseworkers for follow-up. The roster will flag children who have entered foster care in the last 30 days who have not received screening, assessment or follow up. The SWAT Team can create a protocol to share this report with caseworkers and SH to promote continuity of care and monitor completion of required activities in the first month of placement.

6. Initiate Short-Term Plan to Address Immediate Needs

The new First 30 Days and Gap-in-Care Reports can be used to identify children with immediate needs. A case-specific Immediate Needs Tracker Report can be developed to capture for any given period of time a roster of children who have not received screenings, assessments or follow-up. The protocol described above can include guidance for caseworkers on how to engage SH to expedite required screenings, assessments and follow-up needed. The SWAT Team can monitor completion of required screening, assessment and follow-up.

Findings and Recommendations – Full Report

Submitted by Gail Nayowith and Kathleen Noonan

February 12, 2018

I. Introduction

The Final Settlement Agreement (FSA) in Michelle H. v. Haley requires the South Carolina Department of Social Services (SCDSS) to develop a Health Care Improvement Plan (the "Plan") for all children involuntarily placed in DSS foster care in the physical or legal custody of DSS. The Plan is subject to the approval of Co-Monitors Judith Meltzer and Paul Vincent, who under the FSA, have the ability to engage expert contractors "to assist in the development and monitoring of the" Plan. (See Section IV.K). Pursuant to that authority, the co-monitors retained Gail B. Nayowith and Kathleen Noonan to "validate" the Health Plan submitted by DSS on September 29th, 2017.

Specifically, the experts agreed to validate the "infrastructure components," "innovations" and targets as described in the proposed Plan, and identify gaps, if any, in a Findings and Recommendation report.

This Findings and Recommendations report proceeds in four parts: Part I offers an overview of the report. Part II is the methodology including the sources of information used in this discovery and assessment phase of work. Part III includes our findings and assessment of whether the plan element as presented is fine as is = **Concur**, whether it should remain in the Health Plan but needs revision = **Concur with Revisions**, or whether the element should be removed from the Plan = **Do Not Concur**.

As an overall finding, the SCDSS Health Plan submitted to the Court includes important conceptual and structural elements on which to build a robust health system for children in foster care. It does not yet include the operational framework needed for implementation.

In Part IV we propose a reorganization and rethinking of the key building blocks of the SCDSS Health Plan. We offer amendments or alternatives to some core features of the Plan (Concur with Revisions). We also note the need to establish implementation timeframes, identify task leads and describe the staffing, technology, financial or other resources necessary to operationalize the Plan. Further, the Department's efforts to recruit and hire a senior person with the skills and authority to lead the work to modify, operationalize and implement the health plan is an imperative. The revised Plan should include a multi-year phase-in calendar and an estimated budget.

We also include some short-term actions that DSS should take immediately to move the planning and implementation process along. Most urgent, is the need to establish a new cross-agency project management team with high level representatives with decision-making authority from SCDSS, SCDHHS and Select Health (SH). In the short-term, we recommend convening this as a weekly "SWAT Team" leading up to the production of a revised Health Plan to be submitted to the Co-Monitors and the Court. The SWAT Team could work through the most critical elements of the Plan including: developing a data sharing agreement and framework for data use and reporting; articulating the differentiated roles and responsibilities for DSS and IFCCS caseworkers, SH care coordinators and case managers; solving the 30-day enrollment gap to expedite enrollment of children entering foster care into SH, and refining the timelines and targets for key screenings, assessments and services built on AAP guidelines. We also

recommend moving quickly to generate a gaps-in-care data report to identify children who may need prompt attention.

For the revised Plan, we suggest a focus on six core functions that build on and add to original Plan elements:

1. Governance
2. Data Sharing and Reporting
3. Enrollment
4. Care Coordination and Care Management
5. Network Adequacy, Access to Services and Immediate Needs
6. Targets

II. Methodology

We reviewed and considered the elements of the SCDSS Health plan, including its nine infrastructure components, seven innovation areas and select targets, and developed a validation framework to guide our assessment. We sought to examine reports, data, policies and practices already in place. We did not ask SCDSS to create new tools or reports and instead worked from data that is already collected and documents already in use to better understand the operating environment in which the SCDSS Health Plan will be implemented.

The methods used to verify the various plan elements included phone interviews (Appendix), in-person meetings (Appendix), a focus group with foster parents, extensive documentation and data review (Appendix), a hands-on review of the SCDSS CAPSS system and reports, a review of the Medicaid encounter (services provided) and claims data and the SCDHHS MMIS data system, and observation. We considered a case record review. We spent three days on the ground with SCDSS in early January 2018.

III. Validation Findings

Infrastructure

1. Select Health

The choice of a single MCO for children and youth in foster care is a solid strategy for the delivery of health and mental health services. This element is central to South Carolina's Health Plan. The contract between SCDHHS and Select Health (SH) specifies the essential elements, core requirements and necessary practices as relates to the provision of health care to children in foster care. All children in foster care in SC (approximately 4200) are immediately eligible for Medicaid upon entry into foster care placement. All children in foster care are enrolled in the SH health plan within 30 days. This lag creates significant complications that are discussed later in the report.

The SCDHHS/SH contract does not yet acknowledge a role for, or accountability to, the SCDSS. We recommend a reset in the governance relationship between SCDSS, SCDHHS and SH, which is described in detail in the Part IV.

Concur with Revisions

2. The Foster Care Advisory Committee

The re-activated Foster Care Advisory Committee (FCAC) is an important opportunity to bring the SC child serving community together, including both internal and external stakeholders. The FCAC should serve in an advisory capacity, bringing expertise to DSS that informs practice, program and policy development, offering feedback from the field and community, and otherwise offering expertise and guidance on relevant issues like caseworker training, casework practice or clinical quality and the like. The structure of the FCAC should remain flexible so that work groups and members can change as work is completed or new needs emerge. The schedule of quarterly meetings with as-needed work group meetings in between should continue. The FCAC may benefit from an updated charter or statement of purpose to orient members as to their roles and responsibilities.

However, the FCAC – an advisory body that meets on a quarterly basis – cannot be responsible to design or implement the new Health Plan. Instead, as described in our Recommendations, DSS needs a new approach to governance, staff assigned full-time to lead this effort and a reset in its relationship to SCDHHS and SH.

Concur with Revisions

3. Child and Adolescent Psychiatrist

This position now held by Dr. Khetpal serves, in effect, as a Chief Medical Officer (CMO) for DSS. The CMO's responsibilities are detailed in the Plan. Dr. Khetpal is highly regarded by SCDSS staff, by SCDMH and SCDHHS. Her part-time position brings new clinical, health care and psychopharmacology expertise and depth to DSS. Consideration should be given to building out this function.

However, this position is not properly called "Infrastructure" as labeled in the Plan. This essential position is more accurately described as an enhanced clinical staffing resource to DSS operating under the aegis of the new Office of Health and Well-Being. Consideration should be given to making this a full-time position or bringing on additional part-time capacity to support the clinical work. Our understanding is that Dr. Khetpal serves as a clinical consultant, not as a manager lead for DSS. Dr. Khetpal is in a good position to identify clinical staffing resources that would be needed for the new Office.

Concur with Revisions

4. CAPSS Health Screens and the Electronic Health and Education Passport

The electronic record, called CAPSS has the potential to improve both individual child and system-level outcomes, and should replace any paper health records in SCDSS files as soon as is practicable. The time and effort that SCDSS has invested in developing CAPSS will be helpful for the significant work ahead to develop data sharing capacity with HHS and SH.

At this time, caseworkers are hand entering essential health data and trying to piece together health histories on the approximately 4200 children in care from data reported by foster parents or health care providers. This data is already collected by SCDHHS and the contracted MCO - Select Health. The SCDHHS Medicaid Management Information System (MMIS) and SH data system already tracks services provided

(encounter data), claims paid and so forth. We do not believe it is a good use of caseworker time to recreate health care data that is collected with more accuracy and in less time by HHS and SH. Whenever possible, the source of CAPSS data and the E&H Passport entries should be generated to the fullest extent from HHS and SH data feeds. The state's MMIS data, along with contractual reporting requirements for SH, allows for continuous tracking of enrollment, services provided (encounters), gaps in care and other utilization and quality metrics. Because it is a system of record, it can generate timely data that is more reliable than data collected now by hand by SCDSS caseworkers. It should become the basis for populating CAPSS, thereby creating an electronic health record for all children in DSS custody.

DSS and DHHS have begun to sync up their data to create a synchronized roster of eligible children, and are working now to move any remaining children who are not coded as "foster care" into that status. Medicaid claims, service and utilization data from the SCDHHS system of record and SH should populate, along with other ancillary information, the official CAPSS health record for all children in foster care. This is not only important for children while they are in foster care, but will be critical medical history that can follow children once they transition out of foster care. While we understand that setting up a data-sharing exchange will take time and the patience of all involved, it presents an opportunity for SC to be a national model with respect to the health of children in foster care. While we were on site, HHS, SH and DSS verbally agreed to develop a data sharing agreement and protocols for regular data feeds. Protocols will have to be developed around data access and a set of reports to be created. See our Recommendations for more detail on data sharing.

Concur with Revisions

5. Data Gathering and Initial Health Assessment Data

Pursuant to our observation in the previous section, we recommend that DSS focus its efforts on securing a data-sharing agreement with HHS and SH, engage in the development of a Medicaid data capture report on initial screenings and health assessments and secure a *gaps-in-care* report from SH and/or the SCDHHS MMIS. We address the 30-day enrollment gap in our Recommendations.

As a general rule, we do not support the creation or use of ad hoc data or reports pulled from hand-entered health care records. From what we have reviewed, it appears that already stretched caseworkers are being diverted from critical casework tasks to chase health information because there is no data link between DSS, HHS and SH. The result – very likely – is the collection of highly inaccurate information. For the time being, caseworkers are patching together health histories and services needed, but it is not a good long-term solution. We understand that SCDSS developed this approach as a work-around in the absence of critically needed information. Delays in securing information on initial health screenings and assessments is complicated by the fact that children in foster care are not enrolled in SH the day they enter care. This means that the caseworkers and foster parents who must meet SCDSS timeframes for screenings, assessments, and care for immediate needs are in a position of having to juggle appointment scheduling, follow-up visits and also chase down essential screening, assessment and referral information from a child's prior provider. Given the opportunities afforded by having SH as the single MCO for all children in foster care, it seems to run counter to intent to rely on screenings, assessments or treatment plans developed by other plans and providers. In addition to accessing SCDHHS and SH data and tracking, it will also be necessary to address the 30-day enrollment lag.

Do Not Concur

6. Immediate Treatment Needs Identification

This plan element was created in direct response to the lawsuit. Per the discussion above, to meet the conditions of the settlement agreement, a caseworker-dependent workaround was developed in the absence of other sources of data. We recommend against this work-around because we believe DSS should be working with the Medicaid health data (MMIS) through HHS and SH to identify the treatment needs, services rendered or gaps in care for children in custody. Caseworker and supervisory staff resources should, in the short run, be devoted to making sure that children get to medical appointments and receive the care they currently need, not to tracking down historical data. There could be a way to generate a look-back report for a specified time period for a defined cohort of children in foster care to determine whether immediate needs were met. We have requested data from SH to begin the process of identifying children who have screening, assessment and service needs. This should be happening concurrent with the development of a data sharing agreement.

In addition, while we understand that "immediate treatment needs" is defined in the settlement agreement, we think it may be overbroad and poorly understood in the health care sector. DSS could develop a robust "treatment needs" framework that categorizes needs in language that is consistent with how they are captured in the health care world. For example, in our meeting with DMH, they framed MH needs as "routine, urgent or emergent." Our Recommendations include more a more detailed discussion of this issue.

Concur with Revisions

7. Healthcare Needs Assessment Survey

The survey findings are extensive and point to significant service, access and availability gaps in the counties. A companion study is needed to follow-up on this work and to ascertain network adequacy and timely availability of services. This capacity analysis would use administrative data and a set of proxy measures to answer the questions of adequacy and availability. Further, the MCO contract between SCDHHS and SH is conditioned on having an adequate provider network and timely access to services and there are penalties associated with failure to do so. As it stands, we consider this survey to be enhanced context to inform the Health Plan. We do not consider this survey an "infrastructure" component as described in the Plan. We address the issue of network adequacy and access to services in the Recommendations.

Concur with Revisions

8. Training

We have not seen a training plan or training calendar for caseworkers or supervisors. This is a critical infrastructure element that should be elaborated upon in the revised Plan. We spoke to a number of stakeholders who verified that training related to psychotropic medications and case record review had taken place. This training is focused narrowly on psychotropic medication issues or federal compliance

activities. It is unclear whether other health, behavioral health and other health-related training is made available to caseworkers and supervisors. The training plan and calendar should be generated by the new Office of Child Health and Well-Being. However, it is our opinion that there may be other critical building blocks that need to be put in place first, before DSS embarks on creating, purchasing or offering other health-related trainings or bringing a learning management system on line.

Concur with Revisions

9. Office of Health and Wellbeing

The new Office of Health and Wellbeing should play a central role in the development, implementation and monitoring of the DSS Health Plan. By creating this office, DSS can centralize and direct agency activities related to child health, as well as coordinate the extensive inter-agency and community engagement work that is envisioned by the Plan. We discuss the role of this Office in greater detail in our Recommendations. The role, scope of work and leadership authority of the office needs to be more clearly defined, including identifying specifically its role in Plan implementation. Work is underway to recruit a Director for the new Office of Health and Well-Being and the position has been posted. This is a critical position and essential role in the SCDSS Plan.

Concur with Revisions

Health Care Plan Innovations

1. Case Managers to coordinate care for all children and youth in foster care. SCDSS will work with SCDHHS and Select Health to agree to an appropriate caseload for CMs.

DSS, HHS and SH are in agreement that they need to work together to develop a tiered (health) care coordination function. This is a critical component of the Health Plan, and needs significant attention, which we discuss in the Recommendations. This includes defining and describing the SH care coordination role, and defining the DSS case worker role. Both functions are necessary and DSS and SH will have to develop guidelines, training, work flows and protocols.

Concur

2. Assign all SC foster care children to a QTIP[1] or other medical home practice of similar quality

The QTIP program was developed with CHIPRA demonstration funds, but is now an ongoing program of HHS. A process and recruitment plan is needed to identify additional providers who could be certified as "QTIP-like" preferred providers in terms of the quality of practice (proficiency in AAP - Bright Futures approach among other things), and specialized knowledge/training/expertise in working with children in foster care. We discuss this in the Recommendations.

Concur

3. Leverage the SCDHHS Palmetto Coordinated System of Care 1915(c) waiver

The 1915(c) waiver promises to be a very important service for children and youth with SED in South Carolina. To date, SCDHHS has not submitted its waiver request to CMS and the waiver has not been approved. Consequently, it is too early to include this resource in the SCDSS Health Plan waiver. Work is underway to establish the basic infrastructure for the program which will have capacity to serve a limited number of children (our understanding is approximately, 200 in year 1 growing to 600 at full implementation). Eligibility for the program will include SED and a history of hospitalization. Children will be enrolled on a first-come, first-serve basis, with no guaranteed availability for children in foster care. The absence of slot guarantees for children in foster care and the nascent stage of program development, limit our ability to credit this as a Health Plan resource or "innovation" at this time. This said, we strongly encourage SCDSS and SCDHHS to continue planning for the roll-out of these necessary services to eligible foster children.

Do Not Concur

4. Monitor Health Outcomes Using Data

The importance of this element of the Plan cannot be overstated. It is our strong recommendation that quality, utilization, tracking and other reports must be generated from SCDHHS or SH data systems of record. There should be little need for DSS to create its own health data. If the health, dental and behavioral health data feeds from MMIS or SH into CAPSS, the CAPSS records could also be mined for data reports. We elaborate on this earlier in our report. In addition, we have requested that DSS obtain data from SH in the short-term that should answer some basic questions on level of need and services currently provided to children in foster care. It will be important for DSS, as part of its Health Plan, to identify opportunities for health data to be used at the state and local level to actively track the health care needs of children in care. See our Recommendations for more detail.

Concur

5. Enhanced Case Practice

Enhanced case practice is complicated by two competing approaches to case management in the Department. Another layer of complexity is caused by misunderstanding SH's care coordination role. Clarity is needed to differentiate the roles, responsibilities, practices and caseload sizes of SCDSS caseworkers and IFCCS case workers. The development of a new health-informed practice model needs to be incorporated into a broader discussion about care coordination.

Currently, there is substantial role uncertainly around the case management and care coordination functions, which needs attention. This relates to the roles of DSS, HHS, SH as well as foster parents. Care coordination must be a central plan element, but it is not currently well-defined or clearly understood. This is addressed in more detail in the Recommendations.

Concur with Revisions

6. Enhanced Training and Partnerships with Foster Parents and Group Care Providers

DSS has some core foundational work to do with HHS and SH before it can train foster parents or group care providers on its new health care practices and requirements. However, this training is necessary and viewed as infrastructure for the Plan. A health and behavioral health training curriculum for foster parents could be developed by the foster care support organizations or a local university or by DSS in partnership with SH. It would be useful to resolve an ongoing question about whether foster parents should choose the child's health care provider or whether the child should be assigned by SH to a Q-TIP or Q-TIP look-alike provider. We think this could be done by creating a presumption that children will be assigned by SH, but that foster parents have the option to use their own provider (or choice of provider) so long as they notify SH of this designation. In other words, we would not recommend a strict rule, but rather a presumption that allows for flexibility on the ground.

Concur

7. Engagement with the South Carolina Department of Mental Health

At this point, DMH's electronic records are not coded to identify children in foster care. It is not clear to us that doing so would be necessary since SH captures encounter data and would be the payer for BH services rendered by DMH. It would certainly be worth looking into, but secondary to obtaining accessing to the SH data.

What DMH offers to DSS is a network of clinics and providers around the state, including in remote/rural areas, which could be offered as a walk-in service and for scheduled visits as needed. DMH seemed open to more formal arrangements perhaps as a preferred provider for children in foster care. This preferred provider status could be discussed with DSS, DHHS and SH.

Concur with Revisions

Health Care Targets

See our earlier discussion of initial health screens above and immediate treatment needs, and the need for alignment of SCDSS and SCDHHS/SH timeframes**.** It seems premature to set these targets before further discussions among DSS, HHS and SH about sharing data, and about protocols and timeframes related to initial screenings and assessments. DSS will need to work with the Co-Monitors, as set forth in the Settlement Agreement, on the development of targets.

1. Initial Health Screens

Achieving a standard of initial health screens with 14 days of a child entering care cannot be met without addressing the 30-day enrollment lag, discontinuity of providers, and poor sources of data. These targets should be reviewed with DHHS and SH as part of the discussion around aligning timeframes and moving to standardized screening and assessment tool(s).

2. Immediate Treatment Needs

Per our comments above, we recommend setting targets related to this as part of discussions with DHHS and SH on data, treatment approach, etc. The next steps to do this would be through discussions among DSS, DHHS and SH. These discussions would include some agreement on the "look back" parameters defining immediate needs as promised in the Settlement Agreement, as well as an agreement on how regular tracking of immediate needs will be handled going forward. At this point, weekly SWAT Team meetings are needed to move urgent items forward. We recommend that DHHS data be used to generate a gaps in care report. This report will identify children needing attention. SCDSS can use the gaps in care report to do the follow-up promised in the Plan.

IV. Recommendations

The DSS Health Plan includes many of the components needed to build a strong health care system for children in foster care. That said, we believe the Plan needs to be refined and built out, as noted in the early part of the report and again, in more detail below.

Our recommendations are organized around six pillars needed to support a robust health care plan for children in foster care. Relevant elements found in the original Plan can be dropped into this reorganized framework. In addition to reframing, the next version of the Health Plan should specify implementation timeframes, task owners, multi-year resource needs (staffing, technology, other) and identify where changed protocols and staff training will be needed.

In the short term, as noted earlier in the report, and most immediately, DSS should convene a group of high-level decision makers on a weekly basis to begin discussion and expedite action on the foundational components of the Plan. There is no need for to wait for Plan finalization and in fact, getting started on these activities now, will inform and strengthen the next version of the Plan. Acting promptly will offer SCDSS an opportunity to identify operational challenges early and incorporate mitigation strategies into the Plan.

We have organized our recommendations into six pillars:

1. Governance
2. Data Sharing and Reporting
3. Enrollment
4. Care Coordination and Care Management
5. Network Adequacy, Access to Services and Immediate Needs
6. Targets

1. Governance

- The SCDSS Health Plan builds on a model of shared services and differentiated capabilities across relevant state agencies and affiliated organizations. Successful Plan implementation will require a governance entity for coordination, troubleshooting and accountability. A governance structure including DSS, HHS and other relevant state agencies is needed for accountability and to identify and resolve operational challenges through the course of the implementation of this plan. At this stage in the reform effort, an internal state agency-only governance group will need to meet monthly, at minimum, to plan, track progress, resolve disputes, design policies and reports, build

out the specifications for the care coordination function and otherwise share responsibility for operationalizing relevant components of the Health Care Plan.

- To date, the Director of the Office of Child Health and Well-Being position has been posted but remains unfilled. This is a time-critical hire and recruitment of a highly qualified person is essential to securing dedicated, consistent and skilled leadership in a role that has been historically absent in South Carolina. In considering the responsibilities of the Director, it will be important to identify a person who is knowledgeable about the substance and mechanics of Medicaid, health care data, and care management models as well as someone who has a health-related background. A good candidate will also have strong project management skills as these are essential to implement the Health Plan, as well as the capacity to understand and engage within a broader reform strategy/context. We've submitted suggestions for the posting via email.

- Given the importance of data to the Plan, DSS will need to develop a clinically-oriented data team in this office tasked to work with HHS and SH, related departments at SCDSS and other affiliated entities. As well, this office would house the Medical Director, staff the Foster Care Advisory Committee (FCAC), run point for SCDSS on cross-system service coordination and collaboration with the SCDMH and its service continuum and SCDHHS on the development of the 1915(c) waiver protocols, develop policies and procedures and the health and behavioral health training protocols. This team would work with other SCDSS departments to develop dashboards, report templates, inform the QI process and assist with implementation of the SCDSS CSFR PIP.

- DSS needs to work **immediately** to develop a shared Governance agreement between SCDSS and SCDHHS with a defined role for SH, including a timeline for implementation and projection of resource needs. See the next section for more details on this.

2. Data Sharing and Reporting

- We suggest a reset in the relationship between DSS, DHHS and SH. The contract with SH is held by HHS but the customer is DSS on behalf of children in foster care. While DSS is ultimately accountable for meeting the health needs of children in their care, it depends on a strong partnership with HHS and SH to meet its obligations to children. A key component of the reset must be built upon a data-sharing agreement to be developed between the three parties to 1) facilitate completion of CAPSS records for each child; 2) flag, track and follow-up on youngsters identified with immediate needs; 3) insure timely screening and assessment by SH; 4) identify children in need of Intensive Care Coordination from SH; 5) allow for a targeted focus on the health and behavioral health care needs of children in foster care; 6) formalize channels of reporting and accountability.

- DSS needs to put in place the data sharing agreement ASAP. A very aggressive timeline for this would be six months to get the data sharing agreement completed and executed, test and adjust a live data feed and data exchange and begin to generate administrative reports. The data sharing agreement should cover data needed to populate CAPSS, data access permissions and restrictions and include a list of monthly, quarterly, annually or more frequent administrative reports (more than one medication, immediate needs, etc.).

- Synchronize DSS, HHS and SH Timelines. DSS must synchronize its screening and service timelines with HHS and SH. Different standards related to appointment availability on the part of SH need to be reconciled with DSS requirements. Children in foster care will need some prioritization for screening and treatment services, especially upon initial entry into care based on the American Academy of Pediatrics standards, as noted above.

- Generate Data reports from HHS and SH. As an MCO, SH is already required to produce dozens of reports, and is subject to federal and state reporting requirements. In addition, SH told us that they themselves generate "gaps in service" reports for children in foster care. HHS also generates routine data reports, and has additional data on children in foster care (e.g., dental records). DSS needs to determine what can be gleaned from the HHS and SH reports to identify children who have not been screened, and/or are not receiving needed services, or who had adverse reactions to medication or treatment. In the long-term, administrative data reports could be generated by DSS based on the HHS/SH data used to populate CAPSS. Work with SCDHHS and SH to develop a set of templates and special reports and timetable for distribution and build out a monthly and quarterly performance review process. As part of our due diligence, we have requested that DSS obtain data reports from HHS and SH both to begin the process of identifying which children are in need of screenings and services, and to verify that the data is available and can be used to meet its obligations under the settlement agreement.

- In the short-term, we recommend that DSS request immediately from SCDHHS/SH a copy of the "gap in service" reports for children currently in care. In addition, while there are a number of descriptive aggregate data reports from SH that DSS and HHS will want to review over time (e.g., routine psychotropic medication reports; population with two or more chronic conditions; population with asthma diagnosis; etc.), at this point DSS should be requesting data to identify any outlier children or children who are missing screenings or needed services. Accordingly, we recommend that DSS request and review the gaps in service reports ASAP, as well as a report from SH that is focused on children from the original cohort in the case (approximately 2,000) to determine which of those children, based on the encounter and claims data, have not received required screening, assessments and follow up care.

- Consider time-limited staff sharing. DSS should consider embedding a staff person familiar with the MMIS from HHS and/or SH to DSS. This staff person(s) could also, as an interim fix to the problem of the 30-day enrollment lag, identify and record in CAPSS, for all new children who enter care (approximately 40 per month), their prior medical history as per HHS data, and ensure a smooth transition to SH for initial care coordination. This will accelerate the transition to the use of MMIS and SH data to populate CAPSS health records, track gaps in care and the development of reports and protocols and serve as a temporary bridge while enrollment lag issues are corrected.

- The revised Plan should include a timeframe, task owner(s) and resources needed for the development of a data-sharing agreement; a preliminary list of reports to be produced; a protocol and trainings developed for data management, data sharing, report distribution and other activities related to use of SCDHHS Medicaid and/or SH data for CAPSS and production of management reports including a timeline for implementation and projection of resource needs. See the next section for more details on this.

3. Enrollment

- DSS and HHS must address the 30-day time lag between entry into foster care placement and enrollment into SH as a high immediate priority. The vast majority of children coming into the foster care system are Medicaid eligible and already enrolled in one of the state's MCOs. Children entering foster care are automatically eligible for Medicaid but enrollment in the state's foster care MCO plan does not start the day the child enters care. One consequence of this lag is that the child may remain the responsibility of a non-foster care MCO making it difficult to ensure that 7-day, 72-hour and 30-day timeframes for assessment are completed, that immediate needs are identified and addressed and that follow-up is scheduled for all identified health and behavioral health needs. In South Carolina, children are assigned to a Medicaid MCO on a monthly basis. MCOs are paid a per member/per month rate. This means that, depending on the time of the month, for a child that enters foster care, there may be a time lag for them to be picked up as a SH member. Approximately 281 children enter foster care each month and it appears that lifting this administrative barrier would go a long way to satisfying several outstanding issues in the litigation.

- Ensure that all children coming into care have a Medicaid ID that includes a designation - - called a paycat - - that recognizes their foster care eligibility status to expedite enrollment in SH. (Although the majority of children enter foster care with an active Medicaid ID#, SCDSS and SCDHHS believe that 400 children have not been coded as eligible based on their foster care status.)

- The Plan should include the development of a new enrollment protocol that will eliminate or mitigate the 30-day enrollment lag for an estimated 51[2] children entering care each month, including a timeline for development and implementation of the protocol and identifying any resource needs in the revised Plan.

4. Care Coordination and Case Management

- Develop a shared and tiered approach to Care Coordination and Case Management between SCDSS and SCDHHS and SH including definitions, workflow protocols for DSS county case workers, regional IFCCS caseworkers, SH care coordinators and care managers and a timeline for implementation and the clarification and delineation of case management and care coordination responsibilities for both DSS and SH. SCDSS and SCDHHS should identify implementation resource needs.

- Implement SH Care Coordination. All children who enter foster care (approximately 281 children per month) need an early and basic level of care coordination to ensure that their initial screening and assessment is completed, and that any follow up services are put in place. In addition, DSS and SH should identify other routine milestone points for the review of all children by SH care

[2] DSS reported that 82% of children who entered care were enrolled in Medicaid already at time of entry. Based on 281 children entering care each month, this means approximately 51 are not enrolled in Medicaid already at time of entry.

coordination. (DSS must ensure that SH follows the American Academy of Pediatrics Bright Futures recommended screenings, health promotion, anticipatory guidance and health supervision). Finally, the data reports described above should identify children that are already in care who have unmet screening and service needs, and therefore need immediate attention from SH care coordination (and possibly, per below, SH Intensive Care Coordination).

- Define and Implement SH Intensive Care Coordination. DSS and SH must agree on a validated level of need assessment tool to identify DSS children who require "Intensive Care Coordination" (ICC), a function already developed at SH. Currently, SH identifies --using its own criteria-- children in foster care in need of ICC. DSS, HHS and SH need to work together to develop agreed upon criteria for children who qualify for ICC (e.g., children with a certain chronic health care condition). Finally, it will be important to develop a plan to identify how children already in care will be identified for ICC (in our focus group in South Carolina, we met two TFC foster parents who are receiving – and very happy about – ICC from SH).

- Define DSS Case Management and Revisit Tiered Design. DSS case workers are ultimately responsible to ensure that children in foster care receive the health care they need. A detailed scope of work, roles and responsibilities, work flows and relationship of DSS and IFCCS caseworkers and their relationship to SH care coordinators needs clarification and further definition. Moreover, we think the tiered design of DSS case management warrants a review. Currently, there are two types of caseworkers at DSS. SCDSS county-based caseworkers and regionally-based IFCCS workers. Our understanding is that the IFCCS is a vestige of the state's coordinated system of care project that required staff to have behavioral health expertise. IFCCS workers are assigned to children with SED - the highest level of need, but can also be assigned to medically fragile children or children with other special needs. IFCCS workers also carry cases of foster children (1:9) whose care is cross-subsidized by multiple state agencies: special education placements, dual diagnosed. Children placed in residential schools may be served out of state or in remote counties so IFCCS workers' smaller caseloads and duties around case planning and consultation are intended to leave time for traveling long distances that the workload of DSS county caseworkers cannot support.

Children are referred to IFCCS based on the county worker and supervisor's assessment of their level of need, but typically do not get transferred from a county worker to an IFCCS worker, which is regional, until at least 35 days after they have entered care. There are expectations that the IFCCS worker will have additional care management responsibilities, including more frequent contacts, case consultation with schools and service coordination activities, though they are flexible by case.

There are several reasons for concern about any bifurcation of casework resources, including that it can create case assignment inefficiencies and accountability challenges with a transfer from county to regional case management. Also, IFCCS eligibility is open to interpretation with a potential for creating long waiting lists or over/underserving serving children in care. It appears that county caseworker shortages and the poorly articulated residential continuum may have created a work-around centered on IFCCS.

Building on the above, we note a gap in care filled by the IFCCS workers as relates to what appears to be an insufficiently differentiated continuum of clinically-oriented residential programs, very limited access to PRTF beds and group and congregate care settings which are prohibited from offering on-site health or

behavioral health services or staffing with clinically expert treatment teams. Exploration of the rationale for this prohibition is beyond the scope of this study. This also raises concerns about the adequacy of the health and behavioral health services and supports offered to children in group 2 and 3 congregate care beds. A starting point for review might be a data request from DSS to HHS/SH asking for a report on key health/behavioral health indicators for children in residential care group homes 2-3. While this goes beyond our scope of review, we note that frequently during the validation work, children in group care were described as higher need than can be handled presently in either Therapeutic Foster Care or Level 1 group care. Typically, children in congregate care require some on-site medical/clinical support. This is an issue that warrants further review and consideration.

There is a complex interdependency between DSS and SH that warrants careful attention because of an important goal of Least Restrictive Environment (LRE). Work is needed to develop a plan that ties together the child's need for a therapeutically-oriented placement and the assignment of a DSS county or IFCCS case worker and a SH care coordinator/care manager to accomplish the following: 1) complete timely level of need/level of care assessments, 2) assign county or IFCCS caseworkers, 3) assign SH care coordinators and determine appropriateness of SH utilization reviews, prior authorization and other LOC/LON determinations, 4) clarify workflows differentiating the roles and duties of IFCCS caseworkers, DSS caseworkers and SH care coordination for children placed into group care 2-3, residential schools, PRTF, and therapeutic foster family care, 5) determine eligibility for ICEDEC funding where state funds are pooled to cover the placement, tuition, treatment or other costs of placement. These are multifaceted issues, but because the IFCCS is an important resource and because IFCCS workers may, down the road, play a role in LRE placement, these issues warrant consideration and resolution.

As an immediate starting point, it would be useful to align timeframes for IFCCS eligibility with other health, behavioral health and dental assessments happening within the first 30 days of placement in foster care that are conducted by SH or other providers and consider the use of a standardized assessment tool like CALOCUS or CAFUS or CANS. This will necessitate resolution of the 30-day enrollment lag into SH, resolution of level of need assessments and determinations and level of care approvals by SH as discussed in other sections of the report.

5. Network Adequacy, Access to Services, Screening and Immediate Treatment Needs

- Standardize health and behavioral health care screenings and assessments offered through SH providers (Q-TIP and other designated preferred providers who are committed to and proficient in the American Academy of Pediatrics Bright Futures framework for health supervision) through use of validated screening and assessment tools (trauma, CALOCUS, CANS, CAFUS, depression, etc.). This should include an assessment and possible augmentation of reimbursement rates paid for screenings and assessments.

- Include in the revised Plan, a timeframe for developing and implementing an approach to identifying additional Q-TIP or Q-TIP-like providers and an estimate of resources needed to do so. The Plan should also speak to the issue of provider assignment to enable SCDSS and SH to assign more foster children to a preferred provider and address logistical challenges associated with Q-TIP provider assignment: travel and transportation access, current practice by foster parents who now choose the child's health care provider – that will need further attention. We suggest that DSS include in the Plan a mechanism for engaging foster parents and the FCSC to inform the

resolution of these issues.

- Develop a process with SCDSS, SCDHHS and SH for an annual review of network capacity and access to services including a projection of resources needed for implementation activities. Include a timeline for the implementation and development of a protocol and monthly report to track, flag and prompt timely completion of health, dental and behavioral health screenings and assessments, referrals and follow-up needed and to identify immediate needs and gaps in care.

Note: The question about additional training, quarterly/semi-annual convenings (Grand Rounds, meet and greet, etc.) and increased rates for providers that serve children in foster care is one that HHS seemed open to discussing. We raised an issue about a rate that was quoted to us by one provider that seemed low, and they told us they were aware of the issue and were working on it. From our perspective, DSS will be a better position to advocate with respect to provider rates once it has access to Medicaid data, which will show more reliably the types of screenings and services happening for children in custody.

6. Targets

As noted previously, there is an urgent need to align and synchronize DSS, HHS and SH timelines for screenings, assessments, and immediate treatment needs. Jointly with the co-monitors, DSS needs to engage with DHHS and SH to arrive at proposed target dates and benchmarks for completion of screenings, assessments, referral for follow-up and immediate treatment needs.

Appendix I. Interviews

Advocates:

- Erin Hall, CEO, Palmetto Association for Children & Families
- John Shackelford, Director of Government Relations, SC Youth Advocate Program (SC YAP)
- Advocate, Protection & Advocacy for People with Disabilities, Inc.

Foster Parents:

- John Shackelford, Director of Government Relations, SC Youth Advocate Program (SC YAP)
- TFC parents from SCYAP

Medical Professionals:

- Dr. Libby Ralston, Co-Director, Project BEST
- Dr. Elizabeth Wallis, Medical Director, MUSC Foster Care Clinic
- Dr. Olga Rosa, Pediatrician, Palmetto Health Richland

Plaintiffs:

- Stephen Suggs, Appleseed
- Dione Brabham, Appleseed
- Sue Berkowitz, Appleseed
- Erin McGuinness, Children's Rights
- Ira Lustbader, Children's Rights
- Stephanie Persson, Children's Rights
- Matthew Richardson, Wyche

SCDSS:

- Susan Alford, Director, SCDSS
- Taron Davis, Deputy State Director of Child Welfare, SCDSS
- Tammy Bagwell, QA Director, SCDSS
- Holly Pisarik, Internal Monitor, SCDSS
- Diana Tester, Data Coordinator, SCDSS
- Malik Whitaker, Director of Continuous Quality Improvement, SCDSS
- Paulette Salley, IT Director, SCDSS
- Dr. Anita Khetpal, Consultant Psychiatrist, SCDSS
- Jonnieka K. Farr, CAPSS IT SCDSS
- Brad Leake, Data and Accountability Director, SCDSS
- Tim Nix, Lead Clinical Specialist, SCDSS
- Robert Linares, Contract Administrator, SCDSS

SCDHHS:

- Andrea Bickley, Director of Health Informatics & Analytics, SCDSS
- Peter Liggett Deputy Director, Behavioral Health & Long Term Care SCDHHS
- Brian Amick, Deputy Director for Health Programs, SCDHHS

SCDMH:

- Mark Binkley, Medical Director, SCDMH
- Debbie Blalock, Executive Director, SCDMH
- Louise Johnson, Director of Children's Services, SCDMH

SelectHealth:

- Rebecca Engelman, Market President, SelectHealth
- James King, Contract Account Manager, SelectHealth

USC:

- Dr. Cynthia Flynn, USC Center for Child and Family Studies, USC
- Suzanne Sutphin, USC CCFS

Appendix II. Documents Reviewed

- Group Homes with Levels as of 1/10/2018
- Directive Memo – Immediate Implementation of the Education and Health Passport May, 2016
- South Carolina Department of Social Services Health Care Oversight and Coordination Plan 2015- 2019
- 2018 PAFCAF Legislative Priorities
- AAP Periodicity Schedule (Recommendations for Preventative Pediatric Health Care)
- Chapter 7 of the Child Protective and Preventative Services Policy Manual on Babynet Referrals
- Child and Adolescent Level of Care Utilization System (CALOCUS) manual (10/17/2010)
- CAPSS Immediate Treatment Needs screen
- CAPSS screen of Healthcare Passport 10/21/2016 from test site
- County Service Array Survey, Appendix to the Placement Needs Study
- Director of Wellbeing job announcement
- Chapter 8 of the DSS Foster Care Policy Manual on Foster Care and on the Education and Health Passport
- Foster Care Health Advisory Committee Meeting Minutes from 10/04/2017
- South Carolina Department of Health and Human Services Medicaid Policy and Procedures Manual Chapter 204 on MAGI Eligibility Categories
- South Carolina Department of Health and Human Services Medicaid Policy and Procedures Manual Chapter 502 on Foster Care and Adoption
- Healthcare Needs Assessment Analysis from the South Carolina Department of Social Services Healthcare Workgroup, 04/2017
- Immediate Treatment Needs (List of Definitions from Michelle H., Medicaid and an operational definition)
- Directive Memo – South Carolina Department of Social Services Immediate Treatment Needs Practice Directive and Policy Change Announcement 11/15/2017
- Initial Healthcare Screening Reports Summary
- Medicaid Guidelines for Dental Care
- Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents 09/2013
- Medicaid Spending on Children in Foster Care by County – Per Child Per Month, Aggregate Data, 12/28/2017
- Michelle H. Initial Complaint
- South Carolina Department of Social Services organizational/staff chart
- South Carolina Department of Social Services Education and Health Passport
- Section 2 of the Physicians Provider Manual
- Service Array Codebook
- South Carolina Department of Social Services Human Services – Foster Care Children Immediate Treatment Needs Summary Report as of 12/11/2017
- South Carolina Department of Social Services Human Services – Foster Care Children Immediate Treatment Needs Summary Report as of 12/18/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 09/24/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/02/2017

- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/09/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/15/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/22/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 10/29/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/06/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/12/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/19/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 11/26/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/04/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/11/2017
- South Carolina Department of Social Services Human Services – Foster Care Initial Screening Summary Report as of 12/18/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 05/01/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 06/05/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 07/03/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 07/31/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 08/07/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 09/24/2017
- Initial Health Assessments Used for Monitoring Purposes/Initial Health Screenings as of 10/03/2017
- Placement Needs Assessment Baseline Study Final Report, 08/31/2017
- Placement Needs Assessment Report; Appendix B, Appendix C, Appendix D, Appendix E, Appendix F, Appendix G and Appendix H
- South Carolina Department of Social Services Child Welfare Quality Assurance Review Report: Greenwood County, 05/2016
- Greenwood County Comparison Chart
- Greenwood County Quality Assurance Review Summary Case Notes
- CAPSS Health Care and Well-Being User's Manual
- Immediate Entry of Initial Medical, Dental, and Behavioral Health Information
- Michelle H. Settlement Healthcare FAQ's
- Foster Care Children Psychotropics Medications CAPSS extract, 12/2017