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

Monitoring Period III
(October 1, 2017 – March 31, 2018)

Progress of the South Carolina Department of Social Services

Co-Monitors:
Judith Meltzer & Paul Vincent

Co-Monitor Staff:
Rachel Paletta
Elissa Gelber
Gayle Samuels

September 18, 2018

THE CHILD WELFARE POLICY & PRACTICE GROUP

Center for the Study of Social Policy

Michelle H., et al. v. McMaster and Alford
Progress Report for the Period October 1, 2017 – March 31, 2018

TABLE OF CONTENTS

LIST OF TABLES

TABLE

LIST OF FIGURES

FIGURE

Michelle H., et al. v. McMaster and Alford
Progress Report for the Period October 1, 2017 – March 31, 2018

I. INTRODUCTION

This is the third 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 4,500 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 on policy and practice changes and outcomes to be met, some provisions are more open ended, with agreement by Parties 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 establishes a structure in which the Co-Monitors 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

Leadership Changes and Internal Restructuring

During the period under review, there have been multiple changes to strengthen the infrastructure and leadership of South Carolina's Department of Social Services Child Welfare Division. DSS restructured its leadership team and created new positions to provide a more tailored focus on critical functions of the child welfare agency and its reform. Specifically, DSS has created:

- Director of Permanency Management, which oversees Foster Family Licensing and Support, Adoptions, Interstate Compact for the Protection of Children (ICPC) and Independent Living;
- Director of Child Health and Well-Being, which manages Intensive Foster Care and Clinical Services (IFCCS) and Clinical and Behavioral Health Services;
- Director of Safety Management, which administers the State Central Registry of Child Abuse and Neglect, Child Fatality and Near Fatality Review and Out of Home Abuse and Neglect (OHAN) investigations; and
- Director of Family and Community Partnerships, which includes Family Group Conferencing and Kinship Care.

As of the writing of this report, most of these positions have been filled with the exception of the Director of Family and Community Partnerships, which is currently vacant.

On July 16, 2018, Susan Alford resigned as State Director of DSS. On August 9, 2018, Governor Henry McMaster announced the formation of an advisory panel to assist in the search for a new Director. The panel – comprised of state representatives and senators, directors of other state agencies and numerous representatives from community agencies and organizations – is charged with developing a list of qualifications, skills and experience necessary for the next Director. An executive search firm will utilize this information to identify possible candidates for the Governor to interview. Joan Meacham, who was Chief of Staff, is serving as Acting Director while a search for a permanent Director is conducted.

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

Analysis of Five-Year Budget

On April 19, 2018, the Court ordered DSS to develop and submit a comprehensive five-year budget plan that provides year-to-year funding allocations and information about the staff and resources necessary to meet each of the performance requirements in the FSA. On May 22, 2018, DSS submitted the required budget to the Court and during a subsequent status hearing, the Court directed the Co-Monitors to meet with DSS to review the submitted budget. This meeting took place in July 2018, and included the Co-Monitors, DSS staff and their consultant, Public Consulting Group (PCG).

With the assistance of PCG, DSS developed the budget plan by examining spending in previous years; projecting new costs associated with hiring, training and retaining new caseworkers; estimating cost savings by moving children from costly congregate care settings to family-based care; and estimating new costs from implementation of other components of the reform. The budget shared with the Court and the Co-Monitors projects only new dollars needed to supplement existing resources and assumes that current state and federal funding to DSS will remain consistent from prior years. Importantly, the budget document does not include anticipated costs to the Department of Health and Human Services (DHHS), which will likely be necessary expenditures as part of the Health Care Improvement Plan.

DSS recognizes, and the Co-Monitors agree, that the budget submitted in May is an evolving document that will need to be routinely amended as more information is gathered and the required FSA Implementation Plans are finalized. Overall, the Co-Monitors believe that while the five-year budget plan does not yet include every resource need anticipated, the budget represents a good baseline assessment. It clearly identifies that DSS will continue to need significant budget increases over the next four years. It also reflects the important need for the state to move forward aggressively with actions planned to maximize federal revenue potentially available from Title IV-E and Medicaid (Title XIX). Data within the budget also demonstrate the ultimate cost efficiencies of moving children from congregate care to family-based settings. Specifically, the current daily rate of a traditional foster home setting ranges between $13.47 and $17.84, while the daily rate of a group home setting ranges between $101.03 and $176.82.[4] The proposed budget anticipates some redeployment of these funds as the state moves to develop more family foster homes.

Over the next several months, PCG plans to work with DSS on four additional projects including: cost allocation plan review, eligibility rates review, Title IV-E training claiming

[4] See DSS 5-Year Budget, filed 5/22/18, p. 14.

review and a comprehensive federal funding review and assessment. Recommendations will be developed and provided to DSS regarding steps that will need to be taken to increase federal revenue and claiming. As FSA Implementation Plans are completed, the Co-Monitors will continue to review the budget plan to ensure it is amended as needed to include the resources identified as necessary for execution of those Plans.

Areas of Accomplishment

Building the Infrastructure to Meet Children's Health Care Needs

Over the past eight months, with the assistance of consultants hired by the Co-Monitors, DSS developed a Health Care Improvement Plan that will redesign the way health care services are organized and delivered to children in foster care and is intended to create the foundation necessary to meet the requirements of the FSA. Through significant partnership with SC's DHHS and Select Health, the managed care organization (MCO) that serves children in foster care, DSS made significant progress with respect to each of the areas identified as immediate health care reform priorities in the prior monitoring period. In addition to its work to revise the Health Care Improvement Plan – approved by the Co-Monitors in August – DSS identified a Director of its new Office of Child Health and Well-Being; convened a cross-agency leadership team to manage the work of health care improvement; obtained critical health care data; addressed administrative barriers to MCO enrollment; and initiated a process for identifying, tracking and addressing children's immediate health care needs.

Data Audit, Training Plan and Case Practice Model

In response to concerns raised by the Co-Monitors about the validity of data in the DSS's Child and Adult Protective Services System (CAPSS) for measuring performance on a number of FSA measures, DSS began work in January 2018 with Chapin Hall at the University of Chicago to conduct a data audit. There are two primary goals for this project: (1) the validation of data, specifically, review of the data DSS collects for its accuracy and completeness; and (2) the provision of guidance to DSS on how to streamline its processes for data analysis, reporting and evidence use. Since the beginning of the year, Chapin Hall has worked with DSS to identify the analytic questions that need to be answered for either FSA reporting or general management activities (e.g., how many investigations were opened during the month?, what is the average caseload?), the variables relevant to answering these questions (e.g., number of investigations, size of caseloads) and the extent to which there are suspected or observed problems with the validity of these data within CAPSS. As of the writing of this report, most of the groundwork needed to identify priorities and data quality problems has been completed. Chapin Hall staff are working with various DSS workgroups to develop solutions to data quality problems, which

include enhancements to existing CAPSS architecture and/or updates to policies and procedures to provide clarifications on caseworker responsibilities for data input. Through its work thus far, Chapin Hall has identified several strengths within DSS that have been advantageous to the data improvement work, including that: the assembled workgroup has been extremely responsive, recognizes the importance of data to operations and practice and remains open to change as it relates to current ways of performance reporting and management; and the IT team that supports CAPSS is highly flexible and collaborative in its efforts to develop new system architecture and explore opportunities to pull data from other administrative systems. Several challenges have also been identified: primarily, several vacancies in important leadership positions over the course of their work has slowed progress in developing the policy, procedures and related communication with staff that are the precursors to making any changes in caseworker practice or related CAPSS development. Chapin Hall also has recommended an increased investment in DSS's Accountability, Data and Research (ADR) team. Although existing staff have demonstrated exceptional effort in working to meet the reporting needs of DSS, the team includes only four staff. Chapin Hall has urged DSS to consider additional statistician positions, as well as a position dedicated to work with partner agencies with whom DSS needs to share data, such as DHHS.

As discussed later in this report, there remain a number of FSA measures for which performance data cannot currently be reported either because the data are not available or cannot be validated, or because the necessary policy definitions and practice expectations have not been clearly outlined.[5] However, the Co-Monitors have observed the significant time and effort both DSS and Chapin Hall have invested in the data audit and are hopeful that when the work concludes at the end of September 2018, Parties and the Co-Monitors can have confidence in the data being collected and utilized.

Chapin Hall has also begun working with DSS on two other projects. The first, which began earlier this spring, is a comprehensive assessment of DSS staff training and professional development to ensure it meets the needs of DSS's workforce, followed by the development of a revised training and workforce development plan. The second scope of work, initiated in June 2018, is aimed at developing a strategy for DSS to operationalize and implement its draft Case Practice Model. For nearly two years, DSS has made efforts to develop and define elements of a model of case practice to include a vision of the child and family outcomes it seeks to produce and of the agency's practice elements, such as family engagement, child and family teaming, assessment and planning. During this period, the Co-Monitors urged quicker action and DSS recognized the need for external expertise in this area as well. Chapin Hall anticipates that its

[5] These include caseworker and child visits (FSA IV.B.2. & 3.), emergency of temporary placements (FSA IV.E.4. & 5.), referral for staffing and/or assessment for therapeutic foster care placements (FSA IV.I.2.), receipt of recommendations for services or placement (FSA IV.I.3.), level of care placement (FSA IV.I.4.&5.) and health measures (FSA IV.K.4(a) & (b)).

work with DSS on the Case Practice Model will continue into CY2019, which means that the development of staff skills to implement the Case Practice Model is many months away. The Co-Monitors continue to emphasize that the Case Practice Model is fundamental to the success of all other reform efforts underway and that work to complete it must occur simultaneously with planning for caseworker retention and training, quality visitation and improved placement processes.

Areas in Need of Focus and Improvement

Performance data for the current monitoring period – from October 2017 to March 2018 – demonstrate how much improvement is needed to meet the goals and expectations of the FSA. The Co-Monitors had hoped to see more improvement in practice and outcomes by this period. Instead, performance to date demonstrates the systemic problems that prompted the *Michelle H.* lawsuit, and the scope and depth of the necessary reforms. In some areas, performance has declined from baseline levels. And although DSS has worked to produce multiple drafts of Implementation Plans that were due in December 2016, the majority of these Plans have not yet been finalized. Almost all are yet to be approved by the Co-Monitors and remain works in progress. [6]

Practice within DSS's Out-of-Home Abuse and Neglect Investigations

One of the most significant areas of concern is practice within DSS's Out-of-Home Abuse and Neglect (OHAN) unit, which has the responsibility to receive and investigate reports of alleged abuse and neglect of children placed by DSS in out-of-home settings. This is an area in which the Co-Monitors initially thought that DSS could demonstrate early progress. However, although current performance reflects improvements in the validity of screening decisions to investigate or not investigate a referral, investigative practice remains inadequate. This is primarily due to a continued lack of resources so that staff have the time, direction and tools to satisfactorily complete their work. The caseloads of OHAN caseworkers far exceed the required limit and the quality of the work is suffering. Between October 2017 and March 2018, a monthly range of 74 to 91 percent of OHAN caseworkers were responsible for *more* than eight investigations, the established standard. In March 2018, five of the six OHAN caseworkers had caseloads ranging from 10 to 36 investigations.

[6] The OHAN Implementation Plan was approved on September 11, 2017 and Plaintiffs provided consent on November 7, 2017. The Healthcare Improvement Plan was developed with significant assistance from external consultants and was approved on August 23, 2018. The Visitation Implementation Plan has not yet been finalized and approved. External consultants were engaged by the Co-Monitors in June 2018 to assist in developing the Workforce Implementation Plan and Placement Implementation Plan in order to ensure they include the necessary analysis and strategies.

While five new OHAN investigator positions were recently allocated, as of June 2018, there were three investigator vacancies and one supervisor vacancy within current OHAN staff, further compounding the workload strain. DSS reports that until these vacancies and new positions can be filled, staff from other regions of the state will assist the OHAN unit in conducting staffings and supervisory reviews of open investigations, and in expediting hiring for the new and vacant positions. The Co-Monitors think that reducing caseloads and staff turnover must remain an immediate and high priority to address the ongoing concerns about the ability of workers to carry out their responsibilities with quality.

The quality of OHAN practice remains an area of significant concern. As discussed later in this report, a review by the Co-Monitors and USC staff of 32 investigations involving Class Members accepted by OHAN and initiated in March 2018 identified continued poor performance or significant declines in performance since the previous review in September 2017. Reviewers determined that less than one-quarter (21%) of decisions to unfound an investigation were appropriate, mostly due to insufficient information being collected during the investigation, and only one investigation (3%) included contact with all necessary core witnesses. One of the most concerning findings from this review was that only 22 (69%) investigations included contact with all alleged victim children prior to closure of the investigation, meaning that in almost one-third of the investigations reviewed (10), the investigator did not interview and assess all alleged victim children prior to making a decision and closing the investigation. One of the strategies in the OHAN Implementation Plan is development of an investigation practice training curriculum to provide workers with the structure and guidance they need to critically assess children's safety. DSS's reported date for providing this training to staff was December 2017, however, it did not occur. As of the writing of this report, DSS reports that the curriculum is near completion and that training will be provided to current OHAN staff in October 2018 and to newly hired staff in January 2019. This strategy, if implemented with quality and reinforced through appropriate supervision, is an important component to improving the investigative practice reflected in the recent review.

Placement Array and Processes

Improvements to DSS's placement array and processes are a significant focus of the FSA. As required by the September 2015 Interim Order, DSS has significantly reduced the number of children ages six and under placed in congregate care[7] and the number of children staying overnight at a DSS office[8]. Yet, data on the percentage of children placed in congregate care this

[7] During the period under review, 16 Class Members ages six and under were placed in congregate care; 12 of these children met an agreed upon exception either because the child was residing in a treatment facility with their mother or the child was part of a sibling group of four or more children for whom DSS reports a single, family-based placement could not be located.
[8] Between October 2017 and March 2018, DSS reports two children stayed overnight in a DSS office.

monitoring period (22 percent as of March 31, 2018) has not shown progress since the prior period (21 percent as of September 30, 2017). This is likely due to delays in adequately completing both the Placement Needs Assessment and the Placement Implementation Plan, which were to guide a comprehensive and cohesive process for ensuring appropriate placements and services for children throughout the state. DSS submitted a draft Placement Implementation Plan on October 31, 2017, and a revised draft on March 30, 2018, and after review, the Co-Monitors determined that the Plan required substantial revision. Consequently, given the urgency and fundamental importance of placement issues, in June 2018 the Co-Monitors engaged consultants to provide technical assistance in this area. The primary purpose of the consultants' work is to assess and identify gaps in the recommendations, feasibility, resource needs, strategies and timelines outlined in the draft Placement Implementation Plan; to assist DSS in developing an acceptable Plan; and, if needed, support DSS with Plan implementation.

In an effort to build a deeper understanding of placement issues and processes as part of their monitoring work, the Co-Monitors visited several group care facilities in December 2017 where they observed a number of concerning practices and conditions. Although these observations have been shared with DSS, the Co-Monitors determined that additional in-depth review of children's experiences in group care placements was needed. In April 2018, the Co-Monitors informed DSS of their plan to augment their monitoring capacity through the engagement of additional consultants to perform a special review of the quality of congregate care facilities throughout the state, focusing on the capacity to meet the needs of Class Members, and the extent to which these needs could be met in family-based settings. Consultants have been engaged and this assessment is expected to be completed in October 2018 and to include findings and recommendations that will inform the development of the Placement Implementation Plan.

Workforce Recruitment and Retention

All parties, as well as all child welfare practitioners agree that manageable caseloads for caseworkers and adequate supervisory supports are foundational components of a productive and effective workforce. Although having an adequate number of staff is critical, it is equally important that the right kind of staff are recruited, hired, trained and retained by DSS. This is another area of reform where progress has been insufficient. In most months during the monitoring period, fewer than 25 percent of caseworkers had caseloads within the required limit; specifically, in March 2018, only 25 percent of foster care caseworkers, 22 percent of IFCCS caseworkers and 15 percent of adoption caseworkers had caseloads *within* the required limits. Further, with the exception of OHAN supervisors[9], all categories of supervisors were not within the 90 percent requirement of their workload limit. For example, in March 2018, only 42 percent

[9] All three OHAN supervisors met the required limit of six or fewer investigators assigned each month during the period.

of foster care supervisors, 57 percent of IFCCS supervisors and 38 percent of adoption supervisors supervised five or fewer caseworkers, the established standard. DSS's FY2017/2018 budget provided funds for 163 new full time employee positions to support reform efforts in reducing caseload size. As of April 30, 2018, DSS reports only 33 percent of these positions had been filled. Vacancies within existing caseworker and supervisor positions also continue to be a challenge.

The FSA requires DSS to develop a Workload Implementation Plan which includes strategies to meet workload requirements. Several drafts of the Plan have been produced by DSS and the Co-Monitors have provided feedback, consistently asking that DSS include more specificity on budget sequencing, requests and strategies to develop the resources needed to meet the caseload requirements within four years. On May 29, 2018, DSS provided an updated draft of the Workload Implementation Plan with budgeting and resource information. In June 2018, the Co-Monitors hired a consultant with expertise in hiring and recruitment to assess DSS's draft Plan, identify where DSS planning can be strengthened and suggest actionable strategies to enable DSS to meet their workload obligations. This consultant will complete the assessment and provide recommendations by the end of September 2018.

Federal Child and Family Services Review Results

In April 2018, the Children's Bureau released findings from Round 3 of its Child and Family Service Reviews (CFSR) in South Carolina. The CFSR occurred between April and September 2017, and included reviews of 100 randomly selected cases[10] from 10 counties[11] across the state and stakeholder interviews. The CFSR includes a total of 36 items which are organized as child and family outcomes (safety, permanency and well-being) and systemic factors (statewide information system; case review system; quality assurance system; staff and provider training; service array and resource development; agency responsiveness to the community; and foster and adoptive parent licensing, recruitment and retention). DSS was not found to be in *substantial conformity* with any of the safety, permanency or well-being outcomes. DSS was in substantial conformity with one of the seven systemic factors – agency responsiveness to the community.

Practice trends identified by the Children's Bureau based upon CFSR case reviews are consistent with many of the observations of the Co-Monitors. These include lack of quality assessments; the need to focus on engaging parents, youth and caregivers; unstable and multiple placements for children; and lack of access to services. These practices directly impact DSS's ability to meet many FSA measures and highlight the importance of including strategies to improve practice in the required Implementation Plans. For example, it is difficult to find an appropriate and stable

[10] These included 51 in-home cases, 40 foster care cases and nine community-based prevention services cases.
[11] The counties include Aiken, Berkeley, Chesterfield, Fairfield, Greenville, Horry, Jasper, Newberry, Pickens and York.

placement for a child without a quality assessment and access to appropriate supportive and community-based services. And caseworkers must engage with parents and children to ensure that visits occur. DSS is required by the Children's Bureau to develop a Program Improvement Plan (PIP) to address the areas in which it was not found to be in substantial conformity, with priority given to safety interventions. The first draft of the PIP was due on June 4, 2018, and the plan must be implemented over two years. DSS is working to insure the integration of the PIP strategies with those required by the FSA.

Summary

In conclusion, since the beginning of the reform, DSS has not had sufficient capacity to adequately assess challenges, develop corresponding strategies or appropriately effectuate positive change, and steps to build this capacity have taken longer than everyone anticipated. Commentary among providers and within the legislature about the lack of demonstrable progress in areas such as caseloads, health care and placement are reflective of this frustration. DSS has recently developed additional capacity and structure in its central office to lead this work. Its constructive engagement with the health care consultants, DHHS and Select Health on health care planning has offered a model of work in partnership that can accelerate and focus other key areas of work. These very recent developments, plus the additional support now available through external consultants, will hopefully lead to much-needed progress and some positive results for children and families in the next year. This will be a real test of commitments from leadership to manage a multi-year, complex reform.

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[12]; 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 providers, advocacy and community organizations. The Co-Monitors have worked with DSS and USC's Center for Child and Family Studies (CCFS) to establish review protocols to gather performance data and assess current practice. Specific data collection and/or validation activities conducted by the Co-Monitors for the current period include the following:

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

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

- Review of all OHAN investigations involving Class Members that were accepted and initiated in March 2018 to assess for timely initiation, contact with core witnesses, timely completion and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of case files of a statistically valid sample of Class Members with siblings in foster care in March 2018 to assess whether sibling visits had occurred (FSA IV.J.2.);

- Review of case files of a statistically valid sample of Class Members with a goal of reunification in March 2018 to assess whether visits with parents had occurred (FSA IV.J.3.);

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

- Review of case files of children ages six and under who are placed in a congregate care setting (FSA IV.D.2.); and

- Review of all case files of children reported to have remained in a DSS office overnight (FSA IV.D.3.).

In addition to these data collection and reporting functions, the FSA gives the Co-Monitors the responsibility to review and approve Implementation Plans and to set or approve interim benchmarks and outcomes in multiple areas of practice. This has meant that the Co-Monitors and their staff have assumed a technical assistance role in addition to a monitoring function, helping to build capacity, connect DSS leadership with resources from across the country and engage consultants, when needed. The Co-Monitors have also acted in an intermediary role, working at times to bridge differences between DSS and Plaintiffs, and encouraging communication and problem solving among Parties. 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.

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[13]	Final Target	April 2017 – September 2017 Performance	October 2017 – March 2018 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))	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 Workload Implementation Plan is approved.***	OHAN caseworkers: As of September 25, 2017, no (0%) OHAN caseworker had a caseload within the required limit and all (100%) caseworkers had caseloads more than 125% over the limit.	OHAN caseworkers:[16,17] As of March 2018, 17% of OHAN caseworkers had a caseload within the required limit and 67% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 14 – 17%[18]. Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 67 – 83%[19]

[13] 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.

[16] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of caseworker. These random dates are as follows: October 24, 2017; November 6, 2017; December 14, 2017; January 29, 2018; February 8, 2018; March 13, 2018. Performance on this date is compared to other randomly selected dates during the month to ensure limited variability and reported performance is not an anomaly.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
Approved Caseworker Limits:[14, 15] • 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 caseworker: 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		<u>Foster Care caseworkers:</u> 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.	<u>Foster Care caseworkers:</u> As of March 2018, 25% of foster care caseworkers had a caseload within the required limit and 62% of caseworkers had caseloads more than 125% of the limit.

[17] The data audit work being conducted by Chapin Hall has identified potential issues with the quality and accuracy of these data. Specifically, some caseworker profiles still need to be updated, cleaned and/or validated to track case assignments properly. DSS and Chapin Hall plan to engage a small group of counties to test the accuracy of current CAPSS caseload reporting methodology. Additionally, DSS will consider changing policy to dictate that caseworker CAPSS profiles can only be completed by county Human Resources staff or other administrative level personnel instead of caseworker self-identification.

[18] Monthly performance for OHAN caseworker caseloads within the required limit are as follows: October 2017, 14%%; November 2017, 14%; December 2017, 14%; January 2018, 17%; February 2018, 17%; March 2018, 17%.

[19] Monthly performance for OHAN caseworker caseloads more than 125% over the limit are as follows: October 2017, 71%; November 2017, 86%; December 2017, 71%; January 2018, 83%; February 2018, 83%; March 2018, 67%.

[14] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.

[15] 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) the caseworker serves to the total number of families (cases) of Non-Class Members the caseworker also serves. The total number should not exceed 15 children and cases.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
		IFCCS caseworkers: As of September 25, 2017, 10% of IFCCS caseworkers had a caseload within the required limit and 77% of caseworkers had caseloads more than 125% over the limit.	Monthly range of performance for caseworkers within the required limit: 25 – 28%.[20,21] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 57 – 63%[22] IFCCS caseworkers: As of March 2018, 22% of IFCCS caseworkers had a caseload within the required limit and 50% of caseworkers had caseloads more than 125% of the limit.

[20] Monthly performance for foster care caseworker caseloads (which includes newly hired caseworkers, supervisors carrying foster care cases and county foster care caseworkers) within the required limit are as follows: October 2017, 27%; November 2017, 26%; December 2017, 25%; January 2018, 28%; February 2018, 27%; March 2018, 25%.
[21] Monthly caseload performance for only newly hired foster care caseworkers are as follows: October 2017, 14%; November 2017, 13%; December 2017, 12%; January 2018, 22%; February 2018, 21%; March 2018, 28%.
[22] Monthly performance for foster care caseworker caseloads more than 125% over the limit are as follows: October 2017, 62%; November 2017, 62%; December 2017, 63%; January 2018, 57%; February 2018, 59%; March 2018, 62%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
		Adoption caseworkers: 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.	Monthly range of performance for caseworkers within the required limit: 9 - 26%.[23,24] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 50 - 78%[25] Adoption caseworkers: As of March 2018, 15% of adoption caseworkers had a caseload within the required limit and 67% of caseworkers had caseloads more than 125% of the limit.

[23] Monthly performance for IFCCS caseworker caseloads (which includes newly hired caseworkers and supervisors carrying cases) within the required limit are as follows: October 2017, 9%; November 2017, 14%; December 2017, 16%; January 2018, 26%; February 2018, 23%; March 2018, 22%.
[24] Monthly caseload performance for only newly hired IFCCS caseworkers are as follows: October 2017, 0%; November 2017, 33%; December 2017, 50%; January 2018, 83%; February 2018, 67%; March 2018, 78%.
[25] Monthly performance for IFCCS caseworker caseloads more than 125% over the limit are as follows: October 2017, 72%; November 2017, 78%; December 2017, 76%; January 2018, 56%; February 2018, 50%; March 2018, 50%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
			Monthly range of performance for caseworkers within the required limit: 15 - 21%.[26,27] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 64 - 69%[28]
	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.	<u>OHAN Supervisors:</u> As of March 2018, 100% of OHAN supervisors were within the required limit. Monthly range of performance for supervisors within the required limit:100%

[26] Monthly performance for adoption caseworker caseloads (which includes newly hired caseworkers and supervisors carrying cases) within the required limit are as follows: October 2017, 20%; November 2017, 20%; December 2017, 18%; January 2018, 19%; February 2018, 21%; March 2018, 15%.
[27] Monthly caseload performance for only newly hired adoption caseworkers are as follows: October 2017, 14%; November 2017, 14%; December 2017, 0%; January 2018, 14%; February 2018, 14%; March 2018, 14%.
[28] Monthly performance for adoption caseworker caseloads more than 125% over the limit are as follows: October 2017, 65%; November 2017, 66%; December 2017, 68%; January 2018, 64%; February 2018, 69%; March 2018, 67%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
			Foster Care Supervisors: As of March 2018, 42% of foster care supervisors were within the required limit and 36% of supervisors were more than 125% of the limit. Monthly range of performance for foster care supervisors within the required limit: 42 – 45%.[29] Monthly range of performance for supervisors more than 125% of the limit: 35 – 38%.[3] IFCCS Supervisors: As of March 2018, 57% of IFCCS supervisors were within the required limit and 29% of supervisors were more than 125% of the limit.

[29] Monthly performance for foster care supervisors within the required limit are as follows: October 2017, 45%; November 2017, 43%; December 2017, 43%; January 2018, 43%; February 2018, 42%; March 2018, 42%.
[30] Monthly performance for foster care supervisors more than 125% over the limit are as follows: October 2017, 35%; November 2017, 38%; December 2017, 38%; January 2018, 35%; February 2018, 36%; March 2018, 36%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
			Monthly range of performance for IFCCS supervisors within the required limit: 47 – 57%.[31] Monthly range of performance for supervisors more than 125% of the limit: 29 – 32%.[32] <u>Adoption Supervisors:</u> As of March 2018, 38% of adoption supervisors were within the required limit and 19% of supervisors were more than 125% of the limit. Monthly range of performance for adoption supervisors within the required limit: 38 – 61%.[33] Monthly range of performance for supervisors more than 125% of the limit: 11 – 19%.[34]

[31] Monthly performance for IFCCS supervisors within the required limit are as follows: October 2017, 47%; November 2017, 47%; December 2017, 57%; January 2018, 57%; February 2018, 57%; March 2018, 57%.
[32] Monthly performance for IFCCS supervisors more than 125% over the limit are as follows: October 2017, 32%; November 2017, 32%; December 2017, 29%; January 2018, 29%; February 2018, 29%; March 2018, 29%.
[33] Monthly performance for adoption supervisors within the required limit are as follows: October 2017, 58%; November 2017, 58%; December 2017, 61%; January 2018, 38%; February 2018, 38%; March 2018, 38%.
[34] Monthly performance for adoption supervisors more than 125% over the limit are as follows: October 2017, 11%; November 2017, 11%; December 2017, 11%; January 2018, 19%; February 2018, 19%; March 2018, 19%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.	Unable to determine current performance.	Unable to determine current performance.[35]
	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.	Unable to determine current performance.	Unable to determine current performance.[36]
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 March 2018, 90%***	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%	Monthly performance for screening decisions not to investigate determined to be appropriate: October 2017: 92% November 2017: 84% December 2017: 93% January 2018: 89% February 2018: 80% March 2018: 81%

[35] See Section VI for further discussion.
[36] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
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 March 2018, 50%***	In September 2017, there were 38 investigations with decisions to unfound; 58% (22) of these decisions were determined to be appropriate.	In March 2018, there were 29 investigations with decisions to unfound; 21% (6) of these decisions were determined to be appropriate.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 March 2018, 80%***	In September 2017, of the 40 applicable investigations, 80% (32) were timely initiated or had documentation supporting completion of all applicable good faith efforts.	In March 2018, of the 32 applicable investigations, 66% (21) were timely initiated or had documentation supporting completion of all applicable good faith efforts.[37, 38]

[37] Contact was made with all the alleged victim child(ren) within 24 hours in 19 investigations and in two additional investigations, documentation supported completion of all applicable good faith efforts.

[38] 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[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 March 2018, 40%***	In September 2017, none (0%) of the 40 applicable investigations included contact with all necessary core witnesses during the investigation.	In March 2018, 3% (1) of the 32 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[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 March 2018, 75%***	79% of applicable investigations received in September 2017 were appropriately closed within 45 days.	82% of applicable investigations received in March 2018 were appropriately closed within 45 days.[39]

[39] Of the 34 applicable investigations received in March 2018, one investigation was excluded from the 45-day compliance measure as a 15-day extension request was submitted and approved by the OHAN Director. (In one additional investigation, an extension was requested and granted due to the assigned investigator becoming ill; the reviewer determined that this situation did not meet the requirements for a good cause reason to approve an extension and should not be excluded from this measure as another investigator could have been assigned.) Of the remaining 33 investigations, 29 investigations were completed within 45 days, however, reviewers determined that two of the investigations closed within 45 days were closed as unfounded prematurely in an effort to meet the 45-day requirement. Therefore, 27 of the 33 applicable investigations met the FSA standard.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 March 2018, 80%***	88% of applicable investigations received in September 2017 were appropriately closed within 60 days.	88% of applicable investigations received in March 2018 were appropriately closed within 60 days.[40]

[40] Two investigations were determined to be closed prematurely in an effort to meet the deadline and are not considered compliant. Therefore, 30 of the 34 applicable investigations met the FSA standard.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 March 2018, 95%***	93% of applicable investigations received in September 2017 were appropriately closed within 90 days.	88% of applicable investigations received in March 2018 were appropriately closed within 90 days.[41]

[41] Two investigations were determined to be closed prematurely in an effort to meet the deadline and are not considered compliant. Additionally, while conducting the case record review, it was determined that two investigations involving Class Members that were received and initiated in March 2018 were still open and were exceeding 90 days. The files for these investigations could not be provided so information on these two investigations could not be collected for other OHAN measures, however, they could be included for this measure. Therefore, 30 of the 34 applicable investigations met the FSA standard.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 six and under shall be placed in a congregate care setting except with approved exceptions.	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.[42] 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.	In March 2018, there were eight Class Members ages six and under in DSS custody and residing in a congregate care facility. The circumstances of seven 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. Between October 2017 and March 2018, a total of 16 Class Members ages six and under were placed in congregate care. The circumstances of 12 of these young children met an agreed upon exception[43].

[42] 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 order for emergency removal from the parents' custody), also ordered that the children remain in the facility placement.
[43] Applicable exceptions for the referenced children include the child was residing in a treatment facility with their mother or the child was part of a sibling group of four or more children for whom DSS reports a single, family-based placement could not be located.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 April and September 2017, DSS reports three children remained overnight in a DSS office.[44]	Between October 2017 and March 2018, DSS reports two children remained overnight in a DSS office.[45]

[44] 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. The Co-Monitors will continue to explore this issue.
[45] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.***	As of September 30, 2017, 79% (3,225 of 4,079) of children in foster care were placed outside of a congregate care setting.	As of March 31, 2018, 78% (3,313 of 4,226) of children in foster care were placed outside of a congregate care setting.[46, 47]

[46] Twenty-six children who were hospitalized (11) or in a correctional facility (15) are not included in the universe for this measure.

[47] The data audit work being conducted by Chapin Hall has identified potential issues with the quality and accuracy of data related to placement. Specifically, placement type, placement stability and emergency or temporary placements. This may impact the accuracy of data for this measure as well as other placement measures reported herein. DSS and Chapin Hall have a project underway to assess the extent of any issues and will develop a plan for correction as needed. Additionally, DSS data provided for this period do not indicate whether a child's placement in custody is voluntary or involuntary, which would enable reporting to distinguish between Non-Class Members and Class Members. 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 for some placement measures, a small number of Non-Class Members are included in aggregate data. DSS recently developed the capacity to distinguish between children who are voluntarily and involuntarily placed in care and data for the next monitoring period will reflect these enhancements.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.***	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.	As of March 31, 2018, 92% (2,727 of 2,966) of children ages 12 and under in foster care were placed outside of a congregate care setting. [48]

[48] Exceptions have been approved, though not applied during this monitoring period; therefore, performance may be higher than reported. DSS will develop a process for review and approval.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.[49]

[49] DSS is unable to provide the data needed to report on this requirement. DSS has identified two primary barriers to collecting and providing these data: (1) there is not a standard, operational definition for "emergency" or "temporary" placements, and (2) due to a lack of a clear operational definition, placement data utilizing these categories are inconsistently entered by staff into CAPSS. DSS has informed the Co-Monitors that after a definition is agreed upon, a code book of definitions describing each level of foster care will be developed and fields will 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[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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. [50]

[50] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.	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.[51, 52]	Data for this measure is reported on an annual basis and will be included in the next monitoring report.[53]

[51] Specifically, there were a total of 5,186 moves and 1,459,138 total applicable days.
[52] 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.
[53] Performance is reported by fiscal year. The next monitoring report will include performance for October 1, 2017 through September 30, 2018.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Placement Implementation Plan is approved.***	64% (484 of 754) of children entering foster care with their siblings or within 30 days of their siblings from April to September 2017 were placed with at least one of their siblings.	63% (547 of 863) of children entering foster care with their siblings or within 30 days of their siblings from October 2017 to March 2018 were placed with at least one of their siblings on March 30, 2018. [54]

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

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Placement Implementation Plan is approved.***	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 to September 2017 were placed with all of their siblings.	As of March 30, 2018, 38% (324 of 863) of children entering foster care with their siblings or within thirty (30) days of their siblings from October 2017 to March 2018 were placed with all of their siblings.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.	Unable to determine performance.	Unable to determine current performance.[55]

[55] DSS does not currently have a system in place for tracking youth involved with both the juvenile justice and child welfare systems. As discussed in Section VIII below, the Co-Monitors reviewed a number of cases – likely representative of many others – in which youth spent time in DJJ facilities due, in part, to DSS's failure to meet their needs.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Placement Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[56]

[56] 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[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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	Data are not available for this period.	Data are not available for this period.[57]

[57] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 Performance**
	of the Class Members. ***Dates to reach final target and interim benchmarks to be added once Placement 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 Placement Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[58]

[58] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Placement Implementation Plan is approved.***	Data are not available for this period.	Data are not available for this period.[59]

[59] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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.***	In September 2017, 66% of all required visits between siblings occurred for siblings who were not placed together.	In March 2018, 57% of all required visits between siblings occurred for siblings who were not placed together.[60]

[60] 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. As discussed in Section IX below, the data sample identified for review was calculated based on the number of applicable *children* rather than the applicable number of *visits*. As a result, reported performance data may not have the same level of statistical significance. As DSS's capacity to extract aggregate data for this measure improves, calculations will be based on a universe of applicable visits, as required by the FSA.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Visitation Implementation Plan is approved.***	In November 2017, 12% of children with a goal of reunification visited twice with the parent(s) with whom reunification was sought.	In March 2018, 17% of children in foster care with a goal of reunification visited twice with the parent(s) with whom reunification was sought.[61]

[61] 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.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Health Care Improvement Plan is approved.***	Data for this measure are not available.	73% of Class Members who entered foster care between October 1, 2017 and March 31, 2018 received an initial physical health assessment.[62] 52% of Class Members who entered foster care between October 1, 2017 and March 31, 2018 received an initial mental health assessment.[63] 48% of Class Members who entered foster care between October 1, 2017 and March 31, 2018 received an initial dental assessment.[64]

[62] Data on initial assessments is based on Medicaid claims and encounter data and has not been independently validated by the Co-Monitors. Because there is still important work that needs to be done to clarify DSS policy and definitions for assessments and map them to Medicaid claims data, DSS is not yet able to identify details related to these initial assessments.
[63] For children under the age of three, completion of an initial medical assessment was considered compliant for the mental health assessment measure as a developmental assessment and screening is a component of their examination with a primary health care provider.
[64] For purposes of this analysis, children under the age of one were not considered applicable for an initial dental assessment. An oral examine is a component of their examination with a primary health care provider.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements[13]	**Final Target**	**April 2017 – September 2017 Performance**	**October 2017 – March 2018 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 Health Care Improvement Plan is approved.***	Data for this measure are not available.	Data for this measure are not available.

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 March 31, 2018)[65]**
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[66] 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 was provided on October 21, 2016.

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

[66] 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. For more information, see 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 March 31, 2018)[65]**
	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[67] • New caseworker – ½ of the applicable standard for their 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[68] In addition to calculating performance for caseworkers servicing a single type of case, a standard and methodology for caseworkers who have both Class and Non-Class Members[69] (mixed caseloads) on their caseload were provisionally approved in December 2017. See Section V. of this report for detailed discussion of the approved mixed caseload standard and methodology.

[67] 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, DSS reports case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until a placement agreement is signed. 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.

[68] 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.

[69] 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 March 31, 2018)[65]**
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. The Co-Monitors have consistently asked that DSS include more specificity in the Plan on budget sequencing, requests and strategies to develop the resources needed to meet the caseload standards within four years. On May 29, 2018, DSS provided an updated draft of the Workload Implementation Plan with budgeting and resource information. The Co-Monitors have hired a consultant with expertise in hiring and recruitment to assess DSS's draft Plan, identify where DSS planning can be strengthened and suggest strategies that will enable DSS to meet its workload obligations. This consultant was hired in late June 2018 and plans to complete her assessment and provide recommendations by the end of September 2018. 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 March 31, 2018)[65]**
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 during the last reporting period. The Co-Monitors provided feedback to DSS on required data clean-up. In June 2018, DSS began work through its visitation workgroup to address issues with the validity of these data, including the development of draft documentation and quality guidelines to guide caseworkers. DSS has also identified this as an area of focus in its work with Chapin Hall and has reported that it is considering a case record review to assess documentation once the necessary changes to policy manuals and CAPSS screens have been made. As an initial step, DSS agreed in August 2018 to perform a limited review of CAPSS records jointly with the Co-Monitors for the purposes of assessing whether there have been any improvements to the accuracy of the data since last reported, and building an understanding of the documentation issues that have been identified by the Co-Monitors. The Co-Monitors will reassess the need for an Implementation Plan in the next monitoring period, once more information is obtained from this review.

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 March 31, 2018)[65]**
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.	The Co-Monitors approved the OHAN Implementation Plan on September 11, 2017 and Plaintiffs provided their consent to the plan on November 7, 2017. A full update on implementation of the strategies within the Plan is attached as Appendix B. Due to the ongoing vacancies in both supervisor and investigator positions, consistent implementation of many of the Plan's strategies have not occurred.[70]

[70] For example, OHAN management reports that institution of a caseworker office day for completion of documentation and other case management activities would be extremely beneficial; however, this is not possible with the current level of staffing as caseworkers are needed in the field to respond to reports and complete investigative activities. Another strategy that is overdue is development of an investigation training curriculum. Originally estimated to be completed by December 2017, DSS currently reports the curriculum is near complete and the training will be delivered to existing OHAN staff in October 2018 and new staff in January 2019.

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 March 31, 2018)[65]**
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 the required 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 provided requested county level data on March 30, 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 March 31, 2018)[65]**
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.	The Co-Monitors have not yet approved a Plan and interim benchmarks and timelines. DSS submitted a draft Placement Implementation Plan on October 31, 2017, to which the Co-Monitors provided feedback. On March 30, 2018, DSS submitted a revised draft Plan. After reviewing the draft Plan, the Co-Monitors determined that several areas require revision, including improving data analysis and needs projections; clarifying, expanding and operationalizing strategic approaches; elaborating how and when new policies and casework practices will be implemented; and understanding and articulating the undergirding case practice model. After consulting with DSS and Plaintiffs, in June 2018, the Co-Monitors hired consultants to provide technical assistance in multiple phases, which include (1) reviewing the Placement Needs Assessment and draft Implementation Plan to assess the recommendations, feasibility, resource needs, strategies and timelines that have been proposed and identify gaps, if any; (2) assisting DSS in incorporating the information collected to develop an acceptable Plan that meets each of the expectations outlined in the FSA, including a clear case practice model that will be reflected in all aspects of the placement process; and, (3) if needed, supporting DSS with Plan implementation. The Co-Monitors expect that this work will be done in collaboration with the DSS placement workgroup, additional stakeholders and regional/local staff to capitalize on the strengths of the existing planning effort.

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 March 31, 2018)[65]**
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 and under in any non-family group placement by November 28, 2015.	Data indicate that DSS's processes to prevent the placement of Class Members ages six and under in a 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 since entry of the Interim Order. Each month during this monitoring period, the number of Class Members in a congregate care placement ranged from three to eight children. Most of these children were residing in a treatment facility with their mother or were part of a sibling group of four or more for whom DSS reports a single, family-based placement could not be located.

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 March 31, 2018)[65]**
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, completed several rounds of revisions and modifications. The Implementation Plan for visitation could not be approved by the Co-Monitors because reliable baseline data with respect to children with reunification goals were not available. As discussed later in this report, the Co-Monitors and University of South Carolina's Center for Child and Family Studies (USC CCFS) were able to manually collect relevant data beginning in the last monitoring period. DSS submitted a revised Plan on August 11, 2018. The Co-Monitors provided feedback on August 17, 2018 and DSS is currently working to incorporate that feedback into the 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 March 31, 2018)[65]**
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	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 (Kathleen Noonan and Gail Nayowith) 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. DSS worked closely with the consultants to make recommended changes to their Plan and submitted an updated version to the Co-Monitors on June 29, 2018. The Co-Monitors provided feedback to DSS and on August 23, 2018, the Plan was approved pursuant to FSA IV.K.1(a-b). The Co-Monitors will now work with DSS and the consultants to identify all final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, as per Sections IV.K.1(c) and IV.K.5. of the FSA.

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 March 31, 2018)[65]**
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.)		

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. Caseloads overall continue to be well above required limits – with roughly a quarter or less of each type of caseworker within the required limits each month. High caseloads have a significant impact on a caseworker's ability to complete job functions and contribute to unwanted job turnover.

DSS's FY 2017/2018 budget provided funds for 163 new full-time employee positions in DSS. DSS anticipated utilizing 67 of these positions for new IFCCS positions[71], in order to reduce foster care caseworker responsibility for children on the "other lead" list[72]. Fifty-nine of the new positions were allocated toward second and third shift intake caseworkers in select counties and the remainder were designated for either new foster care, family preservation or assessment caseworker positions in county offices. As of April 30, 2018, 54 (33%) of the 163 positions had been filled, including 19 IFCCS caseworkers. In addition to these newly allocated positions, DSS reported that as of May 2018, there are 56 foster care, IFCCS and adoption caseworker vacancies[73] and eight supervisor vacancies statewide; additional vacancies also exist for staff not directly responsible for Class Members cases.

For the first time since monitoring began, DSS is able to provide caseload data for caseworkers and supervisors for each month in the monitoring period. These data were first available in June and July 2018 and have not been independently validated by the Co-Monitors. However, production of the data is a significant step forward. The Co-Monitors will continue to work with DSS and the data audit consultants to validate the accuracy of the caseload data.[74]

[71] 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.

[72] The "other lead" list includes children who are ISCEDC (Interagency System of Caring for Emotionally Disturbed Children) eligible and may be receiving ISCEDC services, however, they are not currently case managed by an IFCCS caseworker due to high IFCCS caseload levels.

[73] Thirty-three of the caseworker vacancies were for foster care caseworkers.

[74] The data audit work being conducted by Chapin Hall has identified potential issues with the quality and accuracy of these data. Specifically, some caseworker profiles still need to be updated, cleaned and/or validated to track case assignments properly. DSS and Chapin Hall plan to engage a small group of counties to test the accuracy of current CAPSS caseload reporting methodology. Additionally, DSS will consider changing policy to dictate that caseworker CAPSS profiles can only be completed by county Human Resources staff or other administrative level personnel instead of caseworker self-identification.

A. Workload Implementation Plan

The FSA required 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)).

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. The Co-Monitors and Plaintiffs have consistently asked that DSS include in the Plan more specificity on budget sequencing, requests and strategies to develop the resources needed to meet the caseload standards within four years.

On May 29, 2018, DSS provided an updated draft of the Workload Implementation Plan with budgeting and resource information. In June 2018, the Co-Monitors hired a consultant with expertise in hiring and recruitment to assess DSS's draft Plan, identify where DSS planning can be strengthened and suggest strategies that will enable DSS to meet their workload obligations. This consultant plans to complete the assessment and provide recommendations by the end of September 2018.

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 and 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.

DSS has many staff with mixed caseloads that include both Class and Non-Class Members. 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 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 their 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 several family preservation cases involving families with multiple children. DSS has indicated that managers are continually assessing 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 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.

Foster Care Caseworkers[75]

The caseload standard for caseworkers who are responsible for providing case management for foster care cases is one caseworker to 15 children (1:15).[76] Between October 2017 and March 2018, a monthly range of 25 to 28 percent of foster care caseworkers had caseloads within the required limit (see Figure 1) and 57 to 63 percent of foster care caseworkers had caseloads more than 125 percent of the caseload limit (see Figure 2). Specifically, on March 13, 2018,[77] there were 205 foster care caseworkers with at least one foster care child on their caseload.[78] Of these 205 caseworkers, 51 (25%) foster care caseworkers had caseloads within the required limit. Additionally, 128 (62%) caseworkers' caseloads were more than 125 percent of the caseload limit.

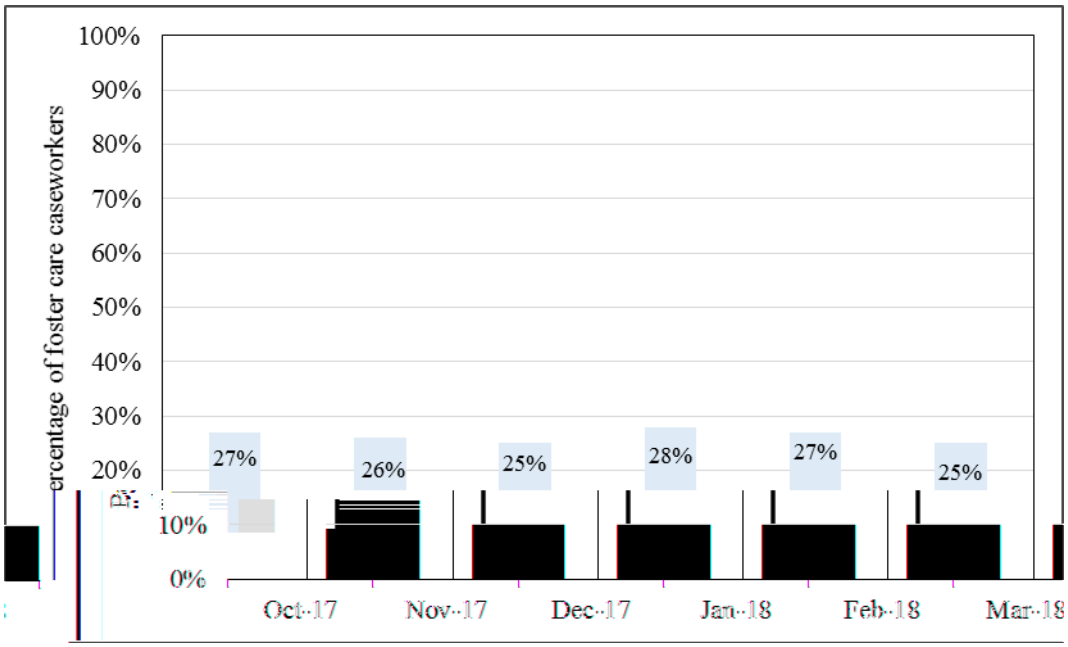
[75] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of caseworker. These random dates are as follows: October 24, 2017; November 6, 2017; December 14, 2017; January 29, 2018; February 8, 2018; March 13, 2018. Performance on this date is compared to other randomly selected dates during the month to ensure limited variability and ensure reported performance is not an anomaly.

[76] In calculating performance, a standard of eight 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 Adult Protective Services (APS) caseworkers.

[77] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of caseworker. The random date for March is March 13, 2018.

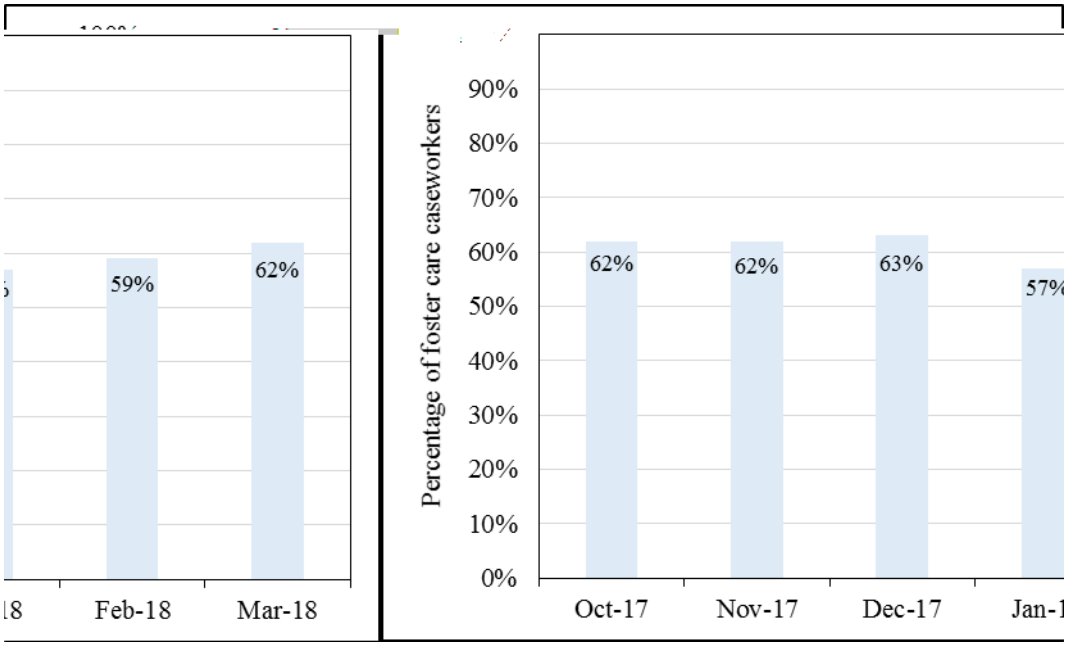
[78] This includes two caseworkers designated as APS caseworkers who were case managing foster care children in addition to their adult clients, 18 supervisors who were carrying caseloads and 32 newly hired foster care caseworkers.

Figure 1: Foster Care Caseworkers within the Required Caseload Limits October 2017 - March 2018



Source: CAPSS Data Provided by DSS

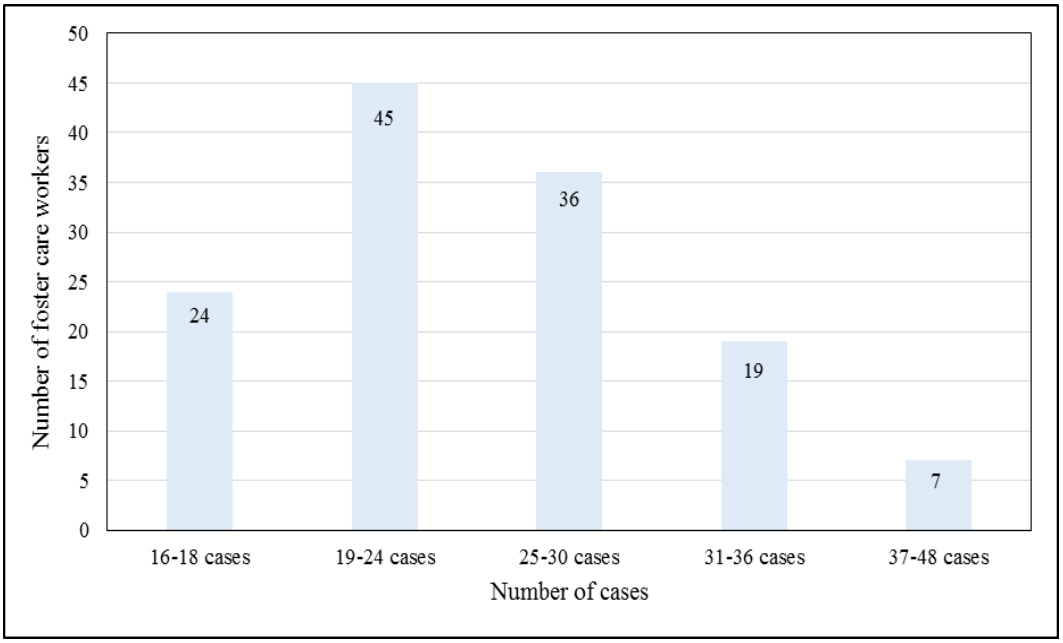
Figure 2: Foster Care Caseworkers over 125% of Required Caseload Limits October 2017 - March 2018



Source: CAPSS Data Provided by DSS

As shown in more detail below, the majority of foster care caseworkers who had caseloads above the limit were substantially over the limit. Almost half (48 percent or 62 of 129) of foster care caseworkers who had been employed for at least six months and were over the caseload limit on March 13, 2018, had caseloads of 25 children and families or higher, with seven caseworkers with caseloads of between 37 and 48 children and families (see Figure 3). For newly hired foster care caseworkers, 16 (70%) of the 23 caseworkers who were over the limit had caseloads at least double the standard of eight children and families (see Figure 4)[79].

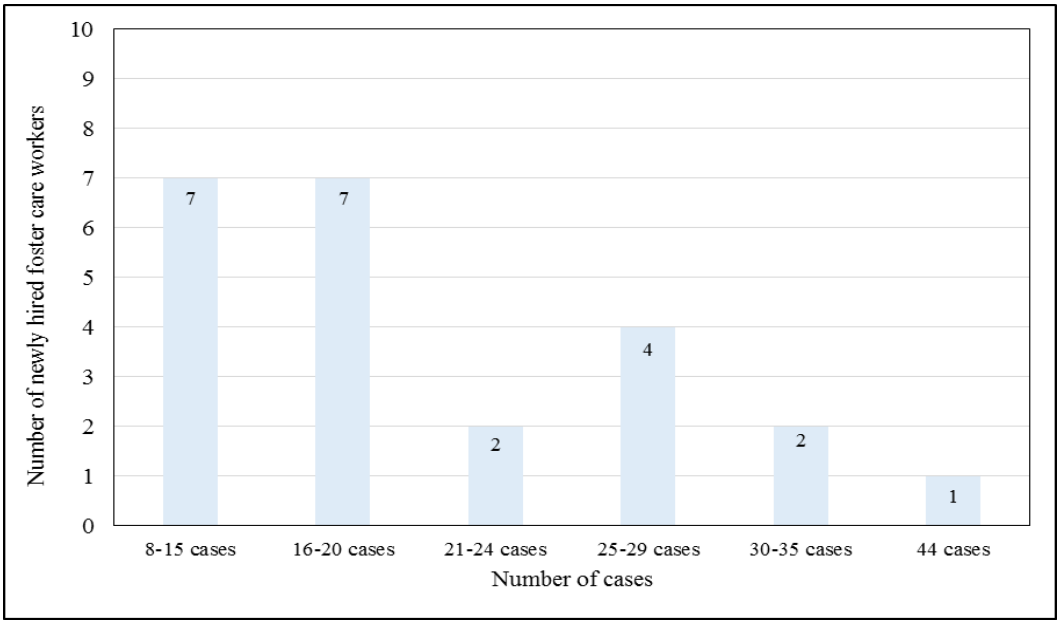
Figure 3: Caseloads for Foster Care Caseworkers that were Over the Limit
March 13, 2018
N = 129



Source: CAPSS Data Provided by DSS

[79] Monthly caseload performance for newly hired foster care caseworkers are as follows: October 2017, 14%; November 2017, 13%; December 2017, 12%; January 2018, 22%; February 2018, 21%; March 2018, 28%.

Figure 4: Caseloads for Newly Hired Foster Care Caseworkers that were Over the Limit
March 13, 2018
N = 23



Source: CAPSS Data Provided by DSS

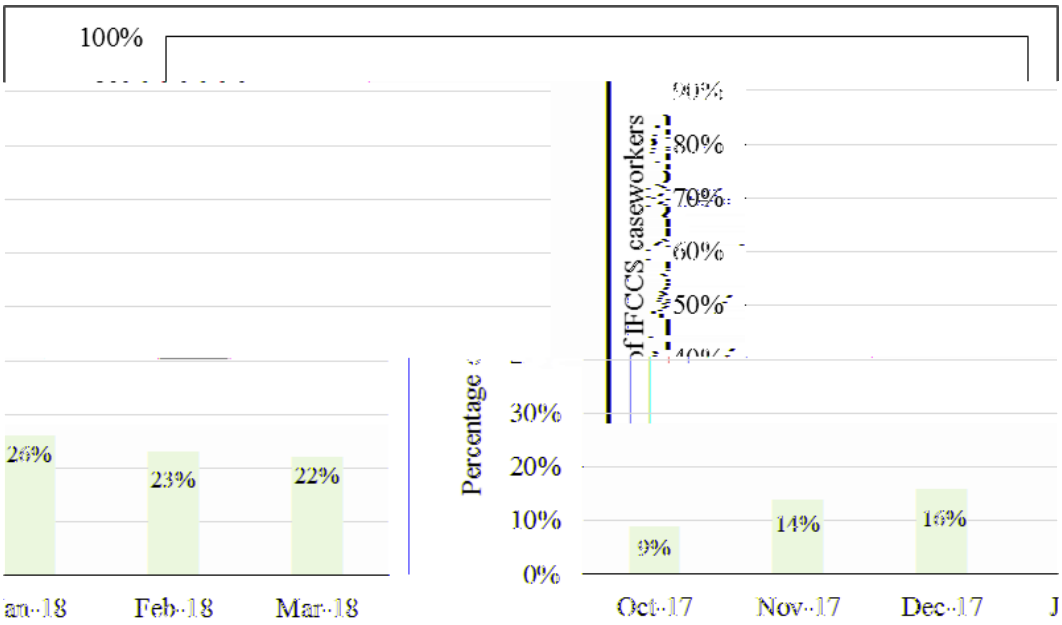
IFCCS Caseworkers

The caseload standard for caseworkers who are responsible for providing case management to children designated as needing IFCCS services is one caseworker to nine children (1:9). Newly hired IFCCS caseworkers should have no more than five children on their caseload for six months after they complete Child Welfare Basic training.

Between October 2017 and March 2018, a monthly range of nine to 26 percent of IFCCS caseworkers were within the required limits, with performance improving after December 2017. Specifically, on March 13, 2018, there were 82 IFCCS caseworkers[80] serving at least one Class Member and 18 (22%) of these caseworkers were within the required caseload limit (see Figure 5) and 41 (50%) caseworkers had caseloads more than 125 percent of the caseload limit (see Figure 6).

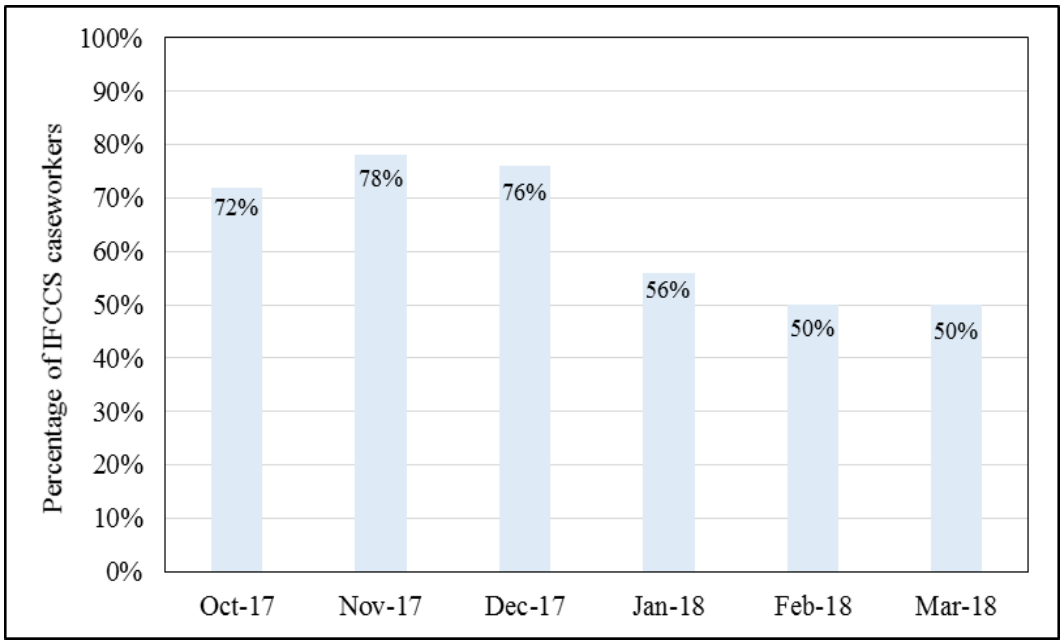
[80] Total includes six supervisors who were carrying cases and nine newly hired IFCCS caseworkers with a caseload standard of five children.

Figure 5: IFCCS Caseworkers within the Required Caseload Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

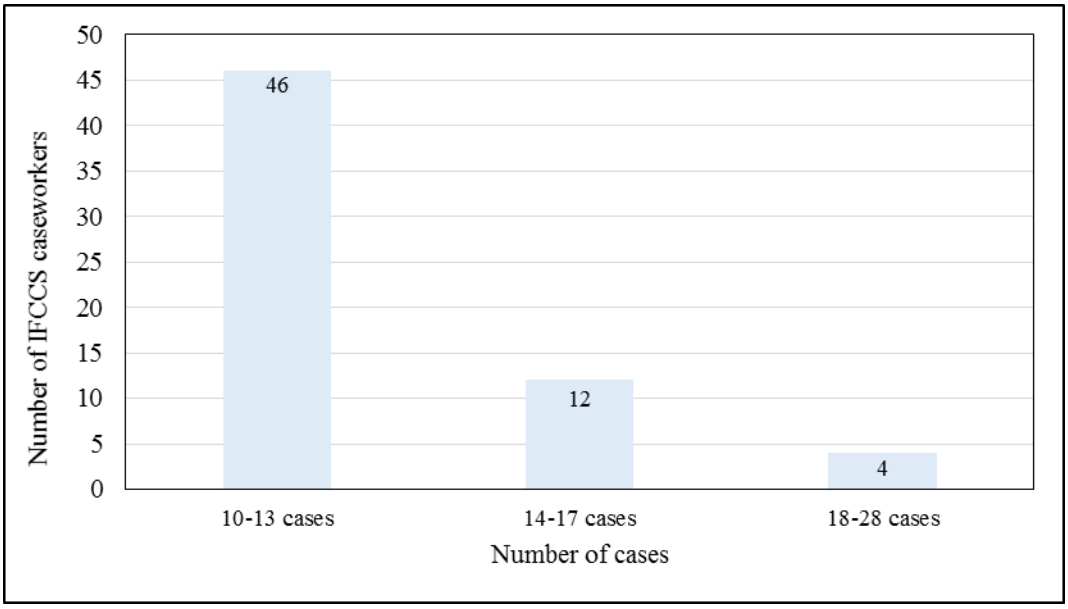
Figure 6: IFCCS Caseworkers over 125% of Required Caseload Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

Figure 7 shows the caseload range for IFCCS caseworkers who were over the required limit on March 13, 2018.[81] The highest number of cases carried by one IFCCS caseworker on that day was 28 children's cases.

Figure 7: Caseloads for IFCCS Caseworkers that were Over the Limit
March 13, 2018
N=62



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).[82]

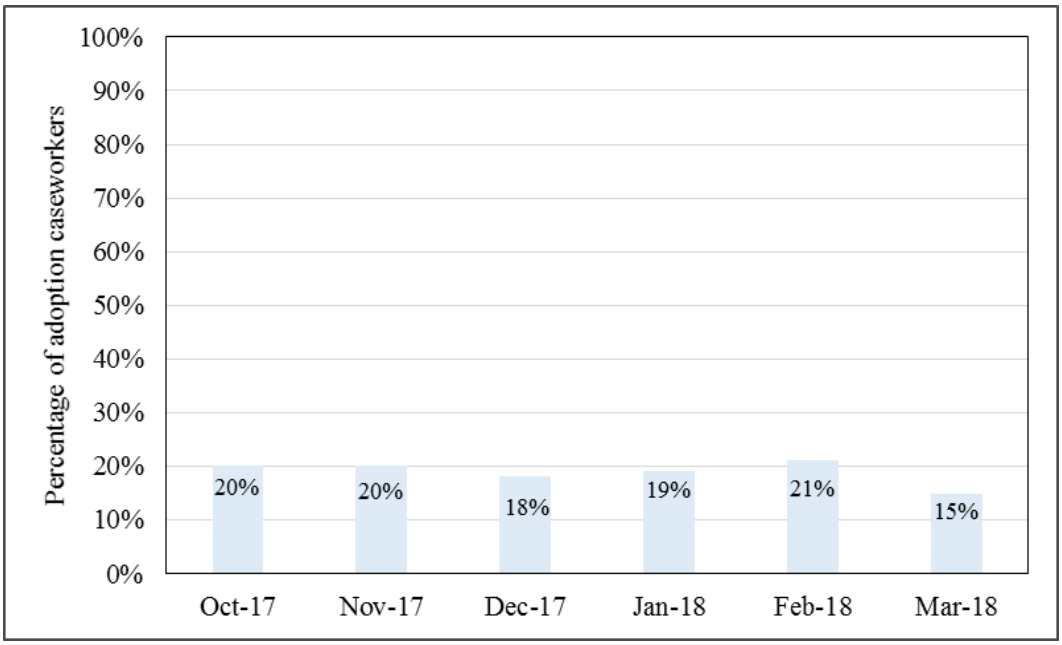
Between October 2017 and March 2018, a monthly range of 15 to 21 percent of adoption caseworkers had caseloads within the required limit (see Figure 8) and 64 to 69 percent had caseloads that exceeded 125 percent of the required limit (see Figure 9). On March 13, 2018,

[81] There were nine newly hired IFCCS caseworkers in March 2018. Two had caseloads over the required limit, with 10 and 11 respectively. These caseworkers caseloads are not reflected in the Figure above as the newly hired standard is different than caseworkers who have been employed for six months or longer. Monthly caseload performance for only newly hired IFCCS caseworkers are as follows: October 2017, 0%; November 2017, 33%; December 2017, 50%; January 2018, 83%; February 2018, 67%; March 2018, 78%.

[82] 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 a placement agreement is signed. 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.

there were 79 adoption caseworkers[83] serving at least one Class Member. Of these 79 caseworkers, 12 (15%) caseworkers had caseloads within the caseload requirement and 53 (67%) caseworkers had caseloads that were more than 125 percent of the limit.

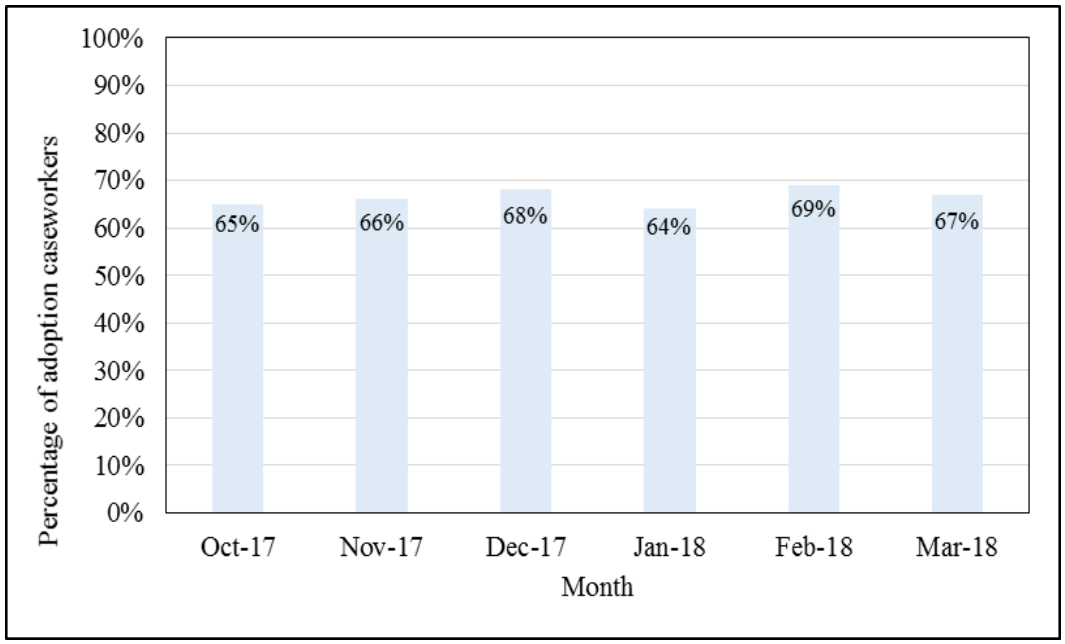
Figure 8: Adoption Caseworkers within the Required Caseload Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

[83] Total includes eight supervisors who were carrying cases and six newly hired adoption caseworkers with a caseload standard of nine children.

Figure 9: Adoption Caseworkers over 125% of Required Caseload Limits October 2017 - March 2018

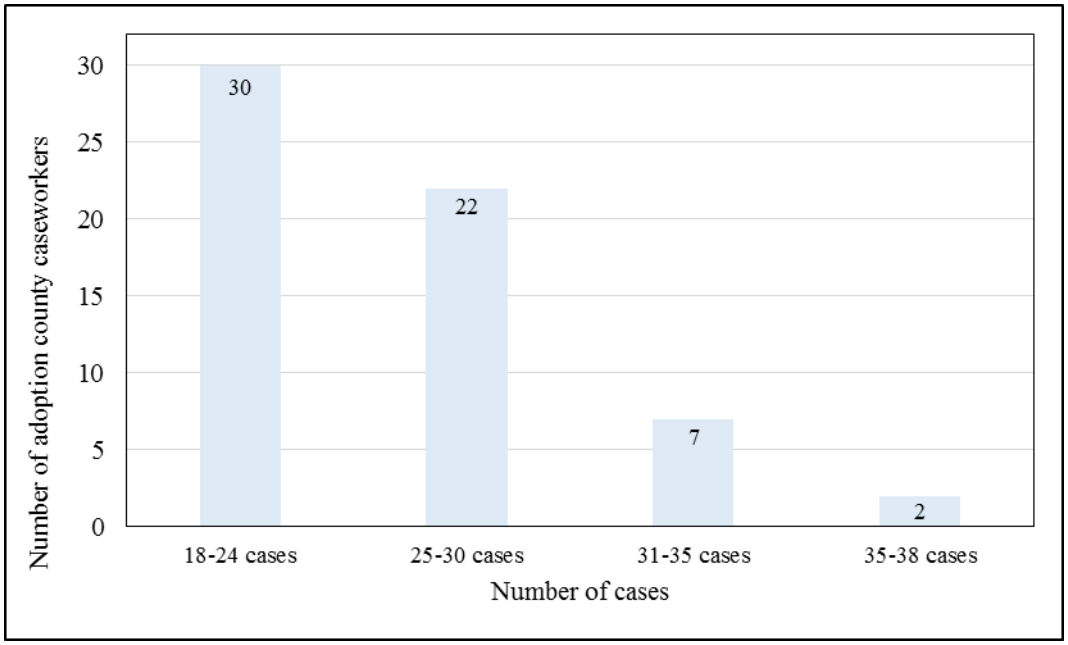


Source: CAPSS Data Provided by DSS

Approximately half (51% or 31 of 61) of caseworkers who had caseloads over the limit on March 13, 2018 and had been employed for six months or longer had caseloads ranging between 25 to 38 children's cases (see Figure 10). Five of the six newly hired adoption caseworkers who had caseloads over the required limit had over double the required limit, with one new adoption caseworker responsible for 29 children's cases[84] (see Figure 11).

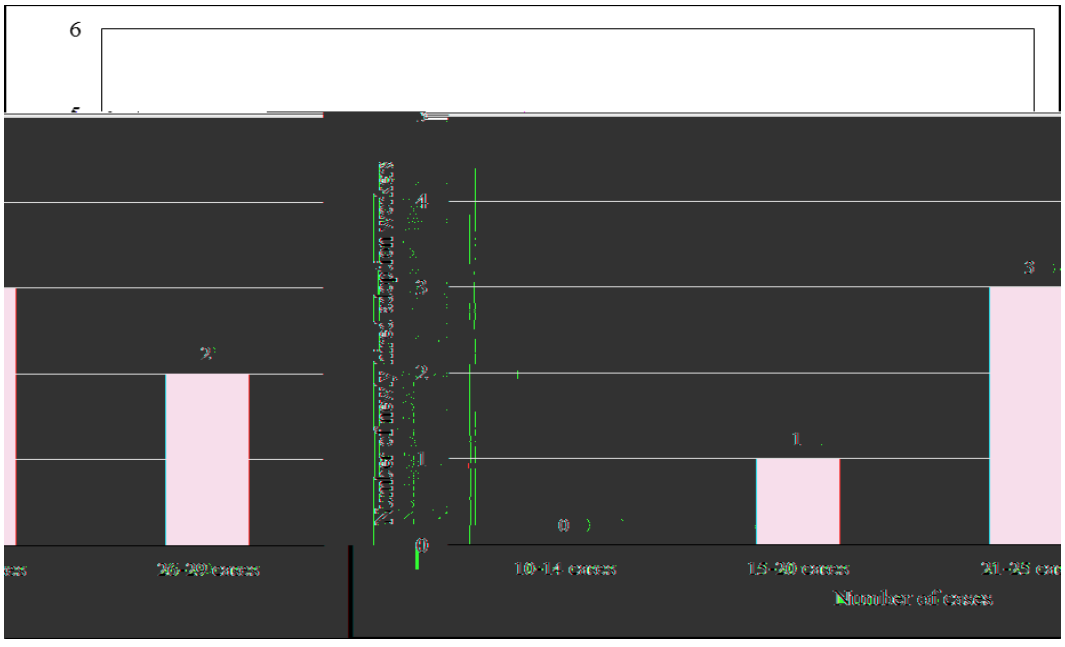
[84] Monthly caseload performance for only newly hired adoption caseworkers are as follows: October 2017, 14%; November 2017, 14%; December 2017, 0%; January 2018, 14%; February 2018, 14%; March 2018, 14%.

Figure 10: Caseloads for Adoption Caseworkers that were Over the Limit
March 13, 2018
N= 61



Source: CAPSS Data Provided by DSS

Figure 11: Caseloads of Newly Hired Adoption Caseworkers that were Over the Limit
March 13, 2018
N=6



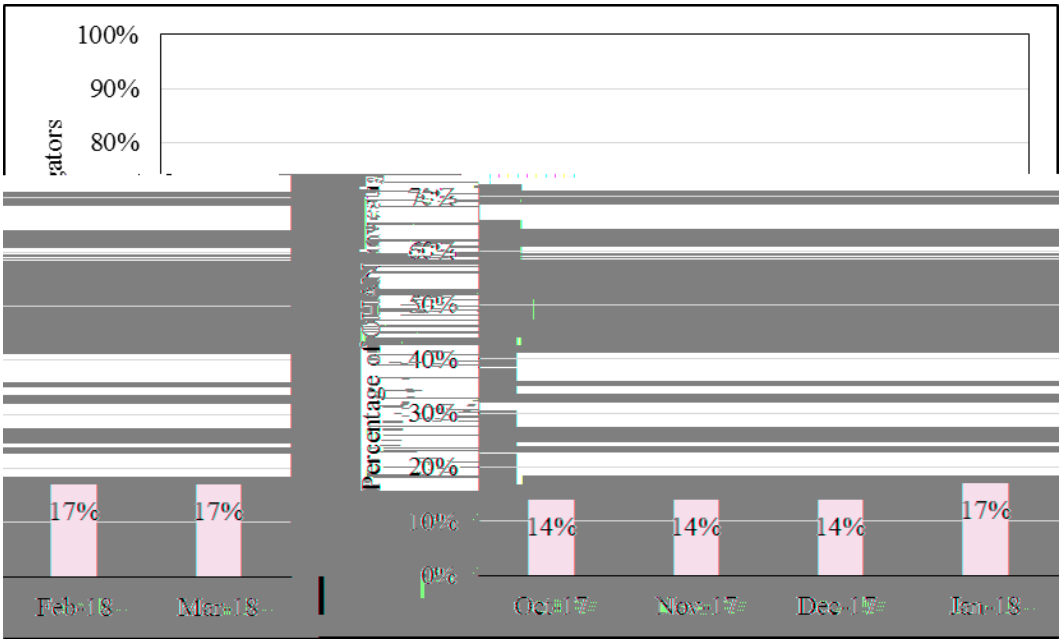
Source: CAPSS Data Provided by DSS

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).

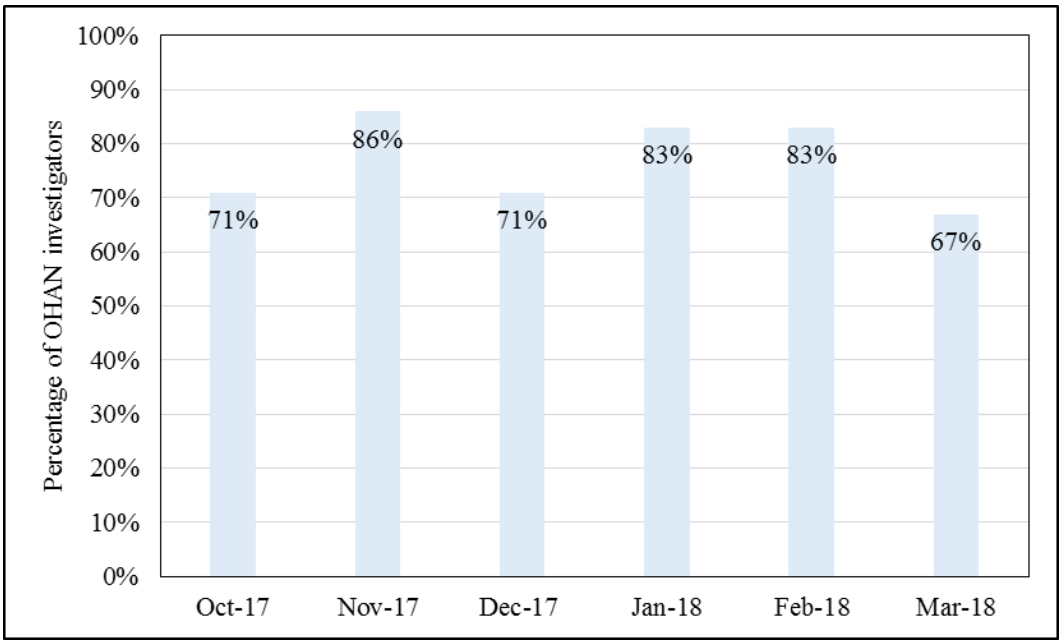
Between October 2017 and March 2018, a monthly range of 14 to 17 percent of OHAN caseworkers had caseloads within the required limits (see Figure 12) and 67 to 86 percent of caseworkers had caseloads of more than 125 percent of the required limit (see Figure 13). Specifically, on March 13, 2018, of the six OHAN investigators, one (17%) investigator had a caseload of eight investigations. The five remaining OHAN investigators had caseloads ranging from 10 to 36 investigations per worker (see Table 3).

Figure 12: OHAN Investigators within the Required Caseload Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

Figure 13: OHAN Investigators over 125% of Required Caseload Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

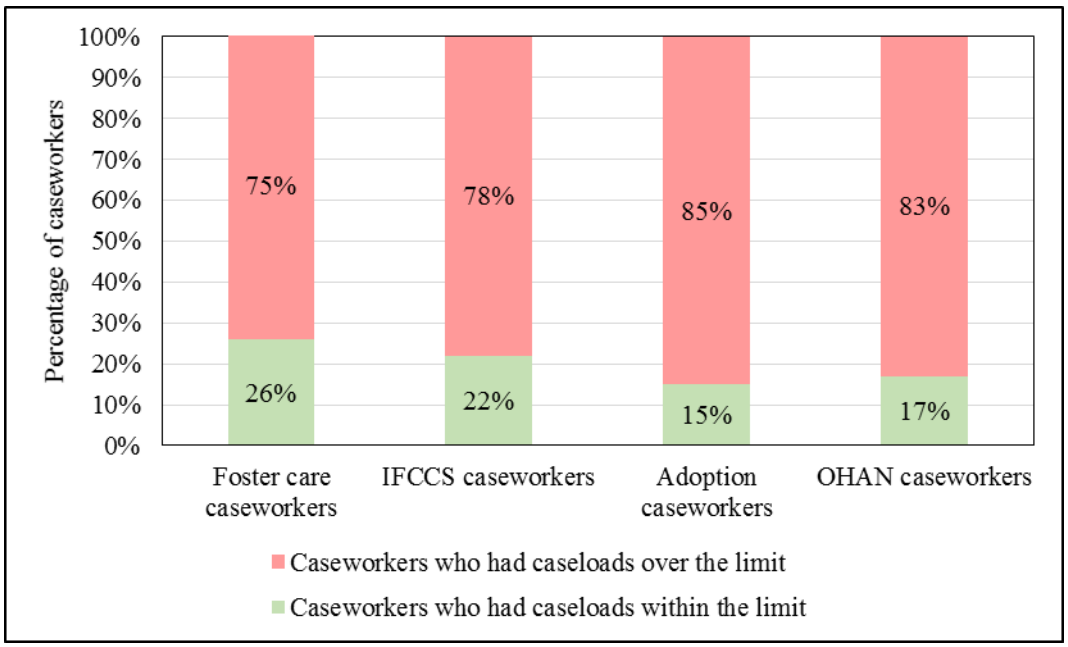
Table 3: Caseloads for OHAN Caseworkers
March 13, 2018
N=6

Caseworker	Number of Investigations
Caseworker 1	8
Caseworker 2	10
Caseworker 3	15
Caseworker 4	24
Caseworker 5	28
Caseworker 6	36
Total – 6 caseworkers	**Total – 121 investigations**

Source: CAPSS Data Provided by DSS

In summary, Figure 14 reflects the percentage of foster care, IFCCS, adoption and OHAN caseworkers within and above the required caseload limits on March 13, 2018.

Figure 14: Foster Care, IFCCS, Adoption and OHAN Caseworkers that were Over and Within the Required Caseload Limits
March 13, 2018



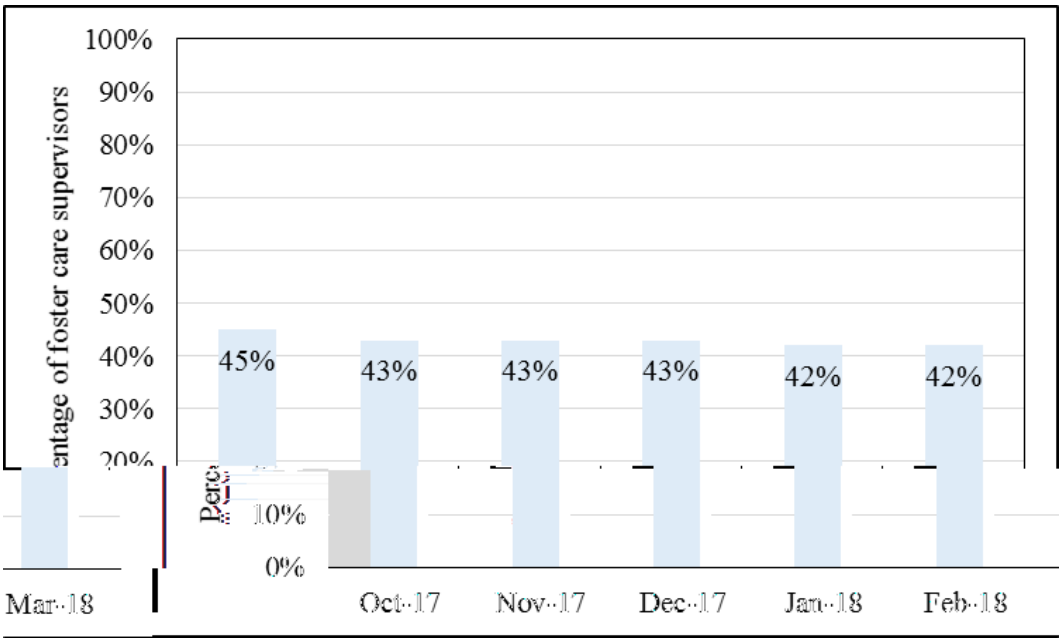
Source: CAPSS Data Provided by DSS

Foster Care Supervisors

The caseload standard for supervisors providing supervision to foster care caseworkers is one supervisor to five caseworkers (1:5).

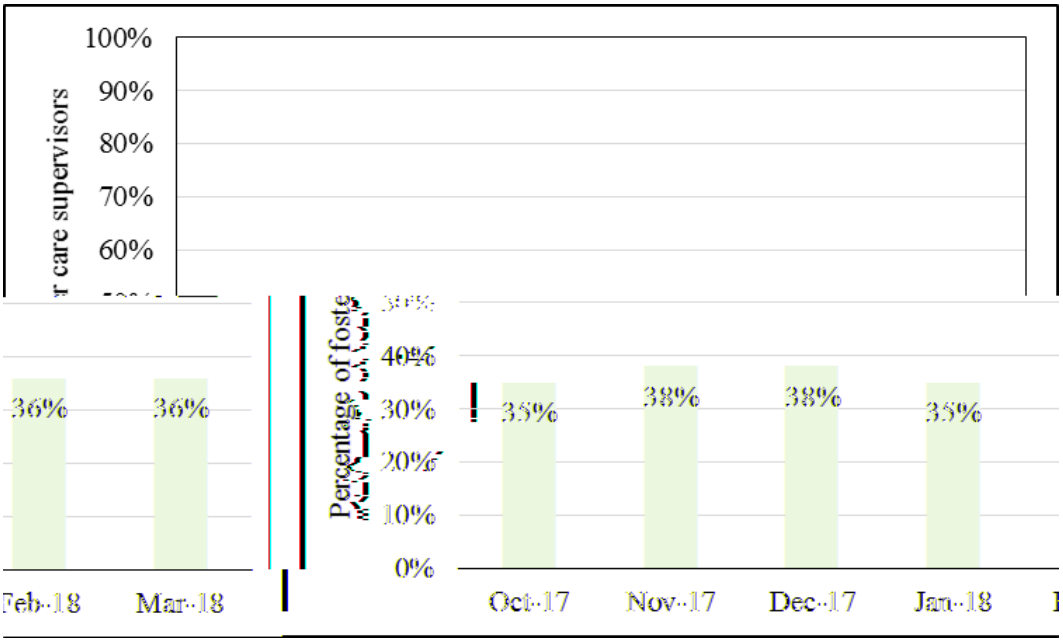
Between October 2017 and March 2018, a monthly range of 42 to 45 percent of foster care supervisors supervised five or fewer caseworkers (see Figure 15) and 35 to 38 percent of supervisors had workloads of more than 125 percent of the required limit (see Figure 16). Specifically, on March 13, 2018, of the 72 supervisors supervising foster care caseworkers, 30 (42%) supervisors supervised five or fewer caseworkers and 26 (36%) supervisors had workloads more than 125 percent over the required limit.

Figure 15: Foster Care Supervisors within the Required Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

Figure 16: Foster Care Supervisors with Workloads
More Than 125% Over the Required Limit
October 2017 - March 2018



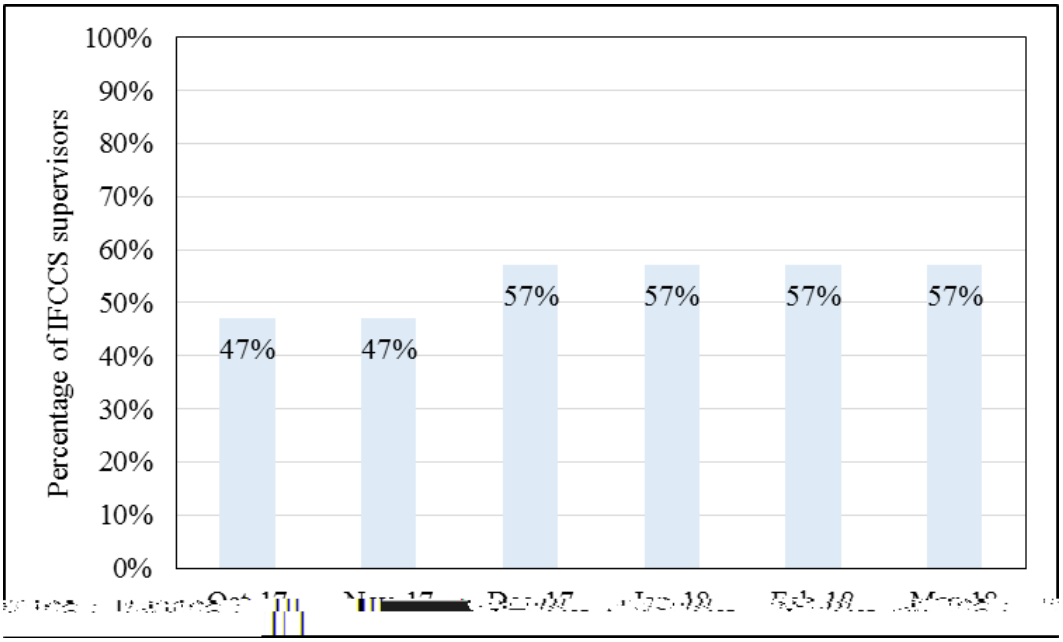
Source: CAPSS Data Provided by DSS

IFCCS Supervisors

The caseload standard for supervisors providing supervision to IFCCS caseworkers is one supervisor to five caseworkers (1:5).

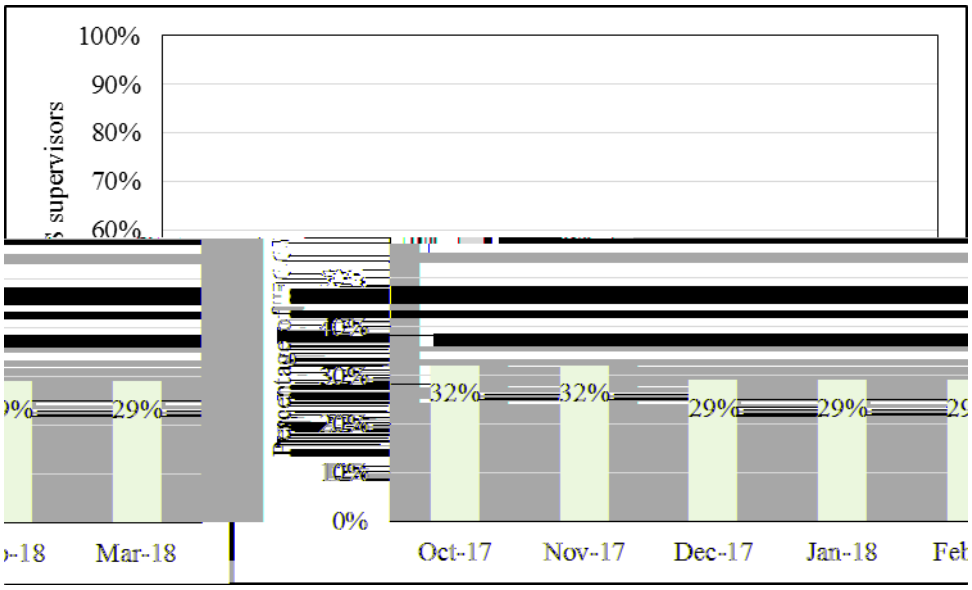
Between October 2017 and March 2018, a monthly range of 47 to 57 percent of IFCCS supervisors supervised five or fewer caseworkers (see Figure 17) and 29 to 32 percent of supervisors had workloads of more than 125 percent of the required limit (see Figure 18). Specifically, on March 13, 2018, of the 21 supervisors supervising IFCCS caseworkers, 12 (57%) supervisors supervised five or fewer caseworkers and six (29%) supervisors had workloads more than 125 percent over the required limit.

Figure 17: IFCCS Supervisors within the Required Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

Figure 18: IFCCS Supervisors with Workloads More Than 125% Over the Required Limit October 2017 - March 2018



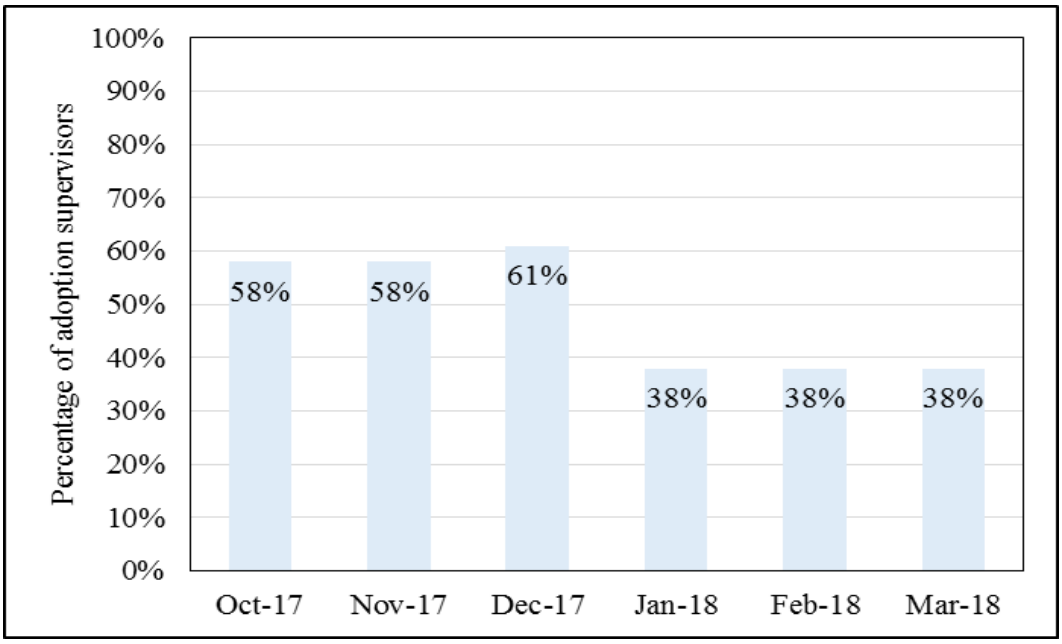
Source: CAPSS Data Provided by DSS

Adoption Supervisors

The caseload standard for supervisors providing supervision to adoption caseworkers is one supervisor to five caseworkers (1:5).

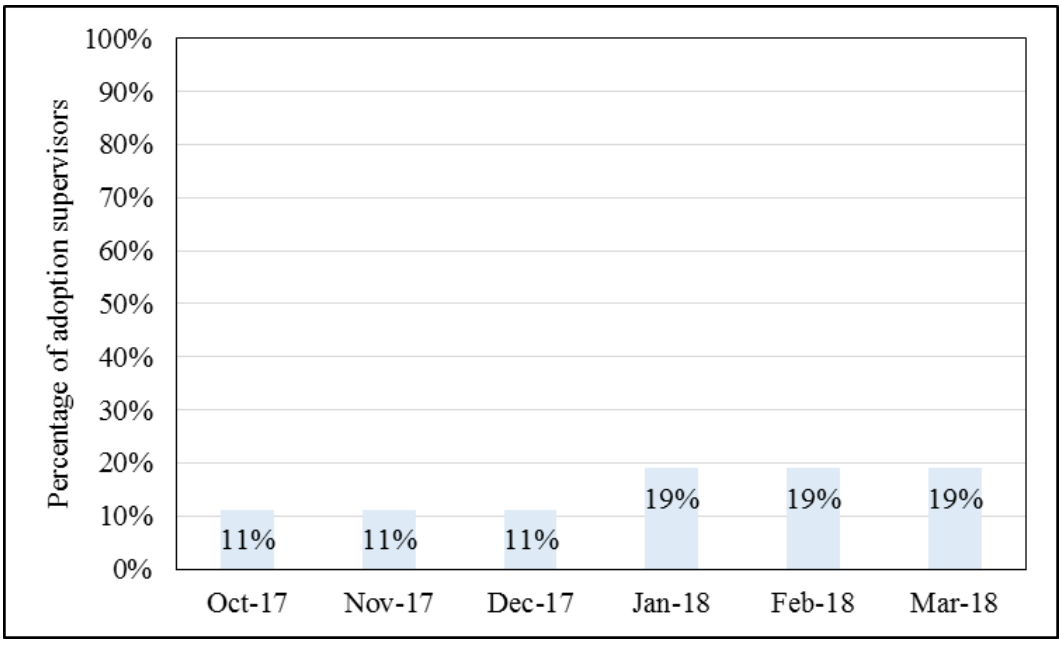
Between October 2017 and March 2018, a monthly range of 38 to 61 percent of adoption supervisors supervised five or fewer caseworkers (see Figure 19) and 11 to 19 percent of supervisors had workloads of more than 125 percent of the required limit (see Figure 20). Specifically, on March 13, 2018, of the 16 supervisors supervising adoption caseworkers, six (38%) supervisors supervised five or fewer caseworkers and three (19%) supervisors had workloads more than 125 percent over the required limit.

Figure 19: Adoption Supervisors within the Required Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

Figure 20: Adoption Supervisors with Workloads
More Than 125% Over the Required Limit
October 2017 - March 2018

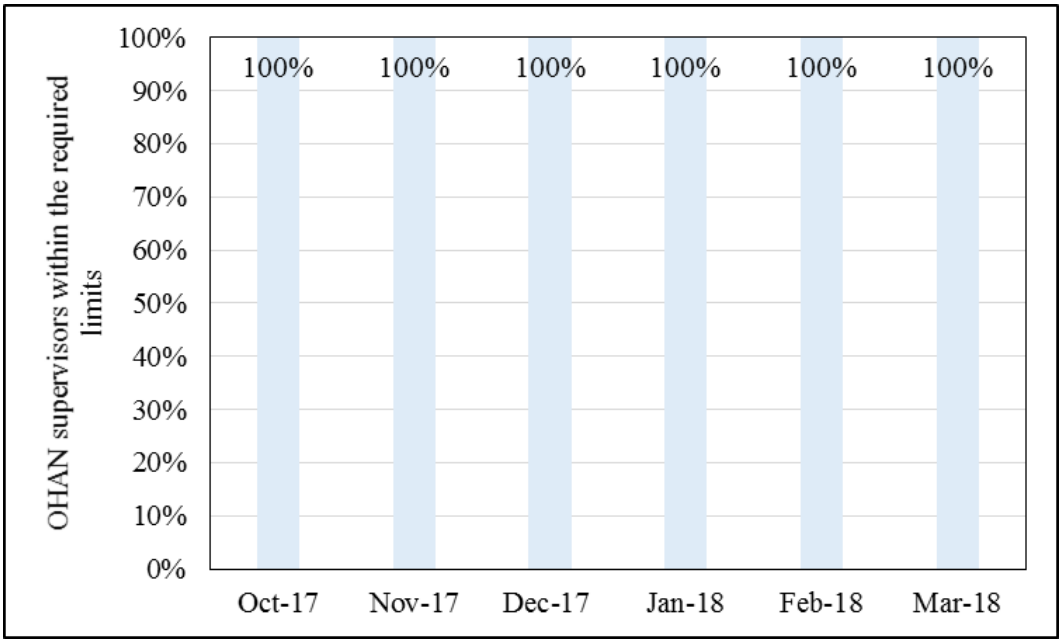


Source: CAPSS Data Provided by DSS

OHAN Supervisors

The standard for supervisors providing supervision to caseworkers conducting OHAN investigations is one supervisor to six investigators (1:6).[85] Between October 2017 and March 2018, there were three OHAN supervisors and each supervised no more than six caseworkers each month (Figure 21).

Figure 21: OHAN Supervisors within the Required Limits
October 2017 - March 2018



Source: CAPSS Data Provided by DSS

VI. CASEWORKER-CHILD VISITS

Visits between caseworkers and children in foster care are critical to a child welfare agency's ability to monitor the safety and well-being of the children in its care. DSS has consistently reported that these visits are a core element of its practice and that caseworkers throughout the state visit with children on a monthly basis in nearly all cases. Due to documentation issues identified in prior reporting periods, the Co-Monitors have been unable to validate the occurrence of visits. In response to Co-Monitor feedback, DSS identified this as an area of work with Chapin Hall and took steps this monitoring period to improve caseworker documentation.

[85] 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.

The Co-Monitors, however, have determined that DSS remains unable to reliably report on this fundamental aspect of practice.

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 visits with children.

DSS reported at the time of entry into the FSA that it was already achieving the final targets related to caseworker-child visits and therefore did not need to develop an Implementation Plan for the caseworker-child visits measures. 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 complete 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 to assess whether the visits were done in accordance with DSS policy. Based on their findings, the Co-Monitors utilized CAPSS data to report performance on both FSA IV.B.2 and FSA IV.B.3, with the disclaimer that further validation would be necessary to assess performance on these measures in later periods.

The Co-Monitors determined during the last monitoring period that documentation continued to be insufficient to allow for reporting on this measure. The Co-Monitors provided feedback to DSS at that time with respect to necessary data cleanup, with the goal of re-evaluating performance for this measure in the current reporting period. In June 2018, DSS began work through its visitation workgroup to address issues with the validity of these data, including the development of draft documentation and quality guidelines for caseworkers. DSS has also identified this as an area of focus in its work with Chapin Hall and has reported that it is considering a case record review to assess documentation once the necessary changes to policy manuals and CAPSS screens have been made. As an initial step, DSS agreed in August 2018 to perform a limited review of CAPSS records jointly with the Co-Monitors to assess whether there have been improvements to the accuracy and quality of the data on visits and to build a common understanding of the validity and documentation issues that have been identified by the Co-Monitors. The Co-Monitors will reassess the need for an Implementation Plan on caseworker-child in the next monitoring period, once additional information is obtained from this review.

It continues to be clear to the Co-Monitors that DSS and Plaintiffs hold vastly different views of what counts as a "visit" under the FSA. DSS's interpretation of the FSA is that the requirement is explicitly focused only on whether a visit literally and factually occurred and where it was held. Plaintiffs' position is that the content (what happens during the visit) must also be examined to ensure not only that the caseworker saw the child, but that it was done in a way that accords with the core purpose of visitation and includes necessary elements as defined by practice standards and DSS policy. Otherwise, in Plaintiffs' interpretation of the FSA, a required "visit" did not occur. As reported in the last monitoring period, the Co-Monitors believe that DSS and Plaintiffs need to discuss and attempt to resolve their differences on the meaning of the FSA requirement on caseworker visits with children in foster care. The Parties have not yet addressed this issue.

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 remain concerned about the lack of reliable documentation in this area and will continue to closely monitor 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 another critical function of 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 the child's 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.

During the current period, data reflect declined and alarming performance in this area. The Co-Monitors think this reflects delays by DSS leadership in responding to OHAN's staffing and support needs, despite repeated, reasonable requests and specific recommendations from OHAN management and the Co-Monitors. Although five new OHAN investigator positions have been recently allocated, as of June 2018, there were three current investigator and one supervisor vacancies within OHAN. This unit has been understaffed and under-resourced for many years, and sustainable improvements will require filling current vacancies; adding new caseworker, supervisor and administrative support staff; and finalizing the investigation practice training curriculum so that workers have the structure and guidance they need to properly assess allegations and children's safety.

As discussed in more detail below, when assessing investigations carried out in March 2018, reviewers determined that less than one-quarter (21%) of decisions to *unfound* were appropriate, mostly due to insufficient information being collected during the investigation. Additionally, only one (3%) of the 32 applicable investigations reviewed included contact with all necessary core witnesses during the investigation. One of the most concerning findings from this review was that only 22 (69%) investigations included contact with all alleged victim children prior to closure of the investigation, meaning that in 10 investigations, the investigator did not interview and assess the safety of all alleged victim children prior to making an investigation decision on whether or not the alleged abuse or neglect occurred and prior to closing the investigation. This level of practice is unacceptable.

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 caseworker 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 training 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 March 31, 2018.

As discussed above, due to the ongoing vacancies in both supervisor and investigator positions, consistent implementation of many of the strategies included in the OHAN Implementation Plan has not occurred. For example, OHAN management reports that institution of a caseworker office day for completion of documentation and other case management activities would be extremely beneficial; however, this is not possible with the current level of staffing as caseworkers are needed in the field to respond to reports and complete investigative activities. Between January and March 2018, 244 referrals were made to OHAN and 169 of these were

accepted for investigation[86]. Data reviewed for investigations conducted in March 2018 show that only four OHAN investigative staff were responsible for all required activities on most investigations. When reviewing documentation for the March 2018 investigations, Co-Monitor staff found that in many instances, dictation notes documenting what occurred during interviews or contacts were not entered until weeks or months after the fact. These delays impact the level of detail and reliability of the information. Another strategy included in the Implementation Plan for which implementation is overdue is development of an investigation training curriculum. Originally estimated to be completed by December 2017, DSS currently reports the curriculum is near complete and the training will be delivered to existing OHAN staff in October 2018 and the new staff who are to be hired in January 2019.

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.[87, 88] OHAN staff make decisions to either accept a referral for investigation or take no further action on the referral (screen out) based upon information collected from reporters to determine if the allegations meet the state's statutory definition of abuse or neglect.[89] 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.[90] 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.

In January 2015, DSS began implementation of a regionalized Intake Hub system which provides central locations for receipt of referrals of abuse and/or neglect against children in the

[86] These data do not include allegations of abuse or neglect at child care facilities that involve Non-Class Members. OHAN staff are also responsible for these intakes and investigations.
[87] 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.
[88] 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.
[89] SC Code § 63-7-20.
[90] 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).

state.[91] A primary objective of this restructuring is to improve the quality and consistency of decisions at the time of intake. As of November 2017, all counties were linked to an Intake Hub. DSS has been considering directing calls related to allegations of abuse and/or neglect for children in foster care to the Intake Hubs instead of directly to centralized OHAN staff. OHAN staff would still be responsible for conducting investigations of those referrals that are accepted. However, a final decision has not been made about this proposal.

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.). Table 4 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 4: Baseline, Timeline and Interim Benchmark 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

All applicable referrals[92] of abuse and/or neglect received and not investigated (screened out) by DSS's OHAN unit between October 2017 and March 2018 were reviewed by Co-Monitor staff.[93] Performance data were collected and are reported separately for each month.

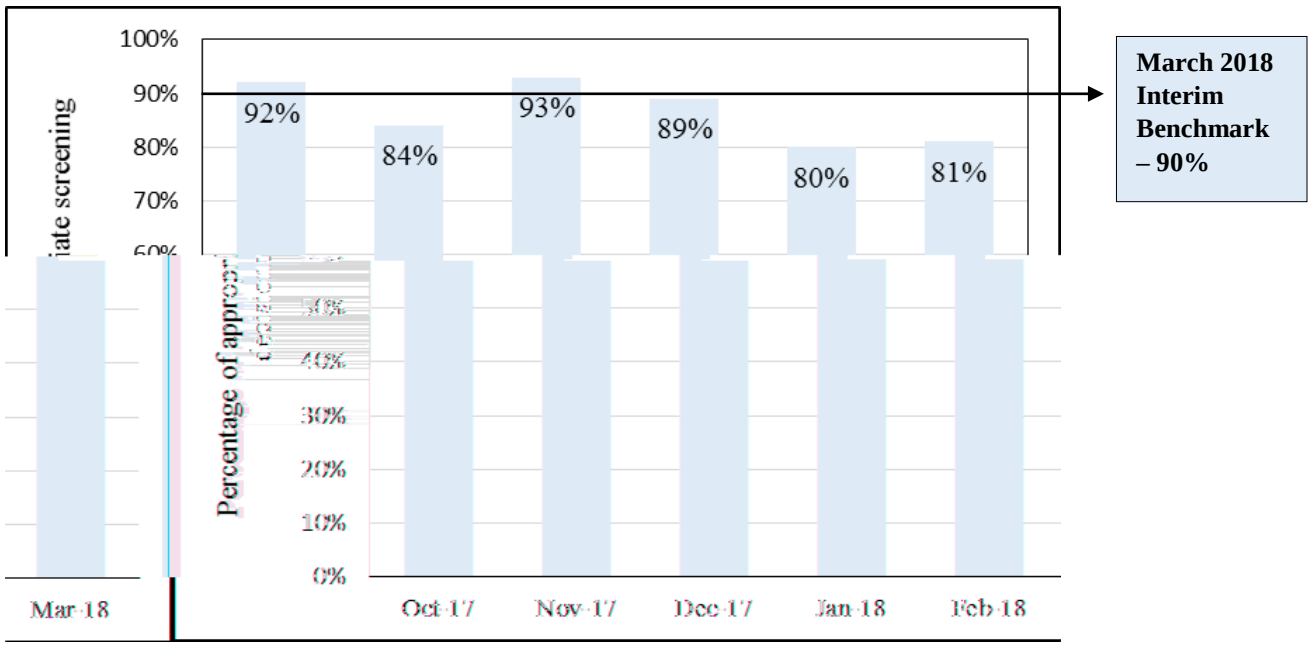
[91] There are a total of seven Intake Hubs within the five state regions.

[92] 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 at this time.

[93] 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.

Between October 2017 and March 2018, the Co-Monitors determined a monthly range of 80 to 93 percent of decisions not to investigate a referral of abuse and/or neglect to be appropriate (see Figure 22). Specifically, in March 2018, 21 (81%) of the 26 applicable screening decisions were deemed appropriate.[94] Although performance during the first several months of the monitoring period appeared to be on track to meet the interim target of 90 percent by March 2018, performance declined in both February and March 2018. In March 2018, the primary reason for disagreement with the screening decision was that insufficient information was collected by the Intake caseworker in order to fully assess the allegations – some referrals only included one to five sentences describing the allegations and did not fully explain the incident, severity or impact on the alleged victim child. Additional guidance and coaching is needed for Intake staff on collecting and documenting necessary information, as well as for mandatory reporters (often the DSS caseworker), who should be prepared to provide this information.

Figure 22: Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect October 2017 - March 2018



Source: Monthly review data, 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

[94] Of note, of the 32 referrals that were accepted for investigation in March 2018, Co-Monitor staff assessed that eight of the referrals should not have been accepted for investigation as there were no allegations of abuse or neglect by a caretaker.

investigation is to be completed within 45 days.[95] 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.[96] 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)[97], contact with core witnesses (one measure), investigation determination decisions (one measure) and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted in June 2018 which examined 32 applicable investigations[98] that were accepted and initiated in March 2018. Most of the investigations involved allegations of physical abuse (16 investigations/50%) and/or physical neglect (13 investigations/41%). Twenty (63%) of the investigations alleged abuse and/or neglect in a foster home and the remaining 12 (38%)[99] investigations alleged abuse and/or neglect in a facility or institution. In approximately half of the investigations (17 investigations/53%), the reporter alleging abuse and/or neglect was a DSS caseworker or supervisor, and in 22 percent (7 investigations), the reporter was a provider or facility staff.

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

[95] Human Service Policy and Procedural Manual, Chapter 7-721. p. 6, 12 (effective date 11/29/2012).
[96] Human Services Policy and Procedural Manual, Chapter 7-721. p. 7 (effective date 11/29/2012).
[97] 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.
[98] A total of 45 reports were accepted in March 2018, however, 13 were determined not appropriate for review for the following reasons – in 10 investigations, 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); one investigation was a duplicate report of allegations that had previously been investigated and was closed; and two investigations were still open and the files could not be provided.
[99] Percentages total more than 100% due to rounding.

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 5 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:

Table 5: 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 6) were approved by the Co-Monitors:

Table 6: 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)

Table 7 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

Table 7: Baseline, Timeline and Interim Benchmarks for Timely Initiation of Investigations

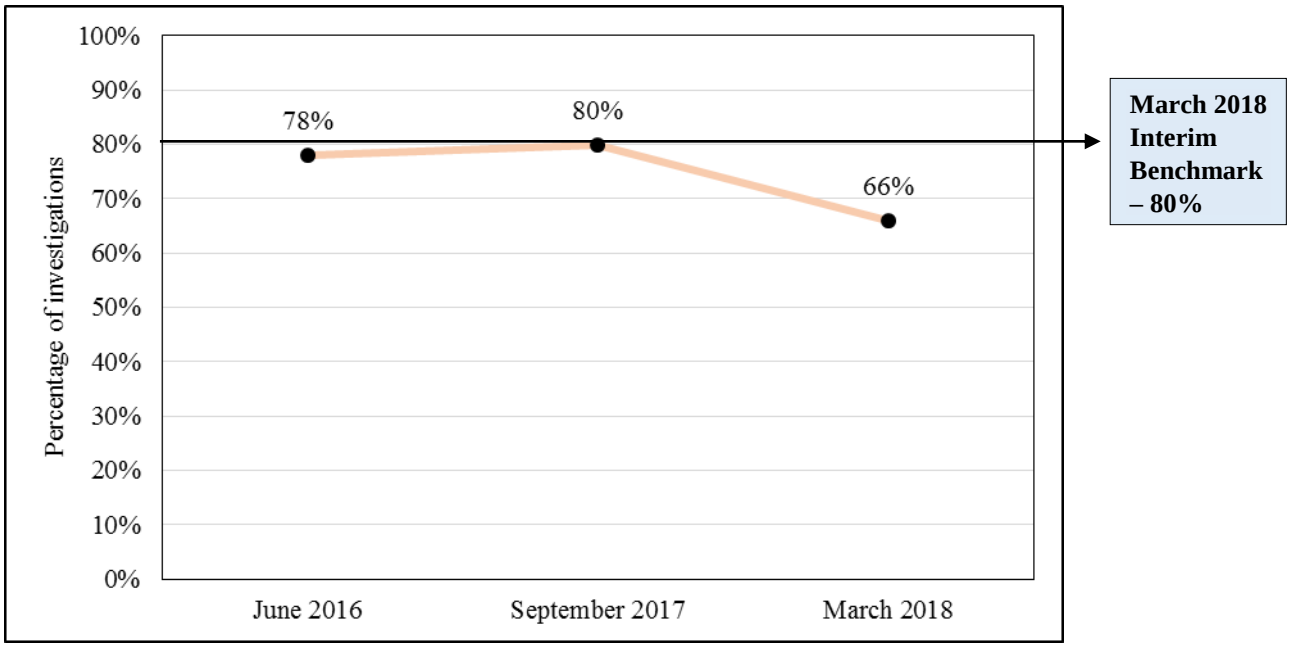
Baseline	
June – November 2016	78%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	78%
March 2018	**80%**
September 2018	80%
March 2019	85%
September 2019	85%
March 2020	90%
September 2020	90%
March 2021	95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of investigations which were received and accepted in March 2018.[100] Of the 32 applicable investigations, contact was made with the all alleged victim child(ren) within 24 hours in 19 (59%) investigations and in two (6%) additional investigations, documentation supported completion of all applicable good faith efforts; total performance for March 2018 is 66 percent, which is below the interim benchmark of 80 percent and a decline from performance during the prior period (see Figure 23).

[100] The Co-Monitors have continued to assess that although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, the aggregate CAPSS report cannot currently be used for reporting due to the following: the CAPSS report does not distinguish between investigations involving Class and Non-Class Members which is required for reporting performance and the Co-Monitors have found instances in which caseworkers have incorrectly documented the time a child is seen. The Co-Monitors will work with DSS to improve the accuracy and reliability of these data for future reporting.

Figure 23: Timely Initiation of Investigations
June 2016 - March 2018



Source: June 2017, January 2018 and June 2018 Case Record Reviews, USC CCFS and Co-Monitor staff

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.[101]

Listed in Table 8 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 the person:

[101] 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: 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

Table 9 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

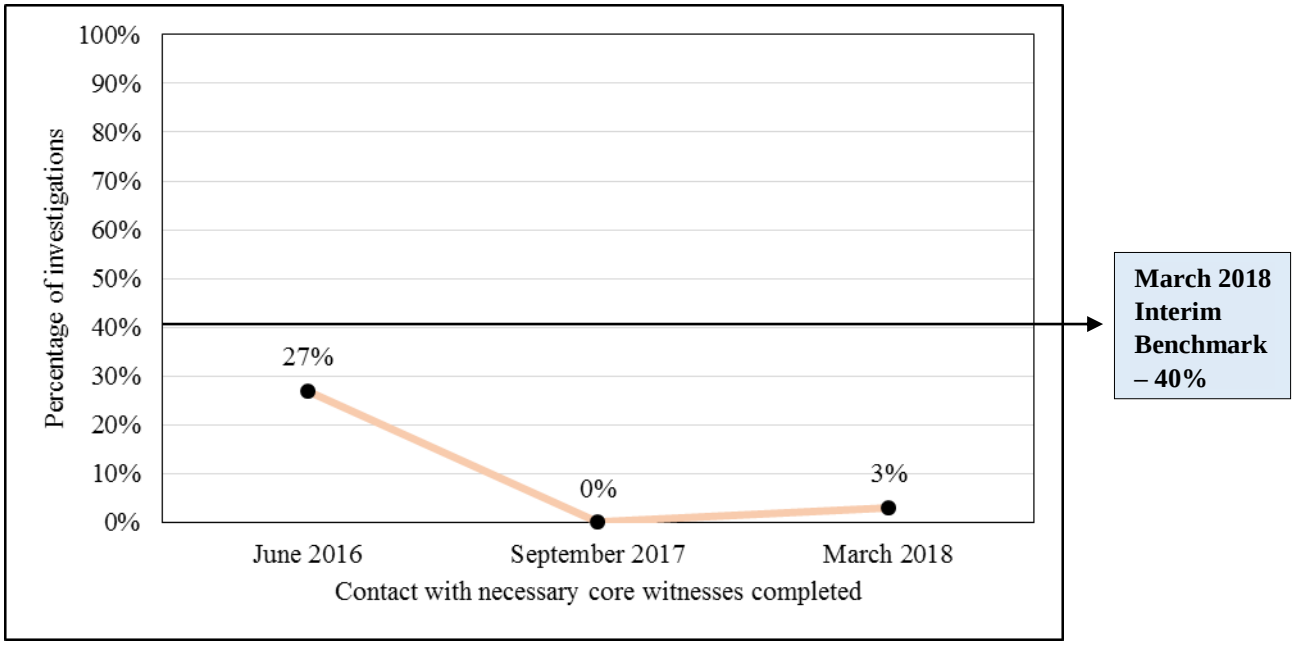
Table 9: Baseline, Timeline and Interim Benchmarks for Contact with All Necessary Core Witnesses during the Investigation

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 March 2018. Only one (3%) of the 32 applicable investigations reflected contact with all necessary core contacts during the investigation (see Figure 24).

Figure 24: Contact with All Necessary Core Witnesses during Investigations June 2016 - March 2018



Source: June 2017, January 2018 and June 2018 Case Record Reviews, USC CCFS and Co-Monitor staff

The following data, presented in Table 10, reflects the frequency of OHAN investigator contact with each category of core witness in the 32 investigations reviewed:

Table 10: Contact with Necessary Core Witnesses during Investigations by Type of Core Witness
March 2018
N=32

Core Witness	Number of Applicable Investigations	Contact with All	Contact with Some	Contact with None
Alleged Victim Child(ren)	32	22 (69%)	1 (3%)	9 (28%)
Reporter	32	13 (41%)	-	19 (59%)
Alleged Perpetrator(s)	27	19 (70%)	5 (19%)	3 (11%)
Law Enforcement	7	-	-	0 (100%)
Alleged Victim Child(ren)'s Caseworker(s)	32	6 (19%)	1 (3%)	25 (78%)
Other Adults in Home or Facility[102]	19	3 (16%)	3 (16%)	13 (68%)
Other Children in Home or Facility[103]	24	1 (4%)	4 (17%)	19 (79%)
Additional Core Witnesses	11[104]	-	1 (9%)	10 (91%)

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

Although performance on this measure for all core witnesses was unacceptable during both the prior period (0%) and this period (3%), there is one significant area of decline that is particularly troubling to the Co-Monitors. During the prior period, all alleged victim children were interviewed or observed (as age or developmentally appropriate) at some point during the course of every investigation. However, of the 32 investigations reviewed in March 2018, only 22 (69%) investigations included contact with all alleged victim children prior to closure of the investigation. In 20 of the investigations in which contact was made, documentation does not indicate that the alleged victim child(ren) was interviewed alone or apart from other adults or the alleged perpetrator as age and developmentally appropriate. The interview with the alleged

[102] 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.
[103] 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.
[104] Additional core witnesses identified by reviewers in 10 investigations included family members, school personnel, mental health providers, medical staff and forensic interviewers.

victim child(ren) is a core investigative task to assess and ensure the safety of children in foster care. This area of practice requires immediate attention and corrective action.

Case Decisions

At the conclusion of the investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[105]

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."

Table 11 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 11: 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%**

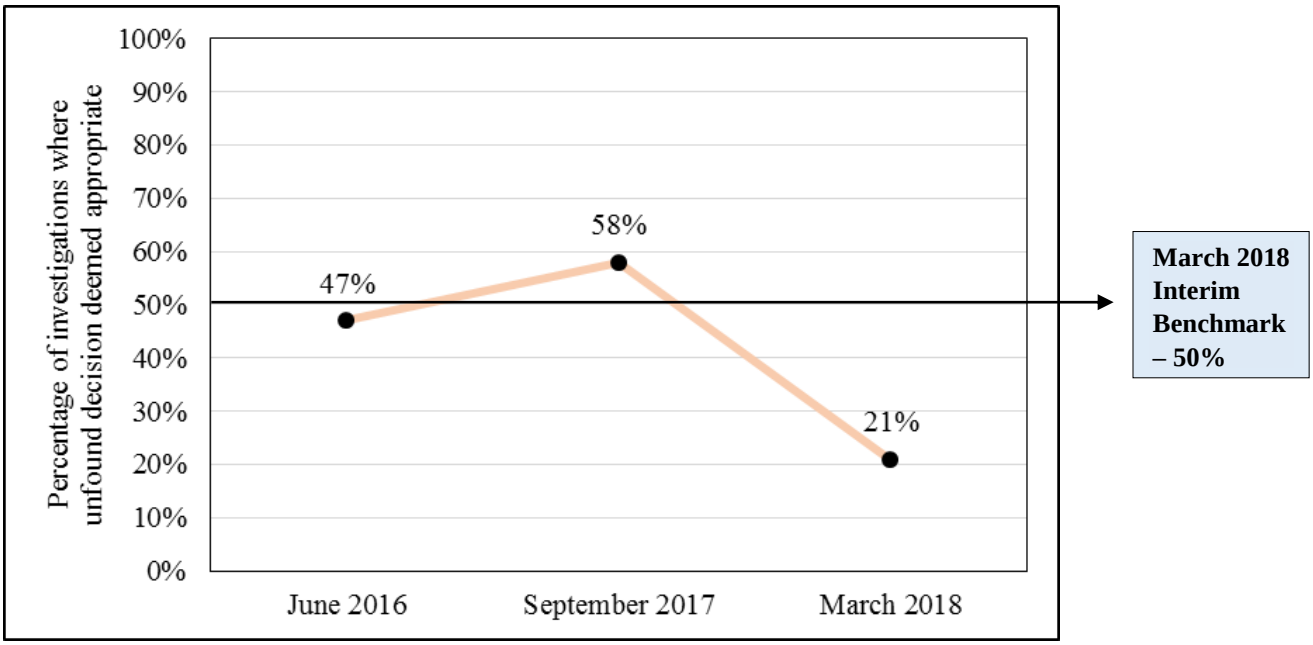
Source: OHAN Implementation Plan

Performance data for this period were collected during the previously referenced case record review of investigations received and accepted in March 2018. Of the 32 applicable investigations, 29 investigations included a case decision to *unfound* the allegations. Reviewers

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

agreed that the case decision to *unfound* the investigation was appropriate in six (21%) of the 29 investigations (see Figure 25). Current performance has declined since the prior period and does not meet the interim benchmark of 50 percent.

Figure 25: Decision to Unfound Investigations Deemed Appropriate
June 2016 - March 2018



Source: June 2017, January 2018 and June 2018 Case Record Reviews, USC CCFS and Co-Monitor staff

For those investigations in which reviewers disagreed with the unfounded decision, in all (23 investigations) the reviewer assessed that the investigator failed to collect sufficient information necessary to make an accurate finding. This was primarily due to the lack of interviews with the children and information collected from collateral contacts.

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.[106] 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 12:

Table 12: Examples of Good Cause Reasons to Extend Investigation Timeframes

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

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

Table 13 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 13: 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

Performance data for this section were collected during the case record review of investigations that were received and initiated in March 2018.[107]

Closure within 45 Days

Of the 34 applicable investigations received and initiated in March 2018[108], one investigation was excluded from the 45 day compliance measure.[109] Of the remaining 33 investigations, 29 investigations were completed within 45 days, however, reviewers determined that two of these investigations were closed as unfounded prematurely in an effort to meet the 45 day requirement, which is not considered compliant under the FSA. Therefore, the review determined that 27 (82%) of the 33 applicable investigations were timely and appropriately closed within 45 days. This meets the interim benchmark for timeliness.

Closure within 60 Days

Three additional investigations (including one with an approved extension request) were closed between 45 and 60 days resulting in performance of 88 percent (30 of 34)[110], on timely completion within 60 days. This meets the interim benchmark for timeliness.

Closure within 90 Days

As previously mentioned, two investigations involving Class Members that were initiated in March 2018 were not yet closed during the time of review and were therefore not assessed on other measures in this section; both were open for longer than 90 days, making performance on timely closure within 90 days also 88 percent.

In sum, current performance exceeds the interim benchmark level for both the 45 and 60 day requirement but does not meet the 90 day requirement. As reflected in Figure 26, current performance represents declines since baseline data were collected in June 2016.

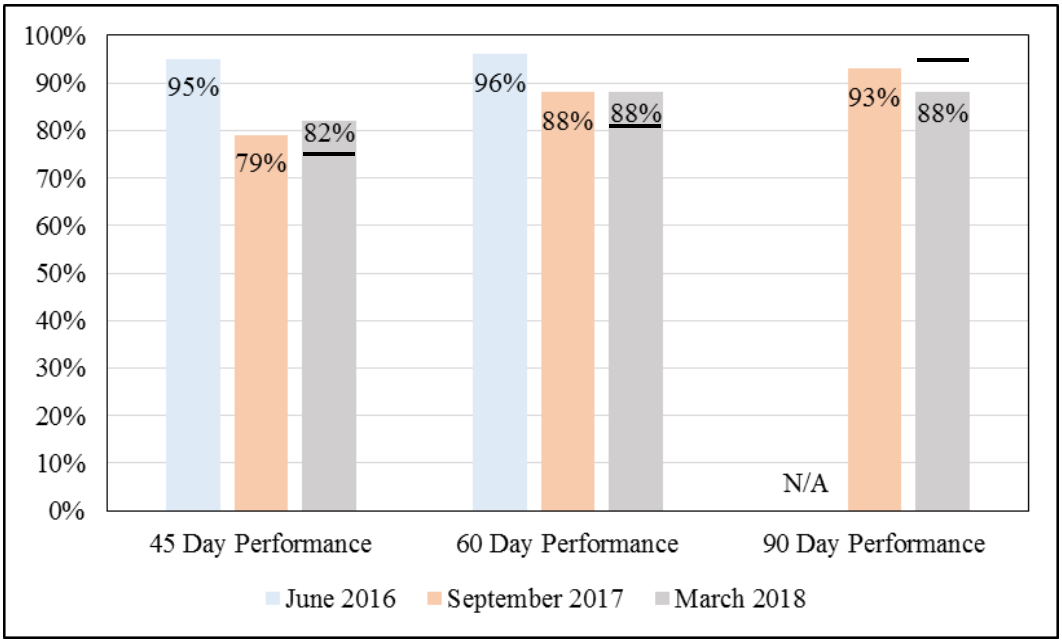
[107] The Co-Monitors have continued to assess that although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, these data cannot currently be used for reporting due to the following: the CAPSS report does not distinguish between investigations involving Class and Non-Class Members which is required for reporting performance and a case record review is required to determine if an investigation is closed prematurely to meet required timeframes.

[108] Other OHAN measures discussed within this section include 32 applicable investigations. While conducting the case record review, it was determined that two investigations involving Class Members that were received and initiated in March 2018 were still open and the files could not be provided. These investigations were able to be assessed for timely closure measures but information could not be collected for other measures within this section.

[109] In one investigation, an extension was requested and granted as the investigator had not interviewed the alleged perpetrator and the forensic interview had not yet occurred. In one additional investigation, an extension was requested and granted due to the assigned investigator becoming ill; the reviewer determined that this situation did not meet the requirements for a good cause reason to approve an extension and should not be excluded from this measure as another investigator could have been assigned.

[110] Based upon the language in the FSA, the two investigations that were closed as unfounded prematurely to meet required timeframes are not considered compliant for any timely closure measure.

Figure 26: Timely Completion of Investigations
March 2018
N=39 within 45 days; N=40 within 60 days; N=40 within 90 days



Lines represent March 2018 Interim Benchmarks

45 Day Performance: 75%

60 Day Performance: 80%

90 Day Performance: 95%

Source: June 2017, January 2018 and June 2018 Case Record Reviews, USC CCFS and Co-Monitor staff

VIII. PLACEMENTS

The requirements of the FSA reflect well-established child welfare principles that children are placed in the most family-like setting appropriate to meet their needs; children are placed with their siblings, whenever possible, and within their home communities; children experience stability, limiting unnecessary placement moves and transitions; and children are cared for by supportive caretakers and receive services necessary to maintain their safety, health and well-being. As the data for the current period reflect, very few children ages six and under currently reside in congregate care, however, too many children ages seven and older continue to live in congregate care settings. Additional progress is also needed to ensure that children are placed with their siblings.

A. Placement Needs Assessment

By February 1, 2017, with prior input from and subject to approval by the Co-Monitors, DSS was to have performed "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 was to 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. USC CCFS initiated a statewide Placement Needs Assessment in February 2017, with an original completion date of June 30, 2017. DSS later requested, and the Co-Monitors agreed, that a report would be submitted on August 31, 2017; DSS submitted a report with data and findings to the Co-Monitors on that date. In late September 2017, the Co-Monitors requested that additional work be completed on placement projections, including an assessment of county versus regional needs, to better address the State's capacity to place Class Members close to their home communities. In December 2017, the Co-Monitors provided additional written feedback to DSS. On March 31, 2018, as part of the updated draft Placement Implementation Plan, DSS provided county-level data related to placement projections, discussed below.

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)).

After reviewing DSS's Placement Needs Assessment, the Co-Monitors shared with DSS that it would be important to include strategies in the Placement Implementation Plan to address several themes identified, including the following:[111]

- Expansion of family foster care resources in every area of the state, including kinship placement resources;
- Engagement of foster parents who can support legal permanency for children and youth;
- Stopping the practice of placing children far from their homes and communities;
- Improvement of placement processes;

[111] Additional information about each bulleted item may be found in the *Michelle H., et al. v. McMaster and Alford Monitoring Period II* report, pgs 81-82. This report is available at: https://www.cssp.org/publications/child-welfare/abstract/Michelle-H.-v.-McMaster-Monitoring-Report-for-April-2017-Sept-2017.pdf

- Modifying practice so that children do not have to change placements, often through a move from traditional to therapeutic foster care, to access more intensive services;
- Utilization of local office expertise and input about foster parent resources in their counties;
- Creation and integration of a unifying vision of what foster care is aimed at achieving for children and families;
- Significantly increasing mental health services for children in all levels of care;
- Enhancing the role of providers and other supports in case planning activities for the children in their care; and
- Addressing CAPSS placement data issues.

On October 31, 2017, DSS submitted a draft Placement Implementation Plan, to which the Co-Monitors provided feedback. On March 30, 2018, DSS submitted a revised draft Plan, acknowledging, with agreement from the Co-Monitors, that the breadth and complexity of the work required to develop placement processes and resources made plan development in this area a particularly difficult task. The Plan submitted reiterated DSS's commitment to some important principles, such as the development and support of kin placements and the need for respite and other supports for foster families. The Plan also highlighted the need for development of caseworkers' skills for engaging families and children, assessing child and family strengths and needs and performing individualized case planning and teaming. There was also acknowledgement of the necessity for collaboration with other systems and agencies to support children, parents and kin. As part of its draft Placement Implementation Plan, DSS also reported that it would be engaging Casey Family Programs[112] to assist with the development of a provider diversification plan.[113]

After reviewing the Placement Implementation Plan, the Co-Monitors determined that it required additional work, including improved data analysis and needs projections. Among other things, the Co-Monitors identified a need for more specific county placement projections; clarification and operationalizing of strategies, policies and practices to be implemented; and articulation of an underlying case practice model. Many sections of the draft Plan were disjointed and did not link strategies with identified goals, such as prioritization of practices to sustain children safely in their own homes to avoid the use of foster care placement.[114] The draft Plan also did not

[112] For more information, see https://www.casey.org/what-we-do/

[113] The Proposed South Carolina Residential Care Redesign Plan consists of six phases to be implemented over a two-year period. These include: Creating a Vision; Data Analysis; Stakeholder Engagement; Resource Analysis/Development (including resources available through the federal Family First and Prevention Services Act); and Strategic Plan Development and Implementation.

[114] For example, while there was recognition of the need to support the development of skills for engaging families and children, the Plan did not include any information about how DSS would implement this change, nor does it reference integration of the case practice model. In fact, there is no mention of the practice model as related to placement decision-making. Similarly, Family

include strategies sufficient to address many of the key themes, outlined above, that the Co-Monitors had recommended that DSS integrate into its Plan after reviewing the Placement Needs Assessment.

As a result, the Co-Monitors informed DSS that they would be engaging consultants with expertise in child welfare reform, practice and placement to assist DSS in further development of the Placement Implementation Plan. On July 1, 2018, the Co-Monitors engaged Kent Berkley and Andy Shookhoff to support the Co-Monitors and DSS by: (1) assessing the recommendations, feasibility, resource needs, strategies and timelines that have been proposed and identify gaps; (2) incorporating the information collected to develop an approvable Plan that meets each of the expectations outlined in the FSA, including a clear case practice model that will be reflected in all aspects of the placement process; and, (3) if needed, supporting DSS with Plan implementation. This work will be done in collaboration with DSS's placement workgroup, key stakeholders and regional and county DSS staff to capitalize on the strengths of the existing planning efforts.

In addition, the health care consultants, engaged earlier by the Co-Monitors, are collaborating with DSS to revisit the intensive foster care structure, assessments, levels of care system and services. This analysis will also inform the Placement Implementation Plan. Placement processes must be streamlined, with strategic sequencing of targeted and flexible approaches to create and sustain stable placement capacity. The placement consultants and DSS will work collaboratively with the health care consultants as they revise and develop the Placement Implementation Plan to incorporate this work.

Prior to DSS's submission of the Placement Implementation Plan, in early December 2017, the Co-Monitors and staff visited several group care facilities to deepen their understanding of placement issues and processes. Information collected from these visits, as well as discussions with stakeholders, OHAN staff and case file reviews reinforced concerns about the conditions and practices in some of the congregate care facilities throughout the state. The Co-Monitors discussed their concerns with DSS, including their observation that the higher level group home structure seemed more punitive than therapeutic at times. They also identified as a problem that the primary method by which children in DSS foster care receive appropriate therapeutic intervention is through placement in highly restrictive psychiatric residential treatment facilities. The lack of engagement between children, families and staff – often made more difficult by the placement of children very far from their homes – was also highlighted as very problematic, especially in cases in which the stated permanency goal is reunification. The Co-Monitors also questioned whether a rate increase was needed for facilities, as many seemed to be functioning

Team Meetings are included as a tool for gathering information and identifying placement, however, there is no discussion of how these teams will be used to identify needs and craft individualized plans for services and other interventions.

with insufficient staff and other resources including nutritional food. The Co-Monitors also identified that there were strengths within the congregate provider community, with a willingness on the part of some providers to work more closely with DSS on a diversification strategy.

DSS's draft Placement Implementation Plan did not set forth a plan for assessing quality of care in these facilities. The Co-Monitors informed DSS in April 2018 of their plan to augment their monitoring capacity through the engagement of consultants, Marci White and George Taylor, affiliated with Co-Monitor Paul Vincent's Child Welfare Policy and Practice Group. Beginning in early July 2018, these consultants, who have expert knowledge about residential and community-based treatment, are performing a special review of the quality of congregate care facilities throughout the state, focusing on the capacity to meet the needs of Class Members, and the extent to which these needs could be met in less restrictive, primarily family-based settings. This work is expected to be completed by October 31, 2018.

Though DSS has acknowledged its need for additional support in these key areas, it initially expressed apprehension about the engagement of additional consultants, citing concerns about internal ability to manage and coordinate the work of multiple consultants, and the overlapping nature of the work with other initiatives and consultants. Over the course of months, the Co-Monitors worked with DSS and clarified and reached agreement on the proposed scopes of work and a plan for coordination.

While working toward an updated Placement Implementation Plan, DSS has reported that it has taken steps to begin addressing some identified concerns, including:

- Development of a partnership with All Pro Dad[115], a program of Family First[116], with support of Tony Dungy, former National Football League coach and player. The goal of partnering with All Pro Dads is to raise awareness of the need for foster and adoptive parents. Recruitment efforts include a Facebook campaign; over 40 billboards; and public service announcements for churches, sports activities and other events. DSS has also worked with local media to feature stories about county-specific needs, featuring the stories of current foster parents, and developed a partnership with the Department of Motor Vehicles, and other state agencies, so that a video about the need for foster and adoptive parents could be screened in waiting rooms throughout the state. Reportedly, these efforts have had a positive impact on the number of foster parent inquiries and has led to the licensing of 253 foster homes between November 2017 and April 2018.[117]

[115] For more information, see https://www.allprodad.com/
[116] For more information, see https://www.familyfirst.net/
[117] 55 of the 253 foster homes licensed were recruited by private Child Placing Agencies.

- Improvement to multiple placement processes, including merging licensure requirements so that there is one process for foster and pre-adoptive parents.
- In January 2018, DSS reports providers were made aware of opportunities to host family team meetings or train and support staff in becoming leads for the practice of family group conferencing through working with National Youth Advocate Program, which has a statewide contract to implement family group conferencing.
- In September 2017, placement providers were introduced to the Building Bridges Initiative[118], which includes a commitment to training on de-escalation approaches to reduce or eliminate the use of restraint or seclusion. Core principles promoted by the Building Bridges Initiative, are in line with best practices in child welfare and include being family-driven; youth-guided; strength-based; culturally and linguistically competent; and individualized; and using eevidence and practice-informed interventions. DSS received feedback from participants in Building Bridges to further inform ongoing placement structures and practices. As of the writing of this report, some providers report beginning to use the model.

C. Performance Data[119]

Placement of Children in Congregate Care

The FSA has multiple requirements related to placement of 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 on March 31, 2018, 78 percent (3,313 of 4,226) of children in foster care were placed outside of a congregate care placement (to include residential treatment and emergency shelters) (see Table 14). [120]

[118] For more information, see www.buildingbridges4youth.org

[119] The data audit work being conducted by Chapin Hall has identified potential issues with the quality and accuracy of data related to placement. Specifically, placement type, placement stability and emergency or temporary placements. This may impact the accuracy of data on placement measures reported herein. DSS and Chapin Hall have a project underway to assess the extent of any issues and will develop a plan for correction as needed. Additionally, current DSS data reports do not indicate whether a child's placement in custody is voluntary or involuntary, which would enable reporting to distinguish between Non-Class Members and Class Members. 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 for some measures discussed throughout this section, a small number of Non-Class Members are included in aggregate data. DSS recently developed the capacity to distinguish between children who are voluntarily and involuntarily placed in care and data for the next monitoring period will reflect these enhancements.

[120] Twenty-six children who were hospitalized (11) or in a correctional/juvenile justice facility (15) are not included in the universe for this measure.

Table 14: Types of Placements for Children as of March 31, 2018

Children in Foster Care	
4,226 (100%)	
Types of Placement for Children in Foster Care	**Number (Percentage) of Children**
Family-Based Setting	3,313 (78%)
Congregate Care, Emergency Shelter or Residential Treatment Facility	913 (22%)
Breakdown by Type of Group Care Facility	
Congregate Care	841 (20%)
Emergency Shelter	4 (<1%)
Residential Treatment Facility	68 (2%)

Source: CAPSS Data Provided by DSS

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.).

The Co-Monitors have approved the following exceptions for placing children ages seven to 12 in a congregate care facility, as outlined in Table 15:

Table 15: Exceptions for Placement of Children Ages 12 and Under in Non-Family-Based Placements

- The child has clinical and medical needs that can **only** be met in a congregate 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 determination of clinical need must be based upon a decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and not an employee of DSS. A determination of medical need must be made by a physician.
- The child is part of a sibling group of four or more.
- The child has been removed and is in the legal custody of the SCDSS and is placed with a parent who is not in SCDSS care, but who is temporarily in a residential group setting for treatment.

DSS reports that internal, child-specific decision-making meetings for children ages seven to 12, or "staffings", regarding whether to continue a congregate placement for a child are being held across the state. Within the past year, meetings have been held to discuss the placements of 170 children and DSS reports that staffings regarding all children would be complete by August 2018.

DSS reports that for the majority of these staffings, there was no uniform process across the state for these meetings. A tool and protocol were finalized in August 2018 in order to provide for more consistent structure and data collection abilities. As DSS embarks on transitioning children, as appropriate, from congregate care facilities, the Co-Monitors have emphasized facilities must provide specialized services to meet the needs of all children remaining in congregate care.

As reflected in Table 16, as of March 31, 2018, 92 percent (2,727 of 2,966) of children ages 12 and under in foster care were residing in a family-based setting. This represents a slight decline from the prior period, when performance was 93 percent.

Table 16: Types of Placements for Children Ages 12 and Under as of March 31, 2018

All Children in Foster Care Ages 12 and Under	
2,966 (100%)	
Types of Placement	**Number (Percentage) of Children**
Family-Based Setting	2,727 (92%)
Congregate Care, Emergency Shelter or Residential Treatment Facility	239 (8%)
Breakdown of Type of Facility	
Congregate Care	218 (7%)
Emergency Shelter	0
Residential Treatment Facility	21 (<1%)

Source: CAPSS Data Provided by DSS

Children Ages Six and Under

The Interim Order, entered September 28, 2015, included provisions to immediately address the placement of children ages six and under in congregate care, 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 17), 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 applicable Regional Director before any child age six or under can be placed in a non-family-based setting.

Table 17: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements

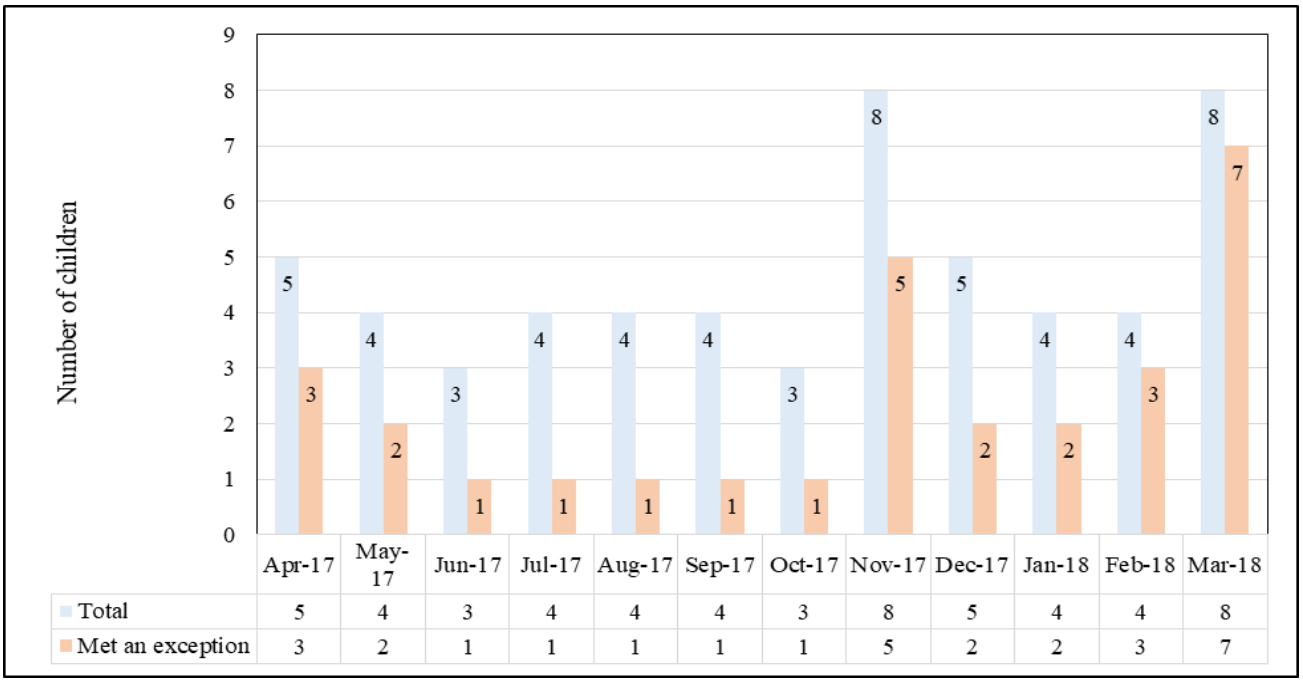
- The child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs.
- The child is the son or daughter of 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.[121]
- Children who are voluntarily placed by their parent or caregiver are not subject to this requirement.

DSS has provided monthly data 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.

As illustrated in Figure 27, DSS reported that the number of Class Members in congregate care placements ranged from three to eight children in each month of the monitoring period. Most of these children were residing in a treatment facility with their mothers or were part of a sibling group of four or more children for whom DSS reports a single, family-based placement could not be located.[122] The Co-Monitors recognize that making individual determinations about placements that best meet a child's current needs are appropriate as long as they are based on sound clinical judgments.

[121] This exception was requested and approved by the Co-Monitors in May 2017 after the initial list of exceptions was approved.
[122] In validating data for this measure, the Co-Monitors identified several situations that did not meet an agreed-upon exception, but are either due to a circumstance which the agency believes to be outside of its control or were caused by a lack of appropriate, available placements. Specifically, one child was in a congregate care facility with siblings at the time DSS filed with the Court to gain custody of the children and the Court ordered that the child remain in that placement; another child was in need of a respite placement and the only placement available was too far from the child's school, therefore, the child spent several weeks in a congregate facility before returning to the child's foster home; and another child entered foster care and stayed in a congregate facility for a short time until a family-based placement was located.

Figure 27: Children Ages Six and Under in Congregate Care
April 2017 - March 2018[123]



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total	5	4	3	4	4	4	3	8	5	4	4	8
Met an exception	3	2	1	1	1	1	1	5	2	2	3	7

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.).

During this monitoring period, the Co-Monitors were notified of one instance of children staying overnight at a DSS office in violation of this provision. DSS reports that in October 2017, two children, age nine and age 11, spent the night in a DSS office while staff were seeking placement for them. The children were taken into protective custody by law enforcement and arrived at a DSS office just after midnight. Multiple DSS staff worked to locate a placement to no avail. At

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

approximately 9:00 AM, it was determined that the children had previously been involved with DSS and had resided with their paternal grandmother. Law enforcement rescinded the decision to take the children into custody, DSS assessed the children's grandmother and released them to her custody.

DSS promptly reported the overnight stay to the Co-Monitors and provided supporting documentation. To facilitate the notification process and ensure the prompt provision of important information, DSS and the Co-Monitors have drafted an Overnight Stay reporting form to be used in future reporting periods.

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 yet been proposed by DSS.

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 is unable to provide the data needed to report on this requirement. DSS has identified two primary barriers to collecting and providing these data: (1) there is not a standard, operational definition for "emergency" or "temporary" placements, and (2) due to a lack of a clear operational definition, placement data utilizing these categories are inconsistently entered by staff into CAPSS. DSS has informed the Co-Monitors that after a definition is agreed upon, a code book of definitions describing each level of foster care will be developed and fields will 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.[124]

Although DSS does not formally or consistently track the use of emergency or temporary placements, DSS data reflect that between October 2017 and March 2018, there were 320 instances of "incentive payments" (with 27 additional pending claims) made to providers to accept placement of a child overnight.[125] Although technically not classified as temporary or emergency placements, the payments are used to support such situations and the Co-Monitors view these as temporary and emergency placements that can contribute to placement instability and exacerbate the trauma of placement.

Pursuant to Change Orders 5 and 7, the following describes situations under which the incentive payments may apply:

1. DSS has 24 to 48 hour notice that a child will be discharged from a resource family home, therapeutic foster home or group care, however, DSS is unable to identify an alternative placement;

2. a child who entered DSS custody on an emergency basis and needs a secure placement that has the staffing, supervision and structural environment to ensure the safety and well-being until an appropriate level of care placement is located and for whom referrals for an appropriate level of care placement have been exhausted; or

3. a child who experiences an unscheduled discharge or release from a resource family home, therapeutic foster home or group care and a search for appropriate level of care placements has been exhausted and a determination made that no placements are immediately available but may be in the near future.

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

[124] The data audit work being conducted by Chapin Hall has identified potential issues with the quality and accuracy of data related to placement. Specifically, placement type, placement stability and emergency or temporary placements.
[125] Per DSS, as of July 14, 2017, a group care facility may receive an additional daily payment of $75 per day for a child accepted to the facility on an emergency basis for up to two weeks, renewable for an additional two weeks. Similarly, as of September 15, 2015, a foster/resource parent may receive an additional $250 per instance of a child accepted for placement on an emergency basis for up to two weeks, renewable for an additional two weeks.

adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member…" (FSA IV.H.1.).

As reported in the last monitoring period, DSS does not have a system in place for tracking youth involved with both the juvenile justice and child welfare systems. In an effort to address the need for interagency coordination, DSS entered into a Memorandum of Understanding (MOU) with the South Carolina DJJ in September 2017. The MOU requires, among other things, the identification of DSS and DJJ liaisons in each county to serve as first points of contact to identify youth involved in each system, provide relevant caseworker contact information and share limited records. The MOU also requires that Interagency Staffings – meetings between DSS and DJJ caseworkers involved with a youth's case – be held within 30 days of "identification," as well as anytime a youth is detained, on "runaway," "offends in placement," or is otherwise at "risk of reoffending."

DSS began implementing the MOU during this monitoring period in partnership with regional attorneys and county DJJ and child welfare staff. DSS has reported that regional attorneys from the Office of General Counsel have been meeting with legal staff and solicitors throughout the state to communicate MOU requirements, and that designated DSS county liaisons have been providing DJJ with relevant contact information and participating in monthly interagency staffings. In addition, DSS has reported that some counties and regions have initiated quarterly collaborative sessions attended by DSS, DJJ, and law enforcement to address roles, processes and implementation challenges.

DSS has also reported that it has developed a test version of a DJJ portal, demonstrated to DSS leadership in June 2018, which will allow designated DJJ staff to access the DSS CAPSS records of children in foster care. DSS is in the process of adjusting the portal in response to DSS leadership feedback. Details regarding protocols for access have not yet been established. DSS anticipates that changes to CAPSS will enable identification of dually involved youth in the future, and will allow for the aggregation of information related to required interagency staffings.

Though DSS has acknowledged that it does not have the ability to track the youth in its care who are involved with DJJ, it has continued to represent that youth are immediately taken into the physical custody of DSS upon exit from juvenile justice placement. No violations of the FSA were reported to the Co-Monitors by DSS again this monitoring period. Stakeholders throughout the state have, however, continued to express concerns to the Co-Monitors that youth are sometimes being held in detention or secure evaluation facilities because there are no appropriate DSS placements available and describe attempts by DSS to transfer responsibility to DJJ for youth with significant behavioral needs or who require a higher level of care because of lack of appropriate placements.

In this monitoring period, the Co-Monitors reviewed a number of cases – likely representative of many others – in which youth spent time in DJJ facilities due, in part, to DSS's failure to meet their needs. For example, in January 2018, a 15-year old youth in Richland County was sent to a secure evaluation center, despite recommendations by DJJ and the solicitor that a community evaluation would be appropriate, because DSS insisted it did not have an appropriate placement for the youth. In December 2017—four months after DSS advocated that charges not be dropped, and after nearly six months of failed placements—a solicitor informed the family court that a 16-year old youth from Williamsburg County was still awaiting a placement appropriate to her severe mental health needs. One month later, in January 2018, the youth was placed at a DJJ secure evaluation center after her behavior escalated, violating the terms of her probation. The Co-Monitors have shared these cases, as well as others, with DSS leadership and requested follow-up be conducted by the agency.

The Co-Monitors remain very concerned that youth continue to spend time in secure facilities because DSS cannot provide the placements and supports likely to keep youth in their communities. This is an urgent need and one that DSS must address immediately in its Placement Implementation Plan work. As a beginning point, it is essential that DSS quickly develop the capability to provide accurate, real-time data that identifies which youth in its care are also involved with DJJ. Until this happens, it will be impossible to ensure that the needs of these youth are being addressed.

Placement Instability

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 (FSA IV.F.1.). Placement instability is defined as the rate of placement moves per 1,000 days of foster care among Class Members (FSA II.O.) and placement moves are changes in foster care placements.

Data for this measure are reported annually and will be included in the next monitoring report. In the prior reporting period, DSS utilized an external data consultant to complete analysis for this measure. The Co-Monitors have had several conversations with DSS staff and their external data consultant to discuss the source and coding of the underlying data for this analysis. Some potential issues have been identified, which may impact the accuracy of this analysis. DSS is currently working with Chapin Hall, its data consultant, to make adjustments to CAPSS to address these issues, as needed.

Sibling Placement

Children in foster care should be placed with their siblings whenever possible. The FSA recognizes the importance of this familial connection and requires that at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings (FSA IV.G.2. & 3.). The FSA 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 draft Placement Implementation Plan and have not been approved by the Co-Monitors.

DSS provided data for 863 children who entered placement between October 2017 and March 2018 with a sibling[126] or within 30 days of their sibling's entry to placement and were still in care on March 30, 2018. As of March 30, 2018, for this cohort of children, as reflected in Table 18, 38 percent (324 of 863) of children were placed with all of their siblings and 63 percent (547 of 863) of children were placed with at least one of their siblings.

Table 18: Sibling Placements for Children Entering Placement between October 2017 and March 2018 as of March 30, 2018 N=863

Sibling Placement Status	Number (Percentage) of Children*	FSA Final Target
Total Number of Children Entering Placement from October 2017 to March 2018 Who Have a Sibling Entering Placement With or Within 30 Days	863	--
Children placed with **All Siblings**	324 (38%)	80%
Children placed with **At Least One Sibling**	547 (63%)	85%
Children **Not Placed With Any Sibling**	316 (37%)	--

Source: CAPSS Data Provided by DSS

* Total percentage does not equal 100 as children can be included in both "at least one sibling" and "all sibling" categories

[126] 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

Children who have been removed from their homes must spend time with family members while in foster care. The FSA includes requirements related to visits between children in foster care and their siblings and parents. DSS performance with respect to sibling visits declined this reporting period. Although a greater percentage of children visited with their parent(s), the vast majority of children in DSS custody continue to spend little or no time with the parent(s) to whom they are supposed to return. This continues to be an area of significant concern for the Co-Monitors.

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 periods, 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, completed several rounds of revisions and modifications. The Implementation Plan for visitation could not be approved by the Co-Monitors because reliable baseline data with respect to children with reunification goals were not available. As discussed below, the Co-Monitors and USC CCFS were able to manually collect relevant data beginning in the last monitoring period. DSS submitted an updated draft Visitation Implementation Plan on August 11, 2018. The Co-Monitors provided feedback to the Plan on August 17, 2018, and DSS is in the process of modifying its Plan so that it can be resubmitted.

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 19:

Table 19: 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.[127]

Although documentation of sibling visits is expected to be entered by caseworkers into CAPSS, the fields that capture this information cannot yet be used to extract aggregate data. In order to assess performance for this measure, in June 2018, USC CCFS and Co-Monitor staff utilized the instrument developed in the first monitoring period to collect data on the occurrence of visits between siblings in foster care. Reviewers looked at a sample of cases for which sibling visits were required in March 2018.[128] Reviewers determined that 157 of the applicable 303 children[129] (52%) had visited with all of their siblings during the month. Of the 146 children who did not

[127] 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.

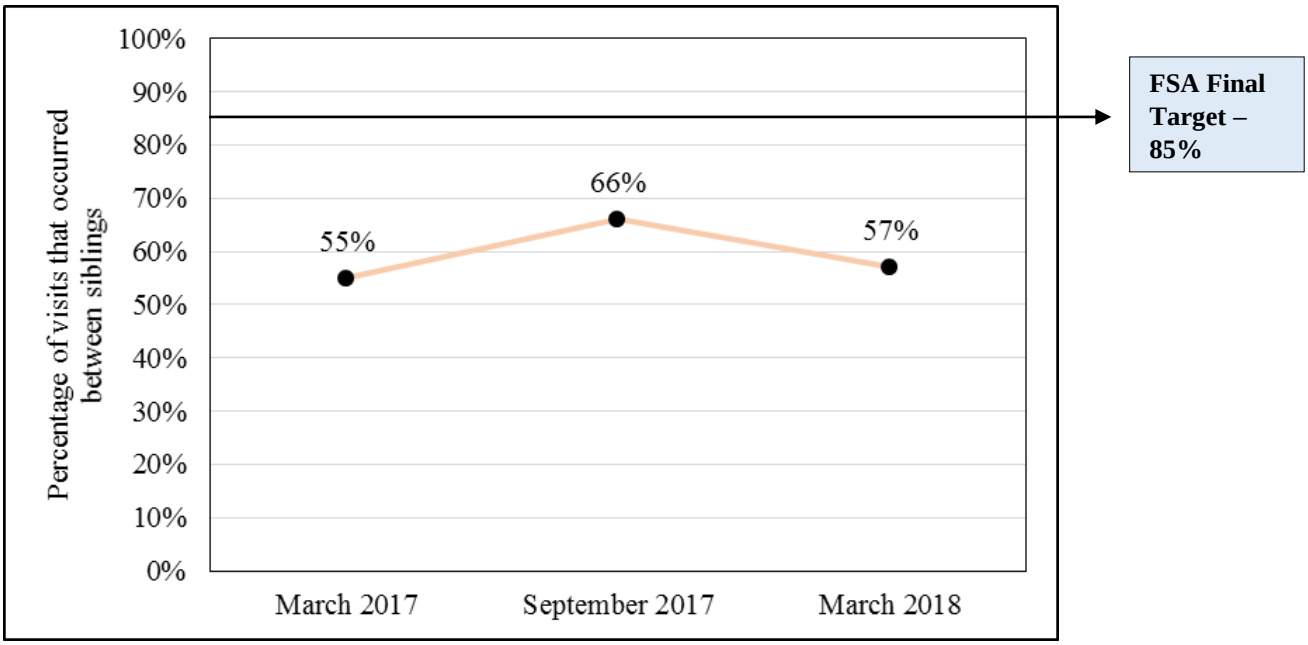
[128] As of March 31, 2018, there were 1,533 children who had been in foster care for at least one month, with siblings in foster care with whom they were not placed. A statistically valid random sample of 308 cases was pulled based on a 95% confidence level and +/- 5% margin of error. Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

[129] Two 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; and one case were excluded because the child or sibling was on runaway status during the month.

visit with all of their siblings, 131 did not visit with any of their siblings (57 percent of children visited with at least one of their siblings). This is a decline since September 2017, when 60 percent of children visited with all of their siblings and 63 percent visited with at least one sibling.

In an effort to align data collection and analysis methodology with the specific FSA definitions for this measure, data were used to calculate performance as a percentage of required visits that occurred in the month reviewed. Reviewers determined that 293 (57%) of 510 required visits[130] between children and the siblings with whom they were not placed occurred in March 2018 (see Figure 28).[131] This is a decline in performance since the last monitoring period, when 66 percent of required visits between children and siblings occurred.

Figure 28: Visits that Occurred between Siblings
March 2017 - March 2018



Source: June 2017, January 2018 and June 2018 Case Record Reviews, USC CCFS and Co-Monitor staff

[130] Data reflect the exclusion of 15 visits for which it was determined that a valid exception applied for one of the reasons discussed above. *See, supra.,* fn 129.

[131] 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 significance as the data discussed earlier. As DSS's capacity to extract aggregate data for this measure improves, calculations will be based on a universe of applicable visits, as required by the FSA.

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 20.

Table 20: 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.[132]

In June 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 March 2018.[133, 134] Performance remains very low. Reviewers determined that only 55 of the applicable 319 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,[135] resulting in performance of 17 percent, as shown in Figure

[132] 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.

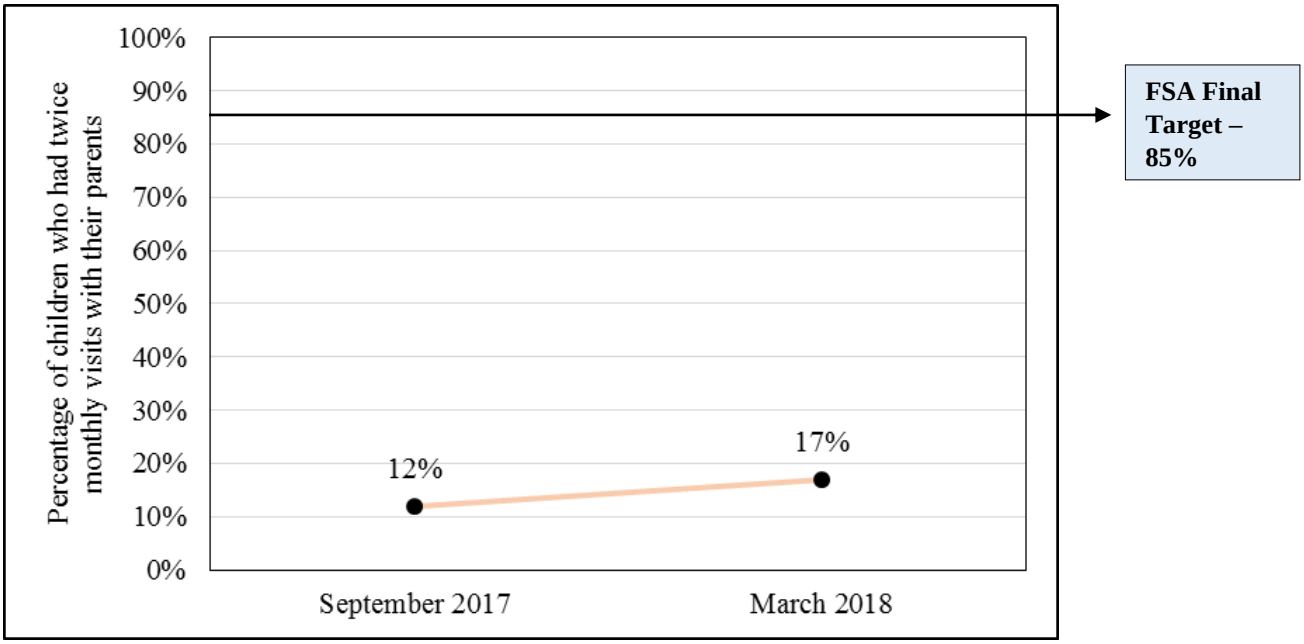
[133] As of March 31, 2018, there were 2,119 children who had been in foster care for at least one month with a goal of "return to home," or "not yet established." A statistically valid random sample of 326 cases was pulled based on a 95% confidence level and +/- 5% margin of error.

[134] 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.

[135] Two cases were 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; one case was excluded because the parent was missing; one case was excluded because visitation was deemed psychologically harmful to the child; and one case was excluded because the parent refused visitation despite efforts by the caseworker.

29. Almost half, 135 (42%) of the applicable children had no contact at all with any parent in the month of March 2018.

Figure 29: Children with Twice Monthly Visits with their Parents
September 2017 - March 2018



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

X. HEALTH CARE

It is essential that child welfare systems provide children in foster care with the supports and services they need to be healthy. This requires the ability to quickly identify children's health and behavioral health needs, to provide high quality preventative and acute care and to maintain a system for tracking care delivery and communicating key health care information. With the assistance of health care consultants, DSS continued to make progress in this area during this monitoring period. Most significantly, DSS obtained Co-Monitor approval for its Health Care Improvement Plan in August. This is an important accomplishment that establishes a strong foundation for meeting the heath care needs of children and youth.

A. Health Care Improvement Plan

The FSA required that by April 3, 2017, DSS, "with prior input and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation concerning initial screening services, periodic screening services, documentation, and health care treatment services for Class Members in the areas of physical

health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. The Plan shall address:

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

After receiving an extension for preparation of the Health Care Improvement Plan (pursuant to the FSA), DSS submitted a draft Plan to the Co-Monitors on September 29, 2017. The draft Plan described work that DSS had undertaken to improve access to and the quality of health care for the children in its care, including the appointment of a Child and Adolescent Psychiatrist; planning for a new DSS Office of Health and Well-Being; 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 care services to children in foster care, the draft Plan did not address many of the complexities that the Co-Monitors believed to be essential to effective implementation. In light of this, and given the importance of the work, in November 2017, the Co-Monitors engaged consultants with specific expertise in child welfare health care reform 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, Department of Mental Health (DMH), Department of Health and Human Services (DHHS), Managed Care Organization (MCO) and community provider staff, were submitted in a Findings and Recommendations Report on February 12, 2018. The report concludes that DSS's draft Health Care Improvement Plan contained important conceptual and structural elements on which to build a robust health care system for children in foster care, but that it did not yet include the operational framework needed for implementation. The consultants identified six priority action items, which they recommended DSS undertake right away, the first of which was the development of a revised plan that includes implementation timeframes, task leads and needed resources, including a multi-year budget.

In the months since the release of the Findings and Recommendations Report, DSS has demonstrated a sustained commitment to improving health care delivery to children in foster

care. It has continued to effectively utilize the consultants' expertise and has made great strides with respect to each of the recommended priority action items as outlined below:

Priority Action Item 1 - Produce a Revised Health Care Improvement Plan:
DSS has worked intensively with the health care consultants and key partners since the submission of the Findings and Recommendations Report, with the goal of refining its Health Care Improvement Plan. On June 29, 2018, DSS submitted a revised Plan to the Co-Monitors. After providing feedback, the Co-Monitors approved the Plan on August 23, 2018. The Health Care Improvement Plan is broad in scope and includes a comprehensive vision for the delivery of health care to children in foster care through collaboration with DHHS and its MCO, Select Health, including mechanisms for sharing and utilizing critical health care data. If well implemented, the Plan has the potential to improve the physical, mental and dental health care of children in foster care throughout the state.

Priority Action Item 2 - Identify an Interim Director of the DSS Office of Health and Well-Being: The consultants recommended that DSS prioritize hiring a permanent Director to oversee its newly established Office of Health and Well-Being, and that it draw on internal staff at partner agencies to fill the role temporarily. On April 27, 2018, after an extensive search, DSS hired Gwynne Goodlett as the Director of the Office of Child Health and Well-Being. She became immediately involved in the development of a revised Health Care Improvement Plan and has been a much-needed project lead in moving the work forward.

Priority Action Item 3 - Identify and Convene a Leadership Team: The consultants recommended that DSS quickly name a cross-agency leadership team with management authority 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 (a "SWAT team"). DSS immediately acted upon this recommendation. Key representatives from DSS, DHHS and Select Health (MCO) have been meeting weekly since March 2018 to discuss issues related to the development and implementation of the Health Care Improvement Plan, including protocols for data sharing, the production of management reports and coordination of health care case management. This team approach has proven essential to Plan development and will continue to play a critical role as implementation begins.

Priority Action Item 4 - 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 to enable DSS access to data necessary to monitor the health care needs of the children in their care. In the interim, the consultants recommended that DSS obtain reports from Select Health that identify children in foster care who have not received required screenings, assessments and follow-up ("gap-in-care

reports"), 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 on their caseloads with identified unmet needs. DSS immediately began work with DHHS and Select Health to initiate data sharing processes, and obtained all data requested from DHHS. In the months ahead, DSS must act expeditiously to sort and understand the data produced so that it can be used to improve health outcomes for children. This must include a system for regular data transfer, reporting and validation that is efficient and reliable, and a well-tested process for rapidly communicating relevant health information to caseworkers in the field.

Priority Action Item 5: Initiate Short-Term Data Workaround to Mitigate the 30-day Enrollment Gap: Although nearly all children in foster care in South Carolina are enrolled in one MCO, Select Health, enrollment is not immediate. The monthly contracting arrangement DHHS has with Select Health has meant that there can be up to a 30-day enrollment lag. In acknowledgement of the challenges this poses to DSS in its efforts to track health claims data for children from the time they enter DSS custody, the consultants recommended that DSS develop and implement a data workaround until DSS puts a longer term solution in place. DSS and DHHS have been working to resolve this issue, with an expected date of completion in January 2019.

Priority Action Item 6 - Initiate Short-Term Plan to Address Immediate Treatment Needs: Given DSS's lack of reliable data on follow-up care identified in prior reporting periods, the consultants recommended that DSS quickly develop a process by which DHHS data could be utilized to identify children who did not receive needed screenings, assessments or follow-up care. DSS began work on this recommendation, and has been developing a process for addressing identified gaps in care. This process is addressed in more detail below.

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 first monitoring period, the Co-Monitors reported data on children who had been in DSS custody for more than 60 days as of October 4, 2016, who had not yet received initial health/medical, dental or mental health assessments based on information entered into CAPSS. Because DSS acknowledged that the data provided were not 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.

Although DSS made significant efforts in the last monitoring period to improve the accuracy of its assessment data, its process depended upon caseworkers to manually enter and update appointments into CAPSS, sometimes months after they occurred. As a result, the data continued to be unreliable. With the help of the health care consultants, DSS made significant progress during this monitoring period in building protocols to allow for access to health care data housed at DHHS and Select Health. DSS and the consultants believe that these data are valid because they are extracted directly from Medicaid claims and billing records. Although there is still work to be done to sort and produce the data in a format that can be utilized by management, shared with caseworkers and reported to the Co-Monitors, the ability to access these data has been a breakthrough for DSS.

In an effort to gauge performance with respect to initial health assessments, DSS produced to the Co-Monitors data reflecting the percentage of children who entered DSS foster care in this monitoring period who received initial physical health, mental health and dental assessments of some kind. Because there is still important work that needs to be done to clarify DSS policy and definitions related to assessments and map them to Medicaid claims data, DSS is not yet able to identify details related to these initial assessments (some, for example, may qualify as Early Prevention Screening Diagnosis and Treatment (EPSDT) visits, while others may correspond only with more limited initial screenings or assessments).

According to the data produced, 738 (73%) of the 1,011 children who entered DSS foster care between October 1, 2017 and March 31, 2018 received an initial physical health assessment. Of these 738 children who received an initial assessment, 463 children received an assessment within 14 days of placement, 143 children received an assessment within 15 to 30 days of placement, 91 children received an assessment within 31 to 60 days of placement and 41 children received an assessment within 61 days or more of placement.

The data also reflect that 525 (52%) of the 1,011 children who entered DSS foster care between October 1, 2017 and March 31, 2018, received an initial mental health assessment.[136] Of the 525 children who received an initial assessment, 269 children received an assessment within 14 days of placement, 108 children received an assessment within 15 to 30 days of placement, 93 children received an assessment within 31 to 60 days of placement and 55 children received an assessment within 61 days or more of placement.

Finally, 431 (48%) of 890 children ages one and older[137] who entered DSS foster care between October 1, 2017 and March 31, 2018, received an initial dental assessment. For those children who received an assessment, 90 children received an assessment within 14 days of placement, 125 children received an assessment within 15 to 30 days of placement, 95 children received an assessment within 31 to 60 days of placement and 121 children received an assessment within 61 days or more of placement.

Table 21: Children who Received Initial Health Assessments
For Children who Entered Care between October 1, 2017 and March 31, 2018

	Total Number of Applicable Children	Total Number (Percent) of Children who Received Assessment	Time to Assessment:			
			1 - 14 Days	15 - 30 Days	31 - 60 Days	61 or More Days
Initial Physical Health Assessment	**1,011**	**738 (73%)**	463	143	91	41
Initial Mental Health Assessment	**1,011**	**525 (52%)**	269	108	93	55
Initial Dental Assessment	**890**	**431 (48%)**	90	125	95	121

Source: DHHS Medicaid claims data

[136] For children under the age of three, completion of an initial medical assessment was considered compliant for the mental health assessment measure as a developmental assessment and screening is a component of their examination with a primary health care provider.
[137] For purposes of this analysis, children under the age of one were not considered applicable for an initial dental assessment. An oral examine is a component of their examination with a primary health care provider.

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 has worked with DHHS and Select Health to build a health care information system that builds on Medicaid data, collected by DHHS and Select Health, to identify children in DSS custody with immediate treatment needs. As with initial assessment data discussed above, DSS and the health care consultants believe that this approach—which utilizes Healthcare Effectiveness Data Information Set (HEDIS) measures among others, required for Medicaid managed care plans by the federal government—is much more likely to produce robust, reliable data than is now captured in CAPSS or initially conceptualized by DSS. Though a significant amount of data has been made available for use in identifying children in need of follow-up care, called "gap-in-care" reports by DHHS, additional work by DSS is needed with DHHS and Select Health to build an understanding of these data and develop a roster and reports to effectively track and follow-up on unmet health care needs. DSS has begun utilizing its CAPSS data to generate an interim child-specific roster for initial screenings and assessments to guide its new, weekly "cadence calls" with regional staff held by the Office of Child Health and Well-Being.

APPENDIX A - Glossary of Acronyms

ADR: Accountability, Data and Research
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
PCG: Public Consulting Group
PIP: Performance Improvement Plan
QA: Quality Assurance
SC: South Carolina
TFC: Therapeutic Foster Care
USC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B - OHAN Implementation Plan Strategy Updates as of March 31, 2018

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 March 31, 2018 [138]
Intake and Investigations			
a. Institute investigative caseworker 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 caseworkers within the unit. As of the writing of this report, five new OHAN investigator positions have been allocated; however, as of June 2018, three vacancies existed. There is also a vacancy for one supervisor. As of June 2018, DSS reports that one candidate for an investigator and one supervisor candidate have been selected and recommended to Human Resources staff. 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. As discussed earlier in this report, during review of OHAN investigations in March 2018, Co-Monitor staff identified instances in which CAPSS data for timely initiation were not accurate.

[138] In some instances, information in this Table reflects the status of actions after March 31, 2018.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of March 31, 2018
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. DSS plans to hold a training in September 2018 on data collection at intake for all staff to ensure more consistency.
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 continue to find that caseworkers and supervisors use this list inconsistently. In the June 2018 review of investigations received in March 2018, reviewers found numerous instances in which a core witness was checked off on the check list but documentation does not indicate this witness had been contacted. DSS report that guided supervision is a first priority when the new supervisor is hired.
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 and CAPSS staff are in the process of designing the system change. DSS reports that once completed, the workgroup will test the CAPSS modification for accuracy.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of March 31, 2018
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 regarding screening referrals 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 the state's general CPS and OHAN. DSS anticipated completion of the new tool in 2017, however, this did not occur.
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 caseworkers and supervisors beginning September 2017. OHAN basic investigative training to occur for existing caseworkers and supervisors by December 2017. All new caseworkers 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 with the assistance of The Children's Law Center and USC CCFS, the investigation training curriculum is near complete and training will be provided to current OHAN staff in October 2018 and newly hired OHAN staff in January 2019.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of March 31, 2018
h. Develop a Provider History report in CAPSS to provide an easy to access and consistent history on providers for use by OHAN caseworkers, supervisors, and reviewers - Preliminary report is currently being tested - Once finalized, report will be automated in CAPSS. - OHAN intake caseworkers 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. DSS has been working with Chapin Hall to develop a process for pulling reports for providers with multiple provider IDs within CAPSS. DSS believes the current process allows them to thoroughly check a provider's history.
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 was developed in November 2017 by the OHAN Workgroup. This policy is awaiting final agency approval.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of March 31, 2018
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. DSS reports more consistent implementation will be concurrent with the hiring of a new supervisor.
- 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.
- 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.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of March 31, 2018
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 and a vacant supervisor position, 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 which cover Charleston County, Ononee County and Cherokee County, the new assignment process was ceased. DSS reports a continued commitment to regional assignments but implementation will not begin until hiring is complete.

APPENDIX C - DSS Health Care Improvement Plan (without attachments), Approved August 23, 2018

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES FOSTER CARE HEALTH PLAN

Michelle H. v. Haley – Approved Health Care Improvement Plan
August 23, 2018

Table of Contents

I. Introduction

The South Carolina Department of Social Services (DSS) is undertaking a comprehensive reform of its child welfare system with a special focus on the heath care needs of children in foster care. In partnership with the South Carolina Department of Health and Human Services (DHHS), DSS is redesigning the way health care services are organized and delivered to children in foster care. Our vision is a fundamentally reformed system that can be a model for other child welfare systems around the country.

The South Carolina Department of Social Services submits this Health Plan to represent and satisfy the commitments it made in the *Michelle H. v. McMaster* Final Settlement Agreement (FSA). The plan includes the Department's goals, system components, activities underway and to be undertaken, timeframes for implementation, deliverables, performance targets and process for quality monitoring and performance review.

II. Priority Actions

Given the expansive scope of the reforms envisioned, DSS is working concurrently on both roll out of the Plan, which will take several years, and on "*priority actions*" that respond to pressing child health issues. Work on these six *priority actions* started in Winter of 2018, before the final Health Plan was complete. The below identifies the six priority actions, and the status of them at the time of writing this Plan.

	Priority Actions	Status as of August 1, 2018
1.	**Produce a Revised Health Plan**	**In process. Target for Completion in mid-August, 2018.** Working with DHHS and Select Health to accomplish. Other new developments: Child health and system goals have been developed. DSS will move to use a validated assessment tool to determine level of care and level of need. Among other things, the Plan will cover initial assessment, comprehensive assessment and follow-up; immediate needs; care coordination and care management; health-related case practice; network adequacy; data and reporting; quality improvement and performance. DSS holds weekly planning meetings with the consultants.
2.	**Identify an Interim Director of DSS Office of Health and Well-Being**	**Completed.** Identified a *PERMANENT* Director[139] who began on April 27th. Work is underway to align staffing and new plan functions, reconfigure the FCHAC (Foster Care Health Advisory Committee) and manage all aspects of the revised Health Plan.

[139] Position Description in Appendix, Section 5.

3.	**Identify and convene a Cross-Agency SWAT Team.**	**Completed.** Consultants[140] recommended that DSS meet weekly with DHHS and Select Health. DSS and DHHS now have standing weekly meetings. In March, DSS, DHHS and Select Health began meeting weekly on data sharing; development of a coordinated health care management model; development of child-specific rosters and aggregate data tracking reports, etc. The consultants attend these ongoing weekly meetings as needed.
4.	**Obtain Gaps in Care Reports from DHHS and Select Health**	**Completed & an ongoing process.** Consultants found that retrospective verification of health history, initial and comprehensive assessments by caseworkers were duplicative, delayed and less reliable than the same information collected and tracked by Select Health. Data sharing, report development and testing, a data dictionary and other elements of a data system are being built now in consultation with consultants. Two reports have been produced using this new data-sharing approach and they show that many more children are getting assessed than were originally identified from third-hand data inputs collected by caseworkers. Contemporaneous collection of information by caseworkers, which now occurs, will continue but be verified by administrative reviews and select case reviews. See no. 6 in this table for more information.
5.	**Initiate Short-Term Data Work Around to Mitigate 30-day Enrollment Gap**	**Ongoing. Resolution by Jan 2019.** The DHHS- Select Health contract is negotiated annually in January of each year. DSS and DHHS will collaborate to create a separate administrative contract to include the development of a weekly notification system for new entrants into (and exits from) foster care. DSS currently uploads rosters to DHHS nightly to identify new entrants into and exits from foster care. DHHS will produce monthly a rostered gaps in care/utilization report capturing initial assessments, assessments or follow-up services provided to new entrants. DSS and DHHS are working to resolve the enrollment issue with an expected date of completion in January 2019 and the eligibility gap after the existing process is automated with an expected completion date in June 2019.

[140] Consultants Gail Nayowith and Kathleen Noonan were identified by the Co-Monitors under the FSA to work with DSS on health care issues.

6.	**Initiate Short-Term Plan to Address Immediate Needs**	**Process in development.** Once the data reports begin to run regularly and the new processes are in place in August 2018, the backlog of children on the immediate needs roster will be reduced. In the short run, to catch up and reach all children on the roster, DSS developed a new process for addressing immediate needs that will roll-out beginning in August 2018: DSS caseworkers will follow up on needed assessments from the DHHS/SH reports and document into the CAPSS (Child and Adult Protective Services System, DSS's Statewide Automated Child Welfare Information System SACWIS) foster care case record any actions taken. After implementation of the practice model, caseworkers will also be expected to enter into case notes, any follow up care needed, including confirmation with foster parents or other caregivers that follow-up visits have occurred. Caseworkers will also be expected to ensure that birth/natural parents are included in health care planning, and apprised of any/all appointments, etc. To assist with verification and to see that that care needs are met, DSS will review the roster of children with high need/risk diagnoses against 30-60-90-day gaps in care/utilization reports, in collaboration with DHHS and Select Health. DSS will also undertake a review of select case records, consistent with CFSR PIP, to ensure that children and youth are getting services they need. These multiple layers of tracking and review, at the individual case level and population level, allow children and youth who might have missed initial assessments, comprehensive assessment or follow up care to be identified and staffed until they receive the care they need.

The following sets forth DSS's health care plan for children and youth in foster care. Section III summarizes the commitments made by DSS related to health care in the Final Settlement Agreement (FSA). Sections IV and V are the core components of the Plan. Section IV identifies the Plan's four child health goals, and Section V identifies the Plan's three system goals. Each goal identifies a task Lead; key activities and deliverables; and a timeframe. Additional materials are included in the appendices.

III. Health Care and Related Placement Commitments in the Final Settlement Agreement

In the final Settlement Agreement (FSA) in *Michelle H. v. McMaster* (FSA), DSS committed to develop and implement a Healthcare Improvement Plan (the "Plan"). In addition, DSS agreed that the Plan would include enforceable dates and targets for phased implementation related to initial assessment services, periodic assessment 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. Pursuant to the FSA, the Plan will 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 the baselines and interim percentage targets for performance improvement in coordinating screens and treatment services.

DSS understands that the commitments it made to health care in the FSA must work in concert with other commitments, including those related to placements for children in foster care. Under the FSA, DSS envisioned that decision-making about placement and services would be based on assessment of strengths and needs. Moreover, under the FSA, DSS committed to a child welfare system in which family-based placements are the presumption over institutional or congregate placements, especially for young children. Special placement resources like residential treatment or therapeutic foster homes (TFCs) are accessed by referral for interagency staffings. Currently, this process involves assessing for eligibility for the Interagency System of Caring for Emotionally Disturbed Children (ISCEDC).

Given the overlap between the health and placement components of the FSA, synchronizing planning and implementation in these areas is critical to the reform envisioned by DSS. For example, the health and behavioral health care initial assessments and comprehensive assessments used when a child enters foster care should inform decisions about higher level of care placements and services for eligible children. For example, DSS is currently able to verbally authorize a provisional 35-day eligibility for ISCEDC inter-agency staffing in cases where the presumption is that a child needs a higher level of care and where corroborating information can be obtained to substantiate the child's ISCEDC eligibility. If used, this presumptive eligibility function could prevent multiple placements and reduce the wait time for a "least restrictive, most appropriate" higher level placement or authorize community-based services and supports to stabilize placements. These details are discussed in this Plan.

The Placement Implementation Plan under development by DSS will make explicit the articulation between level of care (LOC) placement decisions and level of need (LON) services, and will further define the process and assessment tools to be used as part of determining appropriate placements and services for children and youth. Among other things, the Placement Implementation Plan will focus on a teaming model, caregiver and youth engagement and other key supports in the assessment and placement process. To the extent possible, DSS would prefer that children in foster care receive their health, behavioral health and dental services in community settings that also serve children who are not in care. This promotes continuity of care when children are in foster care and access to the same services when they leave care.

In addition to the necessary integration of health care and placement work, DSS's health plan implementation activities will also be important as DSS begins planning for the implementation of new federal legislation - *The Family First Prevention Services Act*. Importantly, the new legislation requires states to move away from non-clinical group residential settings to family foster care and community-based preventive services. DSS has asked the health care consultants for assistance in building out the level of need/level of care assessment process design outlined in the Health Plan to best match a child's service needs with community-based services and a suitable placement. The health assessment features of this process will dovetail with work to strengthen the placement process to be fleshed out in the DSS Placement Implementation Plan. In addition, the new federal law requires child welfare group homes and congregate care to meet new licensing and accreditation standards that were historically more common in PRTFs and other clinically-oriented health care settings and residential treatment programs. The go-live date for certain parts of the federal statute may be as early as October 2019, and DSS wants to be ready for implementation.

DSS began development of the Health Plan in 2017, and submitted a draft to the Co-Monitors on September 29, 2017. The Co-Monitors provided feedback to the draft Plan on October 31, 2017, advising DSS that they would retain consultants to assist the Co-Monitors and staff with validating components identified in the Health Care Plan and identifying additional infrastructure and operational enhancements that may be needed.

The consultants reviewed and considered the elements of the proposed Health Care Plan, including its nine infrastructure components, seven innovation areas and select targets, and developed a validation framework to guide their assessment. They examined reports, data, policies and practices already in place and visited with DSS and its partners for three days in January 2018. The consultants' review culminated in a report which included identification of six priority actions for immediate implementation and their findings and assessment of whether each Plan element should remain in the plan, remain in the Plan with revisions, or be removed from the Plan. As an overall finding, the consultants found that the draft Health Care Plan included important conceptual and structural elements on which to build a robust health system for children in foster care. Since issuance of their report, DSS and the consultants have worked together through two sets of multi-day onsite meetings and weekly check-in calls on implementation of the six priority action items, framing elements of the Plan and on revisions to the Plan. DSS is committed to plan and implement concurrently and is actively engaged in planning and operational improvement activities simultaneously. To this end, DSS has engaged the health care consultants in both aspects of their work.

IV. The Proposed Health Care Pilot and Process Review

DSS proposes a health care pilot and process review that will test, refine and scale the operational elements of the Health Plan. The Health Care Pilot and Process Review will run from October 2018 through February 2019 with system-wide implementation beginning in March 2019 and continuing through the end of the year. It is the view of the healthcare consultants, that the scope of the system redesign envisioned by the Plan, which includes new external partners and new processes, protocols

and capacities internal to the Department, warrants careful testing and process refinement before full statewide implementation. The Health Care Pilot and Process Review will identify, follow, and review the health-related processes and care experience of 20 children entering or re-entering foster care. The sample of children will be selected to represent three types of conditions: children who are typically developing with no serious health or behavioral health conditions; children who have a chronic condition that warrants regular follow-up; and, children with complex medical or serious behavioral health care needs. The goals of the Health Care Pilot and Process Review include process review, testing and refinement in the following areas:

1) Assessing and matching child health and/or behavioral health needs and level of care decisions at the point of placement;
2) Assignment of a single DSS caseworker (county-based or regional IFCCS worker), throughout the child's stay in foster care, informed by the child's health or behavioral health needs;
3) Alignment of DSS casework and Select Health care management tiering, care coordination responsibilities, practice and protocols;
4) Automation of CAPSS data feeds to reduce the documentation burden on DSS casework and IFCCS staff and to leverage data that is available from Select Health and Medicaid system of record;
5) Red flag or high needs rostering of children whose health or behavioral health condition warrants close monitoring (this will include red flags for events like visits to the emergency room); and
6) Production and use of gaps in care/utilization reports derived from administrative data (Medicaid encounter and claims data) and dissemination to DSS field staff for follow-up;
7) Follow-up tracking of high need, immediate need or other special populations of children based on data and through weekly management meetings at leadership level and "cadencing" to field level. Just as a squad or military formation uses a regular, disciplined practice to march to the same beat, cadencing is a process that tracks a specific data element statewide. On weekly or bi-weekly conference calls missing or unclear data is followed until the information is provided or the issue is resolved. This continual improvement process aligns management and field staff to achieve the same goal and develop a forum for continual improvement;
8) Staff training on new health protocols and use of new health tools and reports;
9) Caregiver education and engagement by Select Health; and
10) Identification of the necessary service array, availability and access.

DSS will lead the Health Care Pilot and Process Review in collaboration with DHHS and Select Health with support from the health care consultants. The Health Care Pilot and Process Review will be coordinated with and build on other DSS work streams and consultant projects to avoid duplication and to leverage other resources (e.g., Chapin Hall retained by DSS for assistance on a data audit, development of the DSS case practice model and training and placement experts retained by Monitoring team). The Health Care Pilot and Process Review is discussed below in the relevant Child Health Goals and the System Components sections.

V. Health Care Plan: Child Health Goals

DSS translated its commitments in the FSA and the recommendations of the consultants into four child-centered goals and three key system components. The child health goals set forth the key features of DSS's health care plan for children in foster care.

Child Health Goals

Goal 1.	Each child is linked to a care coordinator matched to the child's needs.
Goal 2.	Each child in foster care has a primary care provider, preferably a medical home, and receives timely screening, assessment and follow-up.
Goal 3.	Each child in foster care has timely access to quality health, behavioral health and dental services.
Goal 4.	Each child in foster care has improved health outcomes.

The child-centered goals speak to the ways in which DSS and its partners will plan for, provide and monitor health, behavioral health and dental services to children in foster care. Each goal is expressed as a set of policy, practice or management activities to be undertaken, and each activity is assigned to a task lead.

Child Health Goal 1: Each child in foster care is linked to a care coordinator matched to the child's needs

This goal speaks to the efforts underway to assign a single DSS caseworker and a Select Health care manager based on each child's individualized clinical needs. This will involve revisiting and refining DSS caseworker roles and responsibilities and aligning DSS caseworker assignment and Select Health care manager assignment to meet the child's safety, permanency, well-being and health care needs.

Coordinated and effective care management is foundational to success in improving outcomes for children in foster care. Currently, both DSS and Select Health tier their basic case management and intensive care coordination activities. DSS bases its decision about the level of care management on a combination of diagnostic assessments, treatment needs and placement type (level of care). Select Health bases its decision on the severity or complexity of the child's health or behavioral health needs (level of need) and other criteria described below. In addition, the Select Health contract requires it to provide a care management system that conforms to the requirements and industry standards stipulated in the National Committee for Quality Assurance (NCQA) requirements for Complex Case Management and by the Standards of Practice of Case Management released by the Case Management Society of America (CMSA). Today, neither DSS nor Select Health use a standardized assessment tool to determine care coordination level. Under this plan, DSS will collaborate with DHHS and Select

Health to explore the use of single severity assessment tool (MCO Contract 5.3.3) to align care management and case assignment. [141]

DSS has two types of child welfare case management: basic county-based case management and regionally-based IFCCS case management. IFCCS workers are expected to have a smaller caseload (9 children) because of the children's health/behavioral health complexity. While there is agreement that IFCCS workers should focus in greater detail on the health needs of the children on their caseload, the practice requirements for county and regional IFCCS caseworkers are not codified. In other words, heightened case work standards related to a child's health status do not currently exist.

As described above, beginning in October 2018, DSS plans to launch a Health Care Pilot and Process Review to, among other things, review and test the process for collecting and using health information for case management decisions. This includes adaptations to the current Children's Services Application (CSA), also called the Uniform Application, assignment to a county or IFCCS/regional caseworker; to understand and make recommendations to improve how case workers obtain health information and services for children on their caseload and document it in CAPSS; to define case management responsibilities for DSS county, IFCCS regional workers and Select Health care management; to consider modifications to the Select Health care management assignment algorithm to include additional health and behavioral health indicators including conditions, prior service use or prior placement in foster care, among others; and, to understand and make recommendations to strengthen DSS's new practice model.

The Heath Plan Pilot will also assist DSS in determining how to align the CSA with the assessment tools used by Select Health providers and with high quality behavioral health and medical providers. DSS will collaborate with DHHS and Select Health to train providers on the new tool chosen by DSS for its child assessments. Other training will include discussion of preferred brief screening tools like SEEK for social determinants of health for young children, the Edinburgh Postnatal Depression Scale for maternal depression, among other options to improve practice quality. Health and behavioral health training content will be folded into the new DSS Training Plan.

DSS will also use the information gathered during the Health Plan Pilot to inform how information about a child's health and well-being can be effectively collected and better utilized as part of the placement decision-making process and family teaming work. In collaboration with the work on the Placement Implementation Plan, DSS will obtain advice from experts, and internal and external stakeholders on whether and how to modify the CSA and/or adopt an alternative standardized assessment protocol. The pilot will review the existing systemic health care processes to also help inform thinking about how to enable children with complex medical or serious behavioral health needs to remain in community-based settings with appropriate supports.

[141] South Carolina has a history of Medicaid innovations for adults with complex health care needs and piloted a case severity screening tool that uses weighted medical and psycho-social markers to stratify clients into low, moderate and high-risk categories. The severity screen and assessment is administered by a caseworker during an initial home visit, scored to determine level of need and then assignment is made to a registered nurse case manager (for moderate-high severity cases), caseworker (moderate severity cases) or community caseworker (moderatelow severity cases).[3] This innovation was awarded the Robert Wood Johnson Culture of Health prize in 2015. This experience offers useful parallels for the changes envisioned for children in foster care.

In preparation for the Health Plan Pilot process, DSS is collaborating with Select Health to better understand the Select Health risk stratification and care coordination assignment methodology and seeks to align Select Health care management tiering with DSS caseworker assignment protocols to best meet the special case management needs of children in foster care. Weekly calls have been scheduled and are underway to understand Select Health's three levels of care coordination: 1) integrated health care management, 2) utilization management, and 3) rapid response care management. DSS will collaborate with DHHS and Select Health to introduce additional data elements for consideration in the risk stratification and care coordination assignment methodology and also for use to build out its own caseworker assignment protocols. These criteria include: repeat maltreatment, polypharmacy, dual diagnosis, significant functional limitations, chronic illness and other relevant indicators of health risk. Concurrently, DSS and the healthcare consultants will develop a matrix (following the lead of other states) defining the role of the county DSS or IFCCS caseworker or the care coordinator from Select Health to be completed by the end of the Health Pilot in February 2019.

The Health Pilot will give DSS an opportunity to look closely at its current case management practice and roles, and those of Select Health. The methodology for the DSS Health Pilot will be developed by September 2018 to make it possible to roll-out the Pilot beginning in October 2018. The pilot methodology includes a process review of 20 child-specific "use cases." The pilot cohort will include both children who are first entering DSS custody, as well as children who are experiencing a placement change, likely to be children who are moving from a lower level of care to a TFC and/or residential placement. These cases will allow DSS to strengthen and develop protocols for case management and Select Health to strengthen care coordination services that can be communicated to all frontline staff. It will also enable a deeper understanding of how this process interacts with the placement process and approach.

DSS intends to define the tiering and caseworker assignment protocols for its own case management practice to best match each child's needs. The pilot will give DSS an opportunity to do this, and to determine what additional support is available through Select Health care coordination. It is expected that DSS will clarify the responsibilities of county, IFCCS and adoption caseworkers as well as develop new processes for assigning caseworkers to children. Caseload size, deployment and responsibilities of the 110 IFCCS workers will also be reviewed.[142] The goal is for each child in foster care to have one DSS case manager who is responsible for their health, well-being, safety and permanency planning.

During the pilot, DSS will work with the Health Care Consultants to test the various roles and functions and develop a case management and care coordination framework for DSS caseworkers (county and IFCCS) and Select Health care managers.

[142] This will be coordinated with the workload implementation plan for distributing cases and having a sufficient number of caseworkers that is in development. It's important to note the explicit intention not to inadvertently increase caseloads for county workers by tightening up the criteria for IFCCS.

To memorialize and implement improvements in care coordination learned from the pilot, DHHS, Select, and DSS will collaborate to create a policy and procedure manual that governs how children in foster care will receive more robust care coordination. The contract governing the relationship between Select Health and DHHS is a common contract for all five Medicaid managed care entities (MCOs) in South Carolina. The MCO contract cannot be altered for just Select Health, because that contract governs all five MCOs and Select is the exclusive MCO for children in foster care. DHHS has offered to collaborate to create a policy and procedure manual specific to Select Health for children in foster care. DHHS has also agreed to review the rate for children in foster care, if Select Health has additional requirements for children in foster care. Rates are changed in July annually. The Health Care Pilot and Process Review will inform additional requirements for children in foster care and can be incorporated into a rate review prior to new rates being issued in July 2019.

By March 2019, and subject to the approval of the Co-Monitors, DSS will utilize the information gathered from the pilot to produce a care coordination and health care case management framework that details the following:

- Detailed articulation of the differentiated roles of DSS foster care, DSS IFCCS caseworkers, and Select Health care managers, with a delineation of processes for case assignment, care management tiering based on child's level of need, expectations for communication, and case consultation and coordination between Select Health and SCDSS to meet the health care needs of all children in foster care, including those with complex health needs, disabilities or serious behavioral health needs;
- Development of related policies, and guidance to the field;
- Delineation of changes to DHHS-Select Health policies and procedures to operationalize the care coordination and health care management framework;
- Detailed financial projections and budget commitments for resources needed to fully implement the care management and coordination activities including any new staff, training or resources to support implementation; Timeline for statewide rollout.

Child Health Goal 1: Elements of the Work Plan

Task Lead(s): DSS Office of Child Well-Being

Key Activities and Deliverables:

- Weekly meetings with Select Health on care coordination practice, processes and protocol
- Weekly meetings with DHHS on data-sharing and refining gaps in care prototype and other reports
- Choose validated assessment tool, train DSS staff, roll out standardized assessment tool in accordance with the processes developed in the Placement Implementation Plan

- Adapt CSA to include health and behavioral clinical and functional assessment questions as recommended by child welfare leadership and the Foster Care Health Advisory Committee.
- Connect health/behavioral health initial assessments and comprehensive assessments to placement decision making processes, informing the Placement Implementation Plan;
- Institute weekly cadence call to staff cases, review progress made and resolve immediate needs beginning August 2018.
- Explore with DHHS, Select Health, QTIP providers and the AAP (American Academy of Pediatrics SC Branch), DSS's plan to use a standard, system-wide screening and assessment tool and ways to integrate the use of this tool and other best practice guidance on delivering health and behavioral health care to children in foster care.
- Produce a comprehensive care coordination and health care case management framework subject to approval of the Co-Monitors.

Timeframe: Health Care Pilot and Process Review October through February 2019, Implementation March 2019

Child Health Goal 2: Each child in foster care has a primary care provider (preferably, a medical home) and receives timely screening, assessment and follow-up care

This goal is expressed by activities related to eligibility determination, enrollment in a single managed care plan, provider assignment, preferred provider designation, screening, assessment and follow-up and managing the response to immediate needs.

A. A Single Managed Care Organization for all children in foster care: Select Health

In recognition of the fact that children in foster care require a more comprehensive, coordinated healthcare delivery model that promotes better access to health, behavioral health and dental services and improves health outcomes, almost six years ago, in November 2012, DSS and DHHS announced the Foster Care Health Initiative, a collaborative effort to better address healthcare delivery to foster care children. As the legal guardian, DSS determined that it is in the best interest of foster children to be enrolled in coordinated and managed care because these children enter the system at high risk of poor developmental and health outcomes and in need of care related to the effects of the neglect, abuse, and associated trauma that brought them into care. Further, many children entering South Carolina's foster care system enter already enrolled in managed care. As a result of this initiative, all children and youth placed into foster care, with few exceptions, are enrolled in First Choice by Select Health of South Carolina, a Managed Care Organization to meet their medical and behavioral health needs.

Select Health is required to provide foster care child members "medically necessary" care.

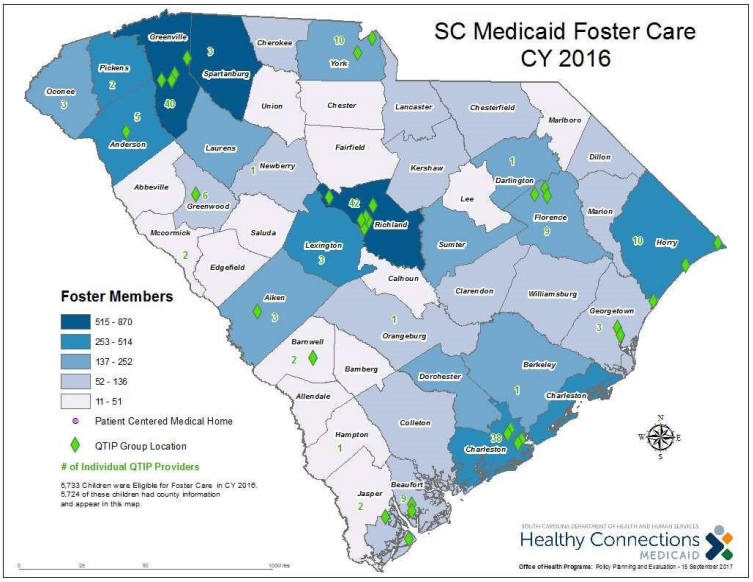
Specific core benefits and service requirements are set forth in Section 4 of the DHHS and Select Health MCO contract[143]. Select Health receives a capitation payment of $950.75 per foster child/per month in FY18. This rate incentivizes the expectation that providing health and behavioral health care to children in foster care requires additional time, care coordination and additional specialty services, principally outpatient behavioral health services, over what is needed by the regular Medicaid child population. A comparison of managed care rates for the two populations illustrates this point with a per member/per month rate (PM/PM) for children aged 1-6 set at $134.00, 7-13 at $144.48 and ages 14-18 set at between $156.73-$185.26 as compared to the PM/PM for all children in foster care set at $950.75.[144]

With this in mind, DSS will collaborate with DHHS and Select Health to identify, plan and implement and care coordination system that works optimally for children in foster care.

Medical Home/QTIP[145]

While all Medicaid providers are required to meet standards of proficiency and quality, some providers are especially well equipped to provide the highest quality care for foster children. As part of its Plan, DSS, DHHS and Select Health are committed to collaborating so that every child in foster care has a high-quality primary care provider, preferably a "medical home," which, among other practices, includes providers who adhere to the American Academy of Pediatrics (AAP) "Bright Futures" standards. To achieve this, DSS will build on lessons learned from the Quality through Innovation in Pediatrics (QTIP) program, a DHHS quality improvement initiative in partnership with the AAP that provides direct support to pediatric providers to engage in quality measurement and practice improvement activities and integrates behavioral health and physical health. The QTIP program now includes approximately 30 providers in South Carolina. The graphic below maps the location of QTIP practices and distribution of children in foster care by county.

[143] DHHS and Select Health Contract in Appendix, Section 4.
[144] All Select Health primary care, specialty care, behavioral health, pharmacies, hospitals and ancillary providers, must be licensed or credentialed under the NCQA Standards and Guidelines for Accreditation of Medicaid Managed Care Organizations, as described earlier in the Plan.
[145] Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit February 2012, Center for Health Care Strategies



The QTIP project began as a grant-funded CHIPRA Quality Demonstration (authorized by 401 (d) of the Children's Health Insurance Program Reauthorization Act of 2009). This QTIP project was accomplished through encouraging and assisting with use of clinical quality measures and incorporation of mental health services into a medical home. Based on the success of the demonstration project, DHHS continued most aspects of the QTIP program.

QTIP practices engage in quality improvement work in several ways, including a Learning Collaborative in concert with the South Carolina Chapter of the American Academy of Pediatrics; on-site training and technical assistance in general quality improvement principles and topic-specific clinical focus areas during annual on-site visits; monthly conference calls; and specific attention to the quality of the EPSDT visits and the completeness of recommended screenings. Through this work, QTIP practices have repeatedly demonstrated better performance on a range of quality measures, when compared to similar practices.

DSS will explore and develop with DHHS and the AAP new ways to supplement the on-going training of practices with foster care specific training materials and consider enhancing the capacity of the AAP to establish a QTIP-like Learning Collaborative or cohort training model for other pediatric practices who seek preferred provider status.

DSS, DHHS, and Select Health will collaborate on the development of provider assignment protocols to take into account factors such as whether a child is already being seen by a current Select Health provider, unique needs of the child, preferences expressed by the birth parent, geographic access, and provider availability. DSS will implement these assignment protocols through a new policy that considers auto-assignment to a “preferred provider,” with an opt-out to preserve foster parent choice, where appropriate. In addition, DHHS and DSS will collaborate with Select Health, and preferred providers to train caseworkers and foster parents in the standardized and comprehensive health and

behavioral health assessment tools. One of the significant recommendations of the DSS Foster Care Health Advisory Committee (FCHAC) was to have a standardized protocol for screenings, assessments, and follow-up for all children entering and in foster care. As discussed earlier in the section on Care Coordination, DSS plans include adoption of a validated and standardized assessment protocol for use by its field staff statewide to ensure necessary health and behavioral health information is collected at the time of placement, to inform decisions about placement and services.

Finally, DSS, DHHS and Select Health will collaborate on ways to further incentivize preferred provider participation, increase the number of high quality preferred providers or otherwise enhance QTIP or QTIP-like practices. DHHS is exploring several ways to introduce a special payment for foster child visits, either as a discrete service code or through the use of modifiers. This work will begin 12 months after implementation of the basic reforms outlined in the Health Plan. Currently, Select Health incentivizes its providers for outstanding performance on certain HEDIS measures (HEDIS measures are discussed in detail below) associated with improved health and behavioral health outcomes for members. DSS wants Select Health to benefit from its incentives for outstanding performance on HEDIS measures most relevant to children in foster care. To accomplish this, DHHS, DSS and Select Health will collaborate to develop the preferred provider designation and incentive package for preferred providers beginning in February 2019 so that this work is completed prior to and reflected in the Select Health rate setting process in July 2019.

Of course, not all providers are, or will be QTIP providers. Given this, DSS plans to collaborate with DHHS, Select Health, the AAP South Carolina Branch, and the Foster Care Health Advisory Committee to: 1) review the performance of all health, behavioral health and dental providers currently serving children in foster care, 2) develop criteria and a process for designation of providers as "preferred provider" as well as minimum or baseline criteria for all providers of services to children in foster care, 3) consider designating QTIP, DMH clinics and FQHCs as preferred providers, 4) provide provider training opportunities and other supports, and 5) consider increased or modified rates to incentivize providers to accept and spend sufficient time with foster care children. Taken together, these actions will increase the availability of quality providers and improve health care quality statewide.

B. Eligibility and Covered Services

Children in foster care are eligible for Medicaid the day they enter placement and the vast majority of children in foster care are covered by Medicaid managed care through Select Health[146]. Select Health provides medical and mental health services and DentaQuest provides dental care. Many children enter foster care already enrolled in Medicaid or Medicaid eligible. The eligibility process for all children in foster care is automatic and each child is assigned a Medicaid number and payment code that allows providers to deliver and bill for services and allows DSS and DHHS to track services rendered, gaps in care/utilization and follow-up needed.

[146] Medicaid coverage is provided for all children in foster care through their 18th birthday with the exception of undocumented children whose health care coverage is paid for by the State of South Carolina.

Enrollment Plan	Unique Children in Foster Care as of 5/4/18
FFS Waiver	65
FFS Non-Waiver	305
Select Health	3832
ATC	40
Blue Choice	50
Molina	44
Well Care	19[147]

The following services are available to children through the Select Health contract[10]: services for emergency medical conditions; inpatient services; post-stabilization care services; specialty services; behavioral health and substance use services; vision and audiology services, referral to out-of-network services; pharmacy and a regularly updated pharmacy formulary of generic and brand medication; EPSDT health and developmental screenings that follow the American Academy of Pediatrics periodicity schedule; second opinion; automated 24/7 toll-free line and staffed call center with information on what to do in case of an emergency and option to talk directly to a nurse or other clinician; and care coordination, among other services.

A small number of children in foster care are not covered by Select Health as shown in the table above. Children who are undocumented are ineligible for Medicaid and receive identical physical, mental and dental benefits paid by 100% state dollars until age 18. Children in any of the nine DHHS fee for service waivers are also not covered by Select Health. As of May 4, 2018, 65 children were in those waivers. Children with complex medical or behavioral health needs may also receive services outside of the Select Health network. DSS tracks health care utilization and outcomes for all children, whether they are in Select Health or in one of the groups that falls outside the MCO contract. DSS will track the care and services for all of these children, whether covered by the Select Health program or through another Medicaid coverage vehicle such as a waiver program.

The current contract between DHHS and Select Health does not differentiate between the benefit and service package provided to children who are in foster care and those who are not. In fact, there is a single contract between DHHS and the five MCOs that operate in South Carolina. Since children in foster care are enrolled in Select Health, the contract does not contain any specific requirements related to foster care children. However, moving forward, Select Health will be expected to enhance its model to offer unique plan elements relevant to children in foster care including, but not limited to, in electronic and paper form: foster care member handbook, ID card, provider directory, health education materials, guidance on member rights, communication and coordination between Select Health and DSS caseworkers.[148] By March 2019, DSS, DHHS and Select Health will collaborate to determine specific requirements and implement policies and procedures for Select Health that will

[147] As of the May 4, 2018 member matched file. [10] SCDHHS-MCO Contract 7/1/2016.
[148] Contract Between SCDHHS and << Contractor>> for the Purchase and Provision of Medical Services Under the SC Medicaid Managed Care Program, July 1, 2016 (Section 3)

include alignment with DSS timeframes and tools for required initial assessments, standardized assessment, follow-up and identification of immediate treatment needs for and data tracking for all foster care children. These will be memorialized in a DHHS-Select Health Foster Care policy and procedure manual.

As noted above, dental services are not provided through the Select Health contract. Rather, all children in foster care receive their dental services through DentaQuest, including regular screenings and annual dental exams, follow-up for dental caries, orthodontia and other oral health needs. By December 2018, DSS will develop a new report to flag, roster and follow-up on gaps in care and introduce this new report into the process for handling all other gaps in care and cadence call process.

C. Enrollment

Although coverage is guaranteed for all children in foster care, the Medicaid system has a builtin enrollment lag of 30 days. DSS, DHHS and Select Health began to address the 30-day time lag as an ***immediate priority*** based on the report by the Health consultants to reduce any gaps between entry into foster care placement and enrollment into Select Health.

As noted earlier, 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 and there is no interruption in any services that they are already receiving; however, enrollment in Select Health does not start automatically the day the child enters care. One consequence of this lag is that a child may remain the responsibility of a health plan or provider not affiliated with Select Health making more challenging to make sure that 7-day, 72-hour and 30-day timeframes for initial assessment and comprehensive assessment are completed, that immediate needs are identified and met, and that follow-up is scheduled for all identified health and behavioral health needs.

Children are assigned to and enrolled in Select Health on a monthly basis. Approximately 284 children entered foster care each month in 2017. However, from January to April of 2018, the monthly average of children entering foster care each month was 368 children, indicating a rise in the number of children entering foster care. During this 30-day period, initial assessments, comprehensive assessments and follow-up are paid fee-for-service or by the MCO that the child had prior to coming into care. Lifting this administrative barrier will address key gaps in care.

There are several administrative steps that can be taken quickly to address the enrollment lag. All children coming into care have a Medicaid ID that includes a designation - - called a recipient service program (RSP) that allows the Medicaid system of record to recognize their foster care eligibility status. Although the majority of children enter foster care with an active Medicaid ID#, DSS and DHHS found that approximately 300 children were deemed ineligible based on a coding error in third party software. Work is ongoing to permanently resolve the software issue. Until that time, DHHS staff manually remedy the problem.

The Plan includes the development of a new enrollment and eligibility protocol that will eliminate the 30-day enrollment lag for an estimated 300 children entering foster care each month, which will be in place by January 2019, the annual date under the state's contractual terms with the MCO by which contractual changes can be made. In the interim, the mitigation plan includes the development and use of existing reporting processes that correct any missing or incorrect enrollment data, matches the current roster of children placed in foster care against CAPSS data and other DSS reports, DHHS Medicaid utilization, claims and other data. These matched files are then used to identify missing health, mental health or dental initial assessments, comprehensive assessments and follow-up. This report, called a "gaps in care/utilization report" will be used to flag unmet need in the first 30 days of foster care placement and throughout the duration of placement. The gaps in care report will be used centrally by the DSS Office of Health and Well-Being and in the field by caseworkers, supervisors and directors. The detail on how DSS will manage to and use the report is described on page 43. DSS received its first gaps in care report in April 2018 and its second report in late May 2018.

Currently, there are two categories or "buckets" of data that DSS is analyzing for the Health Plan: 1) Data collected within the first thirty days of a child entering foster care. This includes initial medical, mental, and dental health assessment data. These data come from CAPSS and are verified through a matching process with DHHS administrative claims data.[149] 2) Data from Select Health, including data on gaps in care. DSS is working to understand how Select Health categorizes and reports gaps in care. To that end, DSS and Select Health are working to understand and clarify data reporting definitions with sources. This will assist DSS in understanding how best to use data that Select Health has at its disposal for children in foster care.

DSS will begin piloting the gaps in care report with the field in August 2018, described in greater detail later in this report. In addition, the Health Care Pilot and Process Review will use the sample of 20 children to develop statewide policies and practice protocols related to care coordination but also to Medicaid enrollment. The enrollment and payment lag described earlier will be addressed by drafting a standalone DHHS-Select Health administrative contract with a go-live date of January 2019. A time-limited enrollment mitigation work around will be used until then, which involves DSS and DHHS manually ensuring that all children that enter foster care are enrolled in Select Health.

D. Screening and Assessment

DSS wants all children in foster care to be appropriately screened and assessed and receive the follow-up services they need. Children can come into foster care with little known or documented about their health history or medical, dental, and mental health needs, and these initial assessments and comprehensive assessments are critical to drive early identification of needs and matching services. Early coordination to track these assessments, identify needs, and procure necessary services, will assist DSS in placing and stabilizing children in the least restrictive most family-like setting, hopefully making each child's first placement, his/her only placement. For those children where a more restrictive setting is necessary, early coordination of these efforts will assist DSS in developing a plan to step the child down to a less restrictive more family-like setting when the child is ready.

[149] Initial Assessment Data in Appendix, Section 10.

Building on the above, DSS plans for all children to receive the appropriate initial assessments and comprehensive assessments in a number of ways, including: tracking children at the time of placement into the level of care coordination that best fits their level of need; and including in the CSA appropriate questions about child health, behavioral health and well-being so that the care coordination, placement and services decisions made at the time of placement are informed by initial health information about the child. As noted earlier, synchronizing any health care initial assessments and assessments with placement decision making, staffing and family teaming is critical.

The term "screening" as typically used by primary care providers involves a brief paper and pencil questionnaire given to a parent or other youth to quickly and easily determine if further assessment is needed. Primary care providers may be able to bill separately for these screenings. Examples include the Modified Checklist for Autism in Toddlers (M-CHAT) or the Ages and Stages Questionnaire (ASQ) which can be completed by a parent in a pediatrician's office during a well-child visit. Depending on the results of the screening, a provider knows whether to refer a child for more thorough assessment, typically performed by another more specialized provider. DSS policy refers to the first medical, mental health, and dental encounters a child has upon entering foster care as "initial assessments". These initial medical, mental and dental health assessments are more detailed than screens and are intended to be thorough enough to determine what follow-up care should be addressed in the child's plan of care.

DSS has previously committed to the following timelines related to collecting health information, initial assessments, and comprehensive assessment and includes the timelines below for reference. Health Plan implementation activities related to initial assessments and comprehensive assessments will be undertaken in collaboration with DHHS, Select Health, DMH and other partners to align and refresh policies, timeframes and practice. The activities and timelines are as follows:

- Within 72 hours of the child's entry into foster care the Foster Care/IFCCS Worker shall gather all necessary, educational and healthcare information for completion of the child's Education and Health Passport (DSS Form 30245), which should be updated at least every three months.
- The Foster Care/IFCCS Worker shall schedule the Initial Medical Assessment and Mental Health Assessment within one business day of a child's removal to foster care. The worker shall schedule a dental health assessment within 14 days of a child's removal into foster care.
- The worker shall facilitate completion of a Comprehensive Medical Assessment within 30 days of the child's Initial Medical Assessment, if a Comprehensive Medical Assessment was not completed during the Initial Medical Assessment.
- If the Initial Mental Health Assessment recommends further assessment or the provision of Mental Health Services, the worker shall facilitate the completion of a Comprehensive Mental Health Assessment within 30 days of the Initial Mental Health Assessment.

- If a child is under the age of three at the time of his or her removal, the worker shall immediately make a referral to BabyNet, South Carolina's interagency Early Intervention System for infants and toddlers.
- If a child is a suspected or known victim of acute physical abuse or sexual abuse, the worker shall schedule a forensic exam within 24 hours.
- The initial dental assessment will occur within thirty calendar days of coming into care. If the child is less than 1 year of age or has not had a tooth emerge or the provider is unwilling to re-exam the child due to previous encounter within six months, an oral exam during the EPSDT/well child visit is acceptable.

As part of the DSS Health Care Pilot and Process Review as discussed earlier in the Health, DHHS, DSS and Select Health will collaborate to determine whether certain children should be targeted for screenings and assessments with preferred providers. For example, children who initially enter care or children who are being moved to a new placement who meet certain health and/or mental health criteria might be referred for screenings and assessments with preferred providers (e.g., QTIP practices, FQHCs or DMH clinics). This will be particularly important for children that DSS has already determined through the CSA to need heightened care coordination. Children needing intensive care coordination include children with certain medically complex or behavioral health conditions or diagnoses such as bipolar disorder or psychotic disorders, or children who are receiving or being prescribed a psychotropic medication(s) and are age six or less, taking an antipsychotic, or are taking four or more psychotropic medications, or who are medically fragile or have an activity-limiting chronic condition. The state's network of 17 SCDMH community mental health centers, are available and may be better utilized by DSS to do 72-hour trauma assessments and leveraged as preferred providers for children with more complex mental health needs. DSS will collaborate with DMH to assess the timely availability of trauma screenings and CMHC clinic capacity to provide child-focused clinical treatment to children in foster care.

As part of their routine case management responsibilities, DSS caseworkers will verify that all children on their caseload have had required screenings and assessments, and any follow-up care needed. Follow-up care will be tracked through the caseworkers' monthly visitation requirements. DSS will rely on the CAPSS system to capture this information and as a source to extract data for reporting purposes. CAPSS currently has encounter type fields that are designated to allow caseworkers to enter the type of assessment, date of assessment, and provider. In addition, caseworkers can describe through dictation the visits as well as link appropriate medical documents to the case. DSS caseworkers will record notes in CAPSS based on discussions they have with birth parents, foster parents and the children themselves about medical, mental health or dental care assessments and issues requiring follow-up. Where a child has an Intensive Care Coordinator from Select Health, the DSS caseworker will inquire and solicit information regularly from birth parents, and either the foster parent or contract provider (if the child is placed in congregate care) so that the child's needs are met. DSS and DHHS will collaborate with Select Health to develop a red flag report to notify the assigned DSS caseworker and supervisor and Select Health care manager, if one is assigned, of children who have not received follow-up care, missed a well-child visit, presented at the

emergency room, was hospitalized or whose utilization patterns suggest may be the subject of repeat maltreatment in care or need referral to specialty services subject of repeat maltreatment.

DSS recognizes that policies and procedures between DHHS and Select Health and DentaQuest will need revisions to meet the current expectations for casework practice for initial assessments. For instance, based on South Carolina Medicaid MCO access standards, providers are required to make a best effort to do initial assessments within 90 days and have appointment availability within four to six weeks for routine office visits, not within 14 days as DSS policy currently requires. DSS will collaborate with DHHS and Select Health to resolve this discrepancy by June 2019. Once set, DSS will develop a training plan for its caseworkers, supervisors and directors on any new policies developed.

In addition, in conjunction with review and modifications to placement processes, DSS will review its existing "interagency-staffing" process (ISCEDC) for children identified as needing therapeutic family foster care or other higher-levels of care. Where possible, modifications will be made so that the decision around an appropriate placement resource happens more quickly than 45 days, especially for children entering foster care for the first time. The Health Care Pilot and Process Review aims to track how this process currently works to identify the best process for children, and where efficiencies could be gained by better coordination between health care and placement assessment processes.
As noted above, DSS will use the Health Care Pilot and Process Review to gather information about these activities between September and February and will finalize recommendations from the Pilot by March 2019.

E. Immediate Needs

Under the FSA, DSS committed to identify "Class Members" (children) with "Immediate Treatment Needs (IN)." DSS has previously established an operational definition for "Immediate Treatment Needs" as a mechanism for focusing case practice. However, there are two issues with the language and intent of this requirement that may need modification: (1) how IN are identified and tracked for the defined cohort of children in foster care; and (2) how immediate treatment needs are defined. DSS is currently undertaking efforts to meet the immediate needs of children using this broad definition. See Appendix for DSS Child Health Fact Sheet which contains categories of immediate treatment needs for children. [150]

First, while DSS has had success requiring caseworkers to track whether children on their caseload have had the appropriate initial assessments and comprehensive assessments, tracking immediate treatment needs through the case record is proving to be more difficult. To meet the conditions of the FSA and before development of the DSS Health Plan, the Parties developed a caseworker-dependent workaround to fill in for in the absence of other sources of data to identify immediate treatment needs in the identified cohort of Class members. The health care consultants retained by the co-monitors recommended against this data workaround for any "look back" analysis because the information collected was unreliable and likely to be incomplete. Instead the consultants recommended that DSS

[150] DSS Child Health Data Fact Sheet in Appendix, Section 6.

use Medicaid encounter, claims and other data of record (MMIS) to identify the treatment needs, services rendered or gaps in care for children in custody.

The consultants recommended that DSS caseworker and supervisory staff resources be devoted instead to making sure that children get to medical appointments and receive the care they currently need, not to track down historical data. The consultants recommended that DSS collaborate with DHHS and Select Health to generate the gaps in care/utilization report for a specified time period for a defined cohort of children in foster care to determine whether their immediate treatment needs were met. The gaps in care reports are based on a list of diagnostic conditions and HEDIS health quality measures used nationally and by many state child welfare systems including New Jersey, Utah, New York and others. In February, DSS requested a gaps in care report from DHHS, which was delivered at the end of April 2018. As noted above, weekly calls between DSS and DHHS to refine and build the report have been ongoing during the months of May and June 2018 and will continue.

DSS expects that once these gaps in are data reports, which will be tested in the Health Care Pilot and Process Review and in weekly cadence calls beginning August, begin to run regularly, the immediate treatment needs roster will be reduced. In the short run, to catch up and reach all children on the immediate treatment needs roster, DSS's new process for addressing immediate needs is as follows: DSS caseworkers will review each child's file on the immediate treatment needs roster and determine what action is required. If an appointment or staffing is required, Office of Child Health and Well-Being staff will monitor the child through completion of the staffing or appointment, whichever is later. The caseworker will enter initial assessment and comprehensive assessment data from the DHHS/Select Health reports into the CAPSS foster care case record. Going forward, caseworkers will also be expected to enter into case notes, any follow-up care needed and confirm with foster parents or other caregivers that follow-up visits have occurred. To assist with verification and so that care needs are met, DSS in collaboration with DHHS and Select Health will review the roster of children missing screenings, assessments or follow-up services and those with high need/risk diagnoses against 30-60-90-day utilization reports. DSS will also use external evaluators to review a random sampling of case records through the Child and Family Services Review (CFSR) case review process. The review will determine whether children and youth receive needed health and behavioral health services. Weekly cadence calls will review all cases on the roster, so that cases are staffed as needed and appropriate services are scheduled, if warranted. These reinforcing layers of tracking and review using qualitative and quantitative data, at the individual case level and aggregated at the population level, allows children and youth who might have missed screening, assessment or follow up to be identified and staffed until they receive the care they need.

DSS has been collaborating with DHHS and Select Health to build reporting and analytic capacity and a format for the development of additional gaps in care/utilization reports that can be reviewed on a rolling basis, every 30-60-90 days at the outset, to track that children are receiving the care they need – tracking is for services covered by Select Health as well as those like dental that are covered outside the Select Health contract and the small number of children in foster care who will still be enrolled in the Medicaid fee for service program. DSS uploads a nightly roster of children who come into care that is be tracked against the DHHS Medicaid enrollment roster for accuracy. In addition, children

with specific diagnoses, including but not limited to diabetes, asthma, sickle cell, and various behavioral health diagnoses, will be tracked and rostered by DSS and Select Health so that they are receiving high quality care and are assigned to a Select Health integrated health care management, if needed. Currently, this care manager assignment from Select Health is time-limited, typically up to six months. DSS will collaborate with DHHS and Select Health to determine if this time limit is appropriate for children in foster care and will work through a protocol for longer duration care management assignment by March 2019. This information will be used by DSS to produce a tracking and red flag report that caseworkers can use to supplement information collected from caregivers and children. Simultaneously, as noted above, DSS caseworkers will incorporate into their monthly visits questions about follow-up medical, mental health and dental care, and make notes of this in the CAPSS electronic case record. DSS envisions a future technology application, to be developed and tested in 2019, that allows verification using DHHS data that will be automatically uploaded into CAPSS. Once this process is complete, existing functionality in CAPSS that gives caseworkers notification prompts for missed follow-up appointments will be more useful in aligning practice to immediate treatment needs.

Second, the health care consultants found that the definition of "immediate treatment needs" as defined in the settlement agreement was overbroad and inconsistent with how the words are used in the health care sector. As part of its Plan, DSS seeks to develop a revised definition that categorizes treatment needs in language that is consistent with the health care field. For example, DMH categorizes needs as either "routine, urgent or emergent" while DHHS defines it as "urgent, non-emergent, routine, and emergent" care. DSS will consult with DHHS, Select Health, DMH and request approval from Co-Monitors and Plaintiffs, for use of a new definition of immediate treatment needs by November 2018. The goal of this exercise is not to reduce DSS's obligations to provide needed care timely for children in its custody. Rather, it is to see that its treatment needs framework will be adopted, understood and used consistently by its health provider partners. Once this framework is revised, DSS will track services accordingly using real-time data capture by caseworkers in CAPSS and quarterly retrospective look-backs using administrative data.

F. Follow Up

DSS is developing a two-part solution for follow-up visits and services. This process will include a practice solution and a data solution. For the practice solution, DSS caseworkers will continue to engage birth parents, foster parents and youth in reporting the status of health care follow-up and identification of any outstanding needs at monthly visits. These case notes, referred to as "dictation" by DSS, and any discharge summary provided by the health/behavioral health provider will be uploaded into CAPSS. Children identified as having unmet follow-up care needs will be rostered with staff assigned to complete follow-up activities and tracked on the DSS weekly cadence call. The weekly roster will be transmitted from DSS to the Select Health Care Coordination Department for tracking, verification and follow-up scheduling assistance for needed appointments, medication management or medical equipment, eyeglasses or other assistive devices needed. This practice solution will be tested in the Health Care Pilot and Process Review that will be completed by February 2019 and new drop-down fields will be created in CAPSS to enable CAPSS to generate weekly and

monthly "*needing follow-up*" rosters. This process will identify individual children in need, and will also surface counties and regions where community-based services are harder to access or altogether unavailable.

A retrospective review of the 30-60-90-day gaps in care/utilization report for children identified as needing follow-up will provide another level of validation. This data solution will require new fields to be added to the report. DSS will be able to use the "*needing follow-up*" roster to ascertain whether children received services in the 30-60-90-day period following the identification of unmet follow-up care needs. Again, this will surface access and availability patterns related to health and other community-based supports.

Child Health Goal 2: Elements of the Work Plan

Task Lead(s): DSS Office of Child Well-Being and Office of Data, Research and Accountability

Key Activities and Deliverables:

Medical Home

- DSS will collaborate with DHHS, Select Health and the Foster Care Health Advisory Committee to establish a preferred provider designation based on HEDIS parameters and provider agreement to participate in cohort learning collaboratives that meet two times a year
- DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given their child psychiatry staffing and regional locations around the state
- DSS, DHHS and Select Health will collaborate to establish a protocol to assign children to a patient-centered medical home, QTIP-like or FQHC preferred provider and caregivers will have the opportunity to opt-out and exercise freedom of choice
- DSS will work with DHHS and the AAP to build out a learning cohort of pediatric practices who wish to work with the foster care population
- DSS will collaborate with DHHS and Select Health to create a manual for policies and procedures specific to children in foster care by 2020 to include incentives for medical homes/preferred providers, timeframes for assessments, etc.

Eligibility and Enrollment

- Build out and pilot test the rostering, tracking and follow-up mechanism for initial assessments, comprehensive assessments and timely follow-up.
- Fix 30-day enrollment lag by January 2019, and in interim, use developed administrative work-around so that children in foster care receive necessary initial assessment, comprehensive assessment and follow up, and the data tracks them as such.

Screening and Assessment

- DSS has already developed aligned timeframes for initial assessments, comprehensive assessments and follow-up that track AAP standards for children in foster care. Those timeframes will be clarified and operationalized for data tracking purposes.
- DSS will develop timeframes that align with FSA requirements, and coordination with placement and re-placement decision-making assessments.
- DSS, DHHS and Select will collaborate on the development of a no-lag enrollment protocol by January 2019.
- DSS and DHHS have already developed and signed a data-sharing agreement.
- DSS, DHHS and Select Health will develop an implementation timeframe for producing regular monthly gaps in care reports.
- DSS will field-test the use of gaps in care reports, cadence calls, and monthly tracking and develop practice guidelines beginning in August 2018 and running through February 2019.
- DSS will include a targeted focus on health and behavioral health in its CFSR PIP and will develop a process for integrating case record review findings into the weekly/monthly cadence calls.
- Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards.

Immediate Needs

- DSS will propose a revised definition of Immediate Needs to more closely match language and conditions that are customarily used in the health care industry by November 2018.
- Use gaps in care and other red flag reports, cadence calls and performance tracking and develop a protocol based on experience beginning in August 2018.

Follow-Up Services

- Develop and pilot practice and data solutions to ensure the regular flow of information to caseworkers and between DSS and DHHS beginning in August 2018.
- DSS will collaborate with DHHS to develop a protocol to identify dental providers and develop a roster of children needing dental care follow-up beginning in August 2018.

Timeframe: Current through February 2019, Draft Select Health Policy and Procedure Manual, May 2019

Child Health Goal 3: Each child in foster care has timely access to quality health, behavioral health and dental services

DSS will accomplish this goal by assessing provider capacity to accept and serve children in foster care, coordinating the annual network adequacy assessments conducted by Select Health and validated by DHHS and use data to develop a process to address capacity gaps. To improve the availability of

high-quality, community-based health and behavioral health services, DSS will collaborate with DHHS and Select Health to develop a process for an annual review of network capacity and access to services at the local, regional and state level. In addition, DSS has developed a monthly report to track, flag and prompt timely completion of health, dental and behavioral health initial assessments. DSS will also develop a protocol for a monthly report and assessments, referrals and follow-up needed and to identify immediate needs and gaps in care as discussed in detail earlier in the Health Plan.

DSS is actively exploring ways to align its own network adequacy assessments with those required by DHHS for Select Health. The network adequacy features envisioned for the new health system for children in foster care are detailed below.

A. DSS sponsored USC Study

In April 2017, the DSS Healthcare Improvement Workgroup, in partnership with the University of South Carolina's Center for Child and Family Studies (USC), undertook a healthcare needs assessment specifically focused on the initial and ongoing health assessments for the physical, mental health, dental, and trauma needs of children in care. Members of the Healthcare Improvement Workgroup, along with USC team members, designed and tested an instrument to be deployed through Survey Monkey. Each county director through their Regional leadership was asked to submit one answer that best represented the circumstances of that county. The instrument was deployed with a 100% response rate. Data was unduplicated where necessary and, in some instances, recoded to be easily summarized for patterns. The survey established baseline capacity needs and gaps and provided useful information to inform DSS's annual discussion of network adequacy with DHHS and Select Health. DSS has a current contract with USC to conduct the needs and capacity survey bi-annually. The survey findings will be used to inform DSS's resource development.

DHHS's network adequacy requirements in the Select Health contract also offer DSS another source for actionable information on community-based service and provider capacity. DHHS and Select Health will revisit the need to supplement this analysis and will develop a process for monitoring and addressing issues of local and regional service availability, access and timeliness and reporting back to DSS about plans to fill service gaps.

Some key findings from the USC study related to the availability of services included:

- Generally, counties felt that they did have sufficient providers to meet their medical needs though some have issues with access within their counties. Those counties who appeared to have issues with access were often rural, with Florence one notable exception. Some counties were more specific in their accessibility barriers. These barriers included a lack of providers in some parts of a given county, limited mental health providers who would see children under 6 years of age, dentists who sometimes did not want to see young children, and not all providers being trained in trauma or otherwise qualified to serve the specialized needs of children in care.

- Over a third of the counties experienced timeliness issues for three or more of the initial assessments.
- Counties experienced a number of barriers to completing their assessments that fell into several "buckets". The first bucket of barriers was related to the lack of placements within a child's home county. Because of the lack of placements in a given county, a child may need to be placed in a county far away from their home county. This led to caseworkers who were not familiar with providers in distant counties and caseworkers having to spend time traveling. They also noted the hardships placed on the child who sometimes had to miss school. A second bucket included wait times and a lack of late or alternative times for appointments. Finally, the third bucket was Medicaid data issues such as inaccurate data in the system or missing Medicaid numbers and/or Medicaid eligibility issues.

B. Case Record Reviews

DSS CFSR case reviews will review questions related to health and behavioral health services. Questions and data collection will focus on the identification of gaps in care, timeliness of care and ease of access. Other sources of information such as case notes in CAPSS, gaps in care/utilization reports and Select Health network adequacy data will also provide feedback to DHHS about the need for additional capacity or a different regional service mix. This will include CFSR Item 12 assessing needs of families and children and providing those services; CFSR Item 13 including parents and children in case planning; CFSR Item 14 frequency and quality of visits between caseworkers and child, CFSR Item 15 frequency and quality of visits between caseworkers and mothers and fathers, CFSR Item 16 educational needs, CFSR Item 17 physical health needs, and CFSR Item 18 behavioral health needs. The information in the case record reviews will further inform DHHS and Select Health's analyses described below so that DSS has a comprehensive view of both community-based services and supports.

C. DHHS and Select Health Network Analyses

DHHS requires Select Health to have a network of providers sufficient to deliver adequate access to services for all children in care, including prevention services, primary and specialty care. The contract also requires Select Health to develop mechanisms to monitor compliance by providers and take corrective action for failure to comply. The DHHS-Select Health contract details minimum provider network adequacy requirements informed by:

- Utilization estimates based on the characteristics and health care needs of the population served
- A geographic service area which in the case of children in foster care requires Select Health to plan for geo-mapped statewide geographic distribution
- Estimates of the number and types of credentialed providers needed who are primary care and specialty care providers, hospitals and other health care providers.
- Estimates of credentialed providers with capacity to accept new patients
- Sufficient credentialed providers who can provide a second opinion

- Distance, travel time, typical means of transportation; physical access
- Meet standards for timely access and respond to urgent care needs
- Standard hours of operation
- 24/7 service access for medically necessary services
- Routine visits within 4-6 weeks
- Wait times that do not exceed 45 minutes for routine schedule appointments
- Urgent care within 48 hours
- Capacity to handle walk-ins

In addition to the network adequacy requirements covered under contract, Select Health must also manage utilization review and prior authorization for services. The "utilization management (UM) function" as it is known by MCOs is not to be confused with the care coordination function. The UM function monitors the child's patterns of service use and pays particular attention to overutilization, underutilization, hospitalization and emergency room use, medication adherence, medical necessity and prior authorization of certain in or out of network services. Network adequacy information will be shared annually by Select Health in a performance improvement meeting with DHHS and DSS. UM data will be provided by DHHS to DSS quarterly to inform casework follow-up with the child and family.

D. Out-of-Network Services

DSS will collaborate with DHHS to review the eligibility and enrollment protocols for the nine waiver programs and other specialty services for high needs children currently operating in South Carolina and refresh its referral protocols. DSS will also collaborate with DHHS and Select Health to develop a notification process so DSS caseworkers and Select Health care managers know which children are receiving out-of-network services. DSS will also collaborate with DHHS to track utilization of dental, waiver and other out-of-network services for children who receive services outside of the Select Health provider network. Review of these programs will include the identification of access and availability of community-based services necessary to meet the health care needs of children in care.

Child Health Goal 3: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being

Key Activities/Deliverables:

USC Study

- DSS to plan a behavioral health and dental services capacity study to be conducted every two years by USC using Medicaid administrative data, qualitative surveys from foster parents, birth families and youth in care and DSS regional office staff
- DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed

CFSR Case Record Review and PIP

- DSS will continue its focus on health and behavioral health services in CFSR case record reviews.
- Using the CFSR quality assurance process, which reviews each of the state's 46 counties every three years, DSS will analyze CFSR review data from the 23 counties in the 2017 cycle. Of the 450 cases for this time period, approximately half were foster care cases. The review included questions from the federal CFSR tool related to physical health including dental (item 17) and mental/behavioral health (item 18).
- DSS will develop corrective action plans and PIPs to address issues that relate wellbeing outcomes 1, 2 and 3 which include CFSR Item 12 assessing needs of families and children and providing those services, CFSR Item 13 including parents and children in case planning, CFSR Item 14 frequency and quality of visits between caseworkers and child, CFSR Item 15 frequency and quality of visits between caseworkers and mothers and fathers, CFSR Item 16 educational needs, CFSR Item 17 physical health needs, and CFSR Item 18 behavioral health needs.

Select Health Network Adequacy Review

- DSS will review the annual External Quality Review Reports for Select Health to determine adequacy of the provider network and quality improvement plans to improve access
- DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues
- DSS will collaborate with DHHS and Select Health to determine network sufficiency, and implement mitigation plans for areas where service or provider capacity is limited

Out-of-Network Services

- DSS will collaborate with DHHS to create a report and roster that tracks services delivered to children in foster care who are either ineligible for Medicaid or utilize services that are not covered by Select Health's per member/per month rate including dental services, Medicaid waiver services and specialty care for medically fragile children among other out-of-network services provided to children in foster care. DSS and DHHS will use the report to recommend changes or improvements needed.
- DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly.

Timeframe: Current through December 2018 to establish basic understanding of methodologies used with annual review thereafter, Network Sufficiency and Topical Studies planned through June 2019

Child Health Goal 4: Each child in foster care has improved health outcomes

DSS is committed to improving the health outcomes for children in its custody. Under the FSA, DSS committed to targets related to initials assessments, comprehensive assessments, and timely follow-up care. DSS also intends to track the health outcomes of the children and youth in its custody. Specifically, DSS will collaborate with its Foster Care Health Advisory Committee (FCHAC) experts, DHHS and Select Health, to determine key outcomes it should track, including those identified by the Academy of Pediatrics Bright Futures program. The targets will include outcomes such as percent % completed medical, mental health and dental initial assessments within X days, % completed assessments within X days, % follow-up visits completed within X weeks, % completed immunizations, % vision and hearing screenings conducted, etc. DSS and Select Health performance will also be benchmarked against HEDIS targets and compared to children served by Select Health who are not placed in foster care. DSS will refresh its measures and targets, collect baseline data and produce an annual report showing work underway and over time to improve from baseline.

Child Health Goal 4: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being and the Office of Data, Reporting and Accountability

Key Activities/Deliverables:

- Develop proposed set of child health outcome benchmarks and targets similar to those in the Center for Health Care Strategies' report "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit" (Allen, 2012).
- Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets
- Finalize benchmarks and targets
- Review/refine annually
- Publish annual report on health status of children and youth in foster care

Timeframe: FCHAC will convene each year in Spring and Fall to review annual performance against benchmarks and targets. The initial review will begin by April 2019.

VI. Child Health Plan: System Components

DSS also translated its commitments in the FSA and the recommendations of the consultants into three key system components. The key system goals speak to the core operating elements of an effective health care system for children in foster care.

Component 1.	Establish the Office of Health and Well-Being and define Internal and External Roles and Responsibilities and build into a sustainable governance structure that provides direction and oversight of initial Health Plan implementation and thereafter ongoing review.
Component 2.	Build out the capacity to collect, analyze, disseminate and use administrative data to drive child health outcomes (including central and field-facing quality improvement processes, incident review and adverse event monitoring and monitoring of network adequacy).
Component 3.	Develop practice guidance, policies and training for the field, birth families, foster parents and contract, placement and treatment providers.

System Component 1. Establish the Office of Health and Well-Being and define internal and external roles and responsibilities developing a sustainable governance structure that provides direction and oversight of Health Plan implementation and ongoing review.

A. Establish the Office of Health and Well-Being

DSS is principally responsible for implementation and oversight of the Plan through the recently created Office of Health and Well-Being within the Division of Child Welfare. The Office is responsible for child and adolescent health, child and adolescent clinical and behavioral health through the IFCCS, therapeutic foster care, specialized treatment services, oversight and monitoring of psychotropic medication, child and adolescent education services and provide support for the Foster Care Health Advisory Committee (FCHAC). This office will develop health and behavioral health policies, procedures, protocols, and practices designed to achieve safety, permanency, and well-being outcomes for children and families. It is also responsible for developing, with internal and external partners, health, behavioral health and other well-being measures and performance targets. This Office has primary responsibility for implementation of this Plan.

The Office is currently staffed with a Director hired in April 2018[151], a Consultant Psychiatrist, Lead Clinical Specialist, and Intensive Foster Care and Clinical Services Administrator. The Director is responsible for building out, refreshing and rolling out all DSS health and behavioral health policies and practice protocols, data reporting and quality assurance and the operation of this new office at DSS. The scope of the reforms underway in foster care will require the Director to provide health and behavioral health leadership and support to related Department activities including guidance on the health and behavioral health components of the case practice model being developed by Chapin Hall, implementation of the CFSR PIP, and the development of the Foster Care Placement Plan. In this capacity, the Director serves as the liaison to DHHS, DMH, Select Health and other external Health Plan implementation partners and stakeholders, is a member of the DSS Foster Care Leadership Team

[151] Position Description in Appendix, Section 5.

and sets strategy, goals and performance targets for health and behavioral health services for children in foster care, attends the Joint Council on Children and Adolescents, leads in the development of department health and behavioral health priorities, policies and practice and leads on the implementation management of the Health Plan. The Director also sets the agenda for the Foster Care Health Advisory Committee, interfaces with USC and internal partners on the bi-annual capacity and network adequacy survey, coordinates the DSS response to the well-being quality improvement components of the CSFR PIP (Program Improvement Plan), which includes physical and behavioral health of children in foster care.

The Child Psychiatrist's responsibilities include psychotropic medication oversight, clinical consultation for regional clinical specialists and other field staff, tracking and follow-up on high need cases (children receiving psychotropic medication, polypharmacy and children < 6), development of protocols for informed consent, enhanced clinical health care and psychopharmacology and behavioral health basic training for DSS and IFCCS casework staff and supervisors.

The Lead Clinical Specialist's duties include providing guidance or specialized clinical assistance to field staff serving children with significant behavioral health needs, oversight of the psychotropic medication management process for youth in psychiatric residential treatment facilities, project management for the implementation of the health and education passport, managing the roster of high needs/immediate needs children and cadence calls to staff cases for follow-up, and provision of field training to DSS caseworkers and supervisors on health and behavioral health policy and practice.

IFCCS develops policies procedures and practices to enable the 110 IFCCS caseworkers achieve safety, permanency, and well-being outcomes for children in need of intensive foster care and clinical services, coordinates the rostering, staffing and follow-up for complex behavioral health cases, participates in community, governmental, and educational activities representing the Child Welfare Services Program, provides input on program related issues, and provides content for IFCCS worker Basic Orientation Training.

Given the significant expansion of duties in DSS's new Office of Health and Well-Being, and the need for deep engagement of other state agencies, stakeholders and partners tied to successful implementation of the Health Plan, DSS will evaluate the need for additional staffing and the phase-in of any additional staff, including additional clinical staff. Detailed information regarding the plan for additional staff will be included in the care coordination and healthcare case management framework discussed above, to be completed by March 2019. One area of consideration will be the addition of up to three Clinical Specialists, including pediatric nurses, who could serve under the supervision of the Lead Clinical Specialist and Chief Medical Officer to enhance training, support and consultation to DSS and IFCCS caseworkers and supervisors, interface with health care providers and support the rostering, tracking and follow-up work needed by high-needs and medically complex children. Another functional consideration will be for up to three staff to build out the team responsible for data analytics, rostering and monitoring and quality and performance improvement, support PIP implementation and quality improvement activities. The preliminary budget model was prepared for submission to the Co-Monitors in May 2018 and is currently under review.

The DSS Office of Health and Well-Being has a lateral relationship with the DSS Director of County Operations to whom all regional and county foster care operations report and the Director of Data, Accountability and Research who produces and analyzes data for DSS. The Office will have functional authority over all policies and procedures related to healthcare and will also serve as clinical advisor to the entire Division of Child Welfare. County and regional operations will be expected to coordinate efforts with the Office of Health and Well-Being to implement the elements in this Plan.

B. Define External Roles and Responsibilities

For the Health Plan to be successful, DSS must collaborate closely and in partnership with multiple state agencies including DHHS, DMH, and Select Health, the MCO that serves children in foster care. DSS and DHHS are lead agencies for the purpose of Health Plan activities. Weekly planning and implementation meetings began in April 2018. SCDMH serves in both a key provider and partner role. Select Health is central to the provision of health and behavioral health services to children in foster care and DSS has reset its relationship with DHHS and Select Health and the three entities are meeting, planning, problem-solving together.

DHHS

The South Carolina Department of Health and Human Services (DHHS) operates, among other activities, the state's Medicaid program and is an essential partner with DSS in ensuring that the health care needs of children in foster care are met. DHHS manages Medicaid eligibility and enrollment; determines covered services; pays for covered services; holds the contract with the managed care organization (MCO) that serves these children and provides fee-for-service payment for medical, behavioral or dental care to a small number of children in foster care with complex needs. DHHS is the state agency that is responsible for federal Medicaid requirements, including implementation of the state Medicaid plan, Home and Community-Based (HCBS) waiver services.

SCDMH

The South Carolina Department of Mental Health (SCDMH) has 17 community mental health centers operating over 60 clinics, with at least one clinical location in every County. The agency operates two psychiatric hospitals, Bryan Psychiatric Hospital in Columbia and Harris Psychiatric Hospital in Anderson, as well as a specialty hospital for substance use disorders, Morris Village, in Columbia. The Department's Bryan Psychiatric Hospital includes the William S. Hall Psychiatric Institute, which consists of three separate hospital units for children and adolescents:

- a latency age hospital unit for patients ages 4 to 12;
- an adolescent unit for patients age 13 to 18; and
- a substance use disorder unit for adolescents age 13-18.

DMH Community Mental Health Centers provide outpatient mental health services, including when needed psychiatric services and medication management. Staff are trained and practice trauma-informed care, and SCDMH Mental Health Centers offer a number of other evidence-based interventions, such as school mental health services. In the 2017–18 school year, SCDMH Mental Health Center therapists provided clinical services in over 600 schools across South Carolina.

Select Health

In recognition of the fact that foster care children require a more comprehensive, coordinated healthcare delivery model that promotes better access and improves health outcomes, in November 2012, DSS and DHHS announced the Foster Care Health Initiative, a collaborative effort to better address healthcare delivery to foster care children. As the legal custodian of children in foster care, DSS determined that it is in the best interest of foster children to be enrolled in a single MCO that could coordinate their care in both their routine health care needs and the special needs that arise for children who have been abused, neglected and placed in state custody. As a result of this initiative, all foster youth, with few exceptions, are enrolled in First Choice by Select Health of South Carolina, a Managed Care Organization. Specific core benefits and service requirements are set forth in Section 4 of the DHHS and Select Health MCO contract. Select Health is paid through a capitation rate, a "per member/per month" fee of $950.75 for each child in foster care. The rate has been adjusted to meet the special needs of children in foster care. In addition to screening, assessment, treatment and follow up, Select Health is also required to provide care management that meets national standards.[152]

C. Develop Governance Structures and Routines

Development and implementation of the Plan will require a tiered governance structure led by DSS with DHHS to keep the lines of communication open, to resolve issues that may arise and to establish accountability mechanisms for DSS internal; cross-agency; and external partners. The governance structure being utilized by DSS to develop and implement the FSA and the Plan are described in the table below. The structures include both internal decision-making groups, and external advisory groups. As part of its priority actions, DSS has recently created a cross-agency SWAT team that meets weekly on implementation issues. This group has proven critical to gaining traction on important cross-agency issues, particularly as it relates to DHHS' role as contract manager to Select Health.

But more than a SWAT team, this plan requires the establishment of, and routine meetings by, a set of new governance bodies, as described below, as well as the continued convening of an outside advisory group. The table below identifies the set of governance groups DSS is convening to implement the Plan. Over time, groups like the SWAT team will be converted to routine governing bodies that meet on a regular basis to oversee and monitor the ongoing health functions described in this Plan.

The table below sets forth the governance structures (including internal "cadence" structure) that DSS will utilize to design, track and implement the Health Plan.

[152] Detailed contractual requirements for Select Health in Appendix, Section 4.

Governance Level/ Group Name	Members*	Responsibilities	Meeting Frequency
Internal/ Cadence Team	• Office of Child Health and Well-Being • DSS Division of CW (includes program support, IT, etc.) • Regional and County Operations	Operations group of Executive Team and Regional Directors for day-to-day management, system and operations planning and system-wide health-related oversight.	Weekly
Internal/Regional	• Regional Directors • County Directors • Performance Coaches	Regional directors share data, identify outliers, and gaps.	Weekly
Internal/ Supervisors	• County supervisors • Caseworkers	Discuss data, identify outliers in unit cases; flag cases for staffing and follow up.	Weekly
Cross-Agency/ SWAT Team	• DSS • DHHS • Select Health	Operations group to coordinate, track and trouble-shoot all aspects of data and analytics to support health care for children in foster care. Develop outlier reports and flags for higher needs children. Develop and track system performance and quality reports.	Weekly

External/Foster Care Health Advisory Committee[153]	• DSS • DHHS • Foster Care Health Advisory Committee • Select Health • SCDMH • Health and Behavioral Health providers, practitioners and organizations, including QTIP and Federally Qualified Health Clinic representatives	Advisory group co-Lead by DSS and DHHS; provides consultation on issues as needing; for example, Access to Care; trauma-informed Care; Medical Assessment.	Quarterly
*Governance group lead in red			

Although successful implementation of this Plan will be a collaborative effort, DSS is principally responsible for its oversight. Three other entities will play a major role in implementation of this Plan: DHHS, Select Health, and the South Carolina Department of Mental Health. Key leads from DSS, DHHS, and Select Health have convened weekly meetings, which will continue throughout the implementation of this Plan. The purpose of these meetings is to develop and revise this Plan, where necessary, monitor implementation, troubleshoot and resolve issues and conflicts that arise.

External partners and stakeholders will serve in an advisory capacity related to implementation issues. The Foster Care Health Advisory Committee (FCHAC) will be instrumental in implementing and monitoring fidelity to the Healthcare Plan. This is an existing committee charged with helping children in foster care have effective and coordinated medical and mental health services and is comprised of a broad representation from the medical and behavioral healthcare fields statewide, including nurses and pediatricians from various clinics, Select Health representatives, Child Advocacy Centers, Department of Mental Health (SCDMH), private community-based Licensed Independent Professionals (LIPs), Palmetto Association for Children and Families, Therapeutic Foster Care agencies, Group Care and Rehabilitative Behavioral Health Services (RBHS) providers, and Foster Parent support agencies. [154] DSS and DHHS will partner together to lead the quarterly FCHAC meetings. DSS expects to reorganize the FCHAC to focus more directly on achieving the healthcare targets set forth in this Plan. The FCHAC has reviewed the draft Plan and discussed it at its June 26, 2018 meeting.

[153] The FCHAC is comprised of representatives from the medical and behavioral healthcare fields statewide, including nurses and pediatricians from various clinics, Select Health representatives, Child Advocacy Centers, Department of Mental Health (DMH), private community-based Licensed Independent Professionals (LIPs), Palmetto Association for Children and Families, Therapeutic Foster Care agencies, Group Care and Rehabilitative Behavioral Health Services (RBHS) providers, and Foster Parent support agencies.

[154] List of FCHAC Members in Appendix, Section 7.

System Component 1: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being

Key Activities and Deliverables

- DSS will develop a working protocol for its internal governance activities including guidance to the field: health data report production and dissemination, cadence calls, follow-up and oversight tracking
- DSS will collaborate with DHHS to develop a data-sharing agreement and schedule for reports
- DSS, DHHS and SH will collaborate to develop a process for data sharing
- DSS, DHHS and SH will collaborate to develop a protocol for resolution of child or provider specific issues
- The Office of Health and Well-Being will work with the Office of Data, Research and Accountability to develop health data management reports and guidance to the field, data analytics, technology solutions through CAPSS

Timeframe: Work has already begun on establishing structures. Governance protocols complete by December 2018; Health Data Management Reports January 2019

System Component 2: Build out the capacity to collect, analyze, disseminate and use administrative data to drive child health outcomes

The Plan's success rests on DSS capacity to collect, analyze, disseminate and use administrative and case data to improve health care services to children in foster care, improve field operations and see that children in foster care receive quality care. While DSS is ultimately accountable for meeting the health needs of children in their care, it depends on a strong partnership and collaboration with DHHS and Select Health to meet its obligations to children.
Key components of the Plan Are built on a data-sharing agreement to be developed between DSS, DHHS and Select Health to:

- Program automatic uploads and facilitate completion of CAPSS records for each child
- Flag, roster, track and follow-up on children identified with immediate needs
- Provide timely screening and assessment
- Identify children in need of IFCCS or Select Health Intensive Care Coordination
- Allow for a targeted focus on the health and behavioral health care needs and follow-up of children in foster care
- Formalize channels of reporting and accountability

As described earlier, DSS and DHHS are collaborating to develop a system-wide database and report that captures health and behavioral health measures for each child in foster care and can be aggregated

by region, county, supervisor and caseworker. Work is also underway to formalize this data-sharing agreement by December 2018. The data agreement will cover sharing data needed to populate CAPSS, data access permissions and restrictions and will include a data dictionary, list of monthly, quarterly, annual or more frequent population health reports (more than one medication, immediate needs, etc.) and other elements.

The Plan contemplates three components of its data and quality improvement system, including a component related to continuous case- and management-level data; immediate need (IN) data as defined in the FSA; and quality improvement. They are described below.

A. Strengthening Use of Case-Level Data and Management-Level Data

DSS and DHHS have begun to link 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 DHHS system of record and Select Health 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 provide 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 South Carolina to be a national model with respect to the health of children in foster care. Given the importance of data to the Plan, DSS is developing a clinically and analytically-oriented data team tasked to work with DHHS and Select Health, related departments at DSS and other affiliated entities. This team will work with other DSS departments to develop dashboards, report templates, inform the quality improvement process and assist with implementation of the DSS CSFR PIP.

Continuous case-level data will mean that a child's case record will be up-to-date as far as whether a child has received appropriate screening and assessments, and any routine, urgent or emergent follow-up care. To accomplish this, DSS county and IFCCS workers will continue to populate CAPSS with information on screenings, assessments and follow-up care as they are currently doing. In the short-term, follow-up care will be documented monthly in case notes. Over the long-term and beginning in March 2019, DSS will collaborate with DHHS and Select Health to determine which data from providers' electronic health record or Medicaid data can auto-populate the DSS CAPSS record. Additionally, DSS will collaborate with DHHS and Select Health to review utilization data to determine which health episodes, if any, for example a trip to the emergency room, should trigger immediate provider contact with Select Health, followed by immediate notification to DSS. Notification of emergency room visits, or injuries identified during a routine health visit can serve as a proxy for identifying maltreatment in care and so should likely be an important immediate notification flag. Over time and as needed, other immediate notifications or red flag reports will be developed between DSS, DHHS and Select Health.

Continuous management-level data will mean that DSS county, regional and central leaders will have regular data reports on key practice and child health indicators, such as percent of children with timely

screenings and assessments or utilization of behavioral health services by children placed in congregate care. These reports will identify certain gaps in care reports that DSS, DHHS and Select Health will use to routinely monitor child health outcomes and field-level performance.

Missing Initial Assessment A missed initial medical, dental or behavioral health assessment becomes an immediate treatment need. DSS began tracking these missed initial assessments in June 2017. Immediate need reports are pulled weekly and reviewed with child welfare leadership Fridays and cadenced with regional health care liaisons on Mondays. The process for staffing immediate needs cases, follow-up activities and monitoring completion of follow-up activities are outlined on page 48 of the Plan.

DSS has begun receiving Medicaid claims and encounter data and tests it against CAPSS data for accuracy and reliability. Using the initial cohort defined in the FSA, DSS is testing a process to cross-reference the two data sets, identify nuances in the data that may require further clarification (medically fragile children who may be unable to participate in a behavioral health initial assessment, healthcare providers who do not bill Medicaid for services provided or batch claims, and claims that may have a lag time), and where it appears certain that a health, behavioral health or dental initial assessment should have been scheduled and was not, provide instruction to the field to immediately schedule the missed initial assessment. Once DSS has refined and streamlined the new gaps in care/utilization report and cadence process, it will begin using it for the FSA cohort--all children who entered care during CY 2017 and are still in care which is a shift in the definition outlined in the FSA. DSS has developed a standardized reporting formal that will enable the caseworkers to report back to the Regional Health Care Coordination Liaisons and for the regional liaisons to report back to the Office of Health and Well-Being in weekly calls. DSS will use its cadence governance process and the gaps in care report to routinely monitor and follow-up on initial assessments, missing assessments and other immediate needs.

Gaps in Care/Utilization

The definition of immediate treatment needs includes, '[a]ny diagnosis that requires follow-up with a medical, mental health, and dental provider outside of the child's normal routine periodic assessments.' To better identify and address unmet need, DSS has asked DHHS and Select Health to prepare gaps in care/utilization reports based on HEDIS (Healthcare Effectiveness Data and Information Set) measures. HEDIS measures are a widely used set of performance measures in the managed care industry developed by the National Committee for Quality Assurance (NCQA). Generally, HEDIS measures address a broad range of important health issues and represent nationally agreed upon practices to improve healthcare quality. Select Health routinely distributes these gaps in care reports to its network providers to identify members or providers who failed to meet a particular HEDIS measure.

In April 2018, DSS compiled a list of the most common diagnoses and conditions for children in foster care and sent this list to DHHS. From that list, DHHS and Select Health selected HEDIS measures that aligned most closely with the identified diagnoses and conditions deemed important.

This list was further refined and expanded with the assistance of a HEDIS expert at DHHS and Select Health's current and former medical director and corporate quality assurance director. The current list includes the HEDIS measures below.

The gaps in care/utilization reports serve as a roster and based on the HEDIS measures tracked, will identify children who require follow up, as required by the immediate treatment need definition; those who are and those who fall below an established HEDIS parameter. The report will also identify lack of access to more preventative health care services such as immunizations, well-child visits, and weight assessment. The gaps in care data can also be queried and organized to produce focused reports on utilization or access challenges by region, by placement type (TFC or congregate care), by diagnosis and by provider, among others. The data can be queried to identify providers who are not adhering to DSS, DHHS or Select Health prescribing standards. DSS and DHHS anticipate producing the first set of gaps in care reports in August 2018.

HEDIS Measures to be Included in Monthly Gaps in Care Report		
Abbreviation/Measure	**Measure Description**	**Notes**
CDC—Comprehensive Diabetes Care	Used to determine if patients age 18-75 with Type I or Type II diabetes received proper testing and care for diabetes during the measurement year.	This diabetes measure will be reported for all children in foster care with age restriction removed (blood pressure <140/90, HbA1c<9, dilated eye exam, and nephropathy screening). Note this measure is dependent on record review.
AMR—Asthma Medication Ratio	Paid pharmacy claims are used to determine if the patient is filling more rescue medication compared to total asthma medication. An AMR less than .5 is a strong indicator that a patient may benefit from a discussion about current medication usage.	This will be reported with actual ratio for each child.

FUH—Follow-Up After Hospitalization for Mental Illness	Used to determine if patients age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, and intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Treatment is measured after a psychiatric hospitalization—7 days, best practice and 30 days to pass the measure.	
ADD—Follow-Up Care for Children Prescribed ADHD Medication	Pharmacy claims data is used to determine if newly prescribed (or restarted with sufficient break) ADHD for 612-year olds had at least three follow-up care visits within a 10-month period, with the first visit being within 30 days of when first ADHD medication was dispensed. Best practice is to get all three visits.	This will be reported with the age restriction removed.
AMM—Antidepressant Medication Management	Used to determine if patients 18 years or older with a diagnosis of major depression who were newly treated with an antidepressant remained on the antidepressant medication for 84 days for the acute phase and 180 days for the continuation phase. Uses pharmacy claims data.	This will be reported with the age restriction removed.
CIS—Child immunization Status: Combo 10	Used to determine if children received immunizations. Includes 4 DTAP, 1 MMR, 3 HepB, 4 PCV, 2 or 3RV, 3 IPV, 3 HIB, 1 VZV, 1 HepA, 2 Influenza. PCPs also document vaccines in the SC immunization registry	

APM—Metabolic Monitoring for Children on Antipsychotics	Used to determine whether children 1-17 years old who are on an antipsychotic also had metabolic monitoring.	
APP—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Used to determine if children 1-17 years old have psychosocial treatments prior to being prescribed antipsychotic medication. Antipsychotics are recommended as a second-line treatment option only after psychosocial interventions have been tried and symptoms are severe and persistent.	Measure only focuses on first appointment, not ongoing appointments. Later consider matching to DHHS claims data to determine if other psychosocial interventions being utilized.
APC—Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Used to determine % of patients 1-17 on two or more antipsychotics concurrently in a 90-day period. Lower % is better.	Fine as is
IET—Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Used to determine % of patients ages 13 and older with a new episode of alcohol or other drug dependence who received initiation of AOD treatment (admission, outpatient visit, intensive outpatient, or partial hospitalization) within 14 days of diagnosis and engagement of AOD treatment after initiation with two or more services within 30 days of initiation visit.	

IMA—Immunizations for Adolescents	Used to determine if males and females turning 13 during the measurement year completed immunizations on or before their 13th birthday: 1 MCV (on or between 11th and 13thbirthday), 1Tdap (on or between 10th and 13thbirthdays), and 3 HPV (on or between 9th and 13thbirthdays) PCPs also document vaccines in the SC immunization registry	
W15—Well-Child Visits in the First 15 Months of Life	Used to determine if babies turning 15 months old completed six or more well-child visits before reaching 15 months of age In order to count, documentation must include evidence of: health history, physical developmental history, mental developmental history, physical exam, and health education/anticipatory guidance	
W34—Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Used to determine children ages 3-6 who had at least one well-care visit with a PCP during the measurement year. In order to count, documentation must include evidence of: health history, physical developmental history, mental developmental history, physical exam, and health education/anticipatory guidance	

AWC—Adolescent Well-Care Visits	Used to determine if patients age 12-21 had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	This will be reported with the age restriction removed.
WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Used to determine if children age 3-17 completed a body mass index percentile, counseling for nutrition and counseling for physical activity. To pass, BMI percentile, height, and weight must be documented.	Note this measure is dependent on record review.

DSS acknowledges that tracking missed initial assessments in the gaps in care reports are the first step in addressing the FSA issue of immediate needs. It is also clear that tracking missed initial assessments is a first step. This leaves unaddressed the following portion of the agreed upon treatment need definition, "Additionally, should the required initial assessments or any routine periodic assessment identify a diagnosis, symptom, or condition resulting in an additional follow-up referral or treatment need, this is considered an immediate treatment need."

The immediate treatment needs report will ultimately be a combination of multiple data elements that will be tracked in an enhanced gaps in care report. It will include HEDIS measures, diagnoses, AAP data standards, and other national child welfare health, behavioral health, and dental measures. To this end, DSS will develop additional reports, request additional more specific claims data, and conduct case reviews with some regularity in the first year of Plan implementation. However, no combination of DSS and Medicaid data alone will be sufficient to address this portion of the definition. DSS will develop, pilot, and implement a robust care management and coordination process to distribute the data, follow-up with providers, caseworkers, birth families and foster parents, and to see that follow-up care is identified and provided. DSS has developed a new protocol internally to identify and address missing initial assessments, comprehensive assessments and follow-up, outlined on page 48.

DSS is collaborating closely with DHHS and Select Health, to build out this data and tracking system, define specific roles and responsibilities for each entity, identify existing resources such as a staff person on loan from DHHS to assist DSS with Medicaid data management and analytics and evaluate the need for additional resources for consideration in a future budget request.
Going forward, DSS anticipates producing or receiving, at a minimum the following data from DHHS, Select Health or DMH on a routine basis, every 30-60-90 days:

- Claims and encounter data related to medical, dental, and mental health initial assessments for all Class Members

- Psychotropic medication red flag data for all Class Members
- Gaps in Care/utilization reports for all Class Members; rosters of all Class Members with Immediate Needs or needing follow-up services (discussed in detail below)
- Weekly cadence and completed follow-up notification reports that flag and roster children with no or partial initial assessments, assessment and follow-up on immediate and other needs

B. Build Data Capacity Related to Immediate Treatment Needs as Defined in the FSA

In the FSA, DSS committed to submit information on the status of initial medical, dental, and mental health assessments for Class Members in an identified cohort. In addition, DSS committed to submitting data related to the immediate treatment needs of Class Members in the same cohort. Accomplishing this required a significant amount of capacity building. Initially, DSS did a significant amount of CAPSS development to build fields for this data, caseworker training to capture this data, and data input. Ultimately, DSS, with the assistance of the healthcare consultants, determined that this method was too burdensome on the caseworkers and not the most reliable method. Instead, DSS began collaborating with DHHS and Select Health to capture this information through claims data.

Recently, DSS received its first initial health assessments report from DHHS for calendar year 2017 for all children in the original FSA cohort and those who entered care in 2017. And, as noted in earlier in Section IV, DSS received its first batch of gaps in care reports in April 2018 which was designed to show the children that need some type of follow-up care. DSS, DHHS, and Select Health continue to refine the methodology for capturing this data, and upon agreement to the best approach, DSS will begin receiving these data on a monthly basis.

Additionally, DSS is developing a protocol for distribution and follow-up on this data as described below. Now, with this new, more reliable method of tracking initial health assessments and other health care utilization, DSS will be better equipped to meet the healthcare needs of children.

The development of management structures and practices is the key to leveraging the value of this data. Building on the governance processes described in the Plan, DSS has built out an Immediate Treatment Need/gaps in care follow-up process to link data reports with follow-up care management. The timing, work flows and management hierarchy will be implemented in August 2018 and is described below:

1) **Leadership Cadence Calls--Fridays**
    - DSS Leadership holds “cadence calls” Friday mornings.
    - Friday calls are with child welfare services leadership: Deputy Director Child Welfare Services, Regional and County Operations Director, Safety Management Director, Permanency Management Director, Child Health and Well-Being Director, Performance Management and Accountability Director, Director of Data, Reporting and Accountability, and Regional Directors.

- Data is presented at the state and regional level. Staff present percent and number of missed initial assessments by type—medical, mental health, and dental.

2) **Individual child level cadence calls--Mondays**

- Regional Healthcare Liaisons for each region have "cadence calls" each Monday with Child Well-Being Staff. These liaisons may be performance coaches, data coordinators, or other staff chosen by the Regional Director. Two are chosen for each region.
- Office of Child Well-Being Staff send spreadsheet lists to liaisons monthly. The liaisons break down the regional list and email individualized lists to each foster care case manager who has a child on the list. The county director, supervisor, and program coordinators are copied on the email.
- Foster care case managers review case files and determine if documentation, follow-up appointments, or case staffing is needed. Foster care case managers report that information back to liaisons.
- During the Monday cadence call, questions and common themes are discussed. Office of Child Well-Being staff gather lessons learned and address systemic barriers. The group works together to continually improve the process.
- Liaisons report back to Office of Child Well-Being staff on a standard spreadsheet on what was found during the file review:
    - Appointment occurred, documentation found in case file: If only a date was entered, the case manager reports any documentation located in the case file. This documentation may include an uploaded linked file or dictation.
    - Appointment occurred, documentation not in case file: If a date was entered, but no documentation is in the case file, foster care case managers can get documentation (such as a discharge summary, patient plan or after visit summary) from the provider. Until documentation is provided, liaisons report on the status of getting documentation in CAPSS.
    - Appointment needed: If there is no evidence that an appointment occurred, then the foster care case manager schedules an appointment and lets the liaison know the date of the appointment. Once an appointment date is scheduled, the appointment is entered in CAPSS for follow up and monitoring.
    - Staffing needed: In cases where a decision needs to be made such as a psychotropic red flag issue, a staffing may need to be scheduled. Each child is followed until the staffing has occurred and a decision has been made.
- For physical health care issues, each child is tracked until documentation is provided in CAPSS that a staffing or a follow-up appointment occurred, whichever is later.
- For psychotropic medication issues, each child is tracked until documentation is provided in CAPSS that a satisfactory staffing occurred with a Regional Clinical Specialist and/or DSS Psychiatrist or a follow up referral appointment occurred with a specialist such as a psychiatrist, whichever is later. For example, a child on multiple psychotropic medications may be staffed and need an appointment with a

psychiatrist. The child would be followed until the appointment with the psychiatrist was complete.

DSS is hopeful that the above processes will allow it to use the data available on children in its care for the benefit of better health care access and outcomes.

C. Strengthen Continuous System-level Quality and Performance Improvement Capacity

At the same time that DSS caseworkers and managers are creating routine access to health care data and that DSS is meeting its commitments related to immediate treatment needs under the FSA, DSS is also collaborating with DHHS and Select Health to coordinate and enhance its continuous system-level quality and performance improvement capacity. This enhanced capacity will track system-wide care quality, investigate adverse events, and review case records among other continuous quality improvement (CQI) activities and use this information to improve policies, practice and staff and foster parent/caregiver/birth family training. The elements of a broad quality improvement system will include several elements:

1. Regular Reporting

A. Quarterly review of DSS/DHHS/Select Health initial assessment and comprehensive assessment data derived from the standard assessment tool that DSS, DHHS and Select Health will identify and use for children and youth in foster care. The use of a standardized tool should allow DSS to develop a comprehensive understanding of the needs of children and youth in its care. These reports will be generated by county and region and will compare quarter-over-quarter performance. DSS will establish performance targets and develop and monitor corrective action plans.

B. Annual Child Health Data Measures Review (HEDIS and others) will be conducted annually to monitor statewide, regional and county improvements in child health outcomes and to monitor adverse events. This will roll up into an annual report on the health of children in foster care.

2. Performance Monitoring and Review

A. Ongoing Select Health Data Reports and Processes. Select Health produces a number of daily, weekly, monthly, quarterly, annually and ad hoc reports for DHHS. These reports run the gamut from claims verification, encounters (services provided, by date), member and provider characteristics to claim payments. DHHS uses the data from Select Health to evaluate access to care, availability of services and quality of care. DHHS also uses this data to assess the cost-effectiveness of Select Health and its performance by validating actual service utilization and determining whether federal Medicaid reporting

requirements have been met. Encounter validation is done by comparing utilization data against health records and reviewing data from other sources. DHHS conducts a minimum of one site visit to Select Health annually and conducts independent audits every three years.

By contract, Select Health must comply with Quality Assessment and Performance Improvement (QAPI) standards established by DHHS and must meet NCQA (National Committee for Quality Assurance) health plan accreditation requirements. In order to meet these robust state and federal mandates, Select Health must have an approved continuous quality improvement program, called a QAPI. Central to the terms of the QAPI, Select Health must operate a Quality Assurance Committee that meets at least quarterly and is comprised of the Chief Medical Officer, quality improvement staff, representative health professionals, network providers with a primary care emphasis and pediatricians. The Select Health QAPI Plan also requires a significant amount of data tracking, health outcomes and performance review and the development of corrective action for any problems identified. Data tracking includes specific statewide and regional utilization and quality and access measures such as over/underutilization, and care quality and appropriateness for all members specifically, members with special health care needs.

The CQI process in place between DHHS and Select Health includes quarterly performance review meetings and the development of Performance Improvement Plans (PIPs) focused on clinical and non-clinical areas of operation when warranted. Progress on PIPs is reported to DHHS annually. In addition to the QAPI Plan and CQI process, Select Health is also subject to a HEDIS compliance audit and regular reporting on Child Core Quality Measures. Select Health is held to a high standard or performance and is subject to fines, established by DHHS if they fail to meet quality and contract requirements.

Select Health also conducts an annual member satisfaction survey of all members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) from the US Agency for Healthcare research and Quality (AHRQ), CAHPS Health Plan Survey required by NCQA for accreditation annually by July 1st. Significant levels of member dissatisfaction triggers CAPs (corrective action plans). DSS in conjunction with DHHS and Select Health will meet annually to review provider quality and performance.

B. Annual Services Review will review the availability, utilization and types of follow-up or specialty services received by children and youth in foster care, episodes of service for children in foster care compared to other South Carolina children enrolled in the Medicaid or CHIP programs. This report will be informed by the network capacity study conducted DHHS/Select Health and by

USC, if appropriate. This review will also include a review of grievances and appeals to Select Health and DHHS that reflect adverse incidents or service decisions.

C. **Annual Topical Reports** will be special reports identified and developed annually by DSS, DHHS and SH to examine key child health issues, such as the use of psychotropics medications by children in foster care; or the prevalence of depression for children in foster care; teen pregnancy; substance misuse or early childhood development. The point of these reports will be for the purposes of developing better system knowledge and capacity related to key child health issues.

3. Case Record Review

Beginning in July 2018, as noted above, DSS will use the case record review component of the CFSR to identify strengths and limitations in its practice around the health and behavioral care for children in foster care. The Office of Health and Well-Being will be responsible for implementing the health and behavioral health components of the PIP including ongoing CQI efforts and monitoring the health-related elements of the case record review. The review will be used as a way to verify administrative data but also to identify more qualitative issues that are not as easily discerned from aggregate data sets. The case reviews, done in tandem with family and child satisfaction surveys, and potentially child and family interviews, will provide a comprehensive view of health care for children in foster care.

4. Annual Family and Child Satisfaction Survey

Conducted by Select Health, the survey will be anonymized, aggregated and shared with DHHS and DSS to ascertain feedback on service access and effectiveness. Consideration will be given to oversampling foster families and youth in care to ensure a strong response rate and generate more useful data.

5. Development of Workplan, Measures and Targets

DSS will develop an implementation workplan with timeframes and task assignments incorporating all Plan implementation activities by late August 2018. The workplan will include the development of a process to select, track and report out performance and quality measures tied to established benchmarks and improvement targets by November 2018.

System Component 2: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being and Office of Data, Reporting and Accountability

Key Activities & Deliverables

- Include capacity in the DSS budget to increase capacity to manage and analyze data (e.g., Medicaid claims data, CAPSS data; Select Health gap in care reports, etc.) and produce actionable dashboards and reports that can be disseminated to caseworkers, supervisors and Regional Directors. DSS will need analysts who are familiar and comfortable working with large administrative data sets
- Produce new reports and annual studies that highlight emerging capacity, quality, access and coordination issues
- Establish a process for DSS and DHHS to review Select Health quality and performance annually
- Develop a process for DSS to assess the performance of its casework staff in securing necessary health care information for children on their caseloads
- DSS to get aggregate member satisfaction data from Select Health annually and develop corrective action plans and mitigation actions to address issues that arise

Timeframes: Quality and performance improvement data, dashboards and reports to be issued monthly, quarterly and annually beginning November 2018.

System Component 3: Develop practice guidance, policies and training for the field, birth families, foster parents and contract, placement and treatment providers.

Implementation of the Plan will require developing new practice guidance for the field, as well as accompanying policies and training. Although the Plan is focused on the health of children and youth in foster care, the case practice contemplated by the Plan focuses on the state's responsibilities related to safety and permanency, and also on the state's capacity to improve child and family well-being. Through a lens of improved child and family well-being, the Plan envisions child welfare case practice that considers the strengths and needs of children, youth and their families from the first-time contact is made with them. In other words, from the moment of contact, caseworkers consider not only what is needed to promote child safety, but how the child welfare system, if it stays involved with the family, can support improved family well-being while simultaneously helping children stay connected to their family and maintain placement stability, if a child is taken into care. With this as a goal, the Plan sets forth below the following approach to the development of system components related to health practice guidance, policies and training.

A. Development of DSS Health Practice Guidance

Under the FSA, DSS committed to a vastly improved child welfare system built on a number of core system and practice components, including focusing on the use and development of family-based placement resources rather than institutions, especially for young children; and on the importance of caseload sizes that allow for family visitation that supports both sibling connections and reunification. DSS is keenly aware that research has shown that children do better growing up with their own families or with substitute, permanent families; and that children and parents that visit more while a child is in foster care are more likely to be reunified.

The Plan described in this document is built on the promise of these (and other) critical practice system building blocks–better family-based placement resources and caseload sizes that support robust family visitation. The health care practices identified in this Plan will be integrated within the context of these improved core practice components being developed by the Department in conjunction with Chapin Hall. Specifically, to complement the child health goals described earlier, DSS will develop health practice guidance for the field that:

- County caseworkers collect information on child health and well-being from initial contact with a family and include it in the child's case record; this is especially important for cases where children are not immediately removed but the caseworker believes they will substantiate abuse or neglect (in other words, cases where there is a chance that the child(ren) will be removed to foster care at a later date);

- County caseworkers include information about child health and well-being in the CSA, including use of the standardized assessment that DSS chooses to use to accompany placement resource requests;

- County caseworkers understand and know how to connect with either DHHS or Select Health for children if there is a likelihood that a child will need a higher level of care management from the start of a case (e.g., caseworkers will have practice guidance that helps them connect with DHHS or SH resources if they need help understanding a child's health at the start of an investigation and/or they need help developing the CSA);

- Regional Placement Units understand and know how to match children to placements that can support their health needs, including seeing that children placed in congregate care settings (group homes and residential facilities) have the health and behavioral health services and treatments that a child needs. This function will be revisited in the DSS Placement Plan and will build on important system practices like family team meetings and other ways to incorporate family voice and choice;

- Regional Placement Units work with county and IFCCS caseworkers to match children to the appropriate level of DSS and Select Health case management and care coordination;

- IFCCS and county caseworkers understand and know how to incorporate their ongoing assessment and monitoring of child health and well-being in visits with children, placement resources (e.g., foster parents, group home child care staff) and birth families, including updating the child's case record on both routine child health matters (e.g., well visits) and any issues that require follow up;

- IFCCS and county caseworkers understand and know how to coordinate and collaborate with Select Health care coordinators, as well as DHHS for children who remain in the fee-for-service Medicaid program; and

- Regional and county leaders understand and know how to supervise as related to health care and well-being issues so that initial assessments and comprehensive assessments are completed timely and use data to manage case practice goals.

As discussed above, DSS will detail additional practice guidance and changes in its care coordination and health care case management framework to be prepared upon completion of the DSS Health Care Pilot and Process Review.

B. Development of Health-Related Policies

DSS will develop health-related policies that reflect the new practice guidelines identified above. Given that the Plan anticipates a pilot phase upon which many of the new practices associated with child health goals will be developed, the formalization of new policies will not occur until early to mid-2019. Policies already in place related to initial assessments and assessment requirements, as well as responsibilities of caseworker staff to track and monitor health and well-being will remain in effect as the pilot rolls out. New policies will build on current requirements with a focus of improving collaboration between DSS, DHHS and Select Health, as well as considering a child's health needs and incorporating them in the context of all placement decisions. DSS will also review, modify and, as needed, develop policies related to consent for treatment and the informed consent process. As discussed above, DSS will detail additional policy changes in the care coordination and health care case management framework to be prepared upon completion of the DSS Health Care Pilot and Process Review.

C. Training and Supervision

Training and supervision are foundational to the effective casework practice and improved operations that lead to improved health for children and youth in foster care. A complete overhaul of DSS's caseworker and supervisor health-related training, will not happen immediately. Rather, DSS will phase its review and modifications to training focusing initially on what will result in the most immediate results for improved child health. In this regard, collaboration with the Chapin Hall consultants developing the Department's case practice model and Training Plan and the Foster Care Health Advisory Committee (FCHAC), as well as the American Academy of Pediatrics (AAP), statewide QTIP network and foster parent association will be leveraged for more rapid feedback. In particular, DSS will engage these groups to determine what health-related training is essential for workers, birth families, foster parents and other placement resources and health and behavioral health providers. Because DSS will be simultaneously implementing and building an improved health care practice lead by the Office of Health and Well-Being and contemplated in the Chapin Hall practice model under development, its training will be organized into two buckets: short-term essentials, and longer-term system training components. The short-term health and behavioral essentials for DSS caseworkers and supervisors will focus on what needs to be done for children and youth to be timely initially assessed, assessed, and receive follow-up services so that any gaps in care are staffed and addressed timely. Longer term health training components will consider including additional modifications to new worker child welfare basic training; IFCCS worker Orientation Training;

supervisory training; foster parent training; working with families; Select Health and DHHS training; and data and monitoring training.

Select Health is required by contract to provide educational information and materials for all enrollees. These materials can be used to inform DSS caseworkers, foster families and other caregivers about how Select Health serves its members and the responsibilities of SH providers and provider networks.

System Component 3: Elements of a Work Plan

Task Lead(s): Office of Child Health and Well-Being

Key Activities and Deliverables

- Develop practice guidance consistent with the Health Care Plan, including clarity for case workers related to their own obligations to meet children's health care needs; coordination with birth families, foster parents and placement providers on child health; and collaboration with Select Health care coordination on child health;
- Develop policies consistent with Health Care Plan; the policies will be informed by the Health Care Pilot and Process Review
- Develop/adapt training for caseworkers and supervisors related to new case management/care coordination processes and roles based on Health Care Pilot and Process Review (20 prototype cases)

Timeframes: Health training essentials will be identified by December 2018 and incorporated into the newly developed child welfare basic and IFCSS case manager trainings beginning in February 2019. Additional health-related training components will be identified by fall 2018 and rolled out by end of 2020. Health practice guidance and health policies will be developed following the Health Care Pilot and Process Review with initial roll-out to occur March 2019.

VII. Resource Needs

The South Carolina Department of Social Services (SCDSS) submitted a comprehensive, fiveyear budget plan (2019 – 2023) to the Court in May 2018 that includes the financial, staffing and other support the agency anticipates will be necessary to meet the performance targets required by the Settlement Agreement. The budget identifies estimated funding requirements for new positions, training, technology, rates, and services needed to facilitate the Implementation Plans associated with meeting Health Care Improvement requirements of the Settlement Agreement and to address budget requirements for each of the performance targets. It is important to note the budget plan only includes new or increased costs to be incurred each year. It is expected that once costs are appropriated for a specific line item, those appropriations will be recurring in subsequent years.

To address the performance targets as part of the health plan, SCDSS anticipates the following costs in the fiscal years outlined below. SCDSS anticipates that many of the costs required as part of the healthcare and mental health plan will be absorbed through the South Carolina Department of Health and Human Services (DHHS) budget and DHHS's managed care contract (MCO) for children in foster care. Determining the appropriate budget for Health Plan activities is an evolving and ongoing process. As specific costs are identified, the following budget will be updated.

Design of an Infrastructure for Tracking and Delivery of Health and Mental Health Services for Children in Foster Care		
Purpose	Amount	Budget Year
Contracts—Consultants to provide agency with support during plan implementation	$90,000	2019
Training--Contract for standardized level of care assessment tool	$30,000	2020
Training—Contract for continuing training for new staff on standardized level of care assessment tool	$3,000[155]	2021
Staff—Office of Well-Being Staff, clinical specialists, and staff to monitor monthly initial assessment reports, psychotropic medication reports and gaps in care. Staff will also identify service array issues, and communicate those gaps to Select Health, develop standards for preferred providers, educate providers on best practices for children in foster care, identify paid and unpaid resources for families and children, and recruit providers when those providers are outside of Select Health's network development goals.	$2,360,582	2020
Staff—Salary increase for staff hired in 2020	$73,031	2021
Staff—Salary increase for all recurring staff	$76,757	2023

[155] These costs will be adjusted to reflect actual costs of implementation, training and fidelity monitoring of a new assessment tool once the pilot is complete and a full care coordination plan has been developed.

VIII. Appendix

1. **FSA Michelle H. Settlement Agreement—See attachment**
2. **Consultant Validation Report—See attachment**
3. **Placement Needs Assessment Baseline Study Final Report—See attachment**
4. **Select Health Scope of Work and DHHS Managed Care Contract—Selections below and full contract found here**
   https://msp.scdhhs.gov/managedcare/sites/default/files/2016%20MCO%20Amendment%205%20%20Risk%20and%20Minor%20Changes.pdf
5. **Position Description for Director of Child Health and Well-Being—See attachment**
6. **DSS Child Health Fact Sheet—See Attachment**
7. **South Carolina DSS Five-Year Comprehensive Budget Narrative—See attachment**
8. **Foster Care Health Advisory Committee Members—See attachment**
9. **DHHS and DSS Data Sharing Memorandum of Agreement**
10. **Initial Assessment Data—See attachment**