FFY 2025-2029 – Iowa Child and Family Services Plan

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IOWA Health and Human Services

FFY 2025-2029

Child and Family Services Plan (CFSP)

STATE OF IOWA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FAMILY WELL-BEING AND PROTECTION

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Once approved by the Federal Children's Bureau, the Iowa Department of Health and Human Services will post the approved FFY 2025-2029 Child and Family Services Plan (CFSP), with attachments to the Iowa Department of Health and Human Services' website, Child and Family Services Plan.

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Section I: Vision and Collaboration

STATE AGENCY ADMINISTERING THE PROGRAMS

Identify the name of the state agency that will administer the title IV-B programs under the plan. Describe the organization, its function, and the organizational unit(s) responsible for the plan and include organizational charts. Except as provided by statute, the same agency is required to administer or supervise the administration of all programs under titles IV-B, IV-E, and XX of the Act (45 CFR 1357.15(e)(1) and (2)).

The Iowa Department of Health and Human Services (HHS) is the state agency that administers the Child Abuse Protection and Treatment Act (CAPTA), the Children's Justice Act (CJA), the Community-Based Child Abuse Protection program (CBCAP), titles IV-A, IV-B, IV-D, IV-E, and XX of the Social Security Act, the John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) and the Education and Training Vouchers (ETV) program. HHS also administers title XIX (Medicaid) and programs related to behavioral health, public health, community access, and aging and disability services.

The Governor of Iowa appoints the HHS Director to lead the agency. HHS comprises 9 divisions with bureaus under each division. The 9 divisions are:

- Compliance
- Administration
- Medicaid
- State-Operated Specialty Care
- Behavioral Health
- Public Health
- Community Access and Eligibility
- Family Well-Being and Protection
- Aging and Disability Services

Under the Division Director, there are discreet Directors who oversee bureaus responsible for the various functions of the division.

The Division of Family Well-Being and Protection is the organizational division responsible for the FFY 2025-2029 Child and Family Services Plan (CFSP). Child Protective Services, which comprises field operations, policy, and the centralized service intake unit, is the organizational unit responsible for the CFSP. Field operations includes service areas comprising counties where children and families receive child abuse protective services, child welfare case management services, child welfare services, economic assistance, Medicaid, childcare, and other services. Policy is responsible for state/federal compliance of child welfare programs. The centralized service intake unit comprises: child abuse hotline, the child abuse registry, IV-E claims unit, and interstate compact.

For more information, please see HHS' Table of Organization (HHS Table of Organization) and HHS' Functional Table of Organization, which shows the aligned functions of HHS (HHS Functional Table of Organization). Also, please see Attachment 1A, Child Protective Services,

Service Area Map, which shows full-time and less than full-time county offices in their respective Service Areas.

VISION STATEMENT

Provide a vision statement that articulates the state's philosophy in providing child and family services and developing or improving a coordinated service-delivery system. The vision should reflect the service principles…, which appear in federal regulations at 45 CFR 1355.25 (45 CFR 1357.15(g)).

HHS has a societal vision that individuals, families, and communities are safe, resilient and empowered to be healthy and self-sufficient. Iowa's child welfare vision statement: "*Family Connections are Always Strengthened and Preserved"* supports HHS' societal vision.

Principles and Commitments:

1. **Family Voice and Choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of involvement. Nothing about the family without the family.
   A. Case planning and services must be family centered.
   B. Children's concerns and identification of caring adults will be specifically solicited and included in case planning.
   C. Children in foster care deserve normalcy and access to activities and experiences similar to their peers.
2. **Team Based.** The team consists of individuals agreed upon by the family and are committed to them. The team is family inclusive, but not family exclusive.
   A. Conferences will be held at multiple key junctions: child safety (pre-removal), case planning, and risk of changes in placement.
   B. Intentional in ensuring that the team members understand their role in advocating for the preservation and support of family connections.
3. **Natural Supports.** The team actively seeks full participation of team members drawn from family members' networks of natural support. This is particularly true when a child is being placed out of home. This must occur from the first contact with a family and ongoing.
   A. Parents and natural support caregivers receive support equivalent to, or greater than, what foster parents receive.
   B. Placement is with a known, caring adult.
4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating the family plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
   A. In-person meetings are necessary to positive engagement, cohesive case planning, and building trust.
   B. Relationship-based work enhances engagement, trust, services, and outcomes. Consistency of workers is critical to effective work. Fewer workers involved with a family are better.
5. **Community-Based.** The team implements service and support strategies that take place in an accessible and in the least restrictive settings as possible; and that safely promote child and family integration into home and community life.

A. Use opportunity of involvement with families to enhance well-being and prevent maltreatment, such as addressing safe sleep and connecting families to Early ACCESS.
B. Services, such as domestic violence, public assistance, mental health and substance abuse, are strategically embedded where family engagement and planning takes place.
C. Connections to community of origin are important.

6. **Culturally Responsive.** The team demonstrates respect for, and builds on the values, preferences, beliefs, culture and identity of, the child/youth and family and their community.
   A. Intentional strategies towards recruiting, hiring and supporting staff who reflect the culture and life experience of the population served.
   B. Family history, culture, life experiences and ethnic identities are relevant and important to establishing a trusting and productive relationship.
7. **Strengths Based.** The plan must identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family by utilizing their community and other team members.
   A. All families and communities have inherent strengths and value.
   B. Leadership will identify opportunities to match worker's strengths and skills with the specific family needs.
8. **Persistence and Creativity.** Despite challenges, the team persists in strengthening and preserving family connections by considering possibilities outside the status quo.
   A. Treating every family as though they were our own drives practice.
   B. Have the courage to recognize when something is not working and commit to pursuing alternative solutions.
9. **Outcome Based.** Goals and strategies of the system and team plans are observable, have measurable indicators of success, monitor progress in terms of these indicators, and revise strategies and plans accordingly.
   A. Documentation of the team's work with a family is timely, accurate and comprehensive.
   B. Case plan goals are measurable, concrete, behaviorally specific and created by the team.
   C. Contracted services are performance-based.
   D. Integrated data from Departments and external sources will be utilized by HHS leaders and service providers to inform, develop and enhance our system of care and outcomes.
10. **Universal.** Practice commitments are relevant, true and applicable for micro and macro interactions.
    A. Insisting on the value of family connections amongst staff at every level is critical to success.
    B. Gaps in the system supporting families and natural supports will be resolved through fiscal, policy and contracting commitments.

COLLABORATION

- *The 2025-2029 CFSP must describe how families, children, youth, Tribes, courts and other partners were involved in key aspects of its development such as: 1) the review of current performance data, 2) assessment of agency strengths and areas needing improvement, and 3) the selection of goals and objectives for improvement in the 2025-2029 CFSP five-year strategic plan.*
- *The description must also specify how families, children, and youth, Tribes, courts and other partners will be involved throughout the five-year period in the implementation of*

the goals and objectives and in the monitoring and reporting of progress (45 CFR 1357.15(l)(4)).

- *To promote equitable treatment and outcomes, the agency must provide information on how it ensured that the engaged communities represented the racial diversity of the families and youth/young adults being served and how the state included those who have been historically underserved or marginalized, and those adversely affected by persistent poverty and inequality in the child welfare system.*
- *In the 2025-2029 CFSP, states must provide information on how the state agency has demonstrated substantial, meaningful and ongoing collaboration with state courts and members of the legal and judicial communities, including the Court Improvement Program (CIP), in the development and implementation of the CFSP and, if applicable, any active state CFSR PIP or title IV-E PIP (section 422(b)(13) of the Act).*

In development of HHS' FFY 2025-2029 Child and Family Services Plan (CFSP), HHS engaged a variety of stakeholders through the following processes:

- HHS compiled stakeholder input received over the past 5 years.
- HHS contracted with Change and Innovation Agency (C!A) to conduct a Child Protective Assessment. More information on this process is below.
- In 2024, HHS central office program managers discussed CFSP goals and objectives, including those goals and objectives specific to services, if applicable, with their respective stakeholders.

It is through these processes, and those described under Additional Collaboration and other sections of this CFSP, that HHS engaged racially diverse families and youth, including those who have been historically underserved or marginalized and those adversely affected by persistent poverty and inequality in Iowa's child welfare system in development of this CFSP.

HHS Child Protective Assessment – In November 2022, HHS contracted with the Change and Innovation Agency (C!A) to conduct a Child Protective Assessment (Assessment). The assessment of Iowa's child welfare system sought to answer the question:

> Are children and families better off because of HHS intervention?

The Assessment included an examination of several HHS functional areas: organizational wide, intake, assessment, case management, adoption/kinship, and licensing. The assessment looked at the system's structural components and aspects of the work:

- Is practice sound and used with fidelity?
- Does practice align with policy?
- Do processes align with policy and practice?
- Do workers have capacity to do the work, and do it well?
- Does technology support practice, workers, and the family?
- Are services effective in lowering risk, improving safety, and culturally appropriate?
- Are all systems functioning in a way that is accountable to the child and family that lead to them being better off?

The Assessment[1] included stakeholder input through:

- Interviews with HHS leadership (10 individuals)
- 30 Customer Focus Groups (representing a variety of internal and external stakeholders), that includes but is not limited to:
  - Internal HHS stakeholders
    - Child welfare - front line staff, supervisors, administrators, quality assurance and improvement staff, IT staff, transition planning specialists (TPS), Native American Unit, Parent Partners program manager, etc.
    - Behavioral Health (BH), Intellectual/Developmental Disability Services, Medicaid, HHS Ombudsman, Foster Care Review Board, Court Appoint Special Advocate (CASA), Public Health Equity Coordinator, etc.
  - Child Welfare Partners Committee (CWPC)
- 18 Stakeholder/Community Groups, that includes but is not limited to:
  - African American Case Consultation Team
  - Bureau of Refugee Services
  - Cultural Equity Alliance Team Members
  - Families First Counseling Services (family-centered service provider)
  - Foster Care Review Board Members
  - Juvenile Justice
  - Legal representatives:
    - County Attorneys/Assistant County Attorneys
    - Assistant Attorney Generals
    - Multiple Disciplinary Advisory Committee, which includes Court Improvement Project representatives
    - Parent Attorneys (Association/Group) – State Public Defender's Office
  - Parent Partners
  - Tribal Nations

Recommendations and strategies were provided for each functional area, with an Implementation Plan Priority List that identified short-term and long-term strategies.

In response to the Assessment, HHS has done the following:

- In SFY 2023, the Iowa legislature provided funding for Iowa's child welfare workforce.
  - Beginning September 28, 2023 all eligible Social Worker II (SWCM), Social Worker III (CPW) and Supervisor staff were offered a one-time $5,000 retention bonus.
  - New staff were offered a one-time recruitment bonus of $2,500.
  - Staff had to agree to stay with HHS CPS for 12 months following payment.
- On December 1, 2023, HHS announced the hire of one Social Worker IV in each service area to help manage complex cases.

Some HHS activities currently in progress are:

- Reclassify the Social Worker II (SWCM) pay baseline to be in line with the Social Worker III (CPW) pay baseline.

[1]Please see HHS Child Protective Assessment, Appendix A: Interviews, pages 189 through 191, for a detailed list of stakeholders.

- Focus on Prevention:
  - Revising Iowa's Title IV-E Prevention Services and Programs plan (Plan) to include a voluntary community pathway, revised definition of candidate for foster care and inclusion of pregnant and/or parenting youth in foster care and adding evidence-based programs (EBPs) to the Plan.
- Support Relative and Fictive Kin:
  - Develop expedited and separate licensing standards for relative or kinship foster family homes.

Collaboration between HHS and Iowa Children's Justice (Court Improvement Program)

Iowa HHS and Children's Justice collaborate in several different ways. Some of these efforts represent memberships on on-going committees and other efforts are tied to specific projects or educational opportunities. Some of the on-going committees or teams are:

- Children's Justice State Council - is comprised of representatives from organizations that are involved in the child welfare system. The primary focus of the council is to address matters that are overarching issues in the child welfare system. The council is chaired by the Chief Justice of the Supreme Court. Members also include: State Court Administrator, chair of the Juvenile Division of the Iowa Judge's Association, the Director over Family Well-Being and Protection from HHS, the State Public Defender, a representative from the Attorney General's Office, chair of the Family and Juvenile Division of the Iowa State Bar Association, the chair of the County Attorney's Association, a representative from the Department of Education, Director of the Governor's Office on Drug Control Policy, Administrator for the Child Advocacy Board, Director of a substance abuse treatment agency and a director from a provider agency.
- Children's Justice Advisory Committee - Federal regulations require the formation of a multi-disciplinary committee to provide recommendations and feedback to the Judicial Branch regarding the implementation of the Court Improvement Program (CIP) grants. Membership includes two representatives from HHS, State Public Defender's Office, a judge from the Court of Appeals, Judges who serve on the juvenile bench, a representative from the County Attorney's Association, Chief Judge of the Meskwaki Tribal Court, two representatives from the Parent Partner Program, a representative for youths' voice and two representatives from provider agencies.
- Cultural Equity Alliance - multi-disciplinary group formed to make recommendations and implement changes to reduce disproportionality and disparities in the child welfare system.
- Family Treatment Court team s- this collaboration occurs on a local level. Each Family Treatment Court has a judge led multidisciplinary team to deliver services needed for families in the program. Team members typically consist of HHS case managers, county attorney, guardian ad litems, attorneys for parents, substance abuse treatment providers, and Parent Partners. Some teams also have mental health clinicians and domestic violence advocates.

Other collaborative efforts are related to specific projects or short-term pilot projects. Current collaborative projects are:

- Pilot project for the new HHS Case Permanency Plan
- Participation on the statewide team for the Sobriety Treatment and Recovery Teams (START) pilot project.

- Participation on the statewide team for the Safe Babies Court

Additionally, HHS staff met with CIP staff to discuss data, analysis, and activities for improvement for aspects of the Case Review System (see *Section II, Current Performance Assessment for Improving Outcomes, Systemic Factors, Case Review System*). CIP staff provided the data and analysis. Ongoing collaboration also will focus on continued data collection and analysis and implementation of activities for improvement.

HHS and ICJ collaborated on round 3 of the CFSR and the development of the Program Improvement Plan (PIP). ICJ staff participated in the implementation of Iowa's PIP. There were several activities in the PIP that ICJ worked with HHS to complete, such as activities related to:

- Implementation of the Safe 4 Home initiative which consisted of asking four questions to reduce the number of unnecessary removals from the parents or caretakers.
- Increase timely, successful permanency through improved quality legal representation. ICJ provided funding for attorneys to complete the NACC Red Book training.
- Effectively engage with substance using parents. Activities related to this strategy focused piloting the infusion of key elements from Family Treatment Courts into on-going CINA cases. Since Iowa is a very rural state, this pilot project is an opportunity to provide additional services and supports to families where there is not enough resources or families to warrant establishing a Family Treatment Court.

HHS and ICJ will collaborate on round 4 of the CFSR in FFY 2026 through CFSR activities, such as the Statewide Assessment, the On-Site Review, and the PIP. HHS has participated in statewide Judicial Trainings in the past and will be again in September, 2024. Additionally, HHS will collaborate with ICJ in preparation for and during the Title IV-E Onsite Review in September in 2025. Historically staff from ICJ have been a reviewer during the Onsite Review and HHS would welcome that going forward.

Collaboration with Judicial System

HHS collaborated substantially and meaningfully with the judicial system through the following processes in support of the development and implementation of the CFSP:

- Chief Justice Christensen and Director Garcia visited 11 communities in 5 months, from July 2022 through November 2022, to listen to almost 700 people who attended these listening sessions.
  - Some of the common themes around opportunities for improvement in all 11 locations included:
    - <u>Judicial Branch:</u>
      - FFPSA (Families First Prevention Services Act) – Attorneys and Judges are not Family First friendly, i.e., not supportive of family or fictive kin placements.
      - Remote hearings – through the pandemic remote hearings were utilized; some parties appreciated the ability to appear remotely while others preferred hearings in the courtroom. The judicial branch had a task force who gathered information on this issue and made recommendations to the Iowa Supreme Court for future hearings. Please see the following for more information:
        - Iowa Rules of Remote Procedure Memorandum - 090723_Memo_for_ch_A66176439761E_EB4F6D58A427F.pdf (iowacourts.gov)

    - Iowa Court Rules of Remote Procedure, Chapter 15 - 090723_Ch_C4C2D2C32C0FF_457A05C05F5A3.pdf (iowacourts.gov)
    - Remote Proceeding Toolkits | Iowa Judicial Branch (iowacourts.gov) for court participant toolkits.
- Permanency and Termination of Parental Rights Hearings – In some areas of the state, the initial permanency hearing was combined with the TPR hearing. ICJ, along with the Chief Justice, have been trying to stop this practice because it interferes with the due process rights for the parents since they are two separate hearings with different goals and expectations.
- Paper Reviews, Waived Hearings, Untimely Orders, Continuances – In some areas of the state, judges have completed paper reviews which does not include any of the parties and it is not considered a court hearing. This is not a widespread practice, but it is one that we are trying to discontinue. In terms of waived hearings, some jurisdictions routinely waive certain hearings. It is unclear whether all parties were consulted, or if this has become the standard practice. Some judges do not issue their orders in a timely manner with some being issued many months later. In these circumstances, the previous court order is in effect and can create conflicts or prevents parties from moving forward in accessing services or achieving permanency for a child. The same can be true of continuing hearings; it can create delays in permanency or connecting families with services. This is an area ICJ staff monitor in their case reviews and assessments to see if this has an adverse effect on permanency.
- No record being made (lack of recording or reporting)
- Lack of interpreter services.

▪ HHS:

- Communication between foster families and HHS – Families told not to bring kids to court, not informed about change in dates or about the court dates, and HHS altering reports.
- HHS/Family-Centered Services (FCS) staff turnover
- Timely reports to the court – This has been an issue in many areas of the state. Reports have been filed the day before or day of a court hearing. When this occurs, the judge, attorneys, and parties have not had an opportunity to read the report. Everyone takes time away from the court hearing to read the report and sometimes this has required the author of the report to testify instead. When reports come in late, attorneys do not have time to meet with their clients before the hearing. There is no statewide standard for what is considered timely submission. As such, some judges are requesting reports be filed in real time instead of waiting for the next court hearing. This allows everyone to address issues in real time instead of delaying it for several months.
- Limits placed on professionally supervised family interactions.
- Concerns about the use of sweat patches for drug testing and accuracy/reliability of the sweat patch results.
- Lack of placement options

- Recruitment challenges for Parent Partners
- Support for Kinship placements
- Navigating ICPC and the barriers those regulations can create for potential placements
- Lack of or long waiting lists for mental health services in rural areas

▪ <u>General:</u>

- Lack of services (quality, specialization, and accessibility)
- Children and youth not in court
- People do not understand that the court process can be adversarial if parties are not in agreement
- Lack of involvement by Parent Partner
- Adoption and guardianship changes
- The need for regular meetings between Service Area Managers (SAMs) and Chief Juvenile Court Officers (JCOs) regarding dual system youth
- State Public Defender (SPD):
  - Lack of attorneys and high caseloads
  - Guardian ad Litem (GAL) reports – Some reports are complete and add valuable information and others are incomplete or do not provide any new information. The added work has caused GALs covering many counties to cut back on workload. Among the added work, GALs have also experienced issues with attorney reimbursement and quality of representation.

o Each meeting also identified local needs that could be addressed, such as lack of interpreter services and redesigned court scheduling.

o After these meetings, Iowa's judicial branch began working on issues that were related to the court. Some examples of this include connecting the court's statewide coordinator for interpreter services with the area of the state that raised this issue and separating permanency and termination hearings. Chief Justice Christensen issued an order regarding remote hearings and as mentioned previously, there is a task force on remote proceedings. The Executive Director of Iowa's Judicial Branch has been meeting with the judges in each judicial district and plan to discuss the possibility of joint meetings between the judicial branch and HHS in the near future.

o Chief Justice Christensen and Director Garcia expect local judicial branch and HHS leaders to continue these regular meetings with all of the local stakeholders in order to develop and maintain ongoing communication and collaboration.

▪ Various judicial system stakeholders participated in the Change and Innovation Agency (C!A) Child Protective Assessment, described above, with their feedback incorporated in other sections of the CFSP.

▪ Judges participate in a variety of multidisciplinary committees and councils, which provided information for the CFSP, and activities for improvement discussed in other parts of the CFSP. For example, judges participated in CIP activities, Safe Babies Court Team, and Citizen Review Panel.

▪ HHS continues to have a memorandum of understanding (MOU) with the Office of the State Public Defender (SPD) for legal representation of children and parents at all stages of child welfare proceedings, including pre-petition.

- Juvenile Court Services (JCS) continues to participate in Iowa's Title IV-E Prevention Services and Programs Plan (Plan), including providing required data for federal reporting. Through its participation in the Plan, JCS anticipates accomplishing a number of goals. These goals include increasing JCOs ability to identify youth at greatest risk of out of home placement, increasing JCOs ability to match youth's needs to evidence based services, reducing recidivism, out of home placement, and trauma, improved community safety, and increased family engagement.

  Additionally, JCS utilizes foster care placement options provided by HHS. Continued collaboration with HHS occurs to improve these services for all children who must utilize them.

Additional Collaboration

Child Welfare Partners Committee (CWPC): The Child Welfare Partners Committee (CWPC) exists because both public and private organizations recognize the need for a strong partnership. It sets the tone for the collaborative public/private workgroups and ensures coordination of messages, activities, and products with those of other stakeholder groups. This committee acts on workgroup recommendations, tests new practices/strategies, and continually evaluates and refines its approaches as needed. The CWPC promotes, practices, and models the way for continued collaboration and quality improvement. The vision of the CWPC is the combined experience and perspective of public and private organizations provide the best opportunity to reach our mutual goals: child safety, permanency, and well-being for Iowa's children and families. Collaboration and shared accountability keep the focus on child welfare outcomes. The CWPC unites individuals from Iowa HHS and private organizations to create better outcomes for Iowa's children and families.

Through collaborative public-private efforts, a more accountable, results-driven, high quality, integrated system of contracted services is created that achieves results consistent with federal and state mandates and the Child and Family Services Review (CFSR) outcomes and performance indicators.

The committee serves as the State's primary vehicle for discussion of current and future policy/practice and fiscal issues related to contracted services. The committee proposes, implements, evaluates, and revises new collaborative policies and/or practices to address issues identified in committee discussions. Both the public and private child welfare organizations have critical roles to play in meeting the needs of Iowa's children and families. A stronger public-private partnership is essential to achieve positive results. The committee meets monthly throughout the year.

Over the next five years, the CWPC will continue to work on identifying gaps in services, policies, and communication while collectively working toward an outcome to address those concerns.

As membership terms expire on the CWPC, selection of new members occurs to maintain the balance of public and private representation. All new members receive orientation to the CWPC including membership roles/responsibilities/expectations, history of the CWPC, and products developed out of the workgroups.

Information on the CWPC is available at https://hhs.iowa.gov/about/advisory-groups/cwpc.

Recruitment, Retention, Training and Supports (RRTS)

Iowa child welfare systems are engaged in substantial, ongoing, and meaningful collaboration to accomplish the goals of protecting children, promoting healthy families, and encouraging personal responsibility. Collaboration was a major theme which drove the objectives and strategies of the previous RRTS CFSP and a focus on collaboration will continue to drive the Iowa RRTS plan for the next five years.

RRTS Contractor, Four Oaks Family Connections recognizes the importance of engaging families, youth, community organizations and other state contractors to work together in addressing the safety, well-being and permanency needs of the children in the child welfare system.

They engage Iowa foster, adoptive and kinship providers by providing direct service in their homes for licensing and support, having monthly contact at a minimum for all licensed foster homes. These contacts include face-to-face and virtual meetings in their homes, as well as additional face-to-face or virtual contacts at support group meetings and trainings. Resource families are additionally engaged with their support caseworkers by using the methods determined to be most convenient for that specific family. Those may include e-mails, phone contacts or messaging.

Over the past two years there has continued to be increased levels of collaboration and partnership between the RRTS contractor, HHS, and resource families. HHS leadership partnered with judicial system leadership to conduct in-person and virtual “listening sessions” in multiple locations around the state. Contractors, resource families, providers, and stakeholders were invited to attend and share their ideas, experiences, concerns, and suggestions. This intentional demonstration of public/private partnership prefaced a waterfall of collaboration opportunities at every level of the child welfare system.

A key priority for collaboration continues for relative/kinship caregivers. Four Oaks Family Connections personnel meet monthly with agencies/organizations providing Kinship Navigator services, a voluntary participation program offering relative/kinship caregivers who have children placed with them a Navigator to provide information, support, and referrals to stabilize the placement. While providing this service, the RRTS provider works with the relative/kinship caregivers to encourage them to become licensed foster care providers, or to assist them in engaging with the initial home study evaluation process to obtain an adoption approval. Meetings between Four Oaks Family Connections and Kinship Navigators are utilized to trouble-shoot problems or barriers with the process to licensure/approval and to discuss specific caregiving families and the supports/resources they will likely need.

HHS is currently in the process of developing a work group to begin the discussion/development of a separate set of licensing or approval standards for relative or kinship foster family homes in response to ACYF-CB-PI-23-10. These new standards would be different from the standards used for non-relative foster family homes.

Four Oaks continues to collaborate with shelters statewide. Team members consisting of shelter staff, RRTS matching staff, RRTS supervisors and leadership from both programs have ongoing discussion about the well-being and permanency needs of each youth served. This collaboration has led to transition planning discussions when youth have not found placement to leave the shelter environment. RRTS staff work closely with shelter staff and take opportunity to meet the youth if possible, making sure that the child's strengths and personality is captured so that the child is no longer just a "referral", but a child RRTS staff eagerly want to serve and locate families for.

The Managed Care Organizations (MCOs) in Iowa also assist in facilitating Managed Care Meetings for children who have higher needs and are waiting in shelter placement for extended periods to identify the additional services and programs that can be sought to better meet a child's needs and allow for placement opportunities. RRTS supervisors and matching staff regularly participate in these meetings.

Tribal connections continue to be strengthened in the Western Service Area with ongoing collaboration with the Winnebago, Omaha, Ponca, and Santee Tribes by RRTS subcontractor being involved in the Nebraska Indian Child Welfare Coalition. RRTS also continues to partner closely with Meskwaki Family Services (MFS), the social service agency of the Sac & Fox Tribe of the Mississippi in Iowa, also known as Meskwaki Nation. They assist MFS personnel in conducting pre-service training, assist with completing home study evaluations, and collaborate to provide on-going support and training for families within the Meskwaki Nation Settlement.

HHS continues collaboration with Iowa Medicaid Enterprises (IME), Mental Health and Disability Services (MHDS) and Targeted Case Management (TCM) on a Therapeutic Foster Home Pilot Project funded through the American Rescue Plan Act (ARPA). The project enhances the child welfare foster care service array, including providing highly skilled support in family settings for children placed in foster care under Iowa Code Chapter 232 and who have needs exceeding what can safely and properly be addressed in a traditional family foster home setting. Cedar Rapids Service Area was chosen for the site of the pilot due to their location and supportive services that include University of Iowa Hospitals and Clinics and Foundation 2 Crisis Support Services.

The TFC program emphasizes Medicaid home and community-based services (HCBS) to support foster care youth at high risk for institutionalization or multiple placements. The array of services identified in the pilot includes the following:

- Behavioral Health Intervention Services (BHIS)
- State plan Habilitation Services
- In-home family therapy
- Applied Behavioral Analysis (as appropriate)
- Crisis Services
- Family Peer Support
- Respite
- The HCBS Waiver that is most appropriate to the child's needs.

Specific homes identified for TFC began the required additional training in September of 2023. As of March 15, 2024, five foster homes are licensed specifically for TFC, three families are licensed to provide respite at a TFC level, and four children have been placed.

The Bridge Meetings/Comfort Calls were a collaboration between HHS and RRTS staff with a mutual goal of helping to meet the basic needs of youth and families during the transition into foster care. This initiative is another example of the critical collaboration between HHS and RRTS in strengthening the service delivery, communication/feedback loops, and the development of trainings and initiatives. Bridge meetings began as a pilot in two service areas and transitioned statewide March 2024.

Bridge Meetings are held to begin the process of creating a relationship between the parents and the foster parents. Bridge Meetings also provide an opportunity for the parent to share information about their child to the foster placement so the foster placement may better support the child. The goal of HHS is to encourage and continue to develop ways for the parent/guardian and the foster parent to have a relationship that is child focused.

A relationship between the foster parent and child's family allows for the foster parent to better care for the child and provide support to the family, if needed. It is anticipated that Bridge Meetings will also reduce the number of placement changes for a child and increase the family's engagement in family interactions. A Comfort Call is a phone call facilitated by HHS and includes the child's family and the placement within 24 hours of placement, though it is best to occur at the time of placement. The Comfort Call provides an opportunity for the child to talk with their family and for the family, placement, and HHS to have a brief conversation regarding the child's medical information, allergies, routines, and to share any other information which might help the child transition into their new setting. This is also an opportunity for the HHS worker to set up the Bridge Meeting. The Bridge Meeting provides an opportunity for the child's family and foster parents to meet and talk about the needs of the child. The meeting will be facilitated by the social worker case manager and lasts about 30 – 40 minutes. The meeting will be held at a place convenient for both the child's family and foster parents. The Bridge Meeting must be held within five business days of the child's removal.

The Foster and Adoptive Advisory Council of Iowa continues to develop into an essential collaboration as the voice for resource families of Iowa. Members of the council consider minimum participation as a one-year time commitment, bi-monthly phone/Zoom conference calls, and follow up time to volunteer to research items requested. The advisory council group was developed to be diverse and represent all areas of foster/adoptive/kin care. Urban and rural, seasoned, and new, and culture/families of color/LGBTQI+ and disabilities were also considered.

The advisory council's current priorities include:

- Advocating for greater access to quality dental care for children in foster care and those who have been adopted.
- Creating and improving a multi-tiered approach to communication from HHS and Four Oaks to foster and adoptive families.
- Recruitment for prospective foster families and champion current foster and adoptive families.

HHS continues to meet monthly with statewide foster care licensing staff and Four Oaks to discuss practice and policy issues and with Service Area Leadership and Four Oaks and subcontractors on a quarterly basis to discuss performance measures and diligent recruitment efforts.

HHS will begin implementing Town Halls for foster parents beginning in May 2024. The goal will be to update foster parents on HHS matters related to foster care and adoption. It also provides foster and adoptive parents a platform to express their concerns, share their experiences and have their voices heard. Town Halls specific to foster parents will be bi-monthly. The first Town Hall will be facilitated by HHS leadership and a community partner representative from Foster Squad. Foster Squad is an organization that provides resources to Iowa foster families. They have also been very involved with legislative changes for foster families.

Disproportionality/Disparity in the Child Welfare System

Statewide Cultural Equity Alliance Steering Committee (CEASC)

The primary purpose of the committee is to develop recommendations for implementing systemic changes focused on reducing minority and ethnic disproportionality and disparity in the child welfare system. This statewide collaborative includes the following representatives: HHS (leadership and field staff), providers, courts, Parent Partners, foster care alumni, immigrant and refugee services, other child welfare partners, domestic violence agencies, juvenile justice, race and ethnic diversity and inclusion advocates.

In 2016, upon CEASC recommendations, the Department officially adopted fifteen Guiding Principles for Cultural Equity (GPCE) as a framework for moving the equity focused efforts forward. The committee based the GPCE on the Office of Minority Health national standards for Culturally and Linguistically Appropriate Services. The CEASC updated its mission and vision at the June 2020 meeting to reflect the continued sense of urgency around pursuing racial and cultural equity. The updated statements are as follows:

- Vision: Eliminating racism and achieving racial and cultural equity in Iowa's child welfare system.
- Mission: Create an antiracist and culturally responsive child welfare system through growth of an equity focused workforce, cross sector collaboration, and policy and practice reform to eliminate disproportionality and disparity in Iowa's child welfare system.

The adopted Guiding Principles for Cultural Equity provided the framework for strategic action planning to:

- Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service areas.
- Provide effective, equitable, understandable, and respectful quality supports, services and interventions that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy and other communication needs.
- Establish culturally and linguistically appropriate goals, policies, and accountability practices, throughout the organizations' planning and operations.

All strategies focus on the collection and maintenance of accurate and reliable disaggregated data to monitor and evaluate the impact of principles on equitable outcomes to inform service delivery.

<u>The following summarizes the work of the CEASC and work groups</u>:

- **Training and Workforce Work Group**:
  - The goal of this workgroup is to:

        - Recruit
        - Retain
        - Promote a culturally and linguistically diverse governance, leadership, and workforce that is responsive to the communities served.
    - The specific focus areas are workforce support enhancements, training, and learning.
    - Implemented requirements for all child protection staff to attend Race: The Power of an Illusion (RPI) training.
    - Continued to review existing training and to make recommendations to strengthen culturally responsive components within these trainings.
    - Reviewed SW 020 training curriculum for new HHS Social Work Case Managers to facilitate incorporation of an equity lens to align with core competencies for the SW 020 training.
    - Recommended a comprehensive review of all HHS trainings for SW 2s, 3s and Supervisors to ensure that social workers are trained in the knowledge and skills necessary to effectively engage with families of all cultures and races.
    - Researched ways to recruit and retain staff to reflect the minority population served.

    This workgroup is currently not meeting, due to the recent realignment within HHS. Training and workforce workgroup shall continue to meet once the Office of Health Equity (OHE) is able to ground the CEA.

- **Practice Work Group**:
    - The goal of this workgroup is to provide:
        - Effective, equitable, quality supports, services and interventions that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy and meets overall communication needs.
    - Facilitated brainstorming exercises to identify focus areas for the group to address their efforts.
        - Identified themes, discussed the scope of possible activities, and further developed a tracking spreadsheet to organize the team's work.
        - Identified themes included growing trust with communities, communicating well, and being accountable.
    - Identified focus area to set best practices with prioritized communities led to a facilitated review of linguistic related policy and resources available to HHS child protection staff who facilitate child protection assessments and staff who provide ongoing case management to families involved in the child welfare system.
        - Included review of the Non-Discrimination Policy and facilitated input from HHS child protection staff and community organizations who support parents and families who may intersect with the child welfare system and English is not their first or preferred language.
    - Developed and implemented a statewide survey to understand statewide utilization of interpreter and translation services and telephone-based resources.
    - Researched resources and tools to provide staff guidance while working with immigrant and refugee populations.
    - Monitored access, continued to disseminate and develop additional CEA Resources.

Recommendations were provided to the Child Welfare Policy Bureau and the OHE for consideration. OHE utilized this information and is currently looking to hire a Language Access Coordinator, who will be hired in Spring 2024.

- **Centering Equity Work Group**:
  - The goal of this workgroup is to:
    - Establish culturally and linguistically appropriate goals, policies, and accountability throughout the organizations' planning, operations, and outcomes.
  - Key focus areas are to:
    - Analyze
    - Understand
    - Effectively use equity data
    - A fusion of an equity lens across child welfare
  - Continued exploration of the ways in which various state agencies collect and use information on race and ethnicity to determine the feasibility of refining existing race and ethnic categories.
  - Supported the development of the CEASC strategic plan to frame current and future equity efforts statewide.
  - Developed analytical disparity/disproportionality tools to understand child placement and distance from their home, which became available at the service area level.
  - Provided guidance to County Equity Teams, the Cultural Equity Alliance, and other community partners of the local county data and promoted utilization of the public facing HHS child welfare dashboard and how to better disaggregate the data by key areas of placements, intakes, removal rate (per 1000), re-entries to foster care, and repeat maltreatment.

Summary of Resources Developed in Partnership with CEASC

Since 2012, development of the following collaborative learning resources occurred, except for Race: The Power of an Illusion (RPI):

- *Guiding Principles for Cultural Equity:* The Cultural Equity Alliance developed and promoted the Guiding Principles for Cultural Equity GPCE to provide the HHS and its partners with a framework for reducing disparities in the child welfare system. The Guiding Principles represent culturally and linguistically appropriate services, when strategically implemented, that promotes equity for families in the child welfare system. Please see Attachment 1B.
- *Race: The Power of an Illusion (RPI) Learning Exchange:* *Race: The Power of an Illusion Learning Exchange* is a 1-day learning exchange designed to increase understanding of the intersections of race, equity, and child welfare. In a safe environment, community partners, colleagues and stakeholders in the child welfare system gather to explore a historical context of race and child welfare, current data, and develop shared terminology to have courageous conversations about how the notion of race affects attitudes, beliefs, and behaviors. Please see Attachment 1C.
- *Continuing Courageous Conversations (CCC):* *Continuing Courageous Conversations - Race: The Power of an Illusion (RPI)* follow-up meeting is an initiative developed to meet the requests of RPI attendees for an opportunity to build ongoing community conversations.
- *Toolkit for Courageous Conversations:* The *Toolkit for Courageous Conversations*, developed in conjunction with the University of Iowa, provides a resource "kit" with ideas, exercises, and activities to increase global cultural knowledge and skills, and capacity for courageous conversations around race and ethnicity, within a group or agency. Toolkit

activities guide participants through learning exercises in 20 - 45 minutes at HHS staff meetings, community gatherings, schools etc. Please see Attachment 1D.

- *SW 020 and CP 200 Trainings:* Cultural equity focused presentations were developed from the ICER presentation to incorporate into the HHS Social Work Case Manager (SWCM) training (SW 020) beginning in SFY 2023.
    - Trainings occur every other month by the Cultural Equity Manager from the Office of Health Equity (OHE) for new social workers
    - Currently OHE is working with ISU and HHS trainers to update the content in both trainings.

- *Cultural Equity Resources Assessment*
  HHS partnered with the AmeriCorps Partnering to Protect Children (APPC) program for a graduate level student in the APPC program to complete a Cultural Equity Resources (CER) Assessment as a cross look at both County Equity teams and Community Partnerships for Protecting Children (CPPC) sites knowledge of and utilization of the Cultural Equity Resources. The CER Assessment comprised of surveying and interviewing Day to Day Managers for County Equity Teams and Coordinators for CPPC sites, as well as HHS leadership and partners and provided a deeper dive into how effective cross team collaboration and community engagement has occurred across the state in equity work efforts within HHS and extending through communities.

  Key recommendations from the CER Assessment included:
    - Greater collaboration between Equity teams, CPPC teams and other community or system specific equity initiatives to identify common membership, goals, or strategies and resources.
    - Ensuring leadership support from HHS and CPPC for consistent investment in the goals and action of teams when membership leadership or needs change.
    - Engagement, and forward movement of key relationship building with local communities disproportionately overrepresented in the child welfare system decision points entering care to better inform policy and practice change on a local and statewide level as it relates to localized data, resources, and organizations.
    - Incorporation of small practice changes in plan-do-study-act (PDSA) rapid cycle tests to inform broader practice impacts or policy changes needed to address disproportionality and disparity.
    - Increasing awareness and support for advancing effective utilization of the Cultural Equity Resources.
- *Cultural Equity Resources Facebook:* The Cultural Equity Resources for Iowa Facebook Page provides easily accessible and current information, such as data, research, training opportunities, and publications focused on disparity and disproportionality in the child welfare system and other intersecting systems. The Cultural Equity Resources Facebook page was re-routed to the HHS social media page in SFY 2024.

Understanding Implicit Racial Bias:

This Learning Exchange, a full day interactive training developed by the HHS' Family Well-Being and Protection Division in collaboration with Dr. Chris Martin of St. Ambrose University, the RPI Facilitators, the Cultural Equity Alliance, and HHS, engages participants as they:

- Discuss terminology and definitions related to implicit bias, particularly racial bias.
- Understand how stereotypes contribute to implicit racial bias formation.
- Recognize implicit bias in individual self and work.
- Learn how implicit bias is measured.

- Use learning to recognize bias in decision making and its impact on others; and
- Develop a change plan to implement with accountability partners.

While *Understanding Implicit Racial Bias* (UIRB) is for HHS staff, this learning exchange benefits others including child welfare stakeholders, law enforcement, legal and judicial community, families, education staff and students, faith-based, and other primary prevention partners like CPPC, etc. Since implicit bias permeates our society, the UIRB Learning Exchange is beneficial for any person interested in expanding their knowledge and understanding of implicit bias development, impact on decision-making and interventions to self-assess and address those biases.

Currently, there is a pause on the UIRB training, due to needed updates. The training includes some outdated statistics and there have been some discussions centered around updating content.

Though utilization of UIRB as a "stand alone" training is permissible, the recommendation is that participants have a basic understanding of racial inequities and injustice. Often participants will have previously attended HHS' *Race: The Power of an Illusion* Learning Exchange (RPI) or other foundational trainings which introduce participants to basic racial history, terminology, and concepts.

Introduction to Cultural Equity Resources (ICER)

This is a 1–2-hour orientation to the resources developed and supported by HHS' Family Well-Being and Protection Division to engage participants as they:

- Learn about and explore the learning exchanges available to attend or host. This includes *Race: The Power of an Illusion* and *Understanding Implicit Racial Bias*.
- Examine key data points around cultural and racial equity nationally and in Iowa, such as via the HHS Child Welfare Dashboard.
- Practice utilization of activities through the Courageous Conversations Toolkit.
- Understand, promote, and incorporate the Guiding Principles.
- Promote utilization of online learning and resources such available trainings and social media.

The Introduction to Cultural Equity Resources (ICER) was developed in 2019 as a presentation to promote full utilization of the cultural equity resources developed. The ICER is for child welfare staff and community partners whose services and populations intersect with the HHS and includes child welfare partners, law enforcement, legal and judicial community, families, early childhood, and education staff, faith-based, etc. These ICERs were offered virtually and in person, and focus on an overview of cultural equity resources, building cultural competency, centering child welfare equity data to audiences in attendance, and considering the next steps, such as hosting additional training and courageous conversations within communities.

Breakthrough Series Collaborative (BSC)

The Iowa Breakthrough Series Collaborative (BSC) is composed of ten local community teams from across the state. Teams meet regularly in their local service areas to develop, implement, and track efforts to reduce disproportionality and disparity for children and families of color. The success of the BSC model is contingent on stakeholder engagement and shared leadership by the team core members. Core members of the BSC team are responsible to work together to develop and rapidly test strategies designed to improve a prevailing issue and practice challenge in child welfare. All team members engage in the development process, testing,

improving, implementing, and spreading successful strategies. Teams share lessons learned via phone conferences and annual meetings called Learning Sessions. Core membership for a BSC team is composed of a minimum of eight (8) individuals including, but not limited to the following:

- HHS Social Work Administrator
- HHS Social Work Supervisor
- HHS Social Worker 2 and/or 3
- Judge
- Court Partner (i.e. county attorney, guardian ad litem, etc...)
- Parent Representative (usually a Parent Partner)
- Young Adult Representative (current or former foster care youth, usually a member of Achieving Maximum Potential (AMP))
- Child Welfare Services Community Partner (usually a local child welfare services provider)

In addition to the core membership identified above, most teams have team members representing the areas of law enforcement, education, mental health, domestic violence, substance abuse, and/or the faith-based community.

For the year 2024, BSC will be paused due to the realignment happening within HHS. The plan is to continue the learning series beginning in 2025, which will allow HHS more time to regather, and to get on back on track.

County Equity Teams:

Annually, the ten County Equity Teams are provided statewide and county specific data packets regarding statewide child population by race (two or more races, African American, Asian, American Indian and Alaskan Native, Native Hawaiian, and Pacific Islander, and White) and by ethnicity (Hispanic and non-Hispanic) based on Woods and Poole data 0-17. Central HHS Quality Assurance/ Improvement office provides disaggregated data specific to the following decision points:

- Accepted referrals: Number of children involved in accepted (screened-in) for investigation or assessment.
- Victims of abuse: Number of children of substantiated or indicated (confirmed or founded).
- In Foster Care: Number of children in out-of-home placement anytime during the state fiscal year, as reported in the AFCARS file.
- Entered Foster Care: Number of children entering during the state fiscal year.
- Exited Foster Care: Number of children who discharged during the state fiscal year.

County Equity Teams Include:

- Polk County
- Scott County
- Des Moines, Dubuque, and Scott Counties
- Woodbury County
- Blackhawk County
- Webester County
- Johnson County
- Linn County
- Wapello County

Due to the transition within HHS, some of the equity teams are continuing to meet and are actively engaged in projects. Other equity teams are requesting support as they are not meeting regularly. OHE would like to continue to see the equity teams to meet on a regular basis. OHE is hoping to be able to identify additional supports for our local teams.

AACCT Project

The African American Case Consultation Team (AACCT) is a team of community representatives who identify as African American to provide consultation and case review with HHS staff in Polk County regarding child welfare cases involving African American children and families to reduce child/family separation, increase reunification, and address causes of disparities. Since its inception in October of 2014, and the result of a PDSA after a series of Courageous Conversations in Polk County in the Spring of 2014, this effort has been a joint project for HHS leadership, Decategorization (DECAT) staff and community volunteers.

The Polk County Equity Team created a strategic plan through funding from Casey Family Programs in 2021 to further develop the program, enhance data collection processes and case documentation, recruit membership and provide orientation to new members, provide compensation for volunteer community representatives time, and increase awareness of the AACCT among HHS and community members through marketing materials and provide team training.

A key goal of this project was to develop a system of data collection that can be maintained and updated to assure that goals are being met, and to provide training to team members and to HHS supervisors and workers to address vicarious trauma and issues that impact disproportionality and disparate treatment of workers of color and children and families of color.

Successes of this project include:

- Creation of team member orientation packet and team member/informational brochure about the project
- Updated case referral document
- Updated case consultation template
- Process for sign up and tracking of case referrals.
- Continued regularly held monthly staffing's despite HHS staff and team member changes/attrition.
- Development of a data tracking tool to track on staffed cases.
- Team member training and development opportunities
- In calendar year (CY) 2022, the AACCT team consulted on 16 cases, and in CY 2023 the team consulted on 12 cases.

Strengths: For more than ten years, Iowa's child welfare system focused on efforts to reduce disproportionality and disparities. In the past ten years, the BSC teams developed many initiatives and strategies across the state through the Plan-Do-Study-Act method. Additionally, the CEA promoted the development of additional learning exchanges through *Race: The Power of an Illusion* and *Understanding Implicit Racial Bias* to inform practice and policies impacting minority communities across the state. There has also been a commitment to building out additional resources for child welfare workers and partners to be able to access necessary information to apply an equity lens to the way in which they engage and serve families. The CEA continues to meet bi-monthly with HHS employees and community partners coming to each meeting.

Opportunities for Improvement: There has been a lot of transition within HHS, during this realignment it left the CEA with some uncertainly as to what direction it will be going. At this time the CEA is now under the Office of Health Equity (OHE), OHE is continuously working to develop a new plan for the CEA. OHE is currently reviewing the mission statement, goals, and projects that have come out of this committee. The commitment to continue the CEA is of the utmost importance to ensure that, disaggregation of child welfare data occurs to continue to assess disproportionality and disparities in practice and policy. This can occur through annual Learning Sessions, strengthening and supporting the local BSC teams across the state.

Please see the following sections in this CFSP for additional stakeholder feedback:

- *Section II, Assessment of Current Performance in Improving Outcomes*
- *Section III, Plan for Enacting Iowa's Vision*
- *Section IV, Services*
- *Section V, Consultation and Coordination Between States and Tribes*

HHS will utilize existing collaborative venues mentioned above and throughout this CFSP to engage stakeholders in the implementation of the goals and objectives and monitoring and reporting of CFSP progress. HHS' Director Garcia and staff also engage and will continue to engage stakeholders, such as internal staff, service providers, judicial community, communities at large, etc., through Town Hall Meetings held every other month. In the future, HHS may utilize focus groups, electronic surveys, and other means to gather qualitative information for continued evaluation of CFSP progress.

Section II: Assessment of Current Performance in Improving Outcomes

In the 2025-2029 CFSP, the state must identify strengths and concerns related to performance on each outcome and systemic factor, including evidence of disproportionality and disparities in services and outcomes. States are encouraged to include an analysis of data regarding significant areas of concern, with particular focus on those areas that may impact goals, objectives, interventions and target populations. For each outcome and systemic factor, states must provide a brief update on any current or planned activities targeted at improving performance or addressing areas of concern identified.

CHILD AND FAMILY OUTCOMES

Case Reviews

Iowa continues to complete case reviews in teams of two, consisting of a Supervisor and Quality Assurance and Improvement (QA&I) Coordinator; each team reviews cases based on a random statewide sample. Iowa completed the Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP) as of December 31, 2023. To understand the most current performance trends and rationale for prioritization of goals, context is provided below through data reflecting performance over time.

Table 2a: Case Reviews						
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022) ****	**SFY 2022/2023 (4/1/2022- 3/31/2023) ****	**CY 2023 (Performance as of end of PIP 1/1/2023 - 12/31/2023)****
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.						
1: Timeliness of Initiating Investigations of Reports of Child Maltreatment	71%	72%	76%	82%	64%	61%
Safety Outcome 2: Children are safely maintained in their homes, whenever possible and appropriate.						
2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care	86%	36%	67%	80%	79%	85%
3: Risk and Safety Assessment and Management	51%	33%	43%	46%	52%	51%
Permanency Outcome 1: Children have permanency and stability in their living situations.						
4: Stability of Foster Care Placement	80%	77%	61%	83%	83%	68%
5: Permanency Goal for Child	85%	73%	80%	88%	85%	95%
6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	60%	53%	63%	70%	73%	75%
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.						

Table 2a: Case Reviews						
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022) ****	**SFY 2022/2023 (4/1/2022- 3/31/2023) ****	**CY 2023 (Performance as of end of PIP 1/1/2023 - 12/31/2023)****
7: Placement with Siblings	88%	72%	92%	74%	96%	96%
8: Visiting with Parents and Siblings in Foster Care	74%	54%	62%	83%	72%	82%
9: Preserving Connections	63%	67%	85%	88%	98%	88%
10: Relative Placement	78%	69%	84%	86%	87%	84%
11: Relationship of Child in Care with Parents	66%	73%	72%	82%	77%	84%
Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.						
12: Needs and Services of Child, Parents, and Foster Parents	45%	35%	45%	57%	62%	62%
▪ 12A: Needs Assessment and Services to Children	66%	63%	68%	82%	83%	77%
▪ 12B: Needs Assessment and Services to Parents	44%	37%	54%	59%	68%	67%
▪ 12C: Needs Assessment and Services to Foster Parents	85%	66%	72%	89%	87%	70%
13: Child and Family Involvement in Case Planning	49%	42%	53%	64%	80%	80%

Table 2a: Case Reviews						
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022) ****	**SFY 2022/2023 (4/1/2022- 3/31/2023) ****	**CY 2023 (Performance as of end of PIP 1/1/2023 - 12/31/2023)****
14: Caseworker Visits with Child	51%	35%	43%	55%	71%	59%
15: Caseworker Visits with Parents	25%	24%	30%	44%	54%	49%
Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.						
16: Educational Needs of the Child	84%	85%	86%	88%	89%	89%
Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.						
17: Physical Health of the Child	59%	37%	52%	63%	55%	52%
18: Mental/Behavioral Health of the Child	56%	66%	63%	64%	58%	50%
Source: *Child and Family Services Review, Iowa, Final Report, 2018 available at https://dhs.iowa.gov/sites/default/files/IA_CFSR_Final_RPT_2018.pdf?062520201554 **HHS Case Reviews utilizing standardized process for period of time indicated.						

CFSR case reviews continued through December 31, 2023 when Iowa's PIP period ended. Iowa implemented multiple strategies throughout the PIP period, targeting identified focus areas from the most recent on-site review held in 2018; these strategies resulted in improved performance as evidenced through the case review data. Iowa has successfully met the following PIP targets:

- Timeliness of face-to-face contact (item 1);
- Safety and Risk Assessment and Management (item 3);
- Stability of Foster Care Placement (item 4);
- Appropriate and timely permanency goals (item 5);
- Efforts to achieve timely permanence (item 6);
- Assessment and services to children, parents, and foster parents (item 12);
- Child and family involvement in case planning (item 13);
- Worker visits with children (item 14); and
- Worker visits with parents (item 15).

Safety Outcome 1

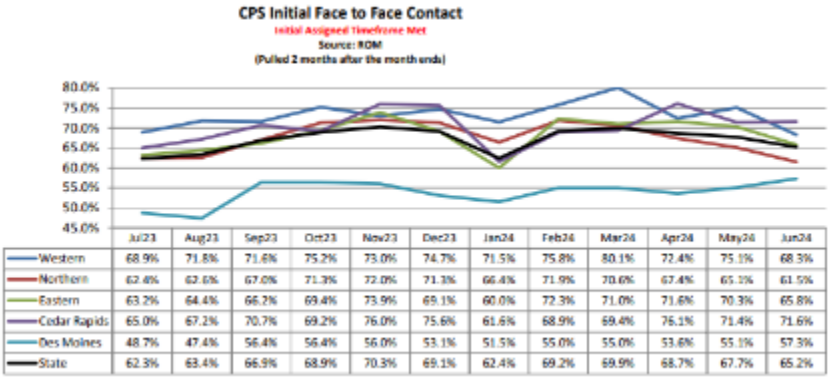
Timely Face to Face Contact with Child Victim(s) (Item 1)

Iowa met the PIP goal for this item at the end of SFY 2021 at 82%; since that time, there has been a decrease in performance, most recently (as of 12/2023) reporting 62%. When analyzing reasons for the decrease, the primary reasons were found to be:

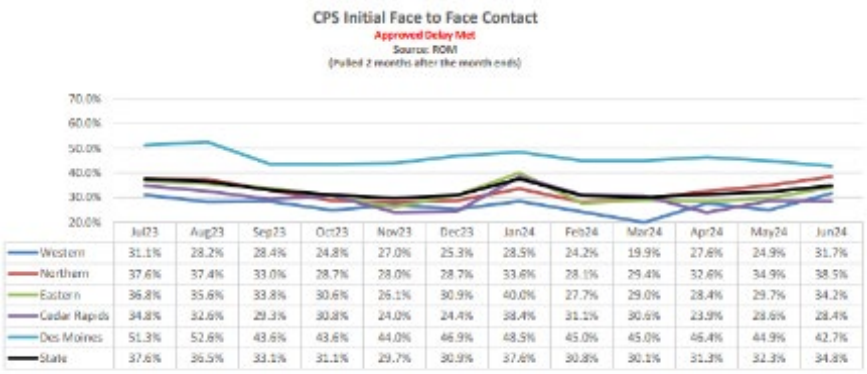
- An initial delay was approved by the supervisor, but the face-to-face follow up to that was not timely (21%)
- Not using all resources available to locate child(ren) (21%).

As part of a PIP initiative, Iowa clarified guidelines around delays in the contact to include specific timelines for communication between the social worker and the supervisor as well as expectations for follow up with the family; previously there was no standard protocol. This change in practice that was made in mid-2021 with full implementation being seen in performance during the reviews conducted in 2022; the decrease in performance data reflects the increased expectations in practice and is not unexpected. Iowa anticipates improvement in this area as the practice becomes standardized and integrated; monitoring will continue to assure this occurs.

Iowa also monitors administrative data regarding timely face to face contacts of alleged child abuse victims. That data is split between those contacts that meet the initial assigned timeframe and those that do not meet that timeframe but have received supervisory approval for delay.



	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	Feb24	Mar24	Apr24	May24	Jun24
Western	68.9%	71.8%	71.6%	75.2%	73.0%	74.7%	71.5%	75.8%	80.1%	72.4%	75.1%	68.3%
Northern	62.4%	62.6%	67.0%	71.3%	72.0%	71.3%	66.4%	71.9%	70.6%	67.4%	65.1%	61.5%
Eastern	63.2%	64.4%	66.2%	69.4%	73.9%	69.1%	60.0%	72.3%	71.0%	71.6%	70.3%	65.8%
Cedar Rapids	65.0%	67.2%	70.7%	69.2%	76.0%	75.6%	61.6%	68.9%	69.4%	76.1%	71.4%	71.6%
Des Moines	48.7%	47.4%	56.4%	56.4%	56.0%	53.1%	51.5%	55.0%	55.0%	53.6%	55.1%	57.3%
State	62.3%	63.4%	66.9%	68.9%	70.3%	69.1%	62.4%	69.2%	69.9%	68.7%	67.7%	65.2%



Between these two data points, Iowa is at 100%. Within JARVIS, the ability to gather all relevant information regarding these initial visits is limited to the basics; when the new CCWIS system is in place it will be more robust as far as determination of the reason for the delay in seeing the child and the subsequent follow up to approved supervisory delays.
Although not a formal performance measure for Iowa, we do continue to look at the frequency of use of the supervisor approved delays. As we are able to gather more aggregate information, this may be an area of analysis as to reasons for being unable to meet the initial timeframe.

Safety Outcome 2

Preventing entry to foster care (Item 2)

As of the end of the non-overlapping year for Iowa's PIP, performance on this item fell just short of the goal. In an effort to better understand Iowa's historic and current performance, a targeted review of this item was conducted by the QA&I bureau in September 2023; additional analysis on the results was completed, including comparison of the results to baseline and ongoing performance, sample size, and performance relative to implementation of key PIP initiatives. Iowa found the following:

Table 2b: Preventing entry to foster care

Dataset Timeframe:	Baseline 2018	PIP monitoring 7/1/2020-6/30/2023	Targeted Review 2023
Foster Care	10	46	51
In Home	4	19	49
DnnFC/IH Performance	100% / 50%	74% / 73%	84% / 82%
Total Reviewed	14 (10 FC, 4 IH)	65 (46 FC, 19 IH)	100 (51 FC, 49 IH)
Overall Performance	86%	63%-83%	83%

Source: HHS

PIP-Related Observations:

- Targeted review results are aligned with the performance we saw during the PIP monitoring period.
- Performance improvement in this area over time coincides with PIP-related strategy implementation; this is a strong indication that the 2018 baseline utilizing a sample of just 14 was not representative of Iowa's performance.

- Timeline of PIP initiatives and performance:
  - **2018:** Baseline established at 86% after review of 14 cases.
  - **July 2020:** PIP implementation begins, including specific timelines for key activities to be completed.
  - **September 2020 through December 2021:** CFSR case reviews conducted; Iowa performs consistently between 63% - 67% during the first six reporting periods, well below established baseline of 86%.
  - **June 2021:** PIP Strategies (SafeCare, Solution Based Casework (SBC), Safe4Home) expected to directly impact performance in this target area are fully implemented and expected to be reflected in case review data in **2022.**
  - **March 2022:** A significant and consistent improvement in performance (76% - 83%) is observed from this point on in this focus area, as expected, aligning with established timelines of PIP strategy implementation.
  - **June – December 2023:** Implementation of additional PIP strategies (ex: Safety Decision Making (SDM), Safety Plans, and Danger/Risk training) are expected to continue to positively impact performance on this focus area.
  - **September 2023:** Targeted review completed of 100 cases; 83% of those cases rated as a Strength, aligned with the new initiatives and progress seen during the PIP monitoring period.
  - **December 2023:** Deadline to meet the target performance; PIP ends, concluding CFSR Round 3.

Iowa ended the non-overlapping year with performance at 85%. Although this did not meet the 86% PIP goal, Iowa believes the analysis of the targeted review demonstrates significant improvement over time, as well as highlighting potential reliability factors when using a small point in time sample as a baseline. Due to the analysis above, Iowa considers this area a strength.

As Iowa enters CFSR Round 4, training is underway on changes to the on-site review instrument (OSRI) and criteria. The focus of this item has been slightly modified and additional clarification provided; Iowa will assess these changes and seek clarification, if needed. While we believe there is a reasonable explanation regarding not having met this PIP item, Iowa prioritizes safety of children and keeping them in their own homes whenever safely possible; as with all performance oversight, we will continue to monitor, analyze, and adjust practices if needed.

<u>Risk and safety assessment (Item 3)</u>
The PIP performance target on assessment of risk and safety for families was achieved in CY 2022. Iowa believes this is the result of ongoing training and use of guidance developed during implementation of the PIP regarding safety assessment and safety plans. Protocol regarding safety assessments requires discussion between social worker and supervisor during regular meetings; this includes reviewing the initial assessment as well as ongoing assessments, discussion of danger versus risk, safety plan effectiveness, etc. Notably, the increase in ongoing assessment coincides with increased performance regarding safety planning and ongoing monitoring of those safety plans (2018 on-site review, item 3C 65%; as of 12/31/23, 78%).

The final report data did indicate a slight decrease in performance overall on this item; review of the data indicated the decrease primarily was caused by:

- relying on family self-reporting issues rather than observations and use of collaterals; and
- incidents of repeat maltreatment related to the original reason for involvement.

Iowa implemented Safe4Home in 2021 with the goal of keeping children safely in their home environment through identification of protective strategies such as family and informal supports. Success is dependent on accurate initial and ongoing assessments. At the time of development of the PIP, Iowa noted that just 9% of cases (3/32) were rated as a strength regarding ongoing assessment during the 2018 on-site review; this was the driving force impacting overall performance on OSRI item 3. Efforts targeting safety assessment have become integrated into practice and both initial and ongoing assessment have shown improvement; this will be discussed more in the goals section of this report.

Table 2c: Item 3: Accurate assessment of all risk and safety concerns		
Timeframe of case reviews completed	**Initial Assessment**	**Ongoing Assessment**
April 2021 – March 2022	71%	57%
April 2022 – March 2023	90%	63%
Jan 2023 – Dec 2023	90%	59%

*Practice Performance Report, CFSR Portal

Current or Planned Activities to Improve Performance on Safety Outcomes 1 and 2: Please see *Section III, Plan for Enacting Iowa's Vision*.

Permanency Outcome 1

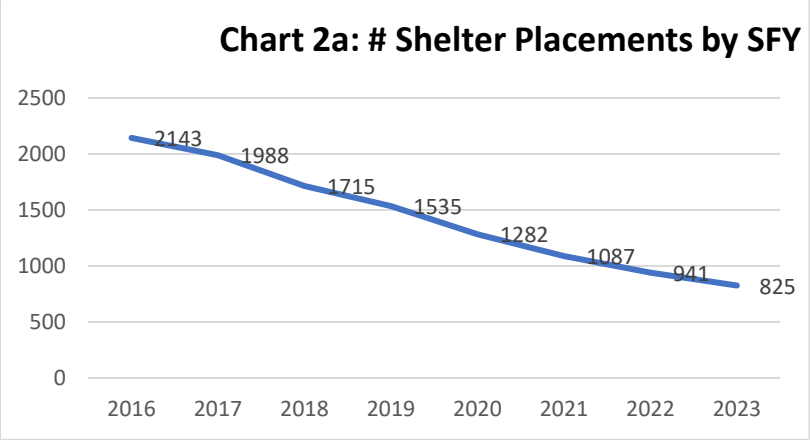
There is a current initiative (April 2024) around development of an expedited licensing process for relatives and fictive kin. Financial constraints have been a factor for many relatives' ability to open their home to care for additional children; creating a path to licensure that removes unnecessary barriers is expected to increase the pool of families able to support children needing placement and potentially the length of time they are able to be involved.

In addition, the increased involvement of relatives and fictive kin is anticipated to have a broad impact on permanency outcomes 1 and 2 in general: stability of placement, timely permanence, placement with siblings, frequent visits with parents, preserving connections may all be enhanced by engaging and supporting relatives and fictive kin. Performance in these areas is related to the state's key performance measures and are routinely monitored, analyzed, and adjusted as needed.

Placement stability (Item 4)

Federal placement stability data continues to validate that Iowa is consistently below the national performance of 4.48 moves per 1,000 days of foster care, most recently 3.77 as indicated in Iowa's 2024 Data Profile. Although it took longer to demonstrate this performance

through the case reviews, Iowa showed steady progress, successfully achieving the PIP target of 88% during the CY 2022 reporting period. Iowa continues to focus on relative and fictive kin placement at entry to care, reducing the use of shelter; as data demonstrates a steady decrease in shelter use, placement stability case review data has shown a complementary improvement in performance.



Since 2016 Iowa has consistently decreased the use of shelter, resulting in a 62% overall reduction between SFY 2016 and SFY 2023. This is believed to be a significant contributing factor resulting in Iowa's successful completion of the placement stability PIP target. Although reduction of shelter use is significant, it's noteworthy that a contributing factor to Iowa's decreased performance on this item had to do with relative placements that were intended to be short-term or temporary; while relative placement is preferable to shelter use, this indicates a continuation of a parallel practice.

Case review data for this item showed a significant decrease in performance regarding stability of placements in the most recent reporting period. A review of the sample cases indicates that primary reasons for this centered around child mental and behavioral health that foster parents were not equipped to manage; it is unknown if additional support to the foster parents may have preserved the placements. In addition, there were several situations where a child was placed with relatives who thought it was going to be short-term, but reunification did not occur as expected and the relatives could not continue as the placement. The licensing process is arduous and time consuming which can be a deterrent to family members. In order to provide supports to relative caregivers more quickly, a workgroup has designed an expedited process for certification of relatives which would allow for financial support. There are many dynamics to this process that need to be coordinated administratively and through code, but this is actively moving forward. Many families are able to make short-term adjustments to accommodate a family member in need of placement but other times there is a need to maintain a longer placement. This could be supported through this streamlined process so families have the needed funds.

Appropriate and Timely Permanency Goals (Item 5)

In May 2023, Iowa was informed this PIP item was successfully completed as of 12/31/2021 by meeting the criteria established by Children's Bureau for "high performing items"; this involved matching the baseline performance for three reporting periods. Iowa's performance in this area continues to demonstrate a positive trend. It's noteworthy that in the last two reporting periods, Iowa demonstrated 95% performance on appropriate and timely permanency goals.

Iowa reviews 40 foster care cases per year; while performance is high, a trend of waiting to discuss concurrent planning with families was identified. This delay led to inefficient use of the time available to be working with the family on a contingent plan. Iowa actively promotes an environment of continuous improvement, including work groups of Field representatives to address prioritized focused areas; multiple work groups that were focused on areas about concurrent planning (example: the transfer process between an ongoing case manager to an adoption case manager) identified this as an area that could be streamlined to shorten the time to permanency for children. This feedback and case review observations led to facilitation of a Lean process targeting concurrent planning, held in June 2023. Specific practices around timeframes for exploring concurrent planning, what this could look like, benefits to achieving permanency, and communication with involved participants have been developed as well as ongoing monitoring of performance.

Timely Permanency (Item 6)

Iowa met this item at 71% during the first PIP reporting period and has continued a positive upward trend; most recently, performance for CY 2023 was reported at 75%. Iowa has continued to focus on timely permanency through evaluating process steps for: successful reunification, the handoff of information from the ongoing case manager to the adoption case manager, and, most recently, standard expectations and guides for concurrent planning. All these initiatives work together to continue promoting timely permanency for children. In addition to case review data, federal measures for permanency are also monitored; Iowa continues to exceed the goals for finalizing permanency within 12 months and within 13-24 months. See "Re-Entry to Foster Care" discussion for data charts relating to timely permanence.

Permanency Outcome 2

Iowa continues to demonstrate strong performance throughout Permanency Outcome 2 measures, which are closely tied with Families First initiatives. Below are several highlights, demonstrating the improvement from baseline in 2018 to the most current 12-month period prior to PIP completion in December 2023.

Placement with siblings (Item 7)

Table 2d: Item 7: Placement with Siblings in Foster Care	2018 Baseline	1/2023 - 12/2023
A. Placed with all siblings in foster care	56%	63%
B. If not placed together, there was a valid reason for the child's separation	73%	89%

Source: HHS

Visiting with parents and siblings in foster care (Item 8)

As reflected in performance throughout the CFSR case review instrument, this item shows a significant improvement in the agency's work with fathers. This was an ongoing focus area through PIP initiatives, supported through updated training focusing on a father's perspective as well as supervisory consultation. These efforts are integrated into practice and will continue.

Table 2e: Item 8: Visits between Parents and Child	2018	1/2023-12/2023
Frequency of visitation between mother and child	89%	90%
Frequency of visitation between father and child	69%	84%
Quality of interactions between mother and child	86%	93%
Quality of interactions between father and child	73%	89%

Source: HHS

Preserving Connections (Item 9)

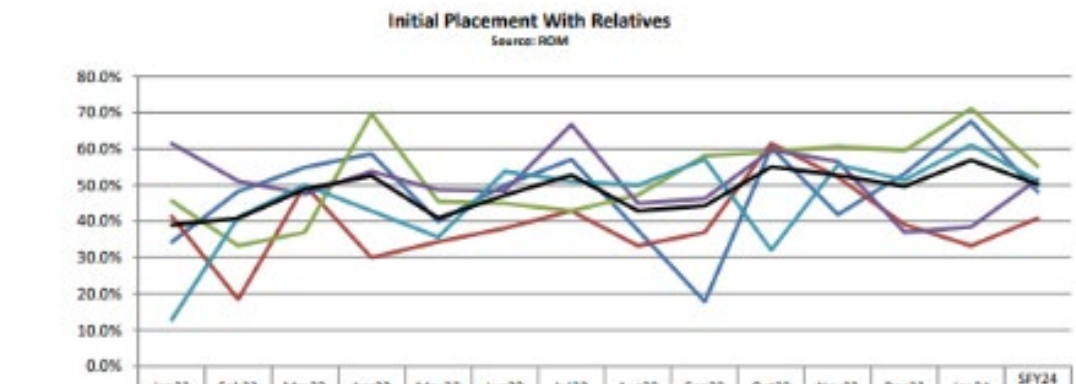
Overall Iowa has promoted maintaining the important connections of a child who resides in foster care; this has been supported by the increased use of relatives as the initial placement, which peaked in June at 60% for SFY24.

In cases reviewed in the final year of the PIP monitoring, the four that were rated ANI in this area involved children between the ages of 2-4 years old that did not have access to extended relatives as much as would have been beneficial. It was noted that these children came into foster care at an age where they had few connections established which made maintaining relative connections that much more important and the results were inconsistent. This is an additional area that could be positively impacted as we continue to increase relative placements.

Relative placement (Item 10)

Iowa monitors frequency with which children are placed with relatives, including when children are placed with relatives at the initial entry into foster care. The graph below shows consistent upward trending (Jan 23: 39%; Jan 24: 57%); this reflects the emphasis on involving non-resident parents in child welfare cases and the efforts to seek out relatives at the beginning of a foster care episode.

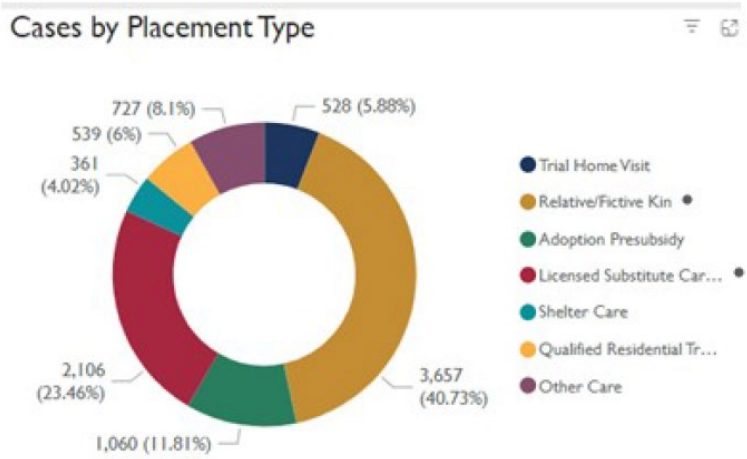
Chart 2b: Initial Placement with Relatives



	Jan23	Feb23	Mar23	Apr23	May23	Jun23	Jul23	Aug23	Sep23	Oct23	Nov23	Dec23	Jan24	SFY24 Avg
Western	34.3%	48.3%	54.9%	58.6%	40.0%	50.0%	57.1%	37.5%	17.9%	60.4%	41.9%	53.2%	67.6%	48.1%
Northern	41.4%	18.5%	50.0%	30.0%	34.4%	38.1%	42.9%	33.3%	37.0%	61.5%	52.2%	39.1%	33.3%	40.9%
Eastern	45.7%	33.3%	37.0%	69.7%	45.5%	45.0%	42.9%	47.3%	58.1%	50.1%	60.7%	59.5%	71.1%	55.2%
Cedar Rapids	61.5%	51.1%	47.6%	53.8%	48.7%	48.4%	66.7%	45.0%	46.3%	59.6%	56.5%	37.0%	38.5%	51.7%
Des Moines	12.8%	41.2%	50.0%	42.9%	35.7%	53.8%	51.1%	50.0%	57.1%	32.1%	55.6%	51.4%	61.1%	51.1%
State	39.0%	40.9%	48.9%	52.6%	40.9%	47.2%	52.8%	42.9%	44.3%	55.1%	52.7%	48.7%	56.9%	50.2%

It's noteworthy that the data above does not include fictive kin. When evaluating point in time placements in family-like settings, 64% of children are placed with a relative or fictive kin.

Chart 2c: Calendar Year 2023



*See HHS Public Dashboard

Relationship of Child in Care with His or Her Parents (Item 11)
Performance on promoting relationships with both parents has significantly improved since the on-site baseline. Of special note is the performance around the relationship between children and fathers. Iowa's PIP had multiple strategies that targeted how we could engage more effectively with fathers and, consistently throughout the PIP results we are seeing the successful results of those efforts.

Item 11: Relationship of Child in Care with His/Her Parents	2018	1/2023 – 12/2023
Concerted efforts were made to promote, support, and otherwise maintain a positive, nurturing relationship between the child in foster care and his or her mother.	78%	87%
Concerted efforts were made to promote, support, and otherwise maintain a positive, nurturing relationship between the child in foster care and his or her father.	50%	90%

Current or Planned Activities to Improve Performance on Permanency Outcomes 1 and 2:
Please see *Section III, Plan for Enacting Iowa's Vision*.

Well-Being Outcome 1

When analyzing Iowa's 2018 on-site review performance a clear trend emerged regarding lack of engagement with fathers, especially during assessment, case planning, and visits with the assigned social worker. Many key activities within Iowa's PIP focused on looking at involvement in a child welfare case through a father's perspective, the benefits of having fathers involved, and ways in which we can more effectively reach out. Data shows a significant improvement regarding father involvement, as depicted in the tables below.

Assessment and services (Item 12)
The PIP goal for assessment and services was met during the reviews conducted between January and December 2021. It's noteworthy that data comparison from the onsite review to the current reporting period indicates a significant increase in performance with fathers; this has been a primary driver in Iowa's increased performance and remains an active strategy.

Table 2f: Item 12: re Father	Assessment	Services
2018 On-site	61%	40%
Jan 2021-Dec 2021	68%	64%
Jan 2022- Dec 2022	70%	73%
Jan 2023 – Dec 2023	73%	77%

Source: HHS

Child and family involvement in case planning (Item 13)

Further aligned with the strategies around fathers, performance on engagement continues to steadily increase. Iowa attributes this to the full implementation of PIP strategies; consistent with results reported in item 12, the engagement of fathers has shown significant increase since Iowa's baseline period and is a strong contributing factor to the increased performance overall.

Table 2g: Item 13 re Father: Active involvement in Case Planning	
2018 On-site	50%
Jan 2021-Dec 2021	61%
Jan 2022-Dec 2022	78%
Jan 2023-Dec 2023	80%

Source: HHS

Iowa also believes Families First initiatives implemented in July 2020 are only now being accurately represented in the case reviews due to the retrospective period under review. It is noted that progress on involvement of families and the assessment of needs and services are running on parallel trends over the last five reporting periods, demonstrating the inter-connectedness of these items; performance in both exceeded the targets established in the PIP and are expected to continue that trend.

Social Worker Visits with Children (Item 14)

While Iowa met this item and continues to remain above the target goal, it is an area that continues to be monitored closely. Recently four focus groups were held with high performing social workers regarding visits with children and supervisors to gather information on what processes they use that make them successful. A lot of good information was gathered, much of it was around personal organizational skills and prioritization, but there was no one thing that stood out as "the answer". There were several areas communicated broadly regarding ways to prevent duplication of work, such as case notes, and sample templates that could be used for tracking. Supervisors continue to work on making tools available and highlighting ways to team together to assure visits are being completed and in a quality manner.

2018 On-site	51%
Jan 2021-Dec 2021	51%.
Jan 2022- Dec 2022	68%
Jan 2023- Dec 2023	59%

Social Worker Visits with Parents (Item 15)

Iowa met the PIP target for this item in the first reporting period at 33%; of note, performance in frequency and quality of visits with both parents significantly improved since the baseline period, until leveling out with the most recent 12-month reporting period as the table below illustrates. This overall increase in performance may be attributed to strategies, resources, and instruction regarding the importance of engaging fathers developed within the PIP.

Table 2h: Worker/Parent Visits	2018	SFY22	SFY23	CY 2023
Both the frequency and quality of caseworker visitation with the mother were sufficient.	43%	62%	69%	67%
Both the frequency and quality of caseworker visitation with the father were sufficient	44%	41%	60%	60%

*OMS: Practice Performance Report, CFSR Portal

While Iowa saw significant improvement in the engagement of fathers, this will continue to be an area monitored and discussed to assure full integration into practice norms. Overall, Iowa would like to increase the frequency and quality of social worker visits with parents; see the Goals section for additional information.

Well-Being Outcome 2

Educational needs of the child (Item 16)

Assessment and provision of educational services continues to be a strength for Iowa, currently performing at 89% based on CFSR case reviews.

Well-Being Outcome 3

Physical health of the child (Item 17)

Mental/Behavioral health of the child (Item 18)

Iowa has maintained performance on these two items since the 2018 baseline period. Identified struggles with physical health services center on dental exams, especially for very young children. Best practice is for children to get their first exam when they get their first tooth or at 12 months of age; Iowa continues to have capacity limitations for pediatric dental services which impact the ability to meet this. This is a known systemic issue for service array.

In addition, limited mental and behavioral health services for children are also known systemic issues. Iowa is actively pursuing strategies to broaden the service array and access to appropriate services specific to children's needs, thereby diverting placements not equipped to meet these needs. A process to establish a Behavioral Health Services System in Iowa supported by Gov. Kim Reynolds has recently been approved. This will combine existing mental health, substance abuse, and other recovery services into one system.

Current or Planned Activities to Improve Performance on Well-Being Outcomes, 1, 2 and 3:

- Well-Being Outcome 1: Please see *Section III, Plan for Enacting Iowa's Vision*.
- Well-Being Outcomes 2 and 3: There are no child welfare specific planned activities to improve performance. However, HHS' establishment of a Behavioral Health Services System will hopefully contribute to improved performance on Well-Being Outcome 3.

National Safety and Permanency Data Indicators

The most current data profile available on the statewide indicators is included below; where possible, additional data sources have been used to determine and explore current performance more fully.

Table 2i: Iowa Risk Standardized Performance on National Safety Data Indicators							
Indicator Name	**Indicator Description**	**National Performance Requirement**	**FFY 2017-2018***	**FFY 2018-2019***	**FFY 2019-2020****	**FFY 2020-2021****	**FFY 2021-2022****
Recurrence of Maltreatment	Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month period, what percent were victims of another substantiated or indicated maltreatment report within 12 months of the initial victimization?	9.7% or less	18.4%	19.4%	19.3%	21.8%	21.2%
Maltreatment in Foster Care	Of all children in foster care during a 12-month period, what was the rate of victimization per 100,000 days of care?	9.07 or less victimizations per 100,000 days in foster care	FFY 2017 only – 28.06	FFY 2018 only – 34.37	FFY 2019 only – 34.26	FFY 2020 only - 31.25	FFY 2021 only – 42.61
Sources: *Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2022 provided by federal Children's Bureau **Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2024, provided by Children's Bureau; Data – AFCARS and NCANDS Submissions as of 2-20-24							

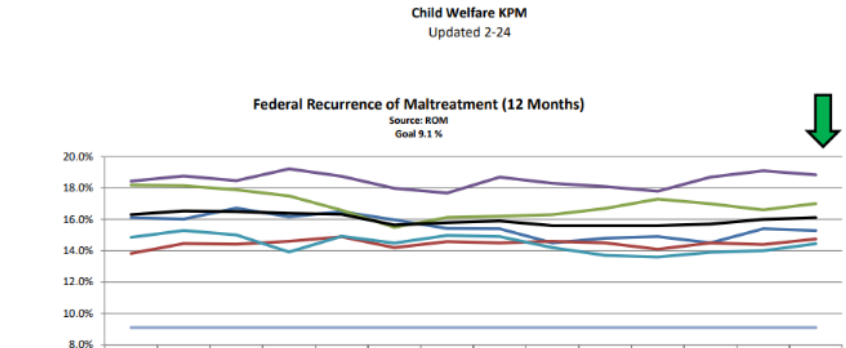
Table 2j: Iowa Risk Standardized Performance on National Permanency Data Indicators							
Indicator Name	**Indicator Description**	**National Performance Requirement**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
Permanency in 12 months for children entering care	Of all children who enter care in a 12-month period, what percent discharged to permanency within 12 months of entering care?	35.2% or higher	39.0%**	36.9%**	37.8%**	----------	----------
Permanency in 12 months for children in care 12-23 months	Of all children in care on the first day of a 12-month period who had been in care continuously between 12 and 23 months, what percent discharged to permanency within 12 months of the first day?	43.8% or higher	66.2%*	66.9%*	67.3%**	64.7%**	68.2%**
Permanency in 12 months for children in care 24 months or more	Of all children in care on the first day of a 12-month period who had been in care continuously for 24 months or more, what percent discharged to permanency within 12 months of the first day?	37.3% or higher	41.0%*	46.3%*	52.3%**	49.0%**	51.7%**
Re-entry to foster care in 12 months	Of all children who exit foster care in a 12-month period to reunification, live with relative, or guardianship, what percent reentered care within 12	5.6% or lower	8.9%*	8.2%**	8.1%**	11.5%**	----------

Table 2j: Iowa Risk Standardized Performance on National Permanency Data Indicators							
Indicator Name	**Indicator Description**	**National Performance Requirement**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**
	months of their discharge?						
Placement Stability	Of all children who enter care in a 12-month period, what was the rate of placement moves per 1,000 days of foster care?	4.48 or lower	2.82*	2.63*	2.94**	2.68**	3.77**
Sources: *Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2022 provided by federal Children's Bureau **Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2024, provided by Children's Bureau; Data – AFCARS and NCANDS Submissions as of 2-20-24							

Recurrence of Maltreatment

Although Iowa has demonstrated a decrease in recurrence of maltreatment since the last data profile was available, it continues to significantly exceed the nationwide expectation; this has long been a focus area. Iowa has reviewed data regarding types of abuse for both initial and subsequent, age of victim, and circumstances surrounding the recurring incident. Analysis indicates that neglect and substance abuse continue to be the most frequent initial and subsequent categories of abuse.

Chart 2d: Recurrence of Maltreatment



Initial Maltreatment Period	Jan23 Feb21 Jan22	Feb23 Mar21 Feb22	Mar23 Apr21 Mar22	Apr23 May21 Apr22	May23 Jun21 May22	Jun23 Jul21 Jun22	Jul23 Aug21 Jul23	Aug23 Sep21 Aug22	Sep23 Oct21 Sep22	Oct23 Nov21 Oct22	Nov23 Dec21 Nov22	Dec23 Jan22 Dec22	Jan24 Feb22 Jan23	SFY24 Avg
Western	16.1%	16.0%	16.7%	16.2%	16.5%	16.0%	15.4%	15.4%	14.5%	14.8%	14.9%	14.5%	15.4%	15.3%
Northern	13.8%	14.5%	14.4%	14.6%	14.9%	14.2%	14.6%	14.5%	14.6%	14.5%	14.1%	14.5%	14.4%	14.7%
Eastern	18.2%	18.2%	17.9%	17.5%	16.6%	15.5%	16.1%	16.2%	16.3%	16.7%	17.3%	17.0%	16.6%	17.0%
Cedar Rapids	18.4%	18.8%	18.5%	19.2%	18.7%	18.0%	17.7%	18.7%	18.3%	18.1%	17.8%	18.7%	19.1%	18.8%
Des Moines	14.9%	15.3%	15.0%	13.9%	14.9%	14.5%	15.0%	14.9%	14.2%	13.7%	13.6%	13.9%	14.0%	14.4%
State	16.3%	16.5%	16.5%	16.4%	16.3%	15.6%	15.8%	15.9%	15.6%	15.6%	15.6%	15.7%	16.0%	16.1%
Goal	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%	9.1%

Iowa continues regular review of data both statewide and within service areas to identify trends resulting in this high rate of re-abuse. Data analysis, case review, and supervisory staffings have not yielded substantive insights to reasons Iowa would be so significantly higher in this area than other states. Iowa is researching performance across all states to determine if there could be a practice difference resulting in the disparity, such as criteria for a new allegation on cases open for services or possibly a difference in categories of abuse. This is a complex issue and Iowa continues to strive to understand factors influencing performance. To aid in exploration around this performance as well as child welfare more broadly, Iowa entered into a consulting agreement with Change and Innovation Agency (C!A) to evaluate key areas of practice. To answer these questions, C!A completed activities such as: focus groups with staff and stakeholders; mapping of the processes for intake, assessment, and ongoing services; review of policy and procedure; and assessment of data related to all aspects of services.

Recommendations were made regarding alternative, streamlined options for allegations that are deemed spurious or clearly not substantiated after an initial visit; other states have implemented an abbreviated process for this type of reports to quickly facilitate closure, thus efficiently freeing staff resources for where and when most needed.

Other efforts being made include:

- Coordination with Early Intervention and Support of HHS to enhance identification of the need and provision of preventive services to families before the situation deteriorates to the point of suspected abuse or neglect. Currently utilization data is being matched between families receiving preventive services and families who have had a child protective assessment; the purpose is to determine characteristics of families who were able to avoid the child welfare system through early interventions versus the contributing factors for families that lead to interaction with the child welfare system.
- Evaluation of the use and effectiveness of Family Assessments. Through routine monthly child protective assessment reviews, the review team noted that there appears to have been some practice drift regarding the purpose and expectations of Family

Assessments; the team noted that many of the documents reviewed closely mirrored the type of intervention as cases that come in on the Child Protective Assessment path. A team delved into the original research and decisions when Iowa implemented differential response; they identified factors impacting this drift including: inconsistent guidance across service areas; implementation of additional requirements beyond the original intent; and some concerns regarding a punitive work culture if something was missed, resulting in a lack of trust. This team also identified ways to realign practice with the original intent and is in the process of developing new guidance, training, and a follow up plan to provide immediate feedback as these reports are completed.

- Iowa has joined the National Partnership for Child Safety (NPCS), a non-profit agency that worked with Tennessee to develop the standard Safe Systems Improvement Tool (SSIT) for the review of critical incidents. This tool promotes a culture of openness, trust, and systems focus to identify trends and areas to be improved; In March 2024, NPCS presented comprehensive information regarding the benefits of this culture and the imperative for top leadership to model the culture. Iowa is actively working toward implementation of the standard SSIT, understanding that success is dependent on broad cultural transformation, demonstrated daily, and infused throughout the work force.
- HHS' Service Business Team (SBT) has assigned a team to evaluate the current practice and establish guidelines around the agency response to open service cases when a safety or risk issue is identified; often this is the same type of situation that brought the family into the child welfare system and the current focus of service. Data indicate that in 2023, social workers accounted for 13% (~7700) of all abuse reports received, with a 70% acceptance rate. An in-depth look at what these involve and establishing consistent statewide practice expectations will assist in understanding the meaning behind the data.

Maltreatment in Foster Care

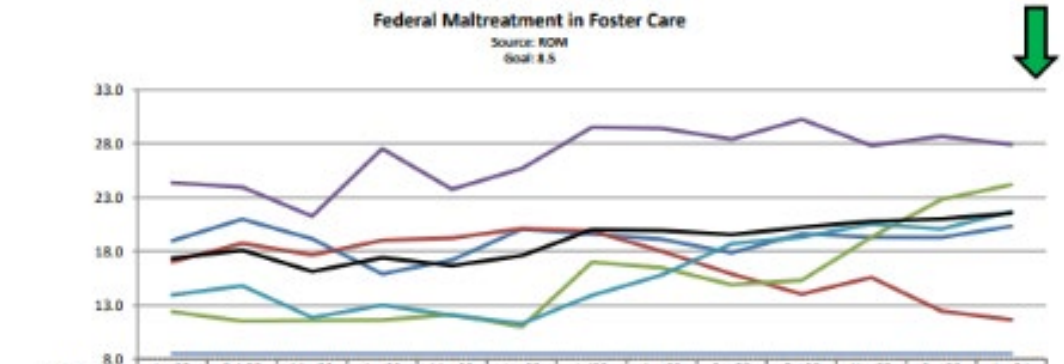
Maltreatment in foster care has been a focus of continuous improvement over the last three years. After conducting multiple sequential reviews to baseline then measure progress following implementation of strategies, this area has shown significant improvement by lowering the rates from 26.3% to 16.1% from March 2022 – March 2023.

The QA&I bureau reviewed cases identified as a child experiencing abuse in foster care to fully explore the circumstances; based on those findings the primary trends were identified:

- The perpetrator type most prevalent was Parent, indicating children were experiencing abuse when on home visits.
- Dates of receipt of a positive drug test was being used as the date of abuse rather than when the testing/incident occurred. This made children who entered foster care due to the incident appear to have been abused while in foster care rather than the incident that prompted the placement. Consistent protocol for dates associated with positive drug tests was implemented.
- In a variation of the above and as reported in previous APSR updates, Iowa's child welfare information system (CWIS) is unable to record times of events; therefore, if a child abuse assessment was initiated and the child subsequently placed in foster care the same day, this would inaccurately be counted as abuse while in care.

Despite this early success, abuse in foster care has shown an increase over the last year, from 16.1 as of March 2023 to 21.5 as of January 2024. Preliminary case reviews indicate a continuation of the issues originally identified as noted above. Workforce turnover has been significant over the last two years which often leads to the need for additional training and follow up; additional research will be conducted to determine specific training needs. Although Iowa continues to use the same CWIS which is unable to utilize a time stamp regarding abuse versus placement, Iowa is actively developing the new comprehensive child welfare information system (CCWIS) which will resolve this issue.

Chart 2e: Maltreatment in Foster Care



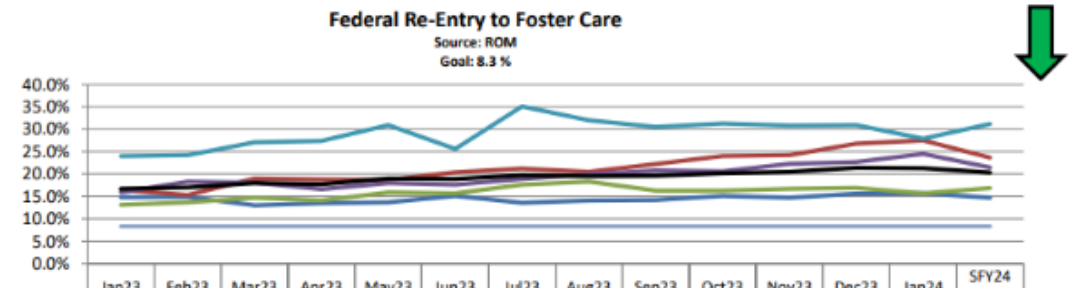
Initial Maltreatment Period	Jan23 Feb22 Jan23	Feb23 Mar22 Feb23	Mar23 Apr22 Mar23	Apr23 May22 Apr23	May23 Jun22 May23	Jun23 Jul22 Jun23	Jul23 Aug22 Jul23	Aug23 Sep22 Aug23	Sep23 Oct22 Sep23	Oct23 Nov22 Oct23	Nov23 Dec22 Nov23	Dec23 Jan23 Dec23	Jan24 Feb23 Jan24
Western	19.0	21.0	19.2	15.9	17.2	20.1	19.6	19.1	17.9	19.6	19.3	19.3	20.3
Northern	17.0	18.7	17.7	19.0	19.2	20.1	19.9	18.0	15.9	14.0	15.6	12.5	11.7
Eastern	12.4	11.5	11.6	11.6	12.1	11.0	17.0	16.5	14.9	15.3	19.3	22.8	24.2
Cedar Rapids	24.4	24.0	21.3	27.5	23.8	25.7	29.5	29.4	28.4	30.2	27.8	28.7	27.9
Des Moines	14.0	14.8	11.9	13.0	12.1	11.3	13.9	15.8	18.7	19.3	20.5	20.1	21.7
State	17.4	18.1	16.1	17.4	16.7	17.6	20.0	19.9	19.6	20.2	20.8	21.0	21.5
Goal	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5

Re-Entry to Foster Care

While Iowa's performance had been steady and very close to national targets, it's noteworthy that as of January 2021 the use of Trial Home Visits (THVs) was discontinued as a standard practice. This resulted in a child being officially discharged from foster care at the point of reunification rather than after a six-month transition period during the THV. Due to this change in definition of "discharge from foster care", Iowa anticipated an increase in the number of children appearing to re-enter foster care.

Data pulled between January 2023 and January 2024 has demonstrated these anticipated changes in performance.

Chart 2f: Re-entry to Foster Care



Entered Care During	Jan23 Feb20 Jan21	Feb23 Mar20 Feb21	Mar23 Apr20 Mar21	Apr23 May20 Apr21	May23 Jun20 May21	Jun23 Jul20 Jun21	Jul23 Aug20 Jul21	Aug23 Sep20 Aug21	Sep23 Oct20 Sep21	Oct23 Nov20 Oct21	Nov23 Dec20 Nov21	Dec23 Jan21 Dec21	Jan24 Feb21 Jan22	SFY24 Avg
Western	14.8%	14.9%	13.0%	13.5%	13.7%	15.1%	13.6%	14.1%	14.2%	15.1%	14.7%	15.6%	15.7%	14.7%
Northern	16.5%	15.3%	19.0%	18.8%	18.7%	20.4%	21.2%	20.5%	22.2%	24.0%	24.2%	26.8%	27.5%	23.7%
Eastern	13.1%	13.7%	14.7%	14.1%	15.9%	15.7%	17.6%	18.3%	16.3%	16.3%	16.7%	16.9%	15.7%	16.8%
Cedar Rapids	15.9%	18.3%	18.1%	16.6%	18.0%	17.6%	18.9%	19.9%	20.8%	20.6%	22.3%	22.7%	24.5%	21.5%
Des Moines	24.0%	24.2%	27.1%	27.4%	30.9%	25.6%	35.1%	32.0%	30.5%	31.3%	30.8%	30.9%	27.9%	31.2%
State	16.7%	17.0%	18.0%	17.7%	19.0%	18.9%	19.7%	19.5%	19.6%	20.2%	20.5%	21.4%	21.3%	20.3%
Goal	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%

To better understand the impact of this change, an analysis of timeframes in which children return to a placement setting following discharge was completed. Historically the trend of re-entering placement in less than 6 months has been increasing, and this continues to be the case:

Table 2k: Re-Entry to Foster Care				
Re-Entry to Foster Care	*June 2021	*June 2022	*June 2023	*February 2024
Re-Entry <6 Months	37%	54%	71%	76%

*ROM Federal Re-Entry

These cases previously did not impact re-entry rates but now play a role. To increase successful reunification, Iowa has focused on steps to prepare both the child and parent(s) through a process to guide planning prior to a child's return from care. A recent workgroup regarding concurrent planning has also built on this concept, reinforcing the thoughtful preparation for reunification.

Re-entry to foster care hit a high of 21.5; while an increase was anticipated, this degree of change was not. Iowa's QA&I Bureau has identified this area as a priority and will develop an approach to identify root causes and engage stakeholders in improvement efforts as part of Iowa's CFSP. See Goals section.

Permanency in 12 months

Chart 2g: Permanency in 12 months (over time)

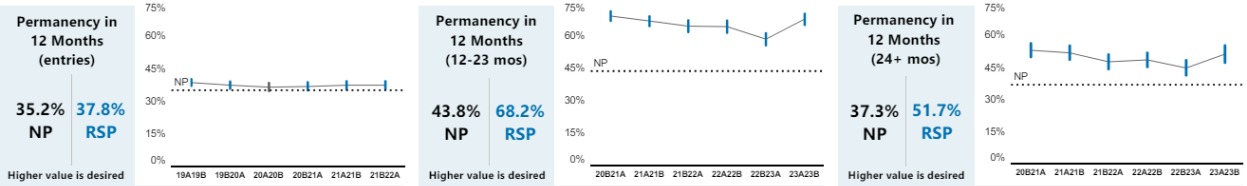
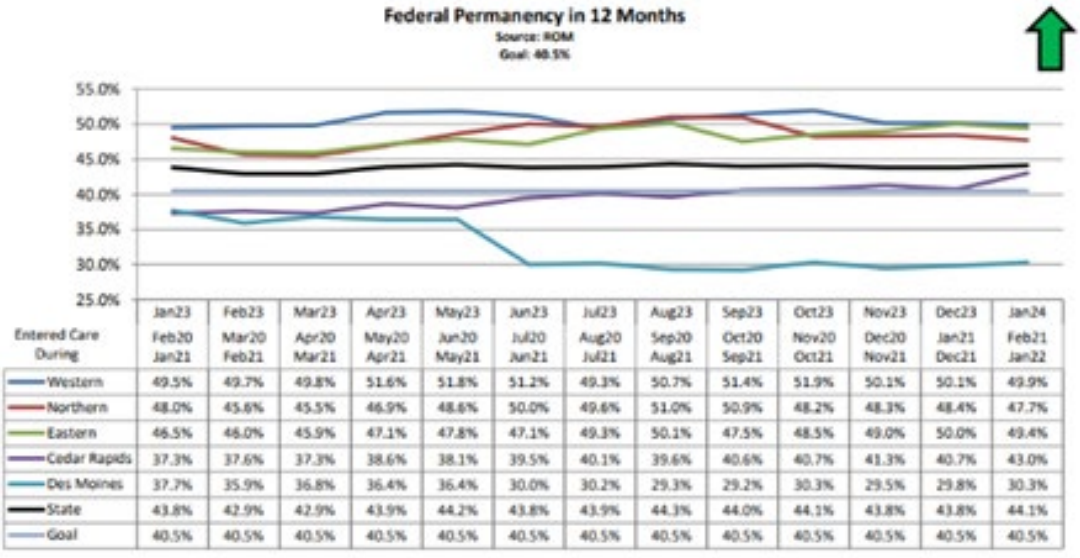
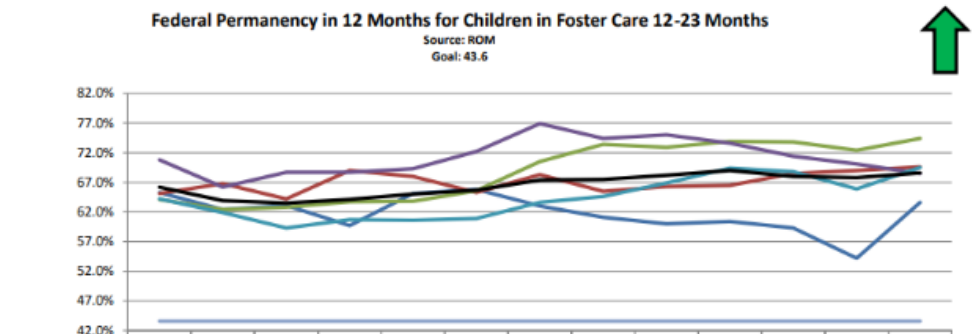


Chart 2h: Permanency in 12 months



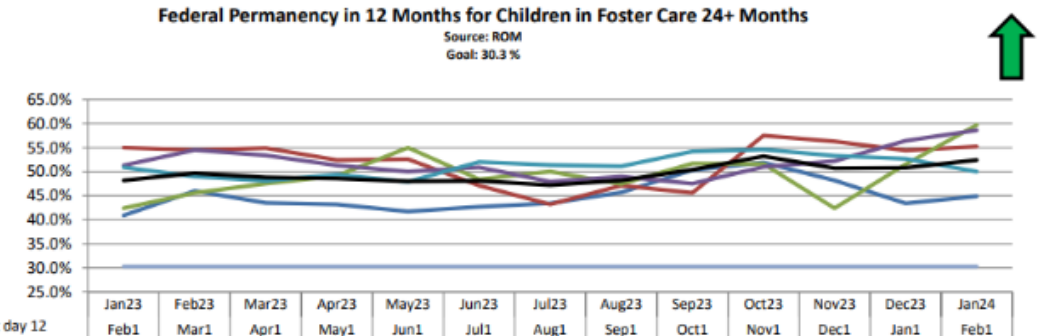
Entered Care During	Jan23 Feb20 Jan21	Feb23 Mar20 Feb21	Mar23 Apr20 Mar21	Apr23 May20 Apr21	May23 Jun20 May21	Jun23 Jul20 Jun21	Jul23 Aug20 Jul21	Aug23 Sep20 Aug21	Sep23 Oct20 Sep21	Oct23 Nov20 Oct21	Nov23 Dec20 Nov21	Dec23 Jan21 Dec21	Jan24 Feb21 Jan22
Western	49.5%	49.7%	49.8%	51.6%	51.8%	51.2%	49.3%	50.7%	51.4%	51.9%	50.1%	50.1%	49.9%
Northern	48.0%	45.6%	45.5%	46.9%	48.6%	50.0%	49.6%	51.0%	50.9%	48.2%	48.3%	48.4%	47.7%
Eastern	46.5%	46.0%	45.9%	47.1%	47.8%	47.1%	49.3%	50.1%	47.5%	48.5%	49.0%	50.0%	49.4%
Cedar Rapids	37.3%	37.6%	37.3%	38.6%	38.1%	39.5%	40.1%	39.6%	40.6%	40.7%	41.3%	40.7%	43.0%
Des Moines	37.7%	35.9%	36.8%	36.4%	36.4%	30.0%	30.2%	29.3%	29.2%	30.3%	29.5%	29.8%	30.3%
State	43.8%	42.9%	42.9%	43.9%	44.2%	43.8%	43.9%	44.3%	44.0%	44.1%	43.8%	43.8%	44.1%
Goal	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%	40.5%

Chart 2i: Permanency in 12 months (12-23 mos)



1st day 12 month period	Jan23 Feb1 2022	Feb23 Mar1 2022	Mar23 Apr1 2022	Apr23 May1 2022	May23 Jun1 2022	Jun23 Jul1 2022	Jul23 Aug1 2022	Aug23 Sep1 2022	Sep23 Oct1 2022	Oct23 Nov1 2022	Nov23 Dec1 2022	Dec23 Jan1 2023	Jan24 Feb1 2023
Western	65.3%	62.4%	63.1%	59.7%	65.1%	65.8%	63.0%	61.1%	60.0%	60.4%	59.3%	54.2%	63.6%
Northern	65.1%	66.8%	64.2%	69.0%	68.0%	65.3%	68.3%	65.5%	66.3%	66.5%	68.5%	69.0%	69.6%
Eastern	64.1%	62.4%	62.8%	63.7%	63.8%	65.6%	70.5%	73.4%	72.9%	73.9%	73.8%	72.4%	74.4%
Cedar Rapids	70.8%	66.2%	68.7%	68.7%	69.3%	72.2%	76.9%	74.4%	75.0%	73.6%	71.4%	70.1%	68.5%
Des Moines	64.2%	61.9%	59.3%	60.7%	60.6%	60.9%	63.6%	64.6%	66.9%	69.4%	68.8%	65.9%	69.5%
State	66.2%	63.9%	63.5%	64.1%	65.0%	65.7%	67.4%	67.5%	68.2%	69.0%	68.0%	67.8%	68.6%
Goal	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%	43.6%

Chart 2j: Permanency in 12 months (24+ mos)



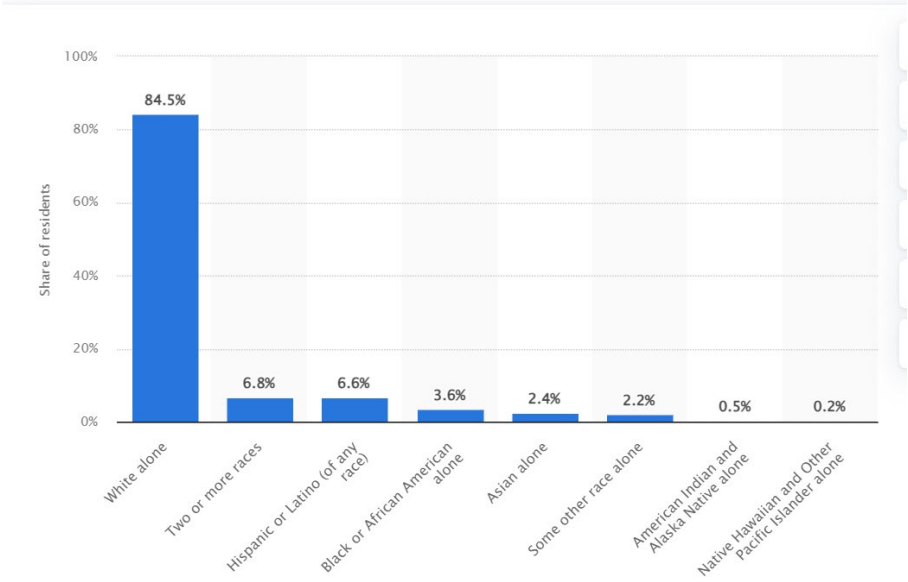
1st day 12 month period	Jan23 Feb1 2022	Feb23 Mar1 2022	Mar23 Apr1 2022	Apr23 May1 2022	May23 Jun1 2022	Jun23 Jul1 2022	Jul23 Aug1 2022	Aug23 Sep1 2022	Sep23 Oct1 2022	Oct23 Nov1 2022	Nov23 Dec1 2022	Dec23 Jan1 2023	Jan24 Feb1 2023
Western	40.9%	46.0%	43.5%	43.2%	41.7%	42.7%	43.4%	45.7%	50.3%	51.9%	48.2%	43.4%	44.9%
Northern	55.0%	54.5%	54.9%	52.4%	52.6%	47.1%	43.2%	47.1%	45.6%	57.5%	56.3%	54.4%	55.2%
Eastern	42.4%	45.6%	47.5%	49.1%	55.0%	48.4%	50.0%	47.4%	51.7%	51.6%	42.4%	51.5%	59.7%
Cedar Rapids	51.3%	54.5%	53.4%	51.3%	50.0%	50.9%	47.9%	49.0%	47.5%	51.0%	52.2%	56.4%	58.6%
Des Moines	50.9%	49.0%	48.1%	49.4%	47.9%	52.0%	51.4%	51.1%	54.2%	54.6%	53.3%	52.7%	50.0%
State	48.2%	49.7%	48.8%	48.6%	48.0%	48.1%	47.2%	48.2%	50.4%	53.2%	50.7%	50.8%	52.4%
Goal	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%	30.3%

A complementary change due to discontinuation of THVs was anticipated and observed in performance on achieving permanence within 12 months; the earlier discharge from foster care has improved time to reunification by six months, reflecting it as improved performance. Iowa demonstrated an increase from 37.8% (FFY 2021 – State Data Profile February 2024) to 52.4% (as of January 2024 State data) including a steady upward trend over the last year. Iowa's performance continues to exceed goals for achieving permanence for children in all three of the federal measures.

Disproportionality
Iowa continues to monitor disproportionality within the child welfare population served and increase awareness of unconscious bias.

As a state, Iowa does not have a diverse population, with 85% of residents identifying as White, 7% as two or more races, and 4% as Black or African American; the chart below includes additional information.

Chart 2k: State of Iowa Residents by Race



Data indicates a disproportionate number of minorities intersect with Iowa's child welfare system; Intake is the first point of contact with the system and upon accepted referrals for suspected abuse we already see a disproportionate distribution across the population. Minority groups are disproportionately represented in accepted referrals between approximately 3 and 5 times their presence in the general population (ROM, 4/2023-3/2024). This has remained consistent and, in some cases, trended upward throughout the last year of data. The same type of disproportionality is seen when exploring who enters foster care. See the charts below for additional detail.

Chart 2l: Disparity in Accepted Referrals

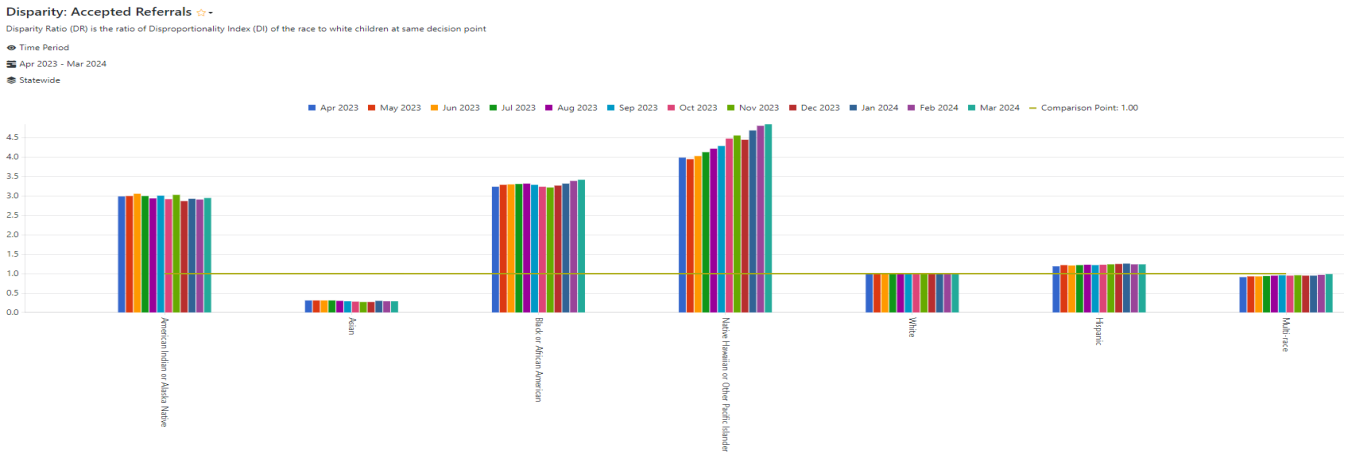
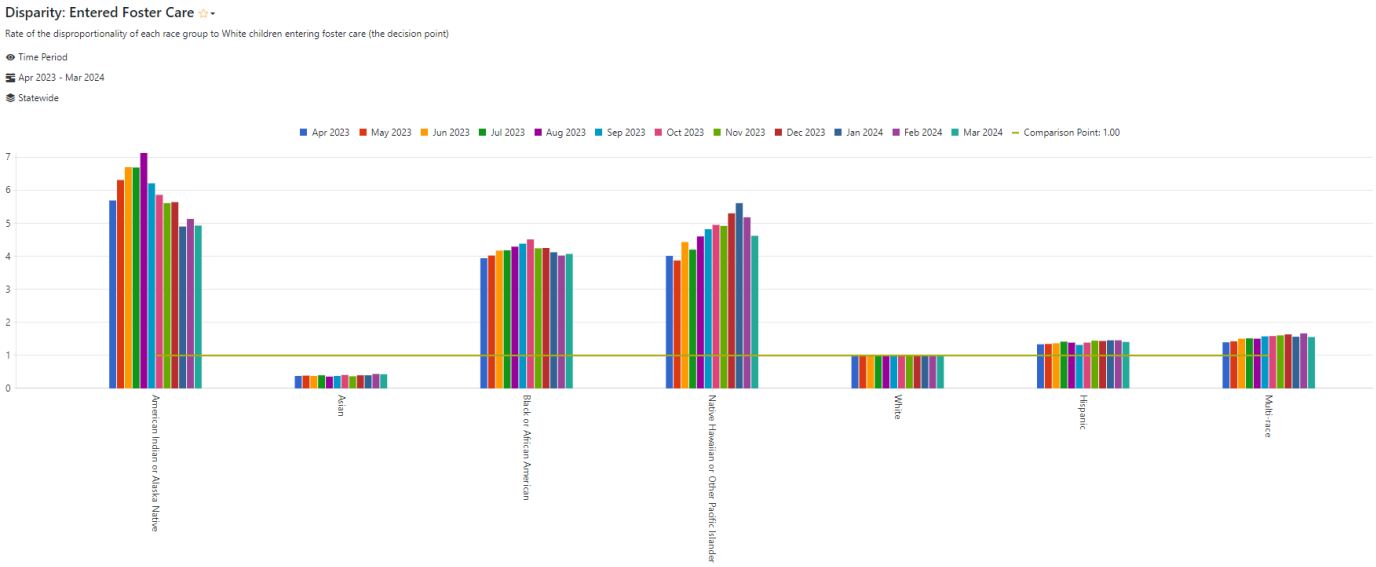


Chart 2m: Disparity in Foster Care Entry



Iowa monitors the population in the child welfare process and is aware of the disproportional representation of minority races in the system. While HHS does not currently have a comprehensive approach to addressing disproportionality, education on unconscious bias has long been provided in conjunction with ongoing training of staff; this has included tools to aid in decision-making such as structured decision-making tools, practices for collecting and synthesizing information, and legal criteria impacting decisions.

These two key decision points are impacted by multiple factors, starting with the source of the information received. Intake receives calls from community members regarding concerns of abuse or neglect of a child; neither race nor ethnicity of the reporter or the subject of the report

are components of the interview, yet data show disproportionality begins at this point. While this is a complex issue with many interwoven dynamics, it is important that we address this issue within HHS but also look at the child welfare system in context of its role in a larger societal system. In the last year, HHS added Iowa Department of Public Health (IDPH) to the agency and enhanced the continuum of services to prevent families from intersecting with child welfare; in addition, legacy IDPH (now HHS) includes a Health Equity component. With these newly acquired resources, Iowa HHS is positioned to address this complex issue more comprehensively.

SYSTEMIC FACTORS

Statewide Information System

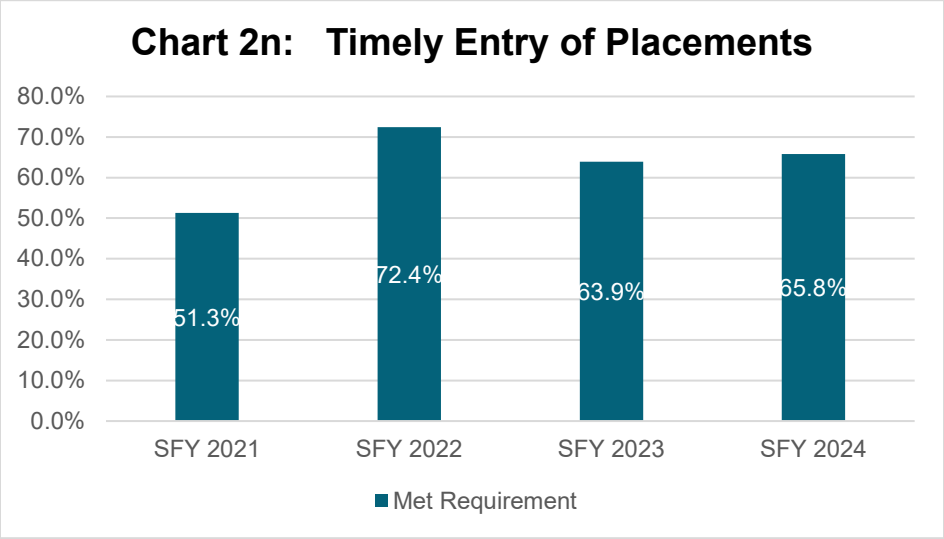
Item 19: Statewide Information System

Iowa's statewide Child Welfare Information System (CWIS), also known as Joining Applications and Reports from Various Information Systems (JARVIS), comprises two important components, Family and Child Services (FACS) and Statewide Tracking of Assessment Reports (STAR). FACS is the child welfare case management and payment system for HHS. It applies to children remaining in the home and in foster care and collects demographic data, caseworker information, household composition, services provided, current status, status history, placement information, and permanency goals, among other information. It tracks the services provided to a monthly average of approximately 18,000 children and automates issuance of over $160 million annually to foster and adoptive parents and other child welfare providers. STAR collects information related to child protective assessments, which includes both child abuse assessments and family assessments.

Iowa's statewide information system also includes components to increase data quality, such as interfacing with income maintenance programs (e.g., food assistance, Temporary Assistance to Needy Families (TANF), Medicaid, etc.) and child support program to collect and confirm the accuracy of case participant demographic information. Additionally, the Childcare Assistance system (KinderTrack (KT)) and JARVIS interface to facilitate system check pulls to see if a perpetrator is conducting a daycare business. The income maintenance programs, the child support program, and the childcare assistance program are all part of HHS. For example, an interface with the statewide income maintenance system application allows child welfare staff to inquire about participants receiving services such as Temporary Assistance to Needy Families (TANF). This interface allows verification of household member names, dates of birth, family's address, and other information obtained and verified during eligibility determination processes by HHS income maintenance personnel.

441 Iowa Administrative Code (IAC) 130.6(4) and (5) requires HHS staff to enter case information into the reporting system and to monitor the case to ensure the information in the reporting system is correct. The information to be entered includes but is not limited to: the status, demographics, location, and permanency goals for children in foster care. Employee's Manual 18C(2): Case Management, Foster Care Placement, requires staff to complete placement entries in FACS within three business days from the date the child initially enters foster care and the date of any foster care placement changes. The data in the chart below shows that performance to meet this requirement has improved over the years, with almost 66%

of the entries meeting the timeliness requirement. Performance on entering location within the three days has become static; this data will be highlighted at the leadership team meetings and reinforced as to the expectations as well as the reasons behind those expectations.



Source: HHS; Note: SFY 2024 data is from July 2023-February 2024

In addition to monitoring timeliness of placement entries, HHS' Bureau of Quality Assurance and Improvement (QA&I) staff examine data accuracy for 100 cases randomly selected from all children served in out of home care. This process compares FACS/AFCARS data with case narrative and file documentation from sources other than FACS/AFCARS (i.e., court orders and narratives, social history, case plan narratives, etc.). The process explores basic demographics (race, sex, and ethnicity), foster care placement data (latest removal, manner of removal, current setting, discharge date, discharge reason), and case plan goal, etc. For the FACS/AFCARS review, data counts as "accurate" when it is consistent with case file documentation. Data counts as "inaccurate" when there is clearly an inconsistency between FACS/AFCARS and case file documentation. Individual data counts as "unable to verify" when data comparison cannot occur because there is no independent paper file source for comparison. Reviewers communicate with case managers when an inconsistency is found; case managers follow up and correct or clarify information as needed. Annually, a statewide report, as well as service area-specific reports, are generated and distributed. These are reviewed at leadership and staff meetings to identify any trends that may need additional action.

Performance on the AFCARS reviews remains high overall, but trends continue regarding the difficulty to verify race and ethnicity; this is an area that is expected to be positively impacted by Iowa's implementation of its CCWIS. Until then, previous the data from previous years will be reviewed to assure accurate calculation. Iowa has definitely had difficulty verifying race and ethnicity which is different from finding contradictory information in the written file. Once that check is complete further exploration will be completed as needed.

Table 2I: AFCARS Data Validation Review						
Element	**Item Description**	**CY 2019**	**CY 2020 Data Not Available**	**CY 2021**	**CY 2022**	**CY 2023 ~~Data Not Available~~**
FC-06	Does the child's DOB in FACS accurately reflect what is listed in paper file documentation?	98%	-----	100%	99%	98%
FC-07	Does the child's Gender in FACS accurately reflect what is listed in paper file documentation?	99%	-----	99%	100%	100%
FC-08	Does the child's Race in FACS accurately reflect what is listed in paper file documentation?	94%	-----	51%	83%	95%
FC-09	Does the child's Hispanic or Latino Ethnicity in FACS accurately reflect what is listed in paper file documentation?	98%	-----	41%	65%	98%
FC-21	Does the child's Date of Latest Removal in FACS accurately reflect what is listed in paper file documentation?	95%	-----	91%	96%	97%
FC-25	Does the child's Manner of Removal in FACS accurately reflect what is listed in paper file documentation?	99%	-----	100%	100%	100%
FC-41	Does the child's Current Setting in FACS accurately reflect what is listed in paper file documentation?	96%	-----	99%	99%	97%
FC-43	Does the child's Case Plan Goal in FACS accurately reflect what is listed in paper file documentation?	96%	-----	96%	96%	91%
FC-56	Does the child's Discharge Date in FACS accurately reflect what is listed in paper file documentation?	96%	-----	91%	94%	90%

Source: HHS

Comprehensive Child Welfare Information System (CCWIS) Development

Over the previous five-year CFSP period, Iowa collaborated with the federal Children's Bureau regarding implementation of its CCWIS. HHS had regular calls with the Children's Bureau to

discuss development of the HHS Project Management Plan, the design, development, and implementation of the CCWIS by user role. HHS commissioned a workgroup in January 2021 to start the work in designing and developing Iowa's CCWIS (aka VISION). In addition to contracted developers, HHS had three groups of HHS staff involved in VISION's design and development:

- Dedicated Field Team Members – VISION Field Team members, selected from the field, worked full-time on this project. They focused on the user experience by helping the VISION development team understand social work practice, policies and workflows within HHS. They helped with the system design to create a workflow that matched the steps staff take in the field, matching available information at each step. They also are heavily involved in final testing.
- Extended Field Feedback Team Members – Each Field Team member had additional team members they could go to for insight into each specialty and gather feedback on system functionality.
- Beta Testing Team – The VISION Beta Testing Team will test VISION and provide feedback before its official release to the field.

In November 2023, HHS held town halls that included information on VISION and a demonstration video, a VISION Implementation Timeline shared with staff, and creation of a VISION SharePoint page. Four to six months before implementation designated extended field feedback team members will conduct light testing and beta testing will occur by a Cedar Rapids Service Area supervisor and team. Two months before implementation the VISION Help Desk will be created and a VISION User Manual will be posted, with training on VISION beginning both virtually and hands-on. Yet to be determined, VISION MVP implementation will occur. These are the core pieces that HHS will implement first. The first modules of VISION will be released to the field in 2024, with subsequent releases planned for later.

Stakeholder feedback from HHS staff and supervisors'[2]:

- Strengths:
  - JARVIS is generally perceived as an effective system that is easy to navigate and is user-friendly.
  - Workers regularly utilize SharePoint
- Areas Needing Improvement:
  - Need to integrate information between teams, programs, and systems
    - Must access several additional systems to effectively do their jobs
  - Need to streamline data entry.
    - Need to minimize or automate repetitive and seemingly unnecessary tasks.
    - Internet connectivity issues with laptops in the field
  - Need to manage documents effectively
    - Storing, managing, and extracting documents are cumbersome and ineffective

[2] For more information, please see - Change & Innovation Agency (C!A). November 2022. *Iowa Department of Health and Human Services, Child Welfare, Final Report of Findings and Recommendations*. pp 54-56.

Current or Planned Activities to Improve Performance

During FFY 2024-2029, Iowa will continue collaboration with the federal Children's Bureau in implementing its CCWIS.

- In FFY 2024, HHS will continue to focus on following development milestones in preparation for the first release:
  - Milestone 1: Child Abuse (CA) - Family Foster Care Pathway
    - One of 5 Child Abuse case pathways/15 total case pathways
    - Production quality release ready from "Magic Button" to "Transfer Case"
  - Milestone 2: All 15 Case Pathways
    - From "Magic Button" through "Transfer" with minimal Living Arrangements, Placements & Services
  - Milestone 3: All 15 Case Pathways + Full Living Arrangements, Placements & Services
    - From "Magic Button" through full "Living Arrangements, Placements and Services"
  - The first release date has yet to be determined. HHS is tentatively targeting late this summer or fall. Once that date is determined, HHS will establish targets for the following activities/deliverables:
    - Beta testing for extended field team feedback
    - User Manual Completion and Review
    - Training Plan
- FFY 2024-2026: Continue to Design, develop, and implement CCWIS by user role.
  - FFY 2024-2025: Social Worker 2s/3s
  - FFY 2024-2025: Supervisors, Service Area Leaders, Support Staff, and Specialized Staff (DoIT, Fiscal, ICPC)
  - FFY 2025-2026: IV-E Staff, Management Analyst/Quality Assurance Staff, Program Managers, Providers, External Partners, and Citizens (reports)
- FFY 2026-2029: Ongoing monitoring and upgrading, as necessary

Case Review System

Item 20: Written Case Plan

441 Iowa Administrative Code (IAC) 130.7(3) requires HHS staff to develop a written case plan jointly with the child, the family, and the caregiver, inclusive of the child's parents. Additionally, a case plan that meets the requirements of Iowa Code 232.2(4) must be filed with the court within 60 days from the date the child enters foster care or the date the department opens a child welfare service case, whichever occurs first. The case permanency plan defined in Iowa Code 232.2(4) indicates that the plan "…is designed to achieve placement in the most appropriate, least restrictive, and most family-like setting available and in close proximity to the parent's home, consistent with the best interests and special needs of the child…".

Furthermore, the definition indicates that the case permanency plan must include, but not be limited to:

- The type and appropriateness of the placement and services to be provided to the child.
- The care and services that will be provided to the child, biological parents, and foster parents.

- How the care and services will meet the needs of the child while in care and will facilitate the child's return home or other permanent placement.
- A designee of the department or other person responsible for placement of a child out-of-state must visit the child at least once every six months
- Documentation of the steps taken to make and finalize an adoption or other permanent placement if the child cannot return to the child's home

HHS' *Family Case Plan, Form 470-3453*, meets the requirements of Iowa Code 232.2(4) for a case permanency plan. The plan includes three main sections:

- Family Case Plan Face Sheet, Part A - includes identifying information, service history and placement history, additional services provided, and court involvement for the family
- Family Case Plan, Part B – includes:
  - Identifying information,
  - Family plan participants,
  - Date of Initial Plan and Family Team Meeting,
  - Anticipated date of case closure,
  - Household composition,
  - Assessment of family functioning across five domains (child well-being, parental capabilities, family safety, family interactions, and home environment) with an "other" domain to include assessment of any area not already covered,
  - Review section, if applicable, and
  - Signature and notifications page that documents individuals' participation in the development of the family plan.
- Child Placement Plan, Part C – includes:
  - A description of the placement and the appropriateness of the placement.
  - The permanency goal for the child including any concurrent permanency goals.
  - A plan for ensuring that the child and family receive services designed to facilitate the return of the child to a safe home or to another permanent placement.
  - The health and educational status of the child.
  - When applicable, a description of the programs and services that will facilitate the child's transition from foster care to adulthood (i.e. the Transition Plan).

HHS is piloting a streamlined case plan and will have more information about this in next year's Annual Progress and Services Report (APSR).

441 IAC 130.7(4) indicates that the HHS case plan must be updated every six months and filed with the court, or more frequently than every six months if significant changes occurred or as required by the court.

The data in Tables 2m and 2n shows improvement in HHS staff involving the mother and father in case planning. HHS plans to continually improve in this area.

Table 2m. Item 13B: The agency made concerted efforts to actively involve the mother in the case planning process.				
Service Type	**Foster Care**	**In-Home Services**	**In-Home Services - DR/AR**	**All Case Types**
SFY20*	71.88% (23) of 32	69.57% (16) of 23	100% (1) of 1	71.43% (40) of 56
SFY21	71.79% (28) of 39	81.48% (22) of 27	0	75.76% (50) of 66
SFY22	78.13% (25) of 32	92% (23) of 25	100% (1) of 1	84.48% (49) of 58
SFY23	83.87% (26) of 31	90.91% (20) of 22	100% (1) of 1	87.04% (47) of 54
SFY24**	88.24% (15) of 17	90.91% (10) of 11	100% (1) of 1	89.66% (26) of 29

*Partial year of CQI data -- not reported to Federal CB
**July 2023-December 2023 (close of PIP)

Table 2n. Item 13C. The agency made concerted efforts to actively involve the father in the case planning process.				
Service Type	**Foster Care**	**In-Home Services**	**In-Home Services - DR/AR**	**All Case Types**
SFY20*	36% (9) of 25	46.67% (7) of 15	0	40% (16) of 40
SFY21	50% (13) of 26	61.9% (13) of 21	0	55.32% (26) of 47
SFY22	41.18% (7) of 17	88.89% (16) of 18	0% (0) of 1	63.89% (23) of 36
SFY23	73.08% (19) of 26	83.33% (15) of 18	100% (1) of 1	77.78% (35) of 45
SFY24**	90.91% (10) of 11	75% (6) of 8	0	84.21% (16) of 19

*Partial year of CQI data -- not reported to Federal CB
**July 2023-December 2023 (close of PIP)

Stakeholder Feedback from Parent Partners and Parent Partner Coordinators: HHS staff collected the following feedback related to this item on January 30, 2024 at a meeting with Parent Partners and Parent Partner Coordinators:

- Strengths:
  - Progress is being seen throughout the state with clients working with workers across the state. There is more of a team approach when it comes to workers listening and considering a family's needs.

    - There has been progress made making the case plan more family friendly (easier to understand) and culturally responsive. The pilot case plan[3] was sent out to Parent Partners to see if there needed to be any changes.
    - Improved engagement with dads and non-custodial parents
    - HHS more family focused and gets more feedback from the family on case planning
- Areas Needing Improvement:
    - Parents can get overwhelmed by expectations outlined in the case plan.
        - Caseworker needs to walk through the case plan with the parent and prioritize what needs to be addressed first.

Item 21: Periodic Reviews

Iowa's policy is that, at least every six months, the juvenile court reviews the child's case plan through a court hearing. Typically, Iowa's juvenile courts conduct a periodic review every three months. The court hearing meets the federal requirement that a review be "conducted by a panel of appropriate people, at least one of whom is not responsible for the case management of or the delivery of services to either the child or the parents" and at least three people take part in the review. These hearings exceed this requirement due to participation of the judge, the county attorney, the HHS worker, the child's guardian ad litem, the child, the parents' attorneys, the parents, etc. In these hearings, there is a comprehensive review of the case, including the child's safety, the continuing necessity for and appropriateness of the out-of-home placement, the extent of compliance with the case plan, and the extent of progress toward mitigating the need for out-of-home care.

The following table answers the question: Of all children in foster care 6 months or more during an FFY, how many children had at least one court review? In reviewing the table, performance has been consistent over the last four FFYs but was only at 75%-78% as of FFY 2023. Policy requires hearings every 6 months. While Judges report that the court is holding review hearings 3 to 4 months after a dispositional hearing the data does not reflect this. A possible factor that may be influencing the data is that many of the children coming into the system are under the age of three and these cases tend to use an expedited permanency process where they go directly to the permanency hearing and do not necessarily have a review hearing.

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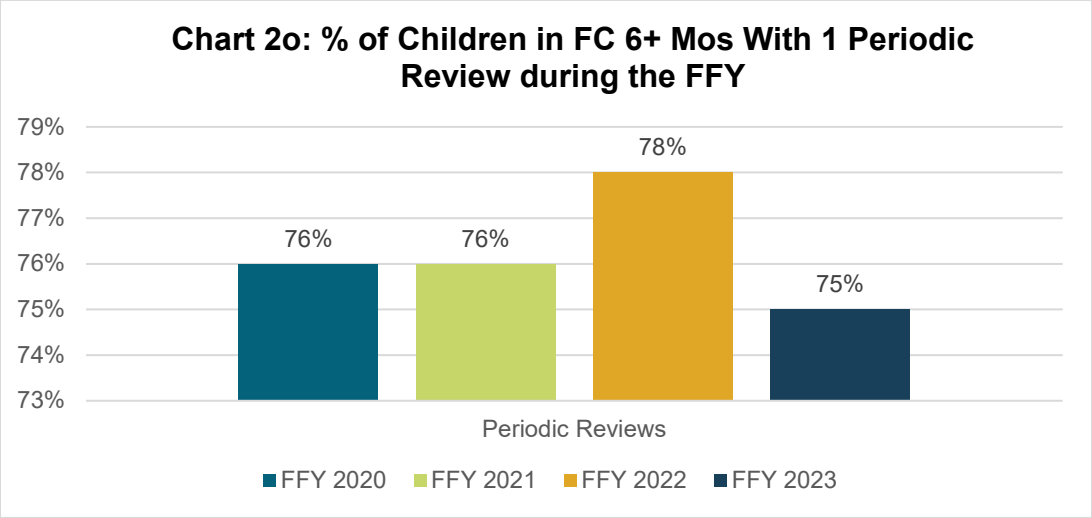


Source: AFCARS

Item 22: Permanency Hearings

Iowa's policy is to conduct permanency hearings within 12 months of the child's removal from the home and at least every twelve months thereafter.

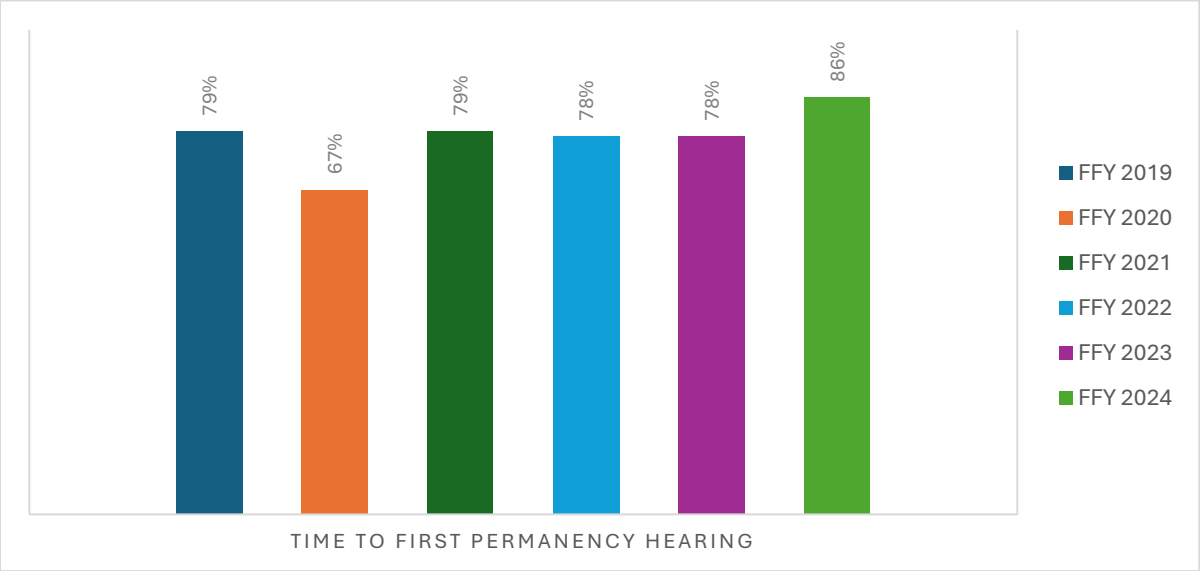
Table 2o represents data collected by Iowa Children's Justice (ICJ). There are no known limitations for the permanency hearing data. Charts 2p and 2q represent the timeliness of permanency and subsequent permanency hearings from 2019 through the end of March 2024.

Court order templates continue to be used that are generic in nature. Some judges and clerks are still leaving the generic "Order" heading which did not identify the type of hearing. Clerks are frequently unable to determine the nature of the hearing without reading the entire order, leading to mistakes in data entry. ICJ staff formed a judicial committee to set up juvenile template orders that reflect the hearings of CINA cases. Going forward work will continue with the judges on not combining permanency and termination hearings. We have begun to make changes in this area with an increase in permanency hearings being held separately. We have also filled some judicial vacancies and added a couple of judicial positions which has had a positive impact on the workload and timeliness of hearings.

Table 2o: Timeliness of Initial and Subsequent Permanency Hearings					
Court Function Indicator ***[Specific, observable, and measurable]*** **Timeliness Permanencies**	**Previous Year Baseline Rate (FY2023)**	**Initial Baseline Rate or Level (FY2024)**		**Target**	**Difference From Baseline** *[Difference in the annual level from the baseline.]*
Time to First Permanency Hearing*	78%	86%		100%	8%

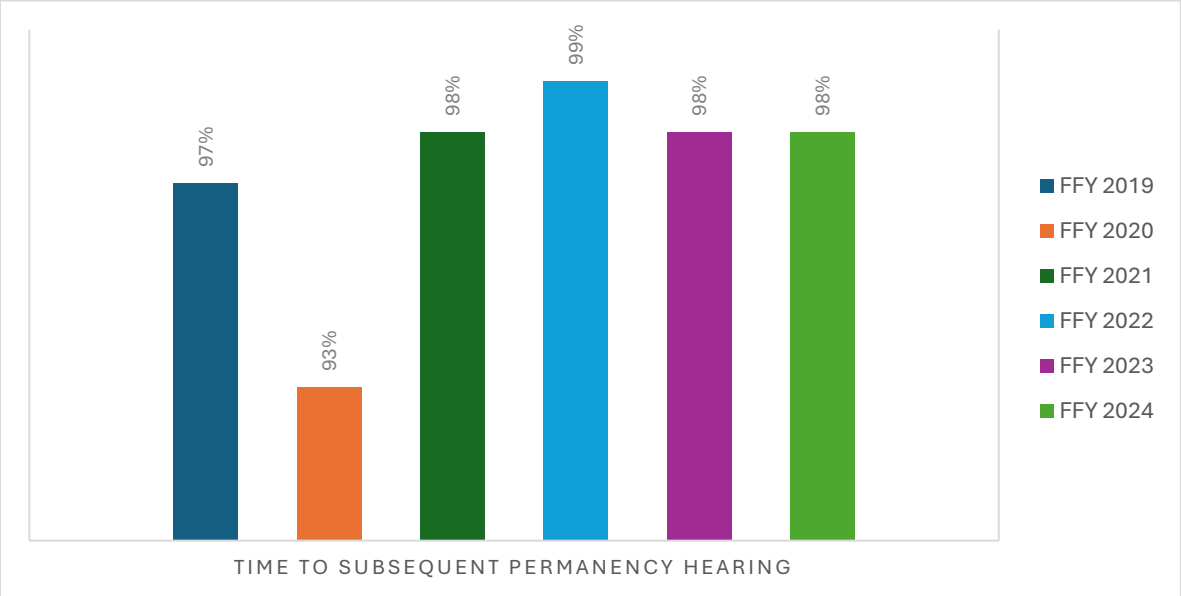
Time to Subsequent Permanency Hearing**	98%	98%		100%	0%

Chart 2p



Source: Iowa Children's Justice; October 2019- March 2024
*From DHS Placement Date to Issuance of the Permanency Hearing Order in 365 days

Chart 2q



Source: Iowa Children's Justice; October 2019- March 2024
**From Permanency Order File Date to the Date of the Last Permanency Review Hearing in 365 days.

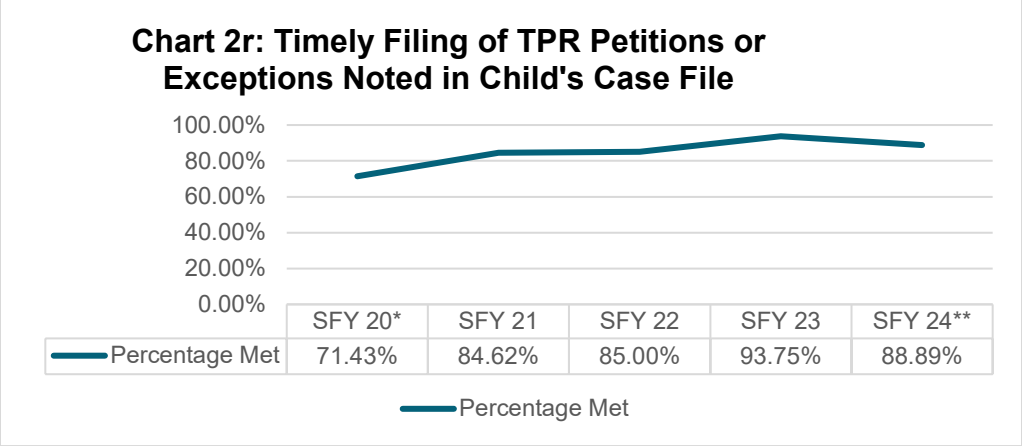
Item 23: Termination of Parental Rights

When a child is in foster care under the responsibility of HHS for 15 of the most recent 22 months, HHS staff follows local protocols to initiate a petition to terminate parental rights unless:

- The child is placed with a relative, or
- There is a compelling reason that it is not in the best interest of the child, or
- HHS has not provided services identified in the case plan necessary for the safe return of the child, and the court grants a limited extension.

If exceptions or compelling reasons to the timely filing of TPR exist, staff documents the exceptions or compelling reasons in the child's case file.

The case review data in the chart below shows improvement in timely filing of TPR petitions or if a TPR petition was not filed, the worker noted exceptions/compelling reasons in the child's case file.



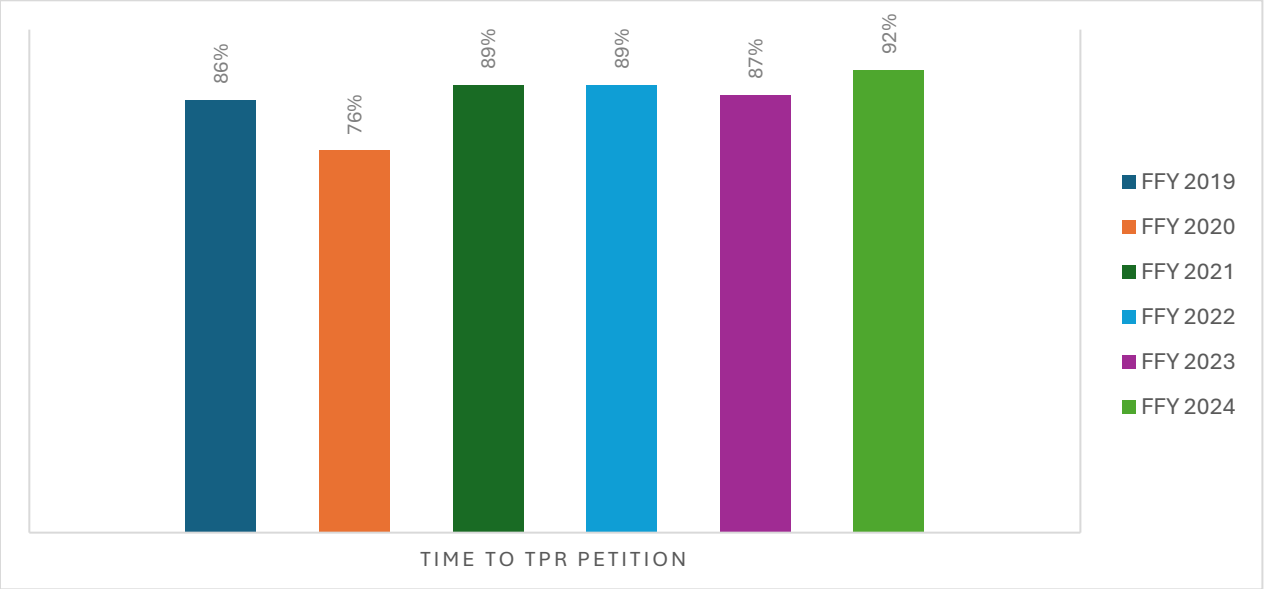
*Partial year of CQI data -- not reported to Federal CB; **July 2023-December 2023 (close of PIP)

There is typically one petition filed for each parent. The county attorney, acting on behalf of HHS staff or by order of the court, usually files the petitions, which must occur by the end of the child's fifteenth month in foster care, unless exceptions or compelling reasons exist as noted above. However, Iowa policy stresses that it is important that permanency planning occur early in all foster care cases and that nothing prevents earlier petitions to terminate parental rights when appropriate.

Table 2p represents data collected by Iowa Children's Justice (ICJ). The data represents TPR petitions filed from across the state. There are no known limitations for the TPR petitions data. Charts 2s and 2t represent the timeliness of termination parental rights petition and termination order from 2019 through the end of March 2024.

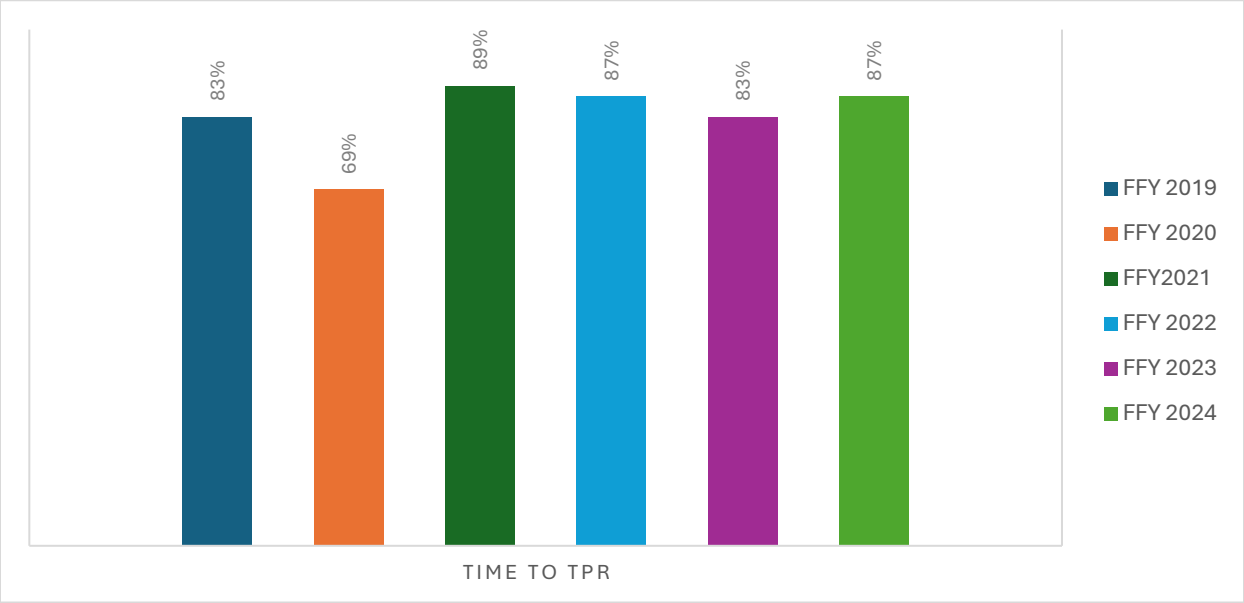
Table 2p: Timeliness of Termination of Parental Rights (TPR) Petitions					
Court Function Indicator ***[Specific, observable, and measurable]*** **Timeliness of Permanency Hearings**	**Previous Year Baseline Rate (FY2023)**	**Initial Baseline Rate or Level (FY2024)**		**Target**	**Difference From Baseline** *[Difference in the annual level from the baseline.]*
Time to TPR Petition	87%	92%		100%	5%

Chart 2s



Source: Iowa Children's Justice, October 2019- March 2024
* Target is 100% of the cases will meet this measure
*From CINA Petition Filing to Termination Petition Filing in 455 days.

Chart 2t



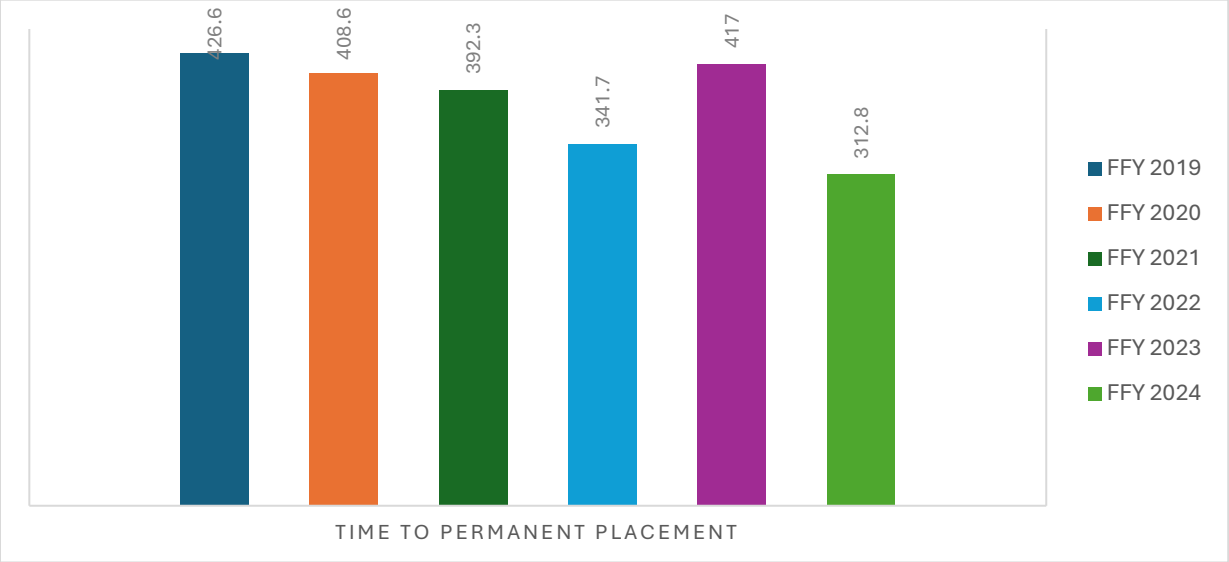
Source: Iowa Children's Justice, October 2019- March 2024
* Target is 100% of the cases will meet this measure
*From CINA Petition Filing to Termination Petition Order in 545 days.

Chart 2u represents the number of days to achieve final permanency for a child from FFY 2019 through the end of March FFY 2024

In reviewing the data around permanency, there was a decrease in the number of cases that came to the attention of the court during pandemic and the cases achieving permanency during 2022 would have been initiated then. One factor may have been that the lower caseload allowed them to move more quickly in achieving final permanency.

The Chief Justice of the Supreme Court and the Director of HHS held listening sessions in 11 locations across the state. The listening sessions included sessions with representatives from HHS, the legal community, private providers, and foster parents/caretakers and CASA. Following these listening sessions, there were renewed efforts towards permanency.

Chart 2u



Source: Iowa Children's Justice, October 2019- March 2024

Item 24: Notice of Hearings and Reviews to Caregivers

The Iowa process by which foster parents, pre-adoptive parents, and relative caregivers of children in foster care receive notification of a court hearing held with respect to the child occurs through the clerk of court or the caseworker. Through the clerk of court, the court uses its' automated system to send notices of upcoming hearings to foster parents and other caretakers. A data match between HHS' foster parent or other caretaker contact information, i.e. name and address, and the court data is the source of information by which the automated system sends the hearing notices. A limitation of this data match may be timely HHS staff data entry to ensure the caregiver's name and address is current (see Item 19 above). The court monitors the automatic notification process to assure it runs timely. Attachment 2A is a sample court notice, which shows information on the hearing date, time and location as well as the caregiver's right to provide information during the hearing.

Current or Planned Activities to Improve Performance on Case Review System:

- Item 20: Written Case Plan - Implement a revised case plan that is user-friendly for families, providers, and court partners
- Item 21: Periodic Reviews – Conduct more analysis on this item. Data is currently being discussed related to periodic review hearings and permanency hearings at quarterly ICJ advisory committee meetings. There is a quarterly timeliness measures report that is run which is based on actual court information and the results of the annual case file review to inform this discussion. Representatives from HHS central policy department and the field which are on the advisory committee participate in these discussions.
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- Item 22: Permanency Hearings – Continue to work on conducting timely initial permanency hearings

- Item 23: Termination of Parental Rights – No planned activity at this time.
- Item 24: Notice of Hearings and Reviews to Caregivers – Review and revise automated court notice. The automated notice of hearings for caregivers is dependent on the current placement information in the HHS case management system. HHS SW IIs have three days to enter new placement information into their system. This information is sent directly to the court's information system. HHS has been working with staff on making sure placement information is current and entered timely. A small work group to revisit the language in the notice, that is automatically sent, was recently convened. The ICJ advisory committee just approved the revised language. Work will be done with the IT Department to update the new language in the court information system.

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Quality Assurance System

Item 25: Quality Assurance System

The QA&I Bureau is a support system for field to collect data, analyze, explore, and structure continuous improvement efforts; these efforts range from streamlining existing processes through the design of processes and implementation plans for new initiatives; diverse workgroups made up of stakeholders are utilized as an efficient way to make meaningful change. Additional information regarding this is shown below.

The QA&I bureau consists of nine QA&I Coordinators and six Management Analysts; this combination of personnel promotes the comprehensive PDCA (Plan-Do-Check-Act) process in the continual improvement cycle. A QA&I coordinator is officed in each service area; the remaining bureau staff are centralized and able to provide statewide support.

Data is collected and analyzed routinely in joint efforts between the QA&I bureau and service area leadership teams; this analysis informs decisions regarding the effectiveness of interventions and whether strategy changes are warranted. The coordinators serve as liaisons between statewide and service area initiatives to assure an aligned approach to continuous improvement; they support statewide standard practices as well as practices that benefit most from local decision-making.

The QA&I bureau discusses service area foci, initiatives, and data; statewide performance and trends; lessons learned through improvement efforts; and new skills/knowledge gained through training that others in the bureau may benefit from. We strive to openly communicate to learn from each other, assure everyone stays informed of initiatives in order to prevent duplication of efforts, and to spread successful practices. Communication is essential and is a primary goal for the QA&I bureau.

There are multiple avenues of intersection between field staff and the QA&I bureau, primarily:

- Service Business Team (SBT) chartered work groups
- Request for QA&I assistance
- Service Area data collection, analysis, exploration, initiatives

The administrative foundation of the QA&I bureau centers on the SBT, the operational decision-making body for the Division of Family Well-Being and Protection, Child Protective Services.

This team integrates feedback received from stakeholders internal and external to HHS, legislative initiatives and requirements, and agency-focused goals with data analysis; they develop a prioritized approach to addressing the work and charter assignments as appropriate. These assignments often involve improving processes, streamlining work in efforts to do more with less, and designing new work processes to stay current on evidence-based programs, best practices, mitigating an identified gap, and legislative mandates. SBT assigns a representative to serve as primary contact for guidance; when objectives are met, results are shared by the team with SBT membership. Information is cascaded through statewide groups such as with Social Work Administrators and Service Area Managers, then cascaded through the service area teams. In addition, representatives from stakeholder groups are included in the work itself, which then leads to ongoing updates with peers. Iowa HHS recognizes that change management is most effective when people who are doing the work are involved in identifying approaches to reach the desired outcome, promoting ownership and empowerment; this is a foundational concept guiding the operation of the QA&I bureau.

Another regular intersection is for specific requests for QA&I assistance. A request form is available on the QA&I SharePoint and is accessible to all of HHS. The requestor can outline the area of focus, data that indicate an opportunity for improvement, the desired outcome, and who will benefit; the QA&I Bureau Chief reviews, assigns priority based on the breadth of impact, consequences of not addressing, consideration of active projects already prioritized, and capacity. The SharePoint request process is newly implemented; all requests, including those prioritized by SBT, utilize this process. Previously, information was tracked but was not systematic or standard; collecting and analyzing actual data on project requests received and the bureau's ability to respond will be used in planning for future needs of the bureau; it will also be analyzed for trends in requests to proactively plan for the use of resources.

The third primary intersection occurs within the service area teams. The QA&I coordinators are deployed throughout the state, with one officed in each of the five service areas. This allows for optimal integration of both service area data and statewide performance, assisting in alignment and consistency; it also allows for exploration of root causes of local trends. Participation as a member of the service area team results in trusted relationships and open conversation in staff meetings when data are shared, discussed, and analyzed; the input of those closest to practice is essential when assessing the underlying factors impacting performance.

In addition to routine communication within the service areas, there are multiple strategies in place to assure statewide feedback is reaching stakeholders:

- Membership of the QA&I Bureau Chief on SBT. This allows for real-time context, coordination, and collaboration as priorities are identified and strategized;
- Ongoing attendance of SBT representative at Social Work Administrator meetings to discuss updates, request involvement, receive feedback, and serve as liaison;
- Participation of the QA&I Bureau Chief in the Supervisory bi-monthly conference call. This is the regular venue for communication of statewide CFSR results, dissemination of PIP progress, and sharing information regarding continuous improvement projects that impact Field staff; there is always an opportunity for questions and Supervisors are asked to email directly if they have feedback they'd rather not present in a group.

- Federal reports are posted to the Iowa HHS website, including CFSR on-site results, PIP, and Progress Reports.

The sharing of information is an ongoing process, as is receiving feedback from stakeholders, in order to effectively utilize the PDCA model. Internal to HHS, multiple avenues are established but it has been more difficult to routinely gain information from external stakeholders regarding their experiences with HHS. Significant changes related to Families First legislation, changes in contracted services, and implementation of multiple CFSR PIP strategies highlighted the need to hear how these were impacting our stakeholders. This prompted HHS to reach out to stakeholders, requesting participation and feedback in multiple geographic areas across the state.

HHS has gone through many changes over the last several years and continues to adjust. Several changes in structure and personnel in key leadership positions led to establishing "town hall" type meetings across the state. While COVID restrictions delayed efforts to make personal contact with stakeholders across the state, the reduction of risk has seen the Director of HHS, leadership of Family Well-Being and Protection and Child Protective Services, and the Court Improvement Project coordinator initiate significant interaction with a wide range of stakeholders; the goal has been to understand their perspective of the child welfare system's strengths, gaps, and opportunities. Iowa leadership held 11 listening sessions across the state with stakeholders between July 2022 and November 2022; this included Courts, Tribal leadership, Foster Parents, Relative Caregivers, Service Contractors, Education representatives, Attorneys, GALs, Community Providers, etc. This information gathered has already impacted decisions within the Department and will be incorporated into strategic planning as well. In addition, Family Well-Being and Protection and Child Protective Services conducted meetings around the state in 2023 focusing on gathering feedback from HHS staff; trends were identified and incorporated into Division planning. Iowa also received results from the C!A assessment of Iowa's child protective services which fed additional context and meaning to some of the input heard from HHS employees. Input prompted focus on turnover through sign-on and retention bonuses, exploration of pay scales due to perceived pay inequities, the need for ongoing opportunity for information to be communicated as well as to communicate with leadership, tension between roles resulting from not fully understanding the conditions under which each work, and more. Routine updates regarding reorganization of HHS have been provided through quarterly Town Hall meetings.

Collaboration has also been integrated with continuous improvement initiatives through participant involvement. A core belief within the QA&I bureau is that identification and inclusion of stakeholders in a process – both internal to HHS and external, such as parents, foster parents, providers, etc. – are essential to the success of any improvement initiative.

Additional examples of inclusion of stakeholders in continuous improvement are efforts that have been made to assure the CCWIS project is fully vetting the needs of Field staff and stakeholders during this planning process. Design groups have been chartered for revamping the Case Permanency Plan and the Case Notes template. The goal of each was to create a document that was easily navigated, the content provided the information needed, and that information was not buried within the documents. Regarding the case permanency plan,

surveys were sent to stakeholders (Court, Field, Families) to gather feedback; at the completion of the design, the draft was piloted with judges and a small group of social workers from each service area; this was followed by a facilitated discussion regarding their feedback. A similar approach was taken with the case notes draft template.

Capacity of the QA&I bureau has been enhanced through the increased use of virtual meetings; projects are evaluated when planning to determine if it's necessary to meet in person (example, the size of the group could impact effectiveness) or if virtual participation would be as effective. This allows for greater participation from representatives across the state and for streamlined work. This also decreases time spent on travel when it is not necessary.

There have been numerous continuous improvement workgroups over the last year prioritized and chartered by SBT focusing on topics such as:

- Family Assessment process, requirements, guidelines
- Re-design of Iowa's Case Permanency Plan to be implemented in coordination with CCWIS
- Re-design of Iowa's Case Note to be implemented in coordination with CCWIS
- Guidelines to address medical marijuana use in child welfare cases
- Concurrent planning
- Bridge meetings
- Adoption records archiving, standardization
- Relative and fictive kin expedited licensing process
- Trauma support to staff
- Focus groups with social workers and supervisors on successful strategies for child visits

The QA&I bureau's role in these activities is to serve as the neutral party that facilitates the workgroup using Lean tools to identify gaps, barriers, and ultimately solutions prioritized by anticipated impact and difficulty. Each of these efforts resulted in team recommendations for improving processes and increasing positive outcomes. Group outcomes include a plan for communication, implementation, and training to assure comprehensive planning. This allows for coordinated implementation, clear timeframes to understand changes seen in practice, and coordinated follow up review of impact statewide.

The workgroups referenced above were each facilitated by two members of the QA&I bureau; generally, experienced facilitators are paired with less experienced facilitators to set up a learning environment. This pairing is beneficial to both as discussions center on "why" and "how", making facilitators think about best ways to achieve outcomes, sometimes utilizing that fresh perspective to adjust the approach. Through this type of mentoring, staff are able to benefit from experiential, hands-on learning; this is a valuable tool in enhancing the capacity of the QA&I team. This approach also promotes teamwork and sharing of expertise. As members of the QA&I team attend trainings, such as Iowa Lean Consortium conferences, Iowa Department of Management classes, community college class, or come across tips learned individually, information is regularly shared with the rest of the bureau through monthly meetings.

Iowa continued the established process for reviewing CFSR cases throughout the PIP period:

- Review teams of 2, consisting of a Supervisor and QAI Coordinator
- Total of 65 cases reviewed/year

Now that Round 3 has been completed, Iowa is now examining lessons learned, and has reached out to other states regarding their processes and what they've found most effective as well as efficient. Information gathered seems to indicate other states are carving out the CFSR process and providing significant resources in order to assure the process is sustainable. Iowa understands that it is in our best interest to increase the number of cases reviewed annually in order to have data that accurately represents performance; in addition, while utilizing focus groups with internal stakeholders, we consistently heard that it's very beneficial to have supervisors involved in the review process. This interaction is seen as a natural way to spread understanding and alignment of practice and CFSR philosophy. The difficulty is limited resources that are pulled in many different directions. Iowa is currently actively evaluating efficiencies to the review process, brainstorming options for different structures that may be possibilities, and trying to land on the best balance possible to assure sustainability and integrity of the reviews in an ever-changing environment.

Iowa recognizes the essential need to collect, analyze, and make decisions based on data; significant progress has been made, and continues to be made, to make data available to stakeholders. While there are many applications in which to view data, the ultimate source of that data is the CWIS system; work continues tailoring the FACS replacement system to the needs of the users on behalf of children and families. (See Statewide Information System Systemic Factor).

Each service area routinely reviews Iowa's Key Performance Measurement (KPM) reports, Results Oriented Management (ROM) reports, case review data (OMS-generated), and a selection of additional reports relevant to service area-specific foci. As discussed previously, the QA&I role with data is integrated, focused on helping others understand what the data represent, coordination with peers as needed, and planning for exploration, case review, additional data analysis, etc. Below are some of the primary data sources, reports, and ways data are used:

OMS: HHS utilizes OMS reports to share data on case reviews quarterly in each of the service areas, comparing the specific service area performance to the statewide performance, generally during unit meetings; this allows for active collaboration on ways to improve performance as well as sharing practices that are working well. This is a coordinated approach utilizing specific case review observations as well as trends/observations identified through OMS reports; this data is integrated with other key performance data that have been identified in Iowa to enhance understanding of performance. The OMS reports are routinely used to explore specifics within individual items. One example used throughout Iowa's PIP monitoring period was item-specific cumulative information on agency performance differences between mothers and fathers; increasing the involvement of fathers was a primary strategy in the PIP and we were able to assess performance across multiple items and timeframes. Statewide trends are compiled based on case review summaries as well as systemic issues that are identified as gaps during the reviews. Service area leadership has expressed the benefits they have seen from these

discussions, not only to understand trends but to build teams through sharing ideas among the supervisors.

Upcoming changes to the OMS for Round 4 will enhance Iowa's ability to generate data more efficiently for geographical areas as selection criteria for cases will be grouped rather than the need to select each county within the area of interest. The OMS provides several reports that are especially helpful and used routinely:

- Statewide Performance Report – used throughout the review and continuous improvement process; this is core information regarding progress.
- Multi-Item Data Analysis Tool – is especially helpful with analyzing performance and trends across multiple characteristics and items.
- Practice Performance Report – provides summarized data specific to the scoring distribution among all sub-items; this also assists in the analysis of interactions between items and trends while providing a concise overview of performance on OSRI sub-items in one report.

Data Dashboards: Members of the QA&I bureau had the opportunity to participate in classes at the local community college that focused on data collection, analysis, and presentation. As a direct result of that training, the QA&I bureau has been actively involved in establishing data dashboards for the Department. This data is used to share performance information with:

- Public stakeholders to be aware of key indicators of how the child welfare system is functioning;
- Service Contractors to monitor their performance on service-related expectations;
- Internal HHS staff regarding current performance, both of HHS and service contractors;
- HHS Leadership for current performance and strategic planning purposes.

These dashboards are very user-friendly, featuring content and visuals selected through collaboration with the stakeholders who would be using the data. In some cases, the data content was based on the foundational purpose of an area (such as child protection) or through routinely asked questions from the public; the intent is to make accessible the information stakeholders consider meaningful, indicative of how Iowa is performing. HHS receives requests for information throughout each year, most concentrated in times of legislative sessions; this data is used to inform decisions regarding potential focus areas. Other data requests are received from news media, programs related to child protection to assess preventive services, and from internal divisions for ongoing oversight of performance outcomes. Regardless of the origin of the request, the QA&I bureau routinely delves into and shares available data to keep stakeholders informed, to enhance understanding, and to assess performance.

Data Hub: In addition to specific data requests, the QA&I bureau established a data hub accessible to all internal staff; multiple ongoing reports generated weekly or monthly are maintained in one location for ease of access. These contain data that have been identified as key performance indicators that are shared and actively reviewed with Field, Policy, and Leadership. The reports contain the detail behind some of the more public reports, so the Department has the ability to explore trends and root causes to inform decisions. A small example of reports housed here include:

- Pending and completed social worker visits with children

- Caseloads
- FCS contract performance measures
- Initial placement with relatives
- QRTP/Shelter placements
- Recurrence of maltreatment
- Federal statewide indicators by service area

Data Sources: Data sources utilized by QA&I routinely include AFCARS, NCANDS, and CWIS; with upcoming implementation of VISION (CCWIS), Iowa anticipates increased accessibility to data in general and enhanced collection of information that will inform decisions and assist performance. Additional data sources utilized by QA&I include Results Oriented Management (ROM) reports, contracted through Kansas University. These reports are accessible to all staff and provide data on such things as the federal statewide indicators, disparity and disproportionality, placement data, etc.; there is also a public view available for these reports in a level of detail that maintains confidentiality.

In combination, the data available are robust, easily accessible, and meaningful; QA&I assists with identifying the specific data elements required to meet the customer's needs, pulling the data together, and assuring the customer understands what the data represent.

Stakeholder Feedback from HHS Quality Improvement Team[4]:

- Strengths:
  - QA staff located in service areas
  - QA staff provide support to service areas through sharing information, best practices, and creating custom reports
  - QA staff use service area data and performance improvement plans to track performance over time
- Areas Needing Improvement:
  - Consistency across service areas
  - Increased focus on the development and documentation of best practices

Current or Planned Activities to Improve Performance on Quality Assurance System: Current or planned activities are described above.

Staff and Provider Training

Item 26: Initial Staff Training

New Worker Training Requirements

HHS requires newly hired social work staff to complete the New Worker Training Plans by the timeframes specified for each course. The New Worker Training Plans serve as a roadmap of the training requirements within the first year of hire. Please see Attachments 6D1 and 6D2.

[4] For more information, please see - Change & Innovation Agency (C!A). November 2022. *Iowa Department of Health and Human Services, Child Welfare, Final Report of Findings and Recommendations*. pp 58-59.

SWCM training prior to caseload assignments is as follows:
New Social Work Case Managers (SWCMs) must complete the initial four days of *SW 020 Foundations of Social Work Case Manager Practice* before assignment to any cases. Following this classroom time, learners will participate in a month-long field learning experience before they return to the classroom for four days during the second part of SW 020.

Newly hired staff will work with their mentors on no more than 10 cases during their field learning experience prior to the completion of SW 020. Suggested types of cases to avoid assigning during the field learning experience timeframe include:

- Sexual abuse cases
- Severe physical abuse
- Previous terminations
- Medical neglect cases
- Child death
- Cases that have multiple CPS substantiation
- Severe domestic violence in the home

CPW training prior to caseload assignments is as follows:
New Child Protection Workers (CPWs) must complete the initial four days of *CP 200 Fundamentals for Child Protection Worker Practice* before assignment of any cases. Following this classroom time, learners participate in a month-long field learning experience before they return to the classroom for the second part of CP 200, which is three days in length.

Newly hired staff receive no more than six Family Assessment or CINA cases during their field learning experience prior to the completion of CP 200. The second half of CP 200 is scheduled months in advance and therefore there are no delays in delivering this training timely. New workers are typically assigned a mentor. In cases where a mentor is unavailable due to staffing issues, it is expected the Supervisor of the new worker will complete and document all of the mentoring activities with the staff.

<u>Supports Provided during the In-Service Training Period</u>
Mentoring Program
HHS redesigned the mentoring program based on the feedback from the Mentoring Self-Assessment results. The redesign incorporates a more formal structure, documentation, and guidance.

The training developed to reintroduce the mentoring program to HHS staff is listed below. Top Child Protective Services leadership presented on the benefits of mentoring as an introduction to each of the trainings.

- A required supervisory webinar
- A required recording for staff who are identified as mentors
- A mentee recording required for new workers

Trainer/Supervisor Meeting to Provide New Worker Feedback
The two dedicated HHS trainers conduct 1 hour-long meetings with the Supervisor of each new worker. The purpose of these meetings is to update each Supervisor on the progress of their new worker during training, review any concerns the trainer had with their progress, as well as

identify areas where the new worker could use some additional training. These calls help Supervisors to key in on what areas to focus their supervision when working with new workers.

New Worker Orientation
All new workers are required to take the New Worker Orientation, which is a recorded training assigned to them in the learning management system (LMS), called Learnsoft. The recorded orientation covers essential information regarding onboarding in a consistent manner.

In addition to this recorded Orientation, in SFY 2023 the *New Worker Course Registration Demonstration* was added as a requirement for new workers. The purpose of the demonstration is to familiarize new workers with the LMS and to assist them with registering for coursework indicated as required training during the first six months of employment on their New Worker Training Plans.

Connecting to Help Desk Staff
Another level of support provided to new staff is access to the CPS Support and Training Help Desks. During SW 020 and CP 200, new staff receive an introduction to these specialized teams of personnel. Service Help Desk staff answer more complicated practice and policy related questions, and the CWIS Help Desk answers information system questions and technical questions that arise.

Performance Assessment
Enhanced Reporting. Starting fiscal year 2020, HHS developed reporting that tracks the average length of time between new worker hire dates and the start of new worker training (SW 020/CP 200), enabling HHS to better assess the length of time it takes to initiate core training for new workers in their first three months of employment.

New Worker Timeframes Data

Table 2q: New Worker Timeframes by State Fiscal Year (SFY) – Social Work Case Managers (SWCMs)

	Average Days to Start of 020/200	# (%) within 30 Days of Hire	# (%) within 60 Days of Hire	# (%) within 90 Days of Hire	# (%) more 90 Days of Hire
SFY 24 New SWCMs (89)	29.5	46 (52%)	41 (46%)	1 (1%)	1 (1%)
SFY 23 New SWCMs	27.5	53 (53%)	43 (43%)	4 (4%)	
SFY 22 New SWCMs	25.6	54 (61%)	32 (36%)	3 (3%)	
SFY 21 New SWCMs	27.4	44 (61%)	24 (33%)	4 (6%)	
SFY 20 New SWCMs	24	48 (59%)	34 (41%)	0 (0%)	

There has been a steady increase in the average number of days between employment start and the start of SWCM new worker training over the past three SFYs, but the increase is minimal and overall new SWCMs are able to access new worker training within 30 days of their

start of employment on average. *SW 020 Foundations of Social Work Case Manager Practice* is offered every two months.

Iowa has entertained the idea of aligning start dates with the first day of training, but determined in collaboration with Social Work Administrators that it is preferable to bring new workers on board as soon as possible. During the span of time between start date and the first day of CP200/SW020, workers begin shadowing with their mentors and other seasoned staff, complete other mandatory trainings, focus on completing appropriate field learning experience activities, etc. It has been noted by a number of SWAs and Supervisors that this type of exposure to the job prior to CP200/SW020 is beneficial to new workers, allowing them to draw more connections between what they have already observed during shadowing of others and what they are taught in the classroom, enhancing their learning experience.

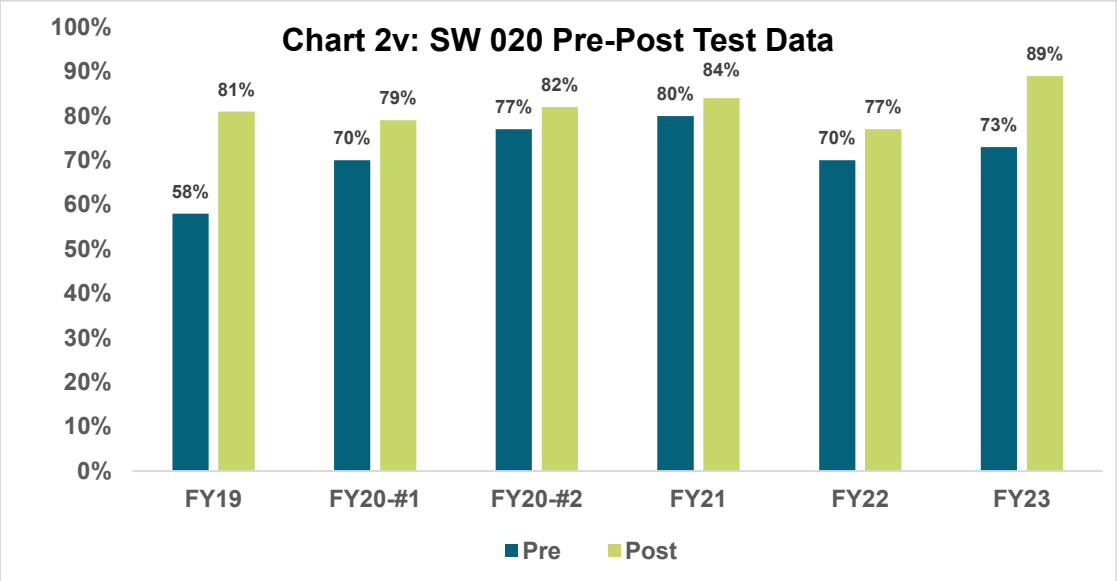
Table 2r: New Worker Timeframes by State Fiscal Year (SFY) – Child Protective Workers (CPWs)

	Average Days to Start of 020/200	# (%) within 30 Days of Hire	# (%) within 60 Days of Hire	# (%) within 90 Days of Hire	# (%) more 90 Days of Hire
SFY 24 New CPWs (48)	22.0	31 (65%)	15 (31%)	2 (4%)	
SFY 23 New CPWs	26.7	16 (50%)	15 (47%)	1 (3%)	
SFY 22 New CPWs	25.9	25 (52%)	22 (46%)	1 (2%)	
SFY 21 New CPWs	25.3	26 (60%)	17 (40%)	0 (0%)	
SFY 20 New CPWs	27	22 (63%)	9 (26%)	4 (11%)	

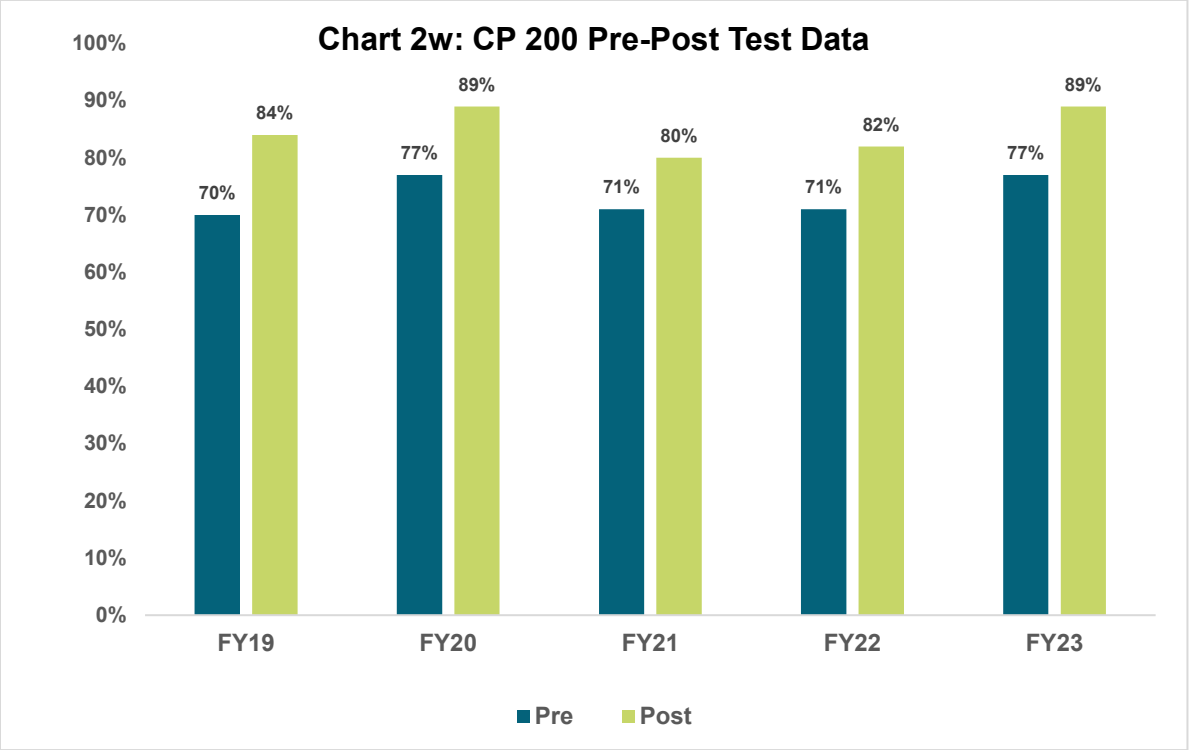
There has been an overall decrease in the average number of days between employment start and the start of CPW new worker training over the past five SFYs, most markedly over the past SFY. Overall, new CPWs are able to access new worker training within 30 days of their start of employment on average. *CP 200 Foundations of Child Protection Worker Practice* is offered every two months.

Pre/Post-Tests: Knowledge checks are administered before and after the training to measure learners' growth in course content knowledge. These results help inform assessments of course efficacy. During the annual course review, the training team critically analyzes questions frequently marked incorrectly and then determines if the course content needs to be enhanced or if the question itself should be updated.

New Worker Pre/Post-Test Data – All Data is for SFY



- As illustrated in the chart above, the average pre-test score showed improvement, rising from 58% in SFY 2019 to 80% in SFY 2021. However, it declined to 70% in SFY 2022. In SFY 2023, there was a slight recovery of the score to 73%. In the post-test, from SFY 2019 to SFY 2021, there were minor fluctuations of less than 5 percentage points within the 80% range, but it dropped to 77% in SFY 2022, reflecting a 7-percentage point decline. Remarkably, there was a significant surge of 12 percentage points in SFY 2023.
- Observing the overall trajectory, both the pre-and post-tests consistently exhibited an upward or stable trajectory, with a decline in SFY 2022 being the sole exception. However, in SFY 2023 both tests returned to an upward trend. Moreover, in SFY 2023 the gap between the pre-test and post-test scores was the largest since SFY 2019.
- HHS is not sure why the data fluctuates as it does as there are many factors that influence the pre-/post-tests scores.
- Note there are two sets of data for SFY 2020 due to a significant change in the test questions mid-year for SW 020.



- As illustrated in the figure above, the average pre-test score showed improvement, rising from 70% in SFY 2019 to 77% in SFY 2020. However, it declined to 71% in both SFY 2021 and SFY 2022. In SFY 2023, this score rebounded to 77%. Similarly, the average post-test scores initially decreased from 89% in SFY 2020 to 80% in SFY 2021 but then followed an upward trajectory, reaching 82% in SFY 2022 and 89% in SFY 2023.
- The greatest improvement in scores between pre- and post-tests occurred in SFY 2019, with an increase of 14 percentage points. Conversely, the smallest change was observed in SFY 2021, with a more modest increase of 9 percentage points.
- In SFY 2023, both pre/post-test scores increased compared to SFY 2022. Interestingly, the gap between the two scores remained similar to that of SFY 2022 despite the overall increase.
- HHS is not sure why the data fluctuates as it does as there are many factors that influence the pre-/post-tests scores.

Post-Training Course Evaluations: After the training, a seven-question survey is administered to learners via the learning management system (LMS) and is available for completion up to 30 days. The survey contains questions identifying position, time in the field, ability to apply content, likelihood to recommend, effectiveness of course engagement, and modality appropriateness.

New Worker Post-Training Evaluation Data

Table 2s: SWCM New Worker Training Evaluation		
	I will be able to apply on the job what I learned during this session. **(1 being the lowest and 5 being the highest) (AVERAGE)**	**How likely is it that you would recommend this training to another person in your position?** **(0 being the lowest and 10 being the highest) (AVERAGE)**
SFY 2024	**4.70**	**8.89**
SFY 2023	**4.78**	**9.02**
SFY 2022	**4.68**	**9.09**
SFY 2021	**4.77**	**9.15**
SFY 2020	**4.66**	**9.13**

Ratings for *SW 020 Foundations of Social Work Case Manager Practice* have remained fairly steady related to worker ability to apply learned concepts and practices on the job over the past five SFYs. Ratings related to the likelihood of recommending the training have steadily decreased, though the difference across SFYs is minimal. It is suspected larger than normal class sizes over the past two years in particular, which is a result of an increase in staff turnover and corresponding hiring, has played a role in this decrease in ratings. As class sizes grow larger, opportunities for more one-on-one attention and discussion with each new SWCM decreases.

The post-training evaluation does include open-ended questions that allows learners to provide narrative feedback on how the training could be improved. The post-training evaluation uses a consistent 5-point scale. The only exception is the Net Promoter Score (NPS) question, which asks learners to rate their likelihood to recommend the training to others in their position on a scale from 0 (not at all likely) to 10 (highly likely). The NPS is calculated by subtracting the percentage of detractors (those who rated their likelihood to recommend between 0-6) from the percentage of promoters (those who rated their likelihood to recommend between 9-10). The NPS is a metric that is used across many different industries.

Table 2t: CPW New Worker Training Evaluation		
	I will be able to apply on the job what I learned during this session. **(1 being the lowest and 5 being the highest) (AVERAGE)**	**How likely is it that you would recommend this training to another person in your position?** **(0 being the lowest and 10 being the highest)** **(AVERAGE)**
SFY 2024	**4.79**	**9.36**
SFY 2023	**4.69**	**9.35**
SFY 2022	**4.67**	**9.27**
SFY 2021	**4.71**	**9.18**
SFY 2020	**4.37**	**8.20**

There has been a steady increase in ratings of *CP 200 Foundations of Child Protection Worker Practice* over the past five SFYs in both areas of measure. This can be attributed to the high-quality facilitators training this course, updated materials, and technology enhancements to the learning.

Non-classroom setting support and education

Mentoring Program: HHS redesigned the mentoring program and developed training about the mentoring program based on the feedback from the Mentoring Self-Assessment results. The redesign incorporates more formal structure, documentation, and guidance.

Master of Social Work Stipend Program: This program aimed to support the workforce needs of HHS by setting up a Master of Social Work (MSW) stipend program at the University of Northern Iowa (UNI). During the last five years, work was done across multiple years to stand up the stipend program for HHS staff. Ultimately, this program did not come fruition as expected. HHS will continue to look for ways to improve support and education in non-classroom settings.

Training Takeaways: Starting in SFY 2023, the training team developed a new, easy to digest publication called Service Training Takeaways. This one-pager is regularly distributed and provides an overview of previous trainings and various initiatives to ensure critical information remains both relevant and at the forefront of practice. Service Training Takeaways will highlight key training points and practices, as well as links to corresponding resources. Training Takeaways distributed to staff since this publication was established include:

- Father Engagement
- Safe Plan of Care
- Domestic Violence
- SDM Safety Assessment

- Safety Planning
- Solution Based Casework
- Reunification
- Coordinating Face to Face Visits with Out of State Placements
- Engaging Relatives
- Family Interaction Planning
- Early ACCESS
- Victim Assistance Section
- Medical Cannabis

Des Moines Area Community College (DMACC) Simulation House: HHS has been utilizing the DMACC Simulation house to facilitate *SP 314 Engagement Fundamentals*. This center provides a realistic setting, complete with traditional home furnishings and top-notch equipment, allowing for enhanced learning and training opportunities. This space is used in conjunction with hired actors to simulate scenarios that HHS staff will encounter on the job, including:

- Engaging an upset parent
- A visit with a child
- Meeting with a provider or other child welfare professional
- CPW to SWCM case handoff

Virtual Home Simulation (VHS): The Virtual Home Simulation (VHS) is cutting-edge technology developed by the University of Utah College of Social Work who has generously shared VHS at no-cost with the Iowa Department of Health and Human Services. VHS provides users with the opportunity to practice identifying a possible risk to the safety of children as well as protective factors and capacities of the caregivers for each case scenario. New workers are provided with immediate feedback on what the "best" assessment decisions are based on an expert consensus profile, given the specific scenario provided. This software allows new workers to practice walking into a real-life home to assess risk and protective factors for child abuse without leaving their desk.

Effective March 1, 2024, any new SWCM, CPW, or Supervisor is required to complete the Simmons case in VHS using the coaching mode during their month-long field experience learning between Part 1 and Part 2 of *SW 020 Foundations of Social Worker Case Management Practice* or *CP 200 Foundations of Child Protection Worker Practice*. VHS is estimated to take 30 minutes to two hours to complete.

Item 27: Ongoing Staff Training

Ongoing Worker Training Requirements

HHS requires social work staff to complete a minimum of 15 training hours each state fiscal year (e.g., July 1, 2023 – June 30, 2024). During the previous CFSP reporting period, the number of training hours required for ongoing staff was modified from 24 hours to 15 hours. Given increasingly high caseloads, HHS determined more established workers (those having completed new worker training requirements) would no longer be required to attend 24 hours of training annually. The requirement was reduced to what is considered to be a more tenable minimum of 15 hours annually. Nonetheless, workers are encouraged to complete more than the 15-hour

minimum. New trainings are developed each year, many of which are mandatory for all or the majority of our staff to take. These mandatory trainings would count toward meeting the 15-hour minimum.

Performance Assessment

On-Demand Training Reporting: In August 2023, on demand training reporting was made available to CPS Supervisors, Social Work Administrators, and Service Area Managers, allowing them to easily identify at a glance which of their staff might not be on target to meet new worker training requirements or annual minimum training hours.

Post-Training Course Evaluations: After the training, a seven-question survey is administered to learners via the learning management system (LMS) and is available for completion up to 30 days. The survey contains questions identifying position, time in the field, ability to apply content, likelihood to recommend, effectiveness of course engagement, and modality appropriateness.

Table 2u: SWCM Ongoing (includes all courses except 200, 202, 020)		
	I will be able to apply on the job what I learned during this session. (1 being the lowest and 5 being the highest) (AVERAGE)	How likely is it that you would recommend this training to another person in your position? (0 being the lowest and 10 being the highest) (AVERAGE)
SFY 2024	**4.34**	**8.17**
SFY 2023	**4.39**	**8.14**
SFY 2022	**4.32**	**8.12**
SFY 2021	**4.33**	**8.21**
SFY 2020	**4.29**	**8.34**

Ratings of trainings taken by more tenured SWCMs (those having completed new worker training requirements) have remained fairly steady related to worker ability to apply learned concepts and practices on the job over the past five SFYs. Ratings related to the likelihood of recommending the training have been steadily increasing over the past three SFYs, though the difference across SFYs is minimal.

Table 2v: CPW Ongoing (includes all courses except 200, 202, 020)		
	I will be able to apply on the job what I learned during this session. (1 being the lowest and 5 being the highest) (AVERAGE)	How likely is it that you would recommend this training to another person in your position? (0 being the lowest and 10 being the highest) (AVERAGE)
SFY 2024	**4.41**	**8.21**
SFY 2023	**4.24**	**7.77**
SFY 2022	**4.34**	**8.00**
SFY 2021	**4.32**	**8.11**
SFY 2020	**3.99**	**7.58**

There has been an overall increase in ratings of trainings taken by more tenured CPWs (those having completed new worker training requirements) over the past five SFYs in both areas of measure.

Table 2w: Supervisors Ongoing (includes all courses except 200, 202, 020)		
	I will be able to apply on the job what I learned during this session. (1 being the lowest and 5 being the highest) (AVERAGE)	How likely is it that you would recommend this training to another person in your position? (0 being the lowest and 10 being the highest) (AVERAGE)
SFY 2024	**4.45**	**8.49**
SFY 2023	**4.38**	**8.34**
SFY 2022	**4.34**	**8.27**
SFY 2021	**4.35**	**8.33**
SFY 2020	**No Data Reported in FY**	**No Data Reported in FY**

There has been a steady increase in ratings of trainings taken by Supervisors over the past five SFYs in both areas of measure.

Strategies to Align Ongoing Training with Job Responsibilities

HHS Service Training Committee: Over the last CFSP reporting period, the HHS Service Training Committee resumed our work with the mission to provide feedback and expertise from

the field that will inform training for social work staff. This group meets on a regular basis to determine how to best meet the needs of staff and attend pilot trainings, which will serve to improve the perceived effectiveness of training.

Incorporation of Lived Experiences: The Service Support and Training team made a concerted effort to incorporate panels, personal stories, and lived experiences into many different courses. The consistent feedback from the Post-Training Evaluation is that these lived experience components bring the concepts to life.

Enhanced Technology: HHS has incorporated more effective technology into training. Since 2020, virtual training tool availability has increased promoting greater possibilities for learner engagement. The use of these tools helps mitigate learner disengagement commonly seen in virtual learning environments. The Service Training team has explored and implemented the following items to enhance the effectiveness of in-person, virtual, and eLearning training. Examples of these include:

- Mentimeter: This tool is used in many virtual and in-person trainings. It provides an interactive, anonymous way for learners to engage in training.
- Poll Everywhere: is a web-based audience response system that allows speakers to integrate live activities directly into their presentations seamlessly. Whether you're presenting in a classroom, at a conference, or during an online meeting, Poll Everywhere enables you to create interactive experiences for your audience.
- Kahoot: is a game-based learning platform that makes it easy to create, share, and play learning games or trivia quizzes in minutes. Whether you're in a classroom or office, Kahoot! unleashes the fun by engaging participants through interactive activities.
- Zoom breakout rooms are used frequently in most virtual trainings with the exception of lunch and learns.
- Closed captioning has been added to eLearning recordings and training videos.
- Articulate software is used to convert recordings into eLearnings that are posted in the HHS Learning Management System for wider distribution to child welfare field.
- Canva design platform is used to create more engaging handouts and course materials.

Annual Course Review (ACR) Overview: The Annual Course Review (ACR) is a critical milestone at the start of each fiscal year. Before the first training sessions, all individuals involved in the design, development, and training support process come together. Their collective efforts contribute to the quality and effectiveness of our training programs. Topics covered during the ACR include:

- Policy and Procedure Updates: We revisit existing policies and procedures to ensure they align with current standards and best practices.
- Course Alignment: Our focus extends to the core components of each course. We meticulously examine learning objectives, learning activities, assessments, and materials. The goal is to achieve seamless alignment across all elements.
- Equity and Inclusion Strategies: Recognizing the importance of diversity, equity, and inclusion, we review and revise strategies to foster an inclusive learning environment and bias awareness among facilitators and participants so they can effectively address the diverse needs of their clients.
- Expertise Collaboration: The Service Training team, well-versed in course alignment, collaborates closely with subject matter experts. Subject matter experts are community

members who have unique expertise in a specialized area. For example, the team works with attorneys, judges, counselors, actors for simulation trainings, and lived experience experts. Their combined knowledge ensures a thorough review.

- Data-Driven Decision-Making: The ACR draws heavily from data collected throughout the fiscal year. This includes post training evaluations, post-tests, and facilitator and hosts' feedback. Training staff monitor CFSR case reading results for ongoing themes and gaps that might require additional training and guidance materials to address. Training staff monitor child protective assessment case reading results for ongoing themes and gaps that might require additional training and guidance materials to address.

Collaboration Strategies

Training Announcements: Training announcements about all HHS-sponsored learning opportunities are sent statewide to providers, tribal representatives, and various other partners.

Quarterly Meetings with Partners: Over the course of SFY 2024, quarterly meetings between the Bureau of Support and Training and representatives from the Coalition of Family and Children's Services in Iowa/Child Welfare Provider Training Academy (CWPTA) have stalled. The Bureau of Support and Training has continued to provide training materials and recordings of HHS CPS trainings at the request of CWPTA staff, has engaged and responded to CWPTA questions regarding the Bureau's training structure and the content of miscellaneous HHS CPS trainings.

HHS continues to engage specific provider agency staff to assist with developing and co-facilitating specific training. Most recently, the Bureau of Support and Training worked with Kathy Thompson and Iowa Children's Justice to gather the content of their recent training on Reasonable and Active Efforts for Iowa judges and other legal personnel, seeking to utilize this same content as the foundation for its own training of HHS CPS staff to ensure a common understanding across agencies.

Collaboration and Incorporation of Lived Experiences: Over the last five years, the Bureau of Support and Training staff collaborated with the following groups to incorporate lived experiences into trainings:

- Child Advocacy Center
- Achieving Maximum Potential (AMP)
- County Attorneys
- Chief Justice Christensen of the Iowa Supreme Court
- Safe Babies Court
- Court Appointed Special Advocates
- Family First Director
- Caring Dads Program
- Parent Partner Program
- Director of Prevent Child Abuse Iowa
- Cultural Equity Alliance
- St. Luke's Child Protection Center
- Iowa Department of Corrections

- Connect and Protect Team
- The Safe at Home Program
- Safe & Together Institute
- The Iowa Office to Combat Human Trafficking
- Chains Interrupted
- Multidisciplinary Team
- One Iowa
- HHS leadership
- HHS Training Committee

Stakeholder Feedback for Initial and Ongoing Staff Training[5]:

- Strengths:
  - Service Training Team members' feedback:
    - Lunch and Learns to assist staff with policy interpretation
    - Videos and webinars available
    - Refresher trainings as needed
- Areas Needing Improvement:
  - Staff and supervisors' feedback:
    - Not given adequate time to train, shadow and be mentored before getting a caseload
    - Supervisors reported very little time to dedicate to coaching and mentoring staff
  - Court Appointed Special Advocates (CASA) feedback: HHS workers lack comprehensive training
  - Iowa County Attorney's Association (ICCA) feedback:
    - New workers need enhanced training
    - Supervisors need to be more proactive in training workers

Item 28: Foster and Adoptive Parent Training

Foster and Adoptive Parents: RRTS is in the second fiscal year of moving from TIPS-MAPP as a pre-service curriculum to using the NTDC curriculum (National Training and Development Curriculum). This new curriculum transitioned from TIPS-MAPP, beginning July 1, 2022.

The NTDC training is based on research and input from experts, families who have experience with fostering or adopting children and former foster and adoptive youth. It is a classroom and online program that prepares foster and adoptive parents with the information and tools needed to parent a child who has experienced trauma, separation, or loss.

The NTDC curriculum consists of three components that help to prepare and provide ongoing development for parents who want to adopt. The first component is a self-assessment which is a self-discovery tool to help prepare applicants the opportunity to identify their strengths and areas they need additional support. The second component is the classroom-based training.

[5] For more information, please see - Change & Innovation Agency (C!A). November 2022. *Iowa Department of Health and Human Services, Child Welfare, Final Report of Findings and Recommendations*. pp 53, 60, 64-65.

Each classroom-based training theme has clearly delineated competencies. This content is also adaptable for a remote training platform. The third component is the Right-Time Training. These trainings' themes contain information that is specific to parents who are already fostering and adopting on a variety of topics to support them as families encounter new challenges.

Four Oaks must have training available for families within 60 days of the family completing an orientation session. The aligned curricula provide families with much of the same information but allows for more flexible and accessible training across the state, especially for families in rural areas. Iowa requires prospective foster families to complete CPR, First Aid, Mandatory Reporter of Child Abuse, Universal Precautions, and Reasonable and Prudent Parenting Standards trainings prior to licensure. This allows new families to receive more specialized training related to the children in their care during the first year of licensure.

The RRTS contractors developed a variety of in-service trainings for foster and adoptive families. Topics include attachment, trauma informed parenting, crisis management, child, and youth mental health first aid, self-care, and other localized areas of interest. Foster and adoptive families may receive trainings in group settings, support groups, or conferences. RRTS caseworkers help families find training that will enhance their skills and are timely and relevant to providing care to children in their home.

CareMatch continues to be the data system HHS utilizes to manage foster and adoptive family licensing/approval activities and has been consistently used in the previous and current RRTS contracts. CareMatch records all demographic information on families, as well as history of children placed in the home. RRTS staff uploads all documents related to licensing and approval into the system and is available to HHS staff. RRTS and HHS staff can pull a variety of reports regarding foster families, children placed in the home, matching rates, and families' progress through the recruitment/licensing flow from inquiry to final decision.

The matching portion of the CareMatch system uses the information about foster families. When a child needs a foster family home, their needs, geographic location, age and gender match against the preferences, geographic location, age, and gender of available foster families.

In October of 2022 HHS began discussions with Five Points, who is the contractor for the CareMatch Program to develop an Enhanced Analytics Reporting Dashboard for RRTS that will also include some Post Adoption Services (PAS) Enhancements. The PAS enhancements will add functionality to manage information regarding post adopt families to improve services, matching, contact and communication. The development of these enhancements has been ongoing since January of 2023 with a goal of completion near roll out of the new RRTS contract on July 1, 2023. Unfortunately, there have been delays with the completion of the project and ultimately implementation. The goal for roll out is approximately April of 2024.

Foster parent required trainings are tracked as part of the home study submission process. For example, CPR and mandatory reporter must be completed prior to submitting home studies, and families must be able to show six hours of on-going training completed at license renewal. The RRTS Caseworker uses the Foster Parent Training Plan to identify training topics that

would be beneficial to individual families based on their needed skill development. All training completed by foster parents should be documented in the home study reports as well as in CareMatch.

The overall prospective resource family response to the curriculum has been very positive and evaluations of the curriculum have seen a notable reduction from TIPS-MAPP in the number of complaints the curriculum is not culturally responsive. Pre-Service Facilitators with experience in both curriculums identify the NTDC curriculum as being more engaging, more appropriate to various adult learning styles, and more responsive to the needs of prospective resource families with its wider array of topics that were left untouched in the MAPP curriculum. One specific example mentioned as being particularly appreciated is the topic of parenting children with sexually reactive behavior.

One adaptation that was made during COVID that has continued to be appreciated by resource families is the use of virtual live interactive training options for both pre-service and in-service. While in-person trainings continue to be well attended, many families appreciate the flexibility of having some training opportunities which are virtual. Rural families in particular comment that virtual trainings offer them a richer menu of training topics to attend.

Staff of State Licensed or Approved Facilities: Iowa's out of home foster care contractors of emergency juvenile shelter (CWES), foster group care/QRTP, and supervised apartment living regularly participate in ongoing training, through internal training, training offered by HHS, training provided through the Child Welfare Provider Training Academy (Training Academy), discussed below, and training through other training venues. The Training Academy provides training to Iowa's child welfare services contractors. The HHS has a contract with the Coalition for Family and Children's Services in Iowa, which provides the Training Academy. Although the training is available to non-members, most of the current HHS' child welfare services contractors are members of this Coalition. Attendance to training under the Training Academy contract is also open to others as space allows, such as HHS staff, foster parents, JCS staff, non-contracted providers, schools, etc.

In addition, licensure standards require training for staff (with a designated staff person responsible for staff development). Internal training includes, but is not limited to, agency policies and procedures, mandatory reporter training and safe use of restraints.
New contracts that began on July 1, 2023, require that Contractors provide all staff with appropriate and comprehensive training to deliver the services for which the individual is responsible and in a manner that teaches staff to promote the safety, permanency, and well-being for each child. Contractors are required to develop a training plan that includes both new staff onboarding training information and ongoing staff annual trainings to submit this plan for HHS review and approval. They are to incorporate any changes to the training plan requested by HHS and submit a final training plan to the HHS within 30 days of HHS' completed review. They are also required to execute, adhere to, and provide training as required by Iowa Administrative Rule and their accreditation.

Information in the training plan and training are to include but not be limited to the following topics:

- The System of Care Guiding Principles, the Family-Centered Model of Practice, JCS's Model of Practice, and the Child Welfare Model of Practice;

- Crisis Interventions and Stabilizations including trauma-informed care, de-escalation techniques, and policies and procedures regarding critical incidents;
- Mandt or comparable training for appropriate physical restraints to ensure safety;
- Mental and behavioral health support, as appropriate to the staff person's role;
- Culturally and Linguistically Appropriate Service Standards (CLASS);
- Domestic violence prevention and support;
- Human trafficking identification, intervention, and prevention; and,
- Transition planning, including use of the Casey Life Skills Assessment tool.

Child Welfare Provider Training Academy: The Child Welfare Provider Training Academy (CWPTA) is a partnership with the Iowa Department of Health and Human Services (HHS) and the Coalition for Family and Children's Services in Iowa. The primary objective of this partnership is to research, develop, and deliver high-quality training programs for child welfare staff and supervisors across the state. The overarching goal of the CWPTA is to enhance Iowa's child welfare system, focusing on safety, permanency, and well-being of families and children.

The CWPTA continues to improve the infrastructure to support private agencies and HHS in their efforts to train and retain child welfare staff and positively impact job performance that is in the best interest of children and families. The CWPTA actively collaborates with the Coalition's Board of Directors, subcontractors, the CWPTA Workgroup, and HHS to coordinate development and ensure effective oversight.

In November 2022, the Coalition responded to an RFP from HHS for continued partnership and contract through the CWPTA. This solicitation sought competitive proposals to enable HHS to select the most qualified contractor to provide training via the Child Welfare Provider Training Academy. The Coalition successfully secured this contract on July 1, 2023. The initial contract term is for two years, with the option to extend for four additional one-year terms.

Over the next five years, the CWPTA anticipates evaluation of the learning modalities recognized to meet the ongoing needs of the child welfare profession. Some opportunities currently identified include:

- Tailoring training schedules to address individual provider needs;
- Assessing the effectiveness of Relias to increase agency participation;
- Introduction of a variety of new trainings, topics decided by child welfare providers, and based on request and need from providers;
- Implementing a continuous review process with the CWPTA Workgroup to align offerings with provider needs;
- Creating a centralized repository of training materials and tools for easy access by members and child welfare staff; and
- Ongoing review of additional topics to consistently deliver high-quality training for child welfare contractors and staff.
- Intentional alignment across CWPTA and HHS training plans to ensure HHS staff and provider staff are being trained on the same topics.
-

The Coalition for Family and Children's Services in Iowa is dedicated to further enhancing its partnership with HHS to advance the initiatives of the CWPTA. Continuous professional development is imperative to bolster the recruitment and retention of child welfare personnel, thereby ensuring favorable outcomes for Iowa's children and families. At the heart of this partnership lies the mission to research, develop, and administer top-tier training programs for child welfare staff and supervisors statewide. The Coalition will continue to work towards the overarching goal of the CWPTA, which is to enhance Iowa's child welfare system, focusing on safety, permanency, and the well-being of families and children.

To view the SFY 2025 CWPTA Training Plan, please see Attachment 6D9.

<u>Stakeholder Feedback for Foster and Adoptive Parent Training:</u>

- Strengths:
  - RRTS Contractors[6]:
    - Transition to the NTDC pre-service curriculum has better prepared families to take children in their homes.
      - RRTS has been able to identify homes during training that may not be able to meet the HHS' goals for foster care.
    - Unintended benefit to COVID was the ability to maintain a virtual technology for ongoing training.
- Areas Needing Improvement:
  - Adoptive Family[7] training needs
    - Families need training around grief and loss and understanding what behavior responses family can expect at different developmental stages
    - Families need to understand they may need additional resources and training as their children develop and these things are completely normal
    - Families need training on how to deal and work with birth family issues. How to have a positive relationship with birth families.
    - Training around food issues and how it related to power and control issues
    - Power and control issues aimed at the maternal figure of the adoptive families

<u>Current or Planned Activities to Improve Performance on Staff and Provider Training:</u>

- Item 26: Initial Staff Training and Item 27: Ongoing Staff Training - Please see *Iowa's Training Plan, Attachment 6D*, and its attachments 6D1-6D10, referenced in *Section VI: Targeted Plans* of this report.
- Item 28: Foster and adoptive parent training (includes staff of state licensed or approved facilities):
  - HHS will work with RRTS and CISR contractors to conduct the following improvement activities:
    - Training Data:
      - In FFY 2025-2029, finalize implementation of a tracking mechanism to ensure completion of required training within specific timeframes.

[6] HHS staff collected the feedback related to this item on January 11, 2024 at a meeting with RRTS contractors.
[7] HHS staff collected the feedback related to this item on January 17, 2024 at a meeting with HHS adoption staff and RRTS staff, Adoptive Home Exchange.

- Training Content:
  - In FFY 2025-2029, in coordination with Cedar Rapids Service Area (CRSA) pilot program of therapeutic family foster care:
    - review existing initial and ongoing training requirements
    - consider additional training needs as expressed through stakeholder interviews, surveys, forums, etc.
    - revise initial and ongoing training requirements, if needed, based on identified needs
    - develop additional training to meet identified needs
  - In FFY 2025-2029, implement revised training and training requirements, if applicable
  - In FFY 2025-2029, continue to monitor progress so that foster care providers, which include staff of state licensed or approved facilities, have the knowledge base and skills needed to carry out their duties regarding foster and adopted children.
  - In FFY 2025-2029, continue to monitor progress regarding completion of NTI National Adoption Competency Mental Health Training for all adoption and post adoption staff to ensure they have the knowledge base and skills needed to carry out their duties regarding adopted children.
  - In FFY 2025-2029 develop an alternative licensing standard for kin and fictive kin placements:
    - review existing licensing requirements
    - review other states alternative licensing standards for kin and fictive kin.
    - develop initial and ongoing training requirements, if needed, based on identified needs.

Service Array and Resource Development

Iowa's child welfare service array provides enhanced flexibility and embraces strength-based, family-focused philosophies of intervention. The goal of the service array is to be responsive to child and family cultural considerations and identities, connect families to informal support systems, bolster their protective capacities, and maintain and strengthen family connections to neighborhoods and communities. Contractors have the flexibility and the opportunity to earn financial incentives when achieving outcomes related to safety, permanency, and child and family well-being. Contractors demonstrate their capacity to hire staff, or contract with community organizations, that reflect the cultural diversity of the service area or county(ies) and describe their plan to tailor services to serve families of different race/ethnicity and cultural backgrounds. Contracted service providers deliver individualized child welfare services to meet the unique needs of the children and family.

Item 29: Array of Services and Item 30: Individualizing Services

Please see Section II: Assessment of Current Performance in Improving Outcomes, Child and Family Outcomes, Case Reviews (specifically Items 2, 12, and 16-18) for data and analysis related to services.

Please see Section IV: Services of this report for information regarding Iowa's child welfare service array.

Stakeholder Feedback[8]:

- Strengths:
  - Leaders across HHS' behavioral health and disability services divisions connect to problem solve and address critical incidents
  - HHS' Bureau of Refugee Services:
    - Receives requests for services from members of Child Protection Services team
    - All staff working in the Bureau are former refugees themselves.
    - Services offered by the Bureau include language support, housing assistance, transportation facilitation, and guidance in navigating school systems.
    - Aims to foster increased trust between the different systems involved in a family's life
  - Recent changes in contracts allow family-centered services (FCS) agencies to receive compensation even for open beds, which assisted in aligning service providers' financial goals with HHS goals.
  - Family Treatment Court and Infusion Courts
    - Continue to support/expand Family Treatment Court and infusion courts to address substance use and family well-being
- Areas Needing Improvement:
  - Multiple stakeholders indicated that existing services do not adequately meet the needs of families served For more information on this see the HHS Heath Care Oversight Plan (page 4).
    - Lack of preventative resources and supports
    - Persons living with behavioral health and/or disabilities
      - Lack of comprehensive mental health services
      - Stakeholders perceived that child welfare does not recognize disability or put services in place to keep families intact
      - Late or delayed diagnosis and identification interfere with eligibility for HCBS waiver services.
      - Child welfare workers not familiar with MCOs, which creates a barrier to accessing services
    - Services geared towards victims and not the perpetrators.
    - Out of home placements:
      - Lack of providing family interactions due to family-centered services (FCS) contract caps and social work case managers (SWCMs) overwhelming caseloads
      - Due to changes in Foster Home Insurance cap some foster parents have been unwilling to take children with behavioral issues due to fear of damage in their home

[8] Sources of Feedback:

- Change & Innovation Agency (C!A). November 2022. *Iowa Department of Health and Human Services, Child Welfare, Final Report of Findings and Recommendations*. *Community Partners and Stakeholders*, pp 57-72.
- HHS central office staff discussions with Parent Partners and Parent Partner Coordinators, RRTS Contractors, Juvenile Court Services, etc.

- Residential placements utilized for children with severe behavioral issues with placement of children in same residential placement who do not need that level of placement results in worsening of symptoms for children without severe behavioral issues
- Need to develop placement options, reunification resources, and step downs from higher levels of care
- Insufficient support provided to children transitioning out of foster care system

- Disproportionately represented groups in child welfare receive disparate services, which leads to disparate outcomes
- Quality of services can be subpar with families getting minimal benefit from the services

- Some stakeholders noted that HHS court reports contain standardized recommendations instead of tailored, individualized recommendations for the family

Current or Planned Activities to Improve Performance on Service Array:

- Revise Title IV-E Prevention Services and Programs Plan to include a community pathway, broader definition of candidate for foster care and inclusion of pregnant and/or parenting youth in foster care, and add prevention services
- Establish new Behavioral Health System effective July 1, 2025, which includes mental health, children's mental health, substance abuse, and disability services
  - For more information on this initiative, please utilize the following links:
    - Behavioral Health System Alignment
    - Behavioral Health System Bill Townhall
- Implement:
  - A workgroup to examine the issues surrounding providing Family Interactions
  - Expedited licensing for relative and fictive kin caregivers
- Train HHS staff and contractors on MCOs and the services available through them

Agency Responsiveness to the Community

Item 31: State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR

Please see the following sections for examples of HHS' engagement and consultation with stakeholders:

- *Section I: Vision and Collaboration, Collaboration*
- *Section II: Systemic Factors, Quality Assurance System*
- *Section III: Plan for Enacting Iowa's Vision, Staff Training, Technical Assistance and Evaluation and Implementation Supports*
- *Section IV: Child and Family Services Continuum, Services Description and Coordination*
- *Section V: Consultation and Coordination Between Iowa and Tribes*

Item 32: Coordination of CFSP Services with Other Federal Programs

Coordination of services or benefits within HHS

HHS is the agency that administers, in addition to child welfare, a variety of services, such as the Family Investment Program (FIP), Iowa's cash benefit under Temporary Assistance to Needy Families (TANF), food assistance, Medicaid, child support, daycare assistance, etc. When child welfare social workers engage children and families, they complete a comprehensive assessment of the family and their circumstances, which might indicate current usage of these services or a need for a referral to these services. The social workers then work with the family and if needed HHS income maintenance, child support or other staff to ensure the family completes the necessary application and provides supportive paperwork for determining the family's eligibility for the services, child support payment amounts, coordination of case planning activities, etc.

For example, the social worker may have concerns about the child's safety and, working with the family, requests protective daycare assistance by working with daycare assistance staff to get such assistance approved and set up. Another example is that a social worker may coordinate case planning activities with those activities under Promise JOBS so that the parents are not overwhelmed with a plethora of activities disconnected from each other. HHS contracts with the Iowa Department of Workforce Development (IWD) to provide PROMISE JOBS services, i.e., employment, post-employment, and training activities through a Family Investment Agreement (FIA) with the family. HHS Bureau of Refugee Services provides PROMISE JOBS services for individuals with limited English proficiency.

Children in foster care may have caregivers who need daycare assistance because the caregiver works. HHS requires that daycare provided to children in foster care is a licensed or registered provider when:

- The foster parents are working, and the child is not in school, and
- The provision of daycare is in the Family Case Plan.

If there is a need, the worker proceeds to request daycare for the foster care provider by completing a form with approval by child welfare leadership, which the daycare staff then process. Iowa then reimburses the foster care provider for daycare costs, limited to the rates allowed in Child Care Assistance policy, as special issuances in the child welfare information system (CWIS).

When a child enters foster care, child welfare staff may enter information into the CWIS to complete an electronic referral to the Foster Care Recovery Unit (FCRU). The amount of parental liability for the child's foster care stay is set by a court order or by an administrative order filed by the FCRU, which is located in the Bureau of Child Support Recovery, with parental liability paid to the Collections Services Center. Referrals to the FCRU are required for all children in family foster care, group care, shelter care, or supervised apartment living. However, referrals are not required for children in PMIC placements, other Medicaid placements (i.e., Iowa Plan), non-licensed relative placements, or subsidized adoption. Child welfare and child support staff work together to ensure referral of parents are appropriate and that child support staff have all the documentation they need.

Child welfare staff continues to collaborate with HHS Medicaid staff to ensure that children in foster care receive appropriate medical care without interruption or difficulties. If there are any difficulties with Medicaid insurance coverage, the social worker or the social worker's supervisor follow-up with managed care organization (MCO) staff or Medicaid staff.

Child welfare staff submits a form to HHS' child support unit for their staff to conduct Parent Locator searches for child welfare staff. This was the same procedure before HHS' Memorandum of Understanding (MOU) with the federal Office of Child Support Enforcement (OCSE).

Iowa utilizes TANF funding for the following child welfare related work and services:

- Child Protective Assessments: HHS utilizes TANF funds to assess reported incidents of child abuse and neglect when the family is ineligible for funding under Title IV-E of the Social Security Act.
- Child Welfare Services: Iowa uses TANF funds for a number of child welfare services. These services include but are not limited to social casework, protective daycare, Family Centered Services (FCS), which includes Family Preservation Services, Solution Based Casework, SafeCare®, Child Safety Conferences, Solution Focused Meetings, Kinship Navigator Services, and drug testing.
- Child Abuse Prevention Program: Iowa's Child Abuse Prevention Program (ICAPP) utilizes TANF, Title IV-B, subpart II, and Community-Based Child Abuse Prevention (CBCAP) funding for prevention services procured through a request for proposal (RFP) for SFY 2021-2025.

Coordination of services or benefits with other state agencies and federally funded programs

Iowa also utilizes the following collaborative venues to link, coordinate, and integrate our services amongst the different service providers and across other service systems, such as early childhood, education, health, mental health, prevention, etc.

Collaboration with Early Childhood

Please see *Section IV: Services, Stephanie Tubbs Jones Child Welfare Services Program, Servies for Children Under the Age of Five* for descriptions of coordination of services or benefits with other state agencies and federally funded programs.

Also, please see *Section IV: Services, Early Intervention and Support Prevention Programs and Services* for coordination of services or benefits with the Maternal, Infant and Early Childhood Home Visiting (MIEHV) program as well as other family support programs.

John H. Chafee Foster Care Program for Successful Transition to Adulthood

Please see *Section IV: Services, John H. Chafee Foster Care Program for Successful Transition to Adulthood* for descriptions of the following coordination of services or benefits with other state agencies and federally funded programs:

- Education and Foster Care
- Iowa Collaboration for Youth Development (ICYD)
- Iowa College Aid Partnership

- Iowa Finance Authority Partnership for Housing
- Foster Youth to Independence
- Medicaid

Child Abuse Prevention Program Advisory Committee (CAPPAC)

The role of the Child Abuse Prevention Program Advisory Committee (CAPPAC), formerly known as the Governor's Advisory Council (GAC), is to assist HHS in the planning and implementation of the Iowa Child Abuse Prevention Program (ICAPP). The duties of the advisory committee, as outlined in Iowa Code §217.3A, include all of the following:

- Advise the Director of Health and Human Services and the Administrator of the Division of Family Well-Being and Protection responsible for child and family programs regarding expenditures of funds received for the child abuse prevention program.
- Review the implementation and effectiveness of legislation and administrative rules concerning the child abuse prevention program.
- Recommend changes in legislation and administrative rules to the general assembly and the appropriate administrative officials.
- Require reports from state agencies and other entities as necessary to perform its duties.
- Receive and review complaints from the public concerning the operation and management of the child abuse prevention program.
- Approve grant proposals.

The CAPPAC plays an important role in decision making around the ICAPP, including changes in the scope of services and the manner by which HHS set funding limits. The CAPPAC participated in the recruitment and review of new member applicants, with five new members beginning their terms on January 1, 2021. Three members who joined the committee in 2021 are no longer participating in the committee. New members began terms in August 2023. The committee reviewed and approved contract renewals for SFY 2024. More information on the CAPPAC is available here: Child Abuse Prevention Program Advisory Committee (CAPPAC) | Health & Human Services (iowa.gov).

Collaboration with Foster Care Review Board:

A pilot citizen foster care review board in Polk County was implemented in July 2021 to review the cases of youth who have legal permanency established as another planned permanent living arrangement (APPLA). The focus of the reviews was on transition planning and services for the youth. Due to a lower-than-expected number of youths with an established APPLA goal, the population reviewed by the pilot program expanded to include the case of some 12–15-year-olds identified by HHS.

The foster care review board received additional training on case permanency planning and the juvenile court process for this age group. The board will continue to review this population in SFY 2024 and beyond.

The top three barriers being monitored for with an APPLA goal include:

- youth needs for employment or job experience,
- youth needs for a housing plan as part of the transition plan, and

- youth needs for certified personal documents (photo ID, social
- security card and/or a birth certificate)

Current or Planned Activities to Improve Performance on Agency Responsiveness to the Community: No activities are planned outside of those noted in this section and throughout the CFSP.

Foster and Adoptive Parent Licensing, Recruitment and Retention

Item 33: Standards Applied Equally

Foster and Adoptive Parent Licensing: Families who apply to HHS to become licensed foster parents or approved adoptive parents are subject to the same rules and requirements to foster or to adopt. All applicants have background checks completed on any adult household member, have a home study completed using the same outline and content requirements, and are subject to the same pre-service training requirements. All licensed foster families must have an unannounced visit completed annually and must have six hours of in-service training annually. All licensed foster families and approved adoptive families have the same licensing/approval duration.

HHS has a process to waive non-safety standards for relatives who apply to become licensed foster parents for a child in their care. Relatives who are caring for a child in the home and who apply to become licensed or approved may have the 33 hours of pre-service training waived, as well as any non-safety standards such as bedroom space, or sibling sharing a room. Licensed relative foster parents are required to complete the same in-service training hours and other licensing requirements as any other licensed foster family.

Non-relative applicants complete the 33 hours of pre-service training, background checks on all adult household members, and the home study. Non-relative foster family applicants may be given a variance to a non-safety standard when an alternative is presented that meets the requirement. An example would be an applicant who cannot secure their divorce decree provides a written statement from a family member that the divorce occurred.

Requests to waive a non-safety standard or allow a variance to meeting a standard are presented in writing to local area leadership. The request is reviewed, and a written decision made to allow or deny the waiver or variance request. Guidance for HHS staff and leadership is outlined in the Foster Family Home manual to ensure that non-safety standards as well as variance standards are evaluated equally by Social Work Administrators. Child specific requests are voided when the child leaves the foster home.

Iowa Department of Human Services

License Capacity Variance Request

Foster Home		County
Address		
License Capacity	No. of Biological/ Adoptive Children	No. of Children Now in Placement

I am requesting approval of a variance in order to:

- ☐ Increase licensed capacity when all licensing standards are met.
- ☐ Exceed licensing capacity in order to keep siblings together.
- ☐ Care for a specific child(ren) which is above the capacity of the foster home and the child needing placement is not a sibling of any children in the home.
- ☐ Variance needed to continue licensing.

This placement is needed because:

Factors supporting recommendation for a variance:

I have contacted workers with placements already in this foster home regarding this variance.

☐ Yes ☐ No

470-3342 (Rev. 9/09) Copy 1 – DHS Licensing File Copy 2 – Child's File Copy 3 – Foster Parent

The Kinship Caregiver Program began July 1, 2021, and continues to provide financial assistance of $10/day for any relative/fictive kin that has a child court ordered to their care. With implementation of Family First, and the goal of keeping children with kin/fictive kin, HHS is

committed to a process that will assist them financially until they can become licensed foster parents. As stated above, HHS has a process to waive non-safety standards tor relatives who apply to become foster parents for a child in their care which may include bedroom space, NTDC training, or siblings sharing a room to promote licensure.

Currently the Kinship Caregiver Program is being funded through 100% state dollars. HHS continues to work towards the transition of this program to a TANF funding structure. A workgroup was established in June 2022 to complete a thorough analysis of the policy, practice, and system changes needed to shift the Kinship Caregiver Program to TANF funding. By utilizing TANF funding to support the families, the monthly amount of the stipend could be increased as well as providing the support longer than the current six months.

In SFY 2023, Iowa licensing data for foster homes indicate that 0% of foster homes were approved without meeting full licensing standards. That continues to be the goal each year moving forward.

This may include families that may have an approved exception to policy to allow licensure of a family pending a specific delay such as well testing results. The exception would allow the licensing of the home and require a safety plan until the well testing had been completed, no foster children being placed in the home, and a written statement that foster children will be provided potable water, including where the water will be obtained and how it will be transported and stored. Currently, all licensed foster family homes meet licensing standards as Iowa has not issued provisional licenses. If after licensure a licensed foster family is found to be out of compliance or no longer meets a licensing standard that has not been waived or given an approved variance, a corrective action plan (CAP) is put in place to correct the deficiencies. Failure to complete the corrective action plan may result in removal of the license.

A work group is currently being established to discuss the use of a provisional license with homes where they are late with required non-safety requirements for licensure as well as for homes where there are safety concerns, and a CAP would be necessary. This would allow families the time and opportunity to correct any deficiencies or concerns and provide necessary documentation to support any decision to deny or revoke a license.

Shelter and Group Facilities: HHS signed a Memorandum of Understanding (MOU) with the Department of Inspections, Appeals and Licensing (DIAL) for the initial licensure survey, annual and other periodically scheduled onsite visits, unannounced visits, complaint investigations, and re-licensure surveys of emergency juvenile shelter and group care facilities. HHS annually updates this MOU, which includes the monitoring of required federal fingerprint and background check requirements identified in Family First legislation. HHS is the licensing agent for these programs and uses the DIAL's written reports and recommendations to make all final licensing decisions before it issues licenses, certificates of approval, and Notices of Decision. HHS may grant exceptions to licensure policies for shelter and group care facilities by HHS when circumstances justify them, but this rarely occurs. Provisional licenses are not common but might occur temporarily in lieu of full licensure in order to give a facility time to correct licensing deficiencies. Not all identified deficiencies result in the need for provisional licensing or a formal corrective action plan. However, the licensee must correct all licensing deficiencies. Services

continue under a provisional license when a determination occurred that there is no jeopardy to the safety of the youth in care. Provisional licenses require corrective action plans that generally last for about 30 days, which is usually sufficient to correct the deficiencies and for the DIAL to re-inspect the program.

Licensing data indicates that HHS issued zero provisional licenses in calendar year (CY) 2023.

Item 34: Requirements for Criminal Background Checks

Foster and Adoptive Parent Licensing: The foster and adoptive parent licensing contractors, under the RRTS contract, prepare and submit licensing packets to Service Area field staff. Licensing packets include the following:

- Universal Precaution self-study training
- Pre-service family profile
- Health Report for foster and adoptive parents
- Immunization of household members including whooping cough (unless exemption)
- Mental Health Questionnaire
- Communicable Disease general agreement
- Foster Care Private Water supply survey (well water)
- Provision for alternate water supply (if applicable)
- Lead Paint Assessment (if needed)
- Firearms Safety Plan (if needed)
- Floor Plan of the home/living space
- Three reference names and addresses (The home study licensing worker selects and contacts three additional references.)
- Criminal background checks
- Auto insurance/registration
- Verification of pet vaccinations
- Verification of marriage licenses/divorce decrees
- Applicable consents to release of information
- The Foster Family Survey Report, which documents the foster family's compliance with all licensing requirements
- The home study summary and recommendation
- All forms obtained through record checks and assessment of the family.

All prospective foster and adoptive families and adults in the home complete record checks as required by federal policy. HHS staff monitors the safety of children in care through ongoing safety and risk assessments conducted during monthly visits with the child and foster parents as part of the case planning process. Service providers also monitor safety of the child through the provision of services and report any concerns to HHS for follow-up.

The RRTS contractors have an HHS approved checklist of all required documents that need to be in a packet. HHS licensing staff review 100% of all packets and advise the RRTS contractor if a document is missing. Missing documents and dates requested are recorded on a tracking tool by HHS.

Caseworkers learned quickly to make adaptations as needed to ensure that consultations with applicants did not delay licensure. RRTS contractors have continued to struggle this past year with staffing issues requiring juggling of caseloads and prioritizing of tasks to ensure that families were licensed timely but have seen improvement recently as the workforce stabilizes.

Due to the new contract specializing the roles of the RRTS caseworkers HHS has received feedback from Four Oaks leadership that staff have felt more job satisfaction and hope this will positively impact staff retention.

Shelter and Group Facilities: The HHS has a MOU with the DIAL for DIAL staff to conduct initial and renewal licensing inspections, which includes review of the facility's child abuse and criminal history checks for new facility employees. As of July 2019, this includes the use of federal fingerprint-based background checks for employees, as described in Family First legislation. Family First applies the same national background check requirements currently applied to foster and adoptive parents and relative guardians to any adult working in a childcare institution, including adults who do not work directly with children. These requirements are the fingerprint-based criminal records checks of national crime databases and child abuse and neglect registry checks from the state or tribe where the adult resided in the preceding five years (collectively referred to as the national background check requirements). Completion of all necessary record checks must occur prior to employment or licensure. Childcare institutions include group homes, residential treatment centers, shelters, and other congregate care settings for which Iowa draws down Title IV-E funding.

HHS staff sends completed application materials for initial and renewal licenses to DIAL for conducting the licensing inspections. DIAL staff provides written reports to HHS staff containing documentation of findings and licensure recommendations within twenty (20) business days following the inspection. When a facility is required to provide a plan of correction, DIAL staff provides its recommendation to HHS staff regarding the plan. HHS staff then makes licensing decisions, including decisions of approval for the corrective action plans, based on the DIAL report and other available information. HHS then issues the licenses to applicants as applicable. Shelter licenses are for one year; foster group care facilities licenses vary from one to three years; and supervised apartment living cluster site licenses are three years.

HHS central office staff took all child welfare, facility contracts that were up for review from January 1, 2023, through March 31, 2024, and reviewed the contractors' DIAL licensing review and unannounced visit reports. For that period, there were 62 reports completed. Of these 62 reports, 51 indicated completion of the criminal background checks in accordance with the federal requirement. 8 of the 11 reports that did not meet requirements were lacking information regarding child abuse checks in states where new hires lived in the past five years. This continues to be a problematic process, as each state carries out these checks differently, and some states will not complete the checks for employment purposes.

Item 35: Diligent Recruitment of Foster and Adoptive Homes

At the start of the contract, July 1, 2023, the Recruitment, Retention, Training and Support of Resource Families (RRTS) provider received child welfare information data on children in foster care in Iowa, including race and ethnicity data, as well as race and ethnicity data on licensed foster parents. The HHS requires that RRTS contractors collaborate with HHS staff in their service area to develop a recruitment and retention plan to address the needs of that area, including foster families of color, families for sibling groups, families for teens and families who can care for children with specialized medical or behavioral needs. HHS and RRTS contractors review these plans throughout the year and adjust the plans as needed based on changes in

the data. The RRTS contractors are also able to track the race and ethnicity of foster families in their area and use that data to track numbers of families and the areas where families live. The new contract has a paid performance measure for the RRTS contractor to increase the number of families of color based on a target provided by HHS. It is an annual target with progress towards the target being tracked and reported quarterly to the service areas.

Table 2x: SFY24 Target for PM2 Recruitment and Retention of Families of Color

Service Area	Baseline	Increase number	Goal
Western	33	2	35
Northern	30	2	32
Eastern	25	1	26
Cedar Rapids	45	2	47
Des Moines	45	2	47

For the last two state fiscal years RRTS providers have run biannual LGBTQI+ specific orientation sessions targeted to LGBTQI+ identified prospective foster/adoptive families as well as families who have children or loved ones who identify as LGBTQI+. We have partnered with PFLAG chapters, Iowa Coalition Against Sexual Assault, Achieving Maximum Potential (AMP), One Iowa, and other community advocacy groups to conduct outreach to LGBTQI+ communities and to educate non-LGBTQI+ stakeholders about the needs of this specific population. We have conducted numerous training sessions, including the first training session on conducting inclusive and affirming home studies for applicants who are Transgender.

For the last two state fiscal years RRTS providers have conducted multiple Spanish language orientation sessions, assisted by Sonia Reyes of the Iowa Human Rights organization. The most recent orientation session had more attendees than the one before. Spanish language recruitment, outreach, and language appropriate orientation sessions will continue to be consistent throughout each state fiscal year. RRTS has added to the number of RRTS team members who are bilingual Spanish/English speakers to further ease the licensing/approval process for applicants whose primary language is Spanish.

Barriers in diligent recruitment have been:

A predominantly white, heterosexual, English only RRTS workforce which is not yet reflective of the communities they are serving. Four Oaks continues to strive to improve the diversity of their workforce and has seen some improvement during this last state fiscal year. We are also constantly training, guiding, and educating our staff towards improvement of their overall cultural responsiveness. Four Oaks is working to establish internship/relationships with undergraduate and graduate level social work programs at colleges and universities across the state to create

the path from education to internship to permanent full-time employment. They also utilize their established relationships with stakeholders and organizations operating in the area of child/family wellness in communities of color to pursue applicants for vacant positions.

Difficulty in locating and utilizing interpretation/translation services for very specific language groups. The most notably difficult language group we have struggled with is Chuukese and have had to go to the closest state (Colorado) with a Chuukese speaker.

See Attachment 6A1 – FFY 2025-2029 Diligent Recruitment Plan for detailed information.

Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

The Interstate Compact on the Placement of Children (ICPC) is a statutory agreement between all states, which provides safety and protection to children in out-of-state placements. Each state adopts and enacts the rules and regulations of ICPC, which govern policies and procedures states must follow when placing children out of state. The agreement also includes directives to a state's financial responsibility for the welfare of each child's placement.

The Iowa ICPC unit is in the Iowa HHS Division of Family Well-Being & Protection, Child Protective Services Operations. ICPC home studies are completed by Iowa's RRTS contractors. The request is sent by Iowa ICPC staff to the RRTS contractors for completion of the home study. Upon completion, the home study is reviewed by Iowa ICPC staff before sending to the sending state. In alignment with the Safe and Timely Act and per the contract with the providers, there is a 60-day timeframe expectation to process and complete parent and relative home studies. Per ICPC Regulation 7 expedited home studies are to be completed within 20 business days and that timeframe is also included in the RRTS contracts. If a worker is requesting licensed foster/adopt home studies, then licensing requirements may not be completed in this 60-day timeframe; however, the worker would receive a preliminary home evaluation.

Completion of a home study includes review of the proposed resource prior to placement in the receiving state. Each home study assesses the safety of the home and ensures the placement resource can meet the individual needs of the child. Once approval of the home occurs and the home receives the placement of the child, the receiving state provides post placement supervision and reports until permanency establishment or until the child returns to the sending state. If a child placed experiences a disruption in the placement, the receiving state would notify and assist in returning the child to the sending state's jurisdiction.

Reports providing data for an overview of the timely completion of home studies are still not available in National Electronic Interstate Compact Enterprise (NEICE). The Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) along with the American Public Human Services Association (APHSA)/Tetrus are continuing to discuss and develop additional reports. The primary focus of APHSA is onboarding additional states to NEICE and supporting those states already using NEICE. There is a report that states can use to track completed, pending and overdue home studies, but that is a "point in time" report and is unable to provide historical data. Iowa ICPC uses this report to track completion of home studies as the case progresses. Additionally, NEICE generates alerts/notices when the due

date is approaching and then the case is flagged once the due date has passed so anytime the case is reviewed, it's clear the home study is overdue.

Below is information from the RRTS providers on timely completion of Iowa ICPC home studies for Calendar Year (CY) 2023. In reviewing the data, we've discovered that there was a higher percentage of home studies not sent within 60 calendar days than prior years. As a result, we met with the Foster Care Program Manager and RRTS Service Contract Specialist to discuss the timeliness of ICPC home studies. It was discussed that there was a change in RRTS provider during the calendar year due to a contract renewal occurring mid calendar year and possible impacts of that change. We identified some cases where updates of the home studies progress were provided; however, the preliminary home evaluation was not sent by RRTS provider. ICPC staff are going to be involved in ongoing discussions with program, contract specialist and providers to address the timeliness of ICPC home studies and areas for improvement. Additionally, we identified there were cases where timing of entries into NEICE impacted timeframes and timeliness outcomes. These are areas where the ICPC Unit is reviewing further. We plan to get review timeliness data for the 1st months of this calendar year to further assess timeliness and possible impacts.

Table 2y: Timely Completion of Iowa ICPC Home Studies – CY 2023			
Reg Type	**Total Completed**	**Total Timely**	**Comments**
Reg 1 & Reg 2	125	66	24 cases of the cases recorded not timely were 1-4 days past the due date 39 cases of the cases recorded not timely were 10 days or less past the due date And additional 4 cases had home study progress updates sent timely, but preliminary home evaluation was delayed
Reg 7	13	5	5 additional cases sent within 1-3 days past due date 1 case the relative was nonresponsive to contract provider for several weeks

Below is data available from NEICE for children whose placement into Iowa occurred during the specified SFY.

Table 2z: Children Placed into Iowa by State Fiscal Year (SFY)			
Type of Request	**SFY 2021 – Number Placed in Iowa**	**SFY 2022 – Number Placed in Iowa**	**SFY 2023 - Number Placed in Iowa**
Reg 1	5	10	5
Reg 2	71	93	69

Reg 4	9	6	3
Reg 7	8	16	6
Reg 12	11	11	18

Below is data available from NEICE for Iowa children whose placement outside of Iowa occurred during the specified SFY.

Table 2aa: Children Placed Outside of Iowa by State Fiscal Year (SFY)			
Type of Request	**SFY 2021 – Number Placed Outside of Iowa**	**SFY 2022 – Number Placed Outside of Iowa**	**SFY 2023 – Number Placed Outside of Iowa**
Reg 1	6	5	2
Reg 2	74	74	75
Reg 4	38	40	65
Reg 7	13	19	18
Reg 12	5	6	11

While a regular timeliness report regarding ICPC processing timeframes is still not readily available in the NEICE system, APHSA and Tetrus have been willing to provide Iowa ICPC with timeliness data when requested. Given resource limitations, the data may not be available immediately upon request. The following is timeliness data for Iowa ICPC's processing of outgoing requests based upon the date the request is sent to Iowa's ICPC unit from our local field staff to the date it is sent to the sending state. This processing time includes the review of the outgoing request and gathering of any additional information to ensure the request is complete. We've identified that possible reason for delays could be caused by the time data entries are made in Neice from the processing time by our ICPC unit. We intend to have further conversations with APHSA and Tetrus to help improve timely completion of home studies for Iowa ICPC. APHSA reported at the AAICPC National Conference in May 2024 that Timely Completion of Iowa data will be soon available through NEICE that will be able to show real time data while it will compare to the National data; however, no timeframe was provide on when that will be available for states.

Table 2bb: Timeliness Data for Iowa ICPC Processing Outgoing Requests			
Type of Request	**SFY 2021 – Average Calendar Days**	**SFY 2022 – Average Calendar Days**	**SFY 2023 – Average Calendar Days**
Reg 1	2.3	3.7	14.5
Reg 2	1.6	1.5	12.4
Reg 4	2.5	2.4	3.4
Reg 7	0.3	1.7	4.2
Reg 12	0.5	0.7	1.2

The RRTS provider assists HHS staff in finding adoptive families for waiting children by:

- Registering the children on the national exchange through AdoptUSKids;
- Providing adoptive families with AdoptUSKids registration information; and
- Facilitating information sharing between adoptive families and HHS adoption workers.

Strengths and Opportunities for Improvement: Iowa continues to have a process in place to ensure effective use of cross-jurisdictional resources. Iowa ICPC has provided on-going training to field staff and supervisors, as well as our licensing agency through Lunch & Learns that pertain to ICPC to help improve timeliness of completed home studies. Iowa ICPC continues to work with other HHS staff, tribal staff, and AG staff on Tribal Customary Adoptions to continue to explore opportunities to improve the process as well as ensure it is available in appropriate situations. In working with other states involving Iowa children placed there and our field staff are pursuing a TCA, we found that not a lot of other states have dealt with this process nor are they using TCA's. Iowa ICPC has included the ICPC National Office into the discussions to increase awareness within the ICPC community as well as assist with discussions. Thus far, other states have been very interested and open to the TCA process, and this included further discussion for the AAICPC/APHSA National Conference that is held yearly. Iowa ICPC has been involved in Team Charter to create an expediated process for relative and fictive kin foster care approval for families in Iowa.

Current or Planned Activities to Improve Performance on Foster and Adoptive Parent Licensing, Recruitment and Retention

- Item 33: Standards Applied Equally & Item 34: Requirements for Criminal Background Checks – None noted except as described above.
- Item 35: See Attachment 6A1 – FFY 2025-2029 Diligent Recruitment Plan for detailed information.
- Item 36:
    - Continue to work with field staff ICPC liaisons to ensure SW field staff have access to and utilize necessary information including required timeframes when working on an ICPC case, including both sending and receiving cases
    - Continue to work with contracted licensing agencies and licensing staff to help improve timeliness of home studies completed through ICPC
    - Pursue possible border agreements with border states and review current border agreement in place for possible changes and improvements
    - Continue discussions within the ICPC community re: use of TCA.

Section III: Plan for Enacting Iowa's Vision

GOALS, OBJECTIVES, AND MEASURES OF PROGRESS

Iowa completed the CFSR Round 3 PIP period as of December 2023 and will complete the Round 4 Statewide Assessment in FFY 2026. Goals and objectives identified below are an extension of the Round 3 PIP focus, and synthesized with information from:

- Analysis of current performance around Safety, Permanency, and Well-Being;
- Iowa HHS vision: "Individuals, families, and communities are safe, resilient and empowered to be healthy and self-sufficient through delivery of high quality, equitable services."

- Iowa HHS child welfare vision: "Family Connections are Always Strengthened and Preserved."
- Results of Change and Innovation Child Protective Assessment (C!A Assessment) – Please see *Section II: Assessment of Current Performance in Improving Outcomes* for rationale for goals and objectives, including data and analysis.

Iowa will work toward improvement in these core areas as stated below until the next CFSR cycle is underway, then they will be incorporated into the PIP if needed following the next on-site review; strategies included with each goal below will provide additional focus during the bridge period between CFSR rounds, as well as actively model Iowa's philosophy of continuous improvement in our work with families.

Goal 1: Children are safely maintained in their homes whenever possible through assessment and effective management of safety and risk.

Objective: Children abused or neglected are safe from re-abuse in their own homes.
Strategy 1: Ongoing assessments of safety and risk will be conducted, and services provided accordingly to safely maintain children in their homes whenever possible.
Strategy 2: Evaluate the current practice and establish guidelines around the agency response to open service cases when a safety or risk issue is identified.
Baseline: Iowa's current rate of re-abuse is 16%.
Measurement: Key Performance Measure based on ROM data, generated and evaluated monthly. Due to the retrospective nature of this report, results of strategies are not expected to impact the data until SFY 2026. Therefore, Iowa will establish an interim measurement process. Case review data for item 3b (ongoing assessment of safety/risk) and analysis of narratives to assess practice frequency, quality, and effectiveness.
Expected Outcome: Continued training and emphasis on ongoing assessment will decrease rates of re-abuse; defining an allegation in an open case may lead to increased understanding of administrative reasons Iowa's re-abuse rate appears high.
Benchmark: Iowa's rate of re-abuse will decrease by 1% each year throughout the duration of the CFSP (measured SFY 2027, 2028, 2029); interim measure, when developed, will provide information to assess performance trends.

Goal 2: Children achieve permanence in their living situation.

Objective: Children reunified with their parents upon discharge from foster care will successfully maintain that living situation without re-entering foster care.
Strategy: The QA&I bureau will conduct reviews on a sample of cases in which children reunified then returned to foster care within the most current six months; data collected will focus on the circumstances of re-entry to identify mitigation strategies.
Baseline: Performance from July 2023 through January 2024 indicated 20.3% of children re-entered care following discharge to reunification; data demonstrate 76% of children who re-enter care do so within 6 months of discharge.
Measurement: Reunification standard process tracking; QA&I will develop a tool to review cases based on the most current six months to measure improvement in real time. The federal statewide indicator regarding re-entry will be the final determinant of progress.

Expected Outcome: Identification of trends that result in re-entry will inform needed practice changes to stabilize children and families upon reunification.
Benchmark: Iowa will reduce the percentage of children who re-enter foster care by 2% per SFY 2027, 2028 and 2029. **Benchmark:** Re-entry within 6 months of discharge will be reduced to a proportionate rate of 50% of children who re-enter within one year by 2028.

Goal 3: Children experience optimal well-being through their family's enhanced capacity to provide for their needs.

Objective 1: Social workers conduct quality visits monthly with children receiving services in-home and in placement.
Objective 2: Social workers conduct quality visits monthly with parents involved in services.
(Quality= comprehensive assessment and management of safety; discussion of goals; progress; status; needs)
Baseline: For CY 2023, performance on social worker visits with parents was 49%; visits with children was at 59%.
Measurement: Iowa CQI case reviews will be used to measure performance on frequency and quality for social worker visits with parents and social worker visits with children.
Expected Outcomes for Children & Families: Routine contact and discussion of progress, barriers, needs provide opportunity to: engage parents and children, empowering them to drive planning; complete ongoing safety, strengths, and needs assessment; determine effectiveness of services and make changes as needed; build a trusting partnership with families.
Benchmark: Performance in this area has fluctuated significantly during the PIP measurement period so milestones include increased consistency across each six-month period in SFY 2025-2029.

STAFF TRAINING, TECHNICAL ASSISTANCE, AND EVALUATION

Staff Training

As detailed in…Training Plan, the 2025-2029 CFSP must include a staff development and training plan in support of the goals and objectives of the CFSP. Explain how the training activities identified in the training plan are designed to support the goals and objectives in the plan.

HHS' staff development and training plan, as outlined in *Attachment 6D, FFY 2025-2029 Training Plan, and its attachments (6D1 through 6D10)*, increases the efficacy of staff to provide comprehensive child protective assessments and case management which supports the safety, permanency, and well-being of children and families they serve. This reflects Iowa's goals and objectives related to the safety, permanency and well-being of children and families served by child welfare system.

For more detailed information, please see *Attachment 6D, FFY 2025-2029 Training Plan, and its attachments (6D1 through 6D10).*

Technical Assistance

Describe technical assistance activities the state will provide to counties and/or other local or regional entities that operate state programs and its impact on the achievement of the goals and objectives of the plan.

HHS front line staff and supervisors receive technical assistance to help with the day-to-day management of their child welfare caseload and to keep them informed of the CFSR outcome measures. The Child Welfare Information System (CWIS) Help Desk, the SPIRS Help Desk, and the Service Help Desk are available to assist staff with questions regarding policy, practice, and data systems usage. Policy and technical staff are available to assist Service Help Desk staff in answering questions of a more complex nature.

The Bureau of Quality Assurance and Improvement (QA&I) conducts case reviews and provides statewide trend feedback to state and local leadership. In addition, they provide support for custom reports from the administrative data systems (CWIS) to assist staff in managing their workflow and caseloads. QA&I staff also facilitates program and process improvement sessions to assist frontline staff in identifying problems and developing specific solutions for implementation and monitoring. HHS reports monthly on a key set of performance measures that track the CFSR outcome measures and caseworker visits with children in foster care. The Bureau of Child Welfare and Community Services provides answers to policy questions that field staff have. HHS holds a bi-monthly meeting with policy staff and front-line supervisors to advise, inform and gather feedback regarding policy changes and their impacts on practice in Iowa.

These activities will continue over the CFSP period as a way to assist our front-line staff in accomplishing the goals of safety, permanency and well-being for children and families of Iowa.

Technical Assistance and Capacity Building

Describe technical assistance and capacity building needs that the state anticipates needing to support achievement of CFSP and CFSR goals and objectives. Describe how capacity building services from all partnering organizations or consultants will assist in achieving the identified goals and objectives.

<u>HHS Child Protective Services Assessment</u>
Iowa HHS contracted for assessment of the child welfare system with Change and Innovation Agency (C!A) in 2022. Over the course of approximately 10 months representatives gathered information from: focus groups consisting of staff in all roles and program areas; agency leadership; process mapping; and analysis of data provided, covering services and outcomes from child protective intake through achieving permanence. Many recommendations were provided, some validating existing perceptions regarding prioritizing work and some new perspectives, including:

- **Focus on Prevention:** increase efforts to support families before child protective services gets involved; enhance community-based resources for mental health and behavioral services to support post-adoptive supports.

- **Increase System Efficiencies:** decrease duplication of documentation; streamline processes; standardize training for new CCWIS.
- **Support Child Welfare Staff:** mentoring program including financial stipends; reduce supervisor to worker ratio.
- **Support Relative Kin and Foster Parents:** expedite the relative/fictive kin licensing process; increase financial supports; remove barriers to services needed for safe case closure.

Recommendations will be prioritized, but there are clearly opportunities for the QA&I bureau to work with field staff to streamline work and reduce redundancy to maximize effective deployment of resources; all of these are intended to increase positive outcomes for children and families, while supporting relatives and child welfare staff.

Outreach to Other States: Iowa has reached out to multiple states to consult on structure of case reviews utilizing the federal tool: number of staff reviewing, what role reviewers come from (QAI, Supervisor, etc.), total number of cases reviewed, schedules of review, time allotted, etc. This peer-to-peer consultation provides the opportunity to understand systems that are working in other states, as well as benefitting from lessons they have already learned through the implementation process. These conversations have broadened Iowa's ability to think beyond how we have "always done the reviews" to identify how other options could be applied in the state. Based on information gathered as well as our own brainstorming, our goal is to increase capacity for the number of cases reviewed while maintaining the quality and integrity of the reviews; this includes exploration of options for reviewers, re-evaluation of standard processes we have in place that go beyond requirements but may not be sustainable, potentially utilizing elements of the federal traditional reviews (such as the QA involvement throughout the review) that could allow for a more efficient use of the QA&I expertise, etc.

These activities will occur over the CFSP period to assist front-line staff in accomplishing the goals and objectives related to safety, permanency and well-being for children and families of Iowa.

Casey Family Programs (CFP): HHS leadership and CFP staff will be meeting in the Summer or Fall of 2024 to discuss technical assistance opportunities from CFP to support achievement of CFSP/CFSR goals and objectives. More information will be provided in next year's Annual Progress and Services Report (APSR).

Evaluation and Research

Describe any evaluation and research activities underway or planned with which the state agency is involved or participating and how they support and are related to the goals and objectives in the plan.

Parent Partner: Please see *Section IV, Services*, MaryLee Allen Promoting Safe and Stable Families for information on University of Nebraska-Lincoln's evaluation efforts for the Parent Partner program.

SafeCare©: Iowa continues to coordinate with the National SafeCare Training and Research Center (NSTRC) to continue evaluation of the effectiveness of SafeCare. The contract for ongoing evaluation plans to continue through June 2026. For the most recent evaluation information please see the Iowa Evaluation Year 2 Report prepared by NSTRC.

In addition to the primary evaluation, Iowa has also coordinated with NSTRC to participate in the Smoke-Free SafeCare research project. Representatives from the Smoke-Free SafeCare project met with Iowa's Family Centered Services providers in 2022 and provided information about the research program and opportunities to partner. All provider agencies shared this information with their staff and individual staff members made their own decisions regarding participation. Iowa currently has 9 providers and 2 families participating in the research program. By the end of the multi-year data gathering process, it is anticipated that 50 providers and 500 families (10 families per provider) will have participated.

These activities support the provision of services to parents so that parents may provide for the safety, permanence, and well-being of their children.

IMPLEMENTATION SUPPORTS

To promote successful implementation of its goals and objectives, all states are encouraged to: 1) align implementation support across the CFSP, CFSR and CFSR PIP; 2) identify the additional supports needed to implement, achieve and sustain each goal and objective; and 3) plan a timeline for ensuring the supports are or will be put in place. Examples of implementation supports include: staffing, training and coaching, financing, data systems, policies, physical space, equipment, and memoranda of understanding with Tribes, other agencies and organizations.

- Workforce Retention Activities: Provide sign-on bonuses to staff; realign pay for social work case managers (SWCMs)
- Training and Coaching: Please see *Attachment 6D, FFY 2025-2029 Training Plan, and its attachments (6D1 through 6D10).*
- Financing: Enhance federal funding through expanding title IV-E Prevention Services to include Healthy Families America (HFA), Motivational Interviewing (MI), Nurse-Family Partnerships (NFP), and Parents as Teachers (PAT).
- Data Systems: HHS will be implementing a comprehensive child welfare information system (CCWIS) over the next five years. For more information, please see *Section II, Assessment of Current Performance in Improving Outcomes, Systemic Factors, Statewide Information System*.
- Quality Assurance and Improvement: Iowa continues to align and streamline the child and family services assessments, plans, and PIP efforts with the goal of a comprehensive view of all that is going on within Iowa's child welfare system. This continues through coordination between Policy Program Managers and the QA&I Bureau.

  As indicated in previous sections, QA&I bureau and service areas work together to support improvement efforts through open communication, joint brainstorming with staff, identification of barriers, and support to address barriers. Implementation of any improvement strategy depends on field support and an ongoing feedback loop.

  Improvement strategies cannot be successful without active support from leadership. This goes back to the role of the Service Business Team in prioritization, communication, and action to address barriers as needed. SBT coordinates with service

area leadership; service area leadership coordinates with their local leadership and workers.

QA&I works closely with the Training and Support bureau to assure supportive communication and guidance to the Field. Results, recommendations, communication, and training resulting from case reviews or workgroups targeting a specific topic are ultimately signed off on by SBT, which is also the body that coordinates between Divisions to assure Policy, Field, QA&I, and Training and Support are aligned.

Section IV: Services

CHILD AND FAMILY SERVICES CONTINUUM

Describe the publicly funded child and family services continuum, including child abuse and neglect prevention, intervention, and treatment services and foster care; family preservation services; family support services; and services to support reunification, adoption, kinship care, independent living, and services for other permanent living arrangements.

Iowa's child and family services continuum, described below, provides services to:

- Protect and promote the welfare of all children.
- Prevent the neglect, abuse, or exploitation of children.
- Support at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner.
- Promote the safety, permanence, and well-being of children at home, in foster care, including kinship placements, and adoptive families.
- Promote permanency for children in foster care through safe and timely reunification, guardianship, or adoption.

Child Abuse and Neglect Prevention

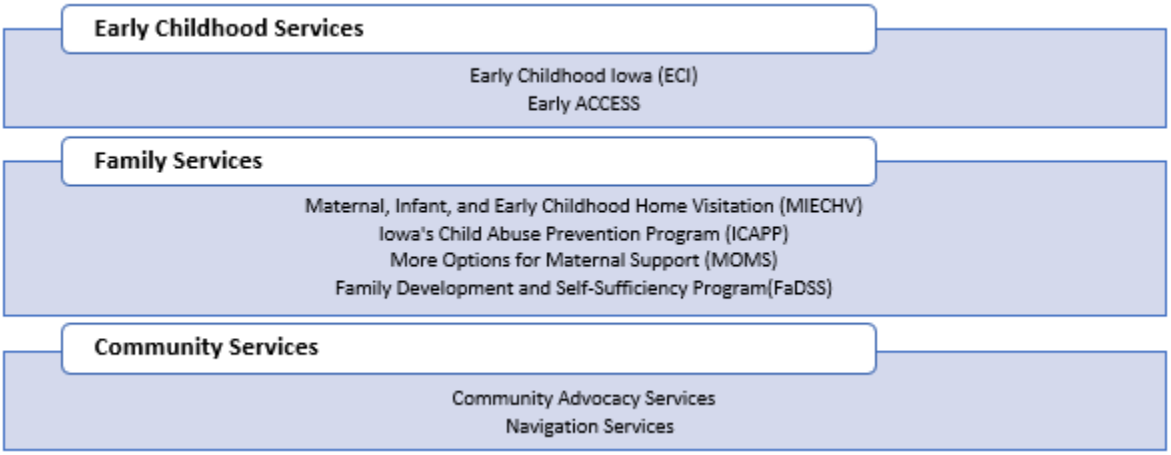
Early Intervention and Support Prevention Programs and Services

Background

The Early Intervention and Support subdivision of the Family Well-Being and Protection Division was established in February 2023 as part of the alignment of state agencies creating the Iowa Department of Health and Human Services (HHS). Each of the programs within the new Early Intervention and Support subdivision were long-standing single programs from four legacy agencies. They had collaborated but had not previously worked within the same team. Most programs are steeped in primary prevention or secondary prevention, focusing on overwhelmed families and children aged 0-5, with some variation. In addition, during the alignment process, the Community Adolescent Pregnancy Prevention Program (CAPP) was nested within the Adolescent Health program in the Division of Community Access.

The Early Intervention and Support subdivision is organized into three bureaus: Early Childhood Services, Family Services, and Community Services. These bureaus represent a continuum of prevention services. The programs under each bureau are shown below. Many of

these programs have been part of Iowa's Prevention Plan for Child Welfare in the past. The activities previously reported for those programs have remained in place during the transition and are intended to remain in place into the future. Changes may occur during additional phases of alignment and will be based on increasing the impact on child and family outcomes. Those changes will appear in future reports.



Current Plans and Projects: Future Focused

Since the launch of the subdivision, efforts focused on ensuring existing programming continued, minimizing any negative impacts on funding requirements, service delivery, and outcomes for program participants. In addition, the team worked to create mission, vision, and north star statements. Those statements are:

MISSION: We leverage resources and utilize data to customize services that meet the needs of families.

VISION: Families have healthy and successful futures through connected systems and targeted programming.

NORTH STAR: More Good Days for Families

The team identified core values for action. These values are meant to be applied across each level of the social ecological model. They include:

- Hope Science
- Human Centered Design
- Social Capital
- Evidence-based Practices
- Research and Data-Informed Decision Making
- Access to Economic and Concrete Supports
- Building Resilient and Thriving Communities

The teams have been working to apply these statements and values to planning a future for child and family prevention services in Iowa. Focus areas have been growing partnerships, launching supportive projects and activities, and making changes to existing programs while building new programs and services.

Key partnership development activities have been focused on:

- Early childhood and K-12 education, including the state's Department of Education Bureau of Early Childhood.
- Economic Assistance and Family Health programs in the HHS Division of Community Access.
- Child Protective Services within the Family Well-Being and Protection Division.

Activities related to developing these partnerships include:

- **Building a plan to enhance the Early ACCESS system.** A major planning event will occur during the summer of 2024. Expected outcomes include a more robust process for engaging families in Early ACCESS services for children identified through Child Abuse and Prevention Treatment Act (CAPTA), advancing screening and service delivery to identified children including follow-up screening and assessment, and identification of programs and services that can support children and families who cannot or choose not to engage with Early ACCESS services (a safety net plan).
- In September of 2023, Iowa was one of ten states selected to participate in **FAST-LC (Families are Stronger Together Learning Community)**. The FAST-LC Core Team is comprised of Family Well-Being and Protection team members and Community Access team members who work collaboratively to benefit Iowa's families. FAST-LC focuses on innovative prevention strategies to mitigate and reduce families' involvement with the child welfare system through partnerships between TANF and Child Welfare programs. Activities to date have included a survey to gather information from program participants on the effectiveness of Economic Assistance and Child Welfare programs and focus groups to learn more about the experiences of program staff who engage with families. The Learning Community will end in October 2024. The expected outcome is to continue to grow TANF and Child Welfare partnerships and infuse the voice of program participants, making these activities the expectation, not the exception.
- Building partnerships with the **Child Protective Services** subdivision started with a presentation on the intake process from the Intake Unit. This presentation was very helpful in understanding how calls to report abuse or neglect are handled and where the opportunities might be for prevention programs to educate potential callers to develop a supportive 'mindset' in Iowa's communities. We also held a workshop with the Child Welfare Policy Team to identify areas of crossover. The opportunities for collaboration were placed in a matrix for next steps. Finally, the outcomes of the focus groups with Child Welfare teams carried out through the FAST-LC will be used to launch additional conversations about opportunities for connecting families and children to prevention programs.

Supporting projects and activities included those that streamline key services, building capacity toward IV-E reimbursement for prevention services, and building surveillance capabilities. Examples include:

- **Intake Data Analysis:** Over 50,000 calls are made to the Child Abuse Hotline (Intake) each year. Many of those calls do not result in an assessment for child abuse or neglect. The data from Intake will be analyzed to develop a more detailed understanding of those calls and callers over the previous 5 years. In addition, Intake data will be connected with family support home visitation data to assist in understanding where families may be underserved and the impact of home visiting services for families who have been identified as having a need. The purpose of this work is to understand the personas of our reporters and the persons of families who are being reported for potential child abuse or neglect. The results of this evaluation will be used to understand the callers

and families, note geographic locations where prevention services are needed, and develop an understanding of prevention service gaps and areas for improvement. In an additional step, we will match the families who have received home visiting services through the MIECHV, ECI, HOPES, and ICAPP programs (DAISEY database) with those present in the child welfare intake data to understand the impact of home visiting services for at-risk families. The linked data will be used to develop heat maps to show areas of the state where prevention programs should be expanded or deployed. Overall, each of the steps within this scope of work will provide a better understanding of how to better serve Iowans through Early Intervention and Support.

- **Iowa's Integrated Data System for Decision Making (I2D2):** In response to the ECI Statewide Needs Assessment and Strategic Planning in 2019, the IA Data Drive was developed and housed by I2D2 to help inform and guide decision-making. In the interactive IA Data Drive, users can view the most used indicators for state and community planning that impacts children and families in Iowa. Additionally, users can generate reports based on region or county to understand what is happening in local areas across the state. In 2024, more updates are planned for the IA Data Drive, including the infusing of additional data sources, inclusion of ACEs indicators and Positive Childhood Experiences (PCEs) indicators, and home visiting needs assessment measures. The primary goal is to bolster the use of this resource for programmatic needs assessments across the array of programs supported by Early Intervention and Support. This will reduce the burden of data collection on agencies who are required to complete a needs assessment and enable more robust meaning-making, connecting the metrics to programmatic strategies and outcomes.
- **Taking Steps to Standardizing Home Visiting practices:** This project was launched in March 2024 in connecting to activities that will enable IV-E Prevention Plan reimbursement. Evidence-based home visiting programs have been funded by three funding sources across three legacy state agencies in the past. This has created non-standard practices in the areas of screening, fidelity monitoring, and continuous quality improvement. Iowa will begin aligning these practices starting with state-funded Healthy Families America and Parents as Teachers programs. The required changes in practice will be inserted into contracts. A phased approach over a few years is planned.

Making changes to existing programs while building new programs and services occurred organically as the Early Intervention and Support team has taken shape. As previously mentioned, the team is working to align and standardize evidence-based family support programs across the spectrum. In addition, the More Options for Maternal Support (MOMS) program and coordination of a Fatherhood 'system' will launch in 2024. Finally, Thrive Iowa, a resource referral program will be implemented.

- **MOMS:** In 2022, the More Options for Maternal Support Program (MOMS) was established to promote healthy pregnancies and childbirth through a network of nonprofit organizations that provide pregnancy support services. The MOMS program is designed to:
    - Provide personalized support to pregnant women to provide stabilization to families.
    - Promote improved pregnancy outcomes, including reducing abortions, by helping women practice sound health-related behaviors and improve prenatal nutrition.
    - Improve child health and development by helping parents provide responsible and competent care for their children.
    - Improve family economic self-sufficiency by linking parents to services that address individual economic and social needs.

- **Fatherhood System Coordination:** A coordinated Fatherhood Engagement model will increase collaboration, improve, and expand services, and optimally engage and support fathers, moving supports upstream to stem more significant interventions downstream. Early Intervention and Support will lead a tiered Fatherhood Engagement model to strengthen policies and practices to involve, engage, and serve fathers and men in Iowa more effectively and increase overall service availability. Implementation will include increasing intra-agency coordination and implementing a comprehensive strategy to build an effective, father-friendly, multigenerational approach. The approach will consist of:
    - An Intra-agency and Interdepartmental Leadership Group.
    - An Agency-wide policy review, assessment and resource mapping.
    - Staff training and case management improvement.
    - Activities to engage fathers and communities creatively and meaningfully.
    - Maximizing TANF funding sources to increase current initiatives, bolster new approaches, and sustain efforts grounded in evidence.
    - Purposeful evaluation and reporting of outcomes to reveal the value of the investments for policymakers, courts, state agencies, and taxpayers.
- **Thrive Iowa** will create a network of navigators to help at-risk individuals find immediate support from community organizations, then follow them over time helping them develop an individualized plan for self-sufficiency and long-term independence. A new team will be created in Early Intervention and Support to implement this program in 2024. This team will:
    - Implement an online system that facilitates the participation of churches, non-profits, and businesses.
    - Establish a network of navigators to work with program participants.
    - Establish a primary entry point for Iowans in need of help or referring organizations to engage with a navigator.

Summary: Over the next five years, Early Intervention and Support will continue to evolve and mature. The impact on children and families will be measurable and the impact on the child welfare system will be notable. Services and programs will be more efficient and effective. The array of prevention services will expand in areas that match the capacity of families to engage. Surveillance mechanisms will be in place to measure need, gauge progress, and support decision making.

The program reports that follow this introduction will depict the former legacy agency pattern of implementation and philosophy. Future reports will be more targeted and synthesized, depicting the planned enhancements and outcomes.

Healthy Opportunities for Parents to Success – Healthy Families Iowa (HOPES-HFI) supports two contractors in 6 Iowa Counties to provide evidence-based Healthy Families America (HFA) services to at-risk communities. The Counties are Black Hawk, Clinton, Des Moines, Floyd, Lee and Tama.

In 2020 a new competitive Request for Proposals was released that narrowed the focus to efforts in fewer counties because of the limited amount of funding received from the General Assembly. At the same time, the Department determined that the administration of the HOPES-HFI program would reflect the same structure as it does for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. In order to accomplish this goal, the Operational

Manual for MIECHV was updated to include the HOPES-HFI program and the DAISEY data system was modified to include HOPES-HFI in the MIECHV benchmarks. Administrative Rules were also updated to reflect that the program would rely on the MIECHV Needs Assessment to determine which Iowa communities would be eligible to receive HOPES-HFI funding.

It takes multiple years to establish a new evidence-based home visiting program in a community that has no experience with the model or the service provider. The first several years has been spent forging relationships built on trust and mutual respect in Tama and Floyd counties where the service was brand new.

The program is coming due for a new competitive RFP in 2025. HHS does not anticipate many changes to programming or locations for services at this time.

Maternal, Infant and Early Childhood Home Visiting (MIECHV) program supports nine contractors serving 17 Iowa counties to provide evidence-based Healthy Families America (HFA), Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) to at-risk families in targeted at-risk communities. Iowa was first awarded MIECHV funding in 2010. The MIECHV administration provides infrastructure support to all home visiting and group-based parent education programs in Iowa that receive federal or state funds with the exception of Head Start and Early Head Start which is limited to coordination efforts.

Due to the COVID-19 Pandemic, all MIECHV home visiting went to virtual only in 2020. HHS was selected for a national leadership role in a rapid response team to assist the field in making the adjustment to virtual. HHS worked with the Parents as Teachers National Center and the Model Developer's Alliance to create a series of webinars and other professional development supports. For more information: https://rapidresponsehomevisiting.org/

HHS also launched a weekly snack and share series specifically for Iowa home visiting providers. The snack and share series focused on mental health, well-being and increasing our understanding of historical racial tensions. The snack and share series continues today but is offered monthly with every other month having a mental health focus for staff well-being.

MIECHV launched a Phones4Families program during the Pandemic to aid the ability of low-income families to stay connected with their support system as well as their family support professional. An evaluation on the effectiveness of virtual home visits in Iowa was conducted. The report may be found here: https://i2d2.iastate.edu/wp-content/uploads/2021/06/I2D2-Phones-for-Families-Report-June-2021.pdf. Iowa's evaluation and other national evaluations all demonstrated the effectiveness of virtual home visits as a way of reaching families that may be reluctant to have a stranger come into their home. Virtual home visits in the MIECHV and HOPES program will continue to be offered at the request of the family when travel is not recommended or in the case of a contagious illness. The aim continues to be working with a family in their home.

MIECHV and HOPES funds are used to support a performance incentive program for home visitors and their supervisors working in those programs. A quarterly performance incentive may be earned when performance achieves preset targets. The program has accomplished two

tasks. We have very little missing data, assessments are completed on time, and turn-over has been reduced. We still have home visitors leave their positions, but it is because of relocation primarily instead of leaving for higher paying jobs.

The MIECHV program provides the DAISEY data system for MIECHV and state-funded family support programs. This enables the state to have up to date data on a state-wide basis at any time. The MIECHV epidemiologist hosts a bi-monthly DAISEY User Group (DUG) for all state level administrators. The DUG determines data needs, report changes and recommendations of future changes to DAISEY. For example, the DAISEY team was made aware this fiscal year that CBCAP requires the state to report the number of parents and children with a disability. The information is collected in DAISEY, but it was not included in a report which made retrieval cumbersome. A new report is slated for development that will include these data elements. For more information on DAISEY: https://daiseyiowa.daiseysolutions.org.

The MIECHV program staff also host the Family Support Leadership group (FSLG) which is composed of all state level home visiting administrators, representatives from statewide associations such as the Iowa Head Start Association, Iowa Family Development Alliance, etc. The FSLG is responsible for making policy recommendations that impact family support programming (includes home visiting.) For example, the FSLG recommended that all family support organizations offer a starting wage of no less than $18 per hour. MIECHV and HOPES included that recommendation in HHS' Request for Applications.

HHS has supported the Institute for the Advancement of Family Support Professionals (Institute), an online learning platform. The Institute has been developed over multiple years in conjunction with the Virginia Department of Health with funding primarily obtained by competitive Health Resources and Services Administration (HRSA) grants. At HRSA's urging, the Institute is transitioning to a stand-alone, private non-profit. Iowa and Virginia will continue to have decision making abilities for the Institute. They will have a permanent seat on the board of directors. The Institute is the primary source for professional development for the home visiting field in Iowa and across the nation. The Institute contains over 80 online modules, digital badges, national core competency framework, a national certification exam, learning guides and numerous other professional development resources. The Institute is powered by software that develops the individual learner's career compass. The career compass illustrates the learner's grasp of each competency area domain and directs the learner for further study in areas where there are gaps. The Institute is available to anyone at no cost. For more information: https://institutefsp.org/.

Iowa Child Abuse Prevention Program (ICAPP)

The Iowa Child Abuse Prevention Program (ICAPP) has a crucial role in HHS preventing child maltreatment in the state. The table below shows families served, children served, counties served, and the funds allocated to the ICAPP program for State Fiscal Year (SFY) 2020-2023.

Table 4a: ICAPP – FFY 2020-2023 Program Data				
ICAPP	Families Served	Children Served	Counties Served	Total Funds
SFY 2020	2,003	9,931	56	$1,562,638.00
SFY 2021	1,428	5,698	43	$1,748,109.00
SFY 2022	1,326	6,258	44	$1,730,632.00
SFY 2023	1,276	5,622	44	$1,753,177.00

During SFY 2020 ICAPP efforts supported $1,562,638.00, connecting 2,003 families, 9,931 children and 56 counties. Since that time there has been an increase in funding allocated to programing and a decrease in families, children and counties served. This data has been utilized to understand the most effective way to reach more families with the programming that currently exists as well as alternative programs that may be more applicable to the families enrolled in the programs throughout the state.

HHS has established an equity team to assess emerging needs in the marginalized populations in the state of Iowa. The table below shows the demographic information of families served showing that most participants have been historically Caucasian. HHS recognizes the need to ensure that other populations have accessible access to culturally appropriate content and that their culture is embedded in the content of the ICAPP programming.

Table 4b: ICAPP Participant Data				
ICAPP	Gender	Race	Age of Participant Caregiver	Participant Caregiver Education
FY 2020	88% female	62% White 18% Hispanic 8% African American	29.5% 30-39 years of age	37% High School Diploma or GED
FY 2021	97% female	76% White 9% African American 12% Asian	27% 26-30 years of age	36% High School Diploma or GED
FY 2022	95% female	76% White 9% African American 12% Asian	45% 30-39 years of age	38% High School Diploma or GED

Table 4b: ICAPP Participant Data				
ICAPP	**Gender**	**Race**	**Age of Participant Caregiver**	**Participant Caregiver Education**
FY 2023	91% female	78% White 6% African American 5% Asian	36% 30-39 years of age	38% High School Diploma or GED

This table demonstrates that typical ICAPP participant caregivers are white, female, had a high school diploma or GED, and are around 30 years of age. This helps to identify who is being reached by ICAPP funding and the discrepancy of marginalized populations that are successfully seeking services for prevention services. This establishes the need for equity in our service programming.

The Future of ICAPP
Collaboration:

- Early Intervention and Support (EIS) is heavily rooted in collaboration. Since the subdivision was developed the focus has been collaboration within our division as well as networking with other divisions within HHS to ensure that all services that are offered best meet the needs of the families of Iowa.
- A Prevention Community of Practice (COP) was established within the EIS subdivision to bring together other prevention professionals within HHS to focus on the definition of prevention and how we can best utilize the programs that are already in existence internally to reach more families and stress the importance of primary prevention.
- The ICAPP Request for Proposal (RFP) team consists of members from the ICAPP program as well as other programs within EIS. This ensures that the funding for ICAPP is utilized to the most potential of offering services to all Iowans.

Data: One of the most exciting opportunities to gain data from ICAPP providers, community members and families has been the ongoing Listening Sessions offered in different spaces throughout the state. This includes HHS staff traveling to different regions in the state to meet with providers and families to discuss the strengths and challenges associated with ICAPP programming in their area. This information will help guide the development of the strategic plan for the future of ICAPP. The conversations are focused on prevention. Participants have the opportunity to discuss their area and the discussion is documented and will be analyzed to determine the services that will have the most impact in those regions of the state.

Program Improvement: Through the collaboration and data collected through the Listening Sessions and the development of the RFP the ICAPP program will continue to serve participants with a focus on improving and growing the accessibility of services to all Iowans. We recognize the need to evolve and continue to improve the services offered in each area that

ICAPP reaches. This will also improve the standardized evidence-based family support services offered to participants.

Equity: ICAPP has identified through data collection and the Listening Sessions that there is a gap in accessible services, information, and communication to our marginalized populations in the state. An equity team is in the process of being developed within HHS and ICAPP will collaborate with this team as well as local providers to ensure that our families have the resources and services needed to feel comfortable and acknowledged in the prevention of child maltreatment.

Over the next five years ICAPP will continue to develop services and programs that focus on primary prevention with the goal of reaching all families in the state of Iowa. It is imperative that ICAPP reaches as many families as possible to demonstrate the importance of reaching families before they become involved in the child welfare system.

More Options for Maternal Support (MOMS) Program

The MOMS program supports a network of nonprofit organizations that provides qualified pregnancy support services to empower women and protect children, promote strong and healthy families, and increase compassionate care to improve pregnancy outcomes and child health and development.

Per Iowa Code § 217.4, the MOMS Program is designed to promote healthy pregnancies and childbirth by:

(1) Providing an approach and personalized support to pregnant women to provide stabilization to families.
(2) Promoting improved pregnancy outcomes, including reducing abortions, by helping women practice sound health-related behaviors and improve prenatal nutrition.
(3) Helping parents provide responsible and competent care for their children.
(4) Improving family economic self-sufficiency by linking parents to services that address individual economic and social needs.

The MOMS Program supports pregnancy support services, defined in State law as nonmedical services that promote childbirth by providing information, counseling, and support services that assist pregnant women or women who believe they may be pregnant to choose childbirth and to make informed decisions regarding the choice of adoption or parenting with respect to their children.

MOMS providers offer clients an array of qualified pregnancy support services including nontherapeutic counseling, parenting education and support services, material items, call center services, medical information and referrals, employment assistance, mentoring, classes relating to pregnancy and parenting, life skills, and employment readiness, housing, nutritional services and education, and adoption education, planning, and services.

Through the MOMS Program, HHS is expanding the depth and reach of our maternal and child health services and diversifying our local partnership base to provide more entry points for expectant parents to access services tailored to their needs.

In 2022, the Iowa General Assembly passed, and Governor Reynolds signed into law, legislation to establish the MOMS Program within the Iowa Department of Health and Human Services to promote healthy pregnancies and childbirth through a network of nonprofit organizations that provide pregnancy support services. The program is currently state funded and appropriated at $1,000,000.

In August 2023, HHS issued a Request for Information to welcome input from entities in the State of Iowa on various aspects of pregnancy support services to inform the MOMS Program.

In 2023, HHS issued two separate requests for proposals (RFP) to establish a third-party administrator to develop and manage a statewide network of nonprofit organizations to provide pregnancy support services in Iowa. HHS did not receive a successful bid for either of those RFPs. Out of an urgency to decrease delays in funding pregnancy support services for women and families, in October 2023, HHS drafted a third RFP to provide funding directly to qualified applicants – or MOMS providers.

In January 2024, HHS announced its intent to award the first round of contracts to four qualified applicants, and to continue building the network. In February 2024, HHS released a second RFP to select additional organizations.

Future Direction of the Program/Goals for 2025-2029

HHS will continue to build the network through subsequent RFPs, expanding statewide coverage of these services, tailored to the diverse needs of local communities and populations. Through ongoing monitoring and evaluation efforts, HHS will ensure MOMS providers are promoting standards of care and competencies in the provision of pregnancy support services, increasing public awareness, access, and use of these services, and building stronger community collaboration and coordination through shared learning and relationships with other programs providing services related to MOMS Program Goals.

Community Partnerships for Protecting Children (CPPC) is an approach that neighborhoods, towns, cities, and states can adopt to improve children's protection from abuse and/or neglect. Communities develop partnerships across collaborative networks to implement prevention strategies, provide early interventions, and share responsibility for the well-being and success of all children and families. The State of Iowa recognizes that the child protection agency, working alone, cannot keep children safe from abuse and neglect. It aims to blend the work and expertise of professionals and community members to bolster supports for vulnerable families and children with the goal of preventing maltreatment or if maltreatment occurred, repeat maltreatment. CPPC is not a "program;" it is a way of working with families and communities to help services and supports to be more inviting, need-based, accessible, and relevant. CPPC incorporates prevention strategies as well as those interventions needed to address abuse, once identified. CPPCs work to reduce negative childhood experiences,

promote everyone's responsibility in supporting children and families around safety, permanency, including both family and kinship connections, and well-being, and is of significant value to Iowa's communities.

The CPPC philosophy and value statements include:

- Families and youth are the experts in what they need to be successful.
- Children do best in families, and should be with their own families, whenever possible.
- Families are stronger when all members, including caregivers, are safe from abuse.
- Local communities benefit from shared decision-making among families, youth, and community partners to shape their own strategies in response to community needs.
- Integration of equitable and culturally responsive approaches to resources, programs, and supports is essential to meeting the needs of diverse families, youth, and communities.
- Supports and services should be linked and accessible in the communities in which families live.
- Parents, caregivers, and youth are vital to making local and statewide policy and practice changes to services and systems which impact them.
- Efforts to reduce abuse and neglect must be closely linked to broader community initiatives and priorities to strengthen protective factors and improve child/family well-being.
- Families and youth need supportive communities to authentically engage with them for healing, connection, and to offer a sense of belonging.

The statement "Families do better when they live in communities where keeping children safe is everybody's responsibility" emphasizes the importance of a community-based approach to child protection that cannot be solely the responsibility of the child protection services agency to ensure the safety and well-being of children. The concept of community responsibility lies at the heart of CPPC's theory of change, and underlying this approach is that child protection is not simply the responsibility of a single public agency but is the responsibility of all elements within a given community.

The long-term focus of CPPC is to support children and families to be safe, remain intact, and enhance child and family well-being by changing the culture around social norms and attitudes to improve child welfare processes, practices, and policies. The approach involves four key strategies implemented together to achieve desired results: Shared Decision Making, Community Neighborhood Networking, Family and Youth Centered Engagement, and Policy and Practice Change. It is through this philosophy, and many years of dedication to the development of the four strategies and implementation, that initiatives flourished with CPPC's support and through CPPC Shared Decision-Making teams who partnered locally to tailor the CPPC approach to meet their community's needs.

Many of HHS child protection statewide initiatives started with CPPC sites piloting innovative ideas focused on child welfare policy and practice changes. These initiatives have included but are not limited to Family Team/Youth Transition Decision-Making, Parent Partners, Cultural Equity Resources, Parent Cafes, and the development of the Connect and Protect consultation

teams and the infusion of the Safe and Together™ model, which is a paradigm shift towards a more domestic violence informed child welfare system.

One of the most noteworthy aspects of CPPC is the structure to engage both professionals and community members, including parents and youth with lived experiences, in helping to create safety, permanency and well-being supports for children and families in their own communities.

Collaboration: CPPC collaborates with a variety of community partners, providers, organizations, and networks. Community partnerships focuses on engaging and educating partners and promoting community involvement to strengthen families and create safety nets for children. These partnerships build linkages and relationships among professionals and informal support systems. The networks are strengthened through professionals' collaboration with other professionals, neighbors helping neighbors, and professionals connecting with community and neighborhood supports. As the Community Partnerships strengthen and additional resources become available, CPPCs can then initiate more structured responses to address community-identified needs such as Parent Cafes, Circles of Support, resources and supports for youth transitioning from foster care to adulthood and community neighborhood hubs, to name a few.

Each of the local 40 CPPC sites across the state creates a network of agencies, neighborhood groups, and families to support the overall mission of community partnerships. Core members of the networks include:

- HHS Child Protection Agency and Juvenile justice
- Parents and youth, including those with prior system involvement
- Education and early childhood
- Physical and mental health
- Domestic violence and substance abuse
- Prevention programs and coalitions
- Volunteers, non-profit, and faith-based
- Law enforcement and legal
- Local government
- Business and civic groups

CPPC is in process of transitioning to the Early Intervention Support (EIS) area of the Family Well-Being and Protection Division, and there is opportunity for CPPC to align more directly with EIS programs and supports in this space. This includes programs such as Early Childhood Iowa, ICAPP, MIECHV, FaDSS program and the Thrive community navigation program. The Thrive program is in the early stages of development and is a closed-loop referral and navigation system which acts as a connection point to link individuals and families to community resources and supports. CPPC will benefit from continuing to center youth, parent, and caregiver voices with lived experience in the Child Protection System (CPS) to provide input to Shared Decision-Making and co-creation of community activities and policy and practice changes, as well as from families and young people experiencing community supports and resources intended to provide support and prevent CPS system involvement.

As the purpose of CPPC is to bring together HHS Child Protection and the community, there is further opportunity to develop a robust upstream prevention approach utilizing the current network of CPPCs across the state, as well as the framework of the 4 CPPC strategies, to connect efforts to support the C!A assessment recommendations for HHS CPS to develop a "warm line" approach to help direct families and those concerned about children and families at risk for CPS entry due to gaps or barriers to essential concrete needs and supportive resources in communities. Existing CPPC networks may help to provide an initial foundation for further developing community resource networks, connecting with Thrive community navigator services, and helping to provide a community resource information and engagement to communities through the CPPC networks to help build a warm line response to prevent families from entering the CPS system.

CPPC teams and networks were engaged in CFSP CPPC plan development through the following avenues:

- CPPC Survey and Focus Group Project SFY 2022
- Health Management Associates (HMA) Service Delivery Assessment Recommendations
- CPPC Executive Committee

In Fall 2021, the CPPC Survey/Focus Group project began in effort to collect information and feedback from CPPC stakeholders across HHS' five service areas. Inquiries were sought through online surveys and focus groups to glean current views of stakeholders who are actively involved with their local CPPC sites. The main goals of the survey/focus group project were to evaluate the status of the CPPC to inform potential program improvements, assessment of how the CPPC Approach aligns with the current prevention context in Iowa and contributes to meaningful change for children and families, and to identify ways to advance the CPPC Approach to further impact positive outcomes for children and families in the community around safety, permanency, and well-being, including preventing children and families from entering or re-entering the child welfare system. Over 100 respondents participated in the survey from all five HHS service areas. Two follow up focus group sessions were held with a total of 8 participants. Involvement in the local CPPC ranged from 1-10+ years, with the highest number of respondents indicating 4-6 years of time involved in their CPPC.

Common findings upon evaluation of the survey and focus group results included the following:

- Families should have access to supports and services in the same communities in which they live, and local partnerships should help formulate strategies and offer those services based on the resources and cultures exclusive to that community.
- The desire for increased resources/funding in local CPPCs to do a number of things such as: expand the reach/access more families who are in need or at risk; fund translators and materials that cater to families whose native language is not English; and compensate community members for their time and input.
- The Individualized Course of Action (ICA) strategy is currently very limiting and should be re-imagined to better meet the changing needs of families and children, in a way that is community-specific, as "one size does not fit all".

- Although a commitment to serving marginalized families and communities of color is articulated in the shared vision, there are some barriers linked to these populations that make it difficult for the shared vision to be efficiently implemented in practice.
- The Family First Prevention Services Act of 2018 aligns very well with the current CPPC Approach/Model and is an opportunity for CPPC members to further partner with HHS and utilize each other's expertise in navigating local community networks to support families to prevent child welfare system involvement.

Key Takeaways from the Survey/Focus Group Project included the following:

- Commitment and accountability from community partners in facilitating family engagement in a collaborative way, are a key strategy in prevention of children and families who are most at risk to enter or remain in the Child Welfare System (CWS).
- A shared vision among CPPC stakeholders, local community members, and families, is necessary to avoid silos and make it easier for families to navigate systems that should help them avoid CWS involvement. "It takes a village."
- The ICA strategy should be revised to focus on community-specific needs with more flexibility and a better coordination of all available resources such as a menu of options/ and programs/flow chart, a universally understood referral process, and trained facilitators and family navigators to better assist families.
- Financial resources drive what is feasible for local CPPCs to accomplish. CPPC stakeholders understand the current gaps and have a desire to obtain necessary means to fill them.
- Accessing and engaging families and communities of color in local activities and decision-making and finding ways to work with cultural and language barriers within those communities, must both be high priorities.
- One size does not fit all when it comes to planning and implementing CPPC efforts to serve communities and families in the ways they need.

In response to the findings from the CPPC survey project, priorities have been focused on support to the CPPC sites in the transition to the new, more flexible Family and Youth Centered Engagement (FYCE) Strategy, updates to the CPPC logic model and CPPC materials, and to provide learning opportunities and support to the CPPC sites to align with the new FYCE strategy and the revised CPPC plan and reporting document which has increased focus on tracking impact and outcomes of CPPC activities.

In SFY 2023, HHS partnered with Health Management Associates (HMA) to conduct a statewide assessment to identify successes and gaps in service delivery as well as opportunities for further service integration. Included in this assessment were 19 service delivery systems across the agency, and specifically included CPPC, Decat, and Early Childhood Iowa in the Division of Family Well-Being and Protection (FWBP). Through the assessment process, internal staff within HHS and external community partners were engaged through surveys, town halls and interviews to identify opportunities within these service areas. HMA provided recommendations to HHS in SFY 2024 for changes to the current service delivery practices based on approaches implemented in other states.

The proposed recommendations from the HMA Summary Assessment for CPPC, ECI and Decat included alignment of some programs within the Community Access Division to reduce administrative burden, enhance quality of service delivery, and preserve local decision making related to service delivery. All three of the options utilize a lead agency model for catchment areas which allows for Iowans to receive services anywhere that meets their needs and does not require to do so in their county/catchment areas of residence. The differences between the options presented below are related to which programs are recommended for integration and method for determining catchment areas:

- Option 1 – This option combines programs into a single contracting structure currently operating under the CSA structure with CPPC, Decat, ECI, and FaDSS and offers three sub-options for developing catchment areas: aligning with the CAA (Community Action Agency) map, aligning with the CSA (Collaborative Service Area) map, or letting counties self-align.
- Option 2 – This option combines CSA programs and FaDSS (Family Development and Self Sufficiency Program) into a single contracting structure and offers three sub-options for developing catchment areas: aligning with the CAA map, aligning with the CSA map, or letting counties self-align.
- Option 3 – This option combines into a single contracting structure CPPC, Decat, ECI, and FaDSS and offers three sub-options for developing catchment areas: aligning with the ECI map, aligning with the CSA map, or aligning with the map that was determined when Option 2 was undertaken.

At the time of this writing, HHS has not decided on HMA's above proposed recommendations for the identified FWBP Division programs. HHS will take a phased approach to the service delivery alignment effort that first focuses on the needs related to behavioral health. HHS will also conduct ongoing stakeholder engagement opportunities related to the governance and structures outlined in the recommendations. Additional information regarding HMA's proposed recommendations and related materials can be found at the link below:
HHS System Alignment | Health & Human Services (iowa.gov)

In March 2024, the HHS CPPC Program Manager reviewed the CFSP CPS overarching goals and objectives with the CPPC Executive Committee (CPEC) at the bi-annual meeting. The CPEC feedback on considering how CPPC aligns with the CPS goals and objectives and summarized that community building support leads to permanency outcomes, and if able to bring the community together effectively, provision of strengthening services develops over time. The CPEC noted that the need to strengthen available supports may look different in one area of the state than another, such as available and accessible transportation for families. The CPEC agreed overall there are opportunities to continue to align the CPPC Approach with all the overarching goals and objectives of CPS for the next five years.

In considering possibilities for CPPC in the five-year plan, the CPEC was asked to respond to what their hopes for CPPC are for the future. Summarized responses to this question included the following:

- CPPC continues to be able to support services for communities and that it fits into the new prevention system space appropriately.

- CPPC continues to grow and continues to exist as a community-based initiative
- To keep build upon the existing CPPC framework, with local oversight and flexible planning.
- Increase communities' feeling of responsibility for children.
- CPPC creates more opportunities for youth to thrive.
- Continued collaboration with and support to local communities.
- Financial backing to continue being a grassroots support.

The CPEC was asked to describe opportunities for CPPC to align with a redesigned prevention delivery model system. Summarized responses included:

- Opportunities to integrate resources to provide more comprehensive supports to children and families.
- Work alongside and support existing local prevention programs and fill needs/gaps that families may identify.
- Consider ways to ensure families see support coming from the community, and to work through stigma of engaging families to participate in HHS initiated preventions programs and not equate this to potential child protective services involvement.
- Growth and collaboration to encompass support to communities and families.
- Shared roles.
- Help families engage with other families.
- To align and collaborate with new programs in the early intervention space that CPPC has not traditionally partnered with.

Finally, the CPEC was asked to share some of the challenges they see in continuing the CPPC Approach in communities with the potential changes to local service delivery. Summarized responses regarding challenges include:

- Communicating positively through an undetermined period of ambiguity.
- Many CPPC Coordinators are doing different jobs, making it difficult to focus on CPPC.
- The unknown scope of the future for alignment of service delivery programs.
- Working in an area that doesn't function well geographically.
- Losing partnerships that have been built.
- Funding (mentioned multiple times) and freedom to make local decisions
- Concern the focus will shift entirely to prevention, and CPPC is replaced with another initiative.

Goal: CPPC will align with the redesigned prevention system to support child and family well-being utilizing the CPPC Approach and the 4 strategies as a framework.
Objective 1: Define CPPC's role in the implementation of Iowa activities in response to HMA Service Delivery Recommendations for an aligned prevention system with ECI, Decat and CPPC.

CPPC site coordination provides an administrative opportunity to align with work in shared strategic spaces, to share opportunities such as community engagement and ownership, utilizing shared resources, determining opportunities for shared data and measurement tools, shared responsibility for community needs assessment, advancing policy and practice changes,

and supporting advancement of aligned priorities. Re-framing the role of CPPC with other prevention system initiatives to determine where CPPC activities align within the continuum of a prevention system, and ensuring activities are not duplicative but are specifically structured to supporting the functionality, capacity, and purpose of the aligned system.

Objective 2: CPPC will utilize existing community partnerships to facilitate new collaborative connections in the aligned prevention space.

CPPCs identify supports and resources in communities geared to meet gaps geared to children and youth and their families 0-18, particularly those involved or at greater risk of entering the child protection or for youth in out of home care transitioning to adulthood. CPPCs can continue to provide a link between the prevention community and child protection services, to continue to maintain a focus on community-based approach to child protection efforts. Utilizing existing CPPC networks and partnerships, opportunities exist to align with HHS initiatives to improve upstream prevention efforts to help ensure families do not become involved in child protection services through offering enhanced opportunities, such as a “warm line” to support families to access needed resources in their communities to meet their needs. CPPC partnerships are diverse and include many of the necessary engaged key community partners, including parents and youth, who may be an active contributor in development of a more robust upstream system. Transition of CPPC into the Early Intervention and Support space provides additional opportunity to align with existing community services, identify and reduce duplication, disassemble silos, and ensure the continuum of available supports is clear and accessible in the community to families, young people, and caregivers who need them.

Objective 3: CPPCs utilize parents, youth, and caregivers with lived experience to provide voice and co-design local shaping of an aligned preventions space.

CPPCs have continued to strengthen family and youth centered engagement lens, particularly with the focus on this strategy change in SFY 2022. CPPC is primed to share lessons learned to overlay Family and Youth Centered Engagement strategy in new spaces, and to bring youth, parent, and caregiver voice to shaping decision-making, co-creating new strategies to address gaps and meet needs, and to have voices from those with lived experiences to help ensure resources, services and supports are helping strengthen child and family well-being, are accessible, and are culturally responsive and supportive to diverse and under-resourced communities.

Opportunities to bridge family and youth engagement initiatives exist in youth mentoring programs, with the Parent Partner Program, through supporting families involved in Kinship Navigator program, through the work to develop more robust linguistic supports through the HHS Office of Health Equity, within the Cultural Equity Alliance to bridge with communities to eliminate disproportionality and disparity in child protection, and through continued spread of Parent Cafes across the state. Partnering with the HHS NYTD Coordinator to communicate the Talking Wall data annually from young people in out of home placement is another opportunity to engage the CPPCs in lifting youth voices, and considering how these impacts accessible community supports for youth.

Parent Cafés provide an opportunity for engaging parents, youth, community members, caregivers, the recovery community, refugee and immigrant communities, parents involved with HHS child protection, and others, in sharing safe spaces for conversation to strengthen protective factors, build informal supportive relationships, learn more about available community resources, and feel connected to their community. Cafés provide an opportunity for community members to be involved in planning for cafes and taking on leadership roles in the café space through participating in training and becoming a café or table host. This initiative has been spread through CPPC since 2018 and has continued to be developed through investment in state certified trainers, as well and opportunities to promote the Parent Café model through the CPPC. Continuing to sustain these efforts throughout the next 5 years of the CFSP aligns with the vision of further developing more robust upstream prevention system.

More information on data collection and evaluation from the National Parent Café Evaluation Report Executive Summary on the Parent Café Model can be found on Be Strong Families webpage at the following link: https://www.bestrongfamilies.org/parent-caf-report-executive-summary

Strengths and opportunities for improvement for CPPC collaborative efforts and system impact:

- Strengths:
  - Engagement of diverse network of state agencies, community-based programs, Parent Partners, and community members to review services and supports and work towards addressing the gaps in services and supports.
  - CPPC builds linkages between formal and informal supports, bridges prevention and tertiary approaches, strengthens awareness and streamlines community resources.
  - CPPC networks provide opportunities to pilot, support, and implement child welfare policy and practice changes (e.g., Parent Partners, Cultural Equity, and Parent Cafés).
  - After collecting feedback from the sites regarding a basic framework for CPPC approaches to grow locally, CPPC Coordinators and CPPC sites across the state received an extensive manual and the CPPC Practice Guide. The CPPC Practice Guide is undergoing revision and is planned for distribution in Spring 2024. The Guide is used as a tool in the introductory (Immersion 101) and advanced sessions to increase the knowledge base of local coordinators and key decision-making members in the communities they serve.
  - Community Partnership Executive Committee reviews the CPPC strategy data, program initiative progress and determines educational and technical assistance needed by the sites to advance the CPPC Approach.
  - Regular updates to the CPPC brochure for distribution among communities to increase awareness of the CPPC approach and to continue to educate sites on the four strategies' revised levels and the CPPC practice manual.
  - Further expansion of the Parent Café model for building formal and informal supports for families in communities.

- CPPC sites collaborate with Iowa HHS Cultural Equity Alliance, Office of Health Equity, and county Equity Teams to educate child protection systems, practice partners and community members on utilizing available tools for promoting systemic changes to reduce minority and ethnic disproportionality in the child protection system.
- Evaluation of the CPPC Approach through a statewide survey and focus groups project has helped guide and shape re-envisioning of CPPC to modernize the Approach and align with current child welfare trends.
- Implementation of the new Family and Youth Centered Engagement (FYCE) strategy, based on extensive feedback from CPPCs, stakeholders and partners on how to improve upon the former ICA strategy by being more flexible to meet the needs of communities.
- FYCE strategy has increased focus on authentic engagement of parents and youth with lived experience at the local level.
- The revised CPPC plan/report document has an increased focus on capturing the work of the CPPCs, and on outcomes of their activities.
- Collaboration, integration, and service mapping with Early Intervention Services will benefit youth, families, caregivers, and local communities.

- <u>Opportunities for Improvement:</u>
  - Work to increase sites' understanding of child protection data and utilizing this data to assess community needs, drive planning and decision making and track changes and outcomes.
  - Develop additional resources for sites to understand how to identify and implement policy, practice changes, and engage youth and parents with lived experience in this process.
  - Continue to identify opportunities for collaboration and community engagement through CPPCs around Family First Implementation.
  - Continued evaluation of the CPPC Approach as all stakeholders stand in partnership with HHS and communities to best support children and families. This will ensure alignment of CPPC within the prevention continuum and further contribute to positive outcomes for children and families in the community.
  - Continued support to CPPC sites implementation of the revised Family and Youth Centered Engagement Strategy (formerly Individualize Course of Action) to be successful in their efforts.
  - Provide continued guidance and support to CPPC sites to center equity and develop/support culturally responsive approaches in their communities.
  - Continued evaluation analysis of the revised CPPC annual plan and report.
  - Ensure successful integration of the CPPC Approach, 4 Strategies, and CPPC Networks into the future aligned prevention service delivery system

Assessment and Intervention

Child Protective Assessments

As outlined in the Iowa HHS Strategic Plan (January 2024 – January 2027), HHS is committed to keeping children of Iowa safe. Guided by principled leadership, HHS is dedicated to authentic engagement and compassionate responsiveness, research-based decision-making processes, and systematic collaborations to address complex challenges that arise in child protection.

Child Protective Services (CPS) aims to keep children in Iowa safe by ensuring families have the needed supports in place to maintain their children safety at home when possible. HHS understands that children don't just need families, child need their families. This is why HHS aligns with a Families First philosophy, which is a commitment to strengthening and preserving connections. Research shows that positive connections create positive outcomes.

To strengthen and preserve connections that achieve positive outcomes, HHS contracted work with an independent agency, the Change and Innovation Agency (C!A), to conduct a Child Protective Assessment. C!A completed the C!A Preliminary Findings Progress Report in February of 2023 and the C!A Final Report in January of 2024. The C!A Recommendations Summary is the HHS response to the final report which highlights key areas of focus that will transform the child welfare system in Iowa and improve outcomes for children and families. As a result, the following three goals are identified for the Child Protection Program:

1. Prevention strategies that reduce unnecessary child welfare involvement and trauma
    a. Promote Early Intervention and Support Services
    b. Establish a prevention and support line (warmline)
    c. Consider the development of a Structured Decision-Making (SDM) tool for intake

    Early Intervention and Support Services act as a bridge to connect families to their community. If families are supported in meeting their needs within the community, they are less likely to be reported for suspected child abuse. Since alignment of the legacy Iowa Department of Public Health and the Iowa Department of Human Services, better connections between the prevention and intervention world of child welfare have led to a greater understanding of each other's roles and the resources available to children and families.

    Whether a family is being reported for suspected abuse, whether there is an open assessment, or whether there is an open service case, it is a priority for Child Protective Services to assess with a family what their needs are and to connect them with services that meet those needs. Because nearly half of abused or neglected children are 5 years of age or younger, it is paramount for Child Protective Services to partner with our prevention colleagues. The Iowa Family Support Network is a single, coordinated website which includes information for referral to many early intervention and support services and continues a statewide resource directory, statewide events, national

resources, and projects and research related to early childhood including early intervention.

In addition to early intervention and support services, HHS is working toward development of a warmline. The warmline is a phone line that proactively supports families and provides information on, and referral to, services to reduce the number of families entering or reentering the Child Protective Services system. Through the warmline, HHS is afforded the opportunity to address critical risk factors that can potentially reduce at least some proportion of families who have or are at risk for child welfare involvement by offering families help and support with a wide variety of needs.

The warmline could have two entry points:

- First, when a report of suspected abuse does not meet criteria for assessment, but the family may benefit from services or supports.
- Second, when families or a support person for a family directly identifies a need for service or support themselves.

In either case, the warmline provides a front door through which families can bypass the child welfare system and access prevention services voluntarily. Use of the warmline aims to proactively identify and correct the underlying issues that could potentially lead to child welfare involvement. By making the shift to a more prevention-focused, and supportive process for those families whose situation does not rise to the level of abuse, HHS can lay additional groundwork to improve overall child well-being and prevent more families from formal engagement with the child welfare system.

As we look at the HHS intake role to reduce unnecessary child welfare involvement and trauma, there is consideration for implementing a Structured Decision-Making tool as part of the front door process. In accordance with Iowa law, HHS accepts all report of suspected child abuse for assessment when the allegation meets all three criteria for abuse in Iowa:

- The victim is under the age of 18 years;
- The allegation involves a caretaker, or a person 14 years of age or older if the allegation is sexual abuse, or a person who engages in child sex trafficking; and
- The allegation meets the definition for child abuse, as defined in Iowa Code §232.68.

If a report of suspected child abuse does not meet the criteria to be accepted for assessment, HHS intake staff reject the report. HHS intake staff must screen all rejected reports to determine whether it meets criteria for a CINA Assessment, to determine if there is a need for the child to be adjudicated a Child In Need of Assistance (CINA) in accordance with Iowa Code §232.96A. HHS uses CINA Assessments to determine if juvenile court intervention should be recommended for a child and also examines the family's strengths and needs to support the families' efforts to provide a safe and stable home environment for their children.

January 1, 2024, marked the 10-year anniversary of Iowa's Differential Response (DR) System. Under the DR System, when HHS intake staff accept a report of suspected child

abuse, staff assign the report to one of two pathways for assessment, a Family Assessment or a Child Abuse Assessment. HHS staff assign accepted reports of suspected abuse as a Family Assessment, Iowa's alternate response, when only Denial of Critical Care is alleged with no imminent danger, death, or injury to a child and additional criteria is met, as outlined in 441 Iowa Administrative Code (IAC) 175.24(2)(b). Cases eligible for a Family Assessment are less serious allegations of abuse.

While the criteria for assessment as well as the which assessment pathway is appropriate is detailed in Iowa Code §232.71B and 441 IAC Chapter 175 and while the intake policy is comprehensive, there are differences in interpretations of policy and decision making that result in inconsistencies in the both the abuse type and pathway of cases being screened in. Developing and implementing a more robust SDM model and intake tool is being considered to support staff in making consistent, equitable decisions. Several of the current tool currently utilized at intake (CPS and CINA Intake Decision Tree, Intake Screening Tool, and CINA guidance tool) could be consolidated and/or updated and absorbed into a SDM tool for intake. In the meantime, monthly meetings between intake and assessment supervisors as well as policy and service help desk representation continue as a means to discuss how policy is interpreted and applied and to communicate a unified understanding moving forward.

Current data on intake is located on the dashboard Intake Summary , available on the HHS website. Additional data related to the prevention strategies above would need to be added upon implementation.

2. Children remain safely in their homes whenever possible
    a. Utilize Structured Decision-Making (SDM) tools to assess safety and risk
    b. Apply 4 Questions/consider reasonable or active efforts to prevent removal
    c. Prioritize placement when removal is necessary

During the course of a Family Assessment, the HHS child protection worker (CPW):

- Visits the home and speaks with individual family members to gather an understanding of the concerns reported, what the family is experiencing, and engages collateral contacts in order to get a holistic view;
- Evaluates safety and risk for the child(ren);
- Engages the family to assess their strengths and needs through a full family functioning assessment; and
- Connects the family to any needed voluntary services.

In effort to improve the way safety was evaluated during the course of an assessment and align with the validated risk assessment tool already in place, HHS worked with Evident Change in 2020-2023 to develop, customize, and implement Structured Decision-Making Safety Assessments to support decision making related to child safety in child welfare services. In November 2023, Evident Change completed their Structured Decision-Making Safety Assessment Post-Implementation Analysis. Results examined safety assessment

findings, safety planning, and placement practices in Iowa during the first years of the SDM Safety Assessment was implemented (February 15, 2022 through February 15, 2023).

HHS continues to monitor use of the SDM safety assessment and track on completion rates, assessment findings, and whether actions align with policy to ensure the safety assessment is being used to support safety planning with families in Iowa. In March 2023, the HHS Service Training Help Desk released a memo to field staff as part of their monthly installment of Service Training Takeaways, highlighting the following:

> *The SDM Safety Assessment implements a full-system approach helping workers best serve families within the context of solution-focused, family-centered practice. The tool combines research with practice strategies, offering workers a framework for consistent decision-making resulting in a fair and equitable process for families served by HHS. The Safety Assessment guides HHS workers to make consistent decisions; however, it does not replace a worker's professional judgment, skills, and experience. People make decisions, though the Safety Assessment guides workers to make better decisions.*

The document below was also provided to review SDM Safety Assessments, why they are important to our agency and the families we serve, as well as some practice reminders.

March 2023 Service Training Takeaways

Monitoring will continue and additional feedback will be considered to identify opportunities for improvement. A full evaluation study to better understand the impact of implementation; reviewing rates of individual items selected on the SDM safety assessment to identify specific resources that may be needed to support families; and staff surveys, interviews or focus groups to provide information not available in the data are all options for consideration of continued monitoring.

During the assessment of safety, staff will make a safety decision to determine if a child is safe, safe with a plan, or unsafe. When there are one or more danger indicators present, a safety plan is required if safety interventions have been identified and agreed upon by all necessary parties. Removal is not sought if the safety interventions mitigate the danger. The state recognizes removing a child from their family causes the child harm and that the harm caused must be weighed against the potential harm in allowing a child to remain with the child's family.

This includes weighing the physical, social, and mental trauma the removal may cause the child. In effort to maintain children safely in their homes whenever possible, HHS will continue to apply the 4 questions, which began as a pilot project in 2020, and consider reasonable or active effort to prevent removal:

- What can we do to remove the danger instead of the child?
- Can someone the child or family knows move into the home to remove the danger?
- Can the caregiver and the child go live with a relative or fictive kin?
- Can the child move temporarily to a relative or fictive kin?

Additionally, staff are asked to consider making a referral to Family Preservation Services (FPS) and if possible, utilize a Child Safety Conference as part of the FPS to identify collaborative solutions to allow the child and family to remain together and if that's not possible, to make effort to place the child with kin or fictive kin caregivers.

When there are one or more danger indicators present and there are no reasonable or active efforts to prevent removal, removal is the only safety intervention possible. In these circumstances, HHS strive to ensure the placement is consistent with the best interests and special needs of the child and in the least restrictive, most family-like setting available in close proximity to the child's home. Every reasonable effort is made to place the child with an adult relative or fictive kin of the child. HHS also works actively to ensure the child stays connected to their kin, culture, and community. When placement is necessary, the Iowa courts are required to first consider placing the child in the custody of the other parent of the child. If the court determines that placing custody of the child with their parents is not in their best interest, the child custody is transferred to HHS for placement of the child in the following order of priority:

- An adult relative of the child (including but not limited to adult siblings and parents of siblings)
- A fictive kin.
- Any other suitable placement identified by the child's relatives.
- An individual licensed to provide foster care (with decision-making authority assigned to the foster care provider for the purpose of applying the reasonable and prudent parent standard during the child's placement)
- A group care facility, shelter care facility, or other residential treatment facility

Current data on removal rates and placements is located on the Removal Rates and Placement Summary dashboards, available on the HHS website.

3. Adequate services prevent repeat maltreatment
   a. Complete Family Functioning Assessment to identify family strengths and needs
   b. Refer to services available in the community
   c. Create Safe Plans of Care for infants affected by substance use

As part of an assessment (and throughout the life of a case), HHS uses a Family Functioning Assessment tool to provide a common lens through which to collect and analyze information concerning all children and families in the child welfare system. Evaluation of the family's functioning requires a thorough interview with the family to determine areas of strength or need when assessing safety, developing a safety plan, or developing a plan to provide for the safety, well-being, and the permanency of the child.

Currently, HHS utilizes five family functioning domain criteria to assist with assessment of the strengths and needs of the child, and of the child's parents, caretakers, home, and family:

- Child well-being
- Parental capabilities (includes use of drugs or alcohol)
- Family safety (includes domestic violence)
- Family interactions
- Home environment

It should be noted that there is currently a workgroup evaluating the Family Functioning Assessment tool in effort collect the same information in a more streamlined process for workers in a way that meets the needs of the family through the course of the child protective assessment as well as feeds into the family case plan if formal HHS case management services were to be offered.

Evaluation of family functioning is the critical first step in understanding the underlying causes that may have led the family to HHS' attention. After synthesis and analysis, the family team uses the information from to develop a "big picture" understanding of the child and family. This common core of shared team intelligence forms the basis for unifying efforts, planning joint strategies, sharing resources, finding what works, and achieving a good match of supports and services for the child and family. This approach to identifying strengths and needs is key to preventing repeat maltreatment.

Repeat maltreatment is also prevented through adequate service referrals that are made at the close of a child protective assessment. CPWs must complete Family Assessment reports by the end of 10 business days, with no finding of abuse, no consideration for placement on the Central Abuse Registry, and no recommendation for court involvement. Successful closure of a Family Assessment indicates the children are safe without further need for intervention. CPWs make recommendations for services available in the community for families with low risk and offer non-agency voluntary (state purchased) services to families at moderate and high-risk. To align with HHS efforts to implement the Family First Prevention Services Act, these non-agency voluntary services are encouraged to use the Solution Based Casework (SBC) approach and are required to complete service plans for each case. However, following a 2024 assessment of Title IV-E claims for Child Protective Services completed by Sivic Solutions Group, LLC, it was noted many programs have been added to the federal clearinghouse, which present expanded opportunities to implement evidence-based programs while drawing down federal IV-E funding to support work. As a result, HHS will be moving toward a transition from SBC to Motivational Interviewing (MI). The change in contracts from SBC to MI will begin July 1, 2024, while the consistent use of MI from the Family Centered Service providers will not be expected until the end of 2024.

If at any time during a Family Assessment the CPW receives information that makes the family ineligible for a Family Assessment, inclusive of a child being "unsafe", HHS staff

reassigns the case to the Child Abuse Assessment pathway. The same CPW continues to work the case.

The Child Abuse Assessment is Iowa's traditional path of assessing reports of suspected child abuse. The HHS CPW utilizes the same family functioning, safety and risk assessments as under the Family Assessment pathway. However, by the end of 20 business days, the CPW must also:

- Make a finding of whether abuse occurred,
- Consider whether a perpetrator's name meets criteria to be placed on the Central Abuse Registry, and
- Determine whether court intervention will be requested.

Findings of whether abuse occurred include:

- "Founded", which means that a preponderance (more than half) of credible evidence supports that child abuse occurred and the circumstances meet the criteria for placement on the Iowa Central Abuse Registry.
- "Confirmed", which means that a preponderance (more than half) of credible evidence supports that child abuse occurred, but the circumstances did not meet the criteria for placement on the Iowa Central Abuse Registry because the incident was minor, isolated, and unlikely to reoccur. (NOTE: Only physical abuse and denial of critical care, lack of supervision or lack of clothing can be confirmed).
- "Not Confirmed", which means there was not a preponderance (more than half) of credible evidence to support that child abuse occurred.

Historically, most child protective assessments are Not Confirmed, as indicated in the child welfare and child abuse statistics data linked below and as aligned with National data. Families with a Not Confirmed outcome, a Confirmed outcome with a Low or Moderate Risk score, and those who are part of a Family Assessment (as mentioned above) are eligible for Non-Agency Voluntary Services to assist in meeting any of their needs. When abuse is Founded or Confirmed with a High-Risk score, a separate group of HHS case managers supervise ongoing services for children and their families through [HHS] Case Management Services.

The 2023 Child Welfare By The Numbers report summarizes the assessment data and findings and includes data related to caseloads, service strategies and results, and expenditures.

The full 2023 Child Welfare data report can be found on the HHS website at: Child Abuse Statistics | Health & Human Services (iowa.gov)

Finally, creating a Safe Plan of Care for infants affected by substance use is another way in which HHS identifies adequate services to prevent repeat maltreatment. The Safe Plan of Care addresses the health and substance use disorder treatment needs of the infant and affected family member or caregiver. Assigning specific individuals to monitor all or part of

the Safe Plan of Care helps to ensure that referrals are made and critical services are provided to the infant and family.

In addition to identification of informal supports, appropriate services in a Safe Plan of Care may include:

- Substance abuse evaluation or treatment
- Medical care
- Visiting nurse services
- Home visitor parenting programs
- Early ACCESS
- Safe sleep education
- Mental health evaluation or treatment
- Victim advocacy (for domestic violence)
- State assistance program application
- Family Preservation Services

Additional details on Safe Plans of Care and how Iowa has implemented the Comprehensive Addiction and Recovery Act of 2016 can be found in the annual report for the Child Abuse Prevention and Treatment Act State Grant.

Current data on repeat maltreatment and reentries to foster care data is located on the Repeat Maltreatment Summary and Re-Entries to Foster Care Summary dashboards, available on the HHS website.

Child Advocacy Centers

A Child Advocacy Center (CAC), also known as a Child Protection Center (CPC), is a medically based facility within a community or an HHS service area that offers a comprehensive, child focused program that allows law enforcement, child protection workers, mental health professionals, prosecutors, and medical personnel to collaborate and work together to handle child abuse cases.

CAC/CPC Services

CAC/CPCs employ staff that specializes in the emotional and physical needs of children who have experienced sexual abuse, severe physical abuse and/or substance use related maltreatment or neglect. Services include forensic interviews, medical exams, treatment, and follow-up services for alleged child victims and their families. These specialized services strive to limit the amount of trauma experienced by child victims and non-offending family members.

In addition to providing services to assist HHS in the assessment of child abuse, the CAC/CPCs coordinate with law enforcement and county attorneys in the prosecution of criminal cases involving child endangerment, child fatalities, sexual abuse, and human trafficking. CAC/CPC staff also offer court testimony in legal proceedings involving cases in which the CAC/CPC provided services. In this way, the CAC/CPCs have assisted HHS, District Court, and Juvenile Court in numerous child abuse cases. Other services provided by CAC/CPCs include multidisciplinary trainings for professionals involved in child welfare services.

CAC/CPC Locations

Currently, there are six CAC/CPCs and one satellite CAC/CPC in Iowa. The names and locations of the CAC/CPCs are as follows:

- Child Protection Response Center, Davenport, Iowa
- Mississippi Valley CAC/CPC, Muscatine, Iowa
- St Luke's CAC/CPC, Hiawatha, Iowa
- Blank Children's STAR Center, Des Moines, Iowa
- Mercy CAC/CPC, Sioux City, Iowa
- Allen CAC/CPC, Waterloo, Iowa
    - Allen's Satellite CAC/CPC, Mason City, Iowa

In addition to Iowa's CAC/CPCs, there is also Project Harmony, a CAC/CPC that is located in Omaha, Nebraska. Project Harmony provides services to children and families within the southwestern area of Iowa.

FFY 2025-2029 Goals & Strategies

To continue to partner with and support the work of the CAC/CPCs, HHS has identified goals and objectives for the FFY 2025-2029 Child and Family Service Plan (CFSP). The intention of the goals and objectives are to promote the use of the CAC/CPCs services to improve outcomes for children and families. Child abuse cases can be complex and require medical and therapeutic experts to assist in the diagnosis, assessment, and disposition of these cases. In addition to providing these services, the CAC/CPCs also work to bring together and help to coordinate the co-occurring investigations of other key players who may be involved in these cases including HHS child protection staff, police departments, and judicial partners.

Goal 1: Increase collaboration between HHS & CAC/CPCs

- Arrange for and participate in quarterly meetings with the CAC/CPCs to discuss current issues and concerns.
- Participate in joint case reviews with the CAC/CPCs to better understand the approach and requirements of each agency.
- Review HHS and CAC/CPC services and supports and work together toward addressing any gaps in services.
- Support the CAC/CPCs in their recertification efforts.

Goal 2: Promote the use of the CAC/CPCs to ensure that children who have experienced child abuse or neglect receive specialized care services.

- Increase HHS referrals to CAC/CPCs in complex child abuse cases.
- Improve rural access to the assessment and treatment services offered through CAC/CPCs
- Ensure that all HHS Multi-Disciplinary Team (MDT) members are aware of the services provided by the CAC/CPCs
- Review the HHS referral process to CAC/CPCs to reduce disproportionality and ensure equity in service referrals.

HHS Drug Testing Services

In child welfare, drug testing is conducted to better protect children. Drug testing results assist in the effort to identify or eliminate substance abuse as a possible contributing factor or risk in a child abuse assessment or child welfare service case. Drug testing results are one component in the accumulated information that needs to be considered in determining the safety of the child. Under HHS policy, drug testing should be limited to situations where behavioral indicators have been observed and/or reported that could potentially impact a child's safety.

HHS endorses a strength-based approach to drug testing. A strength-based approach can help to move a parent/caretaker who is dealing with a substance use disorder toward a more functional level of behavior through abstinence as well as, adherence to the appropriate treatment plan goals regarding recovery. Addiction is a chronic illness that has a powerful and adverse impact on brain functions to the point that an individual can experience a compulsive need for drugs regardless of any consequences. Recovery can be a long-term process which often requires months of substance use disorder treatment and aftercare services. Under a strength-based approach, the role of the HHS worker is to support the client's treatment and recovery and to reduce barriers to treatment services whenever possible. In addition, a non-punitive approach to drug testing can potentially serve as an incentive for the parent/caretaker to stop using drugs, be a positive reinforcement for continued abstinence during the early recovery stage, motivate the parent/caretaker to enter or continue with treatment services, or encourage a parent/caretaker to self-disclose.

A strength-based philosophy and approach to drug testing aligns with and supports the HHS 2025-2029 Child & Family Service Plan (CFSP) vison statement, "Family Connections are Always Strengthened and Preserved" and the CFSP goals that: children are safe from re-abuse, children achieve permanence in their living situation, and that children experience well-being through their family's capacity to provide for their needs.

<u>FFY 2025-2029 Drug Testing Activities</u>

- On June 30, 2025 the current HHS Drug Testing Collection Contract and the HHS Drug Testing Laboratory Services Contract will end. In preparation for new drug testing contracts to begin in 2025, an HHS workgroup has begun meeting to discuss the future needs of the drug testing program and the RFP process that will be followed. This group will continue to meet monthly as they plan for the new contracts.
- New supports for the drug testing program in the coming year will include assistance from Dr Kruse, HHS Medical Director. Dr Kruse has expressed an interest in learning more about the Drug Testing program based on his previous work as a Certified Medical Review Officer for workplace drug testing. Dr Kruse will be working with the Drug Testing Policy Program Manager and the Drug Testing Contract Specialist to learn about the program and offer his expertise in this area.

<u>Drug Testing Strengths & Opportunities for Improvement</u>

As part of the 2024 Iowa's Children's Justice Act (CJA) Three–Year Assessment process (see Iowa's 2024 CJA Grant Application & Three-Year Assessment Report) the Iowa Child Protection Council reviewed the HHS Drug Testing Program. As part of that assessment, the group identified both the strengths and opportunities for improvement within the HHS drug testing program.

- Strengths:

  - The use of statewide drug testing contracts has provided statewide consistency in collection services and laboratory analysis.
  - Expert court testimony regarding drug testing results is available in contested court hearings.
  - The HHS Drug Testing system offers three modes of collection: Fixed Site, In-Home, and Emergency drug testing.
  - HHS practice guidance promotes behavioral indicators, personal appearance, and observation of physical environment to drive testing decisions.
  - Improved drug testing data collection.
  - Multiple types of drug tests are available.
  - Drug testing policy endorses a strength-based approach to testing.
  - Drug testing policy supports testing based on behavioral indicators vs random testing.
- Opportunities for Improvement:
  - Limited hours of operation at various Fixed-Sites.
  - Need to expand substance abuse prevention programs to prevent neglect.
  - Training is needed for Judges to align their decisions with HHS drug testing guidance.
  - HHS drug testing policy doesn't address the role of the court and how HHS collaborates with judicial partners across the state to avoid court ordered testing that may not align with best practice.
  - Need to train Family Centered Service providers in drug testing.
  - Policy directs the sharing of information with parents about testing, but this is not seen in actual practice.
  - Proposed custodian testing.
  - Need to use Child Protection Centers for drug testing of children.
  - Lack of testing in rural areas and in some areas predictable drug testing dates/times.
  - Concerns voiced about faulty sweat patches and positive tests results when parents are adamant they have not used.
  - HHS workers need increased training on drug testing.
  - Faulty sweat patches – concern of false positives
  - Sweat patch reliability questioned.
  - Limited times of onsite testing, especially in rural areas.
  - Increase drug testing accessibility (expand times, transportation assistance, and in home testing options).
  - Train contracted workers on behavioral indicators
  - Think outside the box when safety planning with substance use.
  - Drug testing accessibility (cost, transportation, location of sites for testing).
  - Knowledge of in-home drug testing options.

<u>FFY 2025-2029 Drug Testing Goals & Objectives</u>
Based on the list of opportunities for improvement in drug testing the following Drug Testing Program goals and objectives were identified for 2025-2029.

Goal 1: Accessibility to drug testing services.
- Increase dates/times of operation at Fixed Sites, especially in rural areas of the State.
- Provide transportation assistance to Fixed Sites.
- Expand in-home drug testing.

Goal 2: Collaborate with substance abuse providers to reduce barriers to substance abuse treatment services.

- Increase availability of substance abuse treatment services.
- Ensure referrals to treatment services are being made

Goal 3: Provide Drug Testing training on the use of behavior indicators in determining the need for drug testing and on the validity of sweat patches.

- Judicial partners
- HHS contracted providers
- HHS field staff

Treatment Services and Foster Care

Connect And Protect (CAP) Teams and Consultations

Connect and Protect (CAP) Teams are multi-disciplinary and have membership from the Iowa Department of Health and Human Services, Family Centered Services providers, Parent Partners, and Domestic Violence advocates. CAP teams are the content experts on Safe & Together™ - the model for domestic violence child welfare cases that HHS is responsible for serving. Teams are designed to meet to provide case consultation on domestic violence cases in the style of Safe & Together™ to promote best practice and to assist child welfare partners in working through cases through a domestic violence-informed lens. The Safe and Together model is a perpetrator pattern-based, child-centered, and survivor strengths approach to working with domestic violence the child welfare system. In addition to consultation, CAP Teams also provide information sharing, local training, and answer questions about the model in offices and agencies. Case consultation is approached slightly different on each team, but the Safe & Together™ Mapping Tool provides the basic framework.

The CAP Teams will continue to provide consultation to child protection workers and ongoing case managers on child welfare cases which intersect with domestic violence and are referred for CAP consultation in each of the five service areas during the upcoming five-year period. CAP teams will continue to receive ongoing learning and development through available virtual trainings from the Safe and Together Institute and the CAP Team bi-annual seminars. A workgroup representative of CAP team members, and the HHS Service Trainer and Program Manager who provide training support to the teams, will explore additional strategies to track and evaluate the outcomes of cases who participate in CAP team consultation. HHS is also exploring the addition of expanding dedicated HHS staff time to support the CAP teams through providing observation and feedback to the CAP team consultations.

Family-Centered Services (FCS)

Goal: Through collaboration between the family and public and private agencies, children and families in Iowa will be safe, secure, healthy, and well in their communities. (FCS Mission Statement)

Iowa implemented Family Centered Services (FCS) in July 2020. These services are targeted toward intact families (in-home), families with children placed with kin/fictive kin caregivers, and families with children placed in stranger foster care. The interventions selected for the FCS service array are a direct response to federal Family First legislation. FCS focuses on

addressing identified safety concerns, enhancing caregiver capacities, and reducing risk so that children can remain in their homes as often as possible or return home quickly if out of home placement is necessary.

Family Centered Services contracts began July 1, 2020, after a competitive procurement process. There are nine active contracts with six contractors across the state. Each contractor is contracted to provide services in specific counties, with 18 counties covered by a single contractor and ~~61~~ 81 counties covered by two contractors with alternating case assignment. A similar competitive procurement process will occur in 2025, with the intention of new contracts being implemented no later than July 1, 2026.

Transition from Solution Based Casework® to Family Casework

Beginning July 1, 2020, Iowa's Family Centered Services (FCS) providers implemented Solution Based Casework® (SBC) in response to the federal Family First Prevention Services Act (FFPSA). Iowa was an early adopter of FFPSA, and with the help of Casey Family Programs, selected SBC based on information known at that time. When SBC was later evaluated, it did not meet criteria for inclusion on the IV-E Prevention Services Clearinghouse. Iowa subsequently contracted with Sivic Solutions Group (SSG) in 2023 to evaluate how to maximize IV-E drawdown and one of the recommendations was to transition away from SBC and implement Motivational Interviewing, which is a well-supported practice on the IV-E Prevention Services Clearinghouse.

Effective July 1, 2024, Iowa's Family Centered Services (FCS) providers will begin implementation of Family Casework as the primary in-home service provided to families. Family Casework is defined as "a family-centered model of child welfare practice involving ongoing assessment, case planning, and direct services to families which assists families in building the skills necessary to provide a permanent, safe, and stable environment for the children." Family Casework will include Motivational Interviewing (MI) as Iowa's primary Evidence-Based Intervention (EBI) within general casework practice.

The array of services available under FCS includes Non-Agency Voluntary Services, Family Casework with Motivational Interviewing, Family Focused Meetings, Youth Transition Decision-Making (YTDM) Meetings, SafeCare®, Family Preservation Services with Motivational Interviewing and Child Safety Conferences, and Family Interactions. The FCS contract also incorporates Kinship Navigator Services for kin and fictive kin providing care to children needing out of home placement.

A family is eligible for Family Centered Services (FCS) on an Open Agency case when:

- The child(ren) is adjudicated a Child in Need of Assistance (CINA) by the Juvenile Court; or
- The child(ren) is placed in out of home care under the care and responsibility of HHS; or
- The outcome of the Child Abuse Assessment is:
    - A founded report regardless of risk level, or
    - A confirmed report, high risk

Family Preservation Services are also available during a Child Abuse Assessment when it is determined that there is an immediate safety concern that would otherwise require out of home

placement and the family is agreeable to working with providers to address the immediate safety concern.

Note: FCS will not be available for children placed in shelter or group care placement longer than 30 days; however, FCS will be available for a youth exiting from a QRTP for post-discharge services.

Upon determination that a family is eligible for FCS, the HHS worker assigns the case to an FCS provider and sends referral information for the services which can best meet the family's needs. Each of the services under FCS can be assigned independently of the others or overlapped based on family need. The family's unique needs and circumstances will be taken into consideration when making referrals.

Objectives: The objectives for Family Centered Services are reflected in the Performance Measures laid out in the Family Centered Services contract. They include:

- **Performance Measure 1:** Children served by the contractor are safe from abuse for 12 consecutive months following the conclusion of their case.
- **Performance Measure 2:** Children served by the contractor are safely maintained in their own homes or with kin/fictive kin caregivers during the case.
- **Performance Measure 3:** Children served by the contractor who are reunified or exit foster care do not experience reentry into care within 12 consecutive months of their reunification date.

Description of services

Non-Agency (HHS) Voluntary Services
Non-Agency Voluntary Services provide support and connections to community resources for families who were the subjects of a Child Abuse Assessment or Family Assessment when open Agency services are not required. Families elect whether to participate in Non-Agency Services and the service is available for up to 4 months. Non-Agency Services are short-term and focused on supporting the family as they connect to community resources and building positive connections between family members. The goal of Non-Agency Services is to minimize the likelihood of a family coming deeper into the child welfare system through setting a family up for long-term self-sufficiency.

Participation in Non-Agency Services is voluntary for the family. The family is able to decline or discontinue services at any time. Families eligible for Non-Agency Services do not meet criteria for Agency services. If a family declines Non-Agency Services, no further action is taken. HHS and Non-Agency Services providers provide a full description of Non-Agency Services and encourage participation for all eligible families. If a family initially accepts services when speaking with HHS, Non-Agency Services providers will make efforts to engage the family in the program for 30 days. If the family does not respond to attempts to engage after 30 days, the Non-Agency Services case is closed.

Supports to a family can include material supports like clothing, food, cleaning supplies, childproofing equipment, or other items needed to ensure safety for the children; connections to community organizations that can assist families with obtaining these items, and parenting enrichment. Providers identify areas where family relationships are strained and work with the family to improve family bonds and communication. Non-Agency Services additionally provide families with connections to community supports such as behavioral health services, health care providers, parenting support groups, and other agencies that can ensure families' needs are

met. Non-Agency Services support the family in rebuilding or establishing informal support networks of extended family and friends.

HHS requires Family Centered Services providers to submit a service summary report when the Non-Agency Services case closes. This report provides an overview of the supports and community connections provided in response to the family's identified needs. Non-Agency reports are reviewed as part of regular case reviews to ensure quality of work with families and documentation.

Family Casework with Motivational Interviewing
Family Centered Services (FCS) empowers families to be the drivers of change. The primary service to families will be Family Casework with Motivational Interviewing. As noted above, Family Casework is designed to support families in building skills to provide safety and stability for the children. This is primarily accomplished through direct services in the home which assess family functioning, identify specific deficits/barriers to child safety, and working with parents to remedy them.

The primary intervention within Family Casework will be Motivational Interviewing (MI). Iowa's FCS provider agencies are already familiar with this intervention, as it is included in Family Preservation Services. Motivational Interviewing supports behavioral change by identifying ambivalence toward change and supporting families through the change process. MI identifies five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. MI supports families in identifying ways that change is possible and selecting options to address safety concerns that mesh with the family's strengths and abilities. Providers support families to see themselves as the experts on their family's unique needs and reinforce that behavior change is possible.

Through the use of open-ended questions and reflective listening, providers guide families to make behavioral changes that support the safety and well-being of the children. Families identify their needs and work with their providers to address barriers, access community resources, and make necessary changes in their homes. This results in families staying together or being reunited as quickly as possible. By focusing on sustained behavioral change, Family Casework with Motivational Interviewing sets families up to achieve their short-term goals as well as recognizing the importance of maintaining positive behavioral change for the long-term. As a result, it is expected that fewer families will come back into the child welfare system because they have the tools and skills to self-correct when challenges occur in the future.

Family Focused Meetings and Youth Transition Decision-Making Meetings
Ensuring families are actively involved in case planning is critical to family success. Iowa has long valued the importance of gathering a family and their support team to identify family strengths, progress, barriers to progress, and planning for overcoming those barriers with the support of the family's team. Due to the transition away from Solution Based Casework, Iowa will utilize a Family Focused Meeting model for case planning.

The Family Focused Meeting model has two phases, with both focused on ensuring consistent messaging between the family, HHS, and FCS team members and amplifying family voice during discussions. In the initial Family Focused Meeting, the family, HHS, and FCS provider will come together to discuss initial steps the family can take and begin to gather a vision of

what the family needs in order to achieve sustained behavioral change. In comprehensive Family Focused Meetings, the family, their supports, HHS, FCS, and invited professional partners will join together to create a clear path forward, with next steps identified for each team member to complete. The format of both meetings closely follows the HHS case plan, ensuring consistency of messaging, clear expectations for the family, and that the family's voice is heard and documented in multiple locations. Through clear communication, the family drives change by being empowered to select goals and steps that are attainable, while being supported by the team to remain focused on child safety as the final goal.

Youth Transition Decision-Making Meetings will continue as well. These meetings are opportunities for a youth to plan for their future. YTDMs are critical for older youth who are likely to age out of care. YTDMs provide the youth opportunities to identify potential supports to guide them into adulthood, develop a plan for housing, education, health care, work, and social relationships. Iowa continues to explore ways to maximize the number of youth ages 16 and older who receive the opportunity to have a YTDM.

SafeCare®
SafeCare® is an evidence-based behavioral parenting model shown to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 in at-risk families. It is a home visitation-based parent training program conducted in three modules, with each module consisting of 6 sessions. Parents who are at-risk for neglect receive instruction on how to have positive parent-child interactions, keep their homes safe, and manage and improve their child's physical health. For more information on SafeCare®, please visit their website, www.safecare.org.

Iowa began coordinating with the FCS provider agencies and SafeCare® beginning in 2016. Initially, the provider agencies were able to elect whether to implement SafeCare® and SafeCare® became a mandatory part of the Family Centered Services contracts beginning July 1, 2020. All six of the agencies providing FCS in Iowa have trained SafeCare® providers. When an eligible family is referred for SafeCare®, HHS sends the referral to the same agency providing other FCS services to ensure continuity of care for the family.

SafeCare® has been very positive for families in Iowa. Due to the positive outcomes already observed, Iowa intends to expand access to SafeCare® by allowing for SafeCare® to be a standalone service beginning July 1, 2024. This will allow for HHS workers to refer families for SafeCare® alone when that is the most appropriate service to support the family's needs or to refer for SafeCare® during a Family Casework case when families need both services to support meeting their needs. HHS staff will receive specific guidance and supervisory support in determining the most appropriate services for each family they serve. According to early research into Iowa's use of SafeCare®, families are less likely to come back into the child welfare system after receiving SafeCare®. The National SafeCare® Training and Research Center (NSTRC) report of their ongoing evaluation of Iowa's SafeCare® program can be found here: https://hhs.iowa.gov/media/7057/download?inline=. By expanding access to SafeCare®, Iowa anticipates fewer families will come back into the child welfare system.

Family Preservation Services with Motivational Interviewing
Family Preservation Services (FPS) with Motivational Interviewing (FPS-MI) and Child Safety Conferences (CSCs) are short term, intensive interventions with families, specifically targeted to cases where children are at imminent risk of removal from their home. HHS refers for FPS-MI to

keep children safe with their families and prevent formal removal from the home. FPS-MI is delivered in 10-day units of service and tightly focuses on the imminent safety concern that would otherwise result in removal of the child from the home.

Child Safety Conferences (CSC) are a critical component of FPS-MI, bringing together the family, their supports, HHS, and FCS to discuss the imminent safety concern and what the family is ready to do to ameliorate the safety concern and prevent removal. The initial CSC occurs within the first 3 days of FPS-MI and a follow up meeting is held 10 days later. The follow up meeting is intended to celebrate successes and talk about any lingering safety needs that could otherwise result in removal.

Family Interactions
Children who are removed from their homes need regular contact with their primary caregivers. Parents need to see their children and have ongoing opportunities to build family bonds. HHS and FCS work with the family and placement to support regular interactions. Ideally, interactions occur in the most natural, homelike setting possible, with kin or other natural supports providing supervision. When necessary, FCS providers can provide up to 10 interactions per month or 20 hours of interaction per month, whichever comes first. FCS and HHS work collaboratively to organize, plan, and assure interactions occur in appropriate, homelike settings whenever possible.

Kinship Navigator Program and Services
When safety cannot be assured in the home and a removal must occur, HHS first looks to kin and fictive kin caregivers who may be able to care for the child. When a child is placed with kin or fictive kin, the Kinship Navigator Program provides immediate support to the caregiver family. This can take the form of assisting kin or fictive kin in obtaining any items necessary to care for the child, connecting the caregiver with community resources to meet the child's needs or the caregiver's needs, and helping the caregiver process the change in relationship dynamics with the child and parents. Iowa is working toward aligning practice with an established Kinship Navigator program to better support kin and fictive kin caregivers, assure needs are identified and addressed in a timely manner, and that kin and fictive kin caregivers have ready access to information about community supports.

Through this array of services available under the Family Centered Services contracts, families involved with Iowa's child welfare system receive support and empowerment to keep their children safe and, in their homes, whenever possible. The focus of all services under FCS is to drive positive behavioral change, which results in better long-term outcomes for children as they are less likely to re-enter the child welfare system. Parents and caregivers are empowered to identify and make choices that work best for their family, resulting in increased confidence of decision-making. Through empowerment and positive behavioral change, parents are better equipped to identify stressors early on and seek out community supports in the future, thereby avoiding a return to the child welfare system.

Fatherhood Services

Caring Dads™
Caring Dads™ is a voluntary program for fathers to develop healthy coping, life, and parenting skills. The program targets fathers currently involved in the child welfare system due to child physical/emotional abuse, neglect, or child exposure to domestic violence. The curriculum

addresses awareness of controlling behaviors, abuse, and neglectful attitudes. Participants receive ways to strengthen their father-child relationships, while maintaining a child-centered approach. Caring Dads™ is a unique opportunity for men to connect as fathers. This interactive learning environment is a combination of active group discussions, exercises, and homework. Caring Dads™ is a weekly two-hour session for 17 weeks. The primary referrals come from HHS staff and participants must sign in each week. HHS staff receives weekly attendance reports on a quarterly basis. Each 17-week cycle has a maximum capacity of 12-15 participants. Over the last two years, two sessions per year occurred with approximately 25 men completing the 17-week session. Currently, there are three participating facilitators for the Caring Dads™ group, including a licensed mental health clinician, and several more facilitators trained. There are many highlights and challenges to each group. The biggest challenge appears to be the initial attitude of the father during the first group session. Typically, participants have a resistance to the group process and the referral in general.

This is quickly curbed with ongoing discussion of personal choices and behaviors. Once the fathers begin to take accountability for their choices, share with the peer group, family members and their social workers, they begin to see positive things happen with their lives and respective cases.

By the end of the 17 weeks, most fathers want to continue with the group as it has become their therapeutic weekly support group. They rely on their peer support. At the conclusion of the group, the fathers receive encouragement to reach out to one another for support, if appropriate. The greatest incentive is the improved relationships with all involved in the case and within their respective family systems.

The current plan is to continue Caring Dads™ in the Des Moines Service Area in Polk County and in the Northern Service Area in Webster County and offer three cohorts per year. Due to limited capacity, expansion of the Caring Dads™ beyond the two areas is not possible at this time but may be possible at some point within the five-year CFSP period.

Promoting Opportunities for Parenting Program

Children and Families of Iowa (CFI) continues to partner with HHS Child Support Recovery Unit to offer the *Promoting Opportunities for Parenting Program*. This opportunity is for any parent who owes back child support to the State of Iowa. They can enter into an agreement with Child Support Recovery, once they have completed the class, to fulfill the written obligations which will lead to their back-child support to be forgiven. This would be an incentive for either parent to attend and complete group. This incentive has been a highly effective engagement strategy for parents to attend and complete the curriculum.

Parent Support

Parent Partner Program

The Iowa Parent Partner Program provides mentoring support to parents with the goal of protecting children from abuse and neglect. Children are safely maintained in their homes whenever possible and appropriate. The Parent Partner Approach works with parents involved in the child protection system, HHS/Child Protection Services (CPS) and the community to enhance families' capacities to provide for their children’s needs.

Parent Partners share experiences and offer recommendations through a variety of opportunities such as foster/adoptive parent training; HHS child protection services training for new and ongoing case managers; local and statewide planning/steering committees and conferences; and Community Partnerships for Protecting Children (CPPC) participation. Parent Partners work with HHS social workers, legal professionals, community-based organizations, and others to provide resources and lift voices and experiences for the parents they mentor. Parent Partners also frequent Family Treatment Court to provide support and coaching for participants. The goal of the Parent Partner Approach is to help parents be successful in completing their child welfare case plan goals by providing families with Parent Partners who are healthy, stable, and model success.

Parent Partners are available in all 99 counties. The current statewide staffing structure includes five Lead Parent Partners, 17 Coordinators (4 are former Parent Partners), five Service Area Coordinators (3 are former Parent Partners), the Operational Coordinator (was a former Parent Partner), the Quality Assurance Coordinator and the State Director. The program has expanded to include a Parent Voice and Inclusion Coordinator position who was added to the state team in SFY 2023.

HHS contracts with the University of Nebraska-Lincoln (UN-L) to host and maintain the Parent Partner database and provide ongoing analysis and evaluation of both the administrative and outcome data. The analysis of the administrative data is an ongoing quasi-experimental design, and the outcome data reflects surveys using the protective factors as a framework. Individuals enter the outcome data into the web-based parent partner database.

Through on-going research, UN-L found a positive statistically significant difference for parents who receive Parent Partner supports. Parents receiving mentoring support from a Parent Partner have a higher rate of reunification and less reentry than families without a Parent Partner. HHS partnered with UN-L to author a research article regarding these findings.

The Parent Partner research study was published in the journal Child & Youth Services Review, September 2019, demonstrating that when HHS-involved parent has a parent partner, there is less re-abuse and children are more likely to return home. This publication and other materials were submitted to the California Evidence-Based Clearinghouse (CEBC) and the federal Prevention Clearinghouse to be reviewed and rated for evidence-base practice. During SFY 2021, HHS received notification that the Iowa Parent Partner Program has received Promising level evidence-based ratings from both the CEBC and the federal Prevention Clearinghouse.

In-Home Prevention/Child Safety Conferences

On July 1st, 2020, the Child Safety Conference (CSC) Parent Partner Program Pilot was implemented across the state. The Parent Partner Program is one of the engagement strategies to support families during the Child Safety Conference process and through the journey of the child welfare process. CSCs are a key component of Iowa's implementation of Family First and provide a conference facilitated opportunity for parents of children at imminent risk of removal and placement in foster care. Parent Partner support at the CSC focuses on families who are at risk for abuse if appropriate supports and/or resources are not provided and will participate in a

CSC as a result of participation in Family Preservation services. These families will potentially remain intact through the CSC process with appropriate resources and the ongoing support of a Parent Partner. The pilot program to offer support at the CSC and on-going as prevention to out of home placement became part of the Parent Partner Program contract target population in SFY 2024.

In-Home Prevention Support Evaluation

HHS has been working with the University of Nebraska-Lincoln (UN-L) to prepare for quasi-experimental evaluation design that replicates the methodology utilized for evaluation of the traditional Iowa Parent Partner model to evaluate the effectiveness of the Iowa model when working with families that have participated in a Child Safety Conference (CSC) and receive in-home prevention support. Evaluation of child welfare primary outcomes will focus on prevention of out of placement and time until case closure. Additional data will be utilized to explore secondary outcomes such as cases experiencing subsequent removal and types of placements (kinship vs. non-kinship), time in out of home care, and rate of reunifications.

Families who participated in a CSC and receive in-home prevention support will be matched with non-participant families from across the state via propensity score matching to closely replicate the effects of randomization. Non-participating families are parents that chose to decline Parent Partner program support. The evaluation drew data beginning on July 1, 2021, when the CSC in-home prevention pilot was fully operational. As the number of parents participating in in-home prevention support has increased, the ability to pull an appropriate sample size for evaluation is getting closer. UN-L anticipates beginning data analysis for this evaluation in SFY 2025.

HHS has explored with UN-L additional fidelity measures of Parent Partner support for parents whose children remain at home in preventing subsequent removal. This has included review of the fidelity measure checklist and engaging Parent Partner feedback on potential changes or additions to the fidelity checklist and self-assessment forms to be applicable in supporting families who have not experienced removal.

Collaboration

Parent Partners collaborate with HHS CPS staff to promote parent engagement though the life of a child protection case. Parent Partners also engage with the community to increase awareness regarding the protection of children; work with community-based organizations to provide resources and strive to develop community partnerships. Parent Partners participate in a variety of local and state committees geared to policy and practice changes in child protection and that are directed to improving the well-being of families. Parent Partners collaborate with the judicial/juvenile justice system, community providers focused on domestic violence, mental health and substance use, community organizations providing resources to meet concrete needs such as food assistance, transportation, childcare, and housing stability, and inclusion courts such as Family Treatment Court and Safe Babies Court. In these spaces, Parent Partners bring lived expertise through their own experiences, in addition to the voices of parents they provide mentoring support to.

The Parent Partners' Policy and Practice Recommendation Team was implemented in SFY 2019 for incorporating statewide Parent Partners collective feedback on recommendations for child welfare policy and practice changes. This structure integrates feedback from the local Parent Partner program, Parent Partner Service Area Steering Committees, and the Parent Partner Program State Advisory Committee. The team is comprised of Parent Partners with representation from each of the service areas and meets quarterly to discuss and compile recommendations. HHS CPS leadership also attends these meetings to dialogue with the committee and share system changes and updates. Annually, formal recommendations for child protection policy and practice changes are submitted to the HHS Program Manager.

In January 2024, the Parent Partner Policy and Practice Committee was engaged to provide feedback on the overarching CFSP goals and objectives for 2025-2029. Parent Partners on the committee shared in response that progress is observed with parents working more effectively with their case managers across the state, and there appears to be an increase in a team approach when it comes to case managers listening to the parent and considering a family's needs. Parent Partners expressed seeing progress on case plans being more family friendly and easier to understand, as well as an increase in case plans that are culturally responsive to the parents. One Parent Partner on the committee is also participating on the workgroup for re-designing the case plan document and has provided ongoing updates to the committee. Parent Partners shared concerns that there may be continued areas of disconnect with attorneys who are not meeting with parents outside of court, or only meeting for a short time before a court hearing begins.

Further shared with the Policy and Practice Committee were the goals and direction for the Parent Partner Program detailed in the next section. Parent Partners expressed they would like to see more shadowing and role-playing opportunities provided for new Parent Partners who may be feeling apprehensive about mentoring parents on their own.

Parent Partner Coordinators also had the opportunity to review and provide feedback to the CFSP goals and objectives and Parent Partner program goals in January 2024. Coordinator feedback included themes surrounding inconsistencies on responses to similar type cases, in addition to variations on court partner response to cases from county to county; improve consistency in practice changes by ensuring HHS and provider accountability, expand the utilization of infusion courts across the state such as Family Treatment Court; address workforce challenges to ensure families' permanency goals are not disrupted due to worker turnover; ensure families have clear and understandable case plans; and that HHS case manager contacts are consistent and supportive of the parent's input on where the HHS visits the child (e.g., not visit the child at school if the parent requests this.)

Parent Partner Coordinators expressed system wide strengths and improvements around engagement with dads and non-custodial parents, increased focus on family centered case planning, increased collaboration, and effort to be solution focused and have a positive approach between HHS and providers; HHS is more open to hearing from parents with lived experiences, and overall, HHS is more focused on keeping families intact whenever possible. Coordinators emphasized the importance of Parent Partners in positively impacting these important system changes.

HHS will continue to engage with Parent Partners and program staff about the progress on CFSP goals objectives, as well as Parent Partner Program goals. This will occur through the Parent Partner Policy and Practice Committee regularly scheduled Parent Partner meetings with HHS staff, Parent Partners and program; continued opportunities for Parent Partners to participate in committees, workgroups, and trainings for HHS CPS staff; and through periodic focus groups, such as those focused on potential changes to language on the fidelity checklist and self-assessment forms.

Direction for 2025-2029 Parent Partner Plan

The Parent Partner Program has set the bar both in Iowa and on the national stage for successful implementation of a statewide peer mentoring program to support parents involved in the child protection system. Parent Partners are available in all 99 counties in Iowa to provide mentoring support to parents. Fully trained Parent Partners can mentor a range of 5 parents, to up to 15 parents, depending on their availability and experience with mentoring. As the Parent Partner Program is both a career development opportunity and a steppingstone for parents as they enter or re-enter the workforce, Parent Partners often move on from the program to new career opportunities, secondary education, or due to other life changes The Parent Partner Program must then continuously partner with HHS to engage with new prospective Parent Partners who have experienced successful case closure to maintain capacity to match parents with Parent Partners across the state to provide mentoring supports. The following program goals set the direction for the next five years to meet these needs:

Goal 1: Referrals to the program will be consistent statewide for parents who meet criteria to receive Parent Partner support.
Objective 1: Parents will be consistently referred to the Parent Partner Program early in their child protection case for support and mentoring by a Parent Partner. This includes at the time of removal and during family preservation services through the Child Safety Conference.

The Parent Partner Program will continue to partner with HHS to ensure that referrals to the program are consistent across the state. As the HHS workforce changes, the Parent Partner Program continues to provide ongoing communication via training, meeting participation, and other methods to HHS CPS staff regarding the process for referral of a parent to the Parent Partner Program, including referral for the Parent Partner to participate in a Child Safety Conference. Parent Partner Program staff will also work toward increased communication with HHS referring staff, to ensure closed loop referrals with HHS on intake status and parent engagement into the program. The HHS Program Manager will continue to work with the program contractor to identify communication plans to reflect this objective.

Goal 2: Increase timely peer support to parents referred to the Parent Partner Program.
Objective 1: In partnership with HHS, the Parent Partner Program will increase the number of available Parent Partners to provide timely support to parents and decrease waitlist times.

The Parent Partner Program will continue to provide education on the Parent Partner Program to new HHS child protection staff, in addition to marketing the program to HHS local teams through attending unit meetings, organizing meet and greets, and maintaining ongoing communication between the program and local HHS staff. HHS case managers and

supervisors participate in Parent Partner service area steering committees, the statewide advisory committee, and attend the annual Parent Partner Summit. New child protection workers and social worker case managers also attend Building a Better Future (BABF) Training, a three-day experiential training for new Parent Partners and child protection staff to learn more about each other's experiences and roles in the child welfare system.

The Parent Partner Program will continue to partner with HHS to engage with parents at successful case closure to consider becoming a Parent Partner. HHS staff can help support recruitment efforts by talking with parents about this opportunity prior to case closure, particularly with parents who received Parent Partner support during their case. The Parent Partner Program can also continue to educate HHS staff on recruitment needs for the program through the previously mentioned spaces that HHS and Parent Partners participate in.

Objective 2: The Parent Partner Program will increase engagement of parents referred to the program and will increase the number of completed intakes by 10%.

As demonstrated by the data set below reflecting the 5-year period of the number of referrals and resulting intakes, 39.1% of referrals to the Parent Partner Program have resulted in intakes into the program. As the Parent Partner Program is voluntary for parents, a variety of factors contribute to intake into the program such as parents who are not interested in participating, who disengage, who are still actively using substances, etc. The goal for the Parent Partner Program is to increase engagement of parents into the program through improving timely communication to parents, continued coaching and support to Parent Partners on engagement of parents into the program, and by building on the capacity of available Parent Partners to support parents.

Table 4c: Parent Partner Program Referral and Intakes by HHS Service Area SFY 2020-2024 (through December 31, 2023)

Service Area	Number of Referred Families	Number of Completed Intakes	Percent of Referrals with Completed Intake
Des Moines	1289	631	49%
Western	1995	792	39.7%
Cedar Rapids	1937	815	42.1%
Northern	1619	528	32.6%
Eastern	1620	544	33.6%
Statewide	8460	3310	39.1%

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

The Parent Partner Program contractor is in process of developing a plan for hiring an initial 5 Parent Partner Specialists to assist with strengthening capacity to provide Parent Partner support at Child Safety Conferences (CSC). CSCs are offered during Family Preservation Services and frequently occur in a short turnaround time. Parent Partner Specialists will provide an opportunity to fill gaps to ensure parents have support at the CSC and are also engaged to continue to have peer support during the life of the case. The Parent Partner Specialist role will

also provide an avenue for existing Parent Partners to move into staff positions, while continuing to utilize their lived experience and an ability to provide support to parents in the program.

Goal 3: Parents who receive peer support by a Parent Partner will help prevent out of home placement.
Objective 1: HHS will partner with the University of Nebraska-Lincoln to evaluate outcomes of the Parent Partner Program to provide peer mentoring and support to parents as a prevention to out of home placement.

As mentioned previously, HHS has been working with the University of Nebraska-Lincoln (UN-L) to prepare for quasi-experimental evaluation design that replicates the methodology utilized for evaluation of the traditional Iowa Parent Partner model to evaluate the effectiveness of the Iowa model when working with families that have participated in a Child Safety Conference (CSC) and receive in-home prevention support. Evaluation of child welfare primary outcomes will focus on prevention of out of placement and time until case closure.

Goal 4: Parent Partners will be representative of parents they provide mentoring and support to.
Objective 1: Parent Partner Program will recruit and engage with parents who are racially, ethnically, and culturally diverse to become Parent Partners. The program will recruit males to become Parent Partners to increase available support to fathers.

The Parent Partner Program has been diligent in increasing the number of diverse Parent Partners in the program, as well as the number of racial and ethnically diverse parents being supported. Referrals to the program for parents whose first language is not English have also increased, bringing additional need for translation and interpretation resources to effectively support parents. The program has been intentional in providing training to program staff and Parent Partners in culturally responsive practices and has provided ongoing meeting times for Courageous Conversations and for supporting Parent Partners of color through an identified supportive and safe space. The program continues to recognize the need to recruit diverse Parent Partners and incorporate culturally responsive practice to best engage with both parents and peer mentors. This includes recruitment and engagement of male Parent Partners, as waitlists to match male Parent Partners with dads is often a barrier to providing dads with support. The program has also worked to best meet the support needs of parents who identify as LQBTQ+ and have matched parents based on their identified gender with the gender of the Parent Partner with whom they feel most comfortable working. HHS will continue to work with the Parent Partner contractor to develop recruitment plans that prioritize recruitment and engagement of diverse Parent Partners and male Parent Partners into the program.

Recruitment, Retention, Training and Support of Resource Families (RRTS)

A new Recruitment, Retention, Training and Support (RRTS) contract was awarded to Four Oaks Family Connections. This contract began on July 1, 2023, and focuses on the following:

- Statewide contract – eliminating service area contracts and more consolidated structure and points of contact for streamlined service delivery
- Statewide Matching – more efficient single point of referral process and Centralized Statewide Referral, Matching and Information system

- Specialized workers – positions the contractor to select and train staff to roles that meet their interest and ability and ensures a single person will be available and responsive for each Resource Family
- Increased intensity in foster care and adoption supports – face-to-face and phone contact doubled when a child is placed in the home
- Increased awareness of supportive services for post adoptive families that includes not only increased crisis supports, increased respite days, mentoring, and flexible funds for specialized items/services

All information gathered in listening sessions preparing for the RFP for the new contract included comments from foster parents that bi-monthly contact was not enough to promote stability of children in the home and retention of foster parents. Also, continuing caseloads at 35 would exacerbate the current issues with caseworkers not being able to support families and fulfill their other job responsibilities and therefore the caseload size was reduced to 30. By comparing the cost of foster family home placement to QRTP and Shelter it became very clear that HHS needed to support recruitment, retention, and support of foster family homes with the new contract.

Iowa designed the RRTS contract to strengthen and enhance:

- Matching children – The child's foster family match is the best match.
- Well-trained foster parents capable of meeting the needs of children in care.
- Face-to-face support with foster parents to enhance stability.
- Alignment and streamlining roles and responsibilities to meet the fundamental needs of foster parents and children placed.
- Increased capacity for siblings, older youth, and cultural matching.
- Increased capacity for youth with higher levels of needs who could be successful in family-like settings with additional supports and services.
- Integration and communication between foster families, residential providers, and other stakeholders.
- Outreach to non-licensed kin and fictive kin caregivers to encourage them to become licensed foster parents.

The RRTS Contractor is responsible for carrying out the activities related to the licensing of foster families and the approval of adoptive families. The RRTS caseworkers complete the required home visits and paperwork related to initial licensure/approval and for renewals. The RRTS contractors continue to conduct record checks at initial licensure/approval and at renewal. Interstate Compact for the Placement of Children (ICPC) and relative home studies also continue under the new contract.

The RRTS contractor completes pre-service and in-service training in their Service Areas. RRTS transitioned to a pre-service training through National Training and Development Curriculum for Foster and Adoptive Parents (NTDC). This new curriculum transitioned from TIPS-MAPP, beginning July 1, 2022. The NTDC training is based on research and input from experts, families who have experience with fostering or adopting children and former foster and adoptive youth. It is a classroom and online program that prepares foster and adoptive parents with the information and tools needed to parent a child who has experienced trauma, separation, or loss. The RRTS Contractor must have training available for families within 60 days of the family completing an orientation session. Iowa requires prospective foster families to complete CPR, First Aid, Medication Management, Mandatory Reporter of Child Abuse,

Universal Precautions, Reasonable and Prudent Parenting Standards training and Alia – Need for Belonging training (developed by Amelia Franck Meyer) prior to licensure. This allows new families to receive more specialized training related to the children in their care during the first year of licensure.

The NTDC curriculum consists of three components that help to prepare and provide ongoing development for parents who want to adopt. The first component is a self-assessment which is a self-discovery tool to help prepare applicants by providing the opportunity to identify their strengths and areas where they need additional support. The second component is the classroom-based training. Each classroom-based training theme has clearly delineated competencies. This content is also adaptable for a remote training platform. The third component is the Right-Time Training. These trainings' themes contain information that is specific to parents who are already fostering and adopting on a variety of topics to support them as families encounter new challenges.

The RRTS contractor develops a variety of in-service trainings for foster and adoptive families. Topics include attachment, trauma informed parenting, crisis management, child, and youth mental health first aid, self-care, and other localized areas of interest. Foster and adoptive families may receive trainings in group settings, support groups, or conferences. RRTS caseworkers help families find training that will enhance their skills and are timely and relevant to providing care to children in their home.

Building relationships with families is key and having the time to build that relationship is a key component. More contact with families will better support homes, make sure that homes that have not taken placements either close their license or the contractor addresses what obstacles are present, and assist in addressing them. By knowing what families can take placements by having more contact, the goal would be to have timely and better matches and ultimately making the first match the only match which is **Performance Measure One – Stability**.

Table 4d: Stability in Family Foster Care

Service Area	FY23 Q1 Percentage	FY23 Q2 Percentage	FY23 Q3 Percentage	FY23 Q4 Percentage
Western	79.1	70.3	95.0	56.3
Northern	61.1	93.1	80.0	72.7
Eastern	36.8	35.7	37.5	88.2
Cedar Rapids	36.8	42.3	78.6	81.3
Des Moines	67.5	65.9	70.3	65.2

Contractor payment will be made quarterly by service area when greater than or equal to 75% of children in family foster care will be stable in their first placement for six months.

We believe the one caseworker model in the current RRTS contract went too far, resulting in RRTS staff who are ill prepared to do all their areas of work effectively. Workers were pulled in too many different directions which did not allow workers to consistently support their assigned homes.

Specializing roles allows the department to create definition around what is desired in the contract, positions the provider to select and train staff to roles that meet the individuals interest and ability, and caters to our desire to have training staff accessible, specially trained and dedicated where we need them the most, working directly with the family.

Providers would not be limited to a model where all staff only do one thing. In rural areas, when staff are short, or when it makes sense to do so for some other reason, providers should have the ability to adapt as needed.

Performance Measure 2- Recruitment and Retention (Increase in families of families of color) is regarding race and ethnicity and the overall increase in families of color. This is not to say that children should not be placed into the homes of compassionate caregivers of other races. Rather, families of color tend to be more attuned to the struggles of their culture. Research shows that placing children with parents who share their racial background and culture helps to alleviate their trauma and keeps them connected to their community of origin.
Contractor payment will be made annually and will be based on the net increases of 5% of families of color that are currently licensed and retained during each contract year.

Table 4e: SFY 2023 RRTS Performance Measure 2

Service Area	Baseline	Standard	Target Net Increase	Achieved
1 (Western)	376	Gold	408	344 Not Met
		Silver	399	
2 (Northern)	263	Gold	285	224 Not Met
		Silver	279	
3 (Eastern)	163	Gold	177	164 Not Met
		Silver	173	
4 (Cedar Rapids)	338	Gold	367	307 Not Met
		Silver	359	
5 (Des Moines)	400	Gold	434	393 Not Met
		Silver	424	

Table 4f: SFY 2024 Target for PM2 Recruitment and Retention of Families of Color

Service Area	Baseline	Increase number	Goal
Western	33	2	35
Northern	30	2	32
Eastern	25	1	26
Cedar Rapids	45	2	47
Des Moines	45	2	47

Source: HHS CWIS and CareMatch

Performance Measure 3 – Path to Licensure focuses on the contractor facilitating support for kin and fictive kin caregivers. The contractor's performance will be measured on whether the family has received a license to provide foster care. The contractor will receive $250 for each

relative/fictive kin who becomes licensed within 180 calendar days from the date of Referral from HHS or the Kinship Navigator through the FCS contract.

Table 4g: SFY 2023 RRTS Performance Measure 3				
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	36	Gold	43	31
		Silver	43	
2 (Northern)	20	Gold	31	19
		Silver	28	
3 (Eastern)	16	Gold	24	24
		Silver	22	
4 (Cedar Rapids)	53	Gold	61	45
		Silver	59	
5 (Des Moines)	69	Gold	87	59
		Silver	83	

Data Source: HHS CWIS and Care Match

Performance Measure 4 - Safe in Resource home is to ensure that safety is maintained for children in foster and adoptive care. 99% of children in licensed foster family or pre-adoptive care will be safe from abuse by their foster or pre-adoptive parents. The contractor will receive payment quarterly if they achieve this measure based on statewide data.

Data Collection: Statewide data collected by HHS will be used to determine if the performance standards for Performance Measure 4 has been met. Data will include all children in licensed family foster care or pre-adoptive care at any time during the quarter.

Table 4h: RRTS Performance Measure 4 Safe in Resource Home									
	SFY 2024 Q1			**SFY 2024 Q2**			**SFY 2024 Q3**		
Service Area	**Children in Foster Care**	**Children not Subject to Abuse**	**%**	**Children in Foster Care**	**Children not Subject to Abuse**	**%**	**Children in Foster Care**	**Children not Subject to Abuse**	**%**
1 (Western)	458	458	100.0%	434	434	100.0%	372	372	100%
2 (Northern)	327	327	100.0%	313	313	100.0%	300	300	100%
3 (Eastern)	298	298	100.0%	277	276	99.6%	277	278	99.6
4 (Cedar Rapids)	404	403	99.8%	386	386	100.0%	420	420	100%
5 (Des Moines)	411	411	100.0%	380	380	100.0%	317	317	100%
Statewide	1898	1897	99.9%	1790	1789	99.9%	1686	1687	99.9%
Data Source: HHS CCWIS									

Performance Measure 5 – Adoptive and Subsidized Guardianship Families will receive supportive services (No payment incentive) Thirty percent of the families will accept and

participate in services offered during required contractor check-ins which is minimally every six months

Performance Measure 6 - Therapeutic Foster Care (TFC) Resource Parents will be identified and become productive members of Iowa's foster care service array. Performance Incentive Payment: Contractor will receive $5,000 for each TFC Resource home (up to 5) licensed and actively receiving referrals by March 31, 2024. The Contractor will receive $2,500 per additional TFC Resource home (up to five more) licensed and actively receiving referrals by June 30, 2025.

As of April 1, 2024, five foster homes are licensed at the TFC level and three are licensed as TFC respite only.

Performance Measure 7 - Youth Served in Therapeutic Foster Care will reside in a family home with parent or relative upon discharge. (No payment incentive) At least 50% of the children served in Therapeutic Foster Care will exit to a parent or relative.

Currently, HHS has no way to statistically identify the rate at which a child will reunify or exit to the home of a family member, therefore results may vary, and the measure will be reset based on actual performance. The Contractor will not be placed on a corrective action plan (CAP) for non-compliance due to not meeting this performance measure.

Crisis Intervention, Stabilization, and Reunification (CISR)

For the child and family services plan (CFSP) period of 2025-2029, the HHS will continue to focus on the over-arching mission of family connections are always strengthened and preserved. The role of the Crisis Intervention, Stabilization, and Reunification (CISR) contracts will continue in this system.

CISR services represents HHS' intent to provide and support child welfare services and juvenile justice services that:

- are family focused
- are designed to build on family strengths
- enhance parents' or other caregivers' capacity to protect and safely care for children
- connect families to community resources and informal support systems
- ensure children who age out of foster care have the skills and connections to successfully transition to adulthood
- are consistent with the principles of the Child and Family Services Review (CFSR) of child safety, permanency and well-being while encouraging flexibility, innovation, and use of evidence-based practice strategies to build a comprehensive continuity of care system.
- address the Risk Need Responsivity Principles
- utilize research driven practices that are informed by the review of Iowa specific data

CISR services comprise three of Iowa's child welfare services. They are Child Welfare Emergency Services (CWES), Foster Group Care Services (FGCS), and Supervised Apartment Living (SAL). Through competitive procurement under a combined Request for Proposal (RFP), the contracts for each of these services were reprocured on July 1, 2023. The intent of

continuing to combine these three services into a single RFP is to encourage Iowa's child welfare service provider community to begin thinking systematically about better coordination of services and combining efforts to better meet the needs of Iowa children and families.

HHS may annually renew these contracts for up to a six-year period before required to conduct new competitive bidding. The six-year period takes these contracts through June 30, 2029, unless HHS decides to pursue a new procurement.

The CISR services' general scopes of work will continue to focus services to achieve the desired outcomes of safety, permanency, and well-being for children. To that end, these contracts require collaboration between the CISR contractors, HHS, JCS, other child welfare and community services providers, and relevant stakeholders. Strong collaboration will strengthen services, identify gaps or needs, promote best practice, and avoid service duplication. HHS encourages contractors to collaborate with entities such as, but not limited to, the following:

- All other CWES, FGCS/QRTP, and SAL Contractors in all Service Areas
- Family Centered Services (FCS) Contractors; including the facilitators of Family Focused Meetings
- Recruitment, Retention, Training, and Support (RRTS) of Resource Families Contractors
- State and local initiatives such as the breakthrough series collaborative/county equity teams and minority, child, and family initiatives
- Parent Partners
- Youth Transition Decision Making (YTDM) or Youth Centered Planning Meeting (YCPM) Facilitators and Contractors
- Providers of mental health and substance abuse services
- Churches and faith-based community organizations
- The judicial system including judges, county attorneys, and guardians ad litem
- State child welfare and JCS justice initiatives
- Schools or other education entities (AEA)

Efforts will concentrate on families and building on their strengths. The parameters of each contracted service (including performance measures) address needs related to maintaining or achieving permanence, keeping children safe, and assuring well-being. Performance incentives allow contractors to earn additional funding if meeting outcome targets. The performance measures and practice of placing children in their communities of origin (or at least as close to home as possible) by contracting with providers of the services in each of HHS' five Service Areas remains a core tenant of these contracts. Preserving children's connections to their families, home communities, schools, and positive support systems while placed outside their home, and assurances that children who age-out of foster care have the skills and connections needed to successfully transition to young adulthood directly address attention to safety, permanence, and well-being. The program-level goals identified in each of the following sections (CWES, FGCS/QRTP, and SAL) align closely to Iowa's Goal 2: Children achieve permanence in their living situation.

Upcoming in FFY 2025-2029, Iowa continues to roll out the use of Critical Case Managers (SW4's) in each field service area, to address youth with high acuity needs and assist in getting these youth the right level of services and supports. These positions will continue to be

evaluated and built out in order to meet the unique needs of our most acute and vulnerable youth. This work touches youth in all three arms of the CISR umbrella: CWES, QRTP, and SAL. Another cross-collaborative initiative that rolled out recently and that will continue to be evaluated in upcoming years is the Children's SWAT. This meeting allows for HHS to staff our highest need youth with all different manner of providers in the child welfare, Medicaid, and behavioral health spaces. The primary objective of this meeting is to facilitate urgent placement needs for individuals in Iowa.

To do this, all participants commit to:

- Open conversations about what it will take to get to a "yes"
- Being flexible to change and extending beyond established comfort zones
- Doing all we can, collectively, to make incremental changes in the system to support serving Iowans within this state in the least restrictive setting that is appropriate.

Child Welfare Emergency Services (CWES)

CWES are short term and temporary child welfare placements provided through the child welfare system that focus on a child's safety, permanency, and well-being. CWES emphasizes HHS' goal that placement is temporary and is less than fourteen days. CWES contracts shall stabilize and support the child and child's family such that a return to CWES is unnecessary. CWES are intended to immediately respond to the needs of the eligible target population defined for the contract. CWES approaches include temporary informal placements to formal court-ordered Emergency Juvenile Shelter Care (as permitted by the Iowa Code). CWES must be coordinated with other child welfare and juvenile justice services and with other domains of a child's life, including but not limited to, education, family relationships, recreation, health care, and mental or behavioral health care. Contractors shall access available services that youth in their care may need, including accessing Medicaid-covered behavioral support services.

CWES serve the following groups of children:

- Children requiring placement in shelter, as follows:
    - Children referred to CWES with court orders for immediate placement into shelter care; or
    - Children with or without court involvement referred to CWES for whom it has been agreed upon between the contractor and HHS/JCS/Law Enforcement that temporary informal placement into a shelter bed is the most appropriate service.

On the other hand, CWES are intended to address the child welfare/juvenile justice needs of children and families as they relate to safety, permanency, and well-being. Children and families may be involved with CWES for a matter of hours, or perhaps days or weeks if a shelter bed has been ordered, whereas mental health-related treatment may be available as long as needed in order to stabilize psychiatric crises. The contract does not address mental health crisis services.

Desired outcome: Whenever possible, to prevent children from being placed out of home while keeping them safe or to provide a safe and temporary environment when children need a place to stay as they await final disposition of their case by the court.

CWES delivery shall:

- Safeguard children from abuse while receiving CWES.

- Collaborate with entities at the local and state levels to achieve the most desirable case-specific and system outcomes.
- Make decisions with families using approaches that include informal supports and the child's positive support system.
- Ensure a safe and supportive environment for each child receiving CWES.
- Accept all referrals and provide contracted services on a No Reject, No Eject basis.
- Use measurable outcomes to evaluate the quality of CWES.
- Use approaches to services for outcomes that best address the needs of the child welfare and juvenile justice systems.
- Implement Cultural Equity Alliance Guiding Principles as adopted by HHS. Each child engaged in care shall be provided services that address any special language needs, reinforce positive cultural practices, and acknowledge and build upon ethnic, socio-cultural, and linguistic strengths.
- Ensure no child is ever refused services or discharged from service except in HHS approved cases per the Admission and Discharge Protocol.
- Develop and implement written plans for the contractor's response to disasters and other emergency situations that are consistent with state, federal, and local guidelines.
- Utilize HHS-approved tool to assist the child in identifying informal and formal supports and document these efforts.

CWES methodologies for temporary informal shelter care:

- Respond to referrals from HHS/JCS/Law Enforcement within one hour and coordinate the temporary informal shelter care placement with HHS/JCS/Law Enforcement.
- Use HHS' CWES Intake Form to complete documentation for temporary informal shelter care placements. If a youth does not meet criteria for a temporary informal shelter care placement, the contractor shall provide resources and referral information to assist in meeting the needs of that individual. Contractors shall have relationships and contact information for both public and private agencies who can assist families in crisis. Contractors may have formal linkages to these service providers.
- Serve children up to 47 hours outside their home as a temporary informal shelter care placement.
- Develop a crisis plan for the child receiving temporary informal shelter care, in the format and timeframe required by HHS. The contractor shall connect the youth/family to resources and referral information to assist in meeting the needs of the individual. Contractors will make efforts to help the family initiate the services prior to discharge. Contractors will have relationships and contact information for both public and private agencies who can assist families in crisis. Contractors may have formal linkages to these service providers. This information will be provided in writing to youth/family upon discharge on an HHS-approved format.
- Complete a genogram (family mapping) or other HHS-approved tool (Discovering Connections tool) for identifying the child's informal and formal support system.
- Maintain supporting documentation for temporary informal shelter care service provision. The Contractor shall have a case file/record completed for each child and submit documents as required by HHS.
- Complete a case file closure summary for the child when temporary informal shelter care placements conclude, in the format and timeframe required by HHS.

- Provide temporary informal shelter care for all children in the contractor's identified coverage counties.

CWES methodologies for emergency juvenile shelter care shall:

- Accept all referrals for children into its contracted number of Emergency Juvenile Shelter Care beds.
- Discharge children in Emergency Juvenile Shelter Care to a permanent placement at the earliest possible time and work closely with the referral worker to develop a service approach to accomplish this within 14 days from the date of admission.
- Administer the CWES Emergency Juvenile Shelter Care component following the Reasonable and Prudent Parent Standards
- Structure Emergency Juvenile Shelter Placement to pursue the least restrictive and most family-like setting and to maintain family connections as appropriate.
- Utilize HHS' assessment tool (Treatment Outcome Package, or TOP) to assess the well-being of each child and ensure the results are loaded into the TOP tool's online portal. The assessment will be administered by the contractor at the intervals determined by HHS, and assessments will begin on a date agreed upon by the contractor and HHS. Contractor staff shall participate in any required training to learn about the administration of TOP.
- The contractor shall connect the youth/family to resources and referral information to assist in meeting the needs of the individual. Contractors will make efforts to help the family initiate the services prior to discharge. Contractors will have relationships and contact information for both public and private agencies who can assist families in crisis. Contractors may have formal linkages to these service providers. This information will be provided in writing to youth/family upon discharge on an HHS-approved format.
- Follow the requirements of the Admission and Discharge Protocol as it relates to placement in Emergency Juvenile Shelter Care.

Goal: CWES ensures short-term use of shelter as a very time-limited intervention while family/fictive kin is located.
Objectives: The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing youth's needs being adequately met (PM2), keeping youth from advancing further in the system (PM1), and wraparound planning for all youth (PM3).

- **Performance Measure 1 –** For eligible children placed in (47 hour stay) temporary informal shelter care, that are not subsequently placed in emergency juvenile shelter care, Foster Group Care/QRTP, or family foster care placement within 90 days of discharge, the contractor will receive $100.00 per child that does not enter the specified placements.
- **Performance Measure 2 -** For all children whose length of stay in emergency juvenile shelter care is longer than 30 days, the contractor shall provide an appropriate amount of structure and support to manage behaviors so that criminal charges or placement in detention does not result during their shelter stay. Contractor will receive $100.00 per child that does not incur criminal charges or placement in detention during their shelter stay.
- **Performance Measure 3 (no payment incentive) -** The contractor shall create a discharge plan with family to include future identified services needed by the family including both system (only if situation meets criteria) and non-system involved services.

Discharge planning to also include crisis planning and recommendations. Services focus on mental health, substance abuse and physical health needs. Monitored via Contract Specialist review.

Anticipated CWES goals for the CFSP period 2025-2029 include:
HHS will continue to work on the overall mission of shortening the length of stay in shelter for youth and to have youth be placed in the most family-like setting possible. Other strategies that will continue to be explored and built out are:

- Shelter Exchange Proposal-an effort to utilize a “swap” of youth between shelter providers to best suit the youth’s needs. Based on a youth’s circumstances, there may be times that a better fit exists in another shelter. This process allows for this to swap happen in collaboration with HHS.
- Shelter Intercept Proposal-an effort to staff current youth in shelter who have been identified as needing a higher level of care (QRTP or PMIC). This process will allow for QRTP and PMIC providers to hear information about youth currently in shelter and make the best match possible between a youth’s needs and the individual providers’ openings, in collaboration with HHS.

Foster Group Care Services (FGCS)
FGCS/QRTP are a part of the child welfare service array that offers a structured living environment for eligible children in foster care who are considered unable to live in a family situation due to social, emotional, behavioral, or physical disabilities or community safety issues. In 2020, in line with federal expectations contained in Family First legislation (FFPSA), all current FGCS settings in Iowa became Qualified Residential Treatment Programs (QRTP’s). Expectations regarding FGCS settings meeting the requirements and definition of QRTP remain and will continue to do so in the future. The contracted service requirements are to:

- Offer a safe, structured, and stable living environment for children who are considered unable to live in a family situation due to social, emotional, behavioral, physical disabilities, or community safety issues, but are able to interact in a community environment with varying degrees of supervision.
- Maintain all required licensures, certifications, or approvals.
- Accept HHS and JCS referrals and provide contracted services on a No Reject, No Eject basis. Each provider, based on number of guaranteed beds, will have a designated number of rejections that can be used in a calendar year when the contractor chooses to enact them. Other admission/discharge disputes shall be handled following an Agency Protocol that contractors will have the opportunity to contribute to the development of prior to contract start. Separate protocols may be developed for HHS and JCS Youth.
- Facilitate child development and the acquisition of age-appropriate life skills.
- Facilitate the reduction of multiple placements by increasing youth engagement in treatment and targeting high-risk criminogenic areas.
- Help each child develop and maintain relationships with the child’s family and community and ensure each child stays connected to the child’s kin, culture, and community.
- Support a child’s education and ensure the child continues to attend the child’s school of origin whenever possible.
- Provide some combination of general QRTP and/or Specialized Programs, as follows:

- Currently under the FGCS/QRTP umbrella, three (3) specialized programs may be provided-Problematic Sexualized Behavior (PSB), Neurodevelopmental and Co-Morbid Conditions (NACC), and Specialized Delinquency Program (SDP).

Desired outcome: Stabilize the situations of the children in care and reunite them with their family or other lesser restrictive family-like setting at the earliest possible time.

FGCS/QRTP are intended to help a child with high needs thrive and develop the skills necessary to return home. Through the delivery of FGCS/QRTP, the contractor shall meet the needs of the child in out-of-home placement and promote safety, permanency, and well-being. The contractor shall:

- Utilize a service delivery approach that conforms to QRTP standards and Guiding Principles, the Agency's Family-Centered Model of Practice, Child Welfare Model of Practice, Juvenile Court Services' Model of Practice (as applicable), the Federal Child and Family Services Review, ~~and~~ the Family Focused Meeting and the Youth Transition Decision Making Meeting, and Youth Centered Planning Meeting models.
- Provide the following minimum service elements for each child in FGCS/QRTP:
  - Implement each child's service plan;
  - Monitor and record each child's behavior daily;
  - Supervise the daily living activities of each child, including knowing their whereabouts at all times, and provide oversight and maintenance of their general health and well-being;
  - Schedule in-person conferences as needed;
  - Ensure a supportive atmosphere and provide leadership and guidance to each child;
  - Coordinate and participate in internal and external activities of each child; and
  - Maintain ongoing communication with the referring worker.
- Within one (1) hour accept all referrals that are made when there is a vacancy in the program and plan with the referral worker to have the child placed within 72 hours. In limited cases, additional time to place a child (up to no more than 5 days from the referral date) may be allowable for the contractor to best accommodate a referral (for reasons like, but not necessarily limited to, preparing for placement into the most suitable milieu, unique needs of a child, or arranging for proper staffing needs). The additional time will require prior approval from the respective referral authority, i.e., the SAM or designee for Agency referrals or the Chief Juvenile Court Officer or designee for JCS referrals. At no time shall the total number of placements exceed the number specified in a contractor's license.
- All Specialized Delinquency Program (SDP) referrals must be reviewed and approved by the Interagency Placement Review Committee (IPRC). The IPRC utilizes a multi-faceted approach to review all referrals to confirm they meet the program's entry criteria and ensure appropriate programming is available. Following review and approval of a referral by the IPRC, CareMatch shall be updated.
- Provide an array of services and supports to meet the needs, objectives, services, and outcomes described in the Agency's Case Permanency Plan/Juvenile Court Services Plan.

- Provide supervision, planning for daily activities, discipline, guidance, development of peer relationships, and delivery of recreational programs. Community resources in both the location of the contractor (i.e., where the child may be placed) and the location of a child's family may be used for education, recreation, medical, social, and rehabilitation services. The services must be appropriate to the age, gender, sexual orientation, cultural heritage, and the developmental and functional level of the child.
- Administer the FGCS/QRTP program following the Reasonable and Prudent Parent Standards
- Implement Cultural Equity Alliance Guiding Principles as adopted by the Agency. Each child engaged in care shall be provided services that address any special language needs, reinforce positive cultural practices, and acknowledge and build upon ethnic, socio-cultural, and linguistic strengths.
- Provide programs that ensure child welfare and juvenile justice children are not co-mingled whenever possible. In addition, ensure children reside and interact with persons within their own age group and with common treatment needs whenever possible. The behavioral, psychological, emotional, and developmental levels of children shall be considered in the determination of appropriate groupings.
- Facilitate the participation of the child in other necessary programs and services to ensure the child's overall needs are met. Such programs or services include but are not limited to the following:
    - Various medical services;
    - Outpatient mental health or substance abuse treatment;
    - Behavioral Health Intervention Services;
    - Educational or vocational services;
    - Criminogenic need reduction services; and,
    - Other community-based services.
- As appropriate to the children, the contractor services provide individualized care that is responsive to the needs of specific and outlier populations, such as sex offenders, children adjudicated for delinquent acts, children with special needs, etc.
- Utilize the Agency's Treatment Outcome Package (TOP). Follow all Agency TOP instructions including adherence to the timeframes contained therein.
- Design programs with varying levels of structure that can be applied as a child's need for supervision decreases (demonstrated, for example, by a child's increased level of responsibility and self-management). The programming design as well as the setting, to the extent feasible, shall change as a result, focusing on the child acquiring and building life skills that allow the child better access to the community.
- Implement and provide QRTP as defined by the contract.
- Collaborate with clinical resources made available by the Agency.

FGCS methodologies will:

- Use the “One Caseworker Model” and assign an “education specialist” to each child;
- FGCS/QRTP shall be responsible for planning the pro-social daily activities of children, provide discipline, supervision, and guidance as needed, and facilitate the development of peer relationships. While in care, children shall be taught age-appropriate skills and/or skills to reduce criminogenic risk factors if applicable, to help prepare them to return to their communities or to transition to adulthood or future self-sufficiency.

- Implement service plans for each child in care that address identified needs, family and community connections, crisis and stabilization, reintegration planning, education, physical and mental and behavioral health needs and supports, medication management, and discharge.

Goal: The overall goal for HHS and FGCS/QRTP is to increase quality individualized programming to ensure youth are gaining necessary skills and returning to family-like settings whenever possible.
Objectives: The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing discharge to family-like settings and adequate programming to keep youth out of further QRTP placements (HHS) and reduce instances of Recidivism (JCS).

- **Performance Measure 1 – Return to Group Care for CINA Youth- -** In alignment with the Agency's permanency goals, the contractor shall work to help a child return home or to a lower level of care. The best outcomes for most children will include a future where they do not return to FGCS/QRTP after discharge. Accordingly, discharge from and return to FGCS/QRTP will be monitored, and the contractor may earn additional payment based on low levels of return to FGCS/QRTP among CINA Youth. The Agency will be responsible for determining who is re-admitted to FGCS/QRTP.
- **Performance Measure 2 – Recidivism of Children Adjudicated for Delinquent Acts (SJDP) -** In alignment with JCS's Model of Practice, the contractor shall help a youth develop the skills necessary to reduce recidivism (any misdemeanor or felony level offense filed in/referred to Juvenile Court, the adult corrections system, or both, within a twelve-month period after date of discharge from service). Accordingly, recidivism in children who have been referred to and placed in a bed designated for Specialized Delinquency Program (SDP) will be monitored, and the contractor may earn additional payment based upon low levels of recidivism.
- **Performance Measure 3 – Discharge to a Family-Like Setting -** In alignment with the Agency's permanency goals and Family-Centered Model of Practice, the contractor shall help a child develop the skills necessary to return to family or a family-like setting. Accordingly, discharge from FGCS will be monitored, and the contractor may earn additional payment based upon discharge metrics.
- **Performance Measure 4-Recidivism of Children Adjudicated for Delinquent Acts (General JCS Youth) -** In alignment with JCS's Model of Practice, the contractor shall help a youth develop the skills necessary to reduce recidivism (any misdemeanor or felony level offense filed in/referred to Juvenile Court, the adult corrections system, or both, within a twelve-month period after date of discharge from service). Accordingly, recidivism in JCS children will be monitored, and the contractor may earn additional payment based upon low levels of recidivism.

HHS goals anticipated for the CFSP period 2025-2029 include:

- Continue to evaluate the need for congregate out of home placements in light of declining HHS group care populations. Since 2016, Iowa has reduced the number of FGCS/QRTP beds across the state significantly. As of 2024, Iowa is now only contracting for approximately 360 beds statewide, as compared to 660 beds in 2016. Iowa continues to explore alternative ways to meet the needs of youth outside of the "historical" congregate care settings. Iowa will continue to lean heavily on the expertise of our partners at Casey Family Programs and their work around "ending the need for group care" to help inform this work.
- Evaluate QRTP as a level of care due to lack of IV-E drawdown opportunities. There may be an opportunity in Iowa for current QRTP providers to transition to PMIC (PRTF-like) services, which allow for braided Medicaid-funding.
- Continue evolution of QRTP Exchange process- an effort to utilize a "swap" of youth between QRTP providers to best suit the youth's needs. Based on a youth's circumstances, there may be times that a better fit exists in another QRTP. This process allows for this to swap happen in collaboration with HHS.
- Explore the creation of specialized beds to serve females at high risk of Human Trafficking. HHS and current contractors are currently researching potential sites and models for this population.

Supervised Apartment Living (SAL)

SAL is the least restrictive type of foster care placement in Iowa; eligibility begins at age 16½ years old. The living arrangement must provide a child with an environment in which the child can experience living in the community with less supervision than that provided by a foster family or foster group care setting, with services and supports aimed at preparing the child for self-sufficiency. Children in the SAL program are expected to attend school, shop for their food, prepare their own meals, do their own laundry and cleaning, and engage within the community

Scope of the service: SAL contractors provide two types of SAL setting; they are cluster sites and scattered sites. Cluster sites allow a maximum of six children to be located in the same building (such as apartments located in one building or private housing or their own rooms in a shared unit). Contractor staff must be on-site and available at any time more than one youth is present. Scattered sites (e.g., an individual youth's apartment unit in a community) also provide access to SAL staff 24 hours a day, seven days a week and they must be available as needed. Staff supervision and guidance is flexible to meet the needs and behaviors of each individual in the program. SAL contractors are expected to:

- Provide SAL services to eligible children who have the competence and desire to live with increasing independence in the community with supports.
- Provide assessment, guidance, and support for a child to develop life skills to address chores and household duties, budgeting, job searching, job interviewing, and attainment of important personal documents (e.g., driver's license or Social Security Card).
- Promote school attendance and ensure the child is working towards the attainment of a high school diploma or high-school equivalency diploma. Contractors are expected to support the child's enrollment in the child's school of origin and to assist the child with post-secondary planning including vocational and collegiate aspirations.
- Develop an individualized transition plan for each child and assist the child, from the time of SAL admission, to prepare for transition out of the program and into adulthood.
- Accept all referrals and provide contracted services on a No Reject, No Eject basis.

- Maintain all required licensures, certifications, or approvals.
- Ensure youth live in a safe environment.
- Assist youth in developing and maintaining informal supports, family connections, and community connections.

Desired outcome: Youth self-sufficiency and the development of interdependence with their community and the systems that support daily living on one's own.

SAL services and methodologies:

- SAL foster care is the least restrictive placement in the child welfare service array. SAL is designed for children who have the capacity and desire to live relatively independently in a community with less supervision than is provided in a Family Foster Care or FGCS setting and who are presently unable to live with family. SAL offers a community-based living environment with the benefit of a degree of direct supervision, 24-hour support, and life skills training.
- SAL foster care is provided using evidence informed practices, including a framework of Positive Youth Development. The result is client driven, individualized services for youth that ensure that basic needs—physical and psychological health, food and shelter, safety, and other needs—are met, both in the short term, and then when the youth leave the program, they are connected to resources and have the confidence to make decisions, achieve their dreams, and get help when they need it. The SAL provider using the Youth Development Framework will:
    - Create a safe environment for youth, both physically and emotionally
    - Treat youth with respect and involve them in decision making around service delivery
    - Involve youth in programmatic decision making and offer other leadership opportunities
    - Establish and maintain clear, developmentally appropriate boundaries and guidance
    - Engage youth in community life and ensure they have opportunities to make real contributions (volunteering, jobs, arts, culture)
    - Ensure opportunities for youth to develop positive, supportive relationships with adults and peers
    - Encourage and support youth to build new skills
    - Develop and test new knowledge and practical skills
    - Offer awards or honors so youth experience success
    - Help youth overcome mistakes
    - Facilitate supportive youth-adult relationships and partnerships
- The contractor shall utilize real life learning opportunities within the structured SAL community in order to help the child develop life skills needed for successful transition to adulthood. Children in the SAL program are expected to learn new skills, practice them in the program, and demonstrate competency. Examples include:
    - Attend school and/or work
    - Prepare their own budgets
    - Pay their own bills
    - Shop for their own food
    - Prepare their own meals
    - Do their own laundry and cleaning
    - Use public transportation, and
    - Interact in social and community groups

- The goal of SAL is for a child to move to self-sufficiency while developing interdependence with their community and the systems that supports the child's completion of education, development of life skills, and preparation to move into adulthood. SAL contractors shall guide the child to develop skills and abilities to address responsibilities for day-to-day tasks and monitor whether this guidance has been effective or if additional needs exist. These goals are reflected in the SAL Performance Measures.
- A successful SAL program ensures staff are trained to understand the developmental needs of transitioning youth. Additionally, staff training in Positive Youth Development is expected to instill confidence in the staff to assist this population. Finally, staff training in Motivational Interviewing is expected for any staff working directly with SAL youth. Motivational Interviewing (MI) is an evidence-based counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic, and short-term process that takes into consideration how difficult it is to make life changes.
- SAL contractors shall promote a child's participation in Aftercare services once the child has exited SAL services.
- SAL contractors shall monitor whether services and interventions have been effective or if additional needs exist. If additional needs exist, SAL contractors shall adjust programming for that youth to help the child achieve positive outcomes and ensure a healthy transition to adulthood, including connecting that youth with services and supports they will need when they exit the program. SAL contractors shall promote a child's participation in Aftercare services once the child has exited SAL services, if applicable.

The contractor may select to provide one or both categories of SAL settings. These two categories of settings are:

- SAL cluster sites that allow a maximum of six children to be placed in the same building (such as apartments located in one building or private housing). Contractor staff must be on-site and available to the children at any time more than one child is present. A contractor may split a cluster site into more than one facility, as long as those facilities collectively provide the total number of cluster beds listed in the contract. Gender specific cluster sites are not permissible. The contractor shall meet the following requirements for SAL cluster settings:
    - Ensure staff is on-site, present, and available to children at any time when more than one child is present in this type of setting. A SAL cluster setting is defined as having a maximum of up to six (6) children supervised by the contractor who are placed in the same building. The Contractor must provide the number of cluster beds listed in the contract in each cluster site(s) within the contracted Service Area. The contractor may split a cluster site into more than one (1) facility as long as those facilities collectively contain the number of beds listed in the contract.
    - Serve both male and female youth in all cluster sites in accordance with the needs of the Service Area.
    - Utilize real life learning opportunities within the structured community in order to help the youth develop life skills needed for successful transition to adulthood.
    - Within one (1) hour, accept all referrals that are made when there is a vacancy in the program and arrange with the Referral Worker to have the child placed within 48 hours. Contractors shall accept referrals and provide contracted services on a No Reject, No Eject basis.

- SAL scattered sites (e.g., an individual youth's apartment unit) must provide access to SAL contractor staff 24 hours a day, seven days a week. The contractor shall have the capability to serve the number of children in scattered sites as listed in the contract on an as needed basis. The contractor shall meet the following requirements for SAL scattered-site settings:
    - Scattered sites shall be in the same Service Area, or within two contiguous Iowa counties as the contracted cluster site.
    - Assist the child to locate a living arrangement that meets the requirements of the SAL program.
    - Participate with the Referring Worker, the child, and the child's positive support system in making a team decision when it is appropriate or necessary to move a child from a SAL cluster setting to an SAL scattered site setting and vice versa.
    - Partner in their services and offers a host of activities to help the child build confidence, skills, and be prepared.

Throughout the delivery of SAL services, the contractor shall support each child's development of necessary skills, tools, and abilities to attain self-sufficiency while ensuring the safety, permanency, and well-being of the child. The contractor shall:

- Collaborate with the Agency to explore and select safe settings, where the child is able to experience relative independence, learn life skills, and help put the child on a successful path to adulthood.
- Visit each child's SAL placement prior to the child moving in and on a twice per week minimum basis during the initial months and then once per week on-going to confirm there is no reasonable cause for believing that the child's mode of living or living situation presents unacceptable risks to the child's health or safety and that the living arrangement has been approved by the Referring Worker and meets the following minimum standards:
    - Complies with applicable State and local zoning, fire, sanitary, and safety regulations;
    - Provides reasonably convenient access to schools, places of employment, community resources, and services and supports required by the child; and
    - Is reasonably priced to fit within the child's budget.
- Provide ongoing supervision of the child including, but not limited to:
    - Guidance, oversight, and behavior monitoring to ensure that the child's living arrangement is maintained in a safe condition.
    - Ensuring the following:
        - The child has immediate access to their living arrangement 24/7;
        - The child can access SAL staff in the event of an emergency 24/7;
        - The child has access to a functioning telephone;
        - There is an operating smoke alarm on each level of occupancy;
        - The child receives necessary health care;
        - The child receives appropriate and sufficient services and supports that meet individual needs; and
        - The child is complying with Service Plan requirements.
- Implement Cultural Equity Alliance Guiding Principles as adopted by the Agency. Each child engaged in care shall be provided services that address any special language needs, reinforce positive cultural practices, and acknowledge and build upon ethnic, socio-cultural, and linguistic strengths.

- Provide for the child's participation in other necessary programs and services to ensure the child's overall needs are met. Such programs or services include, but are not limited to, the following:
    - Various medical services;
    - Outpatient mental health or substance abuse treatment;
    - Behavioral Health Intervention Services (BHIS);
    - Educational or vocational services;
    - Other community-based services; and
    - Food assistance, if applicable.
- Utilize the Agency's Treatment Outcome Package (TOP). Follow all Agency TOP instructions including adherence to the timeframes contained therein.
- Design SAL programs with varying levels of structure that can be applied as a child's need for supervision changes (for example, demonstrated by a child's increased level of responsibility and self-sufficiency). The programming design as well as the setting, to the extent feasible, should change as a result, focusing on the child acquiring and building life skills that allow the child better access to the community.

Goal: The overall goal for HHS and SAL is to ensure SAL youth gain necessary skills and supports to transition to adulthood successfully.
Objectives: The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing stability, connection to necessary resources, skill-building and building a positive informal support network.

- **Performance Measure 1 – Stability -** In accordance with the Agency's stability and permanency goals and recognizing the importance of a child's completion of education and acquisition of life skills prior to aging out of child welfare programming, the contractor shall promote children's retention in SAL Placement. A child shall not experience an unplanned discharge from SAL services during placement and the contractor shall support a child to remain in SAL to age 18, or older as permitted by law and regulations, or discharge to their family, a family-like Setting, or positive support system placement.
- **Performance Measure 2 – Aftercare Engagement -** The contractor shall continue to communicate with the child after transition by encouraging the child's participation in Aftercare. When eligible, each child is expected to participate in Aftercare and the contractor's responsibility is to advocate for the child's participation in Aftercare to promote the child's success in early adulthood. If a youth transitions from SAL to Aftercare and continues to engage for 3 months, the contractor will receive payment of $100.00.
- **Performance Measure 3 – Life Skills Attainment -** In accordance with the Agency's well-being goals and recognizing the importance of a child's completion of education and acquisition of life skills prior to aging out of child welfare programming, the contractor shall promote children's life skills attainment. The contractor shall track children's performance on their pre-placement and discharge Casey Life Skills Assessments to obtain a measurement of children's acquisition of life skills during their stay in SAL. Contractors shall report using the Agency's online reporting system.
- **Performance Measure 4 – Increase in Positive Informal Supports (no payment incentive) -** In accordance with the Agency's well-being goals and recognizing the importance of a child's positive informal support network prior to aging out of child welfare programming, the contractor shall promote children's increased positive informal supports. The contractor shall track children's performance on the Agency approved Discovery Tool monthly. The Child's Discovery Tool upon entry into the SAL program

and their Discovery Tool on their last month in SAL will be reviewed to obtain a measurement of children's acquisition of positive informal supports during their stay in SAL. Contractors shall report using the Agency's online reporting system.

Anticipated goals for the CFSP period 2025-2029:

- With the introduction of both Positive Youth Development and Motivational Interviewing in the most recent round of SAL contracts starting 7/1/2023, HHS and SAL contractors will be monitoring and analyzing how these evidence-informed practices are impacting overall outcomes for SAL youth.
- Two of the four SAL contractors have recently prioritized updating the physical spaces where SAL youth reside. Iowa HHS is encouraged and excited about the high qualify spaces that these contractors are providing for SAL youth. In years 2025-2029, it is a goal for all SAL spaces to receive updating.

John H. Chafee Foster Care Program for Successful Transition to Adulthood

Agency Administering Chafee

Identify the state agency or agencies that will administer, supervise, or oversee the Chafee program. Describe how the agency that administers the program provides oversight to the programs or agencies that directly provide Chafee services and supports.

The Iowa Department of Health and Human Services (HHS) is the state agency that administers, supervises, or oversees the statewide Chafee Foster Care Program for Successful Transition to Adulthood (Chafee), including the Education and Training Voucher (ETV) Program.

State policy leadership is in the Bureau of Child Welfare and Community Services. The division name changed in 2023 to the Division of Family Well-Being and Protection. The division is now better aligned under one administrator overseeing child welfare policy and field operations. Multiple program managers have responsibility to answer contract and policy questions pertaining to foster care, support legislative changes, and watch practice advancements and data to align efforts with evidence based and proven practices. Transition Planning Specialists (TPS) in HHS field offices support workers in regard to eligibility and procedural questions.

Five HHS regions, called service areas, handle all aspects of case management, selection of foster care programs, and liaison activities with the courts, tribes and other necessary partners. For children in foster care age 14 and older, an HHS case manager or Juvenile Court Officer is responsible for ensuring youth receive the transition supports required by Iowa Code Chapter 232 and the HHS employee manual. Among these supports are youth centered meetings, a life skills assessment, a written case plan, driver's license or state ID, and connection to services they may need as they enter adulthood.

Services to children who have aged out of foster care or who have exited foster care to adoption or subsidized guardianship program at age 16 or older are typically contracted to government or non-government entities. Subcontracts are permissible and used successfully to create statewide coverage. Federal Chafee funds are utilized as are considerable state funds for the Preparation for Adult Living Program (PAL) and the Iowa Foster Care Youth Council, among other resources.

HHS maintains a full time, state level Independent Living (IL) Coordinator. The IL Coordinator is responsible for multiple programs and activities centered on the HHS services and supports for youth transitioning from foster care to adulthood. Responsibilities include, but are not limited to the following:

- Engage stakeholders and contributors in meaningful discussions about services and supports, including strengths, challenges and needs.
- After discussions with internal and external partners, write federal plans and reports.
- Maintain Iowa's strong connections to federal partners and other state transition leads, so we can share effective strategies and improve programs.
- Educate leaders, included lawmakers at the state and federal level, on policy changes needed.
- Monitor performance indicators to ensure internal and external program are helping youth to transition successfully to adulthood.
- Coordinate and oversee monthly meeting and ongoing work of the TPS group, which includes:
    - Five regional TPS
    - Regional supervisors
    - Transition lead administrators
- Manage contracts for the following core transition programs:
    - Iowa Aftercare Services Program, which utilizes combined state and federal funding to serve transitioning youth through a network of child welfare agencies, monitored as follows:
        - Annual reports reviewed by HHS
        - Annual audits conducted by HHS
        - Monthly claims approved by HHS
        - Satisfaction surveys
        - Referring worker feedback (informal)
    - Iowa Foster Care Youth Council, for children in foster care, monitored as follows:
        - Annual reports reviewed by HHS
        - Annual audits conducted by HHS
        - Satisfaction surveys
        - Monthly claims approved by HHS
        - Referring worker feedback (informal)
    - Education and Training Voucher (ETV) program, which utilizes combined state and federal funding to support education attainment of current and former foster are recipients, monitored as follows:
        - Quarterly reports reviewed by HHS
        - Annual reviews by HHS
        - Performance outcomes (retention)
        - Monthly claims approved by HHS
        - Referring worker feedback (informal)

There is one TPS in each of the five HHS service areas. HHS is committed to maintaining these Chafee funded positions. TPS' are social workers who do not carry a caseload. Their primary goal is to help case managers engage youth and provide transition planning for young people in foster care as they transition to adulthood. TPS are responsible for understanding the programs, policies, and processes for foster care transition. TPS are support staff for HHS and JCS case

managers when questions come up around foster care transition. Because of the variety of eligibility criteria in the different programs, their working knowledge of the system is invaluable to staff as well as youth and public and private partners.

The TPS utilize the child welfare information system (CWIS) to check eligibility for ETV, Iowa Aftercare, and other services relying upon foster care experience for eligibility. TPS complete application forms, as needed, or direct the case manager of a child in foster care on how to do so.

Iowa has an electronic tracking system for transition planning activities to ensure youth aged 14 and older in foster care as well as young adult foster care alumni get the support they need and that HHS remains in compliance with all requirements for case planning of transition aged youth. TPS are responsible to record such things as, for example, completion of the Casey Life Skills Assessment (CLSA); assurances youth have a birth certificate and state ID; and the date the case manager meets with the youth 90 days prior to the youth's 18th birthday. TPS send email reminders to case managers when any required item is due. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14. The intent of these emails is to ensure all youth have a viable plan whether leaving at age 18 or whenever they leave foster care.

Each TPS tracks completion of transition plans for every youth, flagging them for review at the child's age of 17 and 4 months' so that the reviews occur by the time the youth is 17 and 6 months. HHS/JCS workers join Transition Committee meetings at their scheduled time (in person or via phone) and present the Transition Plan portion of the case permanency plan for the youth and discuss the case with the Transition Committee. The Transition Committee asks and answers any questions, and provides feedback, resources, and recommendations to the worker about their case and documents this on the Transition Committee Review form during the review. Some workers who do not "pass" the first time are required to return with an improved plan. TPS maintain a list of strengths and needs identified by Local Transition Committee members, which has been fundamental to completing goals for the coming five-year period.

Description of Program Design and Delivery

- *Describe how the state designed and intends to deliver and strengthen programs to achieve the purposes of the Chafee program over the next five years (section 477(b)(2)(A) of the Act). Indicate how these activities and any identified goals align with the state's vision and support those developed as part of the CFSP/CFSR PIP.*
- *Describe how the state has involved youth/young adults in the development of the Chafee plan. Provide the name(s) of the youth organization(s), advisory boards, leadership councils, how they were consulted, and information on any support (financial or other) the state provides to the group or organization.*
- *Describe how the state is incorporating principles of Positive Youth Development (PYD) in its Chafee program.*
- *Describe the state's process for sharing the results of National Youth in Transition Database (NYTD) data collection with families, children, and youth; Tribes, courts and other partners; Independent Living coordinators; service providers and the public.*

Describe how the state, in consultation with youth/ young adult and other community partners, is using these data and any other available data to improve service delivery.

- *Provide information on the state's plan to strengthen the collection of data through NYTD over the next five years.*

HHS is intent on developing and maintaining programs which will positively affect the youth in foster care age 14 and older and those who have exited foster care. In Iowa, these are called transition programs.

Iowa transition program efforts are supported by federal title IV-E funding, Chafee funding and state funding, among other sources. Chafee provides a framework for the services and limited, but flexible, financial support to states which can be used to fund programs for teens in foster care and those who have aged out of the foster care system, to age 26. Chafee established a foundation of support for states, which Iowa has leveraged with state funds to create a comprehensive array of statewide services for youth in foster care and alumni up to age 26.

In federal fiscal years 2025 through 2029, HHS will ensure all political subdivisions implement the Chafee program in a youth driven and statewide consistent manner, by relying on the network of providers and infrastructure described in this report to maintain a firm dedication to statewide consistency and flexibility at the case level. This means the state has statewide contracts for services like Aftercare, Achieving Maximum Potential (AMP), and ETV so young people, including Native youth connected to a tribe or not, across the state have equitable opportunities and receive similar support. Individuals receive youth centered planning, voluntary services, and support, depending on their desire and the youth's assessment of life skills. Individuals receive services tailored to their unique needs. Regular leadership and direct staff meetings with contractors ensure HHS keeps a pulse of the needs in the communities where youth are served. For example, youth and service providers have observed that youth are struggling financially due to inflation and other factors. HHS is working with service providers and youth to educate legislators on a need for increased funding to assuage the financial issues youth are facing.

The purpose of the foster care transition program is to assist youth in acquiring skills and abilities necessary for transition successfully to adulthood. The transition planning program offers a life skills assessment, youth-centered transition plan development process, and transition-related services, supports, activities and referrals to programs. HHS assists youth to acquire necessary documents such as a state ID, Social Security card, and birth certificate. While the program is intended for youth who do not return to permanency prior to age 18, youth who age out of care (at age 17.5 or older) may receive supportive services post exit, as do those who exit to subsidized guardianship or adoption at age 16 or older. Case management services extend to the youth's age of 23, in the Iowa Aftercare Services Program and to age 26 if the youth is participating in the Chafee funded ETV. Iowa Aftercare and ETV are among the programs which will be described in this report.

In accordance with ACYF-CB-PI-18-06, the HHS submitted an assurance in June 2018 that Iowa has in place a program to serve youth in foster care. HHS contracts for a "comparable" state funded program for former foster care youth up to age 21. Iowa Aftercare Services Program has been the primary case management service for youth at age 18 through 22, since 2020. HHS extended Chafee ETV to age 26, in the 2019-2020 school year. Further description of the program extension is in the ETV section of this report.

The Chafee goals include, but are not limited to, helping support youth in relationships, educational attainment and career aspirations; ensuring adequate health care and health care coverage options; and obtaining safe, affordable housing, which perfectly align with the state's goal to help youth transition successfully to adulthood. Iowa believes, if we engage youth, assess for life skills needs, and help youth build a social support system, achievement of these goals will occur, and young people will have the opportunity to enter adulthood and experience positive outcomes. The Chafee goals align perfectly with Iowa's child welfare overarching goals that are essentially around child safety, permanency and well-being.

Iowa organizes the Chafee program around a desire to provide good leadership infrastructure driven by customer input and data, quality life skills assessments for youth, and genuine youth centered planning practice.

The HHS uses state and federal funds (approximately $100K Chafee and $300K state funds) to contract with Youth and Shelter Services (YSS) to deliver the foster care youth council, known as Achieving Maximum Potential (AMP). AMP is a youth engagement program for current and former foster and adoptive youth summarized by the motto "Nothing about us, without us." The primary purpose of AMP is to empower young people to become advocates for themselves and give them a voice in system-level improvements in child welfare policies and practices. When supported through productive partnerships with adults, youth can be authoritative advocates for making the foster care system more responsive and effective.

AMP offers leadership opportunities, service-learning projects, speaking opportunities, and educational/vocational assistance to youth ages 13 and older who were in foster care, adoption, or other out-of-home placements. AMP also offers participating youth opportunities to learn life skills and shares resources available to them as they transition from foster care to adulthood. In recent years, HHS and AMP have developed the Activating Youth Engagement (AYE) policy group, where youth in foster care and alumni can learn skills, contemplate policy issues with state policy leaders, and advocate for change in the foster care and child welfare system. We intend to continue to build on this work in the coming five-year period. HHS has recently invited AMP to oversee development of a revised Youth Bill of Rights and a Transition Information Packet redesign, as two examples.

AMP works to accomplish two primary goals:

- Provide youth an opportunity to support each other through relationship based, trauma informed activities created with youth, for youth and facilitated by trained facilitators. AMP mirrors elements of Positive Youth Development Practices including:
    - *Meeting social needs through "fun" activities and structured social activities*
    - *Instruction to help youth build competencies needed to become successful adults*
    - *Community service to "give back" and become more connected to others.*
    - *Mentoring programs to build relationships and allow teens to share what they have learned with others*
- Provide a venue for youth to learn to advocate with the goal of collectively improving the child welfare system.

HHS involves young people in Child and Family Services Plan (CFSP) development in multiple ways. Below are but a few examples:

- The aforementioned, Activating Youth Engagement (AYE) was formed in 2021 and is ongoing. HHS and AMP collaborate to invite youth with lived experience in foster care, policy staff, and youth advocates to meet where youth and adults can genuinely discuss foster care matters and work side by side to make positive change. Meetings occur at least quarterly but are often more frequent depending on the work. Meetings are attended by youth in foster care, foster care alumni, AMP staff, HHS staff, and occasionally our federal partners. Youth receive help preparing in advance of meetings, as desired, and follow up with achievements and challenges is a valued best practice.

  One of the issues that generated interest with AYE is described below:

  - HF2252 extended the age of foster care in 2022. Essentially, HHS and JCS can permit youth to sign an agreement to remain in Supervised Apartment Living or family foster care to the youth's aged 21, as long as they are pursuing work or school. TPS and the Independent Living Coordinator have been active meeting with HHS staff, AYE youth and providers to discuss the approach and raise awareness to the options newly available to youth transitioning from foster care to adulthood. This is a state funded program at this point.

  When the bill passed and the program rolled out, we realized foster care is not always appropriate and able to meet the needs of all the youth who desire or need foster care past 18. It has been helpful to meet with AYE monthly to discuss guidance, forms and manual needed to implement foster care properly and fully to 21. We tweaked our messaging, so we are clear there is no promise of foster care to 21 for all youth who want it. If a youth's needs can be met elsewhere, they should not be in foster care. AYE and AMP youth have created a "decision guide" that helps a caseworker and a youth breakdown some of the services and supports that are available and get closer to a decision about what is the best option available to the youth. HHS appreciates shared decision making with AYE and AMP youth on this particular project, as well as input we have received from Talking Wall and other engagement work described in this report.

- HHS Director Garcia hosts an annual discussion with children in foster care who are connected with AMP. AMP creates and shares their legislative priorities each year with the director's team and with state lawmakers for AMP's "Day on the Hill". This year, all of AMP's recommendations align with things the department is working on. A press release with presentations by youth on each topic below was provided at the Iowa Capitol on January 30, 2024. Young people with lived experience in foster care delivered powerful and poignant messages about the need to care well for youth in foster care. AMP talked about three items in particular:
  - Foster care bill of rights
  - Compensation to kinship caregivers that aligns with licensed family foster care
  - Financial supports for youth who have aged out of foster care; raising the Preparation for Adult Living stipend to $900 (from $600/month).

  See the 2024 AMP Legislative priorities below:

Day On The Hill 2024 (1).pdf

HHS has been in talks with the 2024 legislature to increase the Preparation for Adult Living (PAL) payment and other payments to youth in the Iowa Aftercare Services Program. HHS and AMP's shared goal is to reduce the number of youths who report not having enough money to meet living expenses, as monitored by the Iowa Aftercare Services Program. Increasing financial stability through employment and housing stability are foundational in the five-year plan.

HHS contracted with the Department of Human Rights (DHR) in 2016 to survey youth, track data, and create reports for the NYTD federal requirements. HHS chose the DHR as a partner based on their effective researched-based practices. Through grant projects and oversight of state level coalitions, like the statutorily recognized Iowa Collaboration for Youth Development (ICYD), DHR made an impact on child welfare and juvenile justice. Thus, HHS believes this intergovernmental contract helped to increase NYTD participation rate and access to data. HHS intends to capitalize on the skills of DHR staff to help HHS and providers use data to improve services. Social media is a powerful tool to engage youth. Iowa NYTD utilizes the social media platforms of Facebook, Twitter, YouTube, and Google to promote the NYTD survey and youth activities. Iowa NYTD's online presence grew since its inception on October 1, 2016.

HHS transition staff use data to inform and educate. Data is also used to initiate conversations and engage contributors, such as in the following examples:

- The Foster Care to Adulthood in Iowa Annual Report is completed and described in a webinar in January of each year. This is an opportunity to engage child welfare professionals in and outside of the department, youth, and state agency partners in discussions about how we can better support youth. It includes NYTD data, among other sources and established an annual opportunity for the department to discuss services and outcomes with youth, service providers, and state agency partners.
- NYTD data is used to evaluate progress toward CFSP goals, during TPS monthly meetings.
- NYTD data is used to demonstrate the needs of youth, especially the statistics on homelessness and employment, as a basis for why transition planning is so important for youth.
- TPS regularly use the tracking tool and CWIS as a vital part of being able to do their job. It is used to track which youth are placed out of home to ensure timely completion of transition objectives and to ensure the caseworker is aware of what transition supports are available to the individual.
- The IL coordinator has been using NYTD housing data to inspire local partners, including housing authorities and community developers, to stand up housing programs for former foster care youth. We like to think the availability of housing outcome data has inspired Hatch Development Group efforts that house former foster care youth in Cedar Rapids and Des Moines. HHS will continue to tend to these relationships in order to align public and private sector efforts to support former foster care youth.

HHS has aligned with other state agencies in recent years. Among the agencies that joined HHS is the DHR. This is an opportunity to work more closely with the DHR NYTD project, though not much should change around the responsibilities. HHS will maintain the agreement with the DHR to survey youth, track data, and create reports for the NYTD federal requirements. HHS believes this intergovernmental agreement will continue to increase NYTD participation

rate over the coming five years. It promises to help youth and others have access to data. HHS intends to capitalize on the skills of DHR staff to help HHS and providers use data to improve services.

The NYTD contractor will also continue an innovative project, called the “Talking Wall”, mentioned throughout this report, where young people in residential facilities, shelters, and other foster care settings use “sticky notes” on the wall to express their dreams of improvements in their own case or in the system.

HHS will continue to provide contractors and citizens who request data basic information from NYTD and Results Oriented Management (ROM). ROM is a collation of data for state and federal reporting requirements. ROM has extensive historical records about assessments and children in placement. Data include child welfare outcomes and tend to be more up to date than federal sources which can run two years behind.

Iowa Aftercare and AMP will continue to be required to submit annual reports, which contribute to federal reports and drive data informed discussions about needed youth services. AMP and Aftercare contracts will continue to include performance measures and associated payments, including but not limited to youth’s perceived financial stability, housing stability and connection to trusted adults.

Serving Youth Across the State

- *Describe how the state has ensured and will continue to ensure that all political subdivisions in the state are served by the Chafee program, though not necessarily in a uniform manner (section 477(b)(2)(B) of the Act).*
- *Provide relevant data from NYTD or other sources that addresses how services vary by region or county.*

Under Iowa’s Transition Planning Program, services are available to all youth in foster care who are 14 years of age and older and youth adopted or who enter Subsidized Guardianship from foster care at age 16 or older.

The population served in federal fiscal year 2024, and who will be eligible in 2025-2029, includes the following:

(1) Is currently in foster care and is 14 years of age or older.

(2) Is under the age of 23 and was adopted from foster care at 16 years of age or older.

(3) Is under the age of 23 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.

(4) Was formerly in foster care and eligible for and participating in Iowa’s aftercare services program as described at 441 Iowa Administrative Code (IAC) § 187. Services are to age 23.

(5) Was formerly in foster care and eligible for and participating in Iowa’s postsecondary education and training voucher (ETV) program as described at 42 U.S.C. § 677(a) (6-7). Services are for five years or to age 26, whichever comes first. Services are available on a statewide basis.

The design of the Chafee transition program and how HHS intends to achieve the purposes of Chafee over the next five years is below. Included are descriptions of state and local level oversight, as well as basic program information.

Iowa has selected the Casey Life Skills Assessment (CLSA) as its life skills assessment for teens in foster care. The CLSA is a free tool that assesses the behaviors and competencies youth need to achieve their long-term goals. It aims to set youth on their way toward developing healthy, productive lives. We believe this quality, evidence-informed tool is a good way to view individual strengths and needs of a youth regarding life skills. Moreover, it can open conversations between the caseworker, the youth and their support system, and the care provider.

After the assessment is complete, the case manager works with the youth and their team to develop the transition plan, a part of the family case permanency plan, which lays out goals and action steps with the youth. HHS typically uses a youth centered planning session with the youth and those who care about the youth to come up with strengths, needs, goals and areas of concerns for the transition plan. Some youth centered planning meetings are formal and others less formal, depending on the family and the needs of the child. The case manager, the youth, and their team review and update the plan with the overall case plan at a minimum of every 6 months. TPS are available to assist in specific transition planning for youth who will most likely have a difficult transition (this could include youth who will need adult disability services, youth who experienced a number of placement disruptions, youth who have substance abuse issues, etc.).

HHS service areas are responsible to maintain transition committees in accordance with Iowa Code §235.7. Each area maintains two or more local transition committees to address the transition needs of those children receiving child welfare services who are age fourteen or older and have a case permanency plan as defined in Iowa Code §232.2. The HHS adopted rules (441 IAC §202.18) establishing criteria for transition committee membership, operating policies, and basic functions. The rules provide flexibility for a committee to adopt protocols and other procedures appropriate for the geographic area addressed by the committee. Committees review cases no later than the child's age of 17 and 6 months.

The Foster Care to Adulthood in Iowa Annual Report (referenced above) includes NYTD data and other trend data. A TPS may use this data to help guide local transition committee discussions and build local coalitions to improve outcomes. Use of NYTD and other relevant data is expected for the coming five-year period, and as such, is addressed in the five-year plan.

Serving Youth of Various Ages and Stages of Achieving Independence (section 477(b)(2)(C) of the Act)

- *Describe how youth of various ages and at various stages of achieving independence are to be served.*
    - *For states that extended or plan to extend title IV-E foster care assistance to young people ages 18 – 21, address how implementation of this program option has changed or will change the way in which Chafee services are targeted to support the successful transition to adulthood. The state must provide available data on participation and discuss how it affects or may drive continuous quality improvement in the delivery of Chafee services.*

- *For states that have elected or plan to extend Chafee services to age 23, provide a description of the services offered or to be offered to youth ages 21 – 22 (up through 23rd birthday) and how the expansion of the program will be implemented, including how youth, service providers, and community partners were or will be informed of the change.*
- *Describe how the state ensures it makes available services to youth formerly in foster who moved to the state after exiting foster care in another state. Note that section 477(b)(3)(A) requires states to certify that they will provide assistance and federally funded Chafee Program services to youth who have aged out of foster care and have not attained 21 years of age (or 23 as applicable). It is irrelevant where the youth "aged out" of foster care. The state in which the youth resides is responsible for services if the state provides the services needed by the youth/young adult. (See CWPM 3.1F, Question 3.)*

Iowa has not taken the option to extend foster care to 21, however, in accordance with ACYF-CB-PI-18-06, HHS submitted certification of a "comparable" program in our Annual Progress and Services Report, dated June 2018, along with Attachment A, Chafee Assurance, which the federal Children's Bureau approved. HHS also submitted the Chafee Assurance again, as required, as part of this year's submission. HHS contracts for a "comparable" state funded program for former foster care youth up to age 21. Iowa Aftercare Services Program began providing services for youth aged 21 and 22 in January 2020 and has continued to do so since that time. Participation data is included later in this report. HHS worked with Iowa College Aid to extend Chafee ETV to age 26 starting with the 2019-2020 school year. A description of this program extension is in the ETV section of this report.

HHS believes young people develop at different ages and in different stages. It is for this reason, for teens in foster care of any type, Iowa utilizes the Casey Life Skills Assessment (CLSA), described in this section, and youth centered planning meetings, such as the Youth Transition Decision-Making (YTDM) meetings. A youth driven model ensures young people express their dreams, receive help to engage trusted adults and formal and informal connections, and help to realize their dreams. Social work case managers (SWCMs)/juvenile court officers (JCO)s and TPSs constantly monitor the process. Iowa convenes and conducts reviews of final transition plans in Local Transition Committees across the state.

The Iowa Foster Care Youth Council (AMP) is a contracted service intended to offer fun social and developmental activities to children in all kinds of foster care. AMP has lots of fun things to do such as an annual camp, game nights, movies, hikes, and chances for youth to engage in civic opportunities and volunteering. AMP is totally voluntary, so the youth get to select activities that fit their interest and ability. AMP reports are available online at AMPIOWA (weareampiowa.com). Their services are mentioned throughout this report.

Collaboration with other States to Ensure Service Availability for Youth

Iowa ensures Chafee funded services are available to youth formerly in foster who moved to the state of Iowa after exiting foster care in another state. HHS staff, including regional Transition Planning Specialists and Iowa Aftercare Services Providers are trained and aware they are to route all requests to the Independent Living Coordinator who confirms the youth's eligibility with the counterpart in the sending state. This is typically a quick process including a phone call and a follow up email. The Iowa Independent Living Coordinator, after confirming eligibility and

ensuring a release of information is signed by the youth, allowing Iowa to share this information, contacts Aftercare staff and the youth to make a "warm handoff". Aftercare will initiate services for the eligible youth immediately. Furthermore, for Iowa youth who are moving to another state, case managers and Iowa Aftercare Services Program staff inform the youth about available services in the receiving state. Typically, a Transition Planning Specialists or Independent Living Coordinator will reach out to counterparts in the receiving state, in order to collect information for the youth/Aftercare provider and facilitate eligibility determination. All youth who age out of Iowa foster care are provided a letter proving they were in foster care. This document may be used to prove eligibility for Chafee funded services in other states. effort to connect them with available services in other states receive the benefit of Chafee funded services if they permanently reside in Iowa.

Collaboration with Other Private and Public Agencies (section 477(b)(2)(D) of the Act)

- *Discuss how the state involves the public and private sectors in helping youth in foster care achieve independence.*
- *Provide information on the title IV-B/IV-E agency's efforts to coordinate with the state Medicaid agency to support the state's implementation of requirements to offer Medicaid to eligible young adults formerly in foster care who move to a new state after January 1, 2023. (See ACYF-CB-IM-23-04 and State Health Official Letter.)*
- *Provide information on the actions taken to address the housing needs of young adults in transition from foster care. Outline the federal, state, local, and public/private resources utilized to support a range of safe, affordable, and age-appropriate housing options for young people. Include information on the state's proposed efforts to support and facilitate the coordination of child welfare agencies and Public Housing Authorities (PHAs) to utilize Foster Youth to Independence (FYI) vouchers. To support the implementation, the Administration on Children, Youth and Families (ACYF) issued "Leveraging The U.S. Department of Housing and Urban Development's Foster Youth to Independence (FYI) Program for Eligible Youth Experiencing or At-Risk of Experiencing Homelessness" to grant recipients of the Runaway and Homeless Youth program.*

HHS is a large agency with many internal partners that can help youth on their path to adulthood. HHS also involves outside public and private sectors in helping youth in foster care on their path. Below are several examples of partnerships that contributed to achievements.

Education and Foster Care: HHS maintains a contract with the Iowa Department of Education to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. The Division of Family Well-Being and Protection wrote the contract with a maximum of $300,000 per year. HHS identified lead staff in policy and field operations at central office, as well as points of contact in each of HHS' five service areas who work closely with similarly positioned staff in education. Efforts are to accomplish the following:

- Children in foster care remain in the school of origin, unless it is determined that it is not in his or her best interest to do so;
- If determined the child needs to change schools, the child shall be immediately enrolled;
- HHS maintains designated service area points of contact (POC) for all school districts; and

- Districts and local HHS have a Memorandum of Agreement that identifies key aspects of the law, transportation guidelines, and dispute resolution processes.

Approximately twenty youth are transported to their home school on any given day, when the transportation is paid for under this contract. We suspect many more youth are transported but the districts do not claim the payment. HHS and education partners are committed to continuing to address information sharing, so we can get a better sense of how many youths are able to remain in the school of origin and of those, how many need transportation. The Comprehensive Child Welfare Information System (CCWIS) is our best opportunity to do this statewide.

The Iowa Collaboration for Youth Development (ICYD): Council members are leaders of 12 state entities with the vision that "All Iowa youth will be safe, healthy, successful, and prepared for adulthood." The ICYD Council oversees the activities of the State of Iowa Youth Advisory Council (SIYAC) and sought input from these youth leaders in the development of more effective policies, practices, programs, and this report. SIYAC consists of youth between 14 to 21 years of age who reside in Iowa, with the purpose to fostering communication with the governor, general assembly, and state and local policymakers regarding programs, policies, and practices affecting youth and families and to advocate on important issues affecting youth.

Iowa College Aid Partnership: Since 2004, HHS has contracted with the Iowa College Student Aid Commission (College Aid) to implement and administer the Chafee ETV program, which is an invaluable partnership. The only Chafee ETV expense for College Aid to administer the ETV program is the cost of one full time employee and any costs to the National Clearinghouse regarding student data.

HHS provides access via a data sharing contract for College Aid to view CWIS screens to verify eligibility. College Aid staff work closely with field and policy staff to ensure information gets out about FAFSA and ETV. College Aid coordinates communication between child welfare, youth and the schools they attend.

The ETV coordinator and other contractors attend regional "Futurefest" and similar events for teens in foster care and alumni. They set up a table with materials and answer questions for youth. The ETV coordinator attends other trainings and meetings as requested by HHS and other partners. More information about the ETV program is later in this report.

Iowa Finance Authority Partnership for Housing: HHS contracted with the Iowa Finance Authority (IFA), a state agency, for the past ten years to implement and administer the Aftercare Rent Subsidy Program (rent subsidy) for youth in Iowa's aftercare program. For 2020, HHS entered into another up to six-year contract. Rent subsidies are typically Chafee funded and can go as high as $450 per month.

Aftercare self-sufficiency advocates assist youth in completing the rent subsidy application, based on a budget created with the youth. IFA funds and monitors the activities of aftercare who work directly with the youth. This has been an innovative partnership since IFA also partners with local housing authorities and Section 8 housing. Since IFA is basically the "state's mortgager", this partnership also raised awareness for low rent housing; IFA is the state entity that awards tax credits to low-income housing projects on a statewide basis. Because more youth are eligible for PAL funding and other housing programs, such as Foster Youth to Independence, there is less need for rent subsidy. As of the writing of this report, there are nine

youth participating. The reality of our reduced federal funding is that we may need to reduce or eliminate rent subsidy in coming years. Fortunately, if we take full advantage of federal housing grants, we can mitigate or avoid any instability for youth this may cause.

Foster Youth to Independence: The Department of Housing and Urban Development (HUD) announced Foster Youth to Independence (FYI) in Notice PIH 2019-20. FYI is an initiative targeting housing assistance and supportive services to young people with a child welfare history who are at-risk-of or experiencing homelessness.

HHS is trying to increase our current modest utilization of the FYI youth housing vouchers. The Children's Bureau has been particularly responsive to states in region 7. State representatives have reported challenges with local housing authorities not helping create agreements applying for FYI vouchers. The voucher requests need to come from the local housing authorities, so child welfare agencies depend on them.

Agreements have been made with eleven entities, including city housing authorities and regional housing authorities, as of January 1, 2024, for FYI housing vouchers. Vouchers are currently available and being issued to youth in those areas.

HHS is emphasizing the use of Family Unification Programs (FUP). FUP is a Housing Choice Voucher program funded through HUD. FUP promotes family unification by providing housing assistance to families for whom the lack of adequate housing is a primary factor in the separation of children from their parents and it will also help youth who have aged out of foster care who are unable to reside with their parents, up to age 24. FUP is in Boone, Dallas, Marion, Story, Madison and Polk counties. HHS continues to encourage Public Housing Authorities to apply for FUP and FYI in areas where there are high number of youths needing housing assistance.

Amy Hance, Children and Family Program Specialist has invited Iowa's IL Coordinator and other Iowa transition team members to regular housing meetings with Missouri, Nebraska, and Kansas representatives so we can break down barriers and get ideas. The meetings leave us feeling heard, but challenges remain and in Iowa the number of vouchers available has been stagnant.

Despite challenges, over the last 5 years HHS has increased housing opportunities for youth aging out of care. In the coming five-year period, TPS and other advocates for youth have identified that housing should be a top priority. Data bears this out, as NYTD data shows housing instability for former foster care youth exceeds 25% in Iowa. HHS will continue to increase housing voucher opportunities in coming years by advocating with Public Housing Authorities or City Housing Authorities across the state to offer FUP and FYI. Housing is a goal in the new CFSP.

Medicaid: Iowa's state plan amendment updated the Expanded Medicaid for Independent Young Adults (EMIYA) eligibility requirements due to a modification in the Social Security Act. The criteria for youth who aged out of foster care prior to December 31, 2022, has not changed. For youth who aged out of foster care on or after January 1, 2023, they will be eligible for foster care youth Medicaid coverage group regardless of whether they reside in the state in which they aged out.

Readers will see in the data below that over the past five years, enrollment has remained stable, even though the number of youths who became eligible (based on count of youth in care at age 18) has decreased from 369 to 233 since federal fiscal year 2023, according to ROM Foster Care Counts data.

When reviewing the recommendations from the Local Transition Committee's and others, it became apparent that Medicaid funded services are needed, especially in rural communities. HHS has added a goal to the new CFSP to identify and expand access to services for transitioning youth.

Table 4i: MIYA and E-MIYA Expenditures and Enrollment				
Calendar Year (CY)	**Total $$**	**Federal $$**	**State $$**	**Enrollment**
2019	$3,801,377	$2,293,613	$1,507,764	993
2020	$4,357,263	$2,943,105	$1,414,158	1100
2021	$4,501,861	$3,063,396	$1,438,465	1136
2022	$4,926,736	$3,379,329	$1,547,407	1140
2023	$4,789,153	$3,223,832	$1,565,321	1070

Determining Eligibility for Benefits and Services (section 477(b)(2)(E) of the Act)

Address how the state uses objective criteria to determine eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.

TPS are the go-to people for HHS social work case managers and juvenile court officers who work to ensure youth under their responsibility have all of the supports they need to be successful. TPS also confirm eligibility for programs for example, when there is an application for services, during youth centered meetings, and when other colleagues from other states have a youth who is moving to Iowa and wants to connect youth to Iowa programs or services.

Iowa has an electronic tracking system for transition planning activities to ensure youth aged 14 and older in foster care as well as young adult foster care alumni get the support they need and that HHS remains in compliance with all requirements for case planning of transition aged youth. TPS are responsible to record such things as the date when youth over the age of 14 complete the Casey Life Skills Assessment, the date of the Local Transition Committee's approval of the youth's transition plan, and the date the case manager meets with the youth 90 days prior to the youth's 18th birthday. TPS send workers a checklist of transition responsibilities.

The TPS utilize the child welfare information system (CWIS) to check eligibility for ETV, Iowa Aftercare, and other services relying upon foster care experience for eligibility. TPS complete application forms, as needed, or direct the case manager of a child in foster care on how to do so.

The HHS SharePoint has a host of resources for workers that defines eligibility for programs. Expectations and timelines are available through the SharePoint, helpdesk staff, and TPS. HHS' website has a transition page which makes program eligibility and other information readily available to anyone who uses the Internet. The Chafee funded Iowa Aftercare Services Program, and the Iowa Foster Care Youth Council are both contracted to have a website with eligibility information.

Youth can apply for HHS Chafee funded programs themselves. They also may be referred by their caseworker, family members or mentors. Information on benefits and service are publicly available. Youth have a right to challenge a decision through the appeal process. Appeal process information is provided to them in writing, whenever a decision about eligibility for a program is made, via a notice of decision form. Iowa Aftercare, for example, provides ten-day notice before any action takes place, so the youth can appeal if they choose. Positive actions, such as an approved payment, do not require ten days' notice. HHS defends an appeal about once every two years.

Contracts with Chafee funded providers, including AMP and Aftercare, require outreach efforts and a website. Both programs use social media to connect with youth and community partners. When a youth applies for the program or is referred, the providers typically get a signed release of information from the youth and confirm eligibility with HHS TPS or the IL Coordinator.

Cooperation in National Evaluations (section 477(b)(2)(F) of the Act)

Provide a statement that indicates that the state agency will cooperate in any federal national evaluations of the effects of the programs in achieving the purposes of Chafee.

HHS will cooperate in any national evaluations of the effects of the programs in achieving the purposes of Chafee.

HHS reports NYTD data semi-annually and is proud to report full no-penalty compliance since implementation.

A full report on ETV is later in this report.

Chafee Training

States must provide information on specific training planned for FYs 2025-2029 in support of the goals and objectives of the Chafee plan. Chafee training may be incorporated into the training information discussed in the Training Plan…for the 2025-2029 CFSP but should be identified as pertaining to Chafee.

Please also note that states are required to certify that they will use training funds provided under the title IV-E foster care and adoption assistance programs to provide training, including training on youth development, to help foster parents, adoptive parents, workers in group homes, and case managers understand and address the issues confronting youth preparing for a successful transition to adulthood and making a permanent connection with a caring adult (section 477(b)(3)(D)).

TPS address training needs of staff and foster care providers. Their oversight of Local Transition Committees (LTCs) places them in a unique position to see the training needs of the

caseworkers. TPS share information on all state and federal laws regarding transition planning and requirements including:

- Role of TPS as support to ongoing workers;
- Youth-centered planning;
- Planning inclusive of the five primary components mentioned above;
- Ensuring smooth access for youth who need services and supports from the adult disability system;
- A written transition plan for each youth in foster care age 14 or older;
- Required documents; and
- Services available, including AMP and Iowa Aftercare Services Program.

All new social work case managers in Iowa travel to Des Moines for comprehensive training. Each training includes a presentation on all aspects of foster care transition planning and connects the new workers to the tools and the TPS who will be their resources for transition in the service areas. The IL coordinator conducts the new caseworker training which includes requirements for caseworkers, services and programs available to youth, and information about how to find and use resources such as manuals, forms, and staff support.

During the FFY 2015-2019 Child and Family Services Plan (CFSP), the HHS completed a transition webinar, (http://training.hs.iastate.edu/course/view.php?id=577#section-3), which remains available for viewing by HHS/JCS, all providers, and to the public. To reach foster and relative care families, training is available using various approaches. In addition to the available webinar described above, the recruitment and retention contractor (RRTS) staff provides training, with some training occurring during foster family support group meetings. TPS continue outreach to providers (foster group care, shelter, supervised apartment living (SAL), and RRTS) to make our training services available.

TPS visit HHS county offices throughout their service area on a periodic basis, some monthly and some less frequently, but always as needed to support the area. They provide formal trainings, attend team meetings, and just “take work and camp out” to get some work done while available for questions as needed. During the past five-year period, TPS have learned to use virtual technology to help workers during one-on-one sessions and training. Supervisor calls, called CIDS calls, are frequently used by TPS and the IL Coordinator to relay or receive information. Among topics covered in 2023 include:

- Clothing allowance for children in foster care
- Human trafficking
- Extended Foster Care
- Education and Foster Care Policy and Practice

TPS train staff at on-going in-service staff trainings and work with caseworkers throughout their area on an individual basis on difficult cases regarding transition needs.

The training information discussed in the FFY 2025-2029 CFSP Training Plan incorporates foster care transition training planned for FFYs 2025-2029. In addition, Chafee goals for FFY 2025-2029 will involve training and support for workers and others, all intended to help HHS staff and contractors comply with Social Security Act transition requirements and to achieve desired outcomes for youth.

CFSP Chafee Goals for 2025-2029 (this is not required by the CFSP, but foster care transition prefers to have specialized goals, in addition to the broader child welfare CFSP goals).

HHS' Independent Living Coordinator and others on the foster care transition team have established relationships with many contributors and stakeholders. These relationships help us get the day-to-day work done, but it also helps us have a good sense of the needs of our community and easy access to intentional discussions around strategic planning and goal setting. Among the groups we remain connected to include Local Transition Committees, the Iowa Foster Care Youth Council, HHS Transition Planning Specialists and their supervisors, the Iowa Aftercare Services Network Provider Panel, and others.

To write this report, certain intentional conversations about the CFSP complemented data from formal reports. While not every recommendation resulted in a specific goal or benchmark, we were able to intentionally review all the recommendations and identify themes and urgent needs. A summary of recommendations is below, including if HHS included the recommendation in the CFSP goals for this section.

Summary of Recommendations:

Local Transition Committees: Iowa Code Section § 235.7 requires HHS to maintain local transition committees to address the transition needs of those children receiving child welfare services who are age sixteen or older and have a case permanency plan as defined in section 232.2. There are committees operating in all five HHS service areas. They are facilitated by Transition Planning Specialists (TPS). Annual local transition reports from each HHS service area include specific suggestions, which have been used to develop this year's CFSP. We've categorized the recommendations by needs:

- **Normalcy and Youth Development:** Continue to actively involve the youth in their transition planning and let them drive the decisions and plans for their future. There needs to be frequent youth-centered meetings, to engage youth to work on their goals and develop a plan.

  Foster care youth often lack financial literacy training or modeling of how to budget, pay bills, etc. Explore basic living skills training curricula that could be taught to youth. Our local Aftercare has developed a relationship with Dupaco in Cedar Rapids to have a financial literacy class offered a few times throughout the year for Aftercare youth.

  Transportation barriers continue to be huge for our teens. There are not enough resources available to assist teens with getting their driver's licenses and getting vehicles. Youth in foster care placement or QRTP frequently do not have the opportunity to learn to drive.

- **Academic:** Youth are not always connected to or aware of the academic supports that could assist them, such as IEP's and 504's. Communication and a team approach is needed between the schools, AEA, IVRS, and the child welfare system to make sure students have the supports needed and are getting their educational needs met and are on track with their credits and graduation requirements. Encourage and support youth to

participate in extra-curricular activities while in placement that they can continue to be involved with after they leave their placement.

Have a centralized state database through the Iowa Department of Education where transcripts of all school students in Iowa can be accessible. Within the Department of Education, have a point person who can facilitate contact with schools so that records are immediately accessible, and credits can be evaluated.

- **Connecting to Existing Services:** Another strong suggestion continues to be using Family Centered Services for teens in care, so HHS workers have an ally in the transition work with youth and so service providers and youth have close collaboration. Iowa Vocational Rehabilitation Services (IVRS) is a valuable service available to our youth, yet very few workers seem to be aware of the service or what they have to offer. Advocate for and increase the opportunities for youth to gain job experience and skills through job shadowing and volunteer opportunities regardless of type of foster care placement. Have providers work with youth on skills needed to obtain and maintain employment.

  Youth Transition Decision Making (YTDM) meetings and transition staff meetings should be held frequently throughout the life of the case to ensure necessary housing referrals are made early on.

  Not all youth are being referred to AMP programs or their special activities, where it is available. AMP is a big benefit for the youth, foster families and providers. AMP facilitators do not know who is in the foster care system to reach out to them until referrals/connections are made.

- **Youth with Disabilities:**
  - Transition to Adult Services: 21 out of 49 (43%) of the youth reviewed (compared to 24% last year), reportedly will need or could benefit from adult services/support due to mental health needs, intellectual disabilities, or developmental disabilities. While the number of older youths aging out of care is decreasing, there is a greater percentage of the youth aging out with significant needs that require additional support into adulthood. There is not a good resource for youth to obtain guardians, when needed, when they do not have anyone willing to do it voluntarily. Another gap that can cause problems is the teens' SSI, meaning it can take some time for SSI to switch payee from HHS to the new payee or the teen themselves. Many youths lack understanding of the significance of their mental health needs and the importance of remaining in treatment after leaving HHS and court supervision. At times SSI is the only funding a youth has available for living expenses. If forms are not completed for a payee change prior to the youth exiting care, there may not be any funds available to the youth upon exiting care. The ID Waiver waiting list continues to be approximately five years. The other waiver waitlists are equally as long.

    Social Workers and JCO's are encouraged to assist youth or identify someone who can help them establish a primary care physician, dentist, optometrist, psychiatrist, and mental health counselor if they are moving to a new area when

they transition to adulthood. Youth should begin making their own medical, dental, eye, and mental health appointments prior to exiting care.

- **Housing:** It is very hard to find property owners willing to work with minors and young adults, who may have one or more of the following barriers: no rental history, lack of financial resources, no one to cosign, no references, and criminal histories. This makes it difficult for transitioning youth to find an apartment. The amount of funds available to a youth in Aftercare is not enough to secure housing that is safe and affordable. This frequently results in the youth being in unstable housing situations or becoming homeless.

- **Transition Planning Specialist (TPS):** TPS have a significant role in developing goals and achieving expected results. TPS meet monthly, with the Independent Living Coordinator often facilitating. Conversations about the APSR and CFSP are regularly part of the discussion. Each TPS knows their designated "lead" goal areas and provide regular updates. The January 2024 TPS meeting, among others was used to review draft goals, provided by the Independent Living Coordinator. Their input is summarized below.

  TPS are committed to collecting youth input into the CFSP goals. They were assured a draft was shared with the AMP foster care youth council at a meeting in the fall. Some TPS attended. During youth council discussion one youth relayed that it could be good to have a flyer or resource guide, describing programs and services, which HHS has added to the CFSP goals. TPS agreed this is a good idea and contemplated how a revised TIP may meet this need.

  TPS are interested in expanding resources, including those in the TIP Binder. There was question if it could be condensed and done electronically, possibly having ability to be able to update specific areas/sections as needed, rather than now how it must be the whole book. HHS has identified this as a key transition project, and as such, it has been added to the CFSP.

  TPS discussed that the last five-year plan included an overwhelming five goals and many objectives; in retrospect, it may have been too many. TPS discussed how they could break down to fewer goals with objectives, without missing important areas of work. After the discussions, we reduced the draft to two goals, with several objectives.

  One objective specifically identified in the draft addressed LGBTQ needs, and a TPS member suggested possibly broadening this to cover "youth identity", such as immigration, sex offender, Native American youth, trafficking, etc., could accomplish more.

  One TPS suggested possibility of adding to a focus on training of new staff since there has been significant turnover. Training is an ongoing effort of TPS and has been included in the child welfare CFSP training section.

  Another question brought up was regarding the work that goes into complex cases. A supervisor expressed it could be good to track when workers reach out to TPS and in what type of cases are TPS being pulled into. While it may not make it to the goals in

this report, it is wise for HHS leadership to begin evaluating overlap of TPS and the new Social Worker 4 staff who are in positions to support staff with complex cases.

- **Iowa Aftercare Services Program:** Research shows that youth who leave foster care to live independently are often at risk of homelessness, less education, unemployment/poverty, and mental health issues. There are a number of reasons for this increased risk. A variety of aftercare services for youth leaving foster care are designed to help address these risks. HHS and YSS, who operate Aftercare, have embarked on research which promises to drive future work. Iowa State University (ISU) researchers, including Carl Weems Ph.D., were the primary researchers. The study was recently published in the Children and Youth Services Review. The purpose of this study was to examine trends in participation and understand the experiences of youth transitioning from foster care who were involved in the Iowa Aftercare Services Program. The ISU researchers, with support from HHS, examined trends in participation, services received, participant reports of service satisfaction, as well as employment and educational data at entry and exit over the past five years.

  The following paragraph is borrowed from the summary in the published paper.

  
  Published Aftercare Paper 4.9.24.pdf

  In summary, the Iowa aftercare program serves a large portion of youth exiting foster care, and participation is associated with high rates of satisfaction with the services, and with high self-sufficiency in housing, finances, and relationships reported. Moreover, youth rates of employment and education are relatively high compared to national estimates, and percentages were greater at exit from the program. The findings from this study suggest opportunities for generally enhancing programs for foster care youth recruitment into aftercare services and mental health services. First, mental health services might be augmented for this population with specific targets for this service as part of aftercare/independent living programming for federal support and federal reporting. This could be facilitated by using more high quality, well established mental health assessments and consistent required data collection procedures. Such screenings are recommended for the general population (Mangione, et al., 2022), and similar assessments could be recommended in policy guidelines for youth transitioning from foster care. Second, opportunities to facilitate the recruitment of males might be intentionally incorporated into formal programs as part of their transitioning services. Last, findings from this study highlight the need to identify and reduce potential barriers to youth accessing all available services (Doucet et al., 2022).

  While working with ISU on this study of Aftercare, HHS has gained important experience using data, and as well, has found a capable partner in developing research based next steps for our CFSP. For example, while participation data for individuals of color are relatively strong, efforts to connect with males and keeping them in the program could be improved. The research validated what we already know from stakeholder discussions, that mental health needs of former foster care youth is a barrier to other important outcomes. This report contributed to our goals having to do with Medicaid funded

services. HHS will support Aftercare in doubling down on outreach efforts for males leaving foster care programs.

- **AYE youth input:** Discussions with AMP about foster care programs and youth needs are part of the day-to-day work. HHS organized CFSP goal discussion meetings with AMP youth, which were held on November 11, 2023 and January 17, 2024, to discuss strengths and needs in foster care and to develop goals for the coming five-year period.

  HHS appreciates the role AMP staff play in coordinating youth schedules and hosting, as well as preparing youth and helping with follow up after the discussions. HHS described the APSR and CFSP to youth and helped all participating recognize the many accomplishments youth have made over the years by sharing their experience and advocating for change.

  In our discussions, youth were asked, “What do you want to see happen within your program?” and “How can HHS improve foster care?” and “What challenges do you see in the foster care system?” Youth were given an opportunity to look over the draft goals and provide input. Just a few of the ideas from the discussion are bulleted below. There was an emphasis on collecting data on certain case planning ideas, so HHS made sure to acknowledge this by including a goal in the 2025-2029 CFSP goals. Youth in foster care said:
  - HHS should use better monitoring and assurance that youth are getting what they need.
  - Do all youth leave care with a birth certificate and a state ID? We should help with that.
  - We need to watch whether youth leave care with the skills they need to get a job and pay for housing.
  - Need to help youth find permanency, so youth do not have to age out of care.
  - Funding (to youth) to keep up with the pace of inflation.
  - Maybe we are missing an opportunity to better engage parents when the youth is a teen.

- **Juvenile Justice:** On April 3rd, 2024, HHS hosted a discussion with multiple juvenile justice staff, including Juvenile Court Services Staff and State Court Administration staff. All but one Chief Juvenile Court Officer was present, as was the Director of Juvenile Justice Programs, Chad Jensen. Judicial Branch staff selected the participants. HHS facilitated the discussion. HHS described CFSP and APSR and let participants know how we are using data and reports to draft goals, and that we are hosting certain stakeholder discussions to refine goals and see what we’ve missed. This was a large and active group. Because justice involved youth comprise more than half of the teenagers in foster care, we need the contributions of justice involved staff and youth. HHS added a goal about working with Vocational Rehabilitation, as a result of the discussion. The group was told that even if a suggestion doesn’t make it to the plan, that doesn’t limit the work we can do together on any item. Comments are summarized below:
  - Reacting to a performance measure to avoid additional charges while in residential care - staff noted that no misdemeanors for the kind of youth being

placed in high-risk settings is a pretty high standard. HHS should be measuring aggravated misdemeanors and above.
  - Goals should be tied to mental health. Back up transition Medicaid goal so it is not just for the youth leaving foster care.
  - Build out service capacity in rural areas.
  - Prevent re-entry into foster care.
  - Need to add a focus on teaching youth about vocational training, not just college.
  - More services needed for females—including deep end like State Training School (STS) and group care.
  - Need to start collecting data on the number of youths coming out of group and shelter with criminal charges.
  - Need to start collecting data on number of youths who cross over to delinquency.
  - We are seeing new charges in placement and charges that are different from what behaviors they showed before coming into care. No data on this, but we should start tracking on it.
  - Youth are coming into care and into services due to mental health needs. Even sometimes this happens when they are at a facility like PMIC where they are supposed to care for the mental needs.
  - Need to strengthen support for QRTP providers—we are losing them in part due to staffing issues. Better funding could help. Certain providers offer a good example of how they can step up to fill a need.
  - Girls residential programming is needed, especially for “deep end” needs.
  - Access to appropriate level of care will help prevent or reduce charges. Should address how we ensure appropriate placement availability.
  - Need to expand capacity to serve youth in their home community—should not have to move far away to get Supervised Apartment Living.

- **Education:** HHS has been challenged for years, to help youth succeed academically as they approach college age. Of course, not everyone wants to go to college. It is for this reason, the new CFSP goals will be used to address services and supports for youth who want to pursue volunteer opportunities or trades, as well as those who want to go to college. For those who do enter college, we intend to coax up the numbers of youth who graduate with a degree or certificate by helping the youth think differently about college. We want them to identify as a college student, giving them college experiences prior to entering college and providing educational services for the youth while in school. HHS has recently entered an agreement for a pilot program called Iowa Better Futures. Services will be provided to participating youth in foster care when they are juniors or seniors in high school. Services are provided by a team organized by the University of Nebraska, who are testing whether the Better Futures program improves higher education access and success for students with foster care experience. The pilot study will be in the HHS Des Moines Service areas. The CFSP benchmarks reflect a desire that HHS service areas learn from the Des Moines area experience. A flier is below.

Iowa Better Futures Flyer.pdf

FFY 2025-2029 CFSP Goals, Objectives, and Benchmarks are as follows:

Goal 1: Meet the transition needs of youth in foster care, age 14 and older, so they are prepared to transition into adulthood and are aware of services and supports available.

- **Objective 1.1:** Identify a reliable method to track, monitor, and follow up to ensure that youth aged 14 and older in foster care have an individualized transition plan.
- **Objective 1.2:** Promote youth centered planning meetings.
  - **Benchmark:** All youth in foster care age 14 and older for at least six months will have a transition plan.
  - **Benchmark:** In year one, create a visual for youth, staff and contractors that describes services for youth transitioning from foster care to adulthood, that includes the application process and how to apply.
- **Objective 1.3:** Ensure youth who age out of foster care have state identification, birth certificate and social security card. Youth should receive assistance getting a driver's license or permit if they want one.
  - **Benchmark**: Increase percentage of youth who enter Iowa Aftercare Services Program with documentation, from 40% to 60% by 2029, based on Iowa Aftercare Services intake data.
- **Objective 1.4:** Utilize NYTD and other existing data to improve service delivery.
  - **Benchmark:** Engage fifty or more staff and colleagues to participate in each of the NYTD Annual Outcomes Report Out webinars.
- **Objective 1.5:** Increase employment, education, and career choices which may appeal to youth.
  - **Benchmark:** Initiate a formal relationship with AmeriCorps and Iowa Works Programs, including but not limited to Vocational Rehabilitation, to create options for paid work experience no later than year three.
  - **Benchmark:** Monitor percent of youth aged 14 and older in foster care who elect to participate in a volunteer work experience, with an initial goal of at least ten percent of youth over age 16 and older volunteering.

Goal 2: Ensure youth transitioning from foster care reliable housing and services plan prior to exit.

- **Objective 2.1:** Make referrals for adult services in advance of age eighteen, for youth expected to age out of foster care. Referrals are expected to be made six months before aging out or later date if directed by the facility.
  - **Benchmark:** The percentage of transition plans approved by Local Transition Committees will exceed 90%.
- **Objective 2.2:** Develop competencies and to understand what to expect and how to talk about and positively address issues that affect LGBTQ+ youth, youth of color, and underserved or disparate populations of youth.
  - **Benchmark:** A resource review will be conducted in year one to identify best practices in affirming care. Youth with lived experience may be consulted.
  - **Benchmark:** Consult with other states in region 7 to identify best approaches to affirming care.

  - **Benchmark:** Policy staff will review and revise the employee manual by the end of year two.
  - **Benchmark:** TPS will review and revise transition training for casework staff by the end the year five.
- **Objective 2.3:** Utilize Medicaid funded services to bridge service support as youth transition from foster care to adulthood, including securing case management and residential programs for those who need them.
  - **Benchmark:** HHS will work with adult services providers to develop clear procedures for making referrals timely. This may include pre-approving youth, so when the youth leaves care, they are approved to enter.

Consultation with Tribes (section 477(b)(3)(G))

States are required to consult with each Indian Tribe located in the state as it relates to determining eligibility for Chafee/ETV benefits and services and ensuring fair and equitable treatment for Indian youth in care.

Iowa ensures that all political subdivisions implement the Chafee program in a youth driven, but statewide consistent manner, by relying on the network of providers and infrastructure described above to maintain a firm dedication to statewide consistency and flexibility at the case level. This means the state has statewide contracts for services like Aftercare, AMP, and ETV so young people, including Native youth, connected to tribes or not, in different areas of the state have equitable opportunities and receive similar support; everyone receives youth centered planning, voluntary services, and support, depending on their desire and the youth's assessment of life skills. Everyone receives services tailored to their unique needs, to the extent practicable.

HHS continues to work collaboratively with the tribes. The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) have their own case managers and culturally specific services to meet the needs of Native Americans. Chafee funded programs, TPS, and ETV intentionally includes tribal partners when delivering resources or opportunities, such as youth conferences, arise.

Iowa's Independent Living Coordinator maintains a good working relationship with Meskwaki Family Services staff and makes effort to engage staff in discussions about services for teens in foster care and alumni as well as provide information about program or protocol changes.

Attachment C. Chafee Program States are required to certify

See Attachment C.

Education and Training Vouchers (ETV) Program

Describe the methods the state will use to operate the ETV program efficiently over the next five years

HHS partners with the Iowa Department of Education's Bureau of Iowa College Aid (Iowa College Aid) to administer the Education and Training Voucher (ETV) program. An

intergovernmental contract administered by HHS ensures there is one full time Coordinator, employed by Iowa College Aid.

As mentioned above, the ETV program, which utilizes combined state and federal funding to support education attainment of current and former foster care recipients, is monitored as follows:

- Quarterly reports reviewed by HHS
- Annual reviews by HHS
- Performance outcomes (retention)
- Monthly claims approved by HHS
- Referring worker feedback (informal)

Each year Iowa's ETV application is available online beginning in October, to coincide with the Free Application for Federal Student Aid (FAFSA) release. Students must submit both a FAFSA and the Iowa Financial Aid Application annually with awards made until depletion of funds. Students renewing their awards prior to March 1st receive priority consideration. Students are eligible for ETV up to the age of 26. Students who received ETV in the previous academic year receive priority consideration, then to students who received ETV in any previous academic year, then new applicants, and finally to students enrolled in a graduate program and have remaining ETV eligibility. Once all funds for a particular academic year are committed, Iowa College Aid starts a waiting list. Students enrolled less than full-time receive a prorated amount. The college/university receives the awards directly, by term, and in most cases by Electronic Funds Transfer. Once full payment of tuition, fees, and room and board charges occurs, the student then receives any remaining funds to assist in paying for the costs of attendance.

Describe the methods the state will use to: (1) ensure that the total amount of educational assistance to a youth under this and any other federal assistance program does not exceed the total cost of attendance (as defined in section 472 of the Higher Education Act of 1965); and (2) to avoid duplication of benefits under this and any other federal or federally assisted benefit program. (See sections 477(b)(3)(J) and (i)(5) of the Act and Attachment D of this PI.)

Completing the FAFSA and IFAA is how a student applies for federal and a majority of state funded scholarships and grants. ETV eligible students apply through the same process ensuring students will receive the maximum amount of financial aid possible to attend college. Iowa College Aid has access to these applications and ensures eligible students are applying for all aid possible.

Colleges/universities sign a certification form annually to attest that all recipients will be awarded according to the ETV program guidelines. Colleges/universities also receive annual guidance when the list of eligible ETV applicants is provided. In addition, Iowa College Aid periodically audits colleges/universities to ensure student awards do not exceed the cost of attendance and are following all other eligibility rules, including, but not limited to, Satisfactory Academic Progress (known as SAP).

Iowa College Aid utilizes a financial aid system called the Iowa College Aid Processing System (ICAPS®) to administer ETV. Iowa College Aid staff use this system to collect applications, determine eligibility, monitor continual eligibility, send notifications to applicants and colleges/universities, monitor commitment levels of spending, and make payments to

colleges/universities. Upon receipt of applications, the program administrator uses the child welfare information system to determine if an applicant was in an eligible status. These statuses, flagged in ICAPS, determine the number of eligible applicants in the program. After eligibility is determined, eligible applicants and their college/university receive a system-generated notification. Once colleges/universities determine a student's attendance, they will notify Iowa College Aid, who will generate a payment. If the student is an Iowa resident, but attends school out of state, the ETV program will support them financially as any child attending in Iowa.

Describe how the program is coordinated with other appropriate education and training programs (section 477(i)(6) of the Act).

The ETV Coordinator also reviews and updates ETV promotional materials, website, brochures and pamphlets and distributes materials statewide to numerous audiences. Students in Iowa receive information about ETV's existence in a variety of ways and learn to apply early in the application cycle.

Former foster youth may also qualify for the All-Iowa Opportunity Scholarship (AIOS). The State of Iowa funds this scholarship and it is available to students who have financial need and are attending an eligible Iowa college/university within two years of graduating high school. Students who self-identify as a current or former foster youth receive first priority for the AIOS, so it is important to notify youth of this program. This scholarship is renewable for four years as long as the student remains continuously enrolled. The application for this program is the same as ETV which does inform students of their eligibility, but there is still more work to be done to inform students of this opportunity. By attending FutureFests, the ETV coordinator will be able to inform more students face to face.

Collaboration: The ETV program continues to collaborate with:

- Iowa Foster Care Youth Council
- College/university financial aid staff
- Other state scholarship and grant program administrators
- Iowa Aftercare Network
- HHS Transition Planning Specialists (TPS)
- GEAR UP Iowa
- Achieving Maximum Potential (AMP)
- Iowa's Tribes

Program support: The ETV Coordinator provides technical assistance, upon request, to college/university staff, Iowa Aftercare Network staff, as well as the TPS and HHS policy staff. Based on our current collaboration, it was determined there was a need to have some specific guidance for employees of the Aftercare program in regard to college readiness for the youth they serve. With the use of data, we are hopeful we can provide Aftercare with guidance that will increase the success rates of our youth.

Goal 1: Collaborate with institutions of higher education (schools) and provider partners to ensure foster care alumni are supported in their pursuit of higher education.

- **Objective 1.1:** Capitalize on key partnerships to identify needed services and supports for students.

  - **Benchmark:** Iowa College Aid and Iowa Aftercare Services will work together to complete staff guidance on college readiness by the end of year two, which may be included in the Iowa Aftercare Services Program employee manual.
  - **Benchmark:** The percentage of youth who complete college or trade school with a certificate or credential will increase between 2025 and 2029.
  - **Benchmark:** At least 15 youth will participate in the Better Futures Program in Des Moines Services Area. Results will be used to inform best practice across the state.
- **Objective 1.2**: Attend FutureFest and other events to share information about best practices, new programs, and timelines for scholarship and grant applications.
  - **Benchmark:** Increased availability of targeted programs to help former foster care students transition and successfully complete high education. Report known programs in annual APSR.
- **Objective 1.3:** Ensure data is available to schools and service providers, including but not limited to applications, enrollment, and outcomes.
  - **Benchmark:** HHS, schools and service providers receive education data from Iowa College Aid in year two and at least annually thereafter.

SERVICE COORDINATION

- *Considering the vision articulated by CB to address disparities and inequality, with a focus on prevention, explain how the services will be linked to, coordinated with, or integrated into other services in the child and family services continuum and how services under the CFSP will be coordinated over the five-year period with services or benefits under other federal or federally assisted programs serving the same populations to achieve the goals and objectives in the plan. This should include how the agency is coordinating services with those provided through the title IV-E Prevention Services plan.*
- *Describe who participates in the coordination process and provide examples of how the process led or will lead to additional coordination of services.*
- *Discuss the approach to include, and the involvement of, other federally funded programs (e.g., Temporary Assistance for Needy Families, Medicaid, Child Care, Head Start, Supplemental Nutrition Assistance Program, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, programs funded by the Substance Abuse and Mental Health Services Administration, the Family Unification Program (FUP) vouchers, programs coordinated or funded by the Office of Juvenile Justice and Delinquency Prevention at the U.S. Department of Justice, and the Social Security Administration, etc.).*
- *Describe the state's approach to involving state, local, Tribal, and community-based public and private providers of programs addressing issues such as substance use disorders, domestic violence, behavioral health, education, and developmental disabilities.*

Please see in this section:

- *Child and Family Services Continuum*
- *Stephanie Tubbs Jones Child Welfare Services Program*
  - *Services for Children Adopted from Other Countries*
  - *Services for Children Under the Age of Five*

    - *Efforts to Track and Prevent Child Maltreatment Deaths*
- *MaryLee Allen Promoting Safe and Stable Families*

Please also see:

- *Section II: Assessment of Current Performance in Improving Outcomes, Systemic Factors, Agency Responsiveness to the Community.*
- *Section V: Consultation and Coordination Between Iowa and Tribes*

Office of Juvenile Justice Delinquency Prevention Act (OJJDP): The Iowa Department of Health and Human Services (HHS) serves as the Designated State Agency for the State of Iowa for the federal Juvenile Justice and Delinquency Prevention Act (JJDPA). The Criminal and Juvenile Justice Planning (CJJP) team leads this work on behalf of Iowa HHS. The Iowa Department of Management provides relevant and required data collection, storage, and analysis. Iowa's Juvenile Justice Advisory Council (JJAC) serves as the State Advisory Group (SAG), for the OJJDP Title II Formula Grants Program.

Iowa will continue to use funding of approximately $600,000 per year, formula grant to serve delinquent youth, focusing on the following priority areas; Serve children at home, with their families, and in their communities, Enhance quality of life, services and opportunities for youth in the juvenile justice system, and Advance healing-centered care. These priority areas are considered equally weighted. The Iowa Juvenile Justice Advisory Council (JJAC), which serves as the State Advisory Group (SAG), selected these priority areas after reviewing research, information, and trend data during a planning retreat in the fall of 2023.

In addition to the considerable state funds for juvenile justice services (approximately 15 million per year), the OJJDP funds are used to pay for community-based delinquency prevention, including evidence-based programming. Due to the nature of these priority areas, multiple partners and cross-systems collaborations are required to attain measurable progress in achieving the goals and objectives. The Judicial Branch and HHS leaders have a shared goal to prevent and reduce out of home placements in foster care, including residential programs.

It should be noted that youth justice councils are rare across the country and Iowa was recognized for the active youth justice council. It was noted in the planning retreat that the expertise the State of Iowa Youth Advisory Council and the Youth Justice Councils possess is critical for work being done in the field of juvenile justice reform

Iowa HHS contracts with Maximus to act as a resource to caseworkers. Maximus acts as a liaison to Social Security Administration. They assist with identification of youth with disabilities and file SSI application paperwork when appropriate. They also track SSA decisions on applicants and appeal on behalf of HHS when appropriate. They review certain placement lists to see if there are children in care who may be eligible for SSI and in need of services. For example, Maximus monitors the QRTP and PMIC lists.

Maximus staff have an excellent understanding of the policies surrounding social security and have relationships with team members in our regional office. In the past year, Maximus has been working with HHS to develop a strong process for communicating with a youth and family about cash benefits and how they can claim any escrow funds when the youth returns home or ages out of foster care, if the youth does not return home. The lead representative from

Maximus attends Local Transition Meetings. Her knowledge of the SSI process has been incredibly helpful. Also, she is keen to recognize when there is a child who may have a disability and their needs can be better addressed through Medicaid services and family supports, including but not limited to financial SSI. TPS receive a Maximus transition list to check the status of youth for whom the state applied for SSI, i.e. where the application is in the process and if a decision occurred. This is very important for youth who will need adult services due to ongoing mental or physical health needs.

For each of the CB grant programs listed below, discuss the approach to engage and meaningfully involve program representatives in service coordination and support of mutual goals and strategies to prevent children abuse, protect children and improve the safety, permanency and well-being of children and families involved in the child welfare system.

- *Community-Based Child Abuse Prevention (CBCAP);*
- *Children's Justice Act (CJA); and*
- *Court Improvement Project (CIP).*

Community-Based Child Abuse Prevention (CBCAP) – Iowa utilizes CBCAP funding in its Iowa Child Abuse Prevention Program, along with PSSF Family Support funding. Utilizing the CBCAP funding in this way supports goals and strategies to prevent child abuse and protect children.

Children's Justice Act (CJA) Grant: Under the Children Justice Act (CJA) Grant, States are required to have established and maintain a State Task Force. In Iowa, the State Task Force is the Child Protection Council. The Council's duties are carried out in accordance with Section 107(a) of the Child Abuse Prevention and Treatment Act as amended by the "CAPTA Reauthorization Act of 2010". The Council is governed by a set of by-laws that stipulates the federal mandates of the State Task Force. As such, it is the duty of the Council to review Iowa's child protection system and to make recommendations to the Iowa Department of Health and Human Services (HHS) on the development, establishment and operation of programs and activities that are designed to improve the child welfare system, and which fall within Section 107(e)(1)(A), (B), and (C) of the Child Abuse Prevention and Treatment Act.

Every three years the Task Force under the CJA grant is required to assess the State's child welfare system and from that review, the Task Force is to develop a set of recommendations on improving the system of delivery for child welfare services as well as, the child protective policies and programs to protect children. The recommendations serve to govern for the next three years, the work of the State Task Force and the activities and initiatives that it supports with CJA funding. The current recommendations of the Child Protection Council are in alignment with and support the goals and objectives of Iowa's Child and Family Services Plan (CFSP) and the outcomes and key initiatives of the State's Child and Family Services Review (CFSR).

To ensure that the members of the Child Protection Council are knowledgeable of and regularly updated as to the work related to Iowa's CFSP and the CFSR the HHS Program Manager who has oversight of these plans is frequently invited to speak at Child Protection Council meetings. Presentations have included an overview of the collaborative effort between federal and state governments in promoting continuous quality improvement in the child welfare system and a description of how states are evaluated relative to the CFSR. Following each presentation, a group discussion is held, and Council members are encouraged to ask questions and to provide feedback.

Council members are regularly invited to participate in individual interviews, focus groups and surveys in support of Iowa's CFSP and the CFSR assessment process.

In addition, HHS Program Managers are invited to speak at Council meetings and present information on current and new HHS child protective programs, initiatives, and services. A discussion follows each presentation in which Council members are able to ask questions and give their feedback on what they believe is the program strengths as well as, the opportunities for improvement in the particular area or program being discussed. Program information and updates are also provided by the Council members themselves. As a member of the Child Protection Council, the Director of Iowa's Court Improvement Project frequently speaks to the group and shares information on the work being done around service coordination and support with HHS and speaks about the mutual goals and strategies they share to prevent child abuse, protect children and improve the safety, permanency and well-being of children and families involved in the child welfare system.

Other system review activities that Council members have engaged in, and which support the CFSP and the CFSR work includes the group's participation in the Iowa's 5-Year Administrative Rules Review with regard to the state's child abuse laws and procedures, a comprehensive review of the HHS Child Abuse Intake Unit in 2021 and two past HHS Case Reviews with regard to the CAPTA/CARA initiative.

Court Improvement Project (CIP): Please see *Section I, Vision and Collaboration, Collaboration* for information about HHS' service coordination and support of mutual goals and strategies with CIP.

SERVICE DESCRIPTION

Provide an assessment of the strengths and gaps in services, including mismatches between available services and family needs as identified through interviews and consultations with families, children, and youth; analysis of available data, including the CFSR results, and consultation with other partners. The state may cross-reference Service Array…rather than including data and an analysis of strengths and concerns in this section.

Please see *Section II: Assessment of Current Performance in Improving Outcomes, Systemic Factors, Service Array* for an assessment of strengths and areas needing improvement in Iowa's child welfare service array.

STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM (TITLE IV-B, SUBPART 1)

HHS will utilize title IV-B, subpart 1, funding as indicated on the CFS-101 for:

- Crisis Intervention (Family Preservation): Family Preservation Services, which is part of the Family-Centered Services (FCS) package;
- Family Reunification Services:
  - Family-Centered Services (FCS) package, except for Family Preservation Services covered above;
- Parent Partner program, which also includes title IV-B, subpart II family preservation and planning funding;
- Foster Care Maintenance:
  - Foster Family & Relative Foster Care
  - Group/Institutional Care

For more information on these services, please see the *Child and Family Services Continuum – Services Description and Coordination* earlier in this section, as noted below:

- Family Centered-Services, pp 134-139
- Parent Partner program, pp 140-146
- Recruitment, Retention, Training, and Supportive Services (RRTS), pp 146-151
- Foster Group Care Services/QRTP, pp 156-160

Services for Children Adopted from Other Countries

Describe the activities that the state plans to take over the next five years to support children adopted from other countries, including the provision of adoption and postadoption supports.

Families who adopt children from other countries will have the ability to access training through Iowa's RRTS contractor. Support groups across the state are also open to any adoptive family, including families who adopt from other countries. Families may receive services through the child welfare system through a CINA assessment or through allegations of abuse or neglect, or through Medicaid based on Medicaid eligibility criteria.

HHS recognizes the need for strong post-adoption supports and services to prevent disruptions and dissolutions of all adoptions, including children adopted from other countries. Limited resources and diverse racial and cultural needs are significant barriers to expanding post-adoption services for families who adopt from other countries. Resources are not limited to available funds, but staff time to develop an array of post-adoption services that can be available to any family. However, HHS will continue to do the following in the next five-year period:

- Work collaboratively with private adoption agencies to identify gaps in services by engaging the Iowa Association of Adoption Agencies in gathering information from families who adopt from other countries and identifying gaps in services.
- Work collaboratively with private adoption agencies to explore creatively how services and supports can assist families who adopt from other countries within current funding and service provision constraints.

Should additional funds become available, HHS will work collaboratively with private adoption agencies to prioritize, develop, and implement services and supports to assist families who adopt from other countries.

Services for Children Under the Age of Five

Describe the activities the state plans to undertake over the next five years to reduce the length of time young children under the age of five are in foster care without a permanent family, and to address the developmental needs of all vulnerable children under age five, including children in foster care, as well as those served in their own homes or in a community-based setting.

Iowa utilizes its child welfare service array to meet the unique needs of children and families served, which includes children under the age of five remaining in the home or in foster care. These services include but are not limited to Family Centered Services (FCS), referrals to Early ACCESS (described below), referral of parents to mental health, substance abuse, domestic violence, employment, and disability services, etc. Another public service available to families is Head Start and Early Head Start. Social work case managers (SWCMs) discuss Head Start and Early Head Start services with families, with the families accessing services through direct application to the programs.

Please see this section, *Child and Family Services Continuum, Family Centered Services* for more information about these services.

The HHS' child protective workers (CPWs), as part of their assessment of child abuse allegations, inclusive of safety and risk assessments, assess the strengths and needs of the children and the family. The HHS' SWCMs build upon the initial assessment of the CPW by:

- working with the family to continually assess the strengths and needs of the children and family;
- connecting the children and family to the appropriate services; and
- monitoring the effectiveness of those services to meet their needs.

The goal is to achieve safety and permanency for these children, in accordance with the Adoption and Safe Families Act (ASFA, P.L. 105-89) guidelines, and achieve child and family well-being. Through clinical case consultation with SWCMs, supervisors provide oversight of the SWCMs' assessment of and provision of age-appropriate services to children. Please see discussions of *Child Abuse Assessments* earlier in this section.

<u>Early ACCESS</u>

Background: The reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) under the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) provides Early Intervention Services for any child under the age of three who is involved in a substantiated case of child abuse or neglect. States must have provisions and procedures in place to refer these children for services. State funding for Early Intervention Services is under Part C of the Individuals with Disabilities Education Improvement Act (IDEA).

Early Intervention Services or Early ACCESS (EA), as the program is referred to in Iowa, was established as a collaborative partnership between three State agencies (Department of Human Services (DHS), Department of Public Health (DPH), Department of Education (DOE)), and the

Child Health Specialty Clinics (CHSC). These agencies and clinics promote, support, and administer EA services. The DOE was the lead agency responsible for administering the program. In 2022 DHS and DPH were merged into one agency and became the Department of Health and Human Servies (HHS). At that time, responsibilities for Early ACCESS liaisons within the agency were considered. A Community Health Consultant resides within the division of Community Access and acts as a liaison with DOE. A CAPTA liaison resides within the bureau of Early Intervention & Support and partners to collaborate with DOE and coordinates CAPTA referrals from HHS to EA services.

Eligibility: EA services are available to any child in Iowa from birth to three years old who demonstrate a 25% developmental delay or who has a known medical, emotional, or physical condition in which there is a high probability of future developmental delays. In response to the Child Abuse Prevention and Treatment Act (CAPTA) under the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), HHS refers any child under the age of three who: a) is the subject of a substantiated case of child abuse or neglect, b) is identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, and/or c) who is identified as developmentally delayed. Infants that fall under the 2016 Comprehensive Addiction and Recovery Act (CARA) are also eligible for a referral to EA. This population includes infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. This includes infants born with and identified as affected by all substance abuse, not just illegal substance abuse.

HHS has committed to ongoing review of data and implementation of continuous quality improvement efforts related to Early ACCESS. In particular, the following strategies have been identified to support efforts related to engagement of families involved with child welfare services:

- Develop a human-centered solution to meet the legal obligations of the referral process while ensuring family engagement.
- Develop educational materials about the program based on parent feedback.
- Offer periodic opportunities to engage parents and caregivers. Utilize Early Periodic Screening, Diagnosis and Treatment (EPSDT) and wellness appointments as additional screening opportunities.
- Build HHS processes to connect services to other family members. Establish the screening tool and screening criteria for children in K-12.
- Build a process for ensuring enrollment of children 2.75 to 5 years in early education. Ensure Early ACCESS screening and Individual Education Plan (IEP) follow-up.
- Build comprehensive HHS referral processes for families and children in the system. Identify the top 5 early childhood services that are needed.
- Build a process for tracking service acceptance and implement follow-up procedures.
- Work with Medicaid to improve billing for early childhood and school-based services.

Additional context related to Early ACCESS includes legislative changes passed in 2024 that are scheduled to take effect July 1, 2025. These changes include redirection of a portion of funds for special education that are currently received by Area Education Agencies (AEA) to be directed to school districts. This change does not include funds for Early ACCESS, however, there may be indirect impacts to the program. There are anticipated impacts to staffing levels for AEA staff serving children under Part B. Some specialist positions funded through Part B also serve children under Part C, such as Occupational, Physical, and Speech therapists. Specific

changes are not known at this time, and additional information and details on AEA budgets/plans are anticipated over the coming year.

Review of recent service data and program trends has led to the prioritization of the following goal areas for focus over the next several years:

- Improve Early ACCESS enrollment rates for children identified through CAPTA referral. Given the downward trend of service acceptance, this is a primary focus, and the program will strive to continue to understand factors impacting engagement and enrollment and identify strategies (including those listed above) to improve upon building relationships with families and promoting services available.
- Continue to assess opportunities to improve upon current referral processes utilizing the portal on the Iowa Family Support. Utilize feedback from HHS staff, AEA providers, and input from families both served in EA and those declining services to identify enhancements for outreach, technology, communications timing, etc.
- Enhance data utilization. In particular, analyzing data related to referral closure, acceptance, and data on families initially declining services, and then are later re-referred. Improve usage of data visualization tools to communicate program outcomes and ensure data continues to drive decision-making.
- Gather and/or develop resources for families not enrolled to aid in supporting child development. Make available to families whose children are screened, but do not qualify for EA services due to child being developmentally on track or who are otherwise ineligible or unable to participate in services.

Please see Iowa's FFY 2020-2024 CFSP Final Report for information on the data reviewed.

Additional Services

Early Childhood Iowa

Early Childhood Iowa (ECI) was founded on the premise that communities and state government can work together to improve the well-being of our youngest children. The initiative is an alliance of stakeholders in Early Care, Health, and Education system that affect a child prenatal to 5 years of age in the state of Iowa. In 2024 the ECI Stakeholders Alliance, as identified in Iowa Code § 256I.12, was repealed. As a result, the intention of the alliance will be directly linked from the ECI State Board. ECI's efforts will continue to prioritize strategies to unite agencies, organizations and community partners from the public and private sectors to speak with a shared voice to support, strengthen and meet the needs of all young children and families. ECI's hub of resources was reconfigured towards the end of 2023 to align website content with the new Iowa Department of Health and Human Services' (HHS) website. Information related to ECI can now be found at https://hhs.iowa.gov/programs/programs-and-services/eci.

In previous reports there were overviews of active public and private component groups. An example of one of these groups included the ECI Results Accountability component group. This past year the group has evolved to serve as a public and private stakeholder group to advise the ECI State Board's state approved statewide indicators to help systems gauge population-based status of indicators that impact ECI's legislated five result areas. Page 17 of the SFY 2023 ECI Annual Report provides an overview of the five result areas and statewide indicators.

In addition to populating the annual population-based status of statewide indicators, the ECI Results Accountability component group actively serves as an advisory group for Iowa's Integrated Data System for Decision-Making (I2D2). I2D2 is a state and university partnership with mutually approved governance documents and nationally recognized data security protocols. I2D2 is still an active member of the University of Pennsylvania's, Actionable Intelligence for Social Policy (AISP) national IDS network (http://www.aisp.upenn.edu/).

During the past year I2D2 was utilized to collect childcare workforce data. As a result, the 2023 Child Care Workforce Study was finalized and information sharing is on-going to interested stakeholder groups and policy-oriented state leadership groups. I2D2's strengths are vast in the ability to securely collect and/or integrate secure data sets to inform evolving system questions; all pending case-by-case approved data sharing and data use agreements. Beyond state approved publications from I2D2 is the IA Data Drive. The IA Data Drive provides county-level data aligned with the statewide indicators, evolving data sets specific to identifying various risk factors for populations, and integration of various population level data sets to jointly inform county-level factors of need or risk.

In addition to workforce data, I2D2 has helped Iowa's early childhood system gain feedback from families statewide. In previous reports the ECI Family Engagement component group was highlighted due to their efforts of a survey of state funded family support home visitation programs. This population was identified as an established service array with established trust among participating families. Extending beyond families receiving family support home visitation services was the opportunity to distribute a statewide survey for families with children prenatal through age five in 2019. The survey was established via the state and university partnership with Iowa State University's I2D2 team. A Qualtrics survey was established and distributed across early childhood system networks. This was replicated in 2022 with additional questions to better understand trends of needs families experience on an on-going and evolving basis. The family survey responses were utilized to inform ECI's current strategic plan and service types local ECI areas can select from to invest in opportunities to strengthen their communities.

Based on the 2022 statewide needs assessment, ECI local areas increased their investments to provide mental health consultation to enhance the quality and capacity of Iowa's early childhood professionals providing family support home visitation services and/or childcare. The goal is to enhance the early childhood workforce's response to better meet the social, emotional, and behavioral needs of young children and their families. To increase a formal workforce preparedness pathway there are two separate credentials that can be earned by anyone working with, or on behalf of, very young children and their families. These credentials focus on strengthening and supporting early relationships that are crucial to a child's social and emotional development. These endorsements, Infant Mental Health Endorsement ® (IMH-E ®) and Early Childhood Mental Health Endorsement ® (ECMH-E ®) signify an early childhood provider has acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, and other caregivers and families. Establishing an infrastructure of early childhood workforce development opportunities to recognize and infuse the endorsement into preservice and in-service professional development has been a struggle. In 2023 there were 36 individuals who participated in direct endorsement application assistance from the ECI funded endorsement coordinator. The participation in training opportunities is

utilized but applying for a full endorsement and completing associated requirements is not as highly sought out.

Infant and Early Childhood Mental Health Consultation/Young Child Wellness Council

The relationships and attachment that infants and toddlers experience with their primary caregivers heavily influences mental health outcomes across the lifespan. To promote healthy infant and early childhood mental health, HHS is planning to do the following over the next several years.

- **Strategy 1:** Implement Visit Host Approach
  - To support infant and early childhood mental health, HHS will begin implementing a Visit Host approach for families participating in Iowa's Infant Toddler Court Program (ITCP) as a way of supporting positive relationships and healthy attachment. This approach is designed to engage families' natural supports (extended family, friends, neighbors, clergy, etc.) who already have a positive relationship with the family and are committed to supporting safe, stable and nurturing relationships among the family unit. Visit Hosts who have been identified and vetted, work in partnership with child welfare staff to ensure that Family Time is occurring frequently, consistently, and authentically, thereby reducing trauma and moving families more quickly towards reunification and permanency. Additionally, this approach significantly reduces workload for child welfare staff and other professional supports.
    - **Goal 1:** By 12/31/24, a Family Time Coordinator will be subcontracted under the Infant Toddler Court grant, and policies and procedures for identifying, vetting and training Visit Hosts will be in place.
    - **Goal 2:** By 6/30/25, at least 8 Visit Host facilitators will be vetted and actively supervising frequent and consistent family interactions for infants and toddlers enrolled in Iowa's Infant Toddler Court program.
    - **Goal 3:** By 6/30/29, at least 40 Visit Host facilitators will have been vetted and actively engaged to supervise frequent and consistent family interactions for infants and toddlers enrolled in Iowa's Infant Toddler Court program.
    - **Goal 4:** By 6/30/29, reunification rates for infants and toddlers enrolled in the Infant Toddler Court program will increase by 5%.
- **Strategy 2:** Provide training to Iowa child welfare staff regarding how relationships, attachment and trauma in early childhood impact child development and well-being, as well as strategies for fostering safe, supportive, and nurturing relationships.
  - To increase professional competencies and support HHS staff in understanding infant and early childhood mental health, staff from the Bureau of Child Welfare and Community Services will work collaboratively with the Service Help Desk to coordinate an optional staff "lunch and learn" virtual training event every six months. Topics to be addressed include early childhood brain development, attachment, trauma, principles of infant mental health, benefits of Reflective Consultation, and resilience capacity.
    - **Goal 1:** By 12/31/24, a structure and plan for supporting HHS staff training on the topic of infant and early childhood mental health will be developed and ready for implementation.

- **Goal 2:** By 6/30/29, at least 8 voluntary lunch and learn sessions on topics related to infant and early childhood mental health will be offered to HHS staff virtually.
- **Goal 3:** By 6/30/29, at least 80% of survey participants will agree or strongly agree that the content of the training events increased their capacity to serve families more effectively.

- **Strategy 3:** Implementation of Sobriety, Treatment, and Recovery Teams (START) Model

Sobriety, Treatment, and Recovery Teams (START)

Model Overview and Rationale: In 2024, Iowa HHS will begin implementation of the evidence-based Sobriety, Treatment and Recovery Teams (START) approach to child welfare delivery for children birth through five and their families. START is a specialized model that has been shown, when implemented with fidelity, to improve outcomes for very young children and their families who are impacted by both parental substance use and child maltreatment. This model emphasizes the importance of collaboration, and systems change across partners, including child welfare agencies, the court system and mental health (MH) and substance use disorder (SUD) treatment providers, to better support families of young children. The START model is designed to serve families involved in the child welfare system with at least one child aged 5 or younger, and one parent diagnosed with a substance use disorder. Overarching goals of START are to ensure child safety and well-being, prevent and/or decrease out-of-home placements, increase parental recovery, increase parenting capacity and family stability, reduce repeat child maltreatment, and improve system capacity for addressing parental substance use and child maltreatment, aligning very closely with the goals of CFSR and CFSP.

START meets the needs of Iowa's child welfare system based upon the following criteria:

- START is an evidence-based practice model that is listed on the Title IV-E Prevention Services Clearinghouse, which would allow Iowa to draw down additional federal prevention funds.
- Most of Iowa's open service cases fit the age group of children ages birth through five.
- A significant percentage of those cases involve parents diagnosed with a substance use disorder.

Although HHS could potentially find another curriculum/program model that addresses parental substance misuse, we would not be able to draw down federal funds, and would therefore, not be able to expand and sustain the initiative long term.

Background: HHS staff completed a search of the Title IV-E Prevention Services Clearinghouse to identify an evidence-based practice model that met the needs of Iowa's child welfare system. The Title IV-E Prevention Services Clearinghouse maintains an updated list of evaluated and tested prevention services and programs. Of the 14 evidence-based practices that address substance use disorders on the Clearinghouse, the national START model is the only model to be rated based on child permanency to avoid out-of-home placement. Other models exist, but they are specific to African American families, youth substance misuse, or parental substance misuse without specific programming to avoid out-of-home placement. The

intent of implementing START is to decrease removals of Iowa's youngest and most vulnerable children.

Contractor and Previous Work: HHS will be contracting with Children and Family Futures (CFF), a nonprofit organization and the proprietary owner of all START materials (including the manual, training curriculum, certification process, and documents). CFF is the only national resource center able to provide training and technical assistance on implementation of the START model. Leadership within the Bureau of Child Welfare Services and Community Supports, and the Division of Family Well-Being and Protection, began exploring START in early 2023, after comparing the model with other evidence-based programs.

In the summer of 2023, HHS entered into an exploratory contract with CFF to examine the model more closely, to facilitate stakeholder conversations and to provide foundational training to identified partners. Throughout the contract, CFF facilitated meetings of an exploratory planning committee to address feasibility of model adoption, site readiness and selection, staffing considerations, potential programmatic issues, alignment with other initiatives, program evaluation, sustainability, and continuous quality improvement. The contractor also provided foundational training to interested community stakeholders about the model as well as anticipated program outcomes, and created a crosswalk document that identifies how START aligns with existing Iowa initiatives (Parent Partners, Safe Babies, Family Treatment Courts and Infusion Courts). Response to this model was positive, and HHS leadership decided to move forward with a contract for implementation. The initial intent is to begin implementing START in two pilot sites (to be selected by the START Steering Committee), with the possibility of expanding to additional sites in the future.

Essential Components: The START model includes a total of eleven Essential Components that must be implemented to fidelity. Five of these components relate to infrastructure, and six components relate to practice. Those components are:

- Child Welfare Based: Services are initiated by, and based in, child welfare for families with the presenting issue of both parental substance use and child maltreatment.
- Collaboration with Partners: A strong collaborative partnership with treatment providers for SUD, co-occurring MH, and other family serving entities is required to develop a coordinated system-of-care.
- Family Mentors: Family mentors are people in long-term recovery from a SUD with experiences that sensitize them to child welfare. Family mentors have a similar role to Iowa's Parent Partner initiative, with an emphasis on a history of SUD.
- The START Dyad: One family mentor is paired with one child welfare worker to form a dyad.
- Program Evaluation: Local and state START jurisdictions must be engaged in continuous quality improvement guided by program evaluation data.
- The START Timeline: START adheres to a rapid timeline that ensures early identification of eligible families after the initial child welfare report and quick access and early retention in SUD/MH treatment services.
- Minimum Work Guidelines: Child welfare staff must meet the START minimum work guidelines that represent a more intensive approach to service delivery than traditional child welfare practice.

- Substance Use and Mental Health Disorder Treatment: Treatment providers use current best practices and evidence-supported interventions in SUD and co-occurring mental health and trauma treatment.
- Shared Decision Making: START must use shared decision-making with families, child welfare staff, and service providers.
- Unifying Families: START keeps children safely with their parents or family whenever possible or reunifies the family when parental recovery is stable and safety factors have been remediated.
- Family-Centered Intervention: START views the family unit as the client and the focus of the entire team and aims to promote a nurturing parent-child relationship and improved parenting capacity.

Approach and National Outcomes: Training and technical assistance activities provided by CFF shall include assisting the state planning team with selecting appropriate implementation sites, providing guidance with developing the program evaluation plan, providing virtual and on-site training, providing direct assistance to selected sites to support implementation, facilitating planning meetings, meeting with HHS leadership, and developing an Iowa START toolkit. Initially, HHS intends to implement START in two pilot sites, and expand to additional sites in the future. Site selection will be determined by the Steering Committee, based upon community interest and readiness.

Evaluation will be an important part of this work. Iowa HHS will contract with a local evaluator to monitor progress of implementation and assess program outcomes. CFF will provide technical assistance on the development of Iowa's evaluation plan. Established outcomes of the START model are remarkable. National evaluation efforts demonstrate that children in START entered out- of-home placement at half the rate of children from a matched comparison group (21% vs. 42%); in addition, mothers in START had higher rates of sobriety and early recovery than a matched comparison group (66% vs. 37%). At case closure, more than 75% of children in START remained with, or were reunified with, their parent. It is estimated that for every $1.00 spent on START, jurisdictions potentially saved $2.22 on costs associated with out-of-home placement.

Activities: Initial activities that will be included in implementation include regular meetings of the statewide START Steering Committee, meetings between HHS leadership and CFF staff to ensure adequate progress, development of an Iowa-specific Toolkit for implementation, site selection activities, evaluation and continuous quality improvement, and training for key stakeholders. Once sites are selected, CFF will provide direct assistance to each site to help develop workforce capacity and community buy-in, offer site level technical assistance, onsite training, and material development. Much of this work will be led by staff from CFF and the HHS Project Director.

Alignment with CFSP: The START initiative aligns very closely with the HHS goals and objectives for the 2025 – 2029 CFSP. Each element of START is designed to promote child safety, permanency and well-being. The model places an emphasis on keeping children safely with their family whenever possible and works to reunify the family once parental recovery is stable and safety factors have been remediated. START provides opportunity for parent voice,

utilizing a shared decision-making process, as well as a family-centered approach through the HHS staff/family mentor dyad. The family mentor brings their own lived experiences to the team and is able to identify both progress in recovery as well as potential relapse behaviors. A dedicated and unified dyad is important to provide consistent messaging, oversight, family contacts, and service delivery. Both partners bring their unique perspectives, complement each other, and evolve as a team.

FFY 2025-2029 Goals: The following are implementation goals for SMART:

- **Goal 1:** By 6/30/25, at least six trainings shall be provided to key staff and stakeholders regarding the START model and relevant topics (such as safety and risk assessment, language, etc.)
- **Goal 2:** By 6/30/26, an Iowa START Toolkit shall be developed and distributed, based on national START standards.
- **Goal 3:** By 6/30/29, at least three local implementation sites will be fully trained and directly implementing the START model.
- **Goal 4:** By 6/30/29, evaluation data will indicate that rates of out of home placement for children in START will decrease by 5% over baseline.

Efforts to Track and Prevent Child Maltreatment Deaths

- *Describe the steps the state is taking to compile complete and accurate information on child maltreatment deaths to be reported to the National Child and Abuse and Neglect Data System (NCANDS), including gathering information fatalities from relevant state organizations, such as the state vital statistics department, child death review teams, law enforcement agencies, or offices of medical examiners, or coroners. The information reported in the CFSP should be developed in consultation with officials responsible for submitting the state's annual NCANDS Agency File to ensure that all information reported to CB is complete and accurate.*
- *Describe the steps the state is taking or has taken to develop and implement a comprehensive, statewide plan to prevent child maltreatment fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts. Provide a copy of, or link to, the state's plan, if available.*

Steps Iowa Is Taking to Track Child Maltreatment Deaths

Iowa HHS compiles complete and accurate information regarding child maltreatment deaths on every report of suspected abuse accepted for a Child Protective Assessment (CPA). As part of a CPA involving a child fatality or near fatality, the assigned Child Protection Worker (CPW) conducts a joint assessment/investigation with law enforcement, utilizes a Child Protection/Advocacy Center for forensic interviews and medical exams as needed, and consults with the medical examiner's office (many times through or in conjunction with law enforcement) to exchange information learned in the assessment/investigation that may assist the medical examiner in determining cause and manner of death. Because law enforcement generally takes the lead on joint child death assessment/investigations, they generally provide the documentation to Vital Statistics to record the child's death.

As the CPW completes their CPA report within the Statewide Tracking of Assessment Reports (STAR) module within JARVIS, Iowa's Child Welfare Information System, they are required to document a fatality type. The CPW must choose the most appropriate fatality type for each child victim listed in the CPA. If the child victim is deceased, the date of the child's death is also captured within the system.

The fatality types include:

- Not Fatal
- Near Fatality (defined in CATPA section 106(b)(4)(A), as "an act that, as certified by a physician, places the child in serious or critical condition")
- Fatal – Abuse a Contributing Factor
- Fatal – Result of Abuse

In preparation for the annual submission to the National Child Abuse and Neglect Data System (NCANDS), HHS completes a manual review of all child maltreatment fatalities. Child maltreatment fatalities include fatalities resulting from abuse or with abuse as a contributing factor. The review is completed to confirm that the results are accurate and that they are not duplicative. Following the review, all child maltreatment fatalities are further analyzed to capture data regarding the cause of death, age of the child victim, and other relevant factors.

Fourteen child fatalities were the result of abuse or abuse as a contributing factor in FFY23. A state review of the maltreatment death data indicated unsafe sleep made up half (seven) of all child maltreatment deaths, involving infants between one and eight months of age. In four of these instances, a parent or relative was co-sleeping with the infant on an adult bed. In two instances, the child was placed in spaces not intended for sleep, namely a couch and a car seat. The final instance involved an in-home child care provider who placed an infant on their tummy in a pack and play and left them unsupervised.

Physical abuse attributed to just over one-quarter (four) of all child maltreatment deaths. Two of these physical abuse incidents were caused by parents, a third was caused by an in-home child care provider, and the final incident was caused by the father of a friend to the mother. The physical abuse incidents involved children between one day and one year of age.

Inadequate medical care accounted for one of all child maltreatment deaths, involving a child who was just born, left without any care provided, and discarded in a ditch after two days. The mother and maternal grandfather were the persons responsible.

An accidental gunshot accounted for one of all child maltreatment deaths, involving a six-year-old child who accessed a gun in the family home and shot himself in the head. The parents were the persons responsible.

Asphyxiation accounted for the final of all child maltreatment deaths, involving a nine-month-old child who was unsupervised for a period of time and choked on their food. An in-home child care provider was the person responsible.

When considering whether any child maltreatment deaths included a history of HHS services, it was determined that five of the child maltreatment deaths had both CPA and service history, one had CPA history only (no service history), and eight had no CPA or service history.

Table 4j: Summary of Child Maltreatment Deaths					
Unsafe Sleep	**Physical Abuse**	**Inadequate Medical Care**	**Accidental Gunshot**	**Asphyxiation**	**Total**
7 (50%)	4 (29%)	1 (7%)	1 (7%)	1 (7%)	14 (100%)

Note: Motor Vehicle Accident, Suicide, Drowning, Ingested Drug, and Hot Car = 0 child maltreatment deaths

Steps Iowa Is Taking to Prevent Child Maltreatment Deaths

Since 1995, the Iowa Child Death Review Team has "aided in the reduction of preventable deaths of children under the age of eighteen years through the identification of unsafe consumer products; identification of unsafe environments; identification of factors that play a role in accidents, homicides and suicides which may be eliminated or counteracted; and promotion of communication, discussion, cooperation, and exchange of ideas and information among agencies investigating child deaths".

Currently, the Iowa Child Death Review Team is comprised of 14 different disciplines with expertise deemed as valuable in the review of child fatalities. Liaisons from 5 state agencies are also designated to assist the team in fulfilling its responsibilities. The HHS liaison reviews child abuse data available in JARVIS, the Child Welfare Information System, for each child death and prepares case records regarding each child. The liaison also attends all review team meetings and sub-committee meetings as needed.

Additionally, the Iowa Child Death Review Team developed protocols for Child Fatality Review Committees (641 IAC § 92), which the state medical examiner appoints on an ad hoc basis, to immediately review the child abuse assessments which involve the fatality of a child under age eighteen. The purpose of the Child Fatality Review Committee is for system improvement that may aide in reducing the likelihood of child death.

It is important to note that in the 2024 Iowa Legislative Session, SF 2385 was signed into law, merging or eliminating many boards and commissions, including the merger of the Iowa Child Death Review Team and the Domestic Abuse Death Review Team into one State Mortality Review Committee. The details of how this merger will be operationalized is still in the planning phase.

To prevent child maltreatment deaths, the data resulting from each years reviews must be analyzed. The data tells us that the majority of Iowa children die by natural means, which includes prematurity, congenital anomalies, infections, cancers, and other illnesses. Natural manners of death are not child abuse and do not meet standards for reporting. In 2019 data (reviewed in 2022-2023), for example, 68 natural deaths comprised 59.4% of all Iowa child deaths. This was a significant decrease in the overall number of natural deaths over the last several years.

The Iowa Child Death Review Team considers other manners of death, such as accidents, suicides, homicides, and undetermined deaths as preventable. The 2019 data reveals accidents claimed the lives of 53 (20.8%) Iowa children, while 35 (18.2%) were undetermined, 24 (14.1%) were suicides, and 8 (4.2%) were homicides. The official manner of death for the remaining 4 (2.1%) were unknown or missing.

Because a child death review does not occur until all assessments, investigations, and data collection are completed, the Iowa Child Death Review Team typically reviews cases from the previous year, with the Annual Report released by the Iowa Office of the State Medical Examiner thereafter. Work to review the child deaths which in occurred in 2019 was completed throughout 2022 and 2023. The most recent report was completed in December 2023, encompassing those deaths that occurred in 2019. This report was distributed to the Governor's Office, the Legislature, and various stakeholders and is available in the attached pdf.

2022-2023 CDRT
Annual Report of 2C

While a summary of child death by demographics is available within the report, suicides and sleep-related and Sudden Unexpected Infant deaths were highlighted as two categories with recurrent identifiable risk factors that could reduce the number of child deaths.

Additional work to prevent child maltreatment deaths occurred following a significant number of child fatalities resulting from unsafe sleep environments. Because these deaths were believed to be completely preventable, the Child Death Review Team convened a subcommittee to create a Statewide Safe Sleep campaign. This campaign, which continues as a workgroup that meets monthly to promote Safe Sleep, was highlighted in the 2015-2019 CFSP and annual report.

To be more intentional about what HHS was doing internally, an HHS Safe Sleep Initiative began by creating a Safe Sleep Workgroup comprised of HHS staff from both central office and field as well as contracted partners.

As a result of the work from this initiative, HHS added a Safe Sleep webpage to the agency's website: Safe Infant Sleep | Health & Human Services (iowa.gov). This webpage provides the very basic A, B, Cs of safe sleep and identifies additional resources to obtain more information, research, data, and educational materials. The webpage lays ground for the Safe Sleep Strategic Plan for HHS practice changes. Additionally, HHS has made progress in implement the Safe Sleep Strategic Plan by completing Safe Sleep specific training for all HHS staff and contractors and providing a Safe Sleep Toolkit, in effort to prevent and reduce child maltreatment deaths.

Additional details on the HHS Safe Sleep Initiative and the work that is being done to prevent child maltreatment deaths can be found in the annual report for the Child Abuse Prevention and Treatment Act State Grant.

Finally, Iowa has officially joined the National Partnership for Child Safety (NPCS). Child welfare has a history of being punitive and reactive. The harsh and critical reactions child welfare receive facilitates "risk adverse" decisions and a "hide the mistakes" culture. Shifting the culture to promote transparency and self-reflection, and out of a punitive, blaming/shaming dynamic, requires that we move away from a culture of fear and promote psychological safety.

NPCS is a member-owned, member-directed, peer-to-peer learning model. The community has invested resources to help refine the science of safety and improvement into a tool in the development of system enhancement. Collaborative models, such as this, have been used to improve safety in hospitals, aviation, and nuclear safety.

Iowa will be leaning into the expertise of NPCS to learn a better way to methodically learn from errors, develop a culture of safety, and embrace the opportunity to be a self-correcting team. One of the areas this work will impact is the way in which HHS currently conducts internal critical incident reviews, most of which involve child fatalities. Please see the Team First Field Guide, 2023 Safety Culture Survey Scales, and the Critical Incident Review Values, Principles, and Mindset documents attached for more detail.


TeamFirst FieldGuide_01.2020.


2023 Safety Culture Survey Scales.docx


Critical Incident Review Values, Princ

To kick off this work, NPCS completed a site visit on March 6, 2024 and the documents included above were shared with HHS in advance. The leaders of NPCS met with HHS Child Protective Services leadership team and the HHS executive leadership team. Michael Cull, the Associate Director at the University of Kentucky at the Center for Innovation in Population Health, led the onsite meeting.

MARYLEE ALLEN PROMOTING SAFE AND STABLE FAMILIES (PSSF) (TITLE IV-B, SUBPART 2)

Family Preservation Services

Iowa received approval from the federal Children's Bureau in 2007 to allocate less than 20% of Promoting Safe and Stable Families (PSSF) funding for family preservation services. Iowa's family preservation services are currently our Family Centered Services (FCS) available statewide. Iowa utilizes a combination of state and federal IV-B, subpart 1 and subpart 2 (Family Preservation), SSBG, TANF, and Medicaid funds for FCS.

For more information about FCS, please see *Family Centered Services,* pages 134-139.

Wrap-Around Emergency Services

The five HHS service areas receive PSSF funds to provide flexible funding for services to low-income families who would have their infants or children returned to their care but for the lack of

such items as diapers, utility hook-up fees, beds or cribs, or house cleaning or rent deposits on apartments, etc. Additionally, service areas may utilize these funds to provide services to allow children to remain in the home, such as mental health and/or substance abuse treatment for children or parents, etc. Usage of these funds supports program goals of assuring safety of children within the home and addressing barriers to reunification.

Family Support Services

Iowa utilizes PSSF Family Support Services funding for the Iowa Child Abuse Prevention Program (ICAPP). For more information on ICAPP, please see *Early Intervention and Support Prevention Programs and Services, Iowa Child Abuse Prevention Program (ICAPP*), pages 109-112.

Family Reunification Services

Iowa allocates PSSF dollars to Family Reunification Services. HHS central office staff removes some of the funding, usually allocated to the five HHS services areas, to include in the Family Centered Services (FCS) contracts. HHS utilizes these funds, in addition to IV-B, subpart 1 funds, in the FCS contracts because the contracts include services to support reunification, such as facilitation of Family Focused Meetings (FFM). Central office staff then allocates the balance to the service areas based upon historical allocations and service area needs. All services to children and their families remain traceable to the eligible child. Service areas determine utilization of the funds they receive and sub-contract with service providers. In some of the service areas, the service area's Decategorization (Decat) committee has responsibility for projects funded under Family Reunification Services.

Services from the following menu are available to children and families, including relative caregivers, during the child's foster care stay and up to 15 months after the child reunifies with the parents or relatives. These services promote the program goal of safe and timely reunification of the child with the family and prevention of foster care re-entry.

Iowa's Family Reunification Services "Menu":

- **Access and Visitation Services** – Supervision of visits between the child and their parents and/or siblings that may be provided by child and family advocates or other contracted providers, including costs associated with transportation connected with the supervision of visits.
- **Child Welfare Mediation Services** – a dispute resolution process seeking to enhance safety, permanency, and well-being for children. When two or more parties are "stuck" on a position, HHS staff uses mediation to help get them "unstuck". The goal of mediation is a fair, balanced and peaceful solution that allows the parties to move forward. Child Welfare Mediation cases often involve children in the middle or children whose parents need help with establishing parenting plans, often with the custodial and/or non-custodial parent. Mediation typically involves about six hours of billable time and sixty days of service.
- **Substance Abuse Services (not paid for by public or private insurance)** – Evaluations, treatment (inpatient, residential, or outpatient), and medications, includes client's co-pays and co-insurance.
- **Mental Health Services (not paid for by public or private insurance)** – Evaluations, including psychosocial, psychological, and psychiatric, and treatment, including therapy (individual, family and/or group), medications, and client's co-pays and co-insurance.

- **Substance Abuse and Mental Health Services Combined (not paid for by public or private insurance)**. Group and home substance abuse services combined with mental health services, includes client's co-pays and co-insurance.
- **Domestic Violence Services**.
- **Daycare, Respite Care, and Therapeutic Camps (not paid for by childcare assistance, HCBS waivers, or other assistance programs)** Includes daycare settings, therapeutic camps and summer camps, crisis nurseries, respite, etc.
- **Fatherhood Programs, including Incarcerated Fathers** – more extensive, intensive and targeted services to assure that fathers, including incarcerated fathers, maintain a positive on-going presence in their child's life, includes support groups.
- **Motherhood Programs, including Moms Off Meth groups and Incarcerated Mothers** – programs and support groups specifically for mothers, including support groups for mothers with past drug usage problems.
- **Transportation Services –** Contracts with transportation service companies, gas cards, bus passes, etc. that enable children and parents to access services above, includes child and family advocates providing transportation for services above other than visits they supervise.

Table 4k: PSSF Family Reunification Expenditures

Services	2020	2021	2022	2023	2024 (7/1/23 – 3/31/24)
Access and Visitation Services	39%	28%	45%	27%	70%
All Other Counseling	34%	26%	10%	15%	13%
Substance Abuse (SA) Services	6%	3%	3%	1%	-----
Mental Health (MH) Services	1%	28%	31%	43%	8%
SA and MH Services Combined	------	------	------	------	-----
Transportation	------	1%	------	1%	-----
Domestic Violence Assistance	------	------	------	1%	-----
Fatherhood Programs	4%	2%	9%	------	4%*
Motherhood Programs	16%	9%	1%	------	-----
Daycare, Respite Care, and Therapeutic Camps	------	2%	1%	1%	5%

Source: HHS; *Listed as Parent/Family Supports

Adoption Promotion and Supportive Services

Iowa's Recruitment, Retention, Training, and Supports (RRTS) contractor, Four Oaks Family Connections continues to engage Iowa foster, adoptive and kinship providers by providing direct service in their homes for licensing and support, having monthly contact at a minimum for all licensed foster and adoptive homes when a child is placed in the home. A new five-year contract went into effect on July 1, 2023. The contacts include face-to- face meetings in their

homes, as well as additional face-to-face contacts at support group meetings and trainings. Support Caseworkers assist adoptive families in connecting with needed supports and services. The Support Caseworkers also maintains contact with providers and HHS workers as needed for updates or to problem solve a situation and assist the family through the adoption process. These supports remain in place until an adoption is finalized. RRTS Support Caseworkers also meet every other month with approved adoptive families even when a child is not placed in the home to discuss opportunities to take placement of children and sibling groups currently available for adoption. It is hoped this will result in timelier and higher-quality adoption matches.

Iowa HHS strongly supports keeping children within their families and communities of origin. HHS continues to encourage more relative and fictive kin caregivers to become licensed foster or adoptive parents. Licensure brings increased financial assistance, concrete supports and training that unlicensed caregivers do not receive. Iowa plans to implement a kinship licensure process in the next reporting period. Iowa HHS plans to work with Four Oaks and collaborate to develop a path to licensure that will work for Iowa kinship families. Feedback with stakeholders and Iowa families regarding this process was sought through the RFP process as well as regular contact with RRTS staff.

Iowa will continue to support quality post adoption and guardianship services through the RRTS contract. Once an adoption is finalized, RRTS offers post adoption supports, which are available to all adoptive families who adopted children and receive or are eligible to receive adoption subsidy. This does include a future need adoption subsidy agreement. Support services are voluntary, and families can self-refer. Referrals can also come from HHS or any community partner working with the family/child. Services are free of charge to the family and may be provided in the family's home. In July 2023 a new RRTS contract with Four Oaks Family Connections was implemented for adoption services which included a more robust and extensive adoption supportive services to better serve Iowa's adoptive families. Families are eligible for services who receive future or special needs adoption subsidy as well as families who received a subsidized guardianship subsidy.

Collaboration: Iowa began a relationship with Reel Hope a private non-profit agency in February 2024 to add additional adoption recruitment services to match Iowa's awaiting children. The Reel Hope Project's goal is to create *a* video for all youth in Iowa who are experiencing foster care and awaiting an adoptive family. Each reel is specific to the child and shows what makes each waiting child unique. These videos are being used as active recruitment by Iowa HHS workers to seek out permanent families and connections for these children. Iowa hopes to continue into the next reporting period with active efforts to seek out and find quality adoptive homes for children to minimize the length of stay in foster care. It is also important that the match for children is a good one to prevent re-entry into the child welfare system after adoption.

Internal Agency Collaboration: The HHS adoption program manager will continue to collaborate with agency staff through "Adoption Summits." The Summit is intended to be an exchange of information with statewide adoption SWCM's, supervisors as well as the Iowa Attorney General's office. These Summits assist with providing the most accurate and current information to the persons who are working directly with families. The Summit also includes worker collaboration and relationship building. Workers were able to share ideas and practices for difficult case situations. Iowa has had three Iowa Adoption Summits. Feedback for these

events has been very positive from attendees and Iowa hopes to continue these events into the next reporting period.

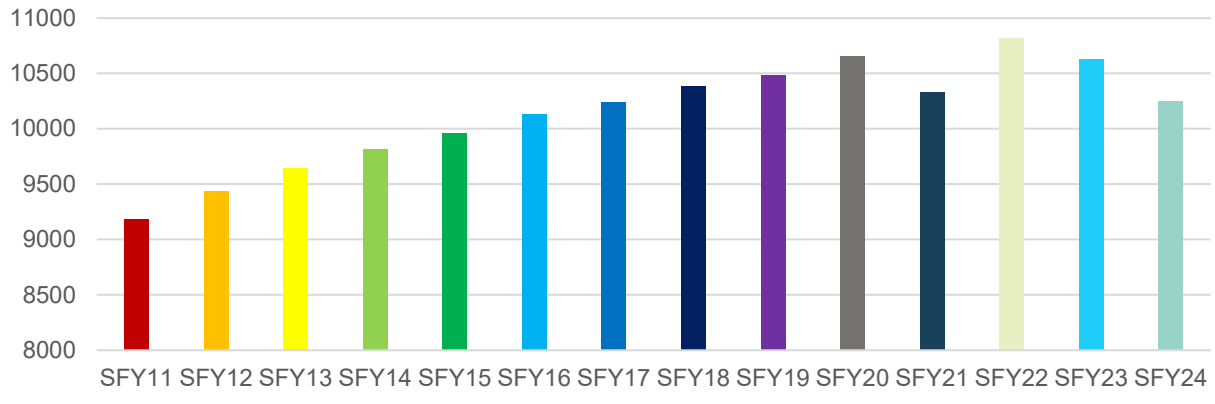
The HHS adoption program manager will continue to hold regular communication with Iowa's HHS adoption workers and Supervisors into the next reporting period.

For more information on *Recruitment, Retention, Training, and Supports (RRTS)*, please see pages 146-151.

Adoption Subsidy Program

When a child adopted from the child welfare system has a special need, HHS provides on-going support and services through the adoption subsidy program. Approximately 83% of all children adopted through HHS have a special needs adoption subsidy agreement, and an additional 17% are eligible for an at-risk agreement, which means the child is at risk of developing a qualifying condition or disability in the future based on the child and family history.

Chart 4a: Number of Children Receiving an Adoption Subsidy Payment by State Fiscal Year



Service Decision-Making Process for Family Support Services

Please see *Early Intervention and Support Prevention Programs and Services* as well as *Iowa Child Abuse Prevention Program (ICAPP)* for information on the service decision-making process for family support services.

Populations at Greatest Risk of Maltreatment

Identify and describe which populations are at the greatest risk of maltreatment, how the state identifies these populations and how services will be targeted to those populations over the next five years.

HHS staff re-assessed the populations at greatest risk of maltreatment and completed a new needs assessment report in February 2024. This assessment occurred in preparation for the new Request for Proposals (RFP) for the Iowa Child Abuse Prevention Program (ICAPP), to be

released in November 2024. To better understand how the risk of child maltreatment varies across Iowa, a county-level risk assessment was conducted. Upon review of available risk factor data, the following risk factors were assessed at the county-level:

Table 4l: Risk Factors
Child population 0 to 5
Child dependency ratio
Teen births
Children living in poverty
Income and economic indicators: ▪ households with children where all parents are in labor force ▪ median income ▪ insurance status ▪ poverty status ▪ single parent households
Housing indicators: ▪ rent >30% of income ▪ mortgage >30% of income ▪ vacancy rates ▪ inadequate housing (lacking plumbing and/or kitchen facilities) ▪ home value
Low birthweight births
Family violence
Community substance use
Prevention funding per child

Counties were ranked based on their performance on these indicators and an overall child maltreatment risk ranking was determined. The 10 counties rated most at risk and the 10 rated the least at risk are listed in the table below. Wapello, Woodbury, Lee, Des Moines, and Appanoose Counties were all in the highest-risk group when the 2017 assessment was completed as well. None of the counties in the lowest-risk group were consistent with the 2017 assessment. Several of the lowest-risk counties were just outside of the top 10 lowest-risk counties in the 2017 assessment. However, Boone and Story were previously ranked 49 and 46, respectively, making significant strides in addressing child maltreatment risks in their communities over the past six years.

Table 4m: Highest and Lowest Risk Counties

Highest-Risk Counties	• Wapello • Appanoose • Woodbury • Davis • Emmet	RISK	• Lucas • Wayne • Crawford • Des Moines • Lee
Lowest-Risk Counties	• Dallas • Grundy • Winneshiek • Madison • Benton		• Bremer • Warren • Story • Boone • Shelby

In addition to the Public Consulting Group's needs assessment (Attachment 4A), the Early Intervention and Support (EIS) team conducted listening sessions in six Iowa communities between February and April 2024. Two sessions were planned in each community; one for providers and one for families. The goal of the sessions was to learn the perspectives of providers related to the opportunities and challenges associated with meeting the needs of families and to learn what families felt produced 'good days' within their communities and what could be done to address and minimize 'bad days'. Attendance at the provider sessions was robust, while attendance at the family sessions was limited. These qualitative results will be combined with the quantitative results to produce an approach to prevention programming for the EIS team.

Conversations revealed trends and patterns within the strengths of communities and barrier areas. Information was reported from a wide, diverse and representative population (programs which serve communities, parents, and leaders speaking on behalf of families within communities).

All six communities, and the programs or entities who took part in the Listening Sessions, identified educational components to be strength areas with capacity related to priorities and initiatives. All Iowa areas spoke to preventative measures and having forceful educational entities in place to support the development of a foundation of knowledge within communities. All sessions spoke to the criticality of prevention measures, versus crisis only supports. All community areas identified multiple educational programs and resources in place, growing, or improvement plans.

All six communities identified strengths and empowerment with the understanding and commitment to one another through collaborative efforts. There was consensus in understanding that community programs working together creates the recipe for full support to families and children. All six communities identified the importance of partnership programming, and the strength in commitment to one another. Continued initiatives to grow capacity with community partnerships, communicative efforts to collaborate efficiently and build systems, which foster the smooth delivery of services through collaborative efforts, was a key component in trends to build upon collaborative strengths of partnerships.

Consensus Trend #1: Backed by strengths-based community qualities: There is a need for an efficient, smooth system to coordinate services to families and communicate efficiently between services in a: 1. Timely 2. Effective, 3. Efficient 4. Progressive 5. Follow-up manner; in order to meet the needs of families in the best way possible. All communities have the commitment and

program collaboration piece; and also spoke to the criticality of intake struggles and an understanding of all services available, without a system that joins all of the program players to families.

Consensus Trend #2: Backed by evidence-based research: Crisis programs and supports are in place and are necessary resources within all Listening Session communities. There is a widespread trend within the feedback offered, that programs understand the criticality of providing educational resources and prevention strategies through Early Intervention programs, prenatal initiatives, and early access to young families. However, communities are seeing consistent upward trends with frequency, duration and intensity of needs within community families. Partnerships and programs are often reverting to crisis strategies, due to immediate and obvious needs in crisis. The criticality of crisis in communities has pulled priorities away from foundational educational programming, which all six communities recognized as the only way to decrease crisis with any sort of sustainability.

Consensus Trend #3: All communities identified the crisis with an increased need to support critical basic needs for families. Critical basic needs are a part of the cycle identified as a trend within all communities: loss of jobs, depression, transportation, lack of quality childcare, increasing cost of living, living wage not keeping up: Poverty is disabling families from meeting their own basic needs.

Consensus Trend #4: All communities identified health needs within communities as a critical missing component. Helplessness due to a cycle and being overwhelmed. Limited or no specialists/medical providers in rural areas or significant travel required. Prevention pieces are missing. Mental health crisis is upon communities (trend), with limited resources and critically changing mental health needs. Health overall is impacting prevention of the whole picture of the healthy Iowan family.

Consensus Trend #5: Funding streams, lack of local control, soft-money, insufficient funds, and sustainability of programs through short-term initiatives were consensus trends: All communities voiced increasing populations, and individual communities having individual needs; calls for local control and funding that stays long term to support long term growth.

Over the next five-year period, Iowa will continue to utilize the Early Intervention and Support service array to meet the needs of children at risk for or who have experienced child abuse and neglect. This will include expanding Iowa's title IV-E Prevention Services and Programs Plan to include a community pathway so that children and families receive assistance as far upstream as possible to prevent child abuse and neglect thereby preventing child welfare system involvement and possible placement into foster care.

For more information, please see *Child and Family Services Continuum, Child Abuse and Neglect Prevention, Early Intervention and Support Prevention Programs and Services* earlier in this section for information on Iowa's child welfare prevention service array.

MONTHLY CASEWORKER VISIT FORMULA GRANTS AND STANDARDS FOR CASEWORKER VISITS

Describe the state's standards for the content and frequency of caseworker visits for children who are in foster care under the responsibility of the state, which, at a minimum, ensure that the children are visited on a monthly basis and that caseworker visits are well-planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency and well-being of the children (section 422(b)(17) of the Act).

HHS caseworkers, social work case managers (SWCMs), shall conduct face-to-face visits with each child receiving services in out-of-home placements. The frequency of the visitation shall be based upon the needs of the child but, at minimum, shall occur once every calendar month. The visit shall take place in the child's place of residence the majority of the time. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

For children placed out of state, a caseworker from the jurisdiction in which the child is placed or a caseworker from the jurisdiction from which the child was placed must visit the child in the placement on a schedule that is consistent with the child's needs. The responsibility and frequency of the visits is negotiated between the states through the Interstate Compact on the Placement of Children (ICPC).

Describe how the state plans to use the Monthly Caseworker Visit Grant over the next five years to improve the quality of caseworker visits, to continue to meet state and federal standards for caseworker visits, and to improve caseworker decision-making on the safety, permanency, and well-being of foster children, and to improve caseworker recruitment, retention and training.

Iowa anticipates that usage of the funds over the five-year plan will include:

- Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. The CareMatch system:
  - Tracks beds in group care, shelter and supervised apartment living and
  - Tracks and matches licensed foster parents and children in foster care. The license agreement contract includes system enhancements, data conversion, training, and an annual licensing fee. The tracking system assists caseworkers in determining the closest and most appropriate placement for the child. Research suggests that children placed closer to home receive more frequent, quality caseworker visits, which in turn impacts caseworkers' assessment of safety, efforts to achieve timely reunification or other permanency goals, and efforts to achieve child and family well-being.
  - CaeMatch upgrades to help better support contracts.
  - Focus groups were held earlier this year with SWCM's and Supervisors to find out the barriers to completing monthly visits. Two of the main barriers that were reported were travel time- distance across the state and large sibling groups being placed across the state. CareMatch helps to locate the closest, most appropriate placement for the child. Iowa's MCV numbers have increased and so far this new FFY the number is now at 95%. It is believed that using CareMatch to locate closer placements has assisted in this increase.

Iowa is in the process of determining other ways to use the funds to better support the achievement of frequent, quality caseworker visits. Iowa is in the process of developing a standardized mentoring stipend program. The purpose of the mentoring program is to support the mentee through their probationary period. Field mentoring reinforces learning with practice in real-life situations and helps to reinforce the quality of visits. Mentors will now be specifically trained and must commit to following a standardized process. The CPS team wants to explore formalized and measurable goals, then use those to provide financial incentives to mentors who are following the standard process and achieving the expected outcomes. Iowa is still determining whether some MCV funds will be utilized for this program. Iowa is also looking for other ways to support social workers in getting visits completed. Iowa will be conducting focus groups with caseworkers who are performing well in this key performance measure to gather information on their successful approaches to completing and documenting quality visits. Iowa will also be conducting a focus group with supervisors to find out the approach of all their workers and learn what is effective for some while also learning what some of the barriers are that staff run into when trying to complete their visits. Results from these focus groups will be in next year's Annual Progress and Services Report (APSR).

Section V: Consultation and Coordination Between Iowa and Tribes

Describe the process used to gather input from tribes for the development of the 2025-2029 CFSP, including the steps taken by the state to reach out to all federally recognized tribes in the state. Provide specific information on the name of tribes and tribal representatives with whom the state has consulted. Please provide information on the outcomes or results of these consultations. States may meet with tribes as a group or individually. (See 45 CFR 1357.15(l) and 45 CFR 1357.16(a)).

Iowa utilized the following processes, outlined below, to gather input from the federally recognized tribe in Iowa, The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) and tribes who have a presence in Iowa.

The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation)

- On March 28, 2024, HHS' Indian Child Welfare Act (ICWA)/Cultural Equity Manager met with Meskwaki Family Services (MFS) Social Worker, Carrie Welton to provide an update on the upcoming CFSP report. HHS and MFS workers discussed the following:
  - Opportunities for improvement:
    - Communication between HHS and MFS
      - Providing updates in all areas of HHS
      - FCS contact person.
    - Relationships at the local and state levels
    - Lack of HHS staff holding themselves accountable for activities in the State/Tribe Agreement

Discussions with Meskwaki Nation

Meskwaki Nation is the only federally recognized Tribe located in Iowa. Meskwaki Family Services (MFS) provides services and supports to tribal families located on and off the Settlement. HHS and MFS developed a strong working relationship for Meskwaki families involved in state court proceedings and tribal court proceedings. Mylene Wanatee, Director of MFS and Oceana Papakee, MFS Social Worker; leadership for Linn and Tama Counties; and central office staff discussed ongoing case specific and systemic issues, as needed, either through scheduled meetings or through email correspondence.

HHS' ICWA/Tribal Relations Program Manager (Federal Programs Program Manager) scheduled meetings with MFS for June 21, 2022, September 27, 2022, February 16, 2023, and March 28, 2023. The meetings scheduled for September and February did not occur due to cancelation. The purpose of these meetings was to discuss the ICWA Training and Technical Assistance contract HHS holds with MFS, discuss any concerns regarding services, and follow up on continued issues.

HHS held a site visit with Meskwaki Nation on November 1, 2022. During this site visit, leadership staff from HHS met with leadership from Meskwaki Nation to tour the museum and Settlement, discuss equity, and build relationships now that IDPH and DHS are merged into one Department. Following this site visit, it was agreed that holding a site visit on an annual basis will be beneficial as relationships are continuing to grow and strengthen. The next site visit has yet to be scheduled.

Email discussions over the last year between the HHS Federal Programs Program Manager and MFS staff, Mylene Wanatee, included but were not limited to the following:

- Continued discussion of Tama County's refusal to pay its share of shelter costs for MFS children in shelter care.
- Revision and execution of the intergovernmental agreement between HHS and Meskwaki Nation.
- Usage of Promoting Safe and Stable Family (PSSF) funding under HHS' contract with MFS.
    - Contract and agreement updates.
    - Questions surrounding adoption subsidy.
    - Background check process for HHS.

HHS and MFS renewed the ICWA Training and Technical Assistance Intergovernmental Agreement (IGA) contract for the next fiscal year. Minor changes were made to the contract, including removal of information related to Emergency PSSF, change in Agency name from DHS to HHS, and future change in Agency location.

- July 24, 2023, HHS ICWA/Tribal Relations Program Manager (Federal Programs Program Manager), along with other HHS employees from the policy bureau and MFS met to discuss the following:
    - Communication between HHS and MFS, as there seems to be a disconnect between both entities.
    - Processes with getting the foster care worker within HHS proper documentation.
    - Processes for getting MFS updated information from multiple programs across HHS.
    - Identifying a contact person for FCS
    - 3055 authorization codes for specific information in FACS.

Discussions with Nebraska Tribes

HHS local, service area, and central office staff actively participates in monthly meetings in Sioux City involving tribes domiciled in other states but who have a significant presence in the area. The Community Initiative for Native Children and Families (CINCF) includes representation from the tribes in the area – Ho-Chunk, Omaha, Ponca, Santee Sioux, and Winnebago. CINCF also includes representatives from area service providers, the judiciary, housing, law enforcement, the Recruitment, Retention, Training, and Supports (RRTS) contractor Four Oaks, health, and education. The group collaboratively works to find resources and support for Native families.

The service area manager (SAM) for the Western Iowa Service Area (WISA), the supervisor of the Native unit, a social work administrator (SWA) for WISA, and Native unit Liaisons regularly attend the meeting and update representatives on new HHS initiatives, data regarding Native children, and concerns related to practice or ICWA compliance. The HHS ICWA program manager receives information regarding ICWA compliance concerns and makes policy or practice changes, in concert with field staff, as needed.

The HHS Native unit in Woodbury County includes five caseworkers and two Native Liaisons. The liaison's role is to exchange cultural and case information between tribes, HHS, and the Native families.

The HHS SAM, SWA, and Native Unit supervisor meets with the four Nebraska Tribes semi-annually or quarterly, depending upon the tribe. The purpose of these meetings is to establish communication, build relationships, and provide a forum to discuss practice and policies that may or may not be going well. These meetings may include Tribal Social Service Directors, ICWA specialists, Tribal Caseworkers, and Supervisors. Topics discussed include, but are not limited to, terminations of parental rights, customary adoptions, relative placements, transfer proceedings, and improving communication.

- Quarterly:
  - Winnebago Tribe of Nebraska:
    - These meetings include the Tribe's Attorney - Roz Koob or Diane Smith, Social Service Director -Kayla Backer, and ICWA Specialist - Elexa Mollett. We have begun including HHS staff from the Des Moines Service Area as they have also formed an ICWA Unit that consists of one case manager. In attendance from the Des Moines Service Area is SAM, Jana Rhoads, and Supervisor Elizabeth Lockwood. Also in attendance is Samantha Magpie from HHS Central Office.
    - During the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns as well as updates on Tribal Customary Adoptions. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the state ICWA/Tribal Relations program manager to address statewide policy concerns.
    - Outcomes attained include strengthening relationships, improved communication, and improved understanding of how each other's programs operate to increase efficiency of services for children and families.
  - Omaha Tribe of Nebraska:
    - These meetings include the Tribe's Attorney – Alexis Zendajas and ICWA Specialist - Kash Echtenkamp. We have begun including HHS staff from the Des Moines

Service Area as they have also formed an ICWA Unit that consists of one case manager. In attendance from the Des Moines Service Area is SAM, Jana Rhoads, and Supervisor Elizabeth Lockwood. Also in attendance is Samantha Magpie from HHS Central Office. Alexis Zendajas has now accepted a position outside of the tribe but is hoping a contract can be created that would keep her on as the tribal attorney. This is still yet to be determined and it is unknown when or if this would occur. Current contact is with Kash Echtencamp and Tribal Attorney General Theresa Rachel.

- Similar to the Winnebago Tribe, during the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns as well as updates on Tribal Customary adoptions. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the state ICWA/Tribal Relations program manager to address statewide policy concerns.
- The outcomes established by these meetings is similar to that of the Winnebago Tribe, i.e. improved communication, and a better understanding of how each other's program's operated to increase efficiency of services for children and families.

- Santee Sioux Tribe of Nebraska:
  - The purpose of meeting with the Santee Sioux Tribe is similar to that of all Tribes, i.e. to establish communication and build relationships. In attendance from the last meeting were representatives of the Santee Sioux Tribe, i.e. Social Services Director, Danielle LaPointe, Supervisor Clarissa LaPlante and ICWA Specialist Renea Helper. We have begun including HHS staff from the Des Moines Service Area as they have also formed an ICWA Unit that consists of one case manager. In attendance from the Des Moines Service Area is SAM, Jana Rhoads, and Supervisor Elizabeth Lockwood. Also in attendance is Samantha Magpie from HHS Central Office. These calls are held virtually through Teams. Discussions include policy updates.
  - Similar to the Winnebago and Omaha Tribe, during the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns as well as updates on Tribal Customary adoptions. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the state ICWA/Tribal Relations program manager to address statewide policy concerns.

- Semi-annual meetings:
  - Ponca Tribe of Nebraska:
    - Attendees include Director of the Ponca Tribe, Stephanie Pospisil, Deputy Director of Tribal Affairs, Penny Lingle, and Executive Director of Tribal Affairs, Courtney Chavez. We have also begun including HHS staff from the Des Moines Service Area as they have also formed an ICWA Unit that consists of one case manager. In attendance from the Des Moines Service Area is SAM, Jana Rhoads, and Supervisor Elizabeth Lockwood. Also in attendance is Samantha Magpie from HHS Central Office. The purpose of the meeting was to build the relationship and communication with the Ponca Tribe. During the meeting, participants discussed policy, services provided by the Ponca Tribe, and the Tribe's position on termination of parental rights hearings and the ability to use Tribal Customary Adoption in permanency hearings.

- Outcomes attained include strengthening relationships, improved communication, and improved understanding of how each other's programs operate to increase efficiency of services for children and families.

Next Steps: In cooperation and consultation with the Tribe(s):

- The State of Iowa and The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) annually meet to discuss the Intergovernmental Agreement that was executed in November 2022 between Iowa and Meskwaki Nation.
- HHS' ICWA/Cultural Equity Manager will continue to hear concerns regarding FCS' provision of services to Native families. State level program discussions regarding these issues will hopefully address them within the next year.
  - A plan to improve and monitor the FCS renewed contract so contractors and HHS have a clear understanding of expectations and what the contractors are being held accountable to with active efforts will be developed.
  - HHS plans to hold in person meetings with FCS, HHS and MFS to continue to address any concerns.
- HHS ICWA/Cultural Equity Manager will schedule quarterly meetings with MFS, which will include updated information coming out of HHS.
- HHS ICWA/Cultural Equity Manager will schedule quarterly meetings with MFS and the foster care payments team to ensure processes are working properly.
- HHS ICWA/Cultural Equity Manager will discuss inclusion of the other tribes or establishing a similar separate call with them.
- Explore the following:
  - HHS staff holding themselves accountable for activities in the State/Tribe Agreement with Meskwaki Nation.
  - Improve HHS accountability through enhanced communication with Tribes.
  - Address the lack of agreements between the State of Iowa and the Tribes not federally recognized in Iowa but who have a presence in Iowa to address foster care, daycare, sharing of home studies, etc.
  - Work with the Tribes to implement agreements.
  - Work with ICWA Training and Technical Assistance contractor to develop trainings, tip sheets, improved processes, etc. to improve ICWA practice.
  - Qualified expert witness (QEW) process not defined in Iowa, including compensation.
  - Develop a QEW process, including possible compensation.
  - Have discussions with judges, county attorneys, and Iowa Children's Justice regarding ICWA related matters, such as "active efforts."
  - Share technical assistance.

Provide a description of the state's plan for ongoing coordination and collaboration with tribes in the implementation and assessment of the 2025- 2029 CFSP. Describe any barriers to this coordination and the state's plans to address these barriers.

The HHS will include representatives from all of the tribes in the annual Quality Improvement focus group where stakeholders from across the state will work together to identify strengths and opportunities to improve Iowa's child welfare system, which will be in the Annual Progress and Services Reports (APSRs). Additionally, HHS will include tribal representatives in the ongoing Service Area meetings, which continue throughout the year to address local interests.

- Meskwaki Nation – quarterly meetings
- Winnebago and Omaha Tribes of Nebraska – twice per year meetings

- Ponca and Santee Sioux Tribes of Nebraska – semi-annual meetings
- Monthly CINCF meetings attended by the various tribes.

Although this was in the CFSP plan for FFY 2020-2024, ongoing meetings are continuing to improve communication between IA and Tribes. Shane Frish and Tom Bouska have taken the lead in coordinating ongoing meetings with the NE Tribes, as they continue to meet regularly. In terms of meetings with Meskwaki Nation, there are ongoing efforts to begin quarterly meetings, as there has been discussion about developing a new Coalition call that can coincide with the CINCF meeting that occurs monthly in Sioux City. This is an ongoing effort to coordinate in order to improve lines of communication between IA and Meskwaki. This would include Polk Co ICWA unit, Meskwaki, ICWA/Cultural Equity Manager, Linn CO Service Area, IA Medicaid Tribal Liaison, Julie Collins, and hopes to expand to external community partners.

Provide a description on the arrangements made with tribes as to who is responsible for providing the child welfare services and protections for tribal children delineated in section 422(b)(8) of the Act, whether the children are under state or tribal jurisdiction. These services and protections include operation of a case review system (as defined in section 475(5) of the Act) for children in foster care; a preplacement preventive services program for children at risk of entering foster care to remain safely with their families; and a service program for children in foster care to facilitate reunification with their families, when safe and appropriate, or to place a child in an adoptive home, legal guardianship or other planned, permanent living arrangement subject to additional requirements outlined in section 475(5)(c) and 475A(a) of the Act. (See 45 CFR 1357.15(q).)

Meskwaki Nation is the only federally recognized tribe domiciled in Iowa and established their tribal court in 2005. HHS and Meskwaki Nation finalized a State/Tribal Agreement initially in 2006, which outlined Tribal and HHS responsibilities for service provision, payment for services, federal reporting and assessing child abuse. HHS and MFS finalized a protocol in June 2011. The protocol further defines the roles and responsibilities of HHS staff and MFS staff in child protective assessments for Meskwaki families who reside on and off the settlement and case management of cases in state court. The HHS and Meskwaki Nation updated the State/Tribal Agreement and Protocol in September 2024. With this agreement, MFS and HHS have hopes to improve the quality of work, with incorporating new ideas that may improve services on both ends. There are hopes to make some changes to the agreement for 2025, with there being a new ICWA worker for HHS, this year will be to evaluate how the agreement is working for both MFS and HHS.

The Tribal/State Agreement states HHS will be responsible for payment for foster care or other child welfare services accessed by Meskwaki Nation children under tribal court jurisdiction. MFS has all case management responsibilities. Children under tribal court jurisdiction may access any service available to a child under state court jurisdiction as long as the child is eligible for HHS services.

The agreement also states the cases of children under tribal court jurisdiction, but for whom HHS pays for services, may be subject to federal review through an IV-E Eligibility Review or through a Child and Family Services Review (CFSR). MFS provides all required IV-E documentation including court orders and family household composition, income and resources,

and ongoing documentation to HHS in order to determine initial and continued eligibility for IV-E claiming.

MFS has responsibility for the management of cases under tribal court jurisdiction and meeting the law of their nation regarding case requirements and a case review system. Tribal law explains case planning requirements including required federal language in case plans. Tribal law also includes periodic review and reporting requirements by MFS. Tribal law addresses case requirements to prevent children's removal from their home, to achieve reunification, and to achieve permanency.

HHS will continue to engage Meskwaki Nation tribal representatives in the CFSR process on-going as well as provide training and technical assistance to assist Meskwaki Nation in their case review process.

HHS performs all case review requirements for Meskwaki Nation children under state court jurisdiction, which includes providing credit reports to children aged 14 or older in foster care.

There are several tribes domiciled in Nebraska and South Dakota who have a presence in the northwest part of Iowa. Currently, the HHS does not have agreements to pay for services for children under the jurisdiction of the tribal courts of these tribes. However, during the five-year period, HHS plans to establish agreements with as many of these tribes as possible. Children under state court jurisdiction are eligible for all child welfare services. HHS pays for these services and manages these cases in collaboration with the child's tribe. Children under the jurisdiction of a tribal court in another state would receive services by that tribe or state.

With there being a new ICWA worker for HHS, there is currently an ongoing plan in progress to develop MOU agreements with Tribes in NE. This MOU agreement will not only assist in the gap with coverage for children being placed in IA from Tribes in NE, but this will also allow IA to be able to legally cover the children under Medicaid. There are also hopes that this agreement can assist with missing youth, and to develop a protocol for children that go missing that HHS can assist with. There is also hope that this agreement can address the elimination of the ICPC process for HHS placing children with Tribes, as the process is quite lengthy and can be a barrier for immediate relative placement. The MOU agreement will be with each Tribe individually in NE and HHS, in hopes to also strengthen the partnerships. The hope is to establish these agreements by 2025, as the process has already began.

Provide a description, developed after consultation with tribes, of the specific measures taken by the state to comply with ICWA. (See section 422(b)(9) of the Act.)

Currently, HHS does not have an automated mechanism to collect data about ICWA compliance. However, as part of developing the comprehensive child welfare information system (CCWIS), Iowa plans to include several adoption and foster care analysis and reporting system (AFCARS) data elements and possibly additional elements related to ICWA compliance. Currently, Iowa determines compliance through periodic case readings, case consultation with tribal representatives, and annual trainings. HHS' CCWIS is called 'VISION'. VISION is set to have different settings in it which will make collecting data for ICWA more accessible.

The ICWA Training and Technical Assistance contract held by Meskwaki Family Services (MFS) uses case reading to determine ICWA compliance and to develop training based on the case reading results. HHS staff pulls data for all children identified as American Indian/Alaska Native

from the HHS' child welfare information system (CWIS). HHS excludes cases under tribal court jurisdiction, delinquent (non-status offenses), and in-home cases from the sample. HHS and MFS agreed that MFS would read a random sample of cases from Woodbury County and case read 100% of all other cases across the state.

Due to Meskwaki Nation facing capacity issues since Covid, there has been a pause in the ICWA compliance with the agreement with HHS. The last time the ICWA compliance was completed was in 2019. With there being a new ICWA worker for HHS, the plan for this year is to evaluate the agreement to determine what is working and what isn't working for MFS. There are hopes to provide as much assistance as possible as well as resources to the ICWA worker with MFS, in hopes this will allow the comfortability to completing the ICWA compliance. There is a plan to evaluate if ICWA compliance is beneficial for MFS to conduct while being understaffed.

Provide information regarding discussions with Indian tribes in the state specifically as it relates to the Chafee program. States may provide this information either in this section or in the Chafee section of the 2025- 2029 CFSP but are requested to indicate clearly where the information is provided.

Please see *Section IV: Services, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)*, Consultation with Tribes (section 477(b)(3)(G)), of this report.

State agencies and tribes must also exchange copies of their 2025-2029 CFSP and their APSRs (45 CFR 1357.15(v)). Describe in detail how the state will meet this requirement for the 2025-2029 CFSP and the plan for exchanging future APSRs.

HHS will provide the FFY 2025-2029 CFSP and subsequent APSRs directly to MFS and to the Four Directions in Sioux City. Additionally, the HHS will explore other avenues of exchanging the FFY 2025-2029 CFSP and subsequent APSRs directly with the tribes in the northwest area of the state.

Section VI: Targeted Plans

Please see the following attachments for the targeted plans:

- Attachment 6A: Foster and Adoptive Parent Diligent Recruitment Plan
  - Attachment 6A1: Five Year Diligent Recruitment Plan
- Attachment 6B: Health Care Oversight and Coordination Plan
  - Attachment 6B1: Psychotropic Medication Advisory Committee Charter
- Attachment 6C: Disaster Plan
  - Attachment 6C1: Health Equity Policy
  - Attachment 6C2: IDPH Health Equity Framework
  - Attachment 6C3: 2024 COOP COG Plan
  - Attachment 6C4: COOP At A Glance – Attachment A
  - Attachment 6C5: Recovery Members Teams - Attachment B
  - Attachment 6C6: Vendors List – Attachment C

- Attachment 6D: Training Plan
  - Attachment 6D1: SWCM and SWCM Supervisors, New Worker Training
  - Attachment 6D2: CPW and CPW Supervisors, New Worker Training
  - Attachment 6D3: Form 470-0020, Mentoring Agreement
  - Attachment 6D4: Field Experience Learning Guide for SWCM FY 24
  - Attachment 6D5: Field Experience Learning Guide for CPW FY 24
  - Attachment 6D6: Mentee SWCM Self-Assessment
  - Attachment 6D7: Mentee CPW Self-Assessment
  - Attachment 6D8: HHS - FFY 2025-2029 Training Plan
  - Attachment 6D9: Child Welfare Provider Training Academy (CWPTA) – FFY 2025-2029 Training Plan
  - Attachment 6D10: CASA and FCRB – FFY 2025-2029 Training Plan

Section VII: Financial Information

PAYMENT LIMITATIONS

Title IV-B, Subpart 1

In FFY 2005, Iowa expended $724,000 under title IV-B, subpart 1, for foster care maintenance. Iowa will allocate the same amount for foster care maintenance in FFY 2025. Iowa did not and does not use title IV-B, subpart 1, funds for childcare or adoption assistance payments.

In FFY 2005, Iowa utilized $241,334 state expenditures, non-federal funds, for foster care maintenance payments as state match for title IV-B, subpart 1. Iowa will apply the same amount of non-federal funds expended for foster care maintenance payments as state match in FFY 2025.

Title IV-B, Subpart 2

Iowa does not utilize 20% of the PSSF funds for the Family Preservation category. Iowa utilizes federal Temporary Assistance for Needy Families (TANF) and Social Services Block Grant (SSBG) as well as state appropriations to fund Iowa's main family preservation service, Family Centered Services. Iowa secured authorization from the Children's Bureau Region VII office in 2007 to utilize less than 20% of PSSF funds for the Family Preservation category.

Table 8 below shows financial information comparing FFY 2022 state and local share spending for subpart 2 programs against the 1992 base year amount as required to meet the non-supplantation requirements in section 432(a)(7)(A) of the Act.

Table 7a: Comparison of FFY 2022 State/Local Spending and 1992 Base Year Spending

Category	FFY 2022	FFY 1992
Family Preservation	131,770	-
Family Support	699,289	581,841
Family Reunification	534,060	-

Table 7a: Comparison of FFY 2022 State/Local Spending and 1992 Base Year Spending		
Category	**FFY 2022**	**FFY 1992**
Adoption Promotion	822,961	-
Other Service-Related Activities	735,763	-
Total Administration	270,873	-
Total	3,194,716	581,841
Source: HHS		

In FY 2007, Iowa began targeting the adoption promotion portion of PSSF funds to provide adoption support services to adoptive families via the statewide Resource and Recruitment contract, which became the Resource, Recruitment, Training and Support of Resource Families (RRTS) contract effective July 1, 2017. Iowa updated the FY 1992 baseline to reflect that change in the use of these funds.