FFY 2020-2024 – Iowa Child and Family Services Plan Final Report

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IOWA Health and Human Services

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FFY 2020-2024
Child and Family Services Plan (CFSP)
Final Report

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 2020-2024 Child and Family Services Plan (CFSP) Final Report, with attachments to the Iowa Department of Health and Human Services' website, Child and Family Services Plan.

Table of Contents

Section I: Collaboration

Provide an update on how the state has engaged in substantial, ongoing and meaningful collaboration in the accomplishment of the 2020-2024 CFSP goals and objectives and the development of the 2020-2024 Final Report.

COLLABORATION WITH FAMILIES, CHILDREN, YOUTH, TRIBES, AND OTHER PARTNERS

Child and Family Services Review (CFSR)

Iowa began implementing its Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), on July 1, 2020. The PIP became Iowa's CFSP goals and objectives. As part of implementing the PIP, HHS collaborated, and continues to collaborate, with a variety of stakeholders, as noted in the PIP. For information on collaboration regarding Iowa's CFSR PIP, please see the following:

- *Attachment 2A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of December 31, 2023*
- *Section II, Update on Assessment of Performance, Plan for Enacting Iowa's Vision and Progress to Improve Outcomes,* later in this report.
- *Section III, Quality Assurance System*

Collaboration with Other Partners

Collaboration with a multitude of different stakeholders, including families, children, youth, tribes, and other partners, continues to be a top priority in Iowa and can be seen in various places throughout this report. For information regarding collaboration with these other partners, please see the following:

- *Section IV, Final Update/Report on Service Description, MaryLee Allen Promoting Safe and Stable Families, Family Preservation, Parent Partners*
- *Section IV, Final Update/Report on Service Description, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)*
- *Section V: Consultation and Coordination between States and Tribes, Discussions with Meskwaki Nation and Discussion with Nebraska Tribes*
- *The Child Abuse Prevention and Treatment Act (CAPTA) report*

COLLABORATION WITH COURTS AND MEMBERS OF THE LEGAL AND JUDICIAL COMMUNITY, INCLUDING COURT IMPROVEMENT PROGRAM

- CIP provided data for the Final Report and collaborated with HHS through various activities in implementing Iowa's CFSR PIP as well as activities with Tribes.
- HHS memorandum of understanding (MOU) with the Office of the State Public Defender (SPD), dated February 2020, for legal representation of children and parents at all stages of child welfare proceedings, including pre-petition, continues into the foreseeable future.
- 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. Please see *Iowa's FFY 2025-2029 Child and Family Services Plan, Section I: Vision and Collaboration, Collaboration* for information on outcomes of these sessions.

- For information on HHS' collaboration with the courts, the legal and judicial community, and CIP, please see:
  - *Section V: Consultation and Coordination Between States and Tribes and*
  - *Attachment 2A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of December 31, 2023*

Through the years, the Iowa Department of Health and Human Services (HHS) has diligently worked to continue collaboration with the County Attorney's Association and the Attorney General's Office. Both the County Attorney's Association and the Attorney General's Office are included among members of the State Council and the ICJ Advisory Council. HHS has continued partnering with the County Attorney's Association in providing a special juvenile track for their annual conference and their fall conference.

ICJ Multi-Disciplinary Committees: There are two opportunities for collaboration with ICJ (Iowa Children's Justice) Multi-Disciplinary Committees. The first group is the ICJ Advisory Committee. This committee is a requirement to receive federal Court Improvement Program funding. 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.

The second committee is the ICJ State Council. This council is made up of representatives with decision-making capabilities from organizations that are involved in the child welfare system. The focus of this council is to address cross-system issues and barriers. 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.

Juvenile Court Services (JCS)

Juvenile Court Services (JCS) made the decision to participate in Family First Prevention Services Act (FFPSA), including administrative claiming and Prevention Service claiming because it directly aligned with JCS' vision of standardizing practices and expanding best practice, evidence-based services.

To participate in FFPSA, JCS engaged in a significant number of program, policy, and practice changes, including statewide standardization of FFPSA policies, procedures, forms, and training. This standardization included the development of a Candidacy Determination process, which included creation of the Candidate for Foster Care Screening Tool (CFST) and the Child Prevention Case Plan (CP2). The CFST, which was developed utilizing current research, not only screens youth for candidacy but assists in identifying youth who are most at risk of out of

home placement, enabling Juvenile Court Officers (JCOs) to concentrate resources where they are most needed. The CP2, while initially developed for FFPSA purposes, has been revised and is now utilized as a comprehensive case plan for all JCS involved youth. This change aligned JCS with best practice approaches to case management. The adoption of the CFST and CP2 benefitted youth by allowing JCOs to target specific risk factors, thereby decreasing recidivism and out of home placement.

The prevention services JCS identified in its part of Iowa's Title IV-E Prevention Services and Programs Plan (Plan) included Functional Family Therapy (FFT) and Multi-systemic Therapy (MST). FFT and MST are intensive, short-term therapeutic models that offer in-home family counseling designed specifically to address a youth's negative behaviors. FFT and MST are the only Title IV-E prevention services identified in the Plan that were rated as "well supported" by the Title IV-E clearinghouse. This rating helps Iowa to meet the federal requirement that 50% of reimbursements are for "well-supported" services.

For JCS to participate in administrative claiming, a method for identifying the amount of time JCS staff spends on Title IV-E eligible activities was needed. As a result, JCS implemented Random Moment Sampling (RMS), a federally approved cost allocation method.

JCS has taken several steps to be compliant with federal Title IV-E requirements. These steps include:

- hiring three new positions – a Project Manager, a CQI Manager, and a Title IV-E & RMS Manager – to oversee specific FFPSA processes,
- a process for tracking all Title IV-E funds received and expended by category,
- the development of a secure web application to capture all pertinent data required for Prevention Services reporting,
- a thorough review and update of all policies and procedures, and
- consultation with Administration of Children and Families, HHS, and the RMS vendor to stay apprised of Title IV-E program and policy changes.

To ensure staff compliance with FFPSA requirements, JCS developed and implemented ongoing FFPSA focused staff training and professional development. As part of this process, JCS developed a standardized approach to training staff, which included mandatory competency assessments for all trainings. These assessments were integrated throughout each training and ensured proficiency of JCS staff in the specific program areas. There were nine (9) FFPSA initial trainings and multiple refresher trainings, followed by Q&A sessions.

Through its participation in FFPSA, JCS hopes to accomplish 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.

Although JCS has faced a number of challenges stemming from an absence of infrastructure and a lack of knowledge and experience related to Title IV-E and federal claiming, their leadership has prioritized working on overcoming these challenges. As a result, JCS expects to

see improvement in youth outcomes through reductions in recidivism, out of home placement, and trauma, increases in family engagement, and decreases in family conflict and child removal.

Additional Collaborations:

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 systems 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' 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 FY23 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.

Child Welfare Service Contractors: Child welfare service contractors provided data discussed throughout this report. They also collaborated amongst each other and with program managers through several venues discussed below and throughout this report.

Annual Statewide Meeting: Historically, there has been a statewide meeting each year that includes representation from current child welfare service contractors, HHS field and central office staff, and other external partners. The purpose of the statewide meeting was to bring HHS and current child welfare service contractors together to continue strengthening relationships and identifying ways to work together across the entire service array to improve our child welfare outcomes. A small number of public and private Child Welfare Partners Committee (CWPC) members volunteered to participate in a planning committee to prepare and plan for the statewide meeting.

The annual statewide meeting has not occurred since SFY 2019, originally this was due to the impact the coronavirus pandemic had on the ability to have large group gatherings. During this time, efforts focused on adjusting the information sharing process in other joint HHS and child welfare services contractor meetings to continue to strengthen relationships and to identify initiatives and activities across the service array that may improve child welfare outcomes. Other means of communication regarding statewide initiatives and progress have been built out to fill the void left by the statewide meeting. There are service area all-contractor meetings where information regarding statewide initiatives is shared.

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 collaborative public/private workgroups and ensures coordination of messages, activities, and products with those of other stakeholder groups. 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 to provide the best opportunity to reach our mutual goals: child safety, permanency, and well-being for Iowa's children and families. The CWPC unites individuals from Iowa and private organizations to create better outcomes for Iowa's children and families.

Through collaborative public and private efforts, a more accountable, results-driven, high quality, integrated system of contracted services has been created that supports achieving 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 on a regular basis throughout the year.

The goal of the CWPC over the last five years was to support HHS with the implementation of the Family First Prevention Services Act (Family First). The Family First project focused on problem-solving potential concerns prior to HHS finalizing decisions as well as trouble-shooting challenges that came up during implementation. CWPC worked through and provided feedback regarding the QRTP clinical admission assessment process, the QRTP post discharge process, and implementation of Family Centered Services (FCS). Committee members utilized the diversity of their roles outside of CWPC as well as leveraged the various workgroups in which they participate to identify information that would be helpful to include in various one-pagers and instructional materials regarding changes. Additionally, the committee members actively disseminated developed information.

During the time period of April 2023 through February 2024, members of the CWPC utilized a Results-Based Conversation approach to identify gaps in services, policies, and communication and then collectively work toward an outcome to address those concerns.

CWPC members have had in-depth conversations around concerns about facilities closing and the decreasing number of beds. Members have discussed ways to address long-term shelter stayers. A new shelter protocol was also rolled out this past year. The state of residential care and acuity needs of youth has been a topic in conversations during CWPC meetings.

CWPC members have discussed the findings from the Child Protective Assessment done by Change and Innovation (C!A). Staff recruitment and retention was identified as a priority for both HHS and provider staff.

Members discussed the new HHS SW4 Complex Case Manager positions. The Service Area Managers (SAMs) are meeting with the CEOs of the Medicaid Managed Care Organizations (MCOs) monthly to work through the gaps and discuss how they can work better together. The meetings have helped create processes and role delineation. Members discussed how the MCOs are engaged and there is better partnership with HHS.

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 committee meetings.

Information on the CWPC is available at Child Welfare Partners Committee | Health & Human Services (iowa.gov).

Recruitment, Retention, Training and Supports (RRTS)

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 (FFY 2023-2024) 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 (WSA) 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 Nation (Sac and Fox Tribe of the Mississippi in Iowa). They assist

Meskwaki Family Services (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.

A Comfort Call/Bridge Meeting work group was developed in the Fall of 2022. A pilot occurred in two service areas (WSA and Cedar Rapids Service Area (CRSA)) in five Iowa counties from December of 2022 – March of 2023. Following the pilot an evaluation of the pilot was conducted resulting in the process transitioning statewide beginning in November of 2023 and ending in March of 2024 with all the counties in Iowa utilizing the Comfort Call/Bridge meeting process.

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.

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 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.

The Foster and Adoptive Advisory Council has advised Iowa Department of Health and Human Services (HHS) and Four Oaks Family Connections regarding legislative and policy matters that have been brought to the council. While the advisory council wants to continue to collaborate and advise HHS and Four Oaks, the council would like to possibly grow and be more active within the legislative process.

The advisory council's 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.

Members of the council are to consider participation as a minimum with 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.

Additional Collaborations/Highlights:
Four Oaks Family Connections RRTS Statewide Director was awarded the Sue Pitts-Fisher Award from the Coalition for Family and Children's Services in Iowa recognizing excellence in public/private partnership and collaboration for work in foster care and adoption.

RRTS collaboration efforts statewide:

- Coalition for Family and Children's Services in Iowa to provide child welfare professionals with training, advocate for resources for foster/adoptive families, and to educate other participating agencies regarding RRTS foster care/adoption/kinship services and needs.
- MCO Amerigroup to provide training to Amerigroup team members on cultural responsiveness with LGBTQ community, to educate regarding needs of foster/adoptive families, and to distribute Amerigroup funded resources such as care packages, information packets, etc., regarding Amerigroup services.
- On-going collaboration with Achieving Maximum Potential (AMP) through hosting joint events, having youth speak at pre-service training, promoting AMP events, hosting meetings at local sites, and supporting AMP Day on the Hill.
- County, city, and other geographically specific collaborations between RRTS Adoption and Permanency Support for National Adoption Month and Adoption Day. We participate in and support at least six events around the state annually
- Beauty Amidst the Ashes, an annual adoption promotion/education conference. RRTS hosts an information session regarding foster care and adoption from the child welfare system, mans a resource table during the conference, and collaborates with gift drives to provide gifts for foster/adoptive children during the holiday season
- Regional collaborations between Family Centered Services (FCS)/RRTS to improve collaboration between Kinship Navigators/RRTS licensing process for kinship caregivers.
- RRTS participation in HHS led Cultural Equity Alliance/Breakthrough Series Collaborative work (diligent recruitment).
- Iowa foundation Chelsea's Dream to provide funding for recruiting advertisement, supplies/care packages or other beneficial services for foster/adoptive families

Additional Collaborations during the current and previous fiscal year SFY 2023 and SFY 2024:

- RRTS team member as presenter at a Cultural Equity Alliance fall conference
- Collaboration between RRTS Training Coordinator/HHS Parent Partners contract to recruit and train identified Parent Partners as foster care/adoption pre-service training facilitators. We have recruited and certified two Parent Partner facilitators during this fiscal year and hope to add more Parent Partners to the roster of trainers.

- Collaboration between RRTS Training Coordinator/HHS contracted AMP program to have AMP youth/facilitators as foster care/adoption pre-service trainers. We currently have one AMP facilitator certified as a pre-service trainer. (diligent recruitment youth voice)
- RRTS/HHS collaboration with independent non-profit Foster Squad and others to provide Operation Santa.
- RRTS collaboration with Season's Center in Northwest Iowa to identify and meet needs of local foster/kinship/adoptive families through training, support, and referral for resources. (diligent recruitment related to rural area recruitment/retention).
- RRTS Collaboration with Iowa Bar Association to provide training on LGBTQ cultural responsiveness for children in care (diligent recruitment).
- RRTS establishment of service area specific Diversity Councils to advise/assist in recruitment/retention of foster/adoptive families.
- RRTS/HHS collaboration to establish Foster Care/Adoption Mentoring program, recruiting, and training experienced foster/adoptive parents to mentor new and less experienced foster/adoptive families. This will be an on-going program.
- RRTS collaboration with HHS to design and implement a pilot for Therapeutic Foster Care.
- RRTS Matching Team members are routinely going to shelters and group care facilities to meet referred children/youth in person to get insight into who they are as people and what they are seeking in a foster/adoptive home.
- RRTS Matching Team members are requesting, facilitating, and partnering in "difficult to match" staffing's with HHS stability staffings, which are held to attempt to preserve placement, and MCO staffings to identify wrap-around services to support children in care.
- RRTS/HHS collaboration in matching children in need of a forever family with an adoptive family, and both are participating in a new collaboration with Reel Hope to create appealing videos of children in need of a forever family.

Disproportionality/Disparity in the Child Welfare System

Statewide Cultural Equity Alliance Steering Committee (CEASC)

The primary purpose of the Cultural Equity Alliance Steering Committee (CEASC) 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 CPS staff), providers, courts, Parent Partners, youth with lived experience in foster care, 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 action strategic 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.

CEASC Strategic Planning Summary

As part of the five-year strategic planning of the Cultural Equity Alliance, the CEASC identified a position to coordinate the statewide racial equity efforts intersecting with child welfare services and community partners. HHS approved this position, the Cultural Equity Statewide Coordinator, and hired in the fall of 2019, through a contract between HHS and Iowa State University's Child Welfare Research and Training Project. This position remained in place through the duration of the contract, which ended in September 2023. The Cultural Equity Statewide Coordinator served as a resource to the many partners involved in working to reduce disproportionality and disparity within Iowa's child welfare system and provided coordination and support to the CESAC and related activities described in this section through the first quarter of SFY 2024.

CEASC meetings occurred bi-monthly during the height of Covid in SFY 2020 and SFY 2021 and were held virtually. In SFY 2022, the meetings tapered to quarterly, with a return to periodic meetings being held in person.

The CEASC has collectively focused efforts on further development of strategic planning around key priorities during the 5-year reporting period, in conjunction with identifying opportunities to align work with the Health and Human Services Alignment and equity focused efforts. The following is a summary of the CEASC meetings by year:

CEASC Meetings Summary SFY 2020

Focus of the CEASC meetings were dedicated to reviewing the mission and vision of the CEASC and drawing upon the momentum of the national conversation tuned in to the impact of biases and violence toward individuals and communities of color. The CEASC decided to update the vision and mission of the committee to reflect the sense of urgency and provide clarity to the mission and vision to create an anti-racist and culturally responsive child welfare system in addressing disproportionality and disparity in child welfare through an equity focused

workforce, cross sector collaboration and policy and practice changes. Meetings were also focused on developments and next steps of the workgroups, which included reviewing SW 020 training curriculum to identify gaps around culturally responsive practice, evaluating statewide availability of interpretive resources, engagement of families and communities impacted by disproportionality and disparity, and continuous improvement and accountability of practice.

CEASC Meetings Summary SFY 2021

The CEASC reviewed the findings and learning from the 7 Judges and 4 Questions pilot utilized in juvenile court cases where families were at risk of removal of children. The CEASC posed questions as to whether the findings could be disaggregated by race and ethnicity, and if questions could be culturally adapted to diverse cultural identities of families. The Family First Dashboard, now titled the Child Welfare Dashboard, was presented to the CEASC as a mechanism for disaggregating out of home removal and placement data by race and ethnicity. CJJP also presented to the committee on the work occurring around juvenile justice and disparities, and response to changing practice on the use of School Resource Officers. Heath Equity Coordinator with legacy IDPH presented on the Health Equity Drivers Forum and developing health equity framework. Initial information about the upcoming alignment of DHS and IPH was shared with the committee. Continued workgroup activities were also reported at each meeting, including some work around strategic action planning and activities for each group. Workgroups continued to meet individually between CEASC meetings.

CEASC Meetings Summary SFY 2022

The CEASC reviewed the HF802 legislation and impacts to the status of HHS CPS staff attendance to RPI and URIB learning exchanges moving from mandatory as part of new worker trainings, to the status of optional to attend. The committee provided recommendations to the Bureau of Service Training and Support to continue to incorporate recommendations for culturally responsive practice to trainings provided to child protection staff. Introduction of applying the LOIP (Learning Outcomes Improvement Tool) for reviewing training curriculums with an equity lens was also presented by ISU CWRTP staff. Discussions by the CEASC further focused on defining accountability to communities impacted by disproportionality and disparity using the Results Based Accountability framework being utilized by the Vision Council and assessing action and alignment levels of the committee. The CEASC has also collaborated with the NYTD Youth Development Coordinator with the Iowa Department of Human Rights to present on the outcomes of the NYTD youth survey and the Youth Talking Wall at the April 2022 CEASC meeting.

CEASC Meetings Summary SFY 2023

The CEASC committee worked to revise the CEASC strategic plan and develop more concrete actions steps and desired outputs of the workgroups, with continued focus on the adopted Guiding Principles. Strengthening recruitment and support of a diverse workforce, improved linguistic supports available to families, and data informed strategies to decrease disproportionality and disparity, as well as opportunities for integration of equity driven practices were identified objectives for the strategic plan. The CEASC also continued discussion on opportunities to align work around youth and families impacted by both the child welfare and juvenile justice system through conversations about shared data points with CJJP staff. The CEASC began review and gathering feedback through a subgroup on the Trifold DHS “At a Glance” Quick Guide for families involved with DHS and CINA proceedings, to update the content and provide to service areas for utilization with families. An update was provided to the committee by the Learning Exchanges Coordinator on the utilization of the RPI and UIRB

learning exchanges, and application of the LOIP tool for incorporating an equitable lens to curriculum updates. The workgroups continued to provide progress updates at each meeting.

CEASC Meeting Summary SFY 2024
Please see the section titled APSR SFY 2024.

The HHS alignment created a shift in oversight of the CEASC and cultural equity focused activities described in this section. In SFY2024, HHS decided to bring the work of the Cultural Equity Coordinator to be housed internally within the Agency. The cultural equity focused coordination and duties transitioned to the Tribal and Cultural Equity Program Manager within the HHS Office of Health Equity in October 2023. The HHS service area geographical shift changes that occurred July 1, 2023, did not have a notable impact to the makeup of the county Equity teams or the work of the CEASC.

CEASC Workgroups Summary
One of the aims of the CEASC is to ensure all interested partners develop a better understanding of how to use these guiding principles and infuse them into the work of the child welfare system. To advance these efforts, several workgroups were formed to focus on various aspects of the GPCE and advancing the goals of the CEASC Strategic Plan. The CEASC revised the configuration and focus of the workgroups in 2020. The CEASC Strategic Plan has three strategic focus areas of Workforce, Practice and Centering Equity, with each workgroup aligned around the key strategies to move forward action items based on the CLAS Standards/ Guiding Principles. The following summarizes the work of the CEASC workgroups from 2020-2024:

CEASC Training and Workforce Workgroup:
The goal of this workgroup is to recruit, retain, and 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. A summary of the work completed by the Training and Workforce Workgroup includes:

- Review and recommendations of 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. A summary report of findings was shared with Bureau of Service Support & Training.
- Partnership with Iowa State University, Child Welfare Research & Training Project (ISU-CWRTP) to identify enhancement of an equity lens to HHS and community partner training and facilitation, which resulted in the equity focused Learning Outcomes Improvement Plan (LOIP). The team recommended the equity focused LOIP be integrated into HHS social worker training, curriculums, and trainers' skill building and development. In addition, recommendations included investment in the Intercultural Development Inventory (IDI) to assess and address challenges in cultural competency of DHS field staff and supervisors.
- Recommendations by the workgroup to include CEA representation on the HHS Training Committee to increase communication, provide insight and information to training curriculums, and avoid duplication of efforts.
- Recommendations for 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. Utilization of subject matter experts to evaluate and edit training curricula using a racial and cultural lens.

- Review of data and specific information about the recruiting, hiring, onboarding, and retaining practices of workforce across the state. Interviews were conducted with frontline and leadership staff, including supervisors, and a Social Work Administrator (SWA). Findings included that job descriptions for field staff were updated, which may have resulted in an increase of applicants and individuals being onboarded with more diverse backgrounds (i.e., medical background) and speaking another language other than English. However, a cultural equity lens was not specifically applied in developing the questions and there is no clear standard practice for conducting exit interviews. The lack of clarity of data from exit interviews can potentially cause a barrier in analyzing trends for why staff is leaving their positions, specifically the staff of color.

In SFY 2024, the workgroup planned to focus on gathering more concrete data to determine trends, researching promising practices being used to recruit, onboard, and retain a diverse workforce in other areas, and engaging with internal HHS groups working on recruitment and retention to develop specific steps to improve the outcomes in the focus areas. The workgroup further recommended guidance be provided to the CEA on how to best support the goal of building an equity-focused, culturally responsive workforce. However, due to the transition of the CEA and equity focused work to the Office of Health Equity, the workgroup did not continue meeting in SFY 2024.

CEASC Practice Workgroup:
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. A summary of the Practice Workgroup efforts includes:

- The Practice workgroup facilitated brainstorming exercises to identify focus areas for the group to address their efforts. The team identified themes, discussed the scope of possible activities, and further developed a tracking spreadsheet to organize the team's work. The team identified themes included growing trust with communities, communicating well, and being accountable. The chosen area of focus the workgroup identified to begin with is to set best practices with prioritized communities.
- The workgroup's 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. This 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. In addition, the workgroup reviewed available training and staff development and support opportunities on linguistic supports to child protection and case management staff.
- Summary recommendations and action items identified by the workgroup included addressing areas such as review of the existing Non-Discrimination Policy and provision of additional training, support, and increased available linguistic resources for child protection staff regarding translation, interpretation and reasonable accommodations for families involved with the child welfare system. Recommendations were provided to the Child Welfare Policy Bureau and the Office of Health Equity for consideration.

The Office of Health Equity utilized information from the CEA Practice Workgroup for linguistic supports, as well as gap assessments from other areas of the agency, to justify the creation of a Language Access and Translation Coordinator position to oversee the development and implementation of an Iowa HHS Language Access plan, oversee expansion of written translation and live interpretation services, and identify areas for quality improvement. This position is being filled in Spring 2024.

CEASC Centering Equity Workgroup:
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 and effectively use equity data, and a fusion of an equity lens across child welfare. A summary of the Centering Equity Workgroup efforts includes:

- Supported the development of the CEASC strategic plan to frame current and future equity efforts statewide.
- Orientation to the public facing child welfare dashboard from the statewide learning session has been incorporated into ICERs shared with equity teams, community partners, and contracted providers in supporting the analysis, understanding, and effective utilization of disaggregated data to inform local and agency courageous conversations and assessing workforce needs to infuse an equity lens.
- Work with HHS Quality Assurance/Improvement to pull statewide and county Equity Team data packets for race and ethnicity (Hispanic/Non-Hispanic) of children aged 0-17 for each county and statewide decision points over the past five years. The workgroup also secured speakers from QA/QI to support and a Social Work Administrator in a breakout at the learning session with county Equity Team members to better understand and utilize the data in their forward action planning.
- Guidance to County Equity Teams, the Cultural Equity Alliance, and other community partners of the local county data and promote 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. The Service Area Manager and Social Work Administrator from the Cedar Rapids Service Area delivered a presentation of the HHS dashboard to the Cultural Equity Alliance in March.

A subcommittee was developed through the CEASC in SFY 2023 to review and make recommendations to update the HHS-At-A-Glance trifold/ Quick Guide for Parents Involved with HHS Child In Need of Assistance Proceedings (CINA. The trifold was developed from a series of courageous conversations between Health and Human Services (HHS), child protection services staff, community organizations, community members, and with the disproportionally overrepresented African American/Black families and in Polk County, Iowa. The trifold's purpose was to provide information and resources about parents' rights and responsibilities. Parents, community, and HHS staff feedback informed the development and updates of the trifold. The trifold was developed and spread across county/service areas in Iowa to help parents and families understand court proceedings in the child welfare process, access resources, and clarify terms and acronyms they may encounter during their involvement. These include:

- Defining permanency
- Providing a right to appeal information
- Process of family meetings

- Court process timeframes
- Contact information for service providers (Child protection staff, incident #, contracted services worker, Attorney, Guardian Ad Litem, Parent Partner, Court Room).

Parent Partners, CEASC members, and HHS child protection staff feedback informed the development and updates of the trifold. In SFY 24, the updates to the CINA Quick Guide were completed based on the subcommittee and key partner recommendations. Rollout of the updated document to child protection staff will occur in spring SFY24. The updated CINA Quick Guide is included below, and is available in Spanish and for translation in other languages as needed:


Comm542.pdf

Summary of Resources Developed and Implemented in Partnership with CEASC (2020-2024)

Through the work of the CEASC, HHS has invested in developing and promoting Cultural Equity Resources over the past ten years through training, learning opportunities, and community presentations. Development and continued implementation of the following collaborative learning resources has occurred over the five-year period:

- *Guiding Principles for Cultural Equity:* The Cultural Equity Alliance developed and promoted the Guiding Principles for Cultural Equity GPCE to provide 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 the attachment of the full Guiding Principles for Cultural Equity below:


CEA- Guiding Principles_CLAS Stanc

- *CultureVision™:* CultureVision™ is a comprehensive database that allows users to easily find information about the specific cultural and ethnic behaviors, beliefs, and practices of diverse populations. While targeted towards medical professionals, the cultural information is relevant for those in the human services field. Culture Vision™ provides access to information regarding 48 different ethnic group categories, 16 religious' groups, and 13 other populations (including people with disabilities, LGBTQ, military/veterans, refugee, homeless, etc.).

  The contract for Culture Vision™ was discontinued following SFY 2021 due continued data reports from the service demonstrating low utilization of Culture Vision™. Due to the high cost to subscribe to CultureVision™, in addition to Cook Ross, who manages the service, announcing it was planning to sell the service to another administrator, HHS made the decision to discontinue the contract to subscribe to this service. The Practice Workgroup explored alternative and less costly options for access to similar information on diverse cultural groups and practices and was unable to identify a similar type of

resource that could be utilized at a reduced cost or no cost option. It was further determined that replacement of CultureVision™ may not provide the greatest benefit, but rather to examine underlying reasons the tool was underutilized.

- *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. In partnership with Casey Family Programs, Iowa developed a train-the-trainer program to implement Race: Power of Illusion (RPI) learning exchanges throughout the state.

- *Understanding Implicit Racial Bias: Rewiring Our Perceptions and Intentions:* This Learning Exchange, a full day interactive training developed by HHS in collaboration with Dr. Chris Martin of St. Ambrose University, the RPI Facilitators, and the Cultural Equity Alliance The learning exchange 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.

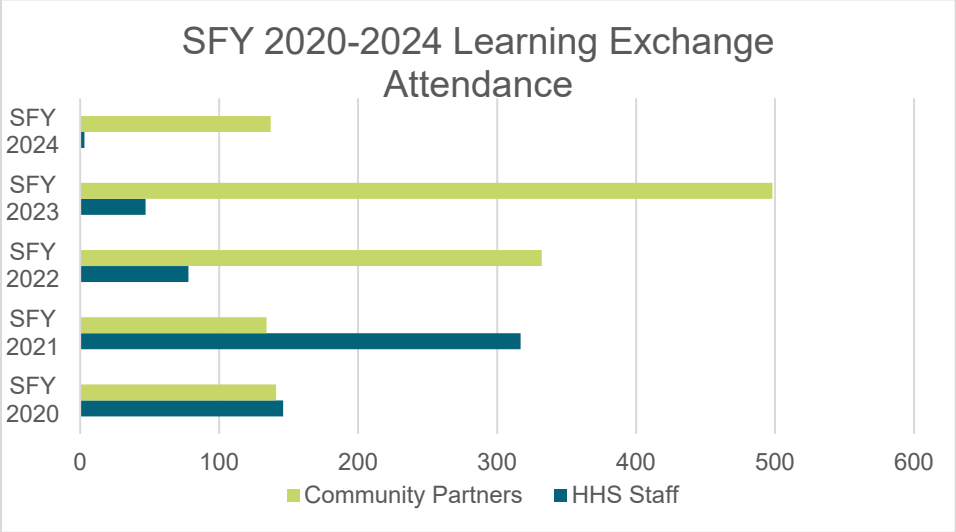
  Understanding Implicit Racial Bias (UIRB) is for HHS staff, child welfare partners, law enforcement, legal and judicial community, families, education staff and students, faith-based, and other primary prevention partners like Community Partnerships for Protecting Children (CPPC), Parent Partners, etc. 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.

  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’s *Race: The Power of an Illusion* Learning Exchange (RPI) or other foundational trainings which introduce participants to basic racial history, terminology, and concepts.

- *Learning Exchanges Summary SFY 2020-2024:* A total of 104 RPI and UIRB Learning Exchanges were held during the 5-year timeframe. Learning exchanges were hosted for both HHS and community partners to attend and were most frequently hosted by CPPC sites and community providers, as well as the Child Welfare Training Academy.

  The number of HHS child welfare staff in attendance of the Learning Exchanges has declined steadily since the Learning Exchanges were made optional for HHS staff. Efforts to encourage HHS attendance included HHS staff received email notifications at a minimum twice a month of upcoming Learning Exchanges through the HHS Service Training Newsletter and from the RPI/UIRB Learning Exchanges promotions.

Chart 1a: SFY 2020-SFY 2024 Learning Exchange Attendance



Please see the attached full descriptions below of the RPI and URIB Learning Exchanges:

RPI Summary.pdf UIRB Summary.pdf

In SFY 2020, coordination and support of the learning exchanges and facilitators was managed through a contract between HHS and the University of Northern Iowa. This coordination transitioned in SFY 2022 to an existing contract between HHS and ISU's CWRTP for coordination of learning and support to CPPC sites. The Cultural Equity Learning Exchange Coordinator through ISU provided coordination of the RPI and UIRB Learning Exchanges which included management of curriculum updates, recruitment, training and guidance to facilitators, evaluation and post exchange survey analysis, and scheduling of the Learning Exchanges at host sites. The previously mentioned developed LOIP tool was utilized for curriculum updates to evaluate training content, design, and delivery through an equity lens, and continuous quality improvement of both the RPI and UIRB curriculums.

At the conclusion of SFY 2023, there were 16 trained facilitators for the Learning Exchanges. Recruitment of new facilitators focused on diversifying the facilitator pool to include more facilitators with lived experience such as growing up in foster care, being adopted, navigating the juvenile justice system or the adult prison system. Additionally, new facilitators included diverse cultural and racial identities and identified as Black, Latinx, bi-racial, white, male, female, and/or as members of the LGBTQ+ community. Training and support were provided to the facilitators through train the trainer process, observation of facilitated exchanges by the Cultural Equity Learning Exchange Coordinator, and through bi-annual meetings and professional development with facilitators.

ISU CWRTP completed an evaluation report of RPI and UIRB Learning Exchanges in April 2023. A Graduate assistant led the work to provide data analysis and report preparation. This evaluation project investigated the knowledge and views of participants before and after the UIRB Learning Exchange and the RPI Learning Exchange through assessing participants' self-reported changes on the post exchange evaluation surveys.

The Understanding Implicit Racial Bias Learning Exchange 2021-2022 report and one page poster summary can be found here:


UIRB Final Report.pdf


UIRB Poster.pdf

The Race: The Power of an Illusion Learning Exchange 2021-2022 report and one page poster summary can be found here:


RPI Report 2022 final.docx.pdf


RPI_Poster.pdf

- *Introduction to Cultural Equity Resources:* 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.

  The 1–2-hour ICER provides an orientation to:
  - 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 as CultureVision™, available trainings, and social media.

  Pre and post response on surveys from participants of ICERs included the importance of considering own identity and identities of the families served; awareness of equity, diversity, inclusion, cultural competence, and cultural humility within their organization or state; data availability to learn and better understand disproportionality and disparate outcomes in the child welfare system; comments and reflections including future training, learning or action steps they intend to take as individuals or organizations. Feedback to

the ICER presentations has been overwhelmingly positive regarding learning growth and knowledge of available resources.

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. Beginning in October 2022, presentations have occurred every other month to Social Work Case Managers. Additional presentations to CPW 200 trainings for Child Protection Case Workers were offered in SFY 2024.

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 DHS staff meetings, community gatherings, schools etc. Please see the Courageous Conversations Toolkit in attachment below:

Toolkit for
Courageous Conversa

- *Cultural Equity Resources Facebook:* The Cultural Equity Resources for Iowa Facebook Page provided easily accessible 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 24.

- *Cultural Equity Resources Assessment:* HHS partnered with the AmeriCorps 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 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 Community Partnerships for Protecting Children sites, as well as DHS 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 DHS 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 DHS 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.

Breakthrough Series Collaborative (BSC)

The Iowa Beyond the 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 partner and community 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; Social Work Supervisor; and HHS Social Worker SWCM or CPW
- Judge and a 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 AMP)
- Child Welfare Services Community Partner (Usually a local child welfare services provider)

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

The following is a summary of the activities under the BSC initiatives during the 2020-2024 reporting period:

Equity Learning Sessions:

During the Covid pandemic, the BSC Annual Equity Learning Sessions were held virtually, and resumed to be held twice per year, in the fall and spring. In November 2022, the fall learning session returned to be held in person. A virtual learning session followed in May 2023. As mentioned previously, the cultural equity work transitioned in Fall 2023 to the HHS Office of Health Equity. Due to the transition, it was determined to postpone the November 2023 learning session to a later date.

At each annual Equity Learning Session, time was devoted to County Equity Teams reporting on a range of team activities and their self-assessment on the development continuum for their teams, which includes team building; data gathering, understanding, assessing, and clarifying local disparity data; planning efforts; and implementation, testing, and spread of developed strategies.

Table 1a: Summary of Equity Learning Session Topics of Focus Areas 2020-2024		
Learning Session	**Session Topics**	**Session Learning Objectives:**
November 2019 In-Person 155 Attendees	▪ Minnesota Guardian Ad Litem, Kelis Houston, on the intersections of parental substance use, poverty and child protection and the criminalization of substance use in communities of color ▪ Workshops on specific populations and knowledge building for participants and teams to inform future strategies to continue to address disparate outcomes ▪ Team engagement, data, and improving outcomes	▪ Celebrate 10 years of BSC and build on promising initiatives, practices, and policy changes ▪ Improve understanding and use of data, field, and family experiences ▪ Assess and plan equitable impactful change and to heal from inequitable practices with culturally and ethnically diverse communities.
October 2020 Virtual 140 attendees	▪ HHS Director Kelly Garica and Janee Harvey, Division Administrator on HHS updates and Family First Implementation ▪ Cultural Equity Resources (CER) Project Summary ▪ Equity Team Self-Assessment	▪ Self-assess and develop plans for team building, identify and address challenges, and measure impact of change ▪ Gain a better understand and build on promising initiatives, practices, and policy changes across the state ▪ Improve understanding and use of data and field, community and family experiences reported in the CER project to inform and guide the work ahead
May 2021 Virtual 120 attendees	▪ HHS SWA presented overview of MEPA and other historical child welfare legislation ▪ HHS SAM and Service Training Bureau Chief demonstration of Iowa HHS Child Welfare Dashboard ▪ Equity Team Updates	▪ Learn how historical legislation affected practice and outcomes for children and families of color ▪ Interpret and utilize data for Equity teams to analyze and develop their planning efforts ▪ Learn how the teams addressed needs/challenge over the last six months
November 2021 Virtual 130 attendees	▪ Director Kelly Garcia on centering of equity in the HHS alignment process ▪ Equity Team spotlights focused on Polk County's AACCT and Wapello County utilization of CCC Toolkit ▪ Marlo Nash, presented on Results Based Accountability (RBA) framework	▪ Provide an update on policy and practice changes occurring at the state level ▪ Share equity team progress in team building, centering data, and Plan-Do-Study-Acts (PDSAs)

Table 1a: Summary of Equity Learning Session Topics of Focus Areas 2020-2024		
Learning Session	**Session Topics**	**Session Learning Objectives:**
		▪ Teams assess action and alignment through RBA model in local and statewide equity efforts
May 2022 Virtual 100 attendees	▪ Director, Kelly Garcia, on HHS alignment and cross systems equity focus on practice and policy. ▪ Janee Harvey, Division Administrator, provided updates on Family First and Iowa Code 232 changes ▪ Woodbury County Equity Team Spotlight focused on disproportionality for native children Resilient Communities (Iowa Child Abuse Prevention Program) and Tribal Customary Adoption ▪ Affinity groups and county equity teams participated in focused conversation	▪ Identify team strategies related to the four quadrants of action and alignment for impactful results ▪ Plan-Do-Study-Act (PDSA) was utilized regarding pilot of customary tribal adoption ▪ Update on state policy changes impacting disproportionality and disparity
November 2022 In person 115 attendees	▪ Iowa Youth Council and AMP (Achieving Maximum Potential). ▪ Healing Centered Engagement in partnership with Iowa ACEs 360 and a young adult that experienced the child welfare system ▪ Panel discussion with a judge, Attorney General, a young adult with lived experience, and the Department of Human Rights moderating a discussion on centering equity in practice and policy ▪ Workshops on working with LQBTQI+ youth in out of home care, Eastern Iowa Equity Team Spotlight PDSA, understanding and analyzing disaggregated data to better utilize locally.	▪ Learn strategies for developing clear plans for action, measuring progress and challenges. ▪ Learn, practice, and model how to have courageous conversations ▪ Authentic engagement strategies of children and families, caregivers, and community members as partners. ▪ Data centered practices to impact disproportionality and disparate outcomes at key child welfare decision points.

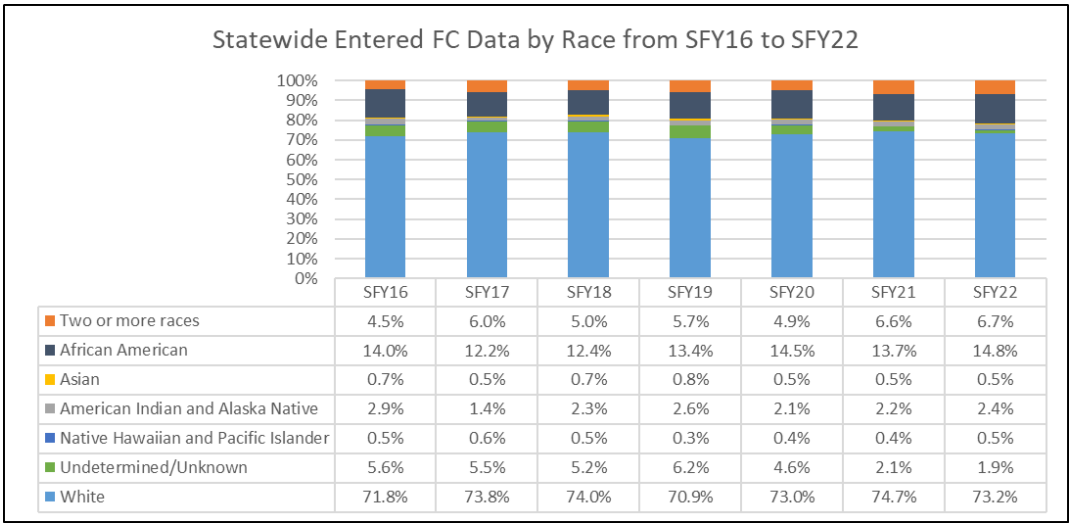
Table 1a: Summary of Equity Learning Session Topics of Focus Areas 2020-2024		
Learning Session	**Session Topics**	**Session Learning Objectives:**
May 2023 Virtual 86 attendees	▪ Kinship Navigator Program overview and culturally responsive services and supports to kinship families ▪ Black Hawk County Equity Team Spotlight on entry data into the system from mandatory reporting to intake to key decision points of disproportionality specific to African American children, ▪ HHS update from the new Child Protection Services Director, Lori Frick	▪ Shared learning environment with others during the session to develop action plans ▪ Learn how others have courageous conversations about eliminating racial and cultural disproportionality and disparities in child welfare at multiple levels and apply the learning to a team or collaborative efforts). ▪ Learn how to implement data-centering practices, equity-focused protocols, and policies for eliminating disproportionality and disparate outcomes as key decision points

<u>County Equity Teams:</u>
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:

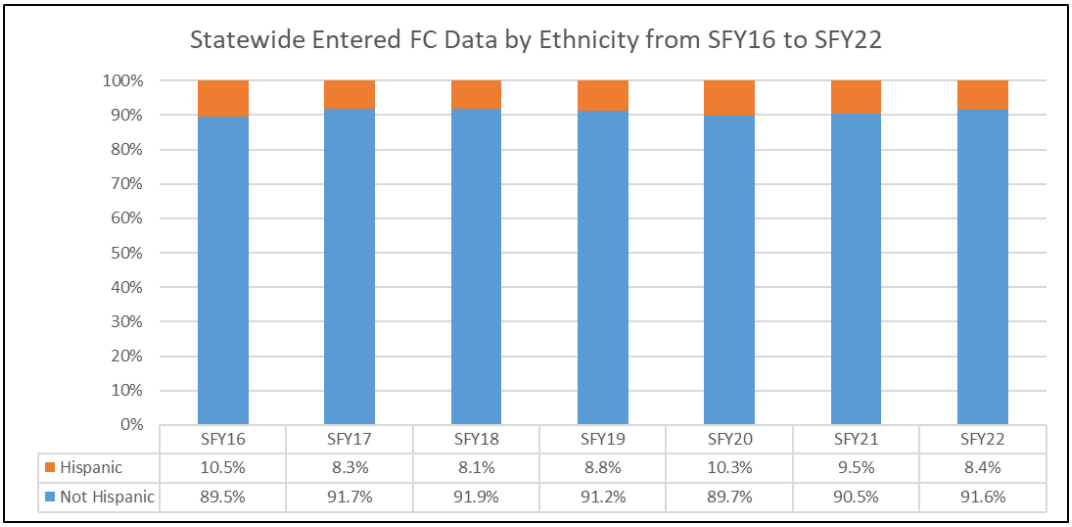
- Accepted referrals: Number of children involved in accepted (screened-in) for investigation or assessment.
- Victims of abuse: Number of children of substantiated or indicated (confirmed or founded).
- In Foster Care: Number of children in out-of-home placement anytime during the state fiscal year,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

An example of data provided to the Equity Teams for each county is shown below regarding Statewide Entered Foster Care data by race and ethnicity from SFY 2016 – SFY 2022. Note, data packets were not provided to the Equity teams in SFY 2024, due to the transition of cultural equity coordination and the decision to postpone the fall equity learning session. Annual county data packets are typically provided to the teams at the learning sessions.

Chart 1b and 1c: Statewide Entered Foster Care Data by Race and by Ethnicity SFY 2016-SFY 2022



	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22
Two or more races	4.5%	6.0%	5.0%	5.7%	4.9%	6.6%	6.7%
African American	14.0%	12.2%	12.4%	13.4%	14.5%	13.7%	14.8%
Asian	0.7%	0.5%	0.7%	0.8%	0.5%	0.5%	0.5%
American Indian and Alaska Native	2.9%	1.4%	2.3%	2.6%	2.1%	2.2%	2.4%
Native Hawaiian and Pacific Islander	0.5%	0.6%	0.5%	0.3%	0.4%	0.4%	0.5%
Undetermined/Unknown	5.6%	5.5%	5.2%	6.2%	4.6%	2.1%	1.9%
White	71.8%	73.8%	74.0%	70.9%	73.0%	74.7%	73.2%



	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22
Hispanic	10.5%	8.3%	8.1%	8.8%	10.3%	9.5%	8.4%
Not Hispanic	89.5%	91.7%	91.9%	91.2%	89.7%	90.5%	91.6%

Additionally, guidance was provided to teams in the learning session or at individual County Team meetings to utilize the HHS agency child welfare dashboard (https://hhs.iowa.gov/dashboard_childwelfare)for more real time reports to utilize in decision making specific to team building, understanding the data and planning PDSAs.

The Cultural Equity Statewide Coordinator provided technical assistance to the teams to focus on leveraging potential collaborations and identifying the next steps in their efforts. In assessing team development and implementation, during the five-year period several teams progressed from team building to data analysis and into planning. Data packets are intended to assist the county Equity Teams in driving their team action planning and development of PDSAs.

The Covid pandemic initially impacted the Equity teams' ability to convene regularly and their continued momentum to carrying out PDSAs. Many teams have experienced attrition or

changes in their Day-to-Day Manager and team members during the 5-year period. However, some teams have found ways to address this, such as meeting virtually, creating subcommittees to move forward PDSA's, leveraging efforts with other initiatives such as local CPPCs, Resilient Communities grantees, Juvenile Justice teams, and/or have made overall efforts to rebuild their teams, with varying degrees of success on this effort.

The Equity Teams have identified several challenges and barriers around capacity to lead the efforts of their county team, and many have expressed a need for additional dedicated staff support and guidance of team efforts. Further identified needs of the teams include increased engagement and community representation, a need for additional funding and resources to support and sustain efforts, and additional guidance provided to the teams to improve the ability to effectively conduct, spread and sustain, successful PDSAs. The following is a summary of each county Equity Team on their activities during this 5-year period:

Des Moines Service Area:

- **Polk County** Equity team worked on projects regarding HHS social worker recruitment, hiring and retention practices, including creation of case scenarios during interviews of field staff to assist in assessing culturally responsive skills and a creation of a support group entitled the Worker of Color (WOC) Support Group. The Polk team evaluated cultural and healing centered staff support, utilizing the Intercultural Development Inventory (IDI) to assess and support their HHS social workers and supervisors.
- The Polk Equity team spearheaded a project to evaluate the effectiveness and outcomes of the African American Case Consultation Team (AACCT), which is a team of community volunteers who provide consultation and case review with HHS staff in Polk County regarding child welfare cases involving Black children and families to reduce child/family separation, increase reunification and improve disparities. See the AACCT section of the report for more information.
- The Polk County Equity Team was spotlighted in the Fall 2021 learning session for team their activities. As of SFY 2024, the Polk Equity is not meeting currently.

Eastern Iowa Service Area:

- **Scott County** Equity Team case review project resulted through team discussion about the process of removals in their area, and how the team could evaluate and reflect on local practice through the case review project. The case review workgroup presented at the Equity Team Spotlight for the Fall 2022 Learning Session. The case reviews focused on African American children within child protection from point of referral, entry, and decision points or primary reason of removals and placements. This included review of case notes and reports assessing whether the language used is fair or biased, and incorporating the Four Questions/Seven Judges and documentation. The team hopes to utilize what is learned from this process to proactively engage organizations that are entry points to mandatory reporting (education, law enforcement, health, social services, etc.) Review of cases continued into SFY 2024 and is planned to spread to other counties in the Eastern Service Area moving forward.
- **Des Moines, Dubuque and Scott Counties** Equity Teams Day to Day Manager through Scott County Kids ended in SFY 2023 due to time commitment and resources needed. Continued funding was also needed to secure an Equity Team facilitator position to serve the three counties through Decategorization beyond SFY 2023, but the approved position went unfilled.

As of SFY 2024, the teams in the Eastern Service Area have no longer continued to meet due to the lack of an available Day to Day Manager. The Eastern Service Area has identified the need for a dedicated staff position to be able to lead and coordinate the three equity teams to move forward.

Western Service Area:

- **Woodbury County** Equity Team through the Attorney General's office, the PDSA framework was utilized to build the strategy around Tribal Customary Adoption (TCA) utilizing existing Iowa Code 232. The purpose of the PDSA is to honor the Tribal custom of avoiding termination of parental rights while allowing for the customary adoption of a child as a permanency option successfully implemented with several children. TCA is a culturally appropriate option for Native American children and provides a permanent home for children but does not require termination of parental rights. The Woodbury County Equity Team, tribes from surrounding states and Iowa, Attorney General's Office, and HHS informed the development and implementation of this PDSA as it rolls out this year and continues to be tracked for improvements.
- Success in these efforts provides Tribes with an option for their tribal children to be involved in State proceedings when looking at long-term placement. The outcome is geared to reduce the number of Native terminations of parental rights in the WSA, specifically Woodbury County.
- The Woodbury team continues to look at cross-strategy collaboration with the Iowa Child Abuse Prevention Program (ICAPP) Resilient Communities Demonstration Project grant to Siouxland Human Investment Partnership (SHIP) & Siouxland Council on Child Abuse and Neglect (SCCAN). The project is entitled "Native Resilient Communities" and engages various partners, including CPPC, county Equity Team, service providers, AGs office, Native Unit, JCS, the School District, Police, Probation, and many others to inform their efforts focused on Native children and families. They continue to elevate education and endorse proactive concrete support for children and families, especially within the K-12 education system, to connect with tribal resources for diversion to child protection system referrals.
- As of SFY 2024, the Woodbury County Equity Team continues to meet regularly but identifies a need for additional data to work from and do not have a clear plan of how to proceed moving forward. In Woodbury Co. there have had 5 tribal customary adoptions thus far. The Woodbury Equity Team is requesting more support to continue their efforts.

Northern Service Area:

- **Black Hawk County** Equity Team is working to establish team building and data analysis to develop PDSAs based on their county disproportionality data. They are working through data disaggregation of reports into child protection by various systems, assessing decision points at intake, and determining founded/confirmed and placement decisions by zip code. Black Hawk Equity team presented on at the May 2023 Learning Session and share resources other teams can utilize to develop their PDSA.
- As of SFY 2024, the Black Hawk Equity Team is not meeting regularly as they feel they don't have the support they need to continue their efforts currently.

- **Webster County** Equity team has had challenges in consistently meeting and identifying its own self-assessment and action plan. As of SFY 2024 there is not an equity team in place for Webster Co, although the HHS Day to Day Manager has been able to join another community team which has been identified as very similar to the equity teams.

The team joined consists of law enforcement, school, treatment counselors, and hospital representatives that come to the table.

Cedar Rapids Service Area:

- **Johnson County** Equity Team is hosting various community conversations to align equity efforts across Juvenile Court Services, Early Childhood Education, child welfare, CPPC, and city/county efforts to support children and families. The primary community focus is proactively engaging the Congolese community though informal community and trust building sessions.
- As of SFY 2024, the Johnson County Equity team is a combined team with the Disproportionate Minority Committee, as they felt it would be more efficient to combine efforts. The team is actively still meeting, and efforts are focused on community education, data collections for disaggregated data for systems for youth, working on policy changes, collaboration with Community Partnerships for Protecting Children, and last year they offered an immigrant forum. They have identified flexibly on their team to address identified challenges in the community.

- **Linn County** Equity Team has new leadership, and members are focused on youth voices in the courtroom and developing a worksheet to be shared with the court. Linn County Decat -CPPC and the Equity Team co-hosted a Housing Services community learning opportunity and are continuing to determine what funding resources are available for their PDSAs.

- **Wapello County** Equity Team has worked to respond to changing demographics and proactively engage Pacific Islanders- Marshallese community members. This team had a similar approach to their initial strategies to engage the Latino/ Hispanic community in previous Plan-Do-Study-Act (PDSA) efforts. The team has worked to build data collaborations with K-12 education and the main local employers to better assess new community members' linguistic and cultural needs and identify resources for accessible and reliable language assistance when needed.
- Wapello County utilized their Equity Team leadership within HHS to facilitate a series of ICERs implementing activities from the Toolkit for Continuing Courageous Conversations with child welfare service staff and community partners and contractors. They were able to provide 3 sessions, 3 hours each in 2021 reaching over 50 individuals for in-person interactive learning in July of 2021. This included HHS staff, Parent Partners, Qualified Residential Treatment Program, and shelter staff. In October 2021, an additional 3 sessions were held with 33 participants. The effort stemmed from objectives to enhance skills address racial inequities by DHS staff and providers to have courageous conversations with each other and communities. Although Wapello County data indicates lower levels disproportionality or disparities, the Equity Team wants to remain proactive as local demographics have changed over the past 10 years. Wapello County Equity Team efforts were also spotlighted at the Fall 2021 learning session.
- As of SFY 2024, the Wapello County team continues to actively meet, however some of the momentum has dwindled following the recent passing of an HHS team member who was an active and dedicated leader of the team. The current Day to Day Manager hopes to dedicate more time to the equity team moving forward and they plan to work on addressing the language barriers that they are currently experiencing in their service area.

AACCT Project

African American Case Consultation Team (AACCT) is a team of community representatives who identify as Black or African American to provide consultation and case review with HHS staff in Polk County regarding child welfare cases involving Black 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, 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.

In 2022-2023, this work aimed to analyze the recruitment and retention of the case consultant team, assessing outcome data on cases consulted by the AACCT to evaluate outcomes and to consider spreading this case consultation practice to other counties in Iowa. Funding from Casey was utilized to compensate the AACCT members and participating in training opportunities about Juvenile Justice, and future vicarious trauma training for team and Black staff, HHS overview of changes and court processes and appeal rights. Some of the members declined compensation or were not permitted due to state or local employment.

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 staffings 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 CY 2022, the AACCT team consulted on 16 cases, and in CY 2023 the team consulted on 12 cases.

Challenges experienced by the project include:

- HHS staffing changes and capacity challenges contributed to difficulty with collection and input into the data tracking tool
- HHS worker turnover mid case on a case previously staffed by the team
- Overall staff changes/decrease of staff on the project team have contributed to less dedicated tome to the project. Case staffing have continued to be a priority despite these challenges and have continued to be held consistently as scheduled.

- Child Protection staff turnover to be able to follow up specific to impact on practice or decision-making and outcomes, and limited resources to collect and input data into the tracking tool.
- Spread of the case consultation practice to other communities or statewide has not yet occurred.

In January 2022, a test data set was generated by the AACCT project leads regarding cases tracked who had received an AACCT consultation from the period of May 2019-January 2020. Data points included whether the case was court involved Yes (8), No (4); permanency goals for the youngest child in FACS including guardianship (1), remaining in the home (4), and reunification (8). Also included in the data set were reasons for HHS involvement: substance use (2), domestic violence (1), other/unknown (9). Recommendations by the AACCT on these cases included increased parental supports (10), financial supports (1), child supports (1) and additional family services and supports (1).
Prior to 2022, there had not been a focus on collecting data. The test data set was generated for the purposes of a baseline understanding on data collection during this period. Since this point, it has been difficult to track data from a process standpoint and demonstrate through metrics the impact of the AACCT on improving caseworker practice.

Caseworkers who staff cases with the AACCT receive feedback on engagement, service provision and how to apply a culturally responsive lens to how we serve and interact with black families. They have indicated the AACCT team has helped them to better engage with families but also to better understand some behaviors and dynamics that are common within black families. Caseworkers may further request a consultation for ideas on how to improve a relative caregiver's protective capacities, how to better support foster parents of different races caring for black children, or to receive guidance on how to facilitate culturally humble conversations with families.

Another positive impact of the team is improved relationships between the local black community and HHS. This has spread throughout the black community by word of mouth which has aided the local black community in knowing HHS was taking steps to improve our service and engagement of black families. While these points of engagement with families and the community may yield positive outcomes, they may not align directly with the data points being looked at.

The Des Moines Service Area HHS Social Work Administrator provided the following context regarding experiences working with the AACCT as a caseworker, "I can also tell you as a former worker and specifically, a black worker, the team allowed me to feel support and validation in circumstances where I was advocating for us to do things in a more culturally responsive way, but maybe receiving pushback from other parties. Having these very difficult and necessary conversations are how we overcome barriers that result in the disproportionate and disparate outcomes for black families, but it can be very challenging and overwhelming to broach this subject as a marginalized person. Staffing cases with the team helped me find my voice in those moments and ultimately serve families better. Other workers of color have provided similar feedback."

Though data collection may demonstrate outcomes of the AACCT consultations for families, it has been a challenge to determine how to collect data in a meaningful way to illustrate the rich

benefits of the team that may not directly result in moving the needle regarding permanency outcomes.

In SFY 2024, the AACCT project leads facilitated a feedback session with HHS CPS supervisors and staff in Polk County about their experiences utilizing the AACCT for consultation on their cases with Black/African American families. The feedback was overwhelmingly positive, with many expressing the benefits the consultations have had on their next steps with families. Constructive feedback included engaging supervisor teams who are less likely to refer for case consultation, to help ease anxiety about the process and reinforce the benefits of case consultation. Mentoring and shadowing on this process are ideas for increasing referrals, and the supervisors plan to continue to collaborate on this effort.

There is also a plan to follow up with caseworkers who engaged in consultation with the AACCT at 30 days and at 90 days, to learn more about the benefits and outcomes of the consultation, and to provide feedback to the AACCT on their efforts. The project team has identified a need to "go back to basics" with this project, recognizing that the qualitative experiences by the families, caseworkers and AACCT are as meaningful and the measurable outcomes, and that both are valuable to the success of the team and in improving the well-being for Black/African American families involved in the child welfare system.

SFY 2024 APSR Report:
In October 2023, coordination of the CEASC transitioned to Samantha Magpie, ICWA/Cultural Equity Manager within the HHS Office of Health Equity. She will be taking over cultural equity coordination duties from Child Welfare Research and Training Project as that contract has now ended with Iowa Health and Human Servies. The following provides a summary of the CEASC meetings and the Equity Learning Exchange between the period of May 2023-April 2024.

<u>May 2023 Equity Learning Session</u>
On May 24, 2023, the Equity Learning Session hosted in collaboration with Iowa Health and Human Services (IA HHS) and Child Welfare Research and Training Project. This learning session had approximately 87 attendees. During this learning exchange, the first session was conducted by Lori Frick as keynote speaker for HHS Director of Child Protection Services to provide an update on HHS equity work. Additional sessions included a presentation by the Kinship Navigator Program and panel and county Equity Team Spotlight: Black Hawk County. See chart on Summary of Equity Learning Session Topics of Focus Areas 2020-2024.

Participants provided feedback for topics to consider for the next learning session: how to improve the cohesiveness/functioning of local teams and establish effective equity team leadership at the local level; integrating more diverse perspectives from families of color, community organizations, supporting LGBTQ children and caregivers, have more concrete idea of how the state is going to implement data from these various projects and culturally responsive resources into everyday practice and state policy; and to have the HHS Quality Improvement team discuss how to use the data.

<u>June 2023 CEASC Meeting</u>
On June 8, 2023, a Cultural Equity Alliance meeting took place virtually, in which was opened by Janice Lane Schroeder and Julie Clark-Albrecht. Iowa Updates came from Janee Harvey and Lori Frick which included, Child Protection Assessment, Change and Innovation Agency (CIA): IHHS-CIA Preliminary Findings Progress Report 02.2023 on the HHS. The CEA, Office of Equity, and HHS Child Protection Services Planning Meetings to align and elevate the CEA and

county equity team efforts. The Trifold Project- “DHS-at-a- Glance” (Quick Guide for Families Involved with DHS and Child in Need of Assistance Proceedings). Both workgroups and County Equity teams were able to provide their updates on the work.

September 2023 CEASC Meeting

On September 14, 2023, a Cultural Equity Alliance meeting took place virtually, in which was opened by Janee Harvey, Division Director and Matt Highland, IHHS Chief of Strategic Operations. They provided CEA and equity framework, transition/opportunities on moving forward. After this transition updated there was an update provided by the Office of Health Equity (OHE), Oliviah Walker. She provided an update on the next steps we are going to see coming from the CEA.

Group discussion included an exercise utilizing the SOAR analysis in which the group worked on strengths, opportunities, aspirations, and results for the next iteration of the CESAC. After the SOAR analysis, the CEA looked at the workgroup updates.

December 2023 CEASC Meeting

On December 14, 2023, a CEASC meeting took place virtually, in which was opened by the Office of Health Equity, Oliviah Walker. The group met Samantha Magpie during this meeting in which she will be taking over the CEASC daily tasks. OHE was able to provide updates such as attending the Memorial March for Lost Children in Sioux City, IA, in addition to the November learning exchanges that were held at the Memorial March, including RPI and UIRB.

Memorial March for Lost Children

The meeting included breaking into two different groups where one group discussed training and capacity building, while the other group discussed strategic planning for the CEA. The group focused on training and capacity building discussed adding more community partners such as educational partners and law enforcement to the committee. Also discussed is a need to work on targeting specific entities to engage with them on what is continuously discuss during the CEASC. Though the equity teams are a part of the broader cultural equity work, they may not be fully represented on the committee, and there is intention to further bring the equity teams together more directly in to the CEASC work.

The group that discussed the CEASC strategic planning decided they would like to see the work of the CEASC be more impactful, and to explore how to apply the trainings and information we give to CPS workers and assess how do we know the information is being retained and applied in practice and how to measure improvement in know outcomes are improving for children and families. The CEASC would like to see new staff retain information, and to see them be supported and competent in application of the learning. The CEASC further wants to see staff be given opportunities to analyze biases and lived experiences, in addition to projects and efforts being effective at the county-level, and how we are communicating between central office and county levels. After both groups met, they were able to report back to the large group.

March 2024 CEASC Meeting

On March 07, 2024, the CEASC meeting took place virtually, and was opened by Samantha Magpie and Diamond Denny from the Office of Health Equity. OHE provided updates which included, RPI and UIRB training as at this time there will be a pause on the training until OHE can explore updates the curriculums. Diamond was able to provide an update on the Health Equity Assessment that is being implemented across HHS. Currently, the assessment is underway, and is currently in the survey phase. OHE also provided an updated on open positions in their office. Janee Harvey presented a summary of the C!A recommendations. The themes of the CIA Assessment covered, increase in prevention efforts, support relatives, kins and foster parents, eliminate barriers to engagement and services, support to child welfare staff, and increase system efficiencies. Janee talked about systems in which the VISION system is set to launch this summer, it will be about 2-3 years before it is a full replacement of FACS. She also spoke about support in which reducing supervisor to worker ratio, and implementing a structured decision-making tool intake, and developing separate licensing standards for relative and fictive kin. Lastly, she covered recruitment and retention investments in which, IV-E stipend program for MSW, expand trauma supportive services, equalize pay difference between SWCM and CPW, and standardize mentoring opportunities toward the goal to “Change the culture of how we are doing the work”.

CEASC members provided feedback at the conclusion of the meeting, and this included the need to determine direction for the CEASC, as it is hard to identify tasks to continue to work on until clearly identifying the direction of the work, and to ensure the efforts are intentional and within the capacity of the members. Moving forward, OHE will work on developing a core leadership team or workgroup to focus on developing on the next CEASC strategic plan. The CEASC will review the previous mission statement and values the previous goals and objectives of the committee and then compare to some goals and values today.

Learning Exchanges and Training

Hosting of the RPI and UIRB learning exchanges have been paused at this time as OHE is exploring opportunities for pursing a contracted services to update the two curriculums, pending any copyright of materials and permissions needed to make any structural modifications. OHE is also working on revamping the presentations for the new social worker trainings SW 020 and CP 200.

Section II: Update on Assessment of Performance, Plan for Enacting Iowa's Vision and Progress to Improve Outcomes

UPDATE ON ASSESSMENT OF PERFORMANCE

Please see *Iowa's FFY 2025-2029 Child and Family Services Plan* for information regarding Iowa's performance on the Child and Family Services Review (CFSR) seven outcomes and seven systemic factors.

PLAN FOR ENACTING IOWA'S VISION

In the 2020-2024 CFSP and subsequent APSRs, states were asked to identify the plan for enacting the state's vision to improve its program, services, and outcomes for children and families over the next five years. In the 2020-2024 Final Report, provide the final update to that plan for enacting the state's vision and plan for improvement.

Iowa's PIP comprised the Plan for Enacting Iowa's Vision. Iowa completed its PIP goals as of June 30, 2022. Summary information on the strategies addressed in the PIP are below. These strategies were developed for the purpose of continuous improvement as measured through Child and Family Services Review (CFSR) case reviews and administrative data. The impact these strategies have had on Iowa's ability to meet PIP performance measures is evidenced in the CFSR case review information.

Strategy 1.1: Ensure child safety during each stage of the case and improve safety and risk assessment and management.

This strategy was successfully implemented in full as of December 2021; ongoing monitoring and evaluation will continue.

The National Council on Crime and Delinquency (NCCD) and an HHS team collaborated to develop safety assessment and planning tools; these were fully implemented when training was completed in December 2021. Since that time Iowa has met the PIP target for OSRI Item 3 (Safety/Risk Assessment and Management). Data generated from the CFSR case reviews is a standing agenda item during team meetings in all service areas; these discussions include analysis, identification of trends, examples, and ideas to improve practice.

Strategy 1.2: Increase face to face initial contact with child victim(s) within the assigned timeframes and, if delays must occur, supervisors and CPWs collaborate to assure the child's safety until face-to-face contact occurs.

This strategy was successfully implemented in full as of June 2021; ongoing monitoring and evaluation will continue.

A statewide group explored both the timeliness of visits within the initially assigned timeframes as well as essential actions/discussions to have with the supervisor if having difficulty with meeting the timeframe. This workgroup developed field guides regarding the standard process for staff and the responsibilities of the supervisor in order to increase consistency of when, why, and how this process is used. Monitoring of timeliness of contact with child victims continues to be a key performance area for Iowa and is monitored monthly with follow up in service areas by Leadership Teams and statewide through the Service Business Team (SBT).

Strategy 1.3: Implement the Safe 4 Home initiative (4 questions) statewide.

This strategy was successfully implemented in full as of December 2020; ongoing monitoring and evaluation will continue.

This strategy has been successfully integrated into practice by both HHS social workers and the Courts. These questions are seen as fundamental to evaluating whether there is a way to keep children safely at home with their parents and are often used in conjunction with Child Safety Conferences, Safety Plans, and Family Preservation services. These varied strategies provide opportunities for families to identify their resources and the support they need to maintain a safe environment for their children.

The number of children in foster care placement in Iowa has decreased significantly over the years; below a chart illustrating this with data over the last four years, which coincides with implementation of the Safe 4 Home initiative.

While it is not possible to draw a direct correlation between this strategy and lower removal rates, this family-centered practice makes sense as foundational questions for teams to consider.

# Children on Placement Caseload at Beginning of State Fiscal Year	
SFY21	4577
SFY22	4268
SFY23	4086
SFY24	3764

Strategy 2.1: Develop resources, strategies, and training to address issues related to identifying, locating, and engaging all fathers

This strategy was successfully completed in full as of July 2021; ongoing monitoring and evaluation will continue.

As indicated in the narrative regarding case review performance, Iowa's PIP focuses specifically on increasing the department's efforts to engage fathers in services. Progress occurred regarding standardizing technical aspects of this, such as locators, practice timeframes to contact fathers, and expectations of efforts, etc. In addition, Iowa worked closely with fathers in the Parent Partner program to:

- narrate their experiences with the child welfare system;
- incorporate their stories and voices; and

- put a face on the effect of HHS practice, which will address adaptive skills through understanding what our system feels like from their perspective: hurdles they faced, perceptions of their importance relative to a mother's importance in the family, and services that may have helped them address issues if offered.

These were all integrated into a new training session which has received significant positive feedback.

Feedback sessions held with parents, social workers, correctional facilities, and other stakeholders in the Fall of 2021 inquired about participants' experiences around HHS efforts to locate and/or engage fathers; feedback was positive from mothers and fathers involved in the child welfare system. Many positive changes were observed regarding: the way HHS partners with families; the training that brings in the father's voice and experiences; and the work with correctional partners in regard to providing space conducive to visits. Iowa recognizes that efforts to engage fathers must be an ongoing practice and continues to include focused conversation during routine supervisor/social worker consultation.

Evidence of the ongoing focus on engagement of fathers is demonstrated in the improved performance in OSRI items 12B, 13, and 15 (See Section for specific data on each of those items as well as the overall performance on OSRI items over time). In each of these areas data analysis prior to PIP implementation showed that lack of father engagement was driving performance. Throughout the PIP period there was a direct correlation between increased engagement of fathers and improvement in overall performance in those areas.

Strategy 2.2: Quality Legal Representation: Increase timely successful permanency through improved quality legal representation.

Red Book Training and an additional specialized training that expands on Iowa-specific interpretation of federal and state statutes has been implemented.

These trainings offer the legal community improved educational opportunities to immerse themselves in child welfare law and practice leading to improved quality of representation and to improved outcomes for Iowa's children and families. CIP will continue to work closely with attorneys to encourage their participation in both training and certification and will monitor these initiatives.

Strategy 2.3: HHS workers enter information regarding a child's initial placement or change in placement within 3 business days of the placement/placement change.

This strategy was successfully completed as of January 2021; ongoing monitoring and evaluation will continue.

Following the development of a standard expectation for timeframes to enter changes into the IT system, Iowa has continued to steadily improve in this area. In the 2021 APSR, performance was reported at 53.5%; 2022 APSR reported performance at 73.4%; the 2023 APSR referred to performance of only one month, but the actual fiscal year as a whole demonstrated performance at 63.9% The most current data for SFY 2024 (July 2023 through February 2024) maintains consistent performance on this measure at 66%.

The approach to this issue centered on communication throughout the department to set a clear expectation; once that was known performance rose to meet the standard. This key activity reinforced the importance of setting standards and communicating clearly. Monitoring has continued through the regular monthly review and discussion within each service area as well as at SBT.

Strategy 3.1: Early engagement of the family in assessment and identification of the needs of the family and services to address those needs.

This strategy was successfully completed in full as of November 2021; ongoing monitoring and evaluation will continue.

As of July 1, 2020, contracted services include a Family Preservation option which provides for intensive services to families who are at high risk of a child being removed from the home; use of this service mandates a Child Safety Conference (CSC) be held to support the family in managing the current crisis while keeping their child/ren safe. The CSC brings the family and their supports as well as professionals together to problem-solve and find creative solutions to barriers. As part of the PIP, Iowa spread the use of CSCs from one service area to all five-service areas across the state.

There was consistent positive feedback across all stakeholder groups regarding this service and its ability to provide an opportunity for families to manage safety through creative problem-solving.

Iowa began a pilot program on Bridge Meetings in two service areas in the state in January 2023, completed at the end of March. These meetings serve to keep parents involved if their child does have to temporarily reside in foster care. Following completion of the Bridge meeting pilot, QA&I Coordinators reached out to parents, foster parents, and social workers who participated in at least one Bridge meeting; all stakeholders reported positive experiences and increased communication when utilizing these meetings. This practice is in process of statewide implementation as of SFY 2024.

Strategy 3.2: Effectively engage with substance using parents

This strategy was successfully completed in full as of November 2021; ongoing monitoring and evaluation will continue.

While the goal for this item was to implement an additional two Infusion sites, a total of four sites were actually implemented as of July 2021; planning for effective evaluation of the impact of these sites was completed in November 2021. These sites continue to operate at this time.

Strategy 3.3: Develop knowledgeable and supportive supervisors in order to equip them as effective leaders to support the goal of meeting parents where they are and improving worker practice.

This strategy was successfully completed in full as of October 2021; ongoing monitoring and evaluation will continue.

Iowa collaborated with National Child Welfare Workforce Institute (NCWWI) representatives to implement a Leadership Academy for Supervisors (LAS) specific to Iowa. A focused curriculum was developed which included participation of multiple HHS leaders. Supervisors completed the

first module between January and September 2021; Iowa is currently on its third cohort, which consists of a combination of new and experienced supervisors. The LAS consist of 6 modules and is 6 months long with a combination of self-directed on-line work, followed by 2-hour monthly discussion sessions. Each month a speaker presents on the topic covered for the month; speakers have included the Director and many representatives who have been recently named to leadership positions within the realigned HHS. The opportunity to hear from and have very candid conversations with HHS Leadership has received much positive feedback, as has the opportunity for supervisors to network with their peers across the state. Recently the NCWWI site revamped the LAS course and starting 2024 the course will consist of 5 modules.

Strategy 4.1: Implement a joint CQI process between HHS and CIP to provide integrated information to shared stakeholders, a shared "systemic" statewide message, and an accessible platform through which stakeholders can provide feedback regarding child welfare performance.

This strategy was successfully completed in full as of October 2021; ongoing monitoring and evaluation will continue.

A framework was developed in September 2021 which outlines the process to be used as CIP and HHS collaborate on shared improvement projects. While there was discussion of focusing on ICWA-related practices, a lack of data availability created a barrier to decision-making. In order to complete testing initially of the framework the team feels it's important to have all elements of the framework available; once the foundational framework is validated, it will be more manageable to address complex areas that may need additional problem-solving and creativity. At this time, Court and HHS representatives are re-opening discussions on proof of concept.

PROGRESS MADE TO IMPROVE OUTCOMES

Please see *Attachment 2A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of December 31, 2023*

IMPLEMENTATION & PROGRAM SUPPORTS

In addition, in the 2020-2024 Final Report, states must:

Summarize the state's training and technical assistance provided to counties and other local or regional entities that operate state programs and its impact on the achievement of 2020-2024 CFSP goals and objectives (45 CFR 1357.16(a)(5)).

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 system (CWIS) to assist staff in managing their workflow and caseloads. The QA&I also facilitates program and process improvement sessions

to assist staff in identifying problems and developing specific solutions for implementation and monitoring. The Division of Child Protective Services reports monthly on a key set of performance measures that track the CFSR outcome measures and caseworker visits with children in foster care. The Division of Family Well-Being and Protection (FWBP) provides answers to policy questions that field staff have. DHS 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.

In May 2020, the Service Help Desk sent out an email to all staff regarding implementation of entering a foster care placement within three business days of the placement. The email indicated the policy was effective immediately. Furthermore, discussion of this policy occurred during May's bi-monthly meeting conference call with front line supervisors. These activities implemented one of the key activities for Goal 2, Strategy 2.3.

HHS also utilized training supports, as outlined in the FFY 2020-2024 Child and Family Services Plan (CFSP), Training Plan, to support staff in implementing Iowa's CFSP and CFSR goals.

These activities occurred to assist HHS' front-line staffs' practice in accomplishing the goals of safety, permanency and well-being for children and families of Iowa.

Describe the technical assistance and capacity building efforts that the state received in FY 2020-2024 in support of the CFSP/APSR and/or CFSR/ CFSR PIP goals and objectives. Describe how capacity building services from partnering organizations or consultants assisted in achieving the identified goals and objectives (45 CFR 1357.16(a)(5).

Iowa received the following technical assistance to support our CFSP/CFSR goals and objectives:

- HHS contracted with the National Council on Crime and Delinquency (NCCD), now Evident Change, for creation and implementation of a new and validated structured decision-making (SDM) tool for safety assessment and planning.
- A key activity mentioned for *Goal 2, Strategy 2.2*, Iowa worked with the Quality Legal Representation Task Force and the National Association of Counsel for Children (NACC) to deliver NACC's "Redbook" training to attorneys and judges serving children and families involved in Iowa's child welfare system.
- As mentioned in *Goal 3, Strategy 3.3*, Iowa collaborated with the National Child Welfare Workforce Institute (NCWWI) to implement a Leadership Academy for Supervisors (LAS) specific to Iowa.
- Casey Family Programs: HHS began receiving technical assistance from Casey Family Programs (CFP) in October 2009. The initial focus was to decrease foster care entries and lengths of stay, particularly for minority children, which continued and evolved over the last ten (10) years. Technical assistance (TA) from CFP focused on the following areas:
    - Increase exits to entries ratio (foster care)
    - Decrease maltreatment recurrence
    - Decrease re-entry into foster care
    - Increase permanency for children within 12 months for children who have been in care 24+ months
    - Decrease child abuse and neglect fatalities

HHS received TA from CFP on the above areas, with continued focus on the following efforts:

- Development and launch of a Safe Sleep Campaign,
- Piloting Child Safety Conferences,
- Expanding our existing Communities of Hope pilot project,
- Piloting approaches to improve family finding efforts,
- Conducting an independent, systematic review of evidence-based interventions that Iowa wants to implement as part of our Family First Prevention Services, e.g. SafeCare®,
- Educating community partners and stakeholders of the impacts of the federal Family First Prevention Services Act,
- Breakthrough Series Collaboration with focus on Race Equity teams,
- Rapid response review team looking at fatality and near fatality cases,
- Western Service Area AG collaboration to promote system transformation through Family First Implementation, with a focus on racial equity - especially in Woodbury County, IA,
- Child Safety Conferences, and
- Policies supporting improvements in front-end safety and risk assessments and decision-making

- HHS received technical assistance from representatives from Florida and Washington State, regarding Division X efforts to provide transportation supports to youth in foster care. The main input received from these meetings was encouragement for HHS to expand opportunities for youth.

Summarize any evaluation and research activities with which the state agency was involved or participated in and how they supported the goals and objectives in the plan (45 CFR 1357.16(a)(5)).

Iowa received approval for its Title IV-E Prevention Services and Programs Plan, which includes a well-designed and rigorous evaluation of SafeCare®, one of Iowa's Title IV-E Prevention Services.

Parent Partner: Researchers from the University of Nebraska-Lincoln's Center on Children, Families and the Law (UN-L) provide semi-annual and annual reports on participants involved with the Parent Partner Program. These reports present data retrieved from the Online Parent Partner Database. The Online Parent Partner Database stores data from seven forms: intake, contact log, client registration form, family self-assessment (entry), family self-assessment (exit), family feedback, and fidelity checklist. The quarterly and annual reports provide analyses of the number of participants completing the entrance and exit Parent Partners participant self-assessments and fidelity to the Parent Partner model.

These activities supported Iowa's goals and objectives related to preventing out of home placement and support parents whose children have been removed from the home.

Section III: Quality Assurance System

Provide a final update to use of and any enhancements to the state's QA system over the last five years.

The Quality Assurance and Improvement (QA&I) Bureau is a support system for field to collect data, analyze, explore, and structure work groups to identify barriers, solutions, and implementation plans. Information below provides a retrospective look of activities around data. HHS leadership made proactive efforts in the last two years to plan and participate in town halls around the state; stakeholders including parents, foster parents, tribal representatives, court representatives, HHS staff of all roles, and more have been invited to share information. Also, during the PIP period, Iowa held focus groups of stakeholders after initiatives were in place for approximately 1.5 years. HHS used information gathered in these venues as part of a comprehensive assessment; feedback from those with lived experience is essential to continuous improvement and process changes to assure services meets needs.

The QA&I bureau worked to include stakeholders in continuous improvement projects over the years. Planning for each project included identifying who was involved, who was affected, and who was the objective voice to question process; this group then comprised a representation able to assess the current process and creatively look for ways to streamline, enhance, and achieve positive outcomes. One example of this was inclusion in the comprehensive child welfare information system (CCWIS) project that required the ability to pull out data that was meaningful to a wide variety of stakeholders; two vital documents included the Case Permanency Plan and the Case Notes Narrative form. A diverse group worked on these and effectively completed a plan, do, check, act (PDCA); efforts in this included initial planning, sending surveys to gather requirements from future users, implementing a pilot that included HHS staff and Judges, gathering more feedback and making changes. This project is nearing a successful conclusion.

HHS enhanced capacity of the QA&I bureau through the increased use of virtual meetings; evaluation of projects included 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 allowed for greater participation from representatives across the state and for streamlined work. This also decreased time spent on travel when it was not necessary.

There have been numerous workgroups over the last year 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
- Adoption records archiving
- Relative and Fictive Kin expedited licensing process
- Trauma support to staff
- Focus groups with social workers and supervisors on successful strategies for child visits

QA&I staff facilitated workgroups; in addition to continuous improvement of processes, these provided newer staff the opportunity for experiential learning with real-time access to a mentor. This pairing was beneficial to both as discussions centered on “why” and “how”, making facilitators think about best ways to achieve outcomes, sometimes utilizing that fresh perspective to adjust the approach.

HHS staff routinely integrated data and decision-making. Each service area routinely reviewed 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 focuses. The QA&I role in this generally was to provide answers to data-related questions as able, to coordinate with peers as needed, and to coordinate a plan for exploration, case review, additional data, analysis, etc.

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 shared performance information with:

- Public stakeholders to be aware of key indicators of how the child welfare system’s 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 user-friendly and developed through collaboration with the stakeholders who would be using the data. Iowa receives requests for information throughout each year, most concentrated in times of legislative sessions; content of the public dashboards was based on identified trends for data requests from the legislators, media, and the general public.

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 identified as key performance indicators that are shared and reviewed with Field, Policy, and Leadership.

CFSR Case Review Process

Iowa initially reviewed cases geographically by reviewers working in the region; as of October 2021, statewide random case review assignments were implemented. This change in process proved beneficial in a number of ways:

- Supervisor reviewers were able to observe practice differences across geographic areas, resulting in sharing of new ideas within their own teams.
- Objectivity of reviewers was maximized because they were reviewing outside of their assigned service area.
- Reviewers were more easily able to cross-train and have the opportunity to create impromptu review teams to assist as needed.
- Conflicts of interest due to direct oversight or involvement in a case were minimized and more easily reassigned to another review team.

Iowa continued to review 65 cases per rolling 12-month quarter to assess outcome performance on the CFSR items addressed in the PIP. The process for these reviews continued to function as intended, and consistent with the state-led process utilized in the 2018 on-site review. Iowa continued with annual training of new supervisor reviewers identified in each service area. This

not only provided for additional depth and back-up abilities for reviewers, but also was an effort to intentionally spread CFSR standards and definitions, making connections between application of the tool and Iowa's practice.

Discussions regarding the balance between enough knowledge to function as a reviewer versus what is needed to positively impact daily practice are in process; information from other states on their approach to training in general as well as specific reviewer training has also been sought as we explore Iowa's approach.

Iowa completed the CFSR Round 3 PIP in December 2023. As we transition to Round 4, Iowa is taking this opportunity to thoroughly assess what is working with our case review process and areas in which we may want to make changes to enhance the process. Additional information regarding current status and collaboration on Round 4 structures is discussed in the FFY 2025-2029 Child and Family Services Plan (CFSP).

Section IV: Final Update/Report on Service Description

Briefly describe the services provided during FYs 2020- 2024 highlighting any changes or additions in services or program design and how the services assisted in achieving program goals (45 CFR 1357.16(a)(4)).

CHILD ABUSE AND NEGLECT PREVENTION

The **Iowa Child Abuse Prevention Program (ICAPP)** was based on the premise that communities are unique and have their own distinct strengths and challenges in assuring the safety and well-being of children, depending upon the resources available. Therefore, ICAPP was structured in such a way that it allowed for local Community-Based Volunteer Coalitions or "Councils" to apply for program funds to implement child abuse prevention projects based on the specific needs of their respective communities. Although this program received state and federal funding from a variety of sources, including Community Based Child Abuse Prevention (CBCAP), title IV-B, subpart II, Promoting Safe and Stable Families (PSSF) remained the largest single source of funding for this program overall. In addition to the local projects, HHS contracted with an external administrator to provide technical assistance, contract monitoring, and program evaluation services.

ICAPP Core Family Support Service Descriptions: The core of funding went to programs typically thought of as "Family Support". These programs included parent development/leadership (education, support, etc.), home visitation (using an evidence-based model), and crisis childcare. Projects were available to provide sexual abuse prevention services through a specific state appropriation. In addition, ICAPP ended crisis childcare with SFY 2020 and launched a new initiative in SFY 2021, called the Resilient Communities Demonstration Projects. Full descriptions of all services are below.

Parent Development: Parent Development programs prevent abuse by teaching parents what to expect from children and how to deal with difficulties. In addition, they provide peer-to-peer support for parents and opportunities for leadership. They assist parents in developing communication and listening skills, effective disciplinary techniques, stress management and coping skills, and teach them what to expect at various stages of child development. Understanding difficult phases of development such as colic, toilet training, and refusal to sleep help lower parents' frustration and anger. Parents participate in parent development programs primarily through group classes, but also home-based sessions, depending on the needs of the family and community. Below are some of the various curricula used:

- The *Nurturing Program*: a curriculum that teaches nurturing skills to parents and children while reinforcing positive family values through multiple home or group-based instruction.
- The *Love and Logic* program: a group-based program that typically occurs in six weeks of sessions.
- *Active Parenting*: a group-based, six-session program that teaches basic skills to parents.
- *Systematic Training for Effective Parenting (STEP)*: group-based skills training for parents dealing with frequent challenges in behavior, often resulting from autocratic parenting styles.

Home Visitation Services: Home visiting programs provide individualized support for parents in the home, making these services flexible and accessible for parents. Home visiting programs foster nurturing and attachment as well as promote resiliency within the family. Home visiting programs tend to identify high-need, high-risk families with newborns or very young children, and some target prenatal populations. Home visitors meet with the family at an agreed-upon time, ideally at a frequency and intensity that matches the family need. Trained professionals or paraprofessionals provide education, support, referrals to community-based services, and model appropriate caregiving strategies. To apply under this category, programs must be using a nationally recognized evidence-based home visitation model. The two primary models funded in Iowa include:

- *Healthy Families America*: a nationally recognized evidence-based home visiting program model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment.
    - Note: For reporting purposes, programs utilizing HFA models received only CBCAP dollars, though the application process was the same for all.
- The *Parents as Teachers (PAT)* Program: a nationally recognized evidence-based home visiting program designed to collaborate with new parents and parents of young children (pregnancy through age five).

Crisis Childcare: Crisis Care was a service, which provided for a temporary, safe environment for children aged birth through 12 years whose parents were unable to meet their needs due to overwhelming circumstances or an emergency in their lives. Services were available to families under stress 24 hours per day, seven days per week and families utilized the services for up to 72 hours at a time. Program staff conducted intake interviews, arranged temporary care for the children with licensed/registered providers, and offered advice and support to parents. Some programs also provided transportation to care, when requested, and traveled to pick up children if necessary.

SFY 2020 (July 1, 2019-June 30, 2020) was the last SFY that funding under ICAPP was available for crisis childcare. The program was only funding two sites under this category (Polk

and Marshall Counties) in SFY 2019-2020, with local projects often challenged with making appropriate referrals for families to utilize the service. In addition, given the research regarding the trauma that can be caused for children with multiple placements with unknown caretakers, it was determined the more trauma-informed approach to service provision would be programming that aims to help families build natural support systems to help in times of stress and crisis. It seemed in some cases that usage of crisis childcare was to avoid or delay a child protective removal, ultimately resulting in more than one placement, as the intent of crisis childcare is short-term. This shift also aligned with supporting relative and fictive kin placements, along with improving placement stability when a child cannot safely remain in the family home.

Resilient Communities Demonstration Projects: A newly funded project in SFY 2021 (beginning July 1, 2020) under ICAPP was the Resilient Communities Demonstration Projects (RCDP). These projects targeted the 17 highest risk counties in the state. A multivariate risk analysis occurred, with counties ranked based on the aggregate standard deviation from the state average on 10 factors correlated with child maltreatment. Of the 17 counties identified as eligible to bid, 14 counties applied for funding and 4 counties were selected for SFY 2021—Des Moines, Lee, Wapello, and Woodbury. Projects began with several "kick-off" meetings via Zoom in August of 2020 to provide training and technical assistance on a number of models/theories and tools related to community level change, including all of the following:

- **Asset-Based Community Development** (Source: DePaul University)
  - *The Asset-Based Community Development Institute (ABCD) was co-founded by two professors at Northwestern University in the early 1990s. Challenging the traditional approach to solving urban problems, which focuses service providers and funding agencies on the needs and deficiencies of neighborhoods, the model developers demonstrated that community assets are key building blocks in sustainable urban and rural community revitalization efforts. These community assets include:*
    - *the skills of local residents*
    - *the power of local associations*
    - *the resources of public, private and non-profit institutions*
    - *the physical infrastructure and space in a community*
    - *the economic resources and potential of local places*
    - *the local history and culture of a neighborhood*
- **Community Readiness Model** (Source: Tri-ethnic Center for Prevention Research)
  - *The Community Readiness Model was developed at the Tri-Ethnic Center to assess how ready a community is to address an issue. The basic premise is that matching an intervention to a community's level of readiness is absolutely essential for success. Efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for success, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.*
- **Community Toolkit** (Source: KU Center for Community Health and Development)
  - *The Community Tool Box is a free, online resource for those working to build healthier communities and bring about social change. Their mission is to promote community health and development by connecting people, ideas, and resources.*
- **Collective Impact** (Source: Collective Impact Forum)
  - *The Collective Impact Forum exists to support the efforts of those who are practicing collective impact in the field. While the rewards of collective impact can*

be great, the work is often demanding. Those who practice it must keep themselves and their teams motivated and moving forward.
    - *The Collective Impact Forum, an initiative of FSG and the Aspen Institute Forum for Community Solutions, is the place to find the tools and training that can help achieve success. It is an expanding network of like-minded individuals coming together from across sectors to share useful experience and knowledge and thereby accelerating the effectiveness, and further adoption, of the collective impact approach as a whole.*
- **Essentials for Childhood** (Source: Centers for Disease Control & Prevention)
    - *Young children experience their world through their relationships with parents and other caregivers. Safe, stable, nurturing relationships and environments are essential to preventing child abuse and neglect. The Essentials for Childhood Framework includes strategies to promote relationships and environments that can help create neighborhoods, communities, and a world in which every child can thrive.*
    - *The Essentials for Childhood Framework is intended for communities committed to both, promoting the positive development of children and families and preventing child abuse and neglect. The framework has four goal areas and suggests strategies based on the best available evidence to achieve each goal. The four goal areas include:*
        - *Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect*
        - *Goal 2: Use data to inform actions*
        - *Goal 3: Create the context for healthy children and families through norms change and programs*
        - *Goal 4: Create the context for healthy children and families through policies*
- **Strengthening Families and Protective Factors Framework** (Source: Center for the Study of Social Policy)
    - *Strengthening Families is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five key Protective Factors.*
        - *Parental resilience*
        - *Social connections*
        - *Knowledge of parenting and child development*
        - *Concrete support in times of need*
        - *Social and emotional competence of children*
- **Systems Thinking** (Source: Waters Center for Systems Thinking)
    - *Systems thinking is a transformational approach to learning, problem-solving and understanding the world. Systems thinking helps people of all ages and walks of life see beyond the heart of a problem to find fair and lasting solutions that deliver benefits. It is about seeing life in motion, recognizing that the big picture is rarely static, but almost always a web of factors that interact to create patterns and change over time. It is a catalyst for learning and leadership — in the classroom, the boardroom or around the kitchen table.*
    - *The Waters Center utilizes a set of Habits, concepts and tools to bring this learning strategy to educational, community and business settings.*

Resilient Communities Demonstration Projects spent SFY 2021 undergoing a community wide comprehensive Needs Assessment, which was due June 30, 2021. Following that, project leads and communities underwent a Strategic Planning initiative for the remainder of the five-year project period. Projects began shifting funding to direct services to families in years 3-5 of the project, though services had to align with the finding of the Needs Assessment and the Strategic Plan developed in the first two years.

ICAPP Data

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.

The table below shows numbers of families served, children served, counties served, and the funds allocated to the ICAPP program for Fiscal Year (FY) 2020-2023.

Table 4a: ICAPP Service Information by SFY

SFY	# of Families Served	# of Children Served	# of Counties Served	Total Funding
2020	2,003	9,931	56	$1,562,638.00
2021	1,428	5,698	43	$1,748,109.00
2022	1,326	6,258	44	$1,730,632.00
2023	1,276	5,622	44	$1,753,177.00

HHS 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 Demographic Information by SFY

SFY	Gender	Race	Age of Participant Caregiver	Participant Caregiver Education
2020	88% female	62% White 18% Hispanic 8% African American	29.5% 30-39 years of age	37% High School Diploma or GED
2021	97% female	76% White 9% African American 12% Asian	27% 26-30 years of age	36% High School Diploma or GED

Table 4b: ICAPP Demographic Information by SFY				
SFY	**Gender**	**Race**	**Age of Participant Caregiver**	**Participant Caregiver Education**
2022	95% female	76% White 9% African American 12% Asian	45% 30-39 years of age	38% High School Diploma or GED
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.

Community Adolescent Pregnancy Prevention (CAPP)

Program Summary Overview

In 1987, Iowa's Governor brought together a broad-based group of stakeholders to determine the top problem areas facing Iowa in the future. One of the areas of concern identified was unplanned adolescent pregnancy. The Iowa Legislature appropriates funds to the Iowa Department of Health and Human Services (HHS) for the Community Adolescent Pregnancy Prevention Program (CAPP) to reduce adolescent pregnancy [1987 Iowa Acts, Chapter 234, Section 203(1)(i)].

The CAPP Program was designed with the following intent:
"*Services are to be provided to adolescents and their parents for the purpose of preventing adolescent pregnancy; to adolescents who are either pregnant or parenting to prevent subsequent pregnancies, promote self-sufficiency and physical and emotional well-being; and to communities to assist them in addressing issues of adolescent pregnancy*."
(Iowa Administrative Code Chapter 441-163)

- Chapter 163, specifically identifies,
  - Statewide Campaign Grant – "awarded for a project providing a statewide campaign which encourages abstinence and provides information which will emphasize prevention of adolescent pregnancies," (Iowa Administrative Code r. 441—163.3(9)).
  - Evaluation Grant – "awarded to provide technical assistance to grantees in assessing their project and developing an evaluation tool for ongoing use," (Iowa Administrative Code r. 441—163.3(10)).

- State Coalition Grant – "awarded to provide assistance to an existing coalition or network focusing on the issues of adolescent pregnancy prevention and services and coalition building in the state," (Iowa Administrative Code r. 441—163.3(11)).
- Community Adolescent Pregnancy Prevention (CAPP) Grants – "awarded to projects providing:
  - Broad-based representation from community or regional representatives including, but not limited to, schools, churches, human service-related organizations, and businesses.
  - Comprehensive programming focusing on the prevention of initial pregnancies during the adolescent years.
  - Services to pregnant and parenting adolescents. Not more than 25 percent of a community grant may be used for these services."

Structure of the CAPP program

- CAPP Administrative Services: Prevent Child Abuse Iowa (PCA Iowa) is contracted through HHS, referred to as the Agency hereafter in this service description, to provide CAPP Administrative Services. This contract includes programmatic support services such as monitoring, training, and technical assistance, along with statewide campaign services and state coalition services. PCA Iowa was awarded funding in SFY 2019 through Request for Proposal #ACFS 19-002. SFY 2024 is the fifth and final year of the five-year project period.
- Local Service Projects: In SFY 2022, the Agency awarded 15 contracts for local service projects, encompassing 44 Iowa counties, through a competitive procurement process. The Agency executed a contract for an initial 1-year contract term (SFY 2023) with the ability to extend the contract for 3 additional 1-year terms (SFY 2024, SFY 2025 & SFY 2026), at the sole discretion of the Agency. These contractors are in year two of a four-year project period. Projects include:
  - Broad-based representation from community or regional representatives including, but not limited to, schools, churches, human service-related organizations, and businesses.
  - Comprehensive programming focusing on the prevention of initial pregnancies during the adolescent years.
  - Services to pregnant and parenting adolescents. Not more than 25 percent of a community grant may be used for these services.
- Evaluation Services: The CAPP program Evaluation has been conducted by the University of Northern Iowa's (UNI) Center for Social and Behavioral Research (CSBR) since February 2010. The purpose of the evaluation is to assess how effectively grantees address risk and protective factors related to pregnancy prevention and the success grantees had in those efforts. While UNI CSBR does not measure behavioral outcomes in this evaluation, they use assessments of student attitudes, beliefs, knowledge, self-efficacy, and positive youth development constructs to explore the impacts on the CAPP participants.

2020-2024 CAPP Program Implementation

The CAPP program serves adolescents and families across the state of Iowa. CAPP grantees are active in their service areas through community outreach, implementation of sexual health education curricula, pregnancy prevention programming, school-based programming, and coalition-building. Refer to Table 4c for 2020-2024 Implementation output measures.

Table 4c: 2020-2024 Implementation Output Measures					
Year	**# of Implementations**	**# of Youth Served**	**# of Individual Sessions**	**# of Matched pre- and post-tests**	**# of Un-matched pre- and post-tests**
SFY 2020	650	11,200	3,400	13,640	4,000
SFY 2021	700	12,600	3,800	15,900	4,600
SFY 2022	460	9,600	2,900	14,800	5,500
SFY 2023	630	12,100	3,700	14,600	5,800

Source: SFY's 2020-2023 Annual reports provided by Center for Social and Behavioral Research University of Northern Iowa

Main Findings: Fidelity Monitoring

CAPP grantees submit online fidelity logs for the curriculum implementations they conducted each year. Grantees were provided paper workbooks to track the fidelity of each implementation and links to online submission forms to submit the data once each implementation finished. Fidelity monitoring submission requirements are calculated using a tiered system that depends on the total number of implementations conducted annually by each grantee as a way to reduce burden on those implementing a large number of programming.

- 5 or fewer implementations – complete a fidelity log for each implementation
- 6 to 20 implementations – complete 5 logs or half of the total, whichever is greater
- 21 to 40 implementations – complete 10 logs or 40% of the total, whichever is greater
- 41+ implementations – complete 15 logs or 20% of the total, whichever is greater

The evaluation utilizes five components to measure fidelity: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation.

- Adherence is the degree to which an implementation is delivered as intended by program developers.
- Exposure refers to the amount of the program to which participants are exposed in comparison to the amount intended.
- Quality of delivery refers to the presentation quality of the educator/facilitator.
- Participant responsiveness is the degree to which participants are engaged in the program or the way they react to the program.
- Program differentiation refers to whether the program's critical components are present and identifies those components that are critical to the success of the program.

Fidelity logs submitted prior to reports of disruptions due to COVID-19 had high fidelity overall. Fidelity prior to COVID-19 was high enough that despite disruptions adherence, exposure, quality of delivery, participant responsiveness, and overall fidelity score averages were higher than in SFY 2019 (Table 4d). The average overall fidelity score was 75%. Program differentiation and participant responsiveness had the highest average score among the domains with 88% and 87%, respectively. Adherence had the lowest average score among all domains, with 71%.

Table 4d: SFY 2020 Average scores by fidelity dimensions and total scores

	Adherence	Exposure	Quality of delivery	Participant responsiveness	Program differentiation	Total Average Score
DTL 6th	96%	89%	91%	92%	95%	95%
DTL 7th	82%	89%	91%	92%	82%	85%
DTL 8th	77%	89%	90%	89%	75%	81%
FLASH MS*	56%	79%	70%	93%	100%	63%
Making Proud Choices*	56%	78%	80%	100%	57%	62%
Love Notes*	57%	77%	58%	78%	98%	60%
3Rs 10*	44%	67%	62%	64%	100%	53%
FLASH HS*	40%	62%	53%	67%	100%	45%
3Rs 8*	29%	59%	49%	83%	100%	40%
Average Score	71%	82%	81%	87%	88%	75%

* = curricula reported to be disrupted by COVID-19

Despite COVID-19 disruptions, the domain scores changed only a few percentage points and the average overall fidelity score improved over SFY 2021 (Table 4e). Program differentiation, quality of delivery, and participant responsiveness had the highest average score among the domains with 87%, 86%, and 85% respectively. Adherence had the lowest average score among all domains, with 69%.

Table 4e: SFY 2021 Average scores by fidelity dimensions and total scores

	Adherence	Exposure	Quality of delivery	Participant responsiveness	Program differentiation	Total Average Score
DTL 6th	88%	84%	98%	89%	89%	90%
DTL 7th	80%	87%	93%	90%	82%	84%
DTL 8th	63%	84%	93%	77%	67%	73%
Love Notes	63%	85%	86%	81%	100%	72%
FLASH MS	65%	67%	80%	90%	100%	70%
Making Proud Choices	53%	75%	75%	89%	55%	63%
FLASH HS	48%	57%	59%	90%	97%	52%
3Rs 10	40%	61%	69%	65%	100%	52%
3Rs 8	35%	52%	54%	78%	100%	44%
Average Score	69%	77%	86%	85%	87%	76%

Overall, fidelity log scores generally improved over SFY 2022 scores (Table 4f). Quality of delivery (93%), program differentiation (87%), and participant responsiveness (87%) had the highest average score among the domains. Adherence had the lowest average score among all domains at 77%.

Table 4f: SFY 2022 Average scores by fidelity dimensions and total scores

	Adherence	Exposure	Quality of delivery	Participant responsiveness	Program differentiation	Total Average Score
DTL 6th	89%	91%	98%	89%	89%	91%
DTL 7th	84%	87%	95%	81%	86%	87%
Love Notes	80%	96%	96%	89%	92%	86%
FLASH MS	77%	91%	95%	93%	100%	82%
DTL 8th	63%	84%	93%	87%	69%	74%
All Other Curricula	55%	77%	80%	79%	84%	65%
FLASH HS	50%	65%	73%	77%	100%	57%
3Rs 8	41%	78%	67%	75%	100%	53%
All Curricula Average Score	77%	87%	93%	85%	87%	82%

Overall, fidelity log scores generally remained steady or decreased compared to SFY 2022 scores (Table 4g). This may be due to a number of factors including, but not limited to, the addition of multiple new grantees and increased restrictions placed on grantee implementations from external sources. Program differentiation (88%), quality of delivery (84%), and exposure (83%) had the highest average score among the domains. Adherence had the lowest average score among all domains at 69%. This indicates that while grantees have to make adaptations to their implementations, they're making time for each program's critical components.

Table 4g: SFY 2023 Average scores by fidelity dimensions and total scores

	Adherence	Exposure	Quality of delivery	Participant responsiveness	Program differentiation	Average Score
DTL 6th	91%	90%	98%	85%	90%	92%
Love Notes	78%	93%	93%	83%	98%	84%
3Rs 8	78%	93%	92%	75%	95%	83%
All Other Curricula	77%	67%	89%	70%	79%	79%
DTL 7th	71%	84%	94%	80%	75%	78%
MPC	71%	87%	88%	77%	71%	76%
DTL 8th	66%	85%	78%	80%	70%	72%
3Rs 9	63%	82%	79%	76%	93%	69%
FLASH MS	58%	86%	79%	83%	96%	67%
3Rs 10	41%	79%	74%	81%	100%	56%
FLASH HS	50%	69%	63%	68%	100%	55%
3Rs 7	48%	56%	64%	89%	100%	55%
Average Score	69%	83%	84%	79%	88%	74%

Table 4h: CAPP Evaluation Highlights: SFY 2020-2024	
SFY	**Evaluation Highlights**
2020	▪ Among matched paper data, statistically significant improvements were seen from pre-test to post-test in participant knowledge about condom use and availability, pregnancy, and STD/HIV transmission. ▪ Self-reported ability to resist peer pressure and set limits, get pregnancy and STD testing, purchase condoms, and discuss sexual health with parents and peers showed statistically significant improvements from pre-test to post-test. ▪ For matched paper data, the perceived likelihood of engaging in sexual intercourse in the next three or six months did not increase from pre-test to post-test, however, the perceived likelihood of condom use increased. ▪ 95% of post-test respondents on paper (92% online) said they learned *a lot* or *some* in the class that they didn't already know. ▪ 99% of post-test respondents on paper and online said it seemed to them like the teacher knew *a lot* or *some* about the topic. ▪ 98% of post-test respondents on paper (99% online) said it seemed to them like the teacher was *very good* or *pretty good* at answering student questions.
2021	▪ Among matched paper data, statistically significant improvements were seen from pre-test to post-test in participant knowledge about condom use and availability, pregnancy, and STD/HIV transmission. ▪ Self-reported ability to resist peer pressure and set limits, get pregnancy and STD testing, purchase condoms, and discuss sexual health with parents and peers showed statistically significant improvements from pre-test to post-test. ▪ Both the perceived likelihood of engaging in sexual intercourse in the next three or six months and the perceived likelihood of condom use showed statistically significant improvements from pre-test to post-test. ▪ 96% of post-test respondents on paper (91% online) said they learned *a lot* or *some* in the class that they didn't already know. ▪ 100% of post-test respondents on paper (99% online) said it seemed to them like the teacher knew *a lot* or *some* about the topic. ▪ 99% of post-test respondents on paper and online said it seemed to them like the teacher was *very good* or *pretty good* at answering student questions.
2022	▪ Statistically significant improvements were seen from pre-test to post-test in participant attitudes and beliefs about setting limits, condom use, and sexual activity. ▪ Statistically significant improvements were seen in knowledge about condom use and availability, pregnancy, common myths around sex, and STD/HIV transmission. ▪ Self-reported ability to resist peer pressure, set limits, get pregnancy and/or STD testing, purchase condoms, and discuss sexual health with parents and peers showed statistically significant improvements from pre-test to post-test. ▪ Respondents at post-test thought they were more likely to have sex in the next three or six months, and the perceived likelihood of condom use also showed a statistically significant increase from pre-test to post-test. We do not have follow-up outcomes data to determine whether or not an increased perception of the likelihood of having sex correlates to a change in behavior. ▪ 96% of post-test respondents said they learned *a lot* or *some* in the class that they didn't already know already.

Table 4h: CAPP Evaluation Highlights: SFY 2020-2024	
SFY	**Evaluation Highlights**
	▪ 99% of post-test respondents said it seemed to them like the teacher knew *a lot* or *some* about the topic and said it seemed to them like the teacher was *very good* or *pretty good* at answering questions. ▪ 42% of post-test respondents felt more comfortable talking with friends about the things they've learned and 33% felt more comfortable talking with parents or trusted adults about the things they've learned.
2023	▪ Statistically significant improvements were seen from pre-test to post-test in participant attitudes and beliefs about setting limits, condom use, and sexual activity. ▪ Statistically significant improvements were seen in knowledge about condom use and availability, pregnancy, common myths around sex, and STD/HIV transmission. ▪ Self-reported ability to resist peer pressure, set limits, get pregnancy and/or STD testing, purchase condoms, and discuss sexual health with parents and peers showed statistically significant improvements from pre-test to post-test. ▪ Respondents at post-test thought they were more likely to have sex in the next three or six months, and the perceived likelihood of condom use also showed a statistically significant increase from pre-test to post-test. ▪ 94% of post-test respondents said they learned *a lot* or *some* in the class that they didn't already know already. ▪ 99% of post-test respondents said it seemed to them like the teacher knew *a lot* or *some* about the topic and said it seemed to them like the teacher was *very good* or *pretty good* at answering questions. ▪ 38% of post-test respondents felt more comfortable talking with friends about the things they've learned and 30% felt more comfortable talking with parents or trusted adults about the things they've learned.
2024	Evaluation activities will be significantly altered in SFY 2024 due to SF496. The SFY 2024 CAPP evaluation will place an enhanced emphasis on process evaluation dimensions and will collect qualitative data from grantees and stakeholders to measure how grantees are adapting to a changing policy landscape. The requirement for pre-/post-tests has been waived in schools for SFY 2024, however pre-/post-test data collection will continue in non-school settings. Fidelity monitoring logs and quarterly reports will continue to be used to gather context around implementations.

SFY 2023 Annual Summary Review

Community Coalition Building and Enhancement: CAPP grantees participate in a broad-based community coalition that includes a focus on adolescent pregnancy prevention (whether the focus is singular or part of another broader community coalition). Coalition meetings, across the state, continue to meet offering a hybrid option in conjunction with in-person meetings. The hybrid option has increased attendance and participation. CAPP grantees routinely encourage coalition membership to include a broad base of subject matter experts: education, law enforcement, child welfare, health and/or mental health, domestic violence, sexual assault, substance abuse, youth, faith-based community, and business community.

Comprehensive Adolescent Pregnancy Prevention Programs

Activity 1. CAPP grantees provide comprehensive program service(s) utilizing evidence-based curricula that has demonstrated effectiveness (through empirical research) in preventing adolescent pregnancies and reducing risk.

Program Development Progress: *Draw the Line/Respect the Line*, *6th – 8th grade*, is the primary curriculum utilized by CAPP grantees. The high school curriculum, *Love Notes*, is the second most curriculum utilized. *Power Through Choices*, *SiHLE*, and the *Teen Outreach Program* are provided in three counties.

PCA Iowa compared SFY 2023 outputs to previous year outputs, and to SFY 2024 projections, to identify trends in service reach (Table 4i).

Table 4i: Implementation Projections			
	SFY 2022	SFY 2023	SFY 2024
Projected # of adolescents served	7,434	7,843	5,889
Adolescents Served	8,730	7,550	Data not yet available

CAPP grantees anticipated serving slightly more youth in SFY 2023 (6%) than in the previous year. Actual services decreased in SFY 2023, as did the number of contracts that met or exceeded 80% of their projections. Grantees reported a variety of internal and external factors that impeded their ability to provide programming with fidelity in the school setting. These factors, in addition to the passing of Senate File (SF) 496, have led grantees to anticipate serving less youth in SFY 2024. SF 496, signed by Governor Kim Reynolds on May 26, 2023, requires school districts to obtain written consent from a student's parent or guardian for surveys (pre/post-tests) and questionnaires and to prohibit instruction on sexual orientation and gender identity to students in kindergarten through sixth grade.

Curricula options for Prevention of Adolescent Pregnancy and Risk Reducing Programs:

- **Draw the Line/Respect the Line** is a 3-year evidence-based curriculum that promotes abstinence by providing students in grades 6, 7 and 8 with the knowledge and skills to prevent HIV, other STD and pregnancy. Using an interactive approach, the program shows students how to set personal limits and meet challenges to those limits. Lessons also include the importance of respecting others' personal limits.
- **Love Notes**. Rather than focusing on what to avoid, Love Notes builds assets and appeals to aspirations. Using a strengths-based approach, it offers young people new conceptual frameworks to help them make informed decisions.
    - Its theory of change hypothesizes that preventing pregnancy must expand beyond teaching young people about the scope of contraceptive options. Rather, interventions must build young people's skills for cultivating healthy relationships, selves, and sexual behaviors: planning and pacing relationships and sex, self-efficacy and resilience around relationships, proven communication skills, and understanding the benefits of deciding when it comes to family formation.
- **Power Through Choices** is an evidence-based prevention curriculum specifically designed for adolescents ages 13–18 in systems of care.
    - The curriculum's goal is to provide youth in systems of care with specific information and skills to help them avoid risk-taking sexual behavior and reduce

the incidence of adolescent pregnancy, HIV, and other sexually transmitted infections (STIs).

- **SiHLE -** Sisters, Informing, Healing, Living, Empowering - is a peer-led, group-level, social-skills training intervention designed to reduce sexual risk behaviors among African American female teenagers who are at high risk of HIV. In addition to HIV prevention, the program addresses relationships, dating, and sexual health within the specific context of the female African American teenage experience. The program draws upon both cultural and gender pride to give participants the skills and motivations to avoid HIV and other STDs**.**
- **The Teen Outreach Program (TOP)** promotes the positive development of adolescents through curriculum-guided, interactive group discussions; positive adult guidance and support; and community service learning. TOP is focused on key topics related to adolescent health and development, including building social, emotional, and life skills; developing a positive sense of self; and connecting with others. Specific curriculum lesson topics include health and wellness (including sexuality), emotion management, and self-understanding among many others. The development of supportive relationships with adult facilitators is a crucial part of the model, as are relationships with other peers in the program.

Activity 2. CAPP grantees provide comprehensive program service(s) that include curricula-based comprehensive sexual health education for adolescents implemented with fidelity.

Program Development Progress: CAPP grantees provide comprehensive program service(s) that include curricula-based comprehensive sexual health education for adolescents. *3Rs* and *FLASH* (elementary – high school) curriculum reach the majority of youth in the CAPP service areas.

CAPP grantees projected lower service outputs for Activity 2 than in SFY 2022 but delivered significantly more services via List B curricula than in the previous year. These projections have been revised down again this year, as grantees anticipate increased restrictions on comprehensive sexual health education offered in Iowa schools. Grantees project serving 24% fewer youth (about 1,000 youth) than they anticipated two years ago. Refer to Table 4j.

Table 4j: Implementation Projections

	FY22	FY23	FY24	Change FY22-FY24
Projections	3931	3498 *(-11%)*	2979 *(-15%)*	*-24%*
Youth Served	2698	4569 *(+69%)*	NA	NA
% of projections	**69%**	**131%**	NA	
% of contracts achieving 80%	**29%**	**73%**	NA	

Curricula options include:

- **Be Proud! Be Responsible! -** To reduce their risk of HIV through behavioral change, adolescents not only need information on their perception of personal vulnerability, but also skills and confidence in their ability to act safely. Be Proud! Be Responsible! is a multi-media, 6-module curriculum that provides adolescents with the knowledge, motivation and skills to change their behaviors in ways that will reduce their risk of

contracting HIV. Although not specifically pregnancy prevention oriented, many of the communication and skills taught help participants avoid unintended pregnancy and other STDs.

- **¡Cuidate!** The word ¡Cuídate!, which means “take care of yourself,” is the theme of this culturally-based program designed to reduce HIV sexual risk among Latino youth. The ¡Cuídate! Program incorporates cultural beliefs that are common among Latino subgroups and associated with sexual risk behavior. The program works to use these beliefs in a positive way to prevent unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.
- **FLASH** is a widely used sexual health education curriculum developed by Public Health – Seattle & King County and designed to prevent adolescent pregnancy, STDs, and sexual violence, and to increase knowledge about the reproductive system and puberty. FLASH is available for elementary, middle, high school and special education classrooms. High School FLASH has been proven effective by rigorous evaluation.
- **Making Proud Choices (5th edition, all versions)** is a curriculum that provides adolescents with the knowledge, confidence and skills necessary to reduce their risk of STIs, HIV and pregnancy by abstaining from sex or using condoms if they choose to have sex. It is based on cognitive-behavioral theories, focus groups and the authors' extensive experience working with youth.
- **Rights, Respect, Responsibility (3Rs)** Rights, Respect, Responsibility is a K-12 sexuality education curriculum that meets the National Sexuality Education Standards. The curriculum seeks to address both the functional knowledge related to sexuality and the specific skills necessary to adopt healthy behaviors. 3Rs reflects the tenets of social learning theory, social cognitive theory and the social ecological model of prevention.
- **Positive Prevention Plus (including Special Populations)** is a 13-lesson curriculum that addresses risk factors and behaviors associated with unplanned teen pregnancy by increasing adolescent's ability to use risk-reduction skills including contraceptive use, resistance and negotiation skills, and accessing reproductive health services.

Activity 3. CAPP grantees provide presentations, workshops and topical programs for adolescents, parents/caregivers of adolescents, youth serving adults, and community leadership.

Program Development Progress*:* Each CAPP grantee provides a minimum of two topical educational opportunities, annually, and in a variety of settings. The topical presentations provide opportunities to reach more youth and their families, inform and educate communities of issues impacting adolescents, and provide opportunities to forge new partnerships within their service areas. The topics most often requested are puberty, hygiene, STI prevention, and healthy relationships. Grantees include lesson content from research-based and/or evidence-informed curricula to inform their presentations.

Activity 4*.* CAPP grantees provide resource and referral information to expectant and parenting adolescents.

Program Development Progress: CAPP grantees provide resources and referrals to expectant and parenting youth. resources and referrals have included pregnancy and STI testing, childcare, Women, Infants, and Children (WIC) clinics, food pantries, diaper bank, housing, mental health, and community engagement and local supports. In addition, CAPP grantees attend outreach events, such as community events, coalitions, resource fairs. This is an opportunity to share general information to the community at large.

Activity 5. Comprehensive Expectant and Parenting Adolescent Services (optional)

Program Development Progress: CAPP grantees provide educational and support program services intended to reduce the likelihood of an additional pregnancy and provide educational socialization opportunities. Expectant and parenting programs vary in their delivery method. The programs have taken in place in settings such as food banks, parks, community centers, WIC clinics, schools, and church activity rooms.

Educational socialization events provide the opportunity for parents, their children, and their extended families to engage in a fun and meaningful way. The purpose of these socializations is two-fold, 1) to meet a developmental need of adolescents, which is connection with their peers, and 2) provide opportunities for expectant and parenting youth to engage with one another, creating a network of support and community. In addition, socialization events provide opportunities for multi-generational engagement and connection.

Ten grantees applied for and were awarded funding to provide services to expectant and parenting youth (Table 4k).

Table 4k: Grantees Awarded Funding

Agency	County	Anticipated # of adolescents reached
Bethany for Children and Families	Scott	5
Cerro Gordo Department of Public Health	Cerro Gordo	6
Child Abuse Prevention Services, Inc.	Marshall	8
Hillcrest Family Services	Dubuque	10
Lutheran Services in Iowa	Buena Vista	8
Lutheran Services in Iowa	Woodbury	8
SuccessLink	Black Hawk	75
The Family Place	Dallas	8
	Marion	6
	Wapello	9
County of Webster	Webster	4
Women's Health and Family Services	Clinton	6

Activity 6. Multi-Generational Home Visiting (Optional)
Well-being for children and well-being for families are intertwined. A two-generation approach aims to create opportunities for families by supporting and equipping both parents and children with the tools they need in order to thrive, while removing the obstacles in their way.

Program Development Progress: CAPP grantees have the option to provide a multi-generational home visiting program to expectant or parenting adolescents and their families

focusing on the needs of the family including delay of additional pregnancy, parenting skills, healthy relationships, and child development utilizing evidence-based, or evidence-informed, or promising practices materials. SFY 2023 was the first year for offering Multi-Generational Home Visiting. Trinity Muscatine Public Health (TMPH) is the only CAPP grantee that provides multi-generational home visiting program. TMPH exceeded their projection of reaching 10 adolescents and served 24 adolescents.

Digital Messaging: As CAPP grantees returned to in-person programming and communities convening more in-person events, PCA Iowa shifted their focus to creating more tangible materials to foster and support connections. “What About You?”, a children’s book, and the “TALK” card deck, were provided to CAPP grantees to utilize themselves and to give out to members and partners in their communities, as a means to engage parents and their families in meaningful conversations.

Compared to the previous year, there was a 9.22% increase in the number of sessions per user (meaning people were returning to the resources/content on a website), an 8.67% increase in the number of pages those users visited during each session (looking at more resources/content when they visited), and a 5.12% increase in the average time a user spent on the webpages.

PCA Iowa utilized YouTube videos to engage youth and saw particular success in acquisition of new viewers during the early period of their roll-out of *Shorts*. Overall, 13,500+ impressions, more than 8,000 views, for a total watch time of 440+ hours.

Digital Media Impressions and Reach

- Facebook: 5634 ("reach": 7037)
- Instagram: 5465 ("reach": 366)
- Twitter: 3811
- LinkedIn: 3825
- YouTube: 13,500

CAPP 2023 Evaluation Services

CAPP Educators served more than 12,100 youth participants through more than 630 sexual health education implementations, representing nearly 3,700 individual sessions. More than 14,600 matched pre- and post-surveys (and more than 5,800 unmatched pre- and post-surveys) were used for analysis. Please see Table 4h above for evaluation highlights.

In 300 sessions, grantees reported providing topical presentations and other community-based strategies to raise awareness and improve access to family planning services to more than 6,000 youth and more than 840 parents, as well as 1,419 referrals for current and expectant teen parents. Grantees engaged in community outreach programs such as:

- Youth development programs,
- Educational presentations related to risk and protective factors,
- Programming specifically for teen parents,
- Service-learning activities,
- Mentoring and counseling programs including support for parenting teens,
- Family and parental involvement activities,
- Health fairs and materials distribution, and

- Drug/alcohol prevention programs

Post-test evaluations show that the most commonly represented topics were pregnancy and STD prevention (54%) and communication with trusted adults (45%). Evaluations of presenters were positive with participants finding the presenter confident, knowledgeable, trustworthy, and engaging. Respondents generally felt more knowledgeable (85%), confident discussing the topics (72%), and more likely to start conversations about these topics (52%) with others.

Fidelity monitoring results show that overall fidelity averaged 74% across all curricular implementations. Overall fidelity scores by curriculum ranged from 92% to 55%. The highest dimension score was program differentiation at 88% and the lowest was program adherence at 69%. The average fidelity score across all curricular implementations decreased from SFY 2022. No fidelity logs specifically cited having disruptions due to COVID-19, compared to 55% in SFY 2021 and 7% in SFY 2022.

Main Findings: Fidelity Monitoring

CAPP grantees submit online fidelity logs for the curriculum implementations they conducted during SFY 2023. Grantees were provided paper workbooks to track the fidelity of each implementation and links to online submission forms to submit the data once each implementation finished. Fidelity monitoring submission requirements are calculated using a tiered system that depends on the total number of implementations conducted annually by each grantee as a way to reduce burden on those implementing a large number of programming.

- 5 or fewer implementations – complete a fidelity log for each implementation
- 6 to 20 implementations – complete 5 logs or half of the total, whichever is greater
- 21 to 40 implementations – complete 10 logs or 40% of the total, whichever is greater
- 41+ implementations – complete 15 logs or 20% of the total, whichever is greater

The evaluation used five components to measure fidelity: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation.

- Adherence is the degree to which an implementation is delivered as intended by program developers.
- Exposure refers to the amount of the program to which participants are exposed in comparison to the amount intended.
- Quality of delivery refers to the presentation quality of the educator/facilitator.
- Participant responsiveness is the degree to which participants are engaged in the program or the way they react to the program.
- Program differentiation refers to whether the program's critical components are present and identifies those components that are critical to the success of the program.

In total, 316 fidelity logs were submitted by 13 grantees for 14 evidence-informed curricula (Table 4l). Three curricula were represented by five or fewer fidelity logs and were not included in this analysis to avoid identifying a specific grantee or educator. No logs in SFY 2023 specifically cited having disruptions due to COVID-19, compared to 7% in SFY 2022 and 55% in SFY 2021. Eleven grantees met the requirements for

fidelity log submissions using the tiered system above and two grantees needed fewer than five additional submissions to meet the requirement. One grantee did not submit any fidelity logs, and another completed almost a third of their required logs.

Please see Table 4g earlier in this service description for information on fidelity log scores.

Table 4l: Number of Fidelity Logs	
Curriculum	**Total Logs**
DTL 6th	57
DTL 8th	45
DTL 7th	37
FLASH High School	37
Love Notes	29
FLASH Middle School	25
3Rs 9	20
3Rs 10	18
Making Proud Choices	17
3Rs 8	11
3Rs 7	8
SiHLE	4
3Rs 6	4
3Rs 11	4
Total	**316**

Source: Community Adolescent Pregnancy Prevention Grant Program Evaluation, FY2023 Annual Report

Qualitative Data

In addition to the fidelity log scores, fidelity logs and quarterly reports were reviewed and analyzed using inductive recursion to identify common themes among the challenges, adaptations, and successes reported by those who implemented the curriculum. The challenges, adaptations, and successes reported by grantees are in alignment with prior years' evaluations.

Challenges and Adaptations

Challenges mentioned by most, if not all, grantees at an organizational level include:

- difficulties working with schools to get programming scheduled,
- limitations on allowed topics or activities, particularly condom demonstrations and programming covering gender identity and sexual orientation,
- cancellation of programming,
- technological disruptions, and
- staff turnover.

Challenges mentioned by multiple grantees at an implementation level include:

- limited time to complete activities, including the time required to complete pre- and post-tests, and to cover additional topics salient to the participants,
- participant engagement and classroom management, in particular the role-play activities were often difficult or embarrassing for the participants,
- participants not completing homework,
- consistent student attendance,
- very small or very large groups,
- pre-existing myths and misconceptions around sex and sexuality,
- working with outdated materials or activities present in each curriculum, and

- prior student trauma.

Grantees adapted to the implementation-level challenges by:

- updating outdated statistics and cultural references present in the curriculum materials,
- combining activities from multiple lessons due to limited available time or other restrictions such as class size or scheduling issues,
- addressing topics that participants found most relevant and covering those issues at the expense of curriculum lessons or activities,
- completing homework together during the lesson or removing it entirely,
- bringing in additional guest speakers; including lessons or information from another curriculum,
- altering the role-play situations or examples provided in the curriculum to better engage students, changing them to discussions, or removing entirely for time, and
- incorporating information about local resources.

Successes

- Grantees noted positive outcomes during the year, including:
  - building contacts with new school districts,
  - completing the first implementations in new counties and school districts, and
  - returning to schools where programming had previously ceased.
- Grantees noted positive outcomes among program participants including:
  - increased self-esteem and self-awareness among participants,
  - hearing participants recommend the programming to others,
  - finding encouraging or positive notes on materials or evaluations,
  - inspiring future sex educators,
  - participants accessing community services,
  - reported conversations by participants with parents or trusted adults,
  - participants recognizing and reporting abuse to grantees, and
  - referrals of students to appropriate services.

Key Takeaways: Fidelity Monitoring

Fidelity was somewhat high but down compared to SFY 2022 (74% vs 82%) with Program Differentiation the highest rated dimension and Adherence the lowest. Each grantee experienced challenges related to time constraints, role-play and homework activities, classroom management, participant engagement, and outdated curriculum. Grantees adapted to these challenges by updating the outdated aspects of the curriculum, adjusting homework requirements, participating in role-play activities, and pivoting to topics salient to the participants, sometimes by including information from another curriculum or local resources.

Main Findings: Teen Birth Rates

In 2022, the provisional teen birth rate in the US was 13.6 births per 1,000 females ages 15-19 (Martin, Hamilton, & Osterman, 2023), representing a continuing decline nationally. The teen birth rate in Iowa was 12.4 births per 1,000 females in 2022. County-specific teen birth rates for counties served by the CAPP grant program were calculated using 2022 data from HHS (Table 4m).

<u>Key Findings: Teen Birth Rates</u>

- For the years 2018-2022, 16 of 44 CAPP counties had average annual teen birth rates below the 2022 national average of 13.6 births per 1,000 females aged 15-19 (Figure 1).
- Among the 30 CAPP counties with reportable data available in both 2018 and 2022, 19

saw reductions in teen birth rates between 2018 and 2022 (Figure 2).

Table 4m: CAPP County Teen Birth Rates from 2018-2021 (rate per 1,000 females 15-19)							
County	2018	2019	2020	2021	2022	% change[7] 2018-2022	Ave. Rate 2018-2022
Appanoose	25.7	17.5	17.0	21.7	27.0	+5.1%	21.9
Audubon	33.3	--	--	--	--	--	13.7
Black Hawk	13.5	16.1	15.1	17.9	14.6	+8.1%	15.4
Boone	13.3	16.7	14.7	7.6	9.0	-32.0%	12.2
Buchanan	11.6	--	--	8.6	--	--	7.0
Buena Vista	22.9	16.3	28.9	15.7	20.3	-11.2%	20.7
Butler	14.8	--	--	--	--	--	7.7
Calhoun	--	--	21.4	--	23.4	--	12.4
Cerro Gordo	18.5	13.0	16.5	14.1	17.4	-6.0%	15.9
Cherokee	27.0	17.6	--	18.9	--	--	16.0
Clarke	17.5	29.7	27.5	--	15.6	-10.9%	19.6
Clay	21.2	21.4	--	--	11.6	-45.5%	12.3
Clinton	17.1	28.9	20.4	13.4	19.5	+14.1%	19.9
Crawford	20.7	12.1	25.2	36.8	35.6	+72.3%	25.8
Dallas	10.6	7.6	5.8	5.9	3.9	-63.6%	6.6
Davis	12.9	9.7	3.1	9.0	--	--	6.9
Decatur	--	--	--	--	--	--	9.7
Des Moines	35.4	34.2	30.2	25.4	23.9	-32.4%	29.8
Dubuque	16.6	10.9	13.0	13.8	13.4	-19.3%	13.6
Emmet	23.1	16.8	--	--	25.2	+8.9%	16.4
Franklin	22.2	28.5	20.5	24.6	26.4	+19.2%	24.4
Greene	--	23.3	--	--	23.7	--	17.1
Guthrie	--	--	--	--	--	--	8.2
Hamilton	16.6	14.2	20.0	32.7	19.2	+15.4%	20.6
Hardin	15.7	16.2	17.4	--	11.5	-26.7%	14.0
Humboldt	--	--	--	16.6	--	--	13.0
Jackson	13.9	19.4	11.0	12.0	14.2	+2.5%	14.1
Louisa	15.7	--	--	--	16.6	+5.6%	11.9
Marion	11.5	9.5	9.5	13.1	8.2	-28.3%	10.4
Marshall	30.4	19.2	23.5	18.3	20.9	-31.4%	22.4
Muscatine	24.8	17.8	16.2	17.7	9.4	-62.2%	17.2
O'Brien	24.8	--	--	20.3	19.5	-21.6%	16.8
Osceola	--	--	--	--	--	--	11.7
Pocahontas	--	--	--	--	--	--	8.7
Polk	18.5	15.1	15.6	14.7	14.5	-21.5%	15.7

Table 4m: CAPP County Teen Birth Rates from 2018-2021 (rate per 1,000 females 15-19)							
County	**2018**	**2019**	**2020**	**2021**	**2022**	**% change[7] 2018-2022**	**Ave. Rate 2018-2022**
Ringgold	--	--	--	--	--	--	15.2
Sac	--	18.7	--	--	--	--	10.3
Scott	20.0	19.9	20.3	15.7	15.5	-22.5%	18.2
Story	3.0	3.6	2.5	3.7	3.8	+26.2%	3.3
Tama	18.7	30.7	16.2	28.7	17.3	-7.4%	22.4
Wapello	29.0	29.2	20.0	22.9	25.5	-12.1%	25.2
Webster	20.7	21.6	22.5	17.2	17.2	-16.5%	19.8
Woodbury	24.3	22.3	21.2	18.3	19.9	-18.3%	21.1
Wright	34.7	15.3	30.6	15.3	30.1	-13.4%	25.3

Note. Birth rate is calculated as the number of births to teen mothers aged 15-19 divided by the population size of females aged 15-19 in each county, multiplied by 1,000. Birth rates are expressed as the number of births
per 1,000 females aged 15-19. Annual data is not calculated for counties with fewer than 5 births in a year.

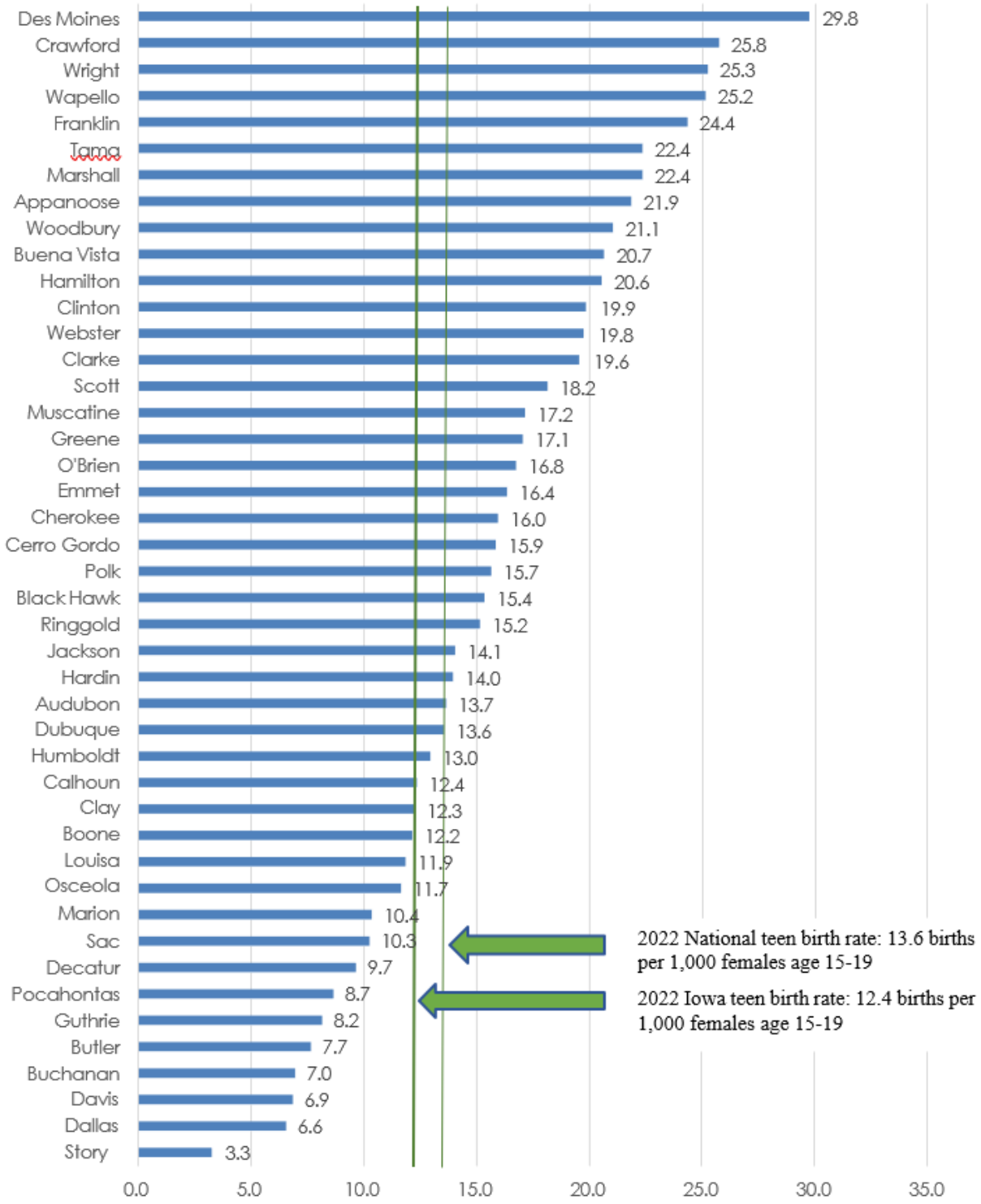


Figure 1. Total 2017-2021 birth rates in counties served by CAPP (rate per 1,000 females 15-19 years old)

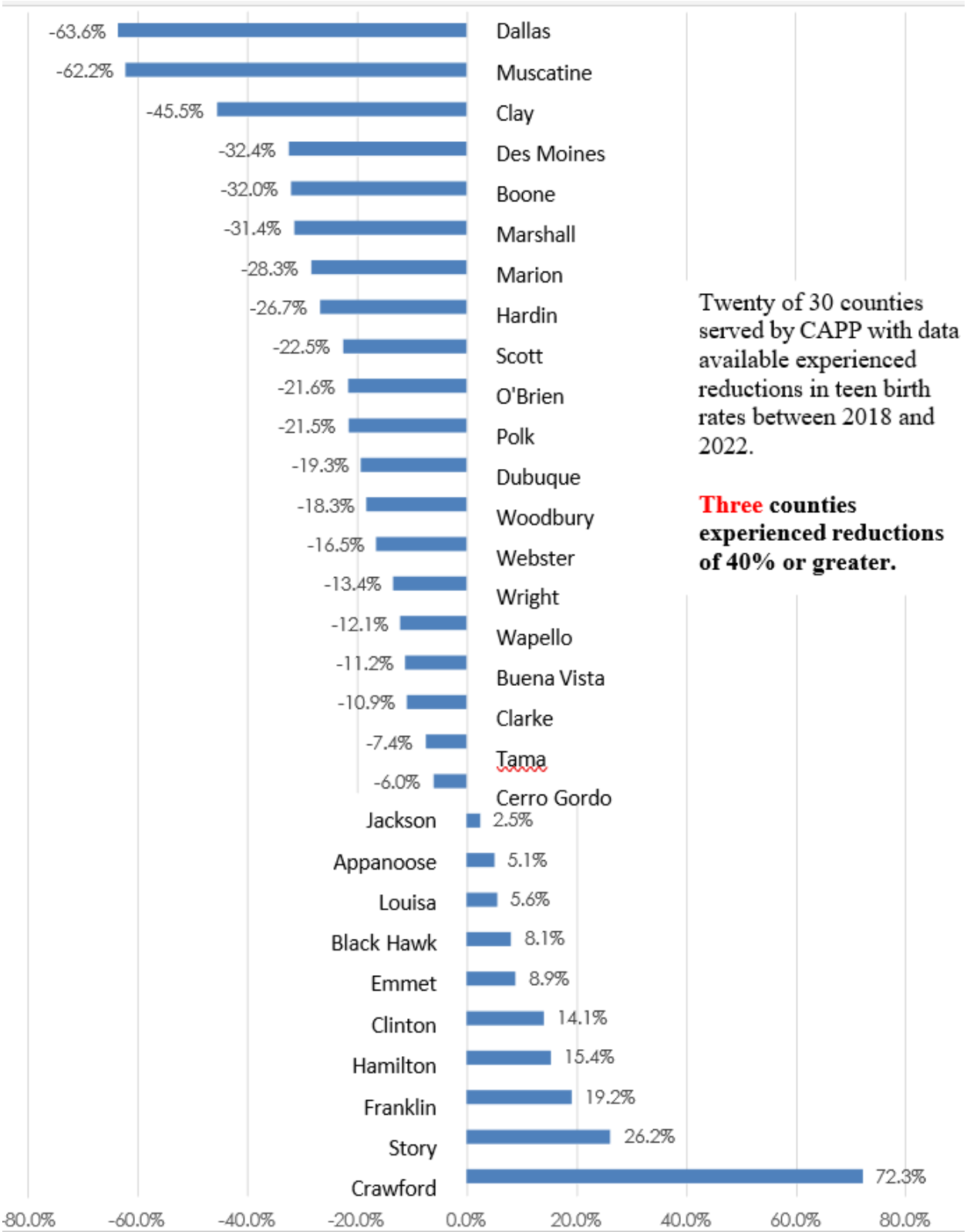


Figure 2. Percent change in teen birth rates from 2017-2021 in counties served by CAPP (counties with reportable data in both 2017 and 2021)

Main Findings: Student Evaluations

Activities 1 - 2: Core Items Pre/Post-test Analysis Results

Overall, 71% of questionnaires submitted were matched from pre-test to post-test – this is in line with last year's overall matched percentage of 73%. This report focuses on the matched analysis. A breakdown of the number of matched pre- and post-tests used for analysis can be found in Table 4n below.

Asterisks are used throughout the figures below to indicate items for which a statistically significant change from pre-test to post-test was observed in the matched data. It is important to note that the number of cases per item in the analysis below may not total to those numbers in Table 4n due to item non-response. Not all respondents answered every question at both pre-test and post-test.

Table 4n: Pre-tests / post-tests matched vs received

Instrument – Mode	Pre-tests received	Post-tests received	Matched respondents	Total % Matched
A – Paper	2,949	2,838	2,055	71%
A – Online	116	98	75	70%
B – Paper	4,183	3,850	2,783	69%
B – Online	302	239	164	61%
PYD – Paper	2,989	2,924	2,226	75%
Total	**10,539**	**9,949**	**7,303**	**71%**

Demographic Characteristics

Demographic characteristics of matched respondents can be seen in Table 4o. On average, respondents were almost 14 years old (range of 10 to 23 years old) and approximately half of respondents were female. Approximately three-quarters of respondents were white, twenty percent Hispanic, and ten percent African American.

Table 4o: Pre-test / post-test demographic characteristics

	Pre-test		Post-test	
	Number	Percent	Number	Percent
Gender – Selected				
Male	2,350	47	2,320	47
Female	2,489	50	2,490	50
Transgender/Non-conforming	166	3	153	3
Race – Selected				
African American or Black	498	10	503	10
Asian	215	4	212	4
Native American or Alaska Native	189	4	180	4

Table 4o: Pre-test / post-test demographic characteristics				
	Pre-test		Post-test	
	Number	Percent	Number	Percent
Native Hawaiian or Pacific Islander	85	2	93	2
White	3,726	73	3,736	74
Other	129	2	121	2
Ethnicity – Selected				
Hispanic	942	19	942	19

Changes in Knowledge

Six knowledge questions were recoded to indicate a correct or incorrect response. An incorrect response included *not sure* and *yes* or *no* depending on the question. Individuals were viewed as improved if they gave an incorrect answer (including *not sure*) at pre-test but the correct answer at post-test. There were significantly more correct responses at post-test than pre-test for all six knowledge items (Figure 3) and the effect size for these changes was medium to large (.2 to .6).

To measure individual improvement from pre-test to post-test, matched cases were analyzed on each of the knowledge items. Most respondents (between 58% and 76%) did not show any change in knowledge from pre-test to post-test. The greatest improvement was seen on the items *Can birth control pills help protect against STI/STDs* (36% improved), *Is it against the law for people under 16 years old to buy condoms* (33% improved), and *Not having sex is the only 100% effective way to avoid pregnancy, HIV, or an STI/STD* (28% improved) (Table 4p).

Two additional questions asked about respondent's perceptions of the sexual activity of their peers. Approximately 15% of respondents agreed that *most of their friends have had sex* and approximately 22% agreed that *most people their age have had sex*.

Table 4p: Knowledge percent change

	Correct to Incorrect	No change, incorrect	No change, correct	Incorrect to correct
Can birth control pills help protect against STI/STDs?	**5%**	**30%**	**28%**	**36%**
Is it against the law for people under 16 years old to buy condoms?	**4%**	**23%**	**40%**	**33%**
Not having sex is the only 100% effective way to avoid pregnancy, HIV, or an STI/STD?	**6%**	**20%**	**46%**	**28%**
Can you get pregnant, get HIV, or get other STI/STDs if you only have sex once without a condom?	**5%**	**12%**	**59%**	**23%**
Can a girl get pregnant the first time she has sex?	**4%**	**14%**	**61%**	**20%**
Are condoms always 100% effective in preventing pregnancy, HIV, and STI/STDs?	**7%**	**10%**	**66%**	**18%**

Note. Bolded items indicate differences that were statistically significant ($p < .05$).

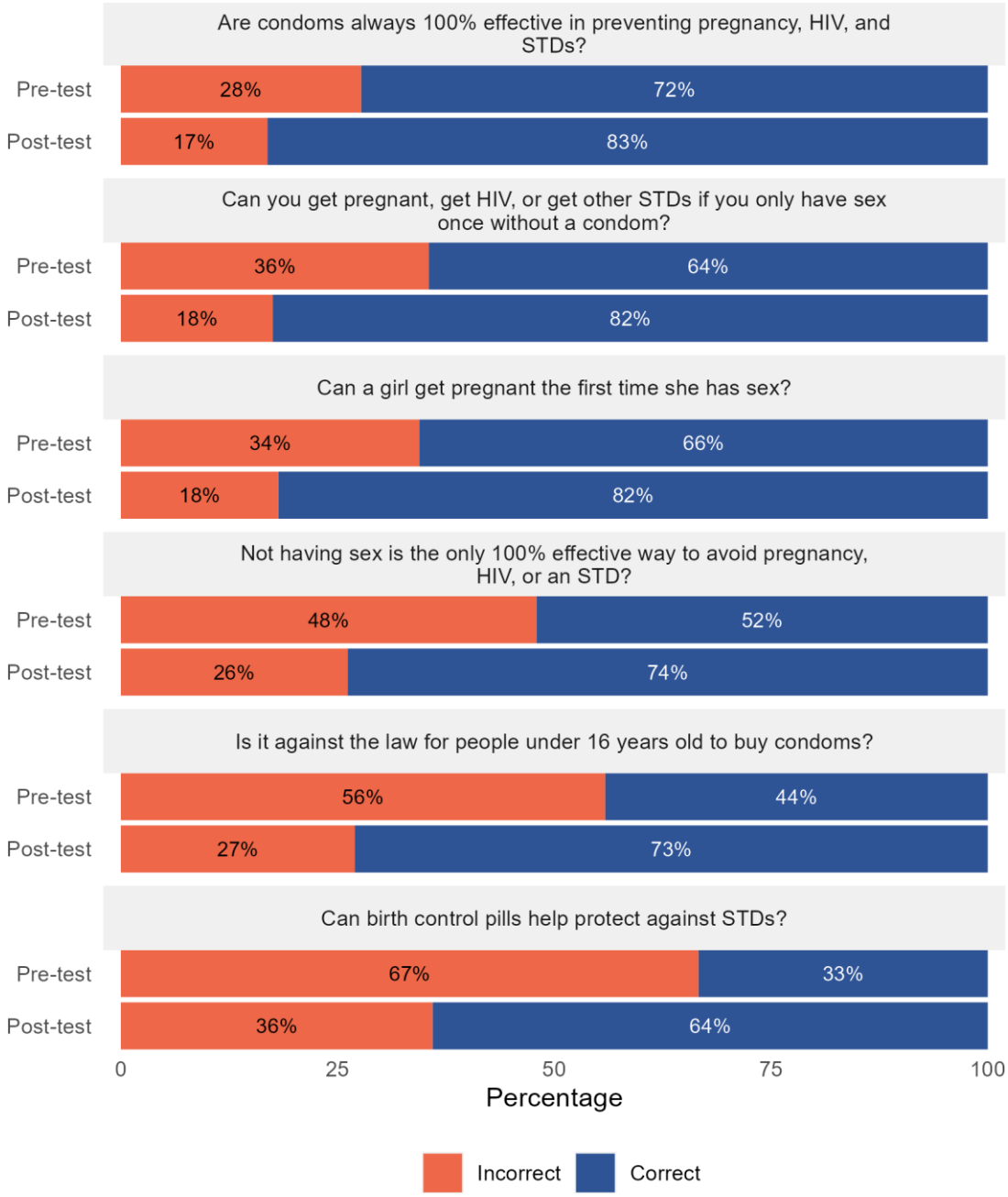


Figure 3. Change in knowledge from pre-test to post-test (Note. Asterisks indicate items with statistically significant differences.
The number of responses range from 5,026 to 5,052)

For the full report, please see Attachment 4A – CAPP FY 23 Annual Report.

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

Leadership Exchange for Adolescent Health Promotion (LEAHP)
On behalf of the advisory committee, the CAPP program manager applied for acceptance into the Center for Disease Control (CDC) LEAHP program. The overarching goal of this leadership opportunity is to build out better statewide communication strategies that impact Iowa adolescents. The Iowa LEAHP team, three national LEAHP team leaders from National Coalition of STD Directors (NCSD) and Child Trends, and two PCA Iowa board members, gathered in-person on May 11, 2023, to discuss the potential impacts of legislation on programming. State leaders from various disciplines and branches of Iowa HHS participated in this half-day session. During SFY 2023, the committee continued to collaborate and share adolescent health resources and training via emails and scheduled meetings. Future participation in the LEAHP has not been determined at this time.

Adolescent Health Advisory Committee
Legacy Iowa Department of Human Services (DHS) formed an interagency advisory committee of relevant stakeholders at the statewide level. The CAPP Administrator is responsible for coordinating and convening the committee meetings. The committee includes representatives from the following agencies or disciplines:

- Legacy DHS
  - The legacy DHS Prevention Program Manager resigned in October 2022.
- Legacy Iowa Department of Public Health (IDPH)
  - Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) Program Managers
- Legacy Iowa Department of Human Rights, Division of Criminal & Juvenile Justice Planning (CJJP)
- Legacy Iowa Department of Human Rights, Office of Latino Affairs
- Iowa Department of Education (DoE), Nursing and Health Curriculum
- Local Public Health Executive Director

With the alignment, legacy Iowa DHS, DPH, and the Department of Human Rights are now one agency. As the CAPP program transitions to the Division of Community Access, the Agency has put the advisory committee on hold. The Agency requires time to develop a strategic plan for improving service delivery, minimizing gaps, sustaining services provided, and how funding streams will collaborate. While multiple funding sources provide a broader base of funding and facilitate synergy, it entails challenges that include varying stakeholder expectations, unaligned grant cycles, varying procurement timelines and systems, and highly variable reporting requirements.

Future Direction of the Program
With the alignment of legacy public health and human service departments into HHS, there has been a great amount of work done to understand where programs should sit and how they should be administered. The Agency's Wellness & Preventive Health section now holds the majority of the Agency's maternal, child and adolescent public health programs and services, including legacy Personal Responsibility Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE) program, and now including CAPP. As teams have merged and brought new programming together, we have reassessed some programs' structures and processes in order to ensure the best use of resources possible and reduce any duplication of administrative work. As a result, the Agency determined it is most resource effective, and will

result in the least confusion possible, for HHS to bring the administration of the CAPP program in-house to mirror the model used in the PREP and SRAE programs. This transition is effective July 1, 2024.

As the CAPP program transitions to the Division of Community Access, the focus of the scope of work and services will shift to overall adolescent development rather than child abuse prevention. While child abuse prevention remains a priority focus in the Division of Family Well-Being and Protection, program staff may collaborate with CAPP program staff when appropriate and applicable. During this transition period, and in the absence of specific planned collaborations, the CAPP program will not be included in future title IV-B reports.

Community Partnerships for Protecting Children (CPPC)
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 statements were updated in SFY 2023 to be more family friendly, engaging and aligned with current language and trends in child welfare practice:

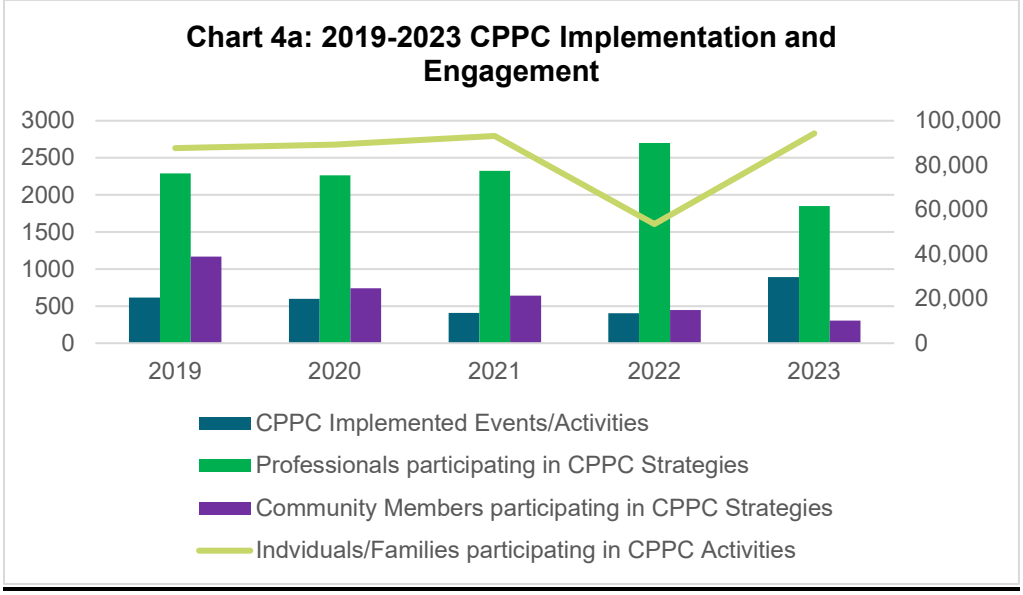
- Families and youth are the experts in what they need to be successful.
- Children do best in families, and should be with their own families, whenever possible.
- Families are stronger when all members, including caregivers, are safe from abuse.
- Local communities benefit from shared decision-making 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 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 welfare 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.

Unless other noted, data provided in the following five-year summary for CPPC reflects the five-year period of SFY 2019-SFY 2023, as these are the state fiscal year periods provided by the CPPCs in reporting during the five-year period. Throughout the five-year period of SFY 2019-SFY 2023, there have been approximately 11,430 professionals and 3306 community members involved in the implementation of the four CPPC strategies. CPPC sites statewide held a total of 2,917 events and activities with approximately 417,920 individuals and families participating in community activities, trainings, and events to engage, educate, and promote community involvement in the CPPC Approach.

Through implementation of the four CPPC strategies, participation in the CPPC and related activities strengthen safety, stability, permanency and well-being for children, youth, and families, and increase and build linkages between professional and informal supports. A breakdown of the CPPC implementation activities and engagement numbers by year is detailed in the chart below.



Community Partnerships for Protecting Children Strategy Summary

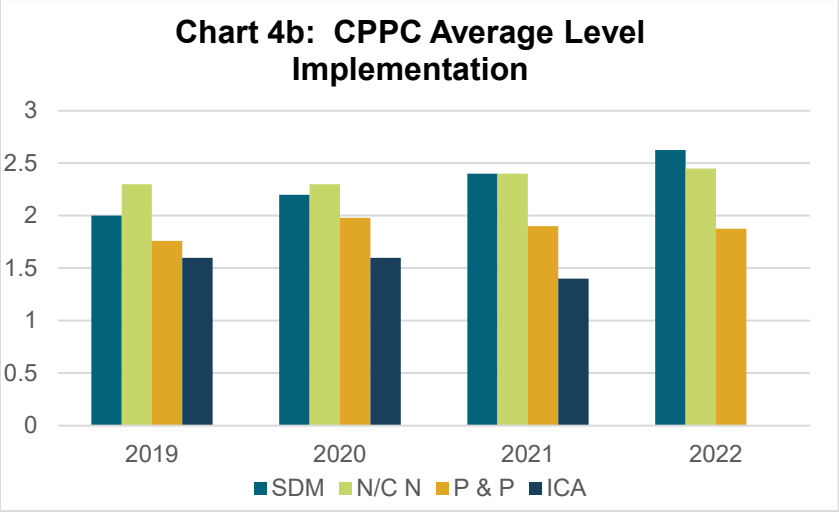
CPPC sites collect performance outcome data on the implementation of all four CPPC strategies. Transition from the former Individualized Course of Action (ICA) strategy to the new Family and Youth Centered Engagement Strategy (FYCE) took effect for the CPPC sites to begin utilizing with their planning for SFY 2023. The change from the ICA strategy to FYCE coincided with an overhaul of the annual plan and reporting form the CPPCs are required to complete regarding their annual plan for implementation of the four strategies and subsequent reporting on progress submitted to the HHS Program Manager each year. The first full year of reporting on the new Family and Youth Centered Engagement strategy using the revised planning and reporting template for SFY 2023 was be submitted by CPPC sites to HHS in August 2023.

To achieve desired results, simultaneous implementation of each of the four CPPC strategies must occur. Implementation of each strategy involves the CPPC sites first identifying or developing plans for activities to identify community needs and strategies and then move toward implementation of their plans as the sites advance their efforts. CPPC sites must also continue to build their Shared Decision-Making Team representation, including involving representatives from domestic violence, substance use and mental health partners, and local provider partners spanning diverse representation. CPPC sites are to include members who represent the demographics and diversity of their communities, in addition to youth and parents with lived experience reflected through current or previous involvement in the child welfare system.

Plans and strategies to increase linkages for informal and professional supports for families in need and increasing collaborations across child welfare and community partners are further reflected through Community Neighborhood Networking activities. As HHS practice and services have shifted to incorporate systemically many of the concepts that CPPC started and implemented (e.g., Family Team Decision-Making (FTDM), Youth Transition Decision-Making, and Parent Partners), this shifted responsibility of the CPPC network, and thus modifications occurred to the expectations of CPPCs over time.

CPPC sites further fluctuate implementation of the 4 strategies based on several factors such as CPPC Coordinator transition, Shared Decision-Making Team membership changes, changes in collaborative relationships within the community partnership, and an identified need to reconfigure and reset the local CPPC structure and associated strategic goals and planning. HHS anticipates that CPPC sites will fluctuate over time with these changes, in addition to changes in community needs and starting new collaborations and initiatives.

Until SFY 2023, CPPC sites previously reported a specific level (1-4) for each strategy obtained during the year. Sites received training on requirements to meet each specific level and written materials to assess the level for each strategy. CPPC transitioned from utilizing the levels of implementation measure for SFY 2023. The averages reflected in Chart 2 includes data on the average level implemented for each CPPC Strategy from reporting for 2022 and for the previous three years.



*CPPC sites were not required to identify a level of implementation on the ICA strategy in SFY 2022 due to the transition the Family and Youth Centered Engagement Strategy.

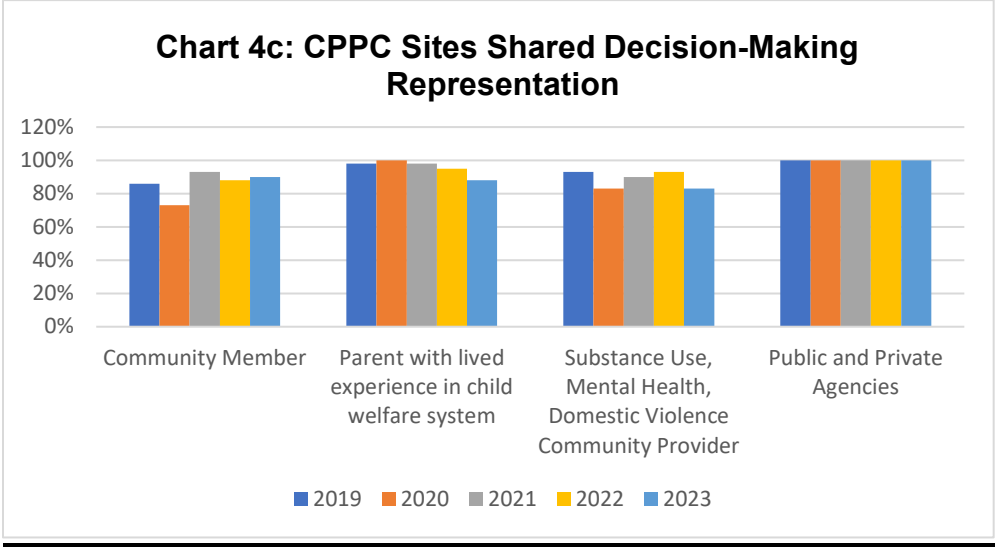
CPPC Coordinators have received training and guidance on completion of their CPPC Annual Plan and Progress Summary report, which reflects their planning and assessment of achievement and progress in each strategy. The planning and reporting document was updated in SFY 2023 to be more user friendly and applicable to capturing the progress and impact of the CPPCs.

CPPC Strategies

Currently, forty CPPC local decision-making groups, involving ninety-ninety counties, guide the implementation of CPPC. Data detailed below on the four key strategies of the CPPC Approach is summarized from the annual reporting periods from 7/1/2019 through 6/30/2023:

1) ***Shared Decision-Making (SDM)****:* Community Partnerships' foundation is the principle of shared responsibility for the safety of children. Organized shared decision-making committees guide the partnerships, which include a wide range of community members and organizations, public and private child welfare and juvenile justice, parents, youth, and HHS to work collaboratively.

The chart below illustrates percentage of representation at CPPC Shared Decision-Making Teams statewide during the reporting period.



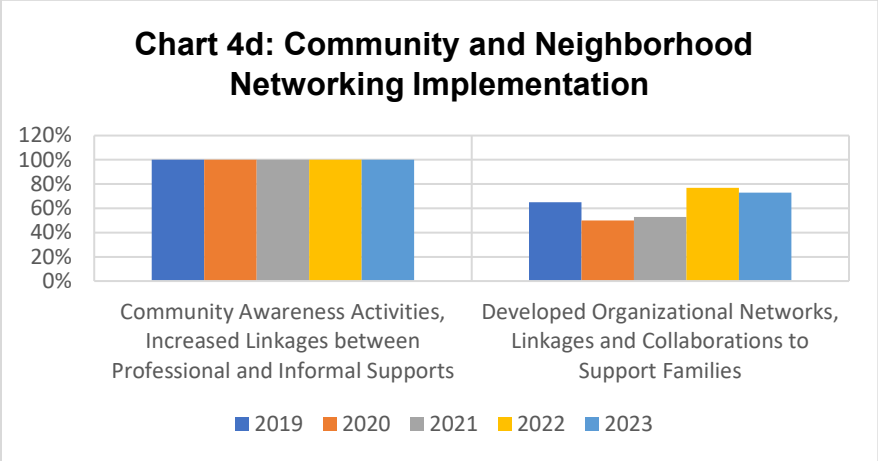
Each community partnership establishes a local Shared Decision-Making body to review the effectiveness of community child safety and well-being and engages community members to participate in and support the initiative. This group is responsible for setting the ongoing direction of the collaboration and leads efforts in reaching out to neighborhood residents, parents, youth, faith institutions, schools, mental health, domestic violence, substance use providers, law enforcement, early childhood providers, preventions partners, etc. to inform the public about the purposes and benefits of community safety and well-being for children and families. In addition, this group takes responsibility for self-evaluating their role and efforts. Shared Decision Making-Teams complete an annual survey to evaluate their common vision, understanding of goals, roles and responsibilities, shared leadership, relationships and trust, plans are clear and well-defined, and members are engaged in the shared decision-making process.

An example of Shared Decision Making in action includes the Linn County CPPC had identified refugee families resettling in the community needed car seats. A barrier to car seat education and installation events was the requirement for families to have their own car to participate. The Shared Decision-Making Team worked with car seat technicians to modify their policy, allowing one car to be utilized by multiple families for education on how to install a car seat. In collaboration with the CPPC and community agencies coordinating the event, interpreters and translated materials were also available for families in their preferred language.

2) **Neighborhood/Community Networking (N/CN):** Focuses on engaging and educating partners and promoting community involvement to strengthen families and create safety nets for children. Partnerships build linkages and relationships among professionals and informal supports.

The chart below demonstrates by year the percentages of CPPC sites that engaged in community `awareness activities and increased awareness of linkages between

professionals and informal supports, and the percentages of CPPC sites who developed and/or increased organizational networks, linkages, and collaborations in the community to support families through their activities.



Community and Neighborhood Networking (CNN) activities include but are not limited to: Neighborhood Hubs, 24/7 Dads programming, Community Equity Teams, Parent Cafes, and Community Events/Activities/Programs linkages and awareness of supports and resources to families and youth and community trainings to increase awareness and knowledge of needs, programs, and services of interest to the community. Specific CNN examples CPPC sites have implemented at the local level throughout the five-year period include:

Table 4q: 2019-2023 CPPC Community Neighborhood and Networking Activities

• Community Resource Fairs • Sesame Street in Communities • Poverty Simulation • Futurefest (for youth transitioning to adulthood) • Apartment in a Suitcase (for youth transitioning- from foster care to adulthood) • Cope Notes • Lemonade for Life training • Youth mentoring program • Mini-grant awards to community providers and programs • Pocket calendars for families • ACEs/Trauma Informed Trainings	• Car seat safety events • Hosting RPI/UIRB Learning Exchanges • QPR (suicide prevention training) • Youth Mental Health First Aid • Parent Cafés • Circles of Support • Caring and Working with LGBTQ Identified Individuals training • Implementation of the Handle with Care program • Back to School events • Celebration events for youth in foster care • Creation and distribution of community resource directories • CPPCs serving as a trusted source of information for

Table 4q: 2019-2023 CPPC Community Neighborhood and Networking Activities	
• National Night Out • Community hubs/hubbing activities for resource distribution	resources and supports in the community

Excerpt from narrative section on highlights and challenges from CPPC report submitted in SFY 2023:

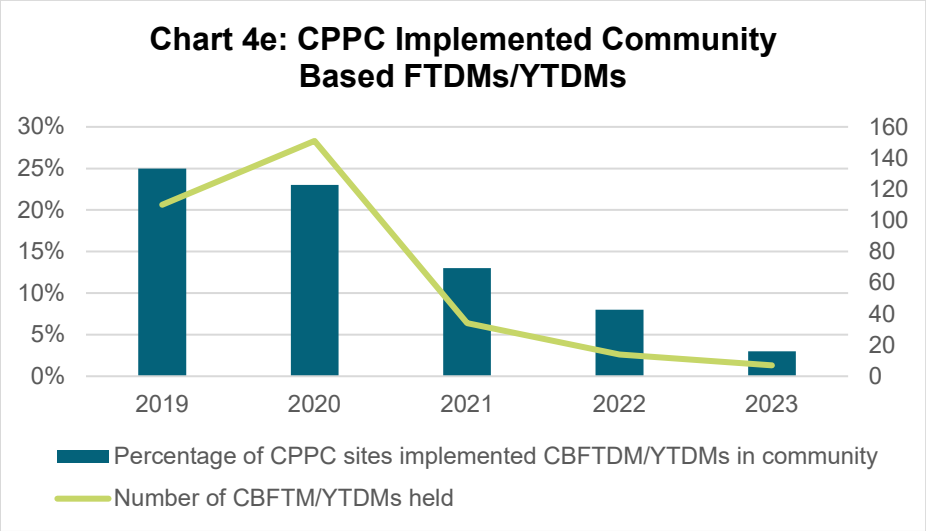
> *"One of the things that might go unnoticed is the way community agencies reach out to CPPC for help when they don't know where to go for help. Almost daily people reach out to CPPC for resources/direction. It's impossible to evaluate the impact of supporting/connecting/promoting agencies within the community, but it is invaluable for families. CPPC makes it easier for agencies to connect with other agencies as well."*

Through the CNN strategy, CPPCs develop important collaborations and linkages to improve the ability to meet needs of children, youth, and families by linking with community partners such as libraries, law enforcement, Family Treatment Courts, housing programs, transportation services, programs for pregnant and parenting teens, and the Aftercare program for youth transitioning to adulthood, to name a few.

3) **Individualized Course of Action/Family and Youth Centered Engagement**

Individualized Course of Action genuinely engages families and youth to identify strengths, resources and supports to reduce barriers and help families succeed. Family team approaches seek to identify and build on strengths so the family can successfully address issues of concern. As HHS transitioned away from FTDM model and to the utilization of Solution Focused Meetings in July 2021.CPPCs transitioned to the Family and Youth Centered Engagement Strategy as of July 1, 2023.

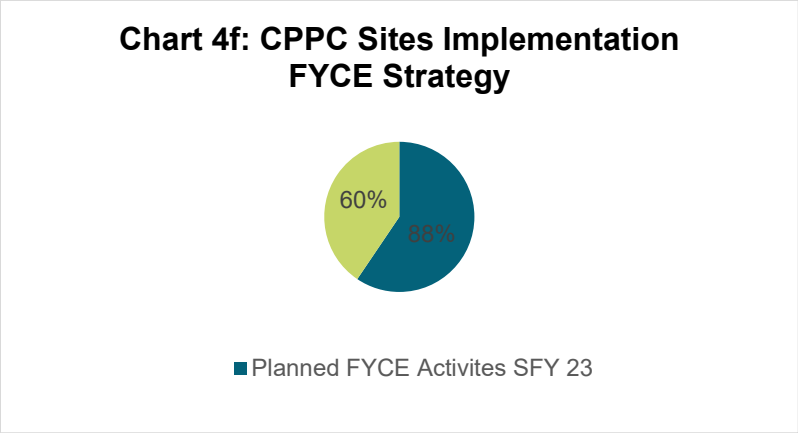
The chart below shows the percentage of CPPC sites implemented Community Based FTDM/YTDM meetings in the community (non-child welfare involved families) and the number of meetings held during the five-year period.



Family Team Decision Making (FTDM) had been a key activity for the Individualized Course of Action (ICA) strategy since the inception of CPPC in Iowa. The transition from the FTDM model in July 2021 for HHS child welfare cases to a family conference model that aligns with Solution Based Casework (SBC) impacted the ability to sustain FTDM in the community within the Individualized Course of Action (ICA) strategy, as community based FTDM meeting facilitators were no longer able to receive training or support in the FTDM model. CPPC sites further struggled to implement community based FTDMs, as reflected in Chart 5 which demonstrates the decline in the number of meetings held by year.

HHS decision to move away from the FTDM model resulted in a series of activities to analyze the CPPC ICA strategy to make necessary changes and re-evaluate the CPPC Approach to align with current shifts in the changing landscape of child welfare. In response to review of the four strategies guiding the CPPC approach, and to support innovative activities built from the community to fill the gaps in the prevention continuum, the Family and Youth Centered Engagement (FYCE) strategy rolled out in SFY 22 as the next iteration of the Individualized Course of Action strategy. The FYCE strategy is defined similarly to Individualized Course of Action, which is to genuinely engage individual families and youth to identify strengths, resources, and supports to reduce barriers and help families and youth succeed.

Family Youth Centered Engagement activities include Parent Cafes, Circles of Support, peer mentoring programs, activities connected to Family Treatment or Wellness courts, building trusting relationships with under-resourced communities, and youth/parent led councils and committees are all examples of potential activities within this strategy. As Youth Transition Decision Making (YTDM) training continues to be available for interested community facilitators to attend, Community Based YTDMs are also an activity for the CPPCs to implement under the FYCE strategy. The menu of activities for the FYCE strategy is not all inclusive and allows for increased flexibility to the approach for CPPCs to meet local needs.



Examples of FYCE implemented activities implemented in SFY 23:

- Asking a youth group to present information at one of our regular monthly meetings
- Youth and Parent representation on the CPPC Executive Committee
- Youth formed Shared Decision-Making Team
- Utilized Courageous Conversations Toolkit activities with youth
- RPI/UIRB Learning Exchanges with youth, Shared Decision-Making Team members, community members and HHS staff
- Culturally affirming programs and community events such as Juneteenth fair, programming for LQBTG parent/youth groups, Traditional Drum Presentation, Native Youth Standing Strong
- Translated program materials in different languages
- Connecting with youth at local schools to form youth groups, or to connect with existing youth groups and providing opportunity for youth voices to be heard.
- Circles of Support
- Increased trust, connection and strengthen relationships with community cultural and ethnic based organizations
- Recovery community activities
- Parent Cafes
- Community connections meals for youth and parents/families that included the following outcomes:
  - 86% of attending families reported a better knowledge of community supports
  - 98% of youth reported they learned a new skill with cooking or about a new food
  - 84% of parents learned about available supports for parents

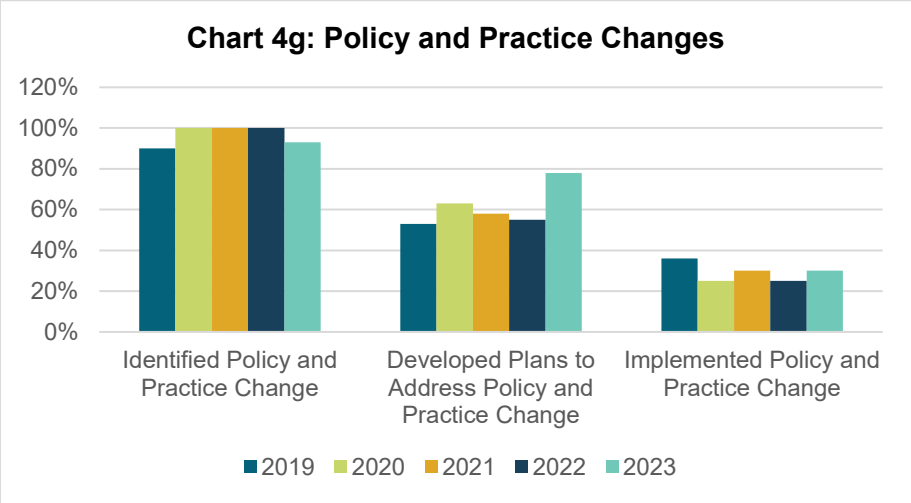
Excerpt from a CPPC report submitted in SFY 2023 under narrative highlights and challenges section of the report:

“CPPC is healing, relationships that are built will always be there, people learn to trust that there is kindness and love in the world. CPPC allows people to lower their defenses, it builds connections among community members and families, it gives people a different way of thinking, and promotes collaboration like nothing else. How can we measure all of these things? I don’t think we can, but I know in my heart that it’s true! Here’s to

Community Partnerships and all of the wonderful things it has brought to so many people!"

4) **Policy and Practice Change**

Community partnerships test innovative approaches, promote best practices, and influence system changes to serve better families and children. Policy and Practice Change involves community members, as well as youth and families directly impacted by the child welfare system, to develop and implement plans to address specific barriers and incorporate best practice approaches in the delivery of services.



For a community to be successful in Policy and Practice Change it needs to routinely assess efforts, identify gaps and barriers, and chart courses to improve policies and practices. Policy and practice changes include addressing service gaps; strengthening communication between HHS and community partners; prevention of re-abuse; stronger collaborations with domestic violence agencies; addressing community needs such as accessible transportation, food security, and housing; human sex trafficking; reducing disproportionality and disparity in child welfare; and increasing community culturally responsive or adapted services and supports.

Examples of CPPC site implemented Policy and Practice Changes included:

- Educating CPPC and community members on use of "My Care Community" provided through Linn County Public Health for accessing long term supports for families. Translation services are also offered.
- Youth and parents with lived experience serving on CPPC teams to provide input and voice into policy and practice changes.
- Utilization of the CPPC SDM team to share organization surveys and questions to gather information regarding the need for policy and practice change.
- Utilizing training and planning efforts in the community through a Healing Centered Engagement framework for ensuring equity focused services,
- Responding to the needs of immigrant and refugee families
- Hosting parent and youth listening sessions and Parent Cafes to engage with families, providers, and policymakers on needs and concerns of families in the community.

- Revising grant applications to make them more accessible for ethnic and culturally based organizations
- Forming relationships with schools, law enforcement, and key partners to implement programs such as Handle with Care, which promote the well-being, stability and safety of children, youth, and families.

Excerpt from a CPPC report submitted in SFY 2023 under the narrative highlights and challenges section of the report:

"The local coordination of CPPC brings providers and community members together to discuss gaps in services. To illustrate this successful model and report a successful highlight, we need only look at the presentation from the Cedar Rapids Library at a monthly CPPC meeting on the reading disparity rates. The data presented at this meeting prompted CPPC, Decat, ECI, county and local foundation to partner together and fund a new literary program that is working with and now providing services to clients being serviced by another agency. This partnership provides multiple outcomes in one programing night. This model and trusted partnerships create additional outcomes for families in a more efficient and cost-effective way."

Collaborations

CPPC engages in collaboration with various state programs and practice partners in a variety of ways. CPPC and the ICAPP program collaborated to hold combined fall regional meetings in 2021 and 2022. Feedback received from attendees is that they appreciate the opportunity to attend the meetings together, learn from one another, and share information relative to efforts where CPPC and ICAPP programs intersect in communities. Additional collaborations are engaged through the CPPC Statewide Convenings and Regional Meetings and are detailed further in the CPPC Education, Training and Support section of the report.

Through the Family and Youth Centered Engagement Strategy, CPPCs engage with parents and youth who have lived experience in child welfare to have their input on SDM teams, as well as represented in other important intersections of the work within the CPPC Approach, including racial and cultural equity. This work requires an on-going collaborative and culturally responsive approach and joining youth, parents, and community members at diverse times (often after hours) and locations (not necessarily where regular meetings occur) where people feel comfortable, that is accessible to them in their neighborhoods and made available at times they can gather.

The ability to host virtual or hybrid meetings provides additional equitable opportunities for those who have access to virtual spaces to join into meetings. Continued guidance is provided to CPPCs to focus their efforts on equitable planning of activities and ensuring parents, youth, and diverse members of communities are engaged for their input, feedback, and involvement. Opportunities to learn more about how to engage youth and parents with lived experience, and the benefits, have been highlighted at the CPPC statewide learning convenings and the CPPC Regional Meetings. The Center for States, Capacity Building document entitled Strategies for Authentic Integration of Family and Youth Voice in Child Welfare has been shared with the CPPC sites in multiple ways, including through an activity facilitated utilizing this document at the CPPC Regional meetings in June 2023 to guide the CPPCs in considering how to authentically engage with youth and parents.

As the four strategies intend for representation of the local CPPCs to partner and be reflective of the community, CPPCs includes diverse representation of community service providers from mental health, domestic violence, substance use, law enforcement, business, foster and kinship caregivers, schools, child abuse prevention councils, health care organizations, MCOs, MIECHV partners, ECI, local public health agencies, faith-based organizations, and HHS. Community members, and youth and parents with lived experience are also critical to a collaborative, shared decision-making space to ensure keeping children and family's safe and well are everyone's responsibility in the community.

In an effort to help the CPPC networks better understand the shift to Family First the CPPCs were provided the recorded training available on the Iowa HHS website presented by Dr. Amelia Franck Meyer with Alia on "The Human Need for Belonging: Building a New Way Together", which underscores the need for children and their families to remain intact and avoid separation by foster care when safely able to provide supports to families to keep them together, to share with their local CPPC teams for viewing and discussion. One example of the video utilized locally is a viewing opportunity sponsored by two CPPC sites, Building Direction for Families and HAWC Partnerships for Protecting Children, who collaborated to schedule and invite area networks and community members to a viewing and discussion at a local high school.

CPPC Education and Training 2020-2024

CPPC coordinators, child welfare system and practice partners, community members involved in local Shared Decision-Making teams, and CPPC community networks attend the Statewide Learning Convenings, Regional meetings, and Immersion trainings for learning opportunities, networking, idea, and strategy sharing, and to celebrate successes. Workshop and presentation topics focus on application of the CPPC Approach, trends in child welfare; local and statewide resources and programs; strategies for engaging communities; and ideas and action planning for application of information across CPPC local sites. These opportunities to learn and collaborate increase the CPPC's capacity to leverage resources and assess gaps in developing plans to meet the needs of children and families in their respective communities.

Through the Iowa State University (ISU) Child Welfare and Research Training Project contract with HHS for CPPC Coordination, the CPPC trainings, site visits, regional meetings, and statewide convenings during much of the reporting period were carried out through the work of the CPPC Statewide Coordinator and CPPC Specialist under the direction and guidance of the HHS CPPC Program Manager. The ISU Contract ended September 2023, as HHS decided to bring this work internally within the Agency, and to work toward transition of CPPC into the Early Intervention and Support (EIS) space of the Family Well-Being and Protection Division. The purpose of this shift is to better align CPPC with EIS services and programs in the community, building toward a redesigned prevention system. Additional information on this shift is in the section titled SFY 24 Summary Report.

CPPC Technical Assistance

Technical assistance through consultations and site visits were held with CPPC Coordinators/CPPC Sites throughout the five-year reporting period, conducted by both the CPPC Statewide Coordinator and the CPPC Specialist. The purpose of technical assistance provided included review and/or assistance in completion of annual CPPC planning/reporting, consultation to the site on implementation of the 4 CPPC strategies, transition planning due to turnover among strategic members of the Shared Decision-Making Team, and observation and

feedback regarding CPPC meetings centered on the 4 strategies, and for other purposes to provide support and TA to the CPPC sites.

During the five-year reporting period, 34 site visits held with CPPC sites. CPPC sites were provided a summary of strengths and needs identified during the site visit, as well as any identified next steps. New CPPC Coordinators received an orientation to the CPPC Approach, 4 Strategies, and reporting and meeting attendance requirements of CPPC sites. In addition, general technical assistance responses were provided via virtual meeting or in person consultation and through email correspondence from the CPPC Coordinator, Specialist and HHS Program Manager in response to CPPC site related questions, concerns, or challenges.

The CPPC Statewide Coordinator worked with the ISU CPPC team to provide quarterly newsletters to the CPPCs on topics related to the CPPC strategies, upcoming trainings and events, cultural equity related resources, and upcoming learning exchanges opportunities to attend or host Race the Power of an Illusion and Understanding Implicit Racial Bias. Many CPPCs hosted the learning exchanges in their communities as an opportunity to begin community conversations, bring together HHS staff and community providers/members for shared learning, and to begin to dialogue on the disproportionality and disparity data in child welfare in their areas.

CPPC Immersion 101 Training
Immersion 101 gives those involved with CPPC (or those interested in being involved) a better understanding of the four strategies of community partnerships. Participants learn about application of the CPPC's strategies and the flexibility of implementation of these strategies to meet local community needs. Participants interact to brainstorm implementation of the four strategies and to develop creative ways to bolster the implementation and activities of the local CPPC. The goal of CPPC Immersion 101 is to engage participants in recognizing the components of CPPC and the value in the implementation of the four strategies. The primary audience members for CPPC Immersion 101 are: new CPPC and Decat Coordinators, Shared Decision-Making Team members, new members of the CPPC, and those who are interested in learning more about CPPC. This includes HHS staff, community members, practice partners, parents, Parent Partners, kinship caregivers, foster parents, agency providers, community leaders, and local city and county government representatives.

During the 5-year reporting period, CPPC sites engaged in 17 held Immersion 101 trainings. In May and June of SFY 2023, two additional Immersion trainings were held since the last reporting period. Due to Covid, between SFY2021-2023 the Immersion trainings were held virtually. In SFY 2024, two CPPC Immersion trainings have been held with a return to in person training at two CPPC sites, with approximately 30 attendees. Participants of the CPPC Immersion trainings report increased understanding of the CPPC Approach and the 4 Strategies, an increased interest and willingness to participate in CPPC related activities and aligned opportunities to meet identified community needs and gaps in services and supports through increased networking and participation by attending the training. Opportunity is provided at the end of each training day for the CPPC site to engage in strategic planning with attendees.

CPPC Regional Meetings: CPPC Regional meetings were held bi-annually for CPPC Coordinators and/or members of Shared Decision-Making Teams in the fall and spring each year. Regional meetings transitioned to being held one time per year in SFY24 and are typically offered in the spring. The Regional Meetings allow CPPC sites to share in shaping the statewide implementation of Community Partnerships. These meetings provide:

- Training and Technical Assistance
- Peer Support
- Statewide Communication
- Networking Opportunities and Information Sharing
- CPPC Site Planning and Implementation Strategies

During the period of SFY2020-SFY2023, the CPPC Regional meetings were held twice a year, in the fall and in the spring. In SFY 2020, the Fall CPPC Regional meetings were focused on Parent Café implementation update, and a presentation from NAMI, In Our Own Voice, which provides space for individuals with lived experience with mental health challenges to share their story and how NAMI and community supports can make a positive difference. The Spring CPPC Regional meetings were held virtually for the first time due to Covid, and focused on an overview of Family Centered Services, ICAPP grantees awards, and a preview of the Cultural Equity Resources Survey for CPPCs and county Equity teams to participate in to learn more about how the available Cultural Equity resources are being utilized

In SFY 2021, the Fall CPPC Regional Meetings were held in collaboration with the Iowa Child Abuse Prevention Program (ICAPP) on topics such as, Family Partnership: Engagement Through Leadership—A Common Understanding; and reports from Resilient Communities projects. Additional agenda items included, Covid Response Sharing and Presentations by Panelists on ‘what worked’ while adjusting to Covid-19 restrictions, and a presentation from the Cultural Equity Statewide Coordinator and the APPC member on the initial findings from the Cultural Equity Resources Survey.

The Spring SFY 2021 regional meetings focused on "Looking at CPPC Efforts Through an Equity Lens" that included a video by local academic and organizer, Kesho Scott, followed by a discussion around the role of the Cultural Equity Alliance, County Equity Teams. This included an activity for CPPC coordinators to complete a worksheet based on their “Listen Fors” to describe what they heard or stood out, and in what ways the material presented on can positively influence their work, who is missing from the table to help strengthen their plans, and to identify the benefit to communities or families if their plan is successful. An additional presentation from WeCanPROSPER Resilience training, which engages participants to improve personal stress management, clarify their resilience needs, identify relevant supportive resources, and build skills to enhance resilience in their daily lives. Following the June 2021 regional meetings, 4 CPPC sites followed up to host WeCanPROPSER trainings at their CPPC local sites.

In SFY 2022, the CPPC fall regional meetings were held in collaboration with the Iowa Child Abuse Prevention Program (ICAPP) on the topic of Result Based Facilitation (RBF) and Results Based Accountability (RBA) with trainer Marlo Nash. The training included learning about Line of Sight for a goal or project, applying and practicing Hold Roles concepts, Hold Roles Conversations, and practicing using a 3R Meeting design. CPPCs were encouraged to practice these skills in facilitating their local meetings and for strategic planning. For the June 2022 Regional Meetings, Polk County CPPC spotlighted a recent Policy and Practice change implemented through their presentation on Addressing Disparate Outcomes through Partnerships and Shared Decision Making. This presentation highlighted their CPPC’s process to review their grant application to be more inclusive for ethnic and culturally based organizations to complete funding requests and the resulting Policy and Practice Change in awarding more ethnic and culturally based organizations grant funding from this work.

For SFY 2023, the CPPC fall regional meetings were offered both virtually and in person in collaboration with the Iowa Child Abuse Prevention Program (ICAPP) on the topics of community engagement strategies through shared partnerships and strategic planning by Linn County CPPC, Decat and ECI, and a spotlight on the Resilient Communities pilot project in Wapello County. Wapello County illustrated their strategies for engaging youth and community feedback through their community needs assessment process. Both spotlights provided CPPC and ICAPP grantees opportunities to learn how to engage with their communities in new ways to identify needs, frameworks for strategic planning, leverage existing resources and funding streams for projects, and move initiatives forward. The Spring CPPC Regional meetings were held in person in the western, central, and eastern service areas; Denison, Coralville, and Johnston, Iowa. The content of the regional meetings focused on the Family and Youth Centered Engagement strategy and utilizing Authentic Engagement strategies with youth and parents, and the IDEAS Impact Framework on developing a strategies, targets, and outcomes, as well as considering moderators in using a theory of change to evaluate and measure a program. There was a total of 35 attendees.

The SFY 2024 CPPC Regional meetings are scheduled to be held in person in April 2024. Topics of focus include presentations from the Aftercare Program for youth transitioning from foster care to adulthood and engaging this program with CPPC, the Youth Connect AmeriCorps Program, Parent Café benefits and hosting requirements, and a conversation with the CPPCs and HHS Early Intervention and Support (EIS) area of Family Well-Being and Protection Division. The purpose of this dialogue is to engage with the CPPCs around the transition of CPPC into the EIS area of the FWBP Division, and for EIS Director and key team leads to learn more about what the CPPC would like to see in the future of a realigned prevention system.

CPPC Statewide Learning Convenings: The CPPC Statewide Learning Convenings occurred on a bi-annual basis, in the spring and fall each year. In SFY 24, the CPPC Statewide Learning Convenings were shifted to be held once per year. A statewide planning committee includes CPPC coordinators and drives the framing of Convenings. Topics of focus for the CPPC Statewide Learning Convenings have included: National perspectives and models of interventions for families affected by substance use disorders in the child welfare system; promotion of relational health through trauma-informed care; update on the children's behavioral health system; updates on Family First Prevention Services implementation; Sesame Street in Communities; resilience building strategies for youth and families; youth mindfulness activities; collective community healing; youth panel on youth engagement; Cope Notes; mobile crisis and suicide prevention; community approach to youth violence intervention; collaboration and collective impact; Parent Cafes; CPPC Shared Decision Making team panel; embedding social workers in the local police department; Your Life Iowa overview; housing and intersection with child welfare system and community solutions; concrete supports for families and youth, and building authentic relationships in communities. CPPC sites have implemented several of the strategies and learning provided through the CPPC Statewide Convenings through bringing the shared initiatives, training topics and presenters, and activities to their local CPPC through implementation, additional training, and sharing information with their teams and networks.

The SFY2024 CPPC Statewide learning convening held in November 2023 included a key presentation by HHS Early Intervention Services Director, Shelley Horak, about the vision for this newly aligned area focused on prevention and early intervention services and supports within the Family Well-Being and Protection area of the Agency. Key speaker Andrea Dencklau from Iowa ACEs 360 also spoke to the audience about the power of Healing Centered Engagement. Breakout sessions included topics on the program Strengthening Families 10-14;

community agency, Monsoon, focused on providing supports and community education regarding the Asian American Pacific Islander community; CPPC supported youth mentoring program; and building relationships with schools to address unmet community needs. A youth mentoring panel, featuring two youth with lived experience, was hosted in the afternoon for the audience to learn more about the benefits of youth mentoring programs in communities. Attendees had the opportunity to walk through CPPC site displays and vendor tables set up throughout the day.

CPPC Initiatives

AmeriCorps Partnering to Protect Children (APPC)

Throughout the five-year reporting period, HHS partnered with Iowa State University (ISU) to implement an AmeriCorps program which provides an AmeriCorps member to CPPC sites to promote the communities' ability to strengthen the four strategies of CPPC. A statewide AmeriCorps program coordinator provided oversight to members serving within each of the host sites Members report monthly on their capacity building activities and corresponding CPPC strategy. Local site supervisors complete an annual assessment of member impact toward achieving their CPPC goals. The purpose of the APPC AmeriCorps program was to expand the CPPC sites' capacity to engage the community and promote child well-being, while simultaneously providing member career development and educational award opportunities through service. Some APPC members had lived experience in the child welfare system, and several members have gone on to begin careers in the human services field following their service term.

During the 2020-2021 APPC program year, the second year of a three-year program evaluation was conducted. This evaluation report described the results of an external assessment of APPC program impact, focusing on the extent to which the scope, reach, and effectiveness of sites increased based on member service during the 2020-2021 program year. Data for this evaluation came from both supervisors and APPC members and included 1) scripted interviews, 2) online surveys, and 3) monthly member reports.

Evaluation results summarize the APPC program successfully enhanced community networking (among service providers) and laid essential foundations for the maintenance and expansion of shared decision-making protocols. While connections with families was less evident, member activities shifted more significantly toward laying the foundation for increased collaborative and coordinated efforts among service providers. The members reported a total of 370 total activities. Like findings from the supervisor surveys, many activities (71%) were classified as neighborhood networking types, followed by shared decision making (14%), policy and practice change (13%) and individualized course of action (2%).

During the SFY 2020-2023 reporting period, at total of 57 APPC members were hosted at CPPC sites across the state. HHS made the decision to no longer provide the match funding for the APPC Program for SFY23. Despite this, the APPC Program and CPPC have continued to maintain a collaborative partnership, and some CPPCS sites have continued to host APPC members independent of the HHS match funding.

The AmeriCorps program through ISU has been in the process of development of a new initiative called Youth Connect AmeriCorps. The Youth Connect program provides an opportunity for youth and young adults who have had lived experience in the foster care system to provide peer support to connecting youth in foster care with programs that will provide support and assistance as they transition to adulthood, such as the Aftercare Program. The

Youth Connect program is interested in connecting their members with CPPCs to provide continued connection to available resources in the community for youth and young adults, as well as to provide youth/young adult voice in the CPPCs. The Youth Connect program will present at the Spring CPPC Regional meetings in April 2024.

Parent Cafés

Parent Cafés is an initiative which has been piloted and promoted through CPPC. CPPC sponsored the initial rollout of Parent Café facilitator and host training through working with the Be Strong Families organization in Illinois. The Parent Café model allows participants "individual deep self-reflection and peer-to-peer learning, opportunity for participants to explore their strengths, learn about the Protective Factors, and create strategies from their own wisdom and experiences to help strengthen their families." (https://www.bestrongfamilies.org/).

Parent Cafés occur in a variety of locations across the state and includes parents in family preservation courts, Parents as Teachers participants, parents of children at various ages and stages, teen parents, fathers, refugees, kinship caregivers, and others in the community.

An Implementation Guidebook was developed in 2019 through a local CPPC well experienced with hosting Parent Cafes. The Guidebook provides tools and resources for both interested and current Parent Café sites as sites plan to implement a Parent Café. Information includes focus population for cafes, location considerations, cost calculator, sample budget, potential funding sources, childcare considerations, décor and food costs, data collections and tracking tools, and range of options to consider based on funding. The CPPC also developed a state networking contact list and conference calls for sites facilitating or interested in Parent Cafés, distributed Monthly "Did You Know?" emails regarding events, trainings, and tips regarding Parent Café and made individual contacts with current and interested CPPC sites and community partners to discuss Parent Café implementation and training opportunities. The implementation guidebook can be viewed at the following link:
https://www.cppconline1.com/uploads/3/7/7/2/37725789/final_guidebook.pdf

The Implementation Guidebook was planned to be updated in SFY24 to bring the information current and add in updated strategies and resources for hosting Parent Cafes, as well as lessons learned from those with experience hosting Cafes around the state, however this project has not occurred at the time of this writing. The HHS Program Manager has updated a Parent Café hosting document, which provides information for interested hosting sites on their roles and responsibilities to coordinate the training the Parent Café trainers to host a Parent Café training, as well as the costs associated with the training. The hosting document, and link to request a Parent Café training, will be provided at the CPPC Regional Meeting in April 2024.

To further expand the Parent Cafe initiative across Iowa, an additional four trainers were identified in 2021 to become Certified Trainers within the Parent Cafe model to facilitate Parent Café Training Institutes (PCTI). A PCTI is a two or three-day (depending on whether offered virtually or in-person) experiential and highly interactive training that prepares parents and providers to convene and conduct Parent Cafes to serve as facilitators and table hosts at the cafes. Participants learn the anatomy of a Parent Cafe, how Parent Cafes strengthen Protective Factors, the research underlying cafes as an educational and engagement strategy, how to create an ambiance conducive to maximizing the effectiveness of the café process, and how to build on the cafe experience to enhance programming for parents and youth. In August 2022, all four trainers had completed the training to become certified to expand the Parent Cafe initiative across Iowa.

As part of additional guidance provided to the Certified Parent Cafe Trainers in Iowa, quarterly meetings were held to provide an opportunity for the Trainers to give feedback, share knowledge, plan for trainings to be held within local CPPCs, and discussion regarding data collection.

Throughout the five-year reporting period, 8 Parent Café Trainings have been hosted and facilitated by the Certified Trainers to train local café hosts in the Parent Café model. Local Parent Café sites affiliated with CPPC networks reported hosting at total of 172 Cafés in their local communities during the period of SFY2020-2024, with approximately 1700+ attendees. Parent Cafes are being held both virtually and in person, with a variety of attendees including, parents of pre-school age children, young parents, youth, grandparents, schools, parents who are being supported in the Parent Partner Program, Family Treatment Court, recovery community, faith-based groups, and general parents in the community. In the Polk County area, the CPPC has supported Cafes geared towards the unique needs of refugee and immigrant communities.

In SFY 2024, community organization in Linn County, Young Parents Network , is offering Parent Cafes specific to families who are involved with HHS Child Protection Services. The cafes are being offered virtually and are open statewide for to referrals of parents by HHS to participate. The Parent Café opportunity is funded by the Linn County Decategorization project.

CPPC Projects 2020-2024
Family Team Decision Making (FTDM) was a key activity for the Individualized Course of Action (ICA) strategy since the inception of CPPC in Iowa. The transition from the FTDM model in July 2021 for HHS child welfare cases to a family conference model that aligns with Solution Based Casework (SBC) impacted the CPPC Individualized Course of Action (ICA) strategy, as community based FTDM meeting facilitators are no longer able to receive training or support in the FTDM model.

This change resulted in a series of activities to analyze the CPPC ICA strategy to make necessary changes and re-evaluate the CPPC Approach to align with current shifts in the changing landscape of child welfare. This work began with changes to the ICA Strategy to transition to the Family and Youth Engagement Centered Strategy, and a revised template for the CPPC annual plan/report.

- **CPPC Survey/Focus Group Project:** In Fall 2021, the CPPC Survey/Focus Group project began in effort to collect information and feedback from CPPC stakeholders across the 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.

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/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.

The full CPPC Survey and Focus Group Summary Report can be found in the attachment below:

CPPC Survey and Focus Group Summar

In response to the findings from the CPPC survey project, modifications to CPPC have been focused on the transition to the new, more flexible Family and Youth Centered Engagement 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.

- **Transition to FYCE Strategy:** The move from Family Team Decision Making (FTDM) resulted in the need to analyze the CPPC ICA strategy to make necessary changes and re-evaluate the CPPC Approach to align with current shifts in the changing landscape of child welfare. In response to review of the four strategies guiding the CPPC approach, and to support innovative activities built from the community to fill the gaps in the prevention continuum, the Family and Youth Centered Engagement (FYCE) strategy rolled out in SFY 2022 as the next iteration of the Individualized Course of Action strategy. The FYCE strategy is defined similarly to Individualized Course of Action, which is to genuinely engage individual families and youth to identify strengths, resources, and supports to reduce barriers and help families and youth succeed.

  The FYCE strategy provides increased flexibility for activities while centering family and youth engagement; allows site opportunities for innovation and to tailor activities to meet

local needs; supports activities that promote Protective Factors and equitable child and family well-being for families at increased risk; and provides opportunity for community resource coordination approaches. CPPCs have increased opportunity to plan and facilitate activities to build trust and connection with under resourced communities, engage with parents and youth with lived experience as key partners in decision making, co-creation and participation in activities to build community connections, strengthen protective factors and resilience, and provide input into policy and practice changes.

- **CPPC Revised Logic Model:** The HHS Program Manager collaborated with the Community Partnerships Executive Committee (CPEC) in SFY23 to revamp the original CPPC Logic Model. This revamp included review and revision of the CPPC vision, values, and core principles, as well as the addition of the FYCE strategy. Core revisions included updated language to be more family friendly and less service oriented, equity-centered, and to better align with current child welfare practice. The results of the CPPC survey project also informed key changes. The goal for the updated CPPC Logic Model is to utilize the model as a working document for the CPEC to evaluate if the CPPC implementation and activities are effective, on track, and if the identified outcomes are being met.

- **CPPC Plan/Report Revisions:** A workgroup comprised of CPPC Coordinators, Decat Coordinators, and HHS Community Liaisons was convened in Fall 2021 to begin reviewing the CPPC annual plan/report document template to provide feedback and suggested changes. As a result, the workgroup determined that the level system of measuring implementation of the four strategies has not been as effective in recent years in capturing the CPPC progress on activities. As the CPPC Approach has now been implemented in Iowa for over two decades, it was determined that measuring the impact and outcomes of the work of the CPPCs may be a more useful approach to evaluating the effectiveness of the CPPCs beyond a focus on the levels of implementation.

  Along with including the updated changes to the FYCE strategy in the revised plan/report document, the additional goal of the revised plan/report template is to better capture priorities and planning of the local CPPC goals and activities, and to report on end of year outcomes of the activities, as well as successes, highlights, and challenges, and to better illustrate the impact of the CPPCs across communities. Though the levels are no longer part of the CPPC measurement on the revised report, the activities within the CPPC strategies have remained the same, apart from the new FYCE strategy. The focus has instead shifted to reporting not only plans for the activities, but also utilization of data in planning for priorities and goals/activities for the year, and to increase tracking and report on outcomes of CPPC activities and their impact on their communities.

  Training was provided to CPPCs by the HHS Program Manager in March 2022 on the revised CPPC plan/report document and the FYCE strategy rollout. Additionally, the CPPCs were provided a guidance document to supplement the revised plan/report template, resources for more information around implementation of the FYCE strategy for the CPPC sites to reference and utilize, and a completed example plan/report for their reference. These materials were distributed again to the CPPC sites in March 2023 in preparation for completion of annual reports submitted in May for SFY24. A webinar was held in February 2024 to review the annual plan and report instructions for CPPC

Coordinators in preparing plans for SFY25. The revised template for the CPPC plan and report is attached below:

CPPC Annual Planning_Reporting T

- **CPPC Brochure:** The in-depth CPPC Brochure went through a thorough process of updates and revisions throughout the last year. The CPPC Brochure design was revised with new visuals, utilizing the style guide and colors of HHS. The updated language in the CPPC vision, values, and core principles is reflected in the updated brochure. Youth and parent quotes have been included describing their experiences participating in their CPPC. Updated examples of activities the CPPC has implemented within each of the four strategies were also included, as well as data points from key initiatives activated through the CPPC including Parent Cafes, the Parent Partner Program, and the Learning Exchanges, Race the Power of and Illusion and Understanding Implicit Racial Bias, which are frequently hosted by CPPCs in communities across Iowa. The updated CPPC Brochure was rolled out at the CPPC regional meetings in June 2023 and printed brochures were provided to the CPPC sites at the November 2023 CPPC Statewide Learning Convening. CPPC Brochure Comm472 8_2023

- **CB FTDM Pilot/Family Connections Gathering:** A workgroup was convened in July 2021 to develop a pilot of revised model and process for Community Based Family Team Decision Making (CB FTDM) meetings. The CB FTDM meeting pilot was developed with the intention to provide an opportunity to connect with parents who have experienced safe HHS case closure in identifying ongoing formal and informal supports in the community. The initial goal of the pilot was to facilitate a supportive family meeting with parents exiting the HHS child welfare system to build community supports to prevent re-abuse and re-entry into the child welfare system and support overall family well-being through strengthening Protective Factors.

  The workgroup's intention was to pilot meeting model and process from a service orientated perspective, to a more family friendly approach around strengthening Protective Factors. As a result, the pilot meeting model was renamed to be called a Family Connections Gathering (FCG). The workgroup developed a brochure for professionals explaining the purpose of the FCG and how to make a referral. A brochure for parents was also developed and translated into Spanish.

  The initial intended population of focus was on parents involved in the Western HHS Service Area, After Care Support Parent Partner Program. This program is available to parents in 7 counties within NW Iowa who have experienced safe case closure from their HHS service case and volunteered to continue receiving Parent Partner mentoring support for six months following case closure. The pilot population was expanded to include additional families experiencing safe HHS case closure. As participation is voluntary, HHS case managers were able to discuss and refer the FCG opportunity to families at case closure if families were interested in participating.

  In February 2022, the facilitators began accepting referrals for the pilot project. HHS referred 2 families. One family was not interested after the facilitators spoke with the parent further. The second parent initially expressed interest in participating in the FCG,

however the facilitators were unable to maintain contact with the parent to coordinate the gathering to take place. The facilitators spoke with a local school district in Spring 2022 about interest in offering the FCG opportunity to families in the school system who may be identified as needing additional support. One parent in crisis was referred by the school district and the facilitators were able to provide crisis support and resources to the parent. However, the parent was not interested in participating in the full FCG process.

During the period of May 2022-December 2022, the pilot struggled to receive referrals from families who were interested in participating in the FCG at HHS case closure. The workgroup determined in June 2022 to strengthen efforts on offering the FCG to families in the local schools in one of the identified counties for the pilot. The facilitators met with school counselors, educators, and school administrators to market the FCG pilot as an opportunity to provide support to families identified in the school system in need of additional support. Brochures were provided for professionals making referrals, and to parents explaining the purpose of the meeting. Marketing of the pilot program continued through December 2022. Unfortunately, no additional families were referred for support through the pilot despite these efforts. The workgroup made the decision to end the FCG pilot at the end of December 2022, determining that additional staff time and resources will be needed to support a more robust implementation of the effort.

SFY 2024 Summary Report

The CPPC HHS Program Manager continued to initiate strategic development and guidance regarding the Family and Youth Centered Engagement strategy to continue to bolster CPPC efforts to embrace the strategy across the state. Work continued to revise key informational materials for the CPPC, revisions to the CPPC Practice Guide, and facilitation of training and learning opportunities through the CPPC Statewide Convenings and Regional meetings, and CPPC Immersion Trainings to enhance these efforts through local examples of implementation, collaborative opportunities for leveraging resources, and site to site networking.

Initial plans for SFY 2024 had included the CPPC State Coordinator to increase direct support and technical assistance to the CPPC sites in this year. As mentioned previously the contract between HHS and ISU CWRTP for training and support to CPPC sites ended in September 2023.

In July 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. This assessment included CPPC, Decatagorization (Decat) and Early Childhood Iowa (ECI) in the Family Well-Being and Protection Division, among several other service delivery and program areas within HHS. The recommendations in the HMA Service Delivery Alignment report describe options for HHS to restructure the three programs/approaches to better focus and streamline resources and service delivery. The HMA report states the overarching goal of these options is to increase local and state coordination in the delivery of family well-being and protection interventions/programs and decrease administrative overlap and duplication in contract and program administration.

The HMA report further recommends a model to align Family Well-Being and Protections Programs with Community Access programs, including 1st Five, Maternal, Child and Adolescent Health, Family Planning Program, I-Smile, WIC and FaDSS, utilizing a lead agency model with catchment areas through which Iowans can access services regardless of county of residence.

This can either be adopted through a combined approach for Community Access and Family Well Being and Protection Programs under a lead agency, or two individual lead agency models for Community Access and Family Well-Being and Protections. The latter includes a single prevention and early intervention model for CPPC, Decat, and ECI.

Transition of the CPPC initiative to Early Intervention and Support area of the agency began in February 2024 and is in process. HHS Early Intervention and Support Director Shelley Horak has addressed the CPPC Coordinators at a webinar held in February, to begin conversations about her vision for CPPCs role in the community-based services and supports housed in the EIS area. The EIS Director and team leadership will facilitate additional discussion and feedback with the CPPCs at the upcoming CPPC Regional meetings in April.

In SFY 2024, three virtual learning opportunities have been offered to date, to provide additional learning for the CPPCs to participate in between the statewide convening in the fall and the regional meetings in the spring. The topics provided to the CPPCs virtually included presentation from the Paternity Affidavit coordinator from Iowa State University on the purpose and process to assist parents in completing the paternity affidavit form in Iowa; a webinar for CPPCs and Parent Partners to learn more about how to effectively engage with Parent Partners in the local CPPC, and an overview of the annual CPPC plan and report requirements. An additional webinar is planned for the CPPC for later this spring on an overview of the Early Access program.

Summary of the strengths and opportunities for improvement for CPPC collaborative efforts and system impact:

- Strengths:
  - Engaged 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 Cafes).
  - 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 a tool used 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 to for building formal and informal supports for families in communities.
  - CPPC sites collaborate with Iowa HHS Cultural Equity Resources and county Equity Teams for child welfare to educate child welfare systems, practice partners and

community members on utilizing available tools for promoting systemic changes to reduce minority and ethnic disproportionality in the child welfare 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 strategy, based on feedback extensive feedback from CPPCs, stakeholders and partners on how to improve upon the former ICA strategy by more flexible to meet the needs of communities rather than a one size fits all approach with CB FTDMS.
    - FYCE strategy will increase 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 the Early Intervention Services area of the Family Well-Being and Protection Division.
- Opportunities for Improvement:
    - Work to increase sites' understanding of child welfare 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.
    - Evaluation analysis of the revised CPPC annual plan and report.

ASSESSMENT AND INTERVENTION

Child Protective Assessments

HHS accepts all reports 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 Child in Need of Assistance (CINA) Assessment, to determine if there is a need for the child to be adjudicated a 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 in order 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. 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.

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.

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.

Most child abuse assessment are Not Confirmed, as indicated in the table below and as aligned with national data. When abuse is Founded, a separate group of HHS case managers oversee ongoing services for children and their families through HHS Case Management Services.

Table 4r: Child Protective Assessments – CY 2019-2023

Calendar Year (CY)	Total Assessed Reports	Family Assessments (Percentage)	Assessments Not Confirmed (Percentage)	Assessments Confirmed & Founded (Percentage)
2023	32,857	6,244 (19%)	18,674 (57%)	7,939 (24%)
2022	34,512	6,302 (18%)	19,693 (57%)	8,517 (25%)
2021	35,593	6,727 (19%)	20,323 (57%)	8,543 (24%)
2020	30,151	6,450 (21%)	15,766 (52%)	7,935 (27%)
2019	33,004	6,543 (20%)	17,947 (54%)	8,514 (26%)

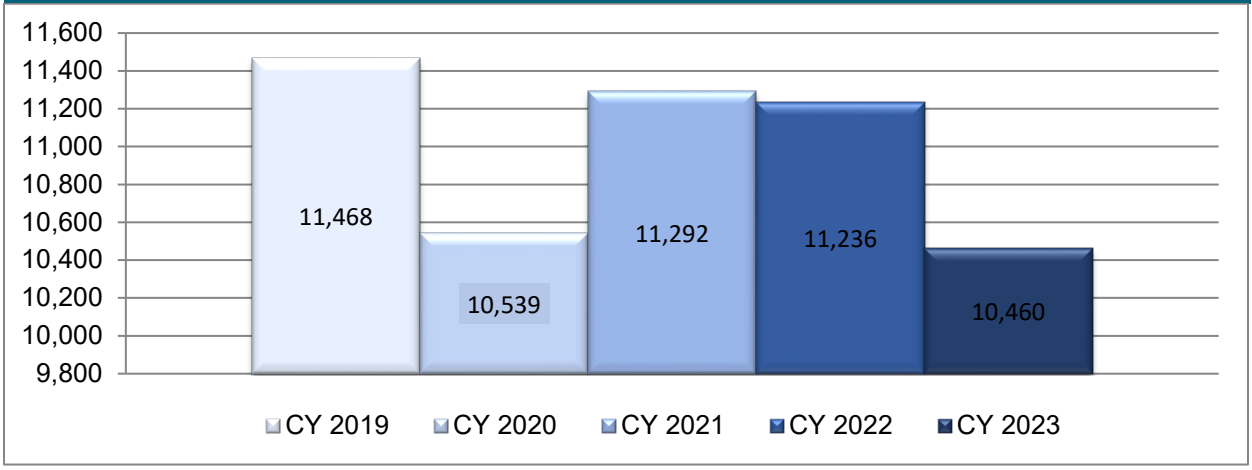
Source: SACWIS

Over the past five years (noting 2019 through 2023 since 2024 abuse statistics will not be available until spring of 2025), the total number of reports of suspected abuse that met assessment criteria have leveled off over the past three years.

The decrease in total assessed reports in 2020 is believed to be a result of the global pandemic from COVID-19, as children were not being seen as regularly when schools closed, and in-person non-emergency medical and mental health appointments ceased for many months.

As a result of totals impacted by the pandemic in 2020, when most mandatory reporters were not routinely seeing children and therefore making less reports of suspected abuse, it was not a surprise to see the total number of assessed reports in 2021 increase by 5,442 assessments when school and in-person appointments with medical and mental health agencies resumed. Assessment totals for 2021 realigned with where totals were pre-pandemic and have remained fairly consistent in 2022 and 2023 as well.

Chart 4h: Total Number of Unique Children Abuse* by Calendar Year (CY)



Source: SACWIS; *Each child abuse report may have multiple children indicated, and an individual child may have more than one abuse report in a given year. In effort to count each child victim once, this chart reflects only the most adverse outcome for each child during the calendar year.

The number of unique children who experienced confirmed or founded abuse over the past five years has fluctuated slightly. While the number dipped as expected in CY 2020, they returned to pre-pandemic totals in CY 2021 and remained in CY 2022. CY 2023 brought another dip in the total number of unique children who experienced confirmed or founded abuse. Although this dip was a total of 776 less unique children who experienced abuse, it was interesting to note that the total dropped even lower than what we saw during the height of the pandemic in CY 2020. This total is directly linked to the increase in Not Confirmed reports.

Table 4s: Age of Total Unique Children Abused

Calendar Year (CY)	5 or <	6-10	11+	Total
2023	46%	26%	28%	100%
2022	46%	26%	28%	100%
2021	48%	25%	27%	100%
2020	47%	26%	27%	100%
2019	46%	27%	27%	100%

Source: SACWIS

The age of children who were victims of confirmed or founded abuse over the past five years has been steady. Children aged five or younger continue to represent slightly less than half of all children abused. Children ages six to ten years old continue to represent approximately one quarter of all children abused while another approximate one quarter represent children 11 years and older.

Table 4t: Percentage of Child Abuse by Category for Confirmed or Founded Assessment					
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Denial of Critical Care	54%	53%	55%	59%	59%
Dangerous Substance	27%	25%	23%	19%	20%
Physical Abuse	7%	7%	7%	7%	7%
Presence of Illegal Drugs in Child's System	7%	9%	9%	9%	9%
Sexual Abuse	4%	5%	4%	4%	4%
Allows Access by Registered Sex Offender	<1%	<1%	1%	1%	<1%
Allows Access to Obscene Materials	<1%	<1%	<1%	<1%	<1%
Mental Injury	<1%	<1%	<1%	<1%	<1%
Child Sex Trafficking	<1%	<1%	<1%	<1%	<1%
Prostitution of a Child	<1%	<1%	<1%	<1%	<1%
Bestiality in the Presence of a Minor	<1%	<1%	<1%	<1%	<1%

Source: SACWIS

The percentage for all 11 categories of abuse have remained consistent over the past five years. Denial of Critical Care has maintained as the largest category of abuse, accounting for over half of all abuse in Iowa. Dangerous Substances continues to account for approximately one quarter of all abuse while Physical Abuse and Presence of Illegal Drugs in a Child's System combined continues to account for nearly a quarter of abuse as well. The remaining six categories of abuse have continued to account for one or less than one percent of all abuse in Iowa over the past five years. See the full calendar year statistics at: https://hhs.iowa.gov/programs/CPS/child-abuse-statistics

An agency dashboard has also been created to show our commitment to continuous improvement, transparency, and accountability for results. Data on the Child Welfare dashboard includes accepted and rejected intake percentages, placement types and totals, and statewide as well as service area level data for removal rates per 1000, re-entries to foster care, and repeat maltreatment. See the agency dashboard data at: https://hhs.iowa.gov/dashboard_welcome

Laws Passed Impacting Child Welfare: There were 10 bills signed into law that impacted child welfare. These amendments are outlined in the 2023 Mandatory Reporter Release, which is published on the State's Mandatory Reporter Webpage

Iowa Child Death Review Team: In review of additional progress made, we look at one of the collaborative efforts in place to prevent future maltreatment fatalities. Since 1995, the Iowa Child Death Review Team's purpose is to "aid 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".

HHS designates a staff liaison to assist the team in fulfilling its responsibilities. The liaison reviews data available in the HHS information systems for each child death and prepares case summaries and statistics 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, 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.

HHS does not receive reports of suspected child abuse on all child deaths. 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%) of Iowa children, while 35 (18.2%) were undetermined, 24 (14.1%) were suicide, and 8 (4.2%) were homicides. The official manner of death for the remaining 4 (2.1%) were unknown or missing.

Iowa Code §232.70 requires mandatory reporters to report such suspected child abuse to HHS. When HHS receives and accepts a report of a child fatality for assessment, staff assigns a one- or twenty-four-hour response time for the child protective worker (CPW) to assure the safety of siblings or any other children involved.

During the course of the HHS child abuse assessment that involves a child death, the CPW collaborates with the following sources and documents any information that assists in making a child abuse finding within the child abuse assessment.

- On all accepted child death cases, the HHS works with local law enforcement and/or the Department of Criminal Investigation (DCI) in a joint assessment/investigation. While law enforcement's role is to determine if a crime occurred and the HHS' role is to determine if abuse occurred, both agencies collaborate on the crime scene investigation/assessment, observations, interviews, etc.
- The CPW also works with the medical examiner's office while the medical examiner conducts an autopsy on the child victim. The CPW and medical examiner's office consult (many times through or in conjunction with law enforcement) to exchange information learned in the investigation/assessment that may assist the medical examiner in

determining cause and manner of death. The ultimate findings of the autopsy can assist in the determinations made in both criminal and child abuse findings.

- Although not every county throughout Iowa has their own Child Death Review Team per se, many counties utilize a variation of multi-disciplinary teams to consult with on child death cases. These consultations assist the CPW in exploring options to barriers and processing the case thoroughly.
- In every child death case that HHS assesses for child abuse, the Bureau of Health Statistics records all child deaths and at times births with a death occurring shortly after birth. Because law enforcement generally takes the lead on death investigations, they generally provide the documentation to Vital Statistics.
- Throughout the course of the assessment, the CPW decides whether abuse occurred and makes the appropriate recommendations and/or referrals to address the family's needs.

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.

Looking back on the past five years of reviews, the 2016 and 2017 annual reports were initially put on hold and remained in draft form as the result of a request from the Iowa Office of Ombudsman to take a deeper dive into the separate cases of child deaths involving two teenagers who had both died as a result of malnutrition inflicted by their adoptive parents. These case reviews took some time to plan and coordinate, involved focus on one case per meeting, and included presentations by law enforcement, HHS, and Iowa Office of Ombudsman to present the case details and answer questions. Review of one case took place on December 19, 2019, and the second case review was on February 27, 2020. The plan was to follow up with further discussion and case recommendations to be included in the 2016 and 2017 annual reports at the next 2020 meeting, however the global pandemic of COVID-19 ceased all scheduled meetings between March 2020 and August 2021. In the meantime, the Iowa Office of Ombudsman released both investigative reports, which resulted in recommendations to improve polices and practice to aid in the prevention of future child maltreatment deaths:

- A Tragedy of Errors: An Investigation of the Death of Natalie Finn
- Misplaced Trust: An Investigation of the Death of Sabrina Ray

Child Death Review Team meetings resumed in September 2021, finishing up 2018 case reviews on September 8, 2021, and March 9, 2022. The follow up discussion and recommendations to complete the 2016 and 2017 Annual Reports took place in 2022-2023 and completion of the Cumulative Annual Report for 2016-2018 followed.

Work to review the child deaths which in occurred in 2019 was completed through 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.

To follow up from the Statewide Safe Sleep campaign that was highlighted in the 2015-2019 CFSP and annual report, HHS focused on an internal Safe Sleep Initiative by creating a Safe Sleep Workgroup comprised of HHS staff from both central office and field as well as contracted partners.

The HHS Safe Sleep Workgroup was convened in June of 2022 with 25 members, including:

- 6 Program Managers who oversee policy for intake and assessment, case management, family centered services, foster care, childcare, and tribal relations;
- 1 Service Help Desk representative
- 5 field staff, representing Social Work Case Managers, Child Protection Workers, and Social Work Supervisors
- 6 contracted staff representing Family Centered Services
- 2 contracted staff representing Foster Care
- 1 Early Childhood Iowa representative

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 implementing 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.

In review of child maltreatment deaths for Iowa, fourteen child fatalities were the result of abuse or abuse as a contributing factor in FFY 2023. This number is slightly lower than the previous year, but higher than the two years prior to that.

Table 4u: Child Maltreatment Deaths – FFY 2019-2023

Federal Fiscal Year (FFY)	Number of Deaths
2023	14
2022	19
2021	12
2020	9
2019	25

Data Source: SACWIS

A state review of the FFY 2023 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 childcare 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 childcare 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 childcare 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 4v: 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

Child Advocacy Centers

CAC/CPC Services

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/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.

The Allen satellite CAC/CPC referenced above was established in 2017 following a comprehensive needs assessment that was conducted by the Iowa Chapter of Children's Advocacy Centers (ICCAC). The needs assessment looked at the gaps within the State as it relates to services provided by CAC/CPCs. The needs assessment considered factors such as location, population density, and child abuse rates. The assessment indicated how critical CAC/CPC services are to child abuse cases and that several counties in Iowa fell outside of the recommended maximum one-hour drive time to a CAC/CPC. To address this need, the Allen Child Protection Center received additional grant funding and private donations to open a satellite location in Mason City, Iowa (Cerro Gordo County).

Child Protection Center Grant Program

The Child Protection Center Grant Program was established in 2001 within what was then the Iowa Department of Public Health (IDPH). The program provides grants to eligible applicants for the purpose of establishing new Child Protection Centers and to support existing ones (Iowa Code Section 135.118). Under the program, grants are available to eligible organizations that meet or are in the process of implementing Child Protection Center standards as established by the National Children's Alliance. These standards relate to the provision of services to child abuse victims and their families who are referred to the CAC/CPCs by HHS or law enforcement agencies. Funding under the Child Protection Center Grant Program is limited to CAC/CPCs in Iowa. Project Harmony that is located in Nebraska receives funding under a separate state appropriation.

In 2022 Blank Children's Hospital, on the behalf of the CAC/CPCs in Iowa, made a request to the Governor's Office for additional funding for the Child Protection Center Grant Program to help address rising costs associated with operating the centers and implementing quality

services. The proposal included potential areas where additional funding could support operations and expand services within the Centers.

The proposed areas of support and expansion included the following:

- Expansion of the CAC/CPC's forensic interview and medical evaluation services to better assist HHS and law enforcement with the assessment of child neglect (Denial of Critical Care) and Drug Endangered Children (DEC) cases.
    - Funding would be used to hire additional staff, expand/renovate facility space and purchase equipment to meet the increased volumes and acuity of needs.
- Statewide planning and implementation of the revised National Children's Alliance Standards of Accreditation for Child Advocacy Centers/Child Protection Centers required in 2023 to provide quality assessment and treatment services to children:
    - Expand mental health services offered through the CAC/CPCs for children who have experienced abuse and for non-offending parents/caregivers and monitor trauma-symptom reduction within these populations to ensure positive health outcomes for children and families.
    - Provide Multidisciplinary Team (MDT) coordination and case review facilitation for cases of child neglect (Denial of Critical Care) and Drug Endangered Children (DEC) to improve collaboration in complex child welfare cases in order to improve positive health outcomes for children and families.
    - Examine and implement strategies to improve rural access to assessment and treatment services offered through CAC/CPCs (i.e., satellite center expansion) to ensure every alleged victim of child abuse in Iowa has access to high quality care.
- Expansion of Foster Care Clinic services to more children to provide specialized primary care services for children who have experienced child abuse or neglect.
- Provide body safety education (child sexual abuse prevention) to children and adults in rural communities who currently lack access to free awareness and training programs.

To implement these initiatives, additional funding in the amount of $300,000 was requested for the Child Protection Grant Program. The request was to retain the $245,000 base formula with the addition of $300,000 which would have been distributed to each CAC/CPC funded under the program using the current formula which is based upon the volume of children that have been served during the previous year. By distributing the additional funding based on this formula, it was believed that CAC/CPCs would be encouraged to continue their outreach efforts to HHS and local law enforcement who may not currently be accessing CAC/CPCs services for their assessments of allegations of child abuse or neglect. Unfortunately, the proposed funding bill for the Child Protection Center Grant Program did not pass.

<u>CAC/CPC Contracts & MOUs</u>

The six Iowa CAC/CPCs operate under a nonmonetary agreement with HHS. The agreement is in the form of a collaborative Memorandum of Understanding (MOU) between HHS and each of the CAC/CPCs. The MOU establishes the guidelines and identifies the services that the CAC/CPCs will provide to HHS clients.

The current MOUs between HHS and each of the CACs/CPAs began in May 2020. The MOUs included a number of revisions and additions with regard to the previous agreement that had been in place. The revisions and additions at that time included:

- The addition of services to include federally recognized Indian Tribes.

- The need to include a representative or a Protective Service Worker from a federally recognized Indian Tribe in consultations and in staffings.
- Clarity on what is considered to be part of the HHS case related to the child abuse information and other material that is provided to the CAC/CPSs including a description of what information can be shared, how it may be shared, and with whom was included in the MOUs.
- Expanded information and directions on Confidentiality.
- An explanation on the use of a Child Protection Assistant Team.
- A section regarding parental consent for an interview at a Child Protection Center.
- An update to the Business Associate Agreement (BAA) and the Qualified Service Organization sections of the MOU.
- Expanded data requirements regarding security certification, security risk assessment, compliance with Cloud services, and the need to complete an HHS Vendor Security Questionnaire.

Each year, the MOUs are formally renewed for the coming year with either a Renewal Letter or an amendment being sent out to each of the Centers. In 2021 an amendment to the MOUs was issued that included new language pertaining to the dissemination of child abuse information. The amendment also addressed the use of a recording of a forensic interview and allowed for the observation of a live interview of a child abuse victim for training and/or peer review purposes. It is now required that before a CPC/CAC may use a recording of a forensic interview or allow for the observation of a live interview for training and/or peer review purposes, a consent form must be signed by the parent or legal guardian of the child. Prior to signing the consent form, the parent or legal guardian must be informed as to how the recording or interview will be used for training or peer review and how their confidential information will be protected from re-dissemination. The amendment made clear that HHS staff may not sign the consent form for the parent or guardian.

In 2023, another amendment to the MOUs was issued which included the following:

- A name change from the Department of Human Services to the Department of Health and Human Services.
- Updates regarding the website address for the online MOU contract terms and conditions and for the BAA.
- A notice of the relocation of the Department of Health and Human Service's main office.
- An extension of the MOU from July 1, 2023, to June 30, 2024.

As there were no revisions or additions to the MOU for SFY 2024, a Renewal Letter was sent out to each of the Child Protection Centers that the MOUs were being extended to June 30, 2025.

In regard to Project Harmony, a formal contract is currently in place between Project Harmony and HHS. As Project Harmony is an out of state provider, funding for this CAC/CPC is approved each year as part of the State's appropriations bill. The scope of work within the Project Harmony contract reflects that of the CAC/CPC MOUs and includes the amendment revisions and additions listed above. The Project Harmony contract has been extended to June 30, 2025.

<u>New Platform for Sending CPC Reports and Recordings</u>

In April 2023, three of Iowa's CAC/CPCs (St Luke's, Allen, and Blank Children's STAR Center) which are all under UnityPoint Health, rolled out a new email-based platform to share forensic

interview reports and recordings as well as medical reports and images with the HHS Service Areas. The new platform is called MOVEit. The advantages of the new email system include the following:

- MOVEit allows for the emailing of larger data files. By contrast, the previous email system had limits that did not allow, in a user-friendly way, for larger files to be sent such as forensic interview recordings or medical images.
- MOVEit provides the most secure way to send sensitive child abuse information. MOVEit is more secure than relying on fax or "snail" mail, which takes more time and is less secure. With MOVEit the CAC/CPCs can track who is receiving the information. MOVEit provides information on when items are sent, received, and opened verses sending information via fax or mail in which the Centers could not be assured who would open/or view the confidential information.
- Previously, DVDs were used. The DVD technology is now outdated. Most computers do not come with a DVD player and copying the DVD has been a challenge when MDT partners want to provide copies to other agencies and judicial entities.
- The MOVEit platform eliminates the cost for postage and reduces waste by eliminating the need for DVDs and paper.

To facilitate the move to this new platform, HHS worked with the IT Division to ensure that any technical issues were addressed and resolved. Prior to the implementation of the new system a Guidance Document was produced for HHS staff with instructions on the use of the new platform. In addition, a presentation of the platform was provided by HHS policy staff on the statewide CIDS call (May 4, 2023) for all supervisors.

<u>CAC/CPC SFY 2024 Activities</u>

- Dissemination of HHS Child Abuse Information: HHS worked with the CAC/CPCs to clarify the process that should be followed when the Centers are asked to release HHS child abuse information that they are responsible for storing. In consultation with the AG's office, it was advised that the Department should be the one releasing or at least authorizing the release of HHS information. An agreement was established that if the Centers are asked for HHS information, they should contact the HHS Service Help Desk that will process these types of requests. This procedure will ensure consistency across the state with regard to the sharing of confidential HHS information.
- MDT Practice Guide: Work is being done by the Iowa Chapter of Children's Advocacy Centers Board of Directors on a proposed best practice guide/resource to be used by MDT members in the investigation and assessment of child and dependent adult abuse. This best practice guide is meant to assist with the joint investigation process between HHS and law enforcement in collaboration with the CAC/CPCs. The majority of the information for the practice guide/resource is being taken off the HHS website and from a best practice guide produced previously from South Carolina. The practice guide is currently being reviewed by HHS.

<u>Interagency/MDT Agreement</u>

The CAC/CPCs put into place a County Interagency Agreement for the use of Multidisciplinary Teams (MDTs). The HHS MDT Agreement is still in use and the Centers may be included on this Agreement, but during the recertification process for the Centers they were made aware that HHS MDT document was not specific enough to the requirements and work of the CAC/CPCs. The County Interagency Agreements will be used by the Centers as they go through the accreditation process.

CAC/CPC Annual Report

Each year, the Iowa Chapter of Children's Advocacy Centers prepares an Annual Report. The 2023 Annual Report includes data and information on the services that Iowa's six CAC/CPCs and Project Harmony provide. In addition to background information, the report includes the total number of children served, the type of cases handled, the funding source of the Iowa Centers, and the number of trainings they provided throughout the past year. A copy of 2023 Annual Report can be found at: www.iowacacs.org

HHS Drug Testing Services

HHS drug testing services are a means to better protect children. Drug testing results help HHS staff to identify and/or eliminate substance abuse as a possible contributing factor or risk in a child abuse case by either confirming or contradicting what HHS staff has learned through direct observation. While drug testing may indicate substance abuse, a positive result should be viewed as one component of the accumulated information to be considered when determining issues of safety and danger for a child.

HHS drug testing protocols and policies promote a strengths-based approach to drug testing. HHS policy endorses the use of strength-based language and strategies to assist the parent/caretaker in moving to a more functional level of behavior through abstinence. The role of the child welfare worker is to support the client's recovery and to reduce barriers to substance abuse treatment services. HHS child welfare workers are also encouraged to consult with any treatment providers who may be involved in the case. Input from substance abuse and mental health providers as well as medical personnel can provide additional insight into the parent/caretaker's substance use disorder and their treatment needs. Such information may help to improve child safety.

HHS drug testing collection and laboratory services are available to children, parents/caretakers, and families involved in a child abuse assessment or during an ongoing child welfare service case. Drug testing is not used during a family assessment; however, if during the course of a family assessment a child protection worker (CPW) determines there are behavioral indicators of potential substance use/abuse and the child's safety is in question, HHS staff may reassign the case as a child abuse assessment at which point, drug testing services are available.

Statewide Drug Testing Contracts

HHS currently contracts for drug testing through two statewide contracts, one for collections services and one for laboratory services. The use of statewide contracts for drug testing began in 2013. Prior to this time, the HHS Service Areas contracted individually for services within their local areas. The move to statewide contracts was done for cost containment reasons and a need for statewide consistency in collection services and laboratory analysis.

The benefits gained from a statewide drug testing system for collection and laboratory services include the following:

- Certification Requirements. Certification requirements include the College of American Pathologists, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Clinical Laboratory Improvement Amendments Program.
- Standardized cutoff levels. All drug testing analysis under these contracts require the industry standard cut off levels established through SAMHSA to ensure that testing of all HHS clients is conducted in the same manner.

- Uniformity in confirming tests. All laboratory testing incorporates immunoassay technology, with positive results verified by Gas Chromatography/Mass Spectrometry (GC/MS), Liquid Chromatography/Mass Spectrometry (LC/MS) or Liquid Chromatography – Mass Spectrometry/Mass Spectrometry (LC-MS/MS).
- Statewide HHS Drug Testing Protocol. The Laboratory and Collections contracts reflect and support the HHS Drug Testing Protocol that aligns with SAMHSA requirements.

Based on the benefits above, the decision was made to continue the use of statewide contracts and on July 1, 2019, two new contracts for Drug Testing Collections and Laboratory Services became effective. Revisions and improvements were added to the contracts based on the knowledge and experience gained with the application of the statewide drug testing system. These included: additional testing sites across the state with an increase and flexibility in the hours of operation at the sites, increased randomization in the drug testing process, system upgrades, adjustments to the drug testing panels based upon a conducted review, and improvements in the tracking and collection of data. These contracts will expire in 2025.

The current contractor for the HHS Drug Testing Collections Services Contract is Central Iowa Juvenile Detention Center (CIJDC). The contractor for the Drug Testing Laboratory Services Contract is Global HR Research, LLC.

Behavioral Indicator Approach to Drug Testing

With an increase in drug testing each year, HHS recognized a need for a more targeted research-based approach to drug testing and the need for additional guidance for workers as to the appropriate type of drug test to authorize and the frequency and duration of testing that should be followed. In researching different approaches to drug testing, it was found that the observation of behavioral indicators is an effective approach to drug testing as it is based on findings that certain types of drugs have specific observable physiological effects and that those effects may be either behavioral, relational, psychological, and/or physical in nature. Under this approach, the observation of behavioral indicators offers a gateway for determining if drug testing is needed.

Based on the findings above a decision was made to redesign the HHS Drug Testing Authorization system to limit testing to cases in which there are behavioral indicators that support the need for a drug test.

Work on redesigning the HHS Drug Authorization System began in 2020 and was completed in 2021. Under the new authorization system, HHS child welfare workers are required to confirm that behavioral indicators have been observed and/or reported prior to authorizing any drug testing. Workers must also confirm that they have documented the behavioral indicators in either the Child Abuse Assessment, Case Plan, and/or in the Case Narrative Section. If no behavioral indicators have been observed and/or reported or have not been documented, the system will not allow a worker to authorize a drug test. Supervisors are not able to override the system and approve testing in these cases. Exceptions to testing without behavioral indicators being observed and/or reported are limited to court ordered testing.

In an effort to better support worker's decisions around drug testing, the redesign of the HHS Drug Testing Authorization System also includes enhancements to guide the workers through the process of determining what type of drug test (urine, hair, patch, etc.) is most appropriate to use and at what frequency and duration the testing should be done based on best practice. Additional features include drop down boxes that provide the following information:

- A description of the three HHS drug testing funding sources (child protection, child welfare, and court ordered testing) to ensure that the worker is checking the correct funding stream based on the type of case.
- Detection times for different types of drugs.
- Information and cautionary notes regarding each type of test.

Following the implementation of the authorization system, a further enhancement was done to allow workers to create new authorizations when needing to make corrective entries or when circumstances change after an initial authorization is submitted.

In June 2021, the HHS Drug Testing Protocols were updated to include the new policy of drug testing based on behavioral indicators. In addition, the Drug Testing Protocols which had always been a standalone document was incorporated into the official HHS Field Manual. Statewide training on the new system was provided in July of 2021 with the implementation of the system in August of that year.

COVID-19 Drug Testing Guidelines

At the start of the pandemic, the majority of the drug testing Fixed-Sites across the State were closed with only a small number of sites remaining open. While the majority of the collection sites closed, in-home testing remained an option but were limited to Child Abuse Assessments and for families involved in the Family Drug Treatment Courts. Testing for ongoing child welfare cases was suspended. As more safety procedures and precautions were implemented, Fixed-Sites reopened, and drug testing services were made available for all child welfare cases. By September 1, 2020, all Fixed-Sites across the State had reopened.

The COVID -19 guidelines and procedures that were made available and/or put into place at all of the drug testing Fixed-Sites included:

- Hand sanitizers in the appropriate areas.
- Prescreening questions for clients.
- The six-foot rule was followed when conducting the prescreening.
- The number of persons allowed in the lobby or waiting area was limited with clients being asked to wait in their car until called.

HHS Drug Testing Training

Substance Abuse training is available to all HHS staff to increase their knowledge of substance abuse and the potential risk it poses to child safety. Following are the current HHS drug testing courses being offered for field staff. The first three trainings listed below were specific to the redesign of the HHS Drug Testing Authorization System. These webinar trainings are currently available to view on LearnSoft and can be accessed by searching their course number and/or title.

- CC 391 Drug Testing Module for CPWs: This course provides the reason behind the redesign and changes to the HHS Authorization System and provides step-by-step system guidance on how to enter drug test authorizations. This is a required course for CPWs and Supervisors.
- CC 392 Drug Testing Module for SWCMs: This course provides the reason behind the redesign and changes to the HHS Authorization System and provides step-by-step system guidance on how to enter drug test authorizations. This is a required course for SWCMs and Supervisors.
- CC 601 Lunch & Learn: Behavioral Indicators of Substance Abuse & Drug Testing: A follow-up Lunch and Learn was offered after the initial webinars listed above. This was

not a required course but was heavily attended by the field. It is now a recording which is available on the training website for anyone to access. The objective of the training is to provide workers with information on how to identify if there are potential substance abuse concerns and when drug testing is appropriate. Handouts offered with this course include material on substance abuse, indicators of potential use, and how to approach drug testing.

There are two courses on substance use for new workers, which are listed below. In the fundamentals course, there is a 30-minute breakout session on HHS Drug Testing Policies & Protocols and throughout the training the importance of assessing for behavioral indicators and using engagement techniques to learn more about a person and their substance use is stressed. During the intermediate course, the discussion focuses on drug testing and notes how it does not indicate if someone has a substance use disorder, just if there is a substance present in their system. Substance Use Fundamentals and Substance Use Intermediate are in-person courses.

- SP 310 Substance Use Fundamentals: This is a one-day, face-to-face training that is required for Social Work Case Managers, Child Protective Workers, and Supervisors within the first six months of employment. This course provides learners with an interactive learning platform in which workers learn the fundamentals of substance abuse and how to connect behavioral indicators to the safety of children. In addition, workers understand how to reference the state's Drug Testing Policy, the connection between behaviors and substances use and how to make a referral based on the indicators.
- SP 410 Substance Use Intermediate: This training assists workers in supporting families struggling with substance use disorders through the treatment and recovery process to help keep families together. This training is required for all staff. SP 310 Substance Use Fundamentals is a pre-requisite for this training.

In addition to the trainings above, drug testing and substance use are included in a number of other HHS courses. Field staff also have access to the following resources and materials:

- Drug testing information can be found on the HHS Drug Testing SharePoint: A variety of different resources are available at this site including documents and reports on laboratory analysis of drug testing, Iowa court rulings in drug testing cases, expert opinions on toxicology reports, and a Q & A document regarding the different types of drug tests that are available under the HHS contracts.
- HHS child welfare workers can also access the website for the National Center on Substance Abuse and Child Welfare. This website offers technical assistance and a large number of resources including publications, webinars, and tools that child welfare workers can use to better serve children and families that are involved in the child welfare system due to substance abuse issues.

HHS Drug Testing SFY 2024 Activities

- HHS Merger: The location and hours of operation of the drug testing Fixed-Sites did not change with the reconfiguration of the HHS Service Areas.
- Exceptions to Policy: An exception to policy procedure was imbedded into the Drug Testing Authorization System. When completing drug testing authorizations, workers are now able to request an exception to policy if needed. Some examples of an Exceptions to Policy would include requesting more than one test per client during a child abuse assessment, or over a 30-day time period for a child welfare case with no court ordered drug testing. The worker must indicate the reason for the exception and provide the

justification for it. Once completed, the request is sent automatically to a Drug Testing mailbox which has been set up. The mailbox is overseen by the HHS Drug Testing Program Manager who reviews the Exceptions to Policy and either approves or denies the request.

- Service Area Drug Testing Coordinators: The HHS Policy Program Manager and the Drug Testing Contract Specialist continue to provide guidance and support to the Service Area Drug Testing Coordinators. Each HHS Service Area has designated a Service Area Drug Testing Coordinator to perform duties related to the Drug Testing Laboratory and Collections contracts. These persons are responsible for the day-to-day implementation of drug testing services within their respective Service Area and for providing ongoing consultation and technical assistance to staff. Additional tasks include arranging for and approving the purchase of supplies from the laboratory contractor, reviewing and submitting invoices to payments and receipts for final processing, calculating the collection error data, and working with the contractors to resolve any Service Area issues that may arise in the provision of services.
- Drug Testing Collections Contractor: The HHS Drug Testing Program Manager and Contract Specialist meet annually with the collection contractor. In addition to an annual meeting, quarterly meetings are held. Teleconferences were also conducted on an as needed basis. Recent topics and discussion items have included the need for clients to have some form of ID when drug testing and the procedure that is followed when they do not, the current chain of custody practices, and testing procedures that are followed if a client is taking legitimate prescriptions that may result in a positive test.
- Drug Testing Laboratory Services Contractor: As the Laboratory Services Contractor resides in the State of New Jersey, there were no face-to-face contractor meetings with HHS. Instead, quarterly teleconferences occurred, with additional email communications and teleconferences arranged if there were any immediate concerns.
- Fixed Site Locations: Fixed-Site Schedules continue to be sent out monthly to the Service Areas. The schedule is prepared by the collections contractor and lists the dates/times of operation and the location of the Fixed Sites. Notices are sent out as needed when changes must be made to the schedule.

Drug Testing Data

With the redesign and implementation of the new HHS Drug Testing Authorization System, HHS is able to now capture additional drug testing data around court ordered funding. While the HHS response to the new data has been somewhat delayed due to the merger and the subsequent reconfiguration of the Service Areas, HHS has continued efforts at the administrative level to coordinate and share the volume of drug testing numbers with both the judicial branch and with the Service Areas. With regard to the court, this includes efforts to educate and encourage the use of substance abuse evaluations and treatment services verses additional testing.

The following data tables reflect the Drug Testing Collections under each of the three funding sources from April 2021 through March 2024. Patches count as two collections, one for application and one for removal of the patch. There is no patch or instant test coverage under the Child Abuse Registry funding stream which is specific to child protective assessments. The data tables also include the percentage of court ordered drug testing to the total number of tests.

Table 4w: Statewide Drug Testing Collections (April 2020 - March 2021)					
Service Area	**Child Abuse Funding**	**Child Welfare Funding**	**Court Ordered Funding**	**Total**	**Percentage of Court Ordered to Testing Total**
Western	956	3,774	440	5170	8.51%
Northern	643	2,538	295	3476	8.49%
Eastern	518	2,044	238	2800	8.50%
Cedar Rapids	1093	4,311	502	5906	8.50%
Des Moines	516	2,035	236	2787	8.47%
TOTAL	3726	14702	1711	20139	8.50%
Source: Iowa Department of Health and Human Services					

Table 4x: Statewide Drug Testing Collections (April 2021 - March 2022)					
Service Area	**Child Abuse Funding**	**Child Welfare Funding**	**Court Ordered Funding**		**Percentage of Court Ordered to Testing Total**
Western	875	3,223	682	4,780	14.27%
Northern	592	2,158	324	3,074	10.54%
Eastern	530	1,840	315	2,685	11.73%
Cedar Rapids	1,006	3,665	727	5,398	13.47%
Des Moines	475	1,730	339	2,544	13.33%
TOTAL	3,478	12,616	2,387	18,481	12.92%
Source: Iowa Department of Health and Human Services					

Table 4y: Statewide Drug Testing Collections (April 2022 - March 2023)					
Service Area	**Child Abuse Funding**	**Child Welfare Funding**	**Court Ordered Funding**	**Total**	**Percentage of Court Ordered to Testing Total**
Western	782	1,039	958	2,779	34.47%
Northern	545	729	851	2,125	40.05%
Eastern	470	1,006	434	1,910	22.72%
Cedar Rapids	891	2,273	5,053	8,217	61.49%
Des Moines	445	1,890	1,303	3,638	35.82%
TOTAL	3,133	6,937	8,599	18,669	46.06%
Source: Iowa Department of Health and Human Services					

Table 4z: Statewide Drug Testing Collections (April 2023 - March 2024)					
Service Area	**Child Abuse Funding**	**Child Welfare Funding**	**Court Ordered Funding**	**Total**	**Percentage of Court Ordered to Testing Total**
Western	800	1,153	1,242	3,195	38.87%
Northern	311	708	1,013	2,032	49.85%
Eastern	705	1,633	550	2,888	19.04%
Cedar Rapids	694	762	6,391	7,847	81.45%
Des Moines	697	1,414	1,173	3,284	35.72%
TOTAL	3,216	5,693	10,387	19,246	53.97%
Source: Iowa Department of Health and Human Services					

Data Analysis

Upon review, the Statewide Drug Testing Collections data tables indicate an initial decrease in drug testing from March 2021 to March 2022 with a small steady increase in testing from March 2022 to March 2024. The decrease coincides with the implementation of the redesigned Drug Testing Authorization System in August 2021. The redesign which included tighter parameters and guidelines supports the current HHS drug testing policy that testing should be based on the observation of behavioral indicators.

In looking at the percentage of Court Ordered Testing to the testing total, the tables indicate that the number of court-ordered drug tests have increased significantly from 2021 – 2024. In the last year, court ordered testing represented 46.06% of all testing statewide. That number increased to 53.97% in 2024. The Cedar Rapids Service Area court ordered testing alone represented 81.45% of all drug testing from April 2023 – March 2024. This is up 19.96% from 2023 for this area. By comparison, testing under child welfare funding during the same period has continued to decrease. Non-court ordered testing dropped form 12,616 in 2022 to 5,693 in 2024.

When reviewing the data it should be noted that Service Area boundaries were adjusted in July 2023, impacting composition of all Service Areas apart from Cedar Rapids, which experienced no change to boundaries. This adjustment impacts Service Area data comparison between current (April 2023-March 2024) and previous reporting periods.

Overall, while Statewide Drug Testing Collections data shows a decrease in the total number of tests collected since the period ending in March of 2021, total collections are on the rise. This can be attributed, in part, to a significant increase in Court Ordered Funding collections for each reporting period, which now accounts for over half of all testing statewide. When Court Ordered Funding is examined further, increases within the Cedar Rapids Service Area consistently outpace other areas. At 81.45% of tests collected within the Cedar Rapids Service Area, the 6,391 Court Ordered Funding collections are more than 5 times greater than the total number of Court Ordered collections in other Service Areas.

Various factors may have contributed to the increase in court ordered testing. The number of child abuse cases that are referred to court may have increased during this time period. Currently, the majority of HHS child abuse cases involve some type of substance abuse which can significantly impact the number of drug tests conducted each year. Other factors may be the number of tests that were authorized in preparation for court. These would include tests conducted prior to, or in anticipation of, a court hearing. The pandemic could also have been a factor which may have inadvertently held drug testing numbers high. Drug use increased during the pandemic as persons dealt with the stress of social limitations, job loss, and the isolation at home. The increase in court ordered drug tests may also reflect the increasing number and availability of drugs both legal and illegal. Any one of these factors or together may have contributed to the higher numbers of court ordered drug tests.

In summary, when evaluating drug testing data, it is important to be aware that additional factors may impact or contribute to either a decrease and/or increase in the number of tests that are conducted over a specific time period. Individual cases or situations involving multiple tests per client can impact the number of drug tests. Following are some examples of this.

- A client may be asked to complete both a patch and urine test as the client previously had attempted to dilute the urine test by drinking excessive amounts of water which can potentially compromise the reliability of a urine test. In this case, the client may be asked to also complete a patch test. Drinking excessive amounts of water will not compromise the results from a patch test.
- In cases where it is evident that a patch has been tampered with, another type of test, such as a hair test, may be used.
- Court orders that prescribe the type(s) of drug test(s), as well as the frequency and duration of the testing. The Court may order several different types of tests for the same client and/or order testing at a higher frequency or for a longer duration than what occurred previously.
- There can be an increase in testing at critical junctures in the Life of the Case such as when the court is thinking of returning the child home.
- Multiple drug tests may also be required due to the detection window for different types of drugs as well as the timing and type of the drug test used. With urine tests, most drugs are excreted into the urine within 48 hours after use. Hair tests can detect drug use over several months but will not detect a drug used within the last 3 days and while a hair test can detect drug use over several months, it cannot tell if the drug use occurred in the first month, second and/or third month.

TREATMENT 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 (HHS) Family Centered Services providers, Parent Partners, and Domestic Violence (DV) 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 DV 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 & Together™ model is a perpetrator pattern-based, child-centered, and survivor strengths approach to working with domestic violence in 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.

Table 4aa: CAP Team Consults by Service Area 2020-2024					
Service Areas	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023 (July-April)**	**SFY 2024 July 2023-March 2024**
Des Moines	28	29	25	20	16
Eastern	14	9	2	10	8
Western	14	5	0	2	5
Northern	15	3	0	3	4
Cedar Rapids	19	12	13	14	5
Totals	90	58	40	49	38

Challenges to consistent facilitation of CAP teams in some areas is attributable to workforce challenges which created some barriers with consistency and ability to facilitate CAP Team consults.

CAP Seminars

Connect and Protect Seminars are one day training sessions for members of the service area CAP Teams to attend that are focused on implementing the Safe & Together™ Model and strengthening the knowledge and skills of the CAP teams. CAP team seminars are held bi-annually and have included topics such as:

- Caring Dads program overview
- Safe at Home Program and Iowa Secretary of State Paul Pate
- Young Adult with lived experience with domestic violence growing up
- Refresher training of the Safe & Together Model™ by Safe and Together Institute trainer, Leah Vejzovic, including principles, tools, coaching approach to consultation, and domestic violence proficient engagement and intervention skills
- Iowa Domestic Abuse Program (IDAP)
- Structural and Cultural Factors Impacting the Latinx Community
- Impact of Brain Injury and Domestic Violence in Child Welfare
- Iowa Coalition Against Domestic Violence
- Supporting Black Women impacted by Domestic Violence and the Child Welfare System
- Small group activities for CAP teams to reflect on team strengths, areas of growth and opportunities to improve, utilization of the mapping tool and application of learning from the seminars.

During the 5-year reporting period, HHS allocated Community Partnership for Protecting Children (CPPC) funds to provide access to online learning on the HHS LMS through the Safe & Together™ Institute. The virtual offerings included the following courses:

- When Domestic Violence Perpetration, Substance Abuse, and Mental Health Meet
- Working with Men as Parents: Fathers' Parenting Choices Matter

Each course included a downloadable discussion guide for staff to use individually or for supervisors to use with teams to help them apply the concepts learned in practice with families. The intended audience for the courses were for CAP team members, HHS supervisors and child protection and case manager staff as Intermediate Level Domestic Violence Courses.

In SFY 2023, the courses were not offered due to unforeseen barriers in the contracting process. However, the courses were offered again to HHS CPWs, SWCMs and CAP team members in SFY 2024.

CAP Teams received additional information and training opportunities available on the HHS LMS for new members, as well as available offerings through Safe & Together™ Institute, including upcoming webinars and practice strategies available on their website.

Additional Activities of the CAP Teams

In August 2021, the HHS Program Manager and HHS Service Team Trainer/subject matter expert (SME) in leading CAP teams facilitated a discussion with the CAP Team leads on viable options for collecting data and outcomes on child welfare cases who are presented for consult to the CAP teams regarding domestic violence. A former CAP team lead, now working on development of the new comprehensive child welfare information system (CCWIS) which will replace HHS' child welfare information system (CWIS), was included in the discussion. The group also discussed the possibility of utilizing the new CCWIS system to make referrals for CAP team consultations. At the center of the discussion were concerns regarding confidentiality of cases and to be cognizant of anything maintained in the case file and in the JARVIS provider portal and what would be accessible if requested.

In October 2021, CCWIS and Bureau of Service Support and Training staff held a follow-up meeting to further explore these considerations. It was clarified that domestic violence information is not protected information and laws regarding Crime Victim Assistance do not transfer to child welfare laws in Iowa. As a result, it is recommended that a referral for a CAP consultation could occur from CCWIS to JARVIS, however additional information related to the case or consultation is not recommended to be included beyond that. HHS will continue to explore workarounds for tracking data collection and outcomes resulting from CAP team consultations in ways that protect the confidentiality and sensitive information of families involved in these cases.

In Fall 2022, the HHS Program Manager and HHS Service Trainer supporting the CAP teams began meeting with the HHS staff members working in Violence Prevention. The purpose of this collaboration is to explore opportunities for child welfare and prevention focused efforts to identify intersections in initiatives related to domestic and intimate partner violence to bolster efforts in each focus area of the work. From this collaboration, the opportunity to connect CAP team training with subject matter experts on Brain Injury was identified. The team will continue to meet on a regular basis to identify additional intersection for resources and support and streamline approaches to training and learning around violence prevention and intervention.

In January 2023, the HHS Program Manager and HHS Service Trainer co-presented to HHS CPS and Case Manager Supervisors and SWAs on the purpose of the CAP teams and how to make a referral to the CAP teams. The presentation provided a refresher regarding the availability of the CAP teams to provide consultation and resources to child welfare staff around domestic violence involved child welfare cases. This focused presentation was also provided to SWCM and CPS staff at a staff lunch and learn in February 2023.

Collaboration occurred in SFY 2023 with the Violence Prevention Coordinators in the HHS Division of Health Promotion and Chronic Disease to determine potential touch points for the CAP teams and violence prevention resources in the agency and in the community. Through this effort, the CAP Team seminar held in June 2023 focused on brain injury and the potential

impact of trauma from domestic/intimate partner violence to the brain regarding parents involved in a child welfare case. Subject matter experts on brain injury and trauma provided a basic overview of brain injury impact, signs that brain injury may be impacting an individual's cognitive and behavioral actions, and resources available for screening and support. Rachel Ramirez, Director of Health and Disability Programs and the Founder of The Center on Partner-Inflicted Brain Injury at The Ohio Domestic Violence Network (ODVN) was the key speaker for the seminar and was joined by leadership staff from the Iowa Brain Injury Alliance and the Brain Injury Program Manager at HHS to discuss community resources and supports for individuals experiencing brain injury, and their families.

In March 2024, the CAP team seminar came together in person for a full day seminar. Courageous Fire lived experience and subject matter expert presented to the teams on perceptions shaped about Black women in history through historical events, media, and intersection with child welfare origins, which have led to bias and stereotypes regarding Black women surviving domestic violence. CAP teams learned ways to consider accessible protective factors for Black women and family units, and how to productively screen and respond to Black women who are survivors of domestic violence and intersect with the child welfare system. Also planned for April 2024 is a virtual learning opportunity for the CAP teams to attend to learn more on the Victims Assistance Program through the Iowa Attorney General's Office.

In a small group activity asking CAP teams to discuss strengths, challenges, consistent use of the mapping tool and strategies to increase referrals, the CAP teams reported out the following summarized statements to the large group:

- Feedback from staff and supervisors who participate in a CAP team consult is helpful
- Scheduling 1-2 CAP team consults consistently each month keeps referrals consistent and the team consistently meeting
- CAP team lead follow-up with HHS worker on consult, or team following up with an additional second consult is helpful
- Continue to market CAP teams to HHS supervisors and at staff/unit meetings to increase referrals
- Consider adding CAP team referrals to the child welfare referral services spreadsheet or into the new CCWIS system, VISION
- Need to identify additional members on some CAP teams due to staff changes or changes in county structure due to HHS service area realignment
- Teams work to stay on task during consult to manage time effectively, can be challenging to complete the full mapping tool in the time available
- Holding hybrid consults so that some team members can attend virtually if not able to attend in person, or holding all team consults virtually.

In Spring SFY 2024, the HHS Program Manager and HHS Service Trainer intend to form a workgroup with representatives from each of the CAP teams geared to explore additional strategies to track and evaluate the outcomes of cases who participate in CAP team consultation. One potential strategy is to request HHS case manager staff who present cases to the CAP teams to complete a survey following the case consultation(s), indicating the value of the consultation and to provide opportunity to give their feedback to the team and describe what actions they were able to take with the case and in supporting the family based on the guidance provided in the consultation. Another strategy is to request the case manager return to the CAP team in 30-60 days for a follow-up staffing to discuss what is working well from the initial consultation.

A workgroup began meeting in June and is in process of developing survey questions to utilize with SWCMs following their consultation(s) with the CAP team to track on next steps and actions on the case resulting from the CAP consult. The workgroup is also in collaboration with Compliance, Communications and DOM-IT on how the survey will be distributed and ensuring security of confidential/protected information that may be shared in the survey responses.

Welcome emails are sent to any new CAP Team Members to orient to the purpose of the teams, training information, and identify their teammates and team leader. New members are also provided with primary Safe & Together™ resources around principles and components, mapping tool, and pathways to harm information. A primary statewide list of CAP Team Members is maintained to ensure adequate information distribution and that training opportunities are made available to the teams across the state.

Family-Centered Services (FCS)

At the start of this 5-year reporting period, Iowa's in-home service array included Family Safety, Risk, and Permanency (FSRP) services for open HHS service cases and Community Care for families assessed at moderate to high risk for re-abuse after a not confirmed or confirmed Child Abuse Assessment or after a Family Assessment. Iowa was in the process of procuring new contracts under the Family Centered Services label. The new Family Centered Services contracts went into effect July 1, 2020. The Family Centered Services contracts remain active.

Community Care (ended 6/30/2020)
Community Care assisted families at high risk of future assessments with connecting to community resources. The goal of this service was to reduce the likelihood of re-abuse occurring through family empowerment, skill-building, and support. This program was administered through a single, statewide, performance-based contract. The table below reflects referrals for Community Care in the final year of the contract.

Table 4bb: Community Care – April 1, 2019 through March 31, 2020			
	Valid Community Care Referrals (Statewide)	**Child Abuse Assessments (Statewide)**	**Family Assessments (Statewide)**
	3061	1719	1342
		Moderate Risk - 1130	Moderate Risk - 871
		High Risk - 589	High Risk - 471
Source: HHS/JARVIS			

The contracted service agency, Children and Families of Iowa, reported that of the 3061 statewide referrals, 1915 families accepted services, which is a 63% acceptance rate.

There were four contract performance measures implemented to evaluate effectiveness of the services. The contractor was held to these measures based on the total number of referred cases, not the number of cases where families accepted the referral. Below are the four contract performance measures:

- **Performance Measure 1 (PM 1)** - The percent of families referred to the Community Care contractor who has a child adjudicated CINA and HHS ordered to provide

supervision or placement within six months of the date of referral to Community Care will be five percent (5%) or less.

- **Performance Measure 2 (PM 2)** - The percent of families referred to the Community Care contractor who has a confirmed or confirmed and placed (founded) report of child abuse or neglect within twelve months where the actual incident occurred fourteen (14) days after the date of referral to Community Care will be nine percent (9%) or less.
- **Performance Measure 3 (PM 3)** - The Community Care contractor will make in-person or telephone contact with all families referred to Community Care within fourteen (14) calendar days of the date of referral from HHS and at least seventy percent (70%) of all high-risk families will achieve successful completion of services when the Community Care service ends.
- **Performance Measure 4 (PM 4)** - The Community Care contractor will make in-person or telephone contact with all families referred to Community Care within fourteen (14) calendar days of the date of referral from HHS and at least sixty five percent (65%) of all moderate risk families will achieve successful completion of services when the Community Care service ends.

The table below reflects the contractor's performance across the Performance Measures during the final reporting period of Community Care.

Table 4cc: Community Care – April 2019 through March 2020			
Performance Measure	**Referral Count**	**Count**	**Percentage**
PM 1	3061	17	1.54%
PM 2	3061	252	8.23%
PM 3	993	497	50.05%
PM 4	2108	1117	52.99%

Source: HHS/JARVIS; The methods of data collection include reports that are generated out of FACS and JARVIS that identify the date of adjudication for PM 1 as well as the incident date of maltreatment for PM 2. As for PM 3 and PM 4, the Community Care Contractor reports on the date of contact made with the family as well as the determination of successful case closure.

Community Care achieved the Performance Measures of keeping children from adjudication and reducing the risk of re-abuse after the family participated in Community Care. While the other two Performance Measures were not met, it is worth noting that the data is based on the total number of referrals and not on the number of cases where the family accepted Community Care services. Given the percentages of moderate and high-risk families who successfully completed Community Care and knowing that only 63% of referred families accepted services, it appears that Community Care had a positive impact on reducing the likelihood of re-abuse occurring.

Family Safety, Risk, and Permanency (FSRP) Services (ended 6/30/2020)

Family Safety, Risk, and Permanency (FSRP) Services were available and provided on open HHS service cases following a Child Abuse Assessment, a Child in Need of Assistance (CINA) assessment, or adjudication as a child in need of assistance in juvenile court. This included eight contractors holding 16 contracts across the state. The contracts for FSRP were not renewed after 6/30/2020 due to the implementation of Family Centered Services contracts on 7/1/2020.

There were four Performance Measures under the FSRP contract:

- **Performance Measure 1 (PM1):** Child(ren) are safe from abuse during the episode of services and for twelve (12) consecutive months following the conclusion of their episode of services.
- **Performance Measure 2 (PM2):** Children are safely maintained in their own homes during episodes of services and for six (6) consecutive months following the conclusion of their episode of services.
- **Performance Measure 3 (PM3):** Child(ren) are reunified within twelve (12) months and remain at home without experiencing reentry into care within twelve (12) consecutive months of their reunification date.
- **Performance Measure 4 (PM4):** Child(ren) achieve permanency through guardianship placement within eighteen (18) months of removal or through adoption within twenty-four (24) months of removal.

The tables below reflect combined performance across the FSRP contracts during the final reporting period for the FSRP contract.

Table 4cc is specific to performance measures one and two for April 1, 2019 through March 31, 2020.

Table 4dd: Family Safety, Risk, and Permanency (FSRP) Services

Performance Measures (PM 1 and PM 2)

April 2019 – March 2020

Number of eligible cases for safety incentives	PM1: Safe from Abuse Incentive Earned		Number of eligible cases for stability incentives	PM2: Family Stability Incentive Earned	
5113	3872	75.72%	**4204**	3000	72.36%

Data Source: HHS – PM 1 incentives are earned twelve (12) months following the end of services. PM 2 incentives are earned six (6) months following the end of services. (Statewide) The methods of data collection include reports generated out of FACS and JARVIS that identify the incident date of maltreatment for PM 1 and the date of removal for PM 2.

Table 4dd is specific to performance measures three and four for April 1, 2019 through March 31, 2020.

Table 4ee: Family Safety, Risk, and Permanency (FSRP) Services

Performance Measures (PM 3 and PM 4)

April 2019 – March 2020

PM 3 – Safe Reunification without Re-entry	PM 4 – Guardian placement within 18 months of removal and Adoption within 24 months of removal
893	741

Data Source: DHS – PM 3 incentives are earned twelve (12) months following the twelve (12) reunification period. PM 4 incentives are earned within eighteen (18) months for guardianship placement and within twenty-four (24) months for finalized adoption following the removal date. (Statewide) The methods of data collection include reports generated out of FACS and JARVIS that identify the reunification date for PM 3 and guardian/adoption date for PM 4. **NOTE:** For PM 3 and PM 4, the numbers listed are for the cases in which incentive was earned, not all cases eligible for the measure.

Case numbers varied throughout the contract. During the April 2019-March 2020 period, case referrals decreased. This correlated with a decrease in the number of calls coming into centralized intake during the early stages of the COVID-19 pandemic. The tables above indicate a strong working relationship between the FSRP contractors (many of whom won contracts to continue under Family Centered Services) and HHS. Just over 75% of children served during the final FSRP reporting period did not experience a new episode of abuse during their case or for 12 months after the case closed. Over 70% of children served during the final reporting period did not experience an out of home placement during their case or for 6 months following case closure.

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 over 18 sessions. Parents who are at-risk for neglect receive instruction on how to have positive parent-child and parent-infant interactions, keep their homes safe, and improve their child's health. For more information on SafeCare®, please visit the following website: www.safecare.org.

Under the FSRP contracts, contractors were able to elect whether to enter into contracts with Georgia State to provide SafeCare®. In the final year of the FSRP contracts, five (5) of the FSRP contractor agencies (Family Access Center, Children and Families of Iowa, Families First, Four Oaks, and Mid-Iowa Family Therapy Clinic) provided SafeCare within some counties of their contract area. Within those agencies, there were ten (10) SafeCare trainers and over 70 approved SafeCare home visit providers. Contractors were not required to provide data on SafeCare to HHS under the FSRP contracts, so there is no data available for SFY 2020. State level HHS staff and Georgia State University staff continued to collaborate with all five FSRP Services contracting organizations to provide them the necessary support, guidance, and technical assistance as they continued through implementation of SafeCare®.

Transition to Family Centered Services FCS

In the summer of 2019, HHS released a procurement with the intention of entering into new contracts for Family Centered Services (FCS). The procurement for FCS was an opportunity for HHS to design an integrated, seamless service delivery between family preservation and evidence-based intervention (EBI) services and to implement new strategies to improve safety, permanency, and well-being outcomes for Iowa's children and families in response to the Family First Prevention Services Act (Family First). Family First is philosophically built upon the principle that children do best with families. A core expectation under Family First is that states must employ evidence-based Interventions (EBIs) demonstrated to effectively strengthen and preserve connections between children and their family. With support from Casey Family Programs, Iowa selected Solution Based Casework® as the primary EBI for the FCS service array. SafeCare® was incorporated into the FCS service array and became a required service under the FCS contract.

The full FCS service array includes Solution Based Casework®, SafeCare®, Family Preservation Services, Solution Focused Meeting (SFM) Facilitation, Youth Transition Decision-Making (YTDM) Meeting Facilitation, and Family Interactions. FCS is available to intact families (in-home), families with children placed with kin/fictive kin caregivers, and families with children placed in stranger foster care. FCS is not available for children placed in shelter or group care placement longer than 30 days; however, FCS is available for a youth exiting from a QRTP for post-discharge services.

HHS held a bidders' conference on August 26, 2019. The purpose of the bidders' conference was to inform prospective bidders about the work to be performed and to provide prospective bidders an opportunity to ask questions regarding the RFP. In addition to the bidders' conference, there were two rounds of written questions submitted by prospective bidders with responses provided by HHS. HHS posted the final round of responses in October 2019.

Bidder proposals were due to HHS on December 16, 2019. Evaluation committees conducted comprehensive, fair, and impartial evaluations of bid proposals. On March 2, 2020, HHS announced the apparent successful bidders through a Notice of Intent to Award. Contract negotiations began on April 20, 2020 and concluded on April 24, 2020.

HHS entered into 10 contracts for FCS with two contractors in each of the five HHS service areas. There were seven contractors across the state with two contractors awarded multiple contracts. This was a change in area coverage from prior years. Under the FSRP Services contracts, three of the five service areas divided into sub areas for eight contract areas. In the month of June 2020, FCS contractors and HHS transitioned existing cases from FSRP Services to FCS. Service delivery for FCS was effective July 1, 2020.

Solution Based Casework (SBC) is an evidence-based case management approach to assessment, case planning, and ongoing casework. The approach helps the caseworker focus on the family in order to support the safety and well-being of their children. The goal is to work in partnership with the family to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them. This approach targets specific everyday events in the life of a family that have caused the family difficulty and represent a situation in which at least one family member cannot reliably maintain the behavior that the family needs to accomplish its goals. The assumptions of SBC include (1) full partnership with the family is a critical and vital goal for each and every family, (2) partnership for protection should focus on patterns of everyday life of the family, and (3) solutions should target the prevention skills needed to reduce the risk in those everyday life situations. SBC is the core framework around service delivery.

An SBC assessment utilizes the family life cycle to frame and locate the "problem" in the difficult developmental challenges that create safety threats to the family in their everyday life (supervising young children, keeping the house clean and safe, teaching the children right from wrong, etc.). SBC case planning organizes those challenges into efforts (Action Plans) the whole family can work on (Family Level Objectives), and those efforts (Action Plans) that certain individuals in the family need to work on (Individual Level Objectives) so that the family challenges go better. These Action Plans are not the typical service delivery plans that measure service compliance, but are behaviorally specific, and are co-developed by the family, FCS contractor, and HHS worker. These plans target needed skills in critical risk areas that can then be demonstrated, documented, and celebrated.

Throughout assessment, case planning, and casework management, SBC builds on solution-focused tenets that child welfare families need significant encouragement to combat discouragement and possess unnoticed and unrecognized skills usable in the anticipation and prevention of child maltreatment. Families are assisted within a forward-looking partnership that searches for exceptions to problems in everyday life and recreates or builds upon their social network with supportive others.

SBC is constructed on four Milestones:

- Consensus Building
- Develop Family Agreement
- Action Plan
- Noticing and Celebrating Change

For more information on SBC®, please visit the following website:
https://www.solutionbasedcasework.com/

In April 2020, HHS selected three of the seven FCS contractors to begin coordinating with Dr. Christensen to schedule initial SBC training. The other four contractors followed, and initial training was phased in through November 2020. All contractors met the requirement of having initial staff training completed by December 1, 2020.

During the first year of implementation, FCS contractors worked directly with SBC model developers to ensure fidelity to the SBC model during training and development of in-house trainers. Work between contractors and SBC model developers continued with ongoing certification process development after all contractor agencies had developed in-house training teams. Representatives from each contractor agency meet with SBC developer staff at least once per month to discuss challenges around training and certification processes.

The initial phases of the COVID-19 pandemic presented significant challenges for implementation of SBC. Model developers had not provided initial training in a virtual format prior to developing the tools for training Iowa's FCS staff. Observation is an essential component of training and certification, which was challenging to complete while following exposure guidelines.

Additionally, the COVID-19 pandemic resulted in significant changes to the workforce available to provide services. All contractors experienced significant challenges recruiting and retaining staff in the wake of the pandemic. Only in the past year have recruitment and retention efforts started to stabilize the provider workforce. HHS and FCS contractors have collaborated extensively to problem solve and ensure that children remain safe in their homes or are able to return home in a timely manner when safety concerns have been addressed. Due to the turnover rate for provider staff, contractors have continually needed to focus on training new staff and building certification processes and fidelity monitoring processes was delayed. As contractors experienced stabilization of staff, they were able to then build out process for certification in SBC.

All contractors currently have at least one certified SBC staff member. One contractor continues to work with SBC developers to develop an approved certification process. The SBC developers review certification applications and approve for this contractor. All other contractors have an approved certification process and have in-house staff who are able to review certification

applications. Once internally approved, the final application is sent to SBC developers for approval and issuance of the certification certificate.

SafeCare® is the evidence-based behavioral parenting intervention selected by HHS to implement under the FCS contracts. SafeCare® is specifically designed for families who have children 0-5 years of age and offers three modules for learning - Health, Safety, and Parent/Child Interactions. SafeCare® is available on open HHS service cases in addition to SBC; however, SafeCare® is not a standalone intervention. FCS contractors will receive compensation for provision of SafeCare®, in addition to SBC, when referred by HHS.

Five of the seven FCS contractors were accredited to provide SafeCare® and able to accept referrals as of July 1, 2020. The remaining two contractors were required to apply for accreditation within three months of the executed FCS contracts and receive accreditation within two years of the FCS contract execution date. These two contractors achieved accreditation within the established timelines and all contractors maintain their accreditation.

HHS continues to collaborate with Georgia State University to provide data for research into the effectiveness of SafeCare. NSTRC has a contract with HHS to provide a 5-year evaluation of services. FCS contractors enter data into the NSTRC SafeCare portal for analysis. Results of the most recent evaluation report can be found at the following link- SafeCare Iowa Year 2 Evaluation Report.

Family Preservation Services (FPS) are short-term, intensive, home-based, crisis interventions. FPS combine skill-based interventions and flexibility, so services are available to families according to their individual needs.

The goal of FPS is to offer families in crisis the supports and skills needed to remain together safely, averting out-of-home placement of children whenever possible. FPS function to modify the home environment and/or family behavior so that the child may remain safely in the parental household or in placement with kin or fictive kin caregivers. The focus of services is to assist in crisis management, restore the family to an acceptable level of functioning, and gain support within their community to remain safely together.

FPS are available to families with children at imminent risk of removal from their home of origin or from kin/fictive kin caregivers and placement in a licensed foster home. FPS are available during a child abuse assessment and anytime during an open HHS service case. Contractors deliver FPS in 10 calendar day units and a family is not eligible for more than three consecutive units of FPS for a maximum of 30 days.

Utilization of Child Safety Conferences (CSCs) occurs for children at risk of removal and placement in foster care. Parents receive invitations to attend a CSC to help identify collaborative solutions that allow the children and family to remain together. If it is not possible for the children to remain in the home, the goal is to ensure that the children are with kin or fictive kin caregivers rather than in a stranger foster care placement.

CSCs occur in order to make key decisions on:

- The safety of the child,
- Service and treatment needs necessary for the child to remain with their parent or parents and/or natural supports,
- Developing a plan to prevent removal,

- The appropriate placement of the child if removal is necessary,
- The child's access and opportunities for normal activities based on the reasonable and prudent parenting standard.

An initial CSC is required within three business days of a referral to FPS with a follow up CSC facilitated within 10 calendar days from the date of the initial CSC. The decisions resulting from a CSC will direct the blend of FPS and supports provided in order to maintain children safety in the home or with kin/fictive kin caregivers. The focus is development of solutions that will remove the risks placing children in imminent risk of removal.

FCS contractors assign Family Support Specialists (FSS) to provide FPS. The FSSs utilize motivational interviewing (MI) to engage and support the family. 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. This practical, empathetic, and short-term process takes into consideration how difficult it is to make life changes. HHS required all FCS contractors to complete training in MI by January 2021.

The FSS providing FPS meets with the family within 24 hours of the HHS referral to assess initial criteria and explain the service to the family. The FSS makes at least eight face-to-face casework contacts within each 10-day unit of service with one of the eight to include the CSC. Six of the casework contacts take place in the child's home of origin. At a minimum, casework contacts are 60 minutes in length and include interventions and assessment of parent/child interaction and other situations that could constitute danger and risk to the children. The FSS ensures a two-hour response time, either face-to-face or by telephone depending on the situation, to any crisis as defined by the family, DHS worker, or FSS that threatens the safety of the children.

The FCS contracts also provide for the facilitation of Family Team Decision-Making (FTDM) Meetings/Solution Focused Meetings (SFMs) and Youth Transition Decision-Making (YTDM) Meetings on open HHS service cases. FTDM/SFM and YTDM Meeting facilitation is included within provision of SBC.

Family Team Decision-Making (FTDM) is both a philosophy and a practice strategy for delivering child welfare services. The HHS child welfare focus is on serving families with children at serious risk of harm from abuse and neglect. Building teams at the time of crisis to support families where there is a risk of serious harm to the child has been identified as a means to address the factors that threaten the child's safety, establish permanency for the child, and promote well-being, which are central expectations in the provision of child welfare services.

Beginning July 1, 2021, FTDMs were replaced with **Solution Focused Meetings (SFM)**. The SFM was designed as an extension of Solution Based Casework®, with a similar focus on building support around families during times of crisis. SFMs draw parents and their supports together to identify areas of need for the family and create next steps plans to increase child safety, engage natural support systems to wrap around the family, and promote sustainable behavioral change. The transition to SFMs has supported family voice in case planning and ensures that the family has opportunities to identify what they see as the best path forward toward increased safety for their children.

Youth Transition Decision-Making (YTDM) is for youth transitioning into adulthood. The model has two key components: Engagement/Stabilization and the Dream Path process to promote self-sufficiency. YTDM applies the FTDM process, philosophy, and practice strategy for youth transitioning into adulthood. Building teams support identified youth and young adults who are at risk of homelessness, unemployment, and poor health as an effective means to address the factors that threaten a successful transition.

Voluntary (Non-HHS) Services: In addition to open HHS service cases, FCS are also available on voluntary non-HHS cases. A non-HHS case means no one in the household is involved with an HHS assigned social work case manager. The FCS contractor has case management and decision-making responsibility, not HHS. Voluntary services are available to eligible families for a maximum of 4 months. FCS voluntary services are similar to services provided under the Community Care contract.

Kinship Navigator Services: Beginning July 1, 2021, HHS added Kinship Navigator Services (KNS) to the FCS contracts statewide. Families First, one of the contracted FCS providers, had piloted a Kinship Navigator Program in the Cedar Rapids Service Area beginning in 2018 and collaborated with HHS to expand KNS to the other contracts.

Research shows there are many benefits to placing child(ren) with kin or other kinship caregivers, including increased stability and safety, as well as the ability to maintain family connections and cultural traditions. Kinship Navigator Programs assist grandparents and other kin who take primary responsibility for care of child(ren) who need a safe and stable placement to understand and access programs and services available to them. As parents struggle with issues that affect their ability to parent their child(ren), it is important to develop resources to support kinship caregivers in learning about, finding, and using programs and services to meet their own needs and the needs of the child(ren) they are raising.

Kinship Navigator Program goals include creating a safe and supportive home environment for child(ren) outside of stranger foster care, including early identification of needs for additional services such as therapy, counseling, educational and/or mental health services and to close the gaps and/or delays with service delivery to kinship caregivers. HHS focuses on providing a responsive strength-based supportive role to kinship caregiver families.

Family Interactions: Connections and bonding between parents and their children are critical components of child well-being and safety. Removing children from their primary homes causes confusion, fear, and a sense of loss for children. Maintaining regular contact between children and their families helps alleviate these feelings and supports successful outcomes for families involved in the child welfare system. Iowa HHS includes facilitation of family interactions in FCS contracts to ensure that children can be safe while spending time with their families and that families can practice new skills that enhance parental capacities and child safety.

Data

The Family Centered Services contract includes Performance Measures (PMs) for Solution Based Casework®, SafeCare®, Family Preservation Services, Kinship Navigator Services and Non-Agency Services. These PMs reflect priority attention on child safety, reunification, and permanency. Contractors may receive performance-based payment for achieving targets on performance measures in addition to the monthly base or unit rate for SBC and Family Preservation Services.

Solution Based Casework®

- **Performance Measure 1 (PM 1):** Children served by the contractor are safe from abuse for twelve (12) consecutive months following the conclusion of their case.
- **Performance Measure 2 (PM 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 (PM 3):** Children served by the contractor who are reunified or exit foster care do not experience reentry within twelve (12) consecutive months of their reunification date.

Table 4ff: Solution Based Casework PM1			
Date range of data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**
Contractor			
Father Flanagan's Boys Home	76.27%	78.34%	77.59%
Family Access Center	78.68%	74.75%	79.24%
Families First - Northern	78.98%	77.11%	76.47%
Mid-Iowa - Northern	75.37%	79.06%	78.62%
Families First - Eastern	75.84%	73.04%	76.99%
Lutheran Services in Iowa	78.23%	75.27%	78.21%
Families First- Cedar Rapids	72.22%	74.50%	80.48%
Four Oaks	76.11%	72.95%	79.86%
Children and Families of Iowa	77.08%	78.61%	83.24%
Mid-Iowa - Des Moines	72.80%	79.56%	83.29%

Source: HHS/JARVIS

This table reflects contractor performance over the past 5 years. Due to this performance measure looking at the 12-month period after case closure, initial data was not available until FFY 2023. While no contractor met the 90% goal, half of the contractors improved year over year. This indicates a correlation between implementation of SBC and an increase in children who do not experience re-abuse within 12 months of case closure.

Table 4gg: Solution Based Casework PM 2				
Date range of data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**	**7/2023-3/2024**
Contractor				
Father Flanagan's Boys Home	97.59%	90.38%	92.68%	92.73%
Family Access Center	97.99%	90.42%	89.70%	91.96%
Families First - Northern	97.74%	92.76%	90.69%	91.12%
Mid-Iowa - Northern	96.05%	93.73%	89.63%	93.04%
Families First - Eastern	99.16%	95.89%	93.05%	97.65%
Lutheran Services in Iowa	98.67%	95.97%	96.88%	n/a
Families First - Cedar Rapids	97.65%	93.70%	90.44%	82.76%
Four Oaks	96.67%	89.80%	90.46%	87.21%

Table 4gg: Solution Based Casework PM 2				
Date range of data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**	**7/2023-3/2024**
Contractor				
Children and Families of Iowa	96.51%	92.45%	88.57%	83.54%
Mid-Iowa - Des Moines	98.52%	89.91%	89.66%	88.58%

Source: HHS/JARVIS

Surprisingly, the number of children who remained safely in their homes or placed with kin/fictive kin decreased year over year. There are multiple factors that may have contributed to this decrease. HHS has placed significant emphasis on placing children with kin/fictive kin and encouraging kin/fictive kin to become licensed as foster parents. The data report above does not have the ability to differentiate between licensed foster parents and licensed kin/fictive kin. It is possible that the decrease in children remaining in the home or with kin/fictive kin is the result of increased kinship placements that have subsequently become licensed. Iowa's juvenile courts are the primary decision-makers regarding removal of children. Courts consider FCS efforts to stabilize families and increase safety for the child in the home, but ultimately make their own decisions based on multiple factors.

Table 4hh: Solution Based Casework PM 3			
Date range of data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**
Contractor			
Father Flanagan's Boys Home	84.88%	94.74%	81.25%
Family Access Center	79.73%	86.21%	73.68%
Families First - Northern	74.55%	80.00%	68.75%
Mid-Iowa - Northern	72.73%	70.00%	75.00%
Families First - Eastern	83.87%	85.00%	80.00%
Lutheran Services in Iowa	95.12%	100.00%	92.31%
Families First - Cedar Rapids	84.62%	66.67%	65.22%
Four Oaks	78.43%	83.33%	72.73%
Children and Families of Iowa	82.61%	70.00%	87.10%
Mid-Iowa - Des Moines	71.19%	70.00%	83.33%

Source: HHS/JARVIS

Year over year, over half of contractors see an increase in the number of cases where children do not experience re-entry to foster care within 12 months of reunification. Like PM 1, this correlates with implementation of SBC and provider staff building skills around service delivery. Staff turnover challenges may have contributed to the data for contractors who saw a decrease in percentages. Other factors, such as court decisions, new reports from mandated reporters, and other external factors, may have contributed to performance as well.

SafeCare®

- Performance Measure 1 (PM 1): 65% of parents in contractor's cases receiving SafeCare will complete and graduate from all three modules.
- Performance Measure 2 (PM 2): 85% of parents in contractor's cases receiving SafeCare will complete the parent-child interactions (PCI)/parent-infant interactions (PII) module.

Table 4ii: SafeCare® PM 1				
Date range for data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**	**7/2023-3/2024**
Contractor				
Father Flanagan's Boys Home	0.00%	0.00%	42.62%	67.65%
Family Access Center	8.22%	30.65%	31.11%	40.43%
Families First - Northern	44.71%	45.74%	30.12%	35.94%
Mid-Iowa - Northern	1.52%	13.85%	36.73%	37.04%
Families First - Eastern	40.48%	40.45%	44.74%	45.13%
Lutheran Services in Iowa	27.27%	11.11%	2.00%	n/a
Families First - Cedar Rapids	0.00%	10.26%	47.06%	56.52%
Four Oaks	24.39%	21.57%	41.51%	27.27%
Children and Families of Iowa	41.82%	28.13%	34.58%	35.56%
Mid-Iowa - Des Moines	27.78%	43.37%	49.38%	26.76%

Source: HHS/JARVIS

Table 4jj: SafeCare PM 2				
Date range for data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**	**7/2023-3/2024**
Contractor				
Father Flanagan's Boys Home	0.00%	3.33%	62.30%	79.41%
Family Access Center	12.33%	45.16%	60.00%	55.32%
Families First - Northern	63.53%	76.60%	62.65%	67.19%
Mid-Iowa - Northern	6.06%	16.92%	46.94%	46.30%
Families First - Eastern	58.33%	67.42%	73.68%	66.37%
Lutheran Services in Iowa	27.27%	20.37%	8.00%	n/a
Families First - Cedar Rapids	3.03%	12.82%	55.88%	63.04%
Four Oaks	26.83%	43.14%	52.83%	54.55%
Children and Families of Iowa	52.73%	36.46%	48.60%	38.89%
Mid-Iowa - Des Moines	48.61%	53.01%	58.02%	32.39%

Source: HHS/JARVIS

HHS data on both SafeCare Performance Measures is uneven for several reasons. These include SafeCare data being entered in multiple locations causing an increase in error rates, cases closing by court order prior to parents having an opportunity to complete SafeCare, inappropriate referrals to SafeCare (parent mental health or substance use too unstable/too great), parents not complying with SafeCare, and/or HHS end dating services before parents complete all modules. The SafeCare Year 2 Evaluation Report provides more robust information on outcomes for families as a result of SafeCare participation. That report reflects that parents who complete at least one module of SafeCare experience a significant reduction in the likelihood of subsequent HHS involvement. That reduction increases with each module completed, i.e., families who complete all 3 modules are the least likely to experience re-entry into the child welfare system.

Family Preservation Services

- **Performance Measure 1 (PM1):** Children served by the contractor during a CPS child abuse assessment will not be removed from their homes and placed into foster care during provision of FPS and for three months following the end date of this service.
- **Performance Measure 2 (PM2):** 80% of children served by the contractor during the CPS child abuse assessment will not suffer maltreatment during provision of FPS and for three months following the end date of service.

Table 4kk: Family Preservation Services PM1				
Date range for data	**7/2020-12/2020**	**4/2021-11/2021**	**4/2022-11/2022**	**4/2023-11/2023**
Contractor				
Father Flanagan's Boys Home	66.67%	92.73%	92.45%	84.85%
Family Access Center	74.19%	87.10%	91.67%	88.89%
Families First - Northern	84.31%	88.89%	82.86%	93.26%
Mid-Iowa - Northern	92.65%	89.29%	90.41%	91.25%
Families First - Eastern	82.76%	92.78%	93.83%	91.43%
Lutheran Services in Iowa	94.59%	86.84%	91.30%	85.71%
Families First - Cedar Rapids	89.66%	79.69%	79.17%	85.48%
Four Oaks	83.87%	89.66%	91.94%	89.66%
Children and Families of Iowa	77.78%	80.95%	73.68%	92.00%
Mid-Iowa - Des Moines	88.24%	79.17%	86.96%	88.89%

Source: HHS/JARVIS

Over half of FCS contractors saw improvement year over year since implementation of Family Preservation Services. This data reflects several factors, including increasing experience with implementation of the model resulting in better outcomes for families, an increased emphasis on keeping children in the home, when possible, through the courts, and that early, intensive interventions can mitigate safety concerns to prevent out-of-home placement. The Family Preservation Services model reflects the belief that families know best what they need to be successful, and that family empowerment results in safety for children.

Table 4ll: Family Preservation Services PM 2				
Date range for data	**7/2020-12/2020**	**4/2021-11/2021**	**4/2022-11/2022**	**4/2023-11/2023**
Contractor				
Father Flanagan's Boys Home	58.82%	75.71%	83.93%	84.21%
Family Access Center	75.76%	86.27%	84.62%	71.43%
Families First - Northern	88.89%	85.11%	91.55%	83.33%
Mid-Iowa - Northern	91.43%	95.00%	78.82%	91.45%
Families First - Eastern	100.00%	78.82%	80.00%	85.21%
Lutheran Services in Iowa	86.84%	84.62%	81.82%	80.85%
Families First - Cedar Rapids	86.67%	60.81%	81.33%	74.00%
Four Oaks	76.47%	78.46%	92.06%	85.00%
Children and Families of Iowa	80.00%	100.00%	85.71%	92.11%

Table 4II: Family Preservation Services PM 2				
Date range for data	**7/2020-12/2020**	**4/2021-11/2021**	**4/2022-11/2022**	**4/2023-11/2023**
Contractor				
Mid-Iowa - Des Moines	100.00%	60.00%	95.65%	82.50%

Source: HHS/JARVIS

Half of contractors showed improvement year over year for families not experiencing additional incidents of maltreatment during their case or in the three months following. This data further points toward the effectiveness of Family Preservation Services, as children are not experiencing re-abuse. Several factors influence contractor success, including how HHS documents additional concerns identified during the Child Protective Assessment and HHS policy around how individual incidents are counted toward re-abuse rates.

Kinship Navigator Services

Performance Measure 1 (PM 1): 90% of Kinship Caregivers who participate in Kinship Navigator Services will receive a minimum of two contacts with the Kinship Specialist per full month the Case is open.

Due to HHS' current data and IT limitations, specific data on this performance measure is not available. It is anticipated that future IT solutions will allow for collection and analysis of Kinship Navigator Services Performance Measure data.

Iowa has seen an increase in kin and fictive kin placements through a joint effort between HHS, courts, and FCS providers identifying and supporting kin and fictive kin caregivers. The Kinship Navigator Program was expanded to all 99 Iowa counties in 2021 and kinship caregivers throughout Iowa receive services.

Kin/fictive kin caregiver testimonials were gathered for a presentation on the Kinship Navigator Services program to the statewide Cultural Equity Alliance in June 2023. Some of the testimonials included were:

- "Having Kinship around during this process made life a little easier. I kind of got into this situation blindsided, not really knowing what I was getting myself into. All I knew at the time was I just wanted to help my family. My kinship worker is amazing. It was great having her through the process, and she became the person who I was able to bounce my thoughts and concerns off of. She made me so comfortable. I was able to ask her any questions or concerns I was having. When I did not understand certain things, I was able to go to my kinship worker. It was easier for me to get in touch with my kinship worker when there were needs or concerns. She was able to advocate for me when I was not able too. Having a Kinship worker made my life and this process less stressful." -Dubuque, IA
- "I love the support this program offers. My worker is always there to answer my questions and lend a helping hand. If she doesn't have an answer, she finds one for me. Great program!" -Muscatine, IA
- "My experience caring for my grandkids since January 23rd, has its challenges and positives. When I got them and seeing them in that condition hurt me and felt bad in what addiction does to a parent(s). I was also thinking about being able to care financially and mental well-being for them. My positives are seeing them every day being happy and healthy and that they are being cared for by me and my family. My grandkids keep me going! With my grandkids being placed with me and my family, my caseworker

referred me to Families First to get into kinship caregiver program. [The kinship specialist] reached out to me to set up home visits appointments to meet the children and I. She helped me get set up with orientation for foster care." -Linn County, IA

- "This Kinship program has helped me with more than just financial support. It has provided me with someone who I really feel advocates for me and helps me emotionally and mentally. My Kinship Navigator has always been a phone call away when I need to talk to her about situations that have come up. She supports me by going with me to court that would otherwise be stressful without her support. She doesn't feel like just another person that comes to your house though out the process, she's really like a friend that comes to listen and support. She's very respectful and accommodating with my work schedule which really helps. I would really recommend enrolling in the Kinship program when it's offered. Kinship Caregiver" - Polk County

Non-Agency Services

- **Performance Measure 1 (PM 1):** Children served by the contractor are safe from abuse for twelve (12) consecutive months following the conclusion of their case.
- **Performance Measure 2 (PM 2):** Children served by the contractor are safely maintained in their own homes or with kin/fictive kin caregivers during the case.

Table 4mm: Non-Agency Services PM 1

Date range of data	7/2020-3/2021	7/2021-3/2022	7/2022-1/2023
Contractor			
Father Flanagan's Boys Home	65.00%	72.83%	69.83%
Family Access Center	75.38%	63.33%	74.80%
Families First - Northern	67.35%	67.09%	66.04%
Mid-Iowa - Northern	56.67%	68.24%	76.92%
Families First - Eastern	68.18%	58.73%	59.32%
Lutheran Services in Iowa	59.26%	54.35%	69.57%
Families First - Cedar Rapids	59.57%	72.41%	73.47%
Four Oaks	60.42%	68.52%	67.31%
Children and Families of Iowa	63.93%	70.00%	75.00%
Mid-Iowa - Des Moines	77.42%	68.92%	73.47%

Source: HHS/JARVIS

In the first year of Family Centered Services, contractors were required to use SBC with Non-Agency cases. This created challenges with family engagement due to the short timeline of Non-Agency Services. Beginning in July 2021, contractors were no longer required to use SBC with Non-Agency cases but encouraged to do so when appropriate to the case. With the challenges of SBC implementation, this could have impacted the data. Other factors that impact family success include how HHS documents additional concerns identified during the Child Protective Assessment and HHS policy around how individual incidents are counted toward re-abuse rates. These factors are beyond contractor control. Even with these factors, well over half of children who experience Non-Agency Services do not experience re-abuse.

Table 4nn: Non-Agency Services PM 2				
Date range of data	**7/2020-3/2021**	**7/2021-3/2022**	**7/2022-3/2023**	**7/2023-3/2024**
Contractor				
Father Flanagan's Boys Home	98.33%	100.00%	100.00%	100.00%
Family Access Center	98.46%	98.88%	100.00%	100.00%
Families First - Northern	100.00%	100.00%	100.00%	100.00%
Mid-Iowa - Northern	100.00%	98.82%	100.00%	100.00%
Families First - Eastern	100.00%	100.00%	100.00%	100.00%
Lutheran Services in Iowa	100.00%	100.00%	97.83%	n/a
Families First - Cedar Rapids	100.00%	100.00%	100.00%	100.00%
Four Oaks	100.00%	100.00%	100.00%	100.00%
Children and Families of Iowa	100.00%	98.75%	100.00%	100.00%
Mid-Iowa - Des Moines	100.00%	98.65%	98.15%	100.00%

Source: HHS/JARVIS

This measure indicates that a high number of families do not experience separation during Non-Agency Services. While these services do not directly involve HHS staff, the data here reflects that safety concerns warranting out of home placement are not occurring while Non-Agency Services are open. This indicates that contractors are engaging families who elect to participate in services and connecting them with community supports, which prevents further involvement with child welfare going forward.

Collaboration

Iowa completed procurement of new Family Centered Services (FCS) contracts beginning in August 2019. Bidder's conferences and written Q&As provided opportunities for bidders to ask clarifying questions and identify potential challenges within the RFP. Iowa HHS completed contract negotiations with successful bidders in the spring of 2020, with the new Family Centered Services contracts going into effect July 1, 2020.

Since the beginning of the current FCS contracts in July 2020, meetings between the HHS Program Manager and FCS contractors have occurred on at least a quarterly basis, though the meetings are generally more frequent. These discussions include conversations around service implementation, staff training and development, connection points with other services available through Iowa's child welfare system and community prevention, the opportunities and challenges of meeting contractual expectations, celebrating the successes of staff and families, and continuing to identify and implement best practices. In addition to scheduled meetings with all contractors together, the Program Manager regularly meets with individual contractor agencies to discuss contractor performance and address challenges. Topics during contractor meetings have included working through SBC implementation, training, and certification challenges; planning for Family Interactions; building out Kinship Navigator Services; reporting and documentation processes; and communication between HHS and FCS frontline staff.

There have also been opportunities for detailed collaboration between the HHS Program Manager and contractor agencies. For example, the Practice Standards for Family Centered Services Contractors, Comm. 660, (https://hhs.iowa.gov/media/6786/download?inline=) were developed jointly with the HHS Program Manager and representatives from each of the contracted FCS provider agencies. This included meetings to discuss what areas to address in

the Practice Standards, division of writing responsibilities among all team members, review and revision of drafts, and final approval prior to expectation of Practice Standards implementation in January 2023. Additionally, FCS supervisors and HHS supervisors presented joint trainings to HHS and FCS frontline staff in January and February of 2023 to help ensure consistent implementation of the Practice Standards and to address challenges in communication.

Contract agencies have, at minimum, quarterly meetings with their local HHS Service Area leadership to discuss area-specific performance and problem-solving challenges. The quarterly meetings include contractors across HHS' contracted service array, including foster care licensing, QRTP, shelter, and juvenile justice services. These meetings provide opportunities to better understand the full array of services across the child welfare system and find ways to connect and collaborate to better serve families. The HHS Program Manager also attends these meetings, which helps identify Service Area specific trends as well as statewide trends. Problematic trends can then be addressed at the appropriate level.

Meetings between FCS contractors and QRTP contractors have occurred at least annually throughout the past 5 years. These meetings provide opportunities for the two groups of contractors to discuss opportunities and challenges in transitioning youth from a QRTP setting into a family-like setting and FCS contractors supporting the family post-QRTP. Primary challenges have been identified as lack of consistent referrals to FCS when QRTP is ending and inadequate preparation of families to accept FCS services upon a child's return to the home. Because referral to FCS is the responsibility of HHS, QRTP staff are evaluating different ways they can support the referral process.

Informal communication via phone and email occurs nearly daily between the HHS Program Manager, contractors, and HHS Contract Specialists who assist in the day-to-day contract monitoring of the FCS contract. These opportunities for informal communication provide rapport building, identify creative solutions to challenging situations, and help ensure that families receive the right services and resources at the right points in time. This informal communication and collaboration serves to consider families on an individual basis and tailor supports to a family's unique circumstances while also following contract expectations and providing equity.

The HHS Program Manager also maintains regular communication with the model developers for Solution Based Casework and SafeCare, the two Evidence Based Interventions selected by Iowa to be part of the Family Centered Services package. In the early stages of Solution Based Casework implementation, the HHS Program Manager facilitated opportunities for Dr. Dana Christensen, SBC model developer, to be available to HHS and FCS frontline staff over the lunch hour. These meetings were opportunities for Dr. Christensen to answer questions, discuss solutions to SBC implementation challenges, and provide perspective on common struggles for families. These sessions were recorded and have been provided to the contractor agencies for re-watching as needed. The HHS Program Manager has monthly meetings with SBC staff to discuss implementation progress and challenges.

HHS also maintains regular contact with the National SafeCare® Training and Research Center (NSTRC) with Georgia State University. HHS has a contract with NSTRC to complete ongoing evaluation of Iowa's SafeCare program. The report for the most recent evaluation period can be viewed at https://hhs.iowa.gov/media/7057/download?inline=. This report indicates that families are seeing benefit from SafeCare sessions, even if they are unable to complete all sessions/modules due to family dynamics or their case closing prior to completion of the

program. HHS is expecting to make modifications to programming to allow for families to complete SafeCare when other services are ready to close.

HHS has also collaborated with NSTRC to facilitate SafeCare staff and participants engaging in a smoke-free home intervention that integrates into SafeCare practice. SafeCare continues to recruit staff and participants for this study to determine whether the intervention results in reduced risk of second-hand smoke exposure for young at-risk children.

Recruitment, Retention, Training and Support of Resource Families (RRTS)

The HHS implemented the Recruitment, Retention, Training and Support of Resource Families (RRTS) contract beginning with SFY 2017 and carried over into the CFSP of 2020-2024. Lutheran Services in Iowa served the Western Service Area and Four Oaks Family Connections received the contract for the Northern Service Area, the Eastern Service Area, the Cedar Rapids Service Area, and the Des Moines Service Area. In the later period of the 2020-2024 CFSP, there was a transition to a new statewide contract with Four Oaks Family Connections.

For the SFY 2020 through 2023 of the CFSP, the contracts were designed 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 relative caregivers to encourage relatives to become licensed foster parents.

The contract required the selected agencies to:

- Develop recruitment and retention plans based on service area needs and data.
- Complete all activities related to licensing foster families and approving adoptive families.
- Provide pre-service and in-service training.
- Perform matching activities.
- Provide required face-to face contacts and support services to foster families through a one caseworker model.
- Identify, train, and support enhanced foster families to care for children coming out of congregate care, psychiatric medical institute for children (PMIC) or long-term shelter stays.
- Have at least one face-to-face meeting with referred relative caregivers to explain the foster home licensing process and the benefits and supports of licensure.
- Provide post-adoption services to families eligible for adoption assistance.

During SFY 2020-2023 recruitment and retention of foster families focused on increasing the net gain of foster families available for general matching. Recruitment and retention plans reflect service area data including the demographics of children coming into care, the geographic

location of children coming into care, and enhancing capacity in the areas needing foster families.

The one caseworker model was the integrated approach to foster family licensing training, matching, support and developing families licensed, approved or in the approval process by one assigned caseworker who follows the family from the beginning of the process to closure. Contractors geographically assign RRTS caseworkers to foster families and have capped caseloads at 35.

RRTS caseworkers are the first point of contact for foster families when they have questions, concerns or needs. The caseworker has firsthand knowledge of the skills, strengths, and needs of foster families on their caseload which allows caseworkers to have direct involvement in the matching process by recommending foster families that can meet the needs of the child coming into care. Caseworkers develop training plans with foster families, coach, and mentor families to enhance their skills, and assist the family with finding resources when needed.

RRTS contractors remain 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.

Each RRTS contractor completes pre-service and in-service training in their Service Areas. Pre-service training consists of Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP), Caring for Our Own, and Deciding Together. Contractors 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. For example, Deciding Together allows training in smaller group settings or individually if needed. 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.

RRTS Contractors transitioned to a Pre-service training through National Training and Development Curriculum for Foster and Adoptive Parents (NTDC). This new curriculum which transitioned from TIPS-MAPP, began 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. 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 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.

Under the RRTS contract from SFY 2020-2023, localized matching was occurring. As stated above, RRTS caseworkers were directly involved in recommending families that could best meet the needs of the child based on the direct knowledge caseworkers had of their families.

Post-adoption support services also continued under the RRTS contract. RRTS caseworkers assisted with the transition from foster care to adoption, developed post-adoption support plans with families, and provided a seamless transition to post-adoption services staff. RRTS contractors were also responsible for providing training and support groups open to all adoptive families, not just families who adopted through HHS. Respite for adoptive families remained in the contract, as well as support for finding homes for waiting children through the AdoptUSKids exchange.

RRTS was and is a performance-based contract. Keeping children stable in their first foster home remains a priority, but the time to measure stability moved from four months to 180 days. The service areas were interested in capacity and wanted to focus on increasing the number of foster families who would be able to take children coming into care, which resulted in a shift from increasing the number of foster families overall to the number of foster families who were available to be matched to a child.

For the years 2020-2023, the incentivized performance measures were as follows:

- **Measure 1 – Stability**: Children placed into a licensed foster family home from their removal home or shelter within the quarterly reporting period will experience stability in placement. A child's first placement should be the child's only placement. The contract payment for performance will be based on the percent of a cohort of children who remain in the same licensed foster home 180 days after placement or:
    - will have exited the licensed foster home to a trial home visit working towards
    - reunification; or
    - will have exited to a relative home; or
    - will have exited to a pre-adoptive placement working toward permanency; or
    - will have attained permanency through adoption or guardianship.

  For SFY 2020 HHS added the emergency foster care placement as an option allows the RRTS contractor to still achieve this performance measure as it is more appropriate for a child to go to a temporary foster care placement as they are working on an appropriate long-term match rather than going into a shelter placement.

  Contract payment was made using the following standards for SFY's 2020-2022 (note: The Gold and Silver Standards are mutually exclusive by quarter, and both cannot be earned for the same quarter):

- Gold Standard (payment of 2.5% of quarterly eligible contract value) – Greater than or equal to 93% of children in family foster care will be stable in their first placement for six (6) months
- Silver Standard (payment of 1.5% of quarterly eligible contract value) – Greater than or equal to 88% of children in family foster care will be stable in their placement for six (6) months

Contract payment will be made using the following standards for SFY 2023 (note: The Gold and Silver Standards are mutually exclusive by quarter, and both cannot be earned for the same quarter):

- Gold Standard (payment of 2.5% of quarterly eligible contract value) – Greater than or equal to 85% of children in family foster care will be stable in their first placement for six (6) months
- Silver Standard (payment of 1.5% of quarterly eligible contract value) – Greater than or equal to 75% of children in family foster care will be stable in their placement for six (6) months

Table 4oo: Stability in Family Foster Care

Service Area	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
	%	%	%	%	%	%
Western	68.0	70.9	69.1	75.1	80.7	75.2
Northern	71.9	75.5	67.0	71.6	64.3	76.7
Eastern	55.1	64.6	75.6	75.7	69.3	49.6
Cedar Rapids	60.4	68.3	78.1	74.8	67.5	59.8
Des Moines	72.9	81.9	78.5	76.4	69.3	67.2

Data Source: HHS CCWIS
Each SFY is an average based on the percentage each quarter

- **Measure 2 – Recruitment and Retention (Overall Net Increase in Families):** The contractor shall increase the net number of licensed foster families available for matching on an annual basis. The contractor's net increase in number of licensed foster families will be based on the number of licensed foster families available for matching on July 1st at the beginning of that contract year and the number of licensed foster families available for matching on June 30th at the end of that same contract year.

  Available for matching means a family that is not providing respite only, or is licensed for a specific child, or has accepted a child within the previous 12 months. Baseline numbers were provided for each service area in September of 2017.

  The contract payment for performance is based on the following increases in net number of families during each year per Service Area:

Table 4pp: RRTS Performance Measure 2								
	SFY 2018				SFY2019			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	251	Gold	280	388 Met Gold	283	Gold	321	412 Met Gold
		Silver	271			Silver	310	
2 (Northern)	205	Gold	232	272 Met Gold	223	Gold	260	321 Met Gold
		Silver	224			Silver	249	
3 (Eastern)	154	Gold	169	175 Met Gold	151	Gold	171	220 Met Gold
		Silver	165			Silver	165	
4 (Cedar Rapids)	207	Gold	239	293 Met Gold	229	Gold	272	393 Met Gold
		Silver	230			Silver	259	
5 (Des Moines)	222	Gold	258	335 Met Gold	262	Gold	310	416 Met Gold
		Silver	247			Silver	296	
	SFY2020				SFY 2021			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	412	Gold	447	426 Not Met	446	Gold	484	391 Not Met
		Silver	437			Silver	473	
2 (Northern)	321	Gold	348	298 Not Met	318	Gold	345	272 Not Met
		Silver	340			Silver	337	
3 (Eastern)	220	Gold	239	190 Not Met	209	Gold	226	175 Not Met
		Silver	233			Silver	221	
4 (Cedar Rapids)	393	Gold	426	356 Not Met	408	Gold	442	375 Not Met
		Silver	417			Silver	432	
5 (Des Moines)	416	Gold	451	428 Not Met	436	Gold	473	410 Not Met
		Silver	441			Silver	462	
	SFY 2022				SFY 2023			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	391	Gold	424	376	376	Gold	408	344
		Silver	414			Silver	399	
2 (Northern)	280	Gold	304	263	263	Gold	285	224
		Silver	297			Silver	279	
3 (Eastern)	175	Gold	190	163	163	Gold	177	164
		Silver	185			Silver	173	
4 (Cedar Rapids)	375	Gold	407	338 t	338	Gold	367	307
		Silver	398			Silver	359	
5 (Des Moines)	410	Gold	445	400	400	Gold	434	393
		Silver	435			Silver	424	
Data Source: DHS CCWIS and CareMatch								

- **Performance Measure 3 – Recruitment and Retention (Increase in Non-White Families):** The contractor shall increase the net number of licensed non-white foster families available for matching on an annual basis. The contractor's net increase in number of licensed non-white foster families will be based on the number of licensed non-white foster families available for matching on July 1st at the beginning of that contract year and the number of licensed non-white foster families available for matching on June 30th at the end of that same contract year. The contract payment for performance is based on the following increases in net number of non-white families during each year per Service Area:

Table 4qq: RRTS Performance Measure 3

	SFY2018				SFY2019			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	16	Gold	26	41	26	Gold	36	38
		Silver	23			Silver	33	
2 (Northern)	8	Gold	19	15	11	Gold	22	22
		Silver	16			Silver	19	
3 (Eastern)	23	Gold	31	19	19	Gold	27	13
		Silver	29			Silver	25	
4 (Cedar Rapids)	29	Gold	37	32	23	Gold	31	39
		Silver	35			Silver	29	
5 (Des Moines)	35	Gold	53	44	33	Gold	51	54
		Silver	49			Silver	47	
	SFY2020				**SFY2021**			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	38	Gold	48	37	39	Gold	48	41
		Silver	45			Silver	45	
2 (Northern)	22	Gold	33	16	21	Gold	32	19
		Silver	30			Silver	29	
3 (Eastern)	13	Gold	21	18	20	Gold	28	16
		Silver	19			Silver	26	
4 (Cedar Rapids)	39	Gold	47	30	40	Gold	48	43
		Silver	45			Silver	46	
5 (Des Moines)	54	Gold	72	69	70	Gold	88	54
		Silver	68			Silver	84	
	SFY2022				**SFY2023**			
Service Area	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**	**Baseline**	**Standard**	**Target Net Increase**	**Achieved**
1 (Western)	41	Gold	51	36	36	Gold	43	31
		Silver	48			Silver	43	
2 (Northern)	19	Gold	30	20	20	Gold	31	19

Table 4qq: RRTS Performance Measure 3								
		Silver	27			Silver	28	
3 (Eastern)	16	Gold	24	16	16	Gold	24	24
		Silver	22			Silver	22	
4 (Cedar Rapids)	43	Gold	51	53	53	Gold	61	45
		Silver	49			Silver	59	
5 (Des Moines)	54	Gold	72	69	69	Gold	87	59
		Silver	68			Silver	83	
Data Source: DHS CCWIS and CareMatch								

- **Performance Measure 4 – Enhanced Foster Family Homes:** The contractor shall be measured on stable placement of children in enhanced foster family homes on an annual basis. The contract payment for performance is based on the following number of stable placements (placements with children who remain in the same enhanced foster family home for three (3) months in the Service Area during the second contract year (note: The Gold and Silver Standards are mutually exclusive by year, and both cannot be earned for the same year):
    - Gold Standard (payment of 2.5% of annual eligible contract value) – Greater than or equal to twelve (12) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year
    - Silver Standard (payment of 1.5% of annual eligible contract value) – Greater than or equal to six (6) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year

Enhanced foster homes did not implement as quickly as anticipated and overall has not been successful. Identified barriers include families not wanting to be limited to only two children; inability to have children not at the enhanced level placed in the home; insufficient wrap around services especially for childcare/supervision for older youth; and difficulty finding respite.

In SFY 2020, a team consisting of representatives from the field, RRTS contractor, and policy met to discuss therapeutic foster care models. The team developed revised criteria for enhanced foster homes, with implementation scheduled for July 2020. Unfortunately, due to the COVID-19 pandemic, foster parents were doing their best to maintain the children they already had in their homes and the option of taking on more responsibility with an enhanced child and the additional training requirements to become an enhanced home was more than most homes could manage.

In SFY 2021, a small team of HHS policy staff met with a group of enhanced foster homes to discuss challenges they encountered as enhanced homes as well as needs that would be necessary for the program to be successful. The foster care program manager is collaborating with community partners sharing their feedback to develop the supports that have been missing for the enhanced homes. Major stressors were discharging planning on behalf of the child that included assistance setting up needed educational and therapeutic services for the child as well as after-hours crisis intervention services.

Unfortunately, due to the COVID-19 pandemic, the revised criteria for enhanced foster homes have not shown much success in increasing the number of homes being designated as enhanced. More families than usual have requested to be placed on hold and not wanting to

take placements or provide even respite because they could not risk their health and their family members health taking a new child into their home with the fear of COVID. There has been a lack of mental health services, daycare issues, and foster families being increasingly stressed trying to juggle their new norm of working from home and children being involved in virtual school. Throughout the COVID-19 pandemic families have been focused on maintaining stability for their own families and not open to changing their status to enhanced.

The Enhanced Foster Family Home Performance Measure was eliminated in an amendment with RRTS contractors on July 1, 2022.

Table 4rr: RRTS Performance Measure 4

	July 2018		**April 2019**		**July 2019**		**April 2020**	
Service Area	**Enhanced homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**
1 (Western)	3	0	2	0	2	1	2	2
2 (Northern)	3	0	2	0	1	1	0	0
3 (Eastern)	3	0	2	1	2	2	1	1
4 (Cedar Rapids)	3	0	1	1	1	1	2	1
5 (Des Moines)	8	0	6	2	5	4	4	2
	July 2020		**April 2021**		**July 2021**		**April 2022**	
Service Area	**Enhanced homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**	**Enhanced homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**
1 (Western)	2	1	2	1	3	2	2	2
2 (Northern)	1	0	0	0	0	0	0	0
3 (Eastern)	1	0	1	0	1	1	1	1
4 (Cedar Rapids)	1	0	1	0	1	0	1	0
5 (Des Moines)	5	0	5	0	5	0	5	0
	July 2022		**April 2023**					
Service Area	**Enhanced homes**	**Children Placed**	**Enhanced Homes**	**Children Placed**				
1 (Western)	2	2	2	3				
2 (Northern)	0	0	0	0				

Table 4rr: RRTS Performance Measure 4								
3 (Eastern)	1	1	1	0				
4 (Cedar Rapids)	1	0	1	0				
5 (Des Moines)	0	0	0	0				
Data Source: DHS CCWIS and CareMatch								

In February of 2022, HHS initiated a work group to develop a Therapeutic Foster Home Pilot Project that would be funded initially with ARPA funds. Therapeutic Foster Care (TFC) would expand on current foster care models in Iowa. The TFC pilot would focus on supporting youth in the foster care system with behavioral health needs. The pilot would focus on youth primarily in the ages of 8-12 years. The intent would be to assist in stabilizing these children's medical/behavioral health needs to facilitate return to the family home or more permanent setting. This would be accomplished with a focus on therapeutic case management. The model emphasizes engagement of the foster youth's family and supporting successful long-term reunification.

HHS continued 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 would enhance the child welfare foster care service array, including providing highly skilled support in family settings for children placed in foster care under Chapter 232 and who have needs exceeding what can safely and properly be addressed in a traditional family foster home setting. A Therapeutic Foster Care (TFC) model program for Iowa goal was to be implemented by HHS as a pilot TFC program in July of 2023 in the Cedar Rapids Service Area. 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 Foundation 2 Crisis Support Services.

By April of 2023 the work group was meeting HHS Leadership for approval of a final budget. Homes were identified and started training in the fall of 2023. As of February 1, 2024, there are three approved and trained TFC homes, three approved and trained TFC respite homes, and two homes currently in TFC training scheduled to be ready to accept children as of mid-February 2024. Two children have been placed in a TFC home and one is currently being transitioned into the third licensed home.

As stated above, this pilot was designed in collaboration between Family Well-being and Protection, Behavioral Health and Disability Services, and Medicaid. The program emphasizes Medicaid home and community-based services 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
- 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.

CareMatch is a data system 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 7/1/2023. Unfortunately, there have been delays with the completion of the project and ultimately implementation. The goal for roll out is approximately March or April of 2024.

For 2023-2024, the latter years of the CFSP, approaches to performance objectives transformed with the development of a new RRTS RFP and ultimate implementation of a new statewide contract for SFY 2024.

The new contract beginning on July 1, 2023, 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.

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 haven't 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**. (See Table 4nn for data)

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 color) is regarding race and ethnicity and the overall increase in non-white families. This is not to say that children shouldn't 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. (See Table 4pp for data)

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.

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 4ss: PM 3 Data

July 2023	Met	Not Met	Total Referrals
HHS	4	25	29
FCS Kinship Navigator	0	1	1
Monthly Totals	4	26	30

Table 4ss: PM 3 Data			
August 2023	**Met**	**Not Met**	**Total Referrals**
HHS	2	32	34
FCS Kinship Navigator	1	7	8
Monthly Totals	3	39	42
September 2023	**Met**	**Not Met**	**Total Referrals**
HHS	2	20	22
FCS Kinship Navigator	2	17	19
Monthly Totals	4	37	41

Source: HHS CCWIS

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.

Table 4tt: RRTS Performance Measure 4 Safe in Resource Home									
	SFY24 Q1			SFY24 Q2			SFY24 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 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 $2500 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, the Agency 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 CAP for non-compliance due to not meeting this performance measure.

Crisis Intervention, Stabilization, and Reunification (CISR)
The HHS implemented Crisis Intervention, Stabilization, and Reunification (CISR) contracts for the final two years of the CFSP period covering 2015 – 2019, and those contracts remained until new contracts began on July 1, 2023. The fundamentals of the three services included in CISR, i.e., child welfare emergency services (CWES), foster group care services (FGCS)/Qualified Residential Treatment Services (QRTP), and supervised apartment living (SAL) (sometimes called independent living) remained relatively the same during this CFSP period, however one significant change did occur. During this CFSP period, Iowa made the shift from Foster Group Care to Qualified Residential Treatment Programs (QRTP's).

During the period of 2020-2024, the HHS continues the evolution of the child welfare system of care. The role of the Crisis Intervention, Stabilization, and Reunification (CISR) contracts to serve youth requiring residential services also continue in this system. The current CISR contracts end June 30, 2029.

Focal points of CISR overall include the following:

- Each child is served near the child's home and/or community.
- Service delivery occurs at a local level, upon the HHS defined Service Areas. Children should be in their communities of origin to preserve connections to their families, home communities, schools, and positive support systems.
- All CISR services use the "One Caseworker Model" to coordinate the delivery of the child's service plan and to be the point of contact for the child, the child's family or other persons in the child's positive support system, and the referring worker. The one caseworker model ensures that a child and the child's family have consistent access to contractor staff and better coordination of services for each child.
- Each child and youth in care receives an "education specialist" to coordinate all education related matters.
- Child welfare services continue integration through collaboration across HHS child welfare contracts and community partners. In the future, the HHS will continue pursuit of a more cohesive and comprehensive array of services.

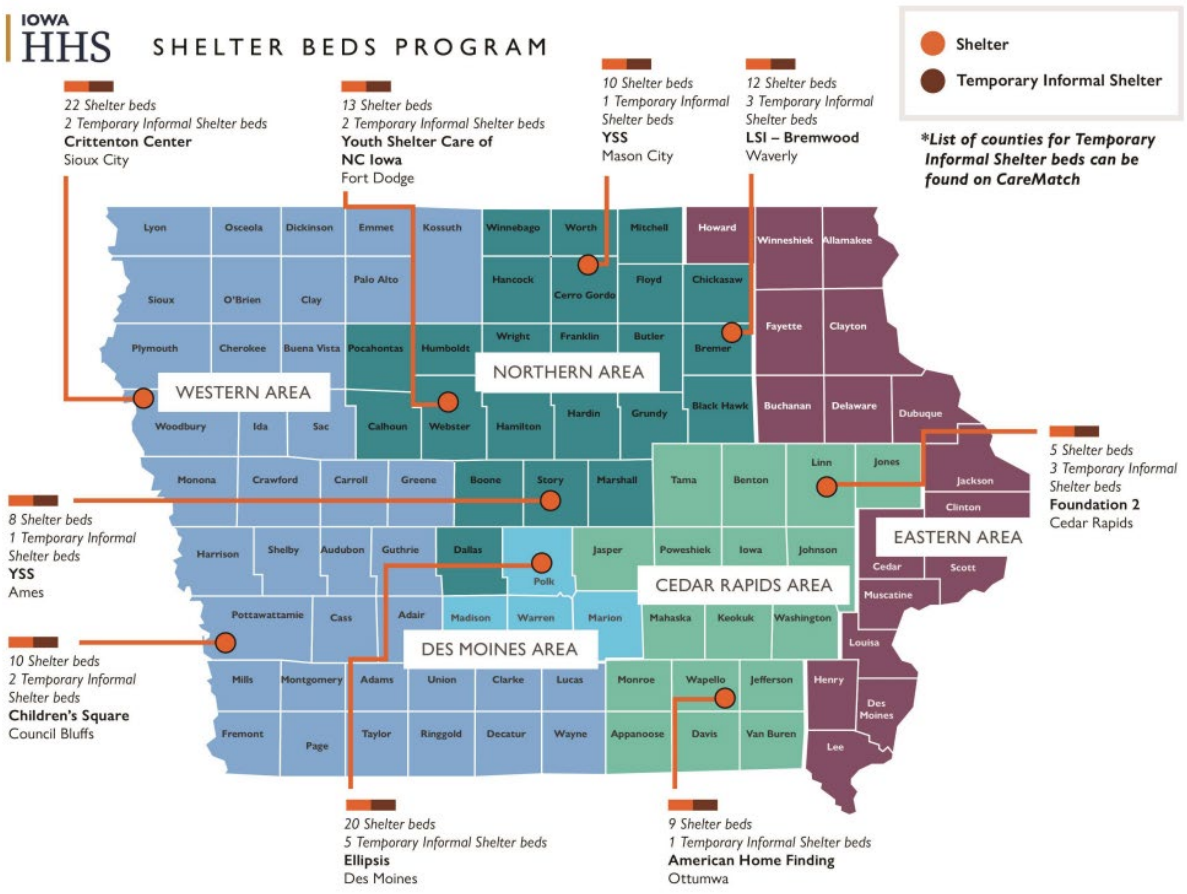
- Contractors will participate with HHS to further develop strategies for and to implement:
- Evidence-based practices;
- Continuity of care for children receiving child welfare services;
- Innovative community-based services that stabilize children and the children's families so that children can return home; and,
- Strategies to engage family members in treatment.

In June 2020, Iowa implemented the transition to Qualified Residential Treatment Programs (QRTP's), with all current foster group care providers becoming QRTP's via a contract amendment with a go live date of July 1, 2020. This shift in practice was made significantly easier by the CISR contracts that were rolled out in 2017 in Iowa. The fundamental ideas of serving youth close to home and transitioning youth to a family-like setting were introduced in these contracts, which aligns well with the implementation of FFPSA. The transition to QRTP included a contract amendment that included the contractor's documentation of; a linkage to 24-hour nursing, their trauma informed treatment model, undergoing a trauma self-assessment, and utilizing an MOU with Family Centered Service contractors for post-discharge service provision for DHS youth. A previous amendment to this contract in April 2020 increased guaranteed bed payments, reduced the number of beds statewide, and provided youth in care with a staff to child ratio of 1:4. In October 2020, final pieces were officially formalized, and Iowa began their official IVE drawdown of funds for DHS youth placed in QRTP's. JCS youth, who also utilize the same programs, are not able to draw down IVE funds as JCS has not finalized a post-discharge service for their youth. JCS does participate in all requirements of QRTP's (clinical assessment, judicial review, length of stay reviews, etc.). During this CFSP reporting period, continued bed adjustments and rate increases were made via contract amendments to better align with the costs of service. QRTP providers now receive a $267/day filled bed rate, and a $200/day unfilled bed rate.

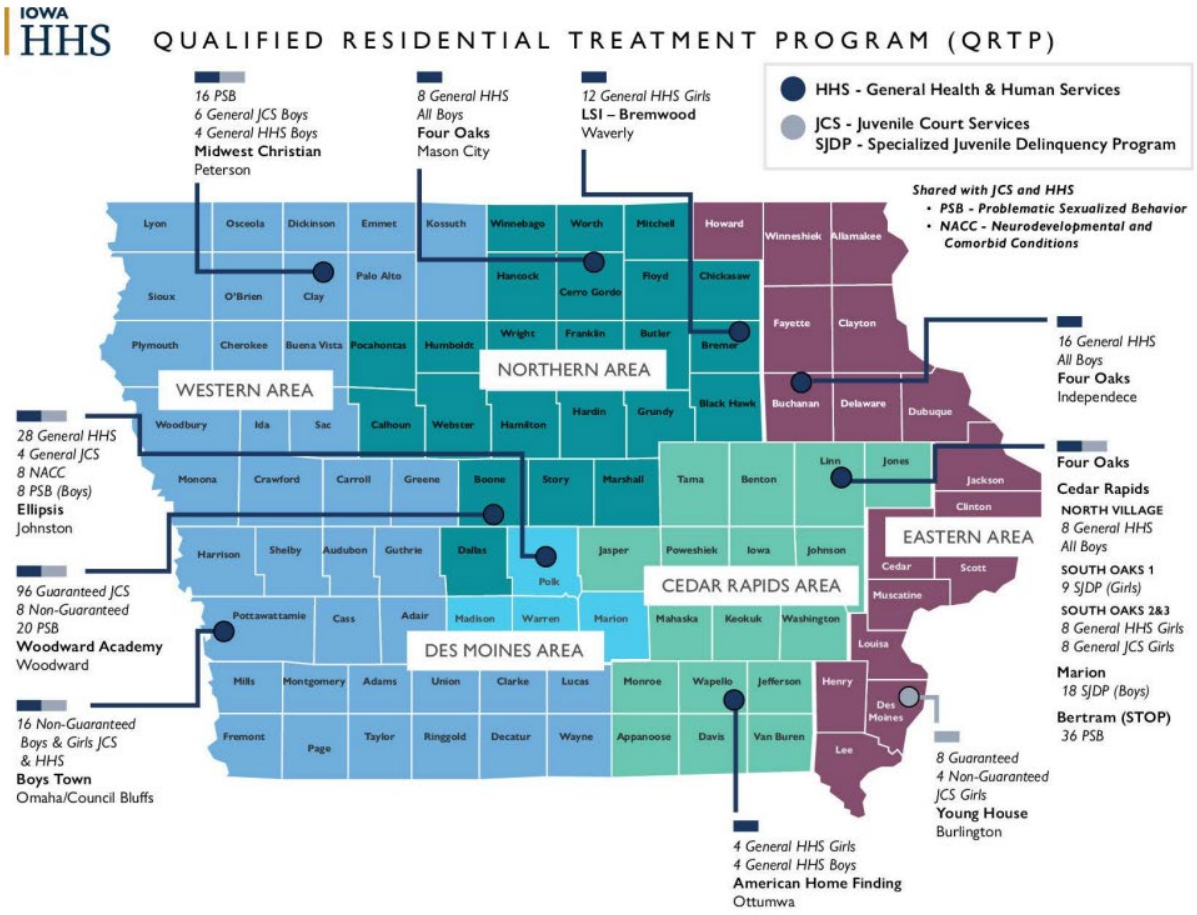
During early 2022, HHS began preparing for a new round of contracts under the CISR umbrella. A core piece of this preparation included Listening Sessions with several key stakeholder groups to discuss what the strengths and needs of the previous contracts were, and what suggestions stakeholders had for how the new contracts could build upon strengths and offer improvement. Ultimately, after an RFP and new contract was written, many core tenants from the previous contracts remain, but some substantive changes were made as well.

See below for an overview of new contract updates:

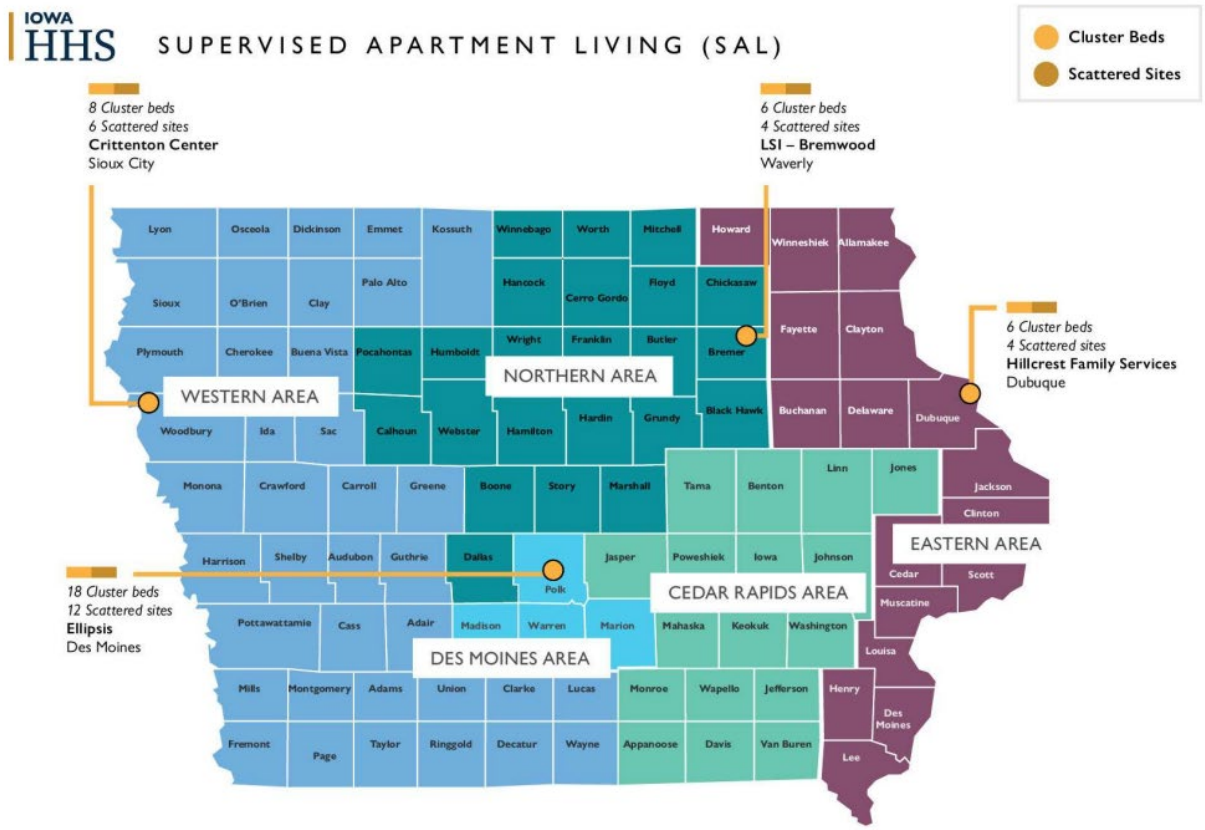
- Child Welfare Emergency Services (CWES)
  - Elimination of Diversion payments due to issues in field with utilization and understanding of services and consistency of services provided across contractors
  - Remaining services offered would include temporary informal shelter beds (no court order) and emergency juvenile shelter care (court order).
  - Temporary informal shelter beds would continue to be offered for 47 hours, and payment would be made via payment/bed structure rather than lump sum payment. - JCS/HHS/Law Enforcement would remain as referral entities for 47-hour beds.
  - Language included in for connection of non-eligible referrals with services.
  - Increased language in for connection with community resources services during and after shelter stays.
  - $20/day supplemental payment to shelter providers for youth in shelter longer than 30 days. After that point it becomes significantly more difficult to manage youth behaviors and treatment needs. Many of these youth are awaiting a different level of care (ICF-ID, PMIC, RBSCL, etc.).



- Qualified Residential Treatment Program (QRTP):
  - Adequate coverage to address the need both statewide and in the service areas for regular QRTP beds, and specialized programs (approximately 30% of beds- NACC, SJDP-male and female, PSB)
  - Continued focus for HHS on placing close to home whenever possible, but will allow for greater flexibility in placement setting/site for JCS cases
  - Continue to utilize No Eject/No Reject process and will utilize a new protocol for staffing referrals/unplanned discharges. These protocols were created in conjunction with the HHS/JCS field staff and providers. Allow a set number of rejects per calendar year per provider based on guaranteed bed size that fall outside the protocol.
  - Created greater separation between HHS and JCS youth, including separate sites/locations based on population. Providers articulated what curriculum/models they will utilize, and how they will program differently for the JCS vs HHS populations. will include information on how they will provide separation between the two populations on their site.
  - Rate increases to address program costs



- Supervised Apartment Living (SAL):
  - Provider-identified and agency approved life skills curriculum will be utilized for youth in SAL. Motivational Interviewing will be utilized as well.
  - Incorporated Positive Youth Development into programming.
  - Incentivized youth completion of program and successful outcomes (school, work, etc.) via performance measures.
  - Emphasized building the youth's informal supports and planning for past-SAL living.
  - Rate increase for SAL which included a request for increased contact for youth in scattered SAL.



Child Welfare Emergency Services

HHS implemented Child Welfare Emergency Services (CWES) statewide beginning with SFY 2012 and the resulting competitively procured contracts carried over into the CFSP of 2015 - 2019. These same contracts remained in place until June 30, 2023. New contracts began on July 1, 2023 and remain in place. CWES (as they existed in the previous contracts ended on 6/30/2023) are fundamentally an array of short term and temporary interventions provided to children (and families) who would ordinarily go to a shelter bed placement. They range from the least restrictive approaches, e.g., crisis or in-home interventions such as family conflict mediations, up to the most restrictive emergency service of out-of-home placement into emergency juvenile shelter care beds (as permitted by the Iowa Code).

During the CFSP period of 2020-2024, the number of contractors varied slightly, but at the end of the report period, there were 9 contractors from around Iowa providing these services. During this period, these services had contract performance measures related to safety, permanency, and well-being. These performance measures were also connected to fiscal incentives.

For the years 2020 through June 30, 2023, of the CFSP, these measures focused on two main initiatives core to the HHS vision of “Family Connections are always strengthened and preserved: diverting youth from entering farther in the formal child welfare or juvenile justice system and discharging youth back into family or family-like settings. In July 2020, however, it was determined that the performance measure related to discharging to family-like settings should be removed, as contractors have little control over discharge setting. For CWES contracts that ended on 6/30/23, the performance measures were:

- **Performance Measure 1 – Divert Children from Placement in Shelter Beds** - In keeping with the Agency's permanency goals and Family-Centered Model of Practice, a key component of CWES shall be to maintain a child in the child's home by providing services in-home and other locations to stabilize situations whenever appropriate and possible. The contractor shall attempt to divert children from placement in shelter beds whenever possible and appropriate.
  - Gold Standard (payment of an additional 5.0% of the measurement quarter's invoiced amount) – Greater than or equal to 85% of children whose shelter alternatives and diversion services ended in the measurement quarter shall not be admitted to shelter for thirty (30) days after the child's CWES shelter alternatives and diversion services case is closed.
  - Silver Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) - Greater than or equal to 75% but less than 85% of children whose shelter alternatives and diversion services ended in the measurement quarter shall not be admitted to shelter for thirty (30) days after the child's CWES alternate services case is closed.

Table 4uu: CWES Performance Measures and Data for SFY 2020 to June 30,2023 - Five Year Average	
Divert from shelter-statewide 5-year average	81.6%
Source: HHS/JARVIS	

- **Performance Measure 2 – Discharge from Shelter Care to Family or a Family-Like Setting** (performance measure ended in July 2020) - In alignment with the Agency's permanency goals and Family-Centered Model of Practice, the contractor shall work to help a child return to their family or a family-like setting. Accordingly, discharge from CWES will be monitored, and contractor may earn additional payment based upon discharge metrics.
  - Gold Standard (payment of an additional 5.0% of the measurement quarter's invoiced amount) – Greater than or equal to 75% of children discharged from shelter care in the measurement quarter will be discharged to their family or a family-like setting.
  - Silver Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) – Greater than or equal to 70% but less than 75% of children discharged from shelter care in the measurement quarter will be discharged to their family or a family-like setting.

Table 4vv: CWES Performance Measures and Data for SFY 2020 (Q1, Q2, Q3: 7/1-2019-3/31/2020)	
Discharge to family-like setting statewide average	53.2%
Source: HHS/JARVIS	

New contracts for CWES have been secured for July 1, 2023. These contracts contain a few major shifts including:

- Focusing the CWES contract on temporary informal shelter beds (47-hour stays with no court order) or emergency juvenile shelter care beds (court ordered). Additional

diversion-type services have been removed from the contract in order to allow shelter contractors to focus solely on serving the youth placed with them.
- In order to address the costs associated with the significant needs of youth who remain in shelter longer than 30 days, HHS will be paying an additional $20/day for youth who remain in shelter longer than 30 days.
- Allowing for greater MCO funding and wraparound support assistance for youth in the shelter setting
- Will be utilizing family mapping, genograms, and tools with youth to assist with identifying formal and informal supports

CWES providers and HHS are both struggling with longer than desirable lengths of stay in shelter. Collaborative work between the two has taken place to put together a protocol for HHS and Shelter staff to follow for youth who are remaining in shelter longer than desired.

CWES providers have begun work on a proposed Shelter Exchange process for youth who are struggling at a particular location. This process would allow for a shelter to “swap” youth with another shelter in order to meet each individual youth in shelter’s needs more effectively.

CWES contractors in Iowa continue to experience significant issues related to hiring and maintaining a quality workforce. HHS continues to partner with contractors and the Coalition for Family & Children’s Services in Iowa to problem-solve this very complicated issue.

Quarterly meetings continue between contractors, HHS and JCS field representatives, and policy staff. These meetings are held to discuss progress or barriers in the programs overall, discuss any updates or changes that have taken place, and to have collaborative discussions about any topics members wish to bring forward.

The new performance measures for the CWES contract starting on July 1, 2023:
- **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.

Table 4ww: CWES Performance Measure 1 Data – 7/1/23 – 12/31/23	
Number of children not admitted to shelter, Foster Group Care/QRTP or Family Foster Care within 90 Days of Temporary Informal Shelter	83
Number of children who received Temporary Informal Shelter Services	152
Performance Measure	69.7%
Source: HHS/JARVIS	

- **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.

Data for first 2 quarters (7/1/23-12/31/23)

Contractor CWES Performance Measure 2 Number of Clients

Percent Totals for all Contracts

Youth with length of stay in emergency juvenile shelter care longer than 30 days do not incur criminal charges or placement in detention during their shelter stay.

Performance Measure Review		SFY24	Q1			Q2			YTD TOTALS		
Contract #	Contractor	Service Area	Eligible D37	Met D38	% Met	Eligible D39	Met D40	% Met	Eligible	Met	% Met
FWBP-CPS 24-017	American Home Finding Association	SA4 Cedar Rapids	9	7	77.8%	6	6	100.0%	15	13	86.7%
FWBP-CPS 24-018	Christian Home Association	SA1 Western	3	3	100.0%	11	11	100.0%	14	14	100.0%
FWBP-CPS 24-019	Florence Crittenton Home	SA1 Western	14	12	85.7%	11	8	72.7%	25	20	80.0%
FWBP-CPS 24-020	Foundation 2, Inc.	SA4 Cedar Rapids	3	3	100.0%	5	5	100.0%	8	8	100.0%
FWBP-CPS 24-021	Lutheran Services in Iowa, Inc.	SA2 Northern	11	11	100.0%	11	7	63.6%	22	18	81.8%
FWBP-CPS 24-022	Ellipsis, Inc.	SA5 Des Moines	22	20	90.9%	16	14	87.5%	38	34	89.5%
FWBP-CPS 24-023	Youth and Shelter Services, Inc	SA2 Northern	8	7	87.5%	8	5	62.5%	16	12	75.0%
FWBP-CPS 24-024	Youth and Shelter Services, Inc	SA2 Northern	4	2	50.0%	2	1	50.0%	6	3	50.0%
FWBP-CPS 24-025	Youth Shelter Care of North Central Iowa, Inc	SA2 Northern	12	9	75.0%	11	8	72.7%	23	17	73.9%
		Total	86	74	85.2%	81	65	78.8%	167	139	81.9%

- **Performance Measure 3** (no payment incentive) - 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.
    - No data available until June 2024.

Foster Group Care Services (FGCS)/Qualified Residential Treatment Programs (QRTP)
QRTP's offer a structured living environment for eligible children considered unable to live in a family situation due to social, emotional, or physical disabilities, but have the ability to interact in a community environment with varying degrees of supervision. Children adjudicated either as a child in need of assistance (CINA) or for committing a delinquent act (delinquents) are court-ordered to this level of care. Some children cannot safely remain in a family home setting due to a need for a more structured environment and more intensive programming to address behavioral issues. For these children, QRTP provides the structure and programming needed in addition to age appropriate and transitional child welfare services.

The contracted service aligns with:

- A safe, structured, and stable living environment for foster care children unable to live in a family situation;
- Compliance with all required licensures, certifications, or approvals;
- Acceptance of all referrals and provide contracted services on a no reject, no eject basis (with the understanding that individual cases may be reviewed with the DHS);
- Facilitating child development and the acquisition of age-appropriate life skills; Helping each child develop and maintain relationships with the child's family and community and ensure each child stays connected to their kin, culture, and community; and
- Support of a child's education and ensuring the child continues to attend the child's school of origin whenever that is in the child's best interest.

As with CWES, the number of contractors varied slightly during this CFSP period. At the end of the report period, there were 7 contractors from across Iowa providing these services (some

contractors operate multiple locations). During the CFSP period, the fundamental service of QRTP did not significantly change, however, approaches to contracting, using, and funding the service transitioned over the course of the CFSP.

In June 2020, Iowa implemented the transition to Qualified Residential Treatment Programs (QRTP's), with all current foster group care providers becoming QRTP's via a contract amendment with a go live date of July 1, 2020. This shift in practice was made significantly easier by the CISR contracts that were rolled out in 2017 in Iowa. The fundamental ideas of serving youth close to home and transitioning youth to a family-like setting were introduced in these contracts, which aligns well with the implementation of FFPSA. The transition to QRTP included a contract amendment that included the contractor's documentation of; a linkage to 24-hour nursing, their trauma informed treatment model, undergoing a trauma self-assessment, and utilizing an MOU with Family Centered Service contractors for post-discharge service provision for DHS youth. A previous amendment to this contract in April 2020 increased guaranteed bed payments, reduced the number of beds statewide, and provided youth in care with a staff to child ratio of 1:4. In October 2020, final pieces were officially formalized, and Iowa began their official IVE drawdown of funds for DHS youth placed in QRTP's. JCS youth, who also utilize the same programs, are not able to draw down IVE funds as JCS has not finalized a post-discharge service for their youth. JCS does participate in all requirements of QRTP's (clinical assessment, judicial review, length of stay reviews, etc.). During this CFSP reporting period, continued bed adjustments and rate increases were made via contract amendments to better align with the costs of service. QRTP providers now receive a $267/day filled bed rate, and a $200/day unfilled bed rate.

Iowa defines a QRTP as a specific category of a non-foster family home setting. These placements must meet detailed assessment, case planning, documentation, judicial determinations and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive title IV-E FCMPs for the placement (sections 472(k)(1)(B) and 475A(c) of the Act). The facility must meet the definition of a CCI at sections 472(c)(2)(A) and (C) of the Act, including it must be licensed (in accordance with section 471(a)(10) of the Act) and that criminal record and child abuse and neglect registry checks must be completed in accordance with section 471(a)(20)(D) of the Act. Further, it must be accredited by one of the independent, not-for-profit organizations specified in the statute or one approved by the Secretary.

Procedure in Iowa for QRTP eligibility and placement

First, consider placing the child in a relative or fictive kin's home. Only if no relatives or other stable, caring adults known to the child are available or willing to accept placement, or such placement would be detrimental to the child's physical, emotional, or mental well-being, will placement in a licensed foster home occur. If a youth has mental or behavioral needs that preclude him or her from residing in a family or family-like setting, then the worker pursues placement in a QRTP. The worker will document the reasons for using a more restrictive placement in the child's case permanency plan.

In order to receive federal reimbursement in a QRTP, the child must have an assessment by a qualified individual not associated with the public agency or the residential program, within 30 days of placement. In Iowa, the qualified individual is a Licensed Practitioner of the Healing Arts (LPHA). The preference would be for this clinician to have a working relationship with the child/family, for example a current therapist or mental health provider. If the child/family were currently not accessing this type of service, the second option would be to utilize an LPHA

provided by the CWES contractors across the state. All CWES/Shelter providers have identified a clinician to assess children for QRTP placement, regardless of whether or not the child physically resides in the CWES/Shelter. Finally, through a waiver granted by the Federal government, the clinical assessment can be completed by a clinician at a QRTP if the youth is unable to secure an assessment via another option.

The LPHA clinician must work with a family and permanency team assembled by the agency while making the assessment. This assessment must use an age-appropriate, evidence-based, validated, and functional assessment tool to assess the child's strengths and needs. In Iowa, the chosen tool is the Treatment Outcome Package (TOP). The assessment shall determine if family members or another appropriate placement can meet the child's needs, consistent with the child's short and long-term goals, in the least restrictive setting consistent with the child's permanency plan. The assessment must also document why having the child/youth live with a foster family or one of the other acceptable non-family foster home settings cannot meet their needs and why a QRTP is the most effective and appropriate level of care for the child/youth. Note - lack of sufficient foster families is not an allowable reason. The assessment shall document the family and permanency team's placement preference that acknowledges the importance of keeping siblings together and if their preference is different from that of the assessor's, the reason why the preferences of the child and the team are not recommended. Finally, the assessment must develop a list of child-specific short- and long-term mental and behavioral health goals. This assessment is a Medicaid-billable service.

It is preferable for a child to have the clinical assessment completed and the recommendation for QRTP as the appropriate level of care made prior to a child being placed in a QRTP. However, some circumstances in Iowa do require a child to be placed in a QRTP and have the clinical assessment completed within 30 days of placement. In circumstances where the assessment is completed prior to placement, the assessment will be part of the referral packet sent to QRTP providers and maintained in the HHS/JCS file through an upload into JARVIS. Follow the orders of the juvenile court when it has been determined that a QRTP placement is in the best interest of the child then follow your Service Area protocol for making a referral to a specific agency.

If the assessment did not occur within 30 days of placement, IV-E reimbursement of foster care maintenance costs is unavailable for the entire placement episode and the state must incur all costs. If the assessment does not support the QRTP placement, the state has 30 days to move the child to an eligible placement or risk losing federal reimbursement. If a state opts to forego completion of an assessment, the state may still place the child into the QRTP setting but IV-E reimbursement for foster care maintenance costs will cease after the first 14 days of placement. Within 60 days of the placement in QRTP, the court must decide that the child's needs cannot be met in a family-like setting and that the QRTP provides the most effective and appropriate level of care in the least restrictive environment. The court must review the clinical assessment/TOP in order to make this determination. In Iowa, at the time of the issuance of the court order for QRTP, HHS/County Attorney will make a motion asking the judge to review administratively the assessment within 60 days. HHS/JCS will upload the assessment as an exhibit for the judge to access to complete this review. Upon completion of the administrative review, the judge will issue an order indicating their decision. HHS/JCS will maintain this order in a legal file, uploaded into JARVIS, and maintained in the court file.

If at the 60-day point, the court has not approved the placement or the court disapproves of the placement, federal IV-E reimbursement terminates for any portion of the placement.

A key component of QRTP's is 6 months of aftercare services after a child leaves care. In Iowa, Family Centered Service providers will be the mechanism for QRTP aftercare for DHS youth, which Iowa is calling post-discharge services, via a Memo of Understanding between FCS providers and QRTP's. One month of overlap in services will occur while QRTP provides contractual discharge support as well.

The last major component of QRTP in Iowa is a thorough review that should take place to determine whether the youth needs to remain in QRTP and that all other options have been explored. This review must also have sign-off from the Director of HHS. In Iowa, the benchmarks at which reviews take place are: For every youth placed in QRTP for more than 12 consecutive months or 18 nonconsecutive months; Or a youth who has not attained age 13yo but has been placed in a QRTP more than six consecutive or nonconsecutive months. Iowa has implemented a two-step group review process to ensure that these reviews are completed, and that youth are accessing a family-like setting as soon as they are able.

The Performance Measures and data for the contracts that existed for the majority of this CFSP period (ended 6/30/23) are below, including some 5-year or summary data.

- **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 after discharge. Accordingly, discharge from and return to FGCS will be monitored, and the contractor may earn additional payment based on low levels of return to FGCS among CINA Youth. The Agency will be responsible for determining who is re-admitted to FGCS.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) – Greater than or equal to 93% of CINA children discharged from FGCS in the measurement quarter will not return to FGCS within one (1) year.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) – Greater than or equal to 90% but less than 93% of CINA children discharged from FGCS in the measurement quarter will not return to FGCS within one (1) year.

Iowa Department of Human Services

FGCS - PM 1 - Return to Group Care for CINA Youth

Performance measure for
Date range : **7/1/2019** to **6/30/3023**,
Service Area : **Statewide** &
Provider(s) : **All Providers**
generated on **1/17/2024 10:26:01 AM** is as follows -

Number of children not re-admitted to FGCS:	**409**
Number of children who exited FGCS:	**700**
Performance measure:	**58.4%**

- **Performance Measure 2– 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.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) – Greater than or equal to 75% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting. For children who have been referred to and placed in a bed designated for…NACC or Specialized Delinquency Program, greater than or equal to 65% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) – Greater than or equal to 65% but less than 75% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting. For children who have been referred to and placed in a bed designated…for NACC or Specialized Delinquency Program, greater than or equal to 55% but less than 65% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.

Iowa Department of Human Services

FGCS - PM 3 - Discharge to a Family-Like Setting

Performance measure for
Date range : **7/1/2019** to **6/30/2023**,
Service Area : **Statewide** &
Provider(s) : **All Providers**
generated on **1/17/2024 10:30:32 AM** is as follows -

NACC Only

Number of children who exited to a family or family like setting:	5
Number of children who exited FGCS:	21
Performance measure:	23.8%

SJDP Only

Number of children who exited to a family or family like setting:	31
Number of children who exited FGCS:	47
Performance measure:	66%

QRTP Only

Number of children who exited to a family or family like setting:	1213
Number of children who exited FGCS:	2337
Performance measure:	51.9%

Combined

Number of children who exited to a family or family like setting:	1249
Number of children who exited FGCS:	2405
Performance measure:	51.9%

- **Performance Measure 3 -Reduction in Recidivism** is hereby added to the contract: 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 will be monitored, and the contractor may earn additional payment based upon low levels of recidivism.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount)- Greater than or equal to 60% of youth discharging from treatment shall not recidivate within a twelve-month period after date of discharge from service.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) -Greater than or equal to 45% but less than 60% of youth discharging from treatment shall not recidivate within a twelve-month period after date of discharge from service.

Table 4xx: FGCS PM 3	7/1/22-9/30/22	10/1/22-12/31/22	Total
Number of Youth Exited	11	13	24
Number of Youth who recidivated	7	1	8
	64%	8%	33%
Source: HHS			

Some collaborative changes that have occurred during this CFSP reporting period include:

- QRTP contractors in Iowa are experiencing significant issues related to hiring and maintaining a quality workforce. HHS continues their work with contractors and the Coalition for Family & Children's Services in Iowa to problem-solve this very complicated issue. Several providers had to reduce guaranteed bed numbers temporarily due to a lack of staff to maintain ratio and safety. HHS implemented a process to allow for these temporary reductions within the contract, and to work collaboratively with the provider to meet and get regular updates on hiring and retention efforts, staffing patterns, etc. Most providers were able to gain staff and return to guaranteed bed numbers within approximately 3 months. This workforce issue impacted the total number of bidders and contractors in the round of contracts beginning July 1, 2023.
- Iowa will continue to evaluate the need for congregate out-of-home placements in light of declining group care populations. Iowa has continued to shift dramatically downward in the number of group care placements utilized (specifically on the HHS side). Current data indicates approximately 400 guaranteed beds are needed to provide the most efficient access to services for youth. The new contract period began in July 2023 with 361 beds. Iowa is rare in that both JCS and HHS youth utilize the same QRTP placements, at a breakdown of usage of approximately 60% JCS and 40% HHS. Discussions about challenges with this shared usage led to the collaborative approach of the RFP and contracts beginning July 1, 2023, which include much greater separation between the two populations.
- In January 2022, a new Specialized Juvenile Delinquency Program (SJDP) program was added under the QRTP umbrella to serve high-risk delinquent youth. Two 9-bed male programs were implemented to serve JCS youth-only at a 1:3 staffing ratio. These programs are separate from other QRTP programming and utilize staff-secure or locked units. One contractor provides a locked unit, and the other a staff-secure unit. During the course of this calendar year, the program providing a locked unit closed due to a desire to no longer offer residential services in the future. It was fortunate that the other program remaining was able and willing to absorb those beds, so the state only had to endure a short-term reduction during the transition of beds. No locked units are used after this transition. The program, which meets the criteria for a QRTP, utilizes an integrated and comprehensive treatment approach that is strength-based and focuses on positive behavior strategies. Under the contract beginning July 1, 2023, 9 female beds will be added to the existing 18 male beds. This program has its' own specific Performance Measure, JCS-led data dashboard tracking elements, and referral review process.
- Current QRTP contractors are also a part of an initiative to better leverage HHS internal resources to support residential partners. Dr. Derek Hess, HHS Clinical Manager, has been working in partnership with The Coalition for Family and Children's Services in Iowa and the HHS Program Manager for Youth Residential Settings to tour facilities and

meet with coalition members. During these meetings, Dr. Hess provides technical assistance to agencies who support at risk children. “This public-private partnership is using a shared model of reform to improve the services and supports for youth and families in Iowa," said Dr. Hess. "We’re collaborating – honestly and courageously – to shift our collective perspective, address our growth edges, and leverage our strengths. It is exciting to be a part of such a committed and energized team.”

- QRTP providers have created a QRTP Exchange process for youth who are struggling at a particular location. This process allows for a QRTP to “swap” youth with another QRTP in order to meet each individual youth in QRTP’s needs more effectively. QRTP providers meet and propose the swap plan to field HHS or JCS staff for approval.
- Quarterly meetings continue between contractors, HHS and JCS field representatives and policy staff. These meetings are held to discuss progress or barriers in the programs overall, discuss any updates or changes that have taken place, and to have collaborative discussions about any topics members wish to bring forward. Quarterly meetings are also held between QRTP contractors and FCS contractors to discuss post-discharge services progress, barriers, etc.

New Performance Measures for the contract beginning July 1, 2023 are below. Data is included for the first 2 quarters of the contract if available.

- **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.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) – Greater than or equal to 93% of CINA children discharged from FGCS/QRTP in the measurement quarter will not return to FGCS within 365 days.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) – Greater than or equal to 90% but less than 93% of CINA children discharged from FGCS/QRTP in the measurement quarter will not return to FGCS within 365 days.
- **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 (SJDP) will be monitored, and the contractor may earn additional payment based upon low levels of recidivism.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount)- Greater than or equal to 60% of youth discharging from SJDP treatment shall not recidivate within a twelve-month period after date of discharge from service.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) -Greater than or equal to 45% but less than 60% of youth discharging from SJDP treatment shall not recidivate within a twelve-month period after date of discharge from service.

- **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.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount) – Greater than or equal to 75% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.
        - For children who have been referred to and placed in a bed designated…for NACC, greater than or equal to 65% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) – Greater than or equal to 65% but less than 75% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.
        - For children who have been referred to and placed in a bed designated…for NACC, greater than or equal to 55% but less than 65% of children discharged from FGCS in the measurement quarter will be discharged to family or a family-like setting.

NACC Only

Number of children who exited to a family or family like setting:	1
Number of children who exited FGCS:	3
Performance measure:	33.3%

SJDP Only

Number of children who exited to a family or family like setting:	13
Number of children who exited FGCS:	22
Performance measure:	59.1%

QRTP Only

Number of children who exited to a family or family like setting:	78
Number of children who exited FGCS:	170
Performance measure:	45.9%

Combined

Number of children who exited to a family or family like setting:	92
Number of children who exited FGCS:	195
Performance measure:	47.2%

- **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.
    - Gold Standard (payment of an additional 2.5% of the measurement quarter's invoiced amount)- Greater than or equal to 50% of youth discharging from FGCS/QRTP shall not recidivate within a twelve-month period after date of discharge from service.
    - Silver Standard (payment of an additional 1.5% of the measurement quarter's invoiced amount) -Greater than or equal to 35% but less than 50% of youth discharging from FGCS/QRTP shall not recidivate within a twelve-month period after date of discharge from service.

Supervised Apartment Living

Supervised apartment living (SAL) offers older youth needing foster care the opportunity to transition to independent living while still receiving supervision, support, and assistance including skill development. SAL comprises two types of living arrangements: 1) cluster site arrangements and 2) scattered site arrangements.

The cluster site arrangement houses up to six youth on a single site with around the clock supervision anytime more than one youth is present. Youth must be at least 16½ years of age to be eligible for SAL cluster site arrangements.

Scattered site arrangements are for youth in their own living arrangement, typically an apartment. Youth must be at least 17 years of age to be eligible for SAL scattered site arrangements.

Contract requirements and administrative rule changes aligned with the performance measures say that youth must first move through cluster site living before living in a scattered site. The purpose is to better prepare youth by developing skills needed to have their own households, understand how to get around to support services or jobs or recreation, create responsible budgets and develop banking habits, pay their bills, etc.

Contractors believe this shift benefits the youth in the program and they see an improvement in the referrals, i.e., the youth referred benefit from this new requirement; the youth referred to the service are more appropriate to the service; and SAL is now more of the program it is intended to be.

HHS implemented Supervised Apartment Living programming statewide beginning with SFY 2012 and the resulting competitively procured contracts carried over into the CFSP of 2015 - 2019. These same contracts remained in place until June 30, 2023. New contracts began on July 1, 2023 and remain in place. Throughout the CFSP period, the SAL program's main goal was to prepare youth to successfully transition to young adulthood by teaching them life skills necessary for successful transition from foster care as the youth aged out. During years 2020-2024 CFSP, the HHS contracted with up to six child welfare agencies across Iowa. As of the writing of this report, HHS contracts with four agencies, and offers SAL cluster and scattered site in four of the five HHS service areas. The SAL program served between approximately 100

-140 youth annually during the period. Most of the contractors provided services in Iowa's more urban areas; primarily due to availability of apartment units and landlords willing to rent to youth under the age of eighteen and the availability of a richer array of community services. During the contracts in place up to July 1, 2023, the below Performance Measures were tracked. These two measures below were also tied to fiscal incentives, to emphasize the goals identified as most important by HHS. Summary data is also included.

- **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.
    - Gold Standard (payment of an additional 5.0% of the measurement period invoiced amount) - Greater than or equal to 60% of children transitioning out of SAL in a six-month measurement period are transitioning at age 18, or older as permitted by law and regulations, or discharging to their family, a family-like setting, or Positive Support System Placement. This will be calculated for each six-month measurement period.
    - Silver Standard (payment of an additional 2.5% of the measurement period invoiced amount) - Greater than or equal to 50% and less than 60% of children transitioning out of SAL in a six-month measurement period are transitioning at age 18, or older as permitted by law and regulations or discharging to their family, a family-like setting, or Positive Support System Placement. This will be calculated for each six-month measurement period.

Table 4yy: SAL PM 1 - 7/1/19-6/30/23	
Number of children who age out or exited to a family/family like setting	266
Youth who exited the SAL program	381
Performance measure:	69.8%
Source: HHS	

- **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 so as to promote the child's success in early adulthood.
    - Gold Standard (payment of an additional 5.0% of the measurement period's invoiced amount) - Greater than or equal to 85% of Aftercare-eligible children in the measurement period will have engaged in at least two contacts during the calendar month of discharge or any of the six full calendar months immediately following the child's date of discharge from SAL, as reported by the Aftercare services provider. A contact occurs in person for a minimum of 30 minutes. This will be calculated for each six-month measurement period.
    - Silver Standard (payment of an additional 2.5% of the measurement period's invoiced amount) - Greater than or equal to 75% but less than 85% of Aftercare-

eligible children in the measurement six-month period will have engaged in at least two contacts during the calendar month of discharge or any of the six full calendar months immediately following the child's date of discharge from SAL, as reported by the Aftercare services provider. A contact occurs in person for a minimum of 30 minutes. This will be calculated for each six-month measurement.

Table 4zz: SAL PM 2 - 7/1/19-6/30/23	
Number of children engaged in at least 2 Aftercare services contacts in one month period within 180 days after exit	113
Youth who exited the SAL program	209
Performance measure:	54.1%
Source: HHS	

As mentioned previously, a new round of contracts began on July 1, 2023, with the below changes incorporated:

- Provider-identified and agency approved life skills curriculum will be utilized for youth in SAL. Motivational Interviewing will be utilized as well.
- Incorporated Positive Youth Development into programming.
- Emphasized building the youth's informal supports and planning for past-SAL living.
- Rate increase for SAL which included a request for increased contact for youth in scattered SAL.

These new contracts also placed a renewed emphasis on stability while in SAL programming and engagement with Aftercare. New Performance Measures were added to also highlight acquisition of Life Skills, and the youth gaining informal supports while in SAL. HHS also adjusted payment methodology on some performance measures to highlight positive work with individual youth, instead of just an overall attainment of a set percentage. See below for an outline of new performance measures and some initial data collected on stability since changes to the measures on July 1, 2023.

- **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.
    - Gold Standard (payment of an additional 5.0% of the measurement period invoiced amount) - Greater than or equal to 70% of children transitioning out of SAL in a six-month measurement period are transitioning at age 18, or older as permitted by law and regulations, or discharging to their family, a family-like setting, or Positive Support System Placement. This will be calculated for each six-month measurement period.
    - Silver Standard (payment of an additional 2.5% of the measurement period invoiced amount) - Greater than or equal to 60% and less than 70% of children transitioning out of SAL in a six-month measurement period are transitioning at age 18, or older as permitted by law and regulations or discharging to their

family, a family-like setting, or Positive Support System Placement. This will be calculated for each six-month measurement period.

Table 4aaa: SAL PM 1 - 7/1/23-1/1/24	
Number of children who age out or exited to a family/family like setting	16
Youth who exited the SAL program	25
Performance measure:	64%
Source: HHS	

- **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.
    - For each youth discharged in the measurement period that has shown improvement in their Casey Life Skills Assessment from pre-placement to discharge from SAL, the contractor will receive payment of $100.00. This will be calculated for each six-month measurement period.
- **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.

THE STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM

Program Goals:

- Protecting and promoting the welfare of all children.
- Preventing the neglect, abuse, or exploitation of children.
- Supporting 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.

- Promoting the safety, permanence, and well-being of children in foster care and adoptive families.
- Providing training, professional development and support to ensure a well-qualified child welfare workforce.

Over the five-year period, HHS utilized title IV-B, subpart 1, funding as indicated on the respective CFS-101s 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 following:

- Family Preservation Services, pp 126-127; 131-133
- Family Centered-Services, pp 120-137
- Parent Partner program, pp 178-197
- Recruitment, Retention, Training, and Supportive Services (RRTS), pp 137-149
- Foster Group Care Services – pp 156-165

SERVICES FOR CHILDREN ADOPTED FROM OTHER COUNTRIES

Families who adopt children from other countries 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 has done the following over the past five-year period:

- Worked 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

Over the five-year period, Iowa utilized its child welfare service array to meet the unique needs of children and families served, which included children under the age of five remaining in the home or in foster care. These services included but were not limited to:

- Prior to July 1, 2020: Community Care, Family Safety, Risk and Permanency (FSRP) services, and SafeCare®, provided by Community Care or FSRP providers.
- Effective July 1, 2020, Iowa's child welfare service array changed. HHS awarded contracts for family-centered services, packaged services, with community based social service providers. The different packages of services include the following:
  - Solution Based Casework® (SBC);
  - Family Team Decision-Making (FTDM) Meeting and Youth Transition Decision-Making (YTDM) Meeting Facilitation
  - SafeCare®; and
  - Family Preservation Services, Child Safety Conference Facilitation, and Motivational Interviewing

  Please see **Family Centered Services (FCS)** earlier in this section for more information about these services and changes in program design that occurred over the five-year period.

Additionally, HHS provided the following services throughout the five-year period:

- Childcare
- Referrals to Early ACCESS (described below)
- Referral of parents to mental health, substance abuse, domestic violence, employment, and disability services, etc.
- HHS social work case managers (SWCMs) discussed Head Start and Early Head Start services with families, with the families' accessing services through direct application to the programs.

HHS' child protective workers (CPWs), as part of their assessment of child abuse allegations, inclusive of safety and risk assessments, assessed the strengths and needs of the children and the family. The HHS' SWCMs built 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 remains 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 provided oversight of the SWCMs' assessment of and provision of age-appropriate services to children.

EARLY ACCESS (IDEA Part C)

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 Services (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.

CFSP Final Report Summary:
Over the last CFSP period (2020-2024) there has been refinements and enhancements to the EA program that have supported the overall CFSP goal to strengthen the EA program through improved processes and procedures, staff training and increased collaboration between the partnering agencies. Ultimately, these efforts are intended to increase and facilitate the number of referrals and services provided to the children and families. Following is a summary of the program changes that have been enacted over the 2020-2024 reporting period.

An enhancement that was implemented at the end of the prior CFSP period (October 2018) was an automatic referral process to EA for children under the age of three that meet the CAPTA referral criteria. When a case meets the criteria, the state child welfare information system (CWIS) generates an email which is sent to the Iowa Family Support Network (IFSN) with the referral information. IFSN then forwards the referral information to the Area Educational Agency (AEA) or Child Health Specialty Clinics (CHSC) who provides EA services. A Service Coordinator (SC) from the AEA or CHSC then contacts the family directly within two business days to discuss early intervention services and offer a screening or evaluation. While HHS' system automatically generates a referral to EA, services are voluntary. Parents have the right to decline EA services at any time. More recently, the automatic referral system has been modified to go through the HHS EA Liaison to review and input referral information directly into

the ACHIEVE system. This has allowed for improved accuracy, ensuring children who have been placed outside of the home are referred with the correct location/contact information. This practice has prevented duplicate and inaccurate referrals, as well as preventing families from receiving a referral call in the event a child has passed away. For a period, the HHS EA Liaison was directly contacting referrals in an effort to boost engagement. This practice shifted back to AEA/CHSC completing the outreach as there wasn't a substantial change in enrollments, which allowed the EA Liaison to focus on other efforts.

Role of HHS Social Worker: While the implementation of the automated system ensures that all eligible HHS children who meet the CAPTA criteria are referred to the EA, there was concern regarding the family awareness of the program, referral process and the number of families who were actually accepting services. In an effort to address these concerns, HHS reviewed the referral process and refined the role of HHS social workers as follows.

Child protection workers (CPWs) are responsible for informing families about the child's referral to EA during a child abuse assessment. Social work case managers (SWCMs), who handle ongoing child welfare cases, may also inform families of EA services at any time during the provision of case management services. In addition, re-referrals for a child may occur by the SWCM at any time if the family declined services when substantiation of the case occurred or if a concern arises that the child may have a delay that would be eligible for services. Social Workers also can refer siblings in the home who are at risk of a delay but who are not identified as a victim.

For those families interested in EA services, the CPW or the SWII will offer to make a referral or provide the family with information on how to self-refer. Regardless of stated interest, all eligible families receive automatic referral to the appropriate CHSC/AEA.

Handouts & Flyers: To better inform families of the EA program and services professional handouts and flyers were designed and distributed statewide to HHS workers to share with families as they discuss the referral process and the EA services. HHS workers were also directed to online resources that are available to families in Iowa.

Training: EA training has now become part of the basic training that all new workers receive. The training for CPWs and SWCMs focuses on potential developmental delays in children and provides instructions on how to encourage families to participate in eligible services and how to make meaningful referrals to EA. Additional, ongoing training with a focus on screening for mental health, substance abuse, and/or domestic violence issues has since been developed and is mandatory for all HHS supervisors and workers. EA information is included during this training to assist workers in referring families to EA services, even if there is not a substantiated case of abuse following the assessment (i.e., in the case of Family Assessments).

HHS EA Liaison: The Department of Health and Human Services now has an HHS Liaison dedicated to the EA program. CAPTA funding was used to establish this position in an effort to better inform social workers about the benefits of EA. The HHS Liaison participated in social worker meetings, presented on a monthly call that included Social Worker Administrators, and sent EA informational brochures to the HHS Service Areas. Through the field communication system, all social workers, supervisors, and administrators received additional information on EA. Overall, the meetings and trainings for HHS field staff increased awareness of the EA program and its benefits.

Collaboration: The HHS Liaison also worked in collaboration with IDE, IDPH, CHSC, and AEAs across the state. Beginning in SFY 2024, the departments of Public Health and Human Services merged into one state department of Health and Human Services. Both departments previously had staff dedicated to supporting Early Intervention services. Both of these roles continue efforts, with one Liaison housed in the HHS Division of Community Access and one Liaison in the HHS Division of Family Well-Being and Protection. Regularly scheduled meetings include a core State Team comprised of six IDE employees with expertise in areas such as, early intervention federal compliance, information technology, autism spectrum disorders, professional development, and Part B special education services. The state Part C Coordinator and Administrative Consultant are among the IDE staff. The State Team also consists of Liaisons from CHSC and two Liaisons with HHS. This team meets twice a month to fulfill their commitment to:

- provide early intervention services and
- support components needed for a coordinated system.

The Iowa Council for Early ACCESS (ICEA) is a parent led Council that advises and assists the IDE in the planning, coordination, and delivery of services to infants and toddlers with special needs and their families. Meetings are held five times a year and consist of parents whose child have received early intervention, IDE, HHS, CHSC, AEA Special Education Directors, AEA Liaison, IDE Counsel, Iowa Insurance Division, and Higher Education, among other community partners. Membership is determined by the Governor's office through an application process.

ICEA Executive Committee meets five times a year to determine the Iowa Council meeting agendas. The agendas include federal compliance, data analysis, parent stories, and topics such as legislation for the current year that may affect early intervention. Executive Committee includes the EA signatory agency staff, Bureau Chiefs, Liaisons, IDE Administrative Consultant, and the Early ACCESS Part C Coordinator.

Early ACCESS regional and community grantees include the nine AEA regions and CHSC. These grantees ensure EA services are carried out across the state. Meetings with AEA's are held six times a year and include the State Team, IDE Administrative Consultant, AEA Special Education Director Liaison, and Liaisons from each of the nine AEA regions.

HHS utilized CAPTA funds for the HHS Liaison to EA to travel to each of the HHS Service Areas to present EA information and to distribute materials for social workers and families. Additional information was provided during this training to assist in referring families to EA. Representatives from local AEAs assisted the HHS Liaison with five presentations on EA services and the collaborative efforts taking place under this program, followed by a question-and-answer session.

COVID: During COVID, early intervention services were provided virtually through varied strategies. Some AEA's provided electronic devices such as iPads and computers, while others relied on smart phones. Each AEA had their own process, but all still provided services virtually. AEA's found strengths in virtual services and have some families still requesting some remote services, rather than fully in home. HHS Director provided IDOE and schools with information on how to keep school children safe in their homes virtually with ideas like asking the child to turn on their camera for attendance. The AEA's utilized this same method by asking the family to see their child on the screen at times.

SFY 2024: SFY20 24 was a year of change for Early ACCESS. Previously, the .75 FTE Early ACCESS liaison position was managed through a contract with Iowa State University and an MOU between the Department of Human Services and the Department of Education. The Bureau of Childcare was responsible for direct supervision of the liaison. In February 2023, due to a major merger between the Department of Human Services and the Department of Public Health (now Iowa HHS), the previous Division of Adult Child and Family Services became the Division of Family Wellbeing and Protection. A new business unit, Early Intervention and Support was instituted in the new Division. The Early ACCESS position moved to this new business unit for supervision.

The individual holding the liaison position vacated the position in July 2023. During the term of this vacancy, the CAPTA referrals were completed by an Early ACCESS liaison in another Division at Iowa HHS and an administrative support staff member from Family Wellbeing and Protection. There was no lag in the referral process while the training and stakeholder engagement activities were paused.

In July 2023, discussions began with the Department of Education about the limitations associated with the current Early ACCESS service model and the impact of those limitations on children who are referred through CAPTA. The major limitations were noted as:

- The short turnaround for completing referrals and questions regarding the requirements during this timeframe.
- The limited understanding of the purpose of the screening and the services by families.
- The rate of acceptance of screening and services by families and caregivers.
- The potential for connecting siblings of the child referred through CAPTA for screening and services.
- The missed opportunities for children who are over 2.75 years old and not enrolled in preschool, Head Start, or Early Head Start.
- Lack of a closed loop referral process between the various services available to and needed by families and caregivers.
- Limited follow-up attempts as the child ages.
- The challenges associated with billing for services noted by providers.

Several discussions and presentations were held during the summer and early fall of 2023. Stakeholders agreed that these issues, and others, should be addressed. Partners agreed that a full-time position, managed by one entity was needed. As a step forward, the contract with Iowa State University was ended, management was directed to the Early Intervention and Support Director at Iowa HHS, and the full-time position was posted in late fall 2023. The new full-time Early ACCESS Coordinator will begin employment on March 1, 2024. This position will provide education and training, stakeholder engagement, project planning and management, and will complete the CAPTA referrals. There will be a strong emphasis on data-driven decision making and building solutions to the current limitations.

A Kaizen event will be held in the summer of 2024 to assess the current status of the program and identify opportunities for improvement. A comprehensive list of stakeholders will be invited. Meetings have already begun to ensure stakeholders are aware of the plans and gather essential input ahead of the event. The results of the planning event will be used to develop an action plan to be carried out by the Early ACCESS Program Coordinator with stakeholders.

Early ACCESS data: The table below reflects the number of CAPTA children (those referred following a Child Protective Assessment) and the number of children that went on to receive services from Early ACCESS through an Individualized Family Service Plan (IFSP):

Table 4bbb: Children who receive Early ACCESS services (following a CPA)			
SFY	**# of Children referred**	**# of Children receiving services**	**Percent of children on IFSP**
2023	2446	209	8.5%
2022	2581	314	12.2%
2021	2483	241	9.7%
2020	2452	333	13.6%
2019	2596	449	17.3%

Total children referred between 2019 and 2023 ranged from 2452 in SFY 2020 to 2596 in SFY 2019, with an average of 2512 each year. Number of children receiving Early ACCESS services ranged from the highest in SFY 19 of 449 children to the lowest rate of 209 in SFY 23. In general, numbers trended down between SFY 19 and SFY 21, with numbers increasing in FY 22 and then decreasing in the most recent year. The below table reflects the number of children 0-3 in foster care and the number that received services from Early ACCESS through an Individualized Family Service Plan (IFSP):

Table 4ccc: Foster Children who receive Early ACCESS services			
SFY	**# of children in foster care below age three**	**# of Children receiving services**	**Percent of children on IFSP**
2023	1415	162	11.4%
2022	1494	239	16.0%
2021	1574	227	14.4%
2020	1835	362	19.7%
2019	2103	474	22.5%

The data for children in foster care reflects an overall downward trend for number of children in care, with the 5-year high at 2103 in 2019 to 1415 in 2023. The number of children in foster care receiving EA services dipped over 2019-2021, which may be attributed to COVID-related decrease in engagement. Service numbers increased from SFY 2021 to 2022 and then decreased from 2022 to 2023.

MARYLEE ALLEN PROMOTING SAFE AND STABLE FAMILIES

Program Goals:

- To prevent child maltreatment among families at risk through the provision of supportive family services.
- To assure children's safety within the home and preserve intact families in which children have been maltreated when the family's problems can be addressed effectively.
- To address the problems of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner in accordance with the Adoption and Safe Families Act of 1997.

- To support adoptive families by providing support services as necessary so that they can make a lifetime commitment to their children.[1]

The services described below under the four main categories of PSSF support achievement of the PSSF goals through the provision of services to children and families to ensure child safety, family safety and stability, timely reunification, and adoptive families' lifelong commitment to their children, which contributes to achieving Iowa's vision that *"Family Connections are Always Strengthened and Preserved".*

Family Preservation

HHS allocates less than 20% of Promoting Safe and Stable Families (PSSF) funding for family preservation services; approved by the Children's Bureau in 2007. 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.

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.

In SFY 2020 and SFY 2021, there were a total of 56 referrals and 21 participants who completed the Caring Dads™ Program in Polk County. In SFY 2022, the Caring Dads™ program was expanded to Webster County in the Northern Service Area. One 17-week cohort was completed. There was a total of three dads who were referred and two successfully completed groups. As a part of the expansion, there was one LISW formally trained in the Caring Dads™ program. There were also two other facilitators, one dad with lived child welfare experience and the other a community liaison with the school.

In SFY 2023, three cohorts were completed, with two in the Des Moines Service Area, and one in Webster County. Each cohort included 16 weekly groups. In Des Moines, 43 participants were referred, with 9 completing the program. In Webster County, 7 participants were referred, with 5 completing the program.

Participants in the SFY 2023 cohorts were asked to complete a survey at the beginning of the program and at the end to evaluate progress and impact. Fifteen participants completed the survey at the beginning of the program, and 9 completed it at the end of the program, with only 7 participants completing both surveys. The survey included 53 questions with varying scales. Some highlights for improvement at the end of the program include:

[1] 42 U.S.C. 629

- "My partner and I have the same goals for our child" improved by .56 from the beginning to the end of the program, indicating that the participant felt both partners had more of the same goals for their child by the end of the program.
- "My partner undermines my parenting" improved by .67 from the beginning to the end of the program, indicating that the participant felt they were being undermined by their partner less at the end of the program.
- "I feel that I am very good at attracting the attention of my child" improved by 1.24 points from the begging of the program to the end, indicating that participants felt they were doing a better in this area by the end of the program.
- "I feel that I am very good at feeding my child, childing his/her diapers, and giving him/her a bath" improved by 1.07 from the beginning of the program to the end, indicating participants reported feeling more confidence in this area by the end of the program.
- "Not being able to stop worrying" (over the past 2 weeks, prior to survey) improved by .58 points from the beginning of the program to the end, indicating participants felt they were worrying less by the end of the program.

In SFY 2024, there were 39 total referrals to the two cohorts in Polk County. In fall 2023, the first cohort graduated with 9 dads completing the program. For the spring group, 12 dads are currently enrolled and on track to graduate from the program in June 2024. For the Webster County cohort, there was a significant increase of referrals, 23 dads were referred to the program. Of those referred, 9 dads are expected to complete the program in May 2024.

There are many highlights and challenges for each group. The biggest challenge that appears is in the initial attitude of the participants during the first group session. Typically, participants resist the group process and the referral in general. However, this quickly changes with ongoing discussion of personal choices and behaviors. Once the participants begin to take accountability for their choices and share with the peer group, family members and their social workers, they begin to see positive things happen within their lives and respective cases.

By the end of the 16 weeks, most fathers want to continue with the group as it has become their therapeutic weekly peer and support group. If appropriate, fathers receive encouragement from the group, to reach out to one another for support at the conclusion of the seven-week group session. The greatest incentive is the improved relationships with all involved in the case and within their respective family systems.

The dads who do engage and complete Caring Dads™ demonstrate a change in their thinking patterns. This is evident by talking about their co-parent in a positive manner, having the ability to express their thoughts and feelings appropriately and their willingness to continue with contact before and after groups. These dads also find support in reaching out to the facilitators and/or each other after their group has been completed. DHS case managers have expressed positive comments about the change in males' attitudes and actions after being in the Caring Dads class.

Facilitators for Caring Dads continue to educate and meet with HHS Child Protection and Social Worker Case Manager staff to increase referrals to the program.

24/7 DADS

24/7 Dads is a 12-week curriculum Children and Families of Iowa (CFI) provides to fathers involved with HHS or at-risk for involvement through the 24/7 Dads curriculum. The program

engages fathers with children 18 years or younger. Groups occur one time per week for at a minimum of 1.5 hours not to exceed 2 hours. Groups are planned on a virtual platform to accommodate father's schedules and to take precautions for COVID-19. The program is designed for custodial and non-custodial fathers, as well as employed or underemployed.

The group-based sessions provide fathers with support and education on topics such as co-parenting, understanding father's roles in parenting, healthy parenting strategies, and positive mother/child(ren) relationships. These topics can be instrumental in parenting or co-parenting children. In addition to learning how to co-parent, each skill learned and demonstrated can have a lifelong impact on the children. Positive outcomes include but are not limited to the following for children: healthy relationships, age-appropriate discipline and learning the mother/father role in a family. Men who complete the twelve-week curriculum receive certificates.

This curriculum is offered through the National Fatherhood Initiative. According to their website the curriculum is an evidence-based program. The Fatherhood Coordinator at CFI collaborates with community partner agencies to engage parents. Collaboration is sought from HHS, Family Treatment Court, Parent Partner Program, Community Partnerships for Protecting Children, Department of Corrections, local substance abuse and mental health organizations, and many other community agencies. CFI utilizes parents who have had lived experience to facilitate each group. CFI has been able to identify several alumni who have successfully completed the program and continue to attend subsequent groups for additional knowledge and potential familiarity in becoming a facilitator. Alumni serve as positive role models for current participants and continue to benefit from the group environment and parenting skills provided through the curriculum.

In SFY 2020, 189 dads completed the 24/7 Dads groups, and 43 moms, and in SFY 2021, 139 dads and 53 moms completed the 12-week group. There was a total of 240 community-based groups held in SFY 2022 and an additional 22 groups held at the Clarinda Correctional Facility. There was a total of 164 fathers in those community-based groups and 37 graduates at the Clarinda Correctional Facility who successfully completed the 12-week group and received a certificate. In SFY 2023, 166 dads and 63 moms completed 24/7 Dads groups, and to date in SFY 2024, there have been a total of 58 dads and 38 moms served in the 12-week programs.

Promoting Opportunities for Parenting

In addition to the strategies as described above, 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 Partner Program

The Iowa Parent Partner Approach seeks to improve outcomes for families around re-abuse and reunification. Parent Partners are individuals who previously had their children removed from their care and were successfully reunited with their children for a year or more. They provide support to parents that are involved with HHS and are working towards reunification. Parent Partners mentor one-on-one, celebrate families' successes and strengths, exemplify advocacy, facilitate trainings and presentations, and collaborate with HHS and child welfare professionals.

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.

Program materials include a Parent Partner Practice Manual, Handbook, forms, and training curricula. Parent Partners have access to flex-funds for their mentees, a collection of local resources guides, and receive reimbursement for their time providing mentoring and support to parents and lived experiences. Through partnering with community colleges, county extension offices and Iowa Workforce Development, Parent Partners receive education on resources available to assist in their professional development goals.

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.

Parent Partner Program Performance

The Parent Partner Program continues to operate as a statewide contract in all 99 counties in Iowa. The current statewide staffing structure includes five Lead Parent Partners, seventeen 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.

The Parent Partner Program provided mentoring and support to 3310 parents engaged in the program during the period of SFY 2020-SFY 2024 (through December 31, 2023). The average number of fully trained Parent Partners available to provide mentoring supports throughout the 5-year reporting period per year was 90 Parent Partners. This does not include the number of

additional Parent Partners who are in training status, or in training and mentoring status. As Parent Partners complete several trainings and shadowing of experienced Parent Partners prior to mentoring on their own, it can take up to 1 year for a new Parent Partner to be fully trained in their role.

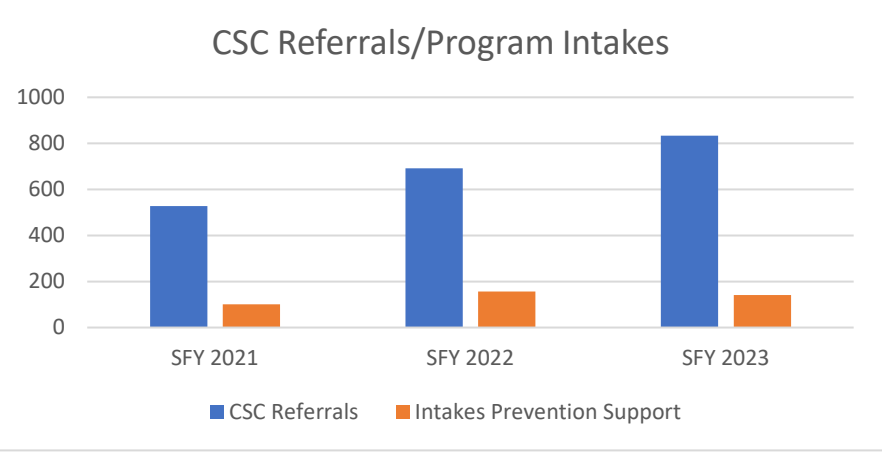
Child Safety Conferences/Parent Partner Prevention Support

On July 1, 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 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 became part of the Parent Partner Program contract target population in SFY 2024.

Although there continues to be some challenges regarding the standard referral process for Parent Partners to support parents during a CSC, the number of referrals to Parent Partners for CSCs have increased as referral challenges have been addressed. To address these challenges conversations with HHS front line staff, supervisors and management have taken place on a routine schedule. CSC referrals continue to be a standard conversation at each one of the five service area meetings between Parent Partner Program and HHS. The HHS Program Manager and the State Parent Partner Director have presented at an all-staff HHS lunch-n-learn, CID's call with supervisors and Social Worker Administrators, as well as working with the HHS training team to add the referral information into the Social Worker 020 training for new staff. The Parent Partner Coordinators continue to keep spreadsheets to track CSC referrals, where the referral came from and the outcome of the referral.

The Parent Partner programs has received the following number of referrals for Parent Partners to support parents during the Child Safety Conference process, and intakes into the program to provide ongoing Parent Partner mentoring support when removal has not occurred following the CSC.

Chart 4i: Parent Partner CSC Referrals/In-Home Prevention Intakes



SFY 2024
At the end of Quarter 3 for SFY 2024, there were a total of 564 CSC referrals made to the Parent Partner Program year to date. Of the 564 referrals, Parent Partners attended 340 initial CSC meetings, and there was a total of 100 intakes into the program for on-going support to prevent out of home placement.

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 will draw on 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.

Parent Partner Evaluation and Research
Researchers from the University of Nebraska-Lincoln's Center on Children, Families and the Law provide quarterly and annual reports on participants involved with the Parent Partner Program. These reports present data retrieved from the Online Parent Partner Database. The Online Parent Partner Database stores data from seven forms: intake, contact log, client registration form, family self-assessment (entry), family self-assessment (exit), family feedback, and fidelity checklist. The quarterly and annual reports provide analyses of the number of participants completing the entrance and exit Parent Partners participant self-assessments and fidelity to the Parent Partner model.

When the statewide contract started initially, one performance measure identified at least 70% of the parents will improve at least one point on the Self-Assessment Exit scale, based on the protective factors. The first 1,200 participants to complete the survey data provided the basis for the percentage.

During the initial expansion of the program type of support (traditional out of home placement support vs in-home prevention support through referral to a Child Safety Conference) was not recorded in the Parent Partner Database. In February 2021, the database was updated to

include the ability to track the type of support offered (traditional vs. in-home). Since it was not possible to definitively distinguish between in-home and traditional support during the full 5-year reporting period, the report provides a combined count of all parent partner cases (in-home and traditional).

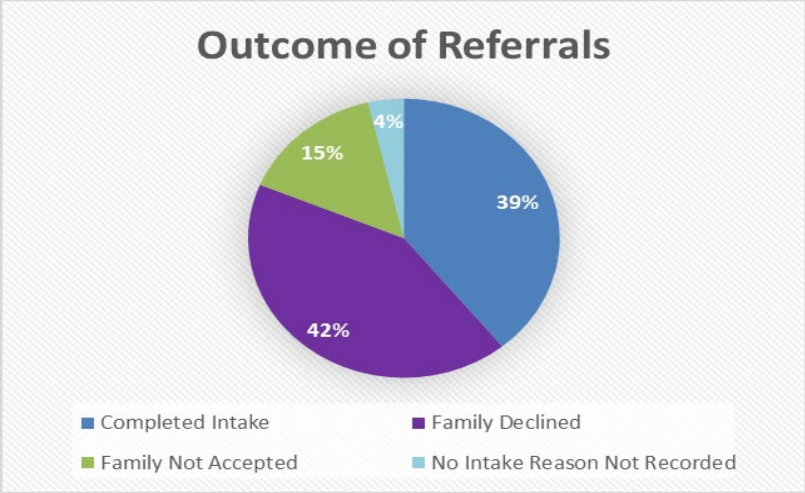
A brief analysis of the data was conducted on families that were referred to the Iowa Parent Partner Program between February 2021 through December 2023. A total of 5,949 parents were referred to the program during this period. About 33.2% of parents referred completed an intake (n=1516). Of the 1,977 parents that completed an intake, 1472 (74.5%) received support through the traditional model and 394 (19.3%) received support through the in-home prevention model, the remaining 111 parents did not have data recorded on type of support.

The following information is an excerpt from the UN-L Iowa Parent Partner Online Database Data Summary Report from SFY 2020 - SFY 2024 (mid-year through December 31, 2023).

Program Referrals

There was a total of 8,460 referrals made to the Iowa Parent Program statewide between July 01, 2019 to December 31st, 2023. About 39.1% (3,310 parents) of referred parents completed an intake. The remaining 5,150 referred parents did not complete an intake either because the client was not accepted for support (n=1271), or they declined support (n=3565). There were 314 referred parents that did not have the reason they did not complete an intake listed.

Chart 4j: Outcomes of Parent Partner Referrals



Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Program Intakes:

Parent Partners entered intake data for 3,310 parents between July 1, 2019 through December 31, 2023. The table below reports on the number of referrals and the percentage of those referred parents that completed an intake in each service area.

Table 4ddd: Parent Partner Program Referral and Intakes by HHS Service			
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

Referred Parents not resulting in Program Intake:

Parent Partners entered data on 5,150 parents who were referred but did not complete an intake and therefore did not receive support from the Iowa Parent Partner Program between July 1, 2019 and December 31, 2023. This count includes parents who were referred but did not complete an intake. Many of these parents (69%) declined Parent Partner support, but 24.7% were not accepted into the Parent Partner Program. The reason parents were not accepted was not listed for all parents, but common reasons included, not having a male parent partner, no contact from parent, closed CPS case, or parental incarceration. The remaining parents did not have a reason listed for why an intake was not completed. The table below reports on the number of referrals and the percentage of those referred parents that did not complete an intake in each service area.

Table 4eee: Percentage of Referrals Not Completing an Intake			
Service Area	**Number of Referred of Parents**	**Number with No Completed Intake**	**Percentage of Referrals Not Completing an Intake**
Des Moines	1289	658	51%
Cedar Rapids	1937	1122	57.9%
Western	1995	1203	60.3%
Northern	1619	1091	67.4%
Eastern	1620	1076	66.4%
Statewide	8460	5150	60.9%

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Demographics and Case Information for Referrals

Demographic information for all referred families is shared in the tables below. The first column includes data on all referred parents, the second column includes data on parents who completed intakes, and the final column reports on parents who did not complete an intake.

Table 4fff: Demographics of Referrals			
Race	**All Referred Parents (n=8460)**	**Completed Intake (n=5150)**	**Did not complete Intake (n=3310)**
American Indian/Alaska Native	195 (5.9%)	99 (3%)	96 (1.9%)
Asian	23 (<.01%)	6 (<.01%)	17 (<.01%)
Black/African American	755 (9%)	280 (8.4%)	475 (9.2%)
White	6527 (77.2%)	2717 (82.1%)	3810 (74%)
Native Hawaiian/Other Pacific Islander	12 (<.01%)	5 (<.01%)	7 (.01%)
Don't know/no response	948 (11.2%)	203 (6%)	759 (14.7%)

Ethnicity	**All Referred Families**	**Completed Intake**	**Did not complete Intake**
Hispanic/Latino	426 (5.0%)	133 (4%)	293 (6%)
Not Hispanic/Latino	8034 (95%)	3177 (96%)	4857 (94%)

Referred Parent	**All Referred Families**	**Completed Intake**	**Did not complete Intake**
Mother	6142 (72.6%)	2791 (45.4%)	3351 (54.6%)
Father	2205 (26.1%)	501 (22.7%)	1704 (77.3%)

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Time to Case Closure

Statewide, the average time between the date of intake and the date the case was closed in the Online Iowa Parent Partner Database was 306 days for cases closed between July 1, 2019 and December 31, 2023. Statewide, the median time between the date the intake was completed and the date the case was closed was 245 days. There was a significant range in case length with a range of 3 days to 2074 days. The table below shows average and median case closure time by service area.

Table 4ggg: Number of Days from Intake Date to Case Closure Date by Service Area		
Service Area	**Average Days from Intake to Case Closure**	**Median Days from Intake to Case Closure**
Des Moines	335	277
Cedar Rapids	334	267
Western	297	244
Northern	302	243
Eastern	240	188
Statewide	**306**	**245**

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Retrospective and Exit Self-Assessments

One-thousand-five-hundred-thirty-three (1533) parents completed at least part of a family self-assessment upon exiting the Parent Partner program and 1,455 completed at least part of a retro family self-assessment between July 1, 2019 and December 31, 2023. Parents rated themselves highest at exit on being able to effectively manage their situation, making appropriate family decisions, having others who will support positive choices and changes, and having someone to talk to in a crisis. Parents rated themselves lowest at exit on their comfort when talking with their HHS worker or other service providers. Overall, scores were similar during this annual reporting period as in previous reporting periods.

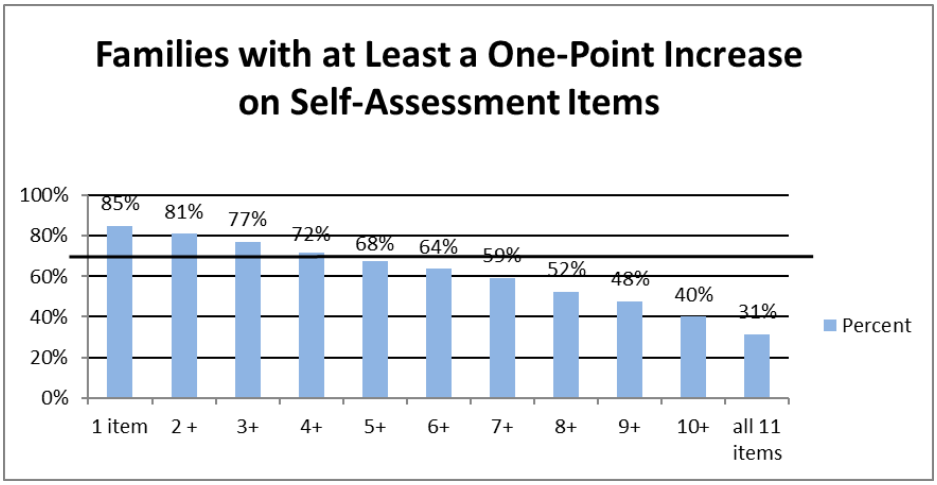
Table 4hhh: Retro and Exit Self-Assessments					
Statement Rated on a scale of 1 (*never*) to 5 (*always*)		Exit		Retro	
		Avg.	N	Avg.	N
1	I am able to find the community resources I need to keep my children safe.	4.7	1533	3.6	1455
2	I am able to complete the steps necessary to get the community resources I need.	4.7	1533	3.5	1455
3	I am able to effectively manage my situation to keep my child(ren) safe when times are stressful.	4.7	1533	3.6	1455
4	I am able to make the appropriate decisions for myself and my family.	4.7	1533	3.6	1455
5	I have others who will listen when I need to talk about my problems.	4.6	1533	3.5	1455
6	I have others who will support positive choices and changes I make.	4.7	1533	3.6	1455
7	I talk reasonably and honestly with others about my situation and problems.	4.7	1533	3.5	1455
8	If there is a crisis in my life I have someone I can talk to.	4.7	1533	3.5	1455
9	I am able to effectively speak up for myself and my family to DHS and other service providers.	4.6	1533	3.4	1455
10	I am able to listen to DHS and other service providers and understand their concerns with my situation.	4.5	1533	3.4	1455
11	I feel comfortable when talking with my DHS worker or other service providers.	4.4	1533	3.1	1455

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Percentage of Families with At Least 1-point Increase from Retro to Exit on At Least Three Measures

One-thousand-four-hundred-seventy (1470) parents fully completed both an exit self-assessment and a retrospective self-assessment between July 1, 2019 and December 31, 2023. The current performance standard is that 70% of parents must have at least a one-point increase from retro to exit self-assessment on at least three items. One-thousand-one-hundred-thirty (1,130) (77%) of parents with complete data met this performance measure during this reporting period. The chart below shows the percentage of parents who reported at least a one-point increase on 1 to 11 self-assessment items. For example, 85% of parents reported at least a one-point increase on one item and 31% of parents reported at least a one-point increase on all 11 self-assessment items.

Chart 4k: Families with a One-Point Increase on Self-Assessment Items



Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Fidelity Checklist

Currently, the Iowa Parent Partner Model measures fidelity with a 10-item scale that asks parents and the parent partner to rate how often they engaged in various activities. The activities have previously been determined to be essential components of the Iowa Parent Partner Program. Parent Partners and parents tend to report similar scores on all the items. The tables below share the average score for each item for parent partners and parents. There were more forms completed by parent partners than parents. The reason for this difference is due to the challenge of collecting data from parents when they are exiting the program. Parents may decide to disengage without discussing it with parent partners and then become unreachable.

Table 4iii: Parent Partner Report of Program Fidelity			
Statement Rated on a scale of 1 (never) to 5 (always)		**Parent Partner Average**	**Number of responses**
1	Encouraged the participant to fulfill case plan activities.	4.6	3326
2	Regular face to face visits.	4.1	3323
3*	Other communication and contact.	4.3	3340
4*	Advocated for needed resources.	4.3	3310
5	Encouraged the participant.	4.6	3334
6*	Connected with community resources.	4.1	3278
7*	Helped connect with the community.	4	3263
8	Coached on communication strategies.	4.3	3304
9	Supported at FTM, court, treatment, and other gatherings.	4.2	3244
10	Coached on what to expect throughout this process.	4.5	3320

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Table 4jjj: Parent Report of Program Fidelity			
Statement Rated on a scale of 1 (*never*) to 5 (*always*)		**Participant Average**	**Number of responses**
1	Encouraged the participant to fulfill case plan activities.	4.8	1549
2	Regular face to face visits.	4.6	1545
3	Other communication and contact.	4.7	1550
4	Advocated for needed resources.	4.7	1540
5	Encouraged the participant.	4.8	1550
6	Connected with community resources.	4.6	1532
7	Helped connect with the community.	4.5	1521
8	Coached on communication strategies.	4.7	1537
9	Supported at FTM, court, treatment, and other gatherings.	4.7	1507
10	Coached on what to expect throughout this process.	4.8	1543

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Family Outcomes

Parents and parent partners also report on family outcomes when the parent exits the program. Parent partners tend to rate the parent lower than the parent rates themselves. The tables below report the average item score from parent partners and parents and is similar to the Fidelity Checklist there were more forms completed by Parent Partners than parents. The reason for this difference is due to the challenge associated with collecting data from parents after they exit the program.

Table 4kkk: Parent Partner Report on Family Outcomes			
Statement Rated on a scale of 1 (*decreased*) to 4 (*significant improvement*)		**Parent Partner Average**	**Number of responses**
1	Relationship with people who are able to connect with resources.	2.9	3086
2	Relationship with people who support positive changes.	2.9	3080
3	Level of communication with DHS worker.	2.8	3013
4	Level of communication with attorney(s).	2.8	2724
5	Ability to advocate appropriately.	2.9	3111
6	Knowledge of what needs to be done for custody of children.	3	3110
7	Ability to get to appointments on time.	2.8	3065
8	Ability to find community resources.	2.9	3064
9	Knowledge of who to contact with needs or concerns regarding the case.	2.9	3089
10	Level of personal responsibility and accountability.	2.9	3109

Table 4kkk: Parent Partner Report on Family Outcomes			
Statement Rated on a scale of 1 (*decreased*) to 4 (*significant improvement*)		**Parent Partner Average**	**Number of responses**
11	Willingness to make changes.	2.9	3108

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

Table 4lll: Parent Report on Family Outcomes			
Statement Rated on a scale of 1 (*decreased*) to 4 (*significant improvement*)		**Participant Average**	**Number of responses**
1*	Relationship with people who are able to connect with resources.	3.4	1530
2*	Relationship with people who support positive changes.	3.4	1537
3*	Level of communication with DHS worker.	3.1	1520
4*	Level of communication with attorney(s).	3.1	1433
5*	Ability to advocate appropriately.	3.5	1534
6*	Knowledge of what needs to be done for custody of children.	3.5	1517
7*	Ability to get to appointments on time.	3.3	1527
8*	Ability to find community resources.	3.4	1530
9*	Knowledge of who to contact with needs or concerns regarding the case.	3.4	1532
10*	Level of personal responsibility and accountability.	3.5	1535
11*	Willingness to make changes.	3.6	1537

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

UN-L: Fidelity Interviews 2020

In SFY 2020, UN-L conducted interviews with parents who both successfully and unsuccessfully participated in the Iowa Parent Partner Approach to gather detailed information about their Parent Partners' fidelity to the program model and to assess the key components of the program. A Research Associate from UNL-CCFL conducted semi-structured telephone interviews with 25 parents (5 from each service area) who participated in the Parent Partner program. The attached UN-L report is an executive summary of their findings:

Parent Partner Case Manager Fidelity Surv

Parent Partner Pilots: In-Home and Continuing Supports

In October 2018, the HHS asked the Parent Partner contract provider to develop a work plan and implement two pilots. One pilot focused on parents involved in the child protective system whose children remain in the home (In-Home Pilot). The purpose of this pilot was to determine

if this shift in target populations had an impact on the fidelity of the Parent Partner model. In SFY 2020, the contractor provided supports through the In-Home Pilot and has reached the target of serving 30 parents in a tri-county area. In SFY 2021 this pilot transitioned to focus statewide on providing mentoring and supports to parents who participate in a Child Safety Conference and their child(ren) remain in the home.

The second pilot was to provide mentoring supports to up to 20 parents who have substance abuse issues, for up to six months after the child protective and court case closes. The purpose of this pilot was to determine if additional mentoring supports would have an impact on relapse and re-entry outcomes.

During SFY 2021 there were nineteen (19) parents referred to this pilot. Of those nineteen (19), thirteen (13) completed the full six months of support after safe case closure. Four (4) individuals left the pilot due to the Parent Partner leaving the program and they declined support from a new Parent Partner and two (2) disengaged with the program for reasons unknown. The pilot program was expanded in SFY 2021 to support a higher capacity, from 20 to 30 parents who can be supported in the pilot program. Data pulled in December 2021 regarding parents who had participated in the continuing support pilot from the period of SFY 2019-SFY 2021 resulted that 85% of parents from the pilot did not experience re-abuse of their children, and 68% of parents who participated did not experience re-entry of their children into out of home placement during this period.

In SFY 2022 there was decreased participation in the pilot, this may be due to changes in staff and Parent Partners in this area, which had contributed to the increased initial participation in the pilot in 2020. HHS worked to address the decrease with CFI and the local HHS, through better clarification of the continuing support pilot process for referral and on-going support to working on referrals to the traditional parent partner program in this area. Due to continued lack of participation and the need to recruit additional parent partners, it has been decided to discontinue the after-support program at the end of SFY 2023.

Out of State Collaborations

As a result of the above-mentioned clearinghouse ratings designations, several states have continued to reach out to Iowa throughout the reporting period to inquire about establishing a Parent Partner Program in their state. In spring 2021, Iowa HHS developed a letter of agreement to utilize with states and organizations who have interest in implementing the Iowa Parent Partner Program and wish to utilize program materials, training curricula, and research. This agreement was developed to ensure that other states, who were asking to implement the Iowa Parent Partner model, follow the fidelity of the program. Assistance to interested states and organizations who enter into the agreement with Iowa HHS includes sharing of program materials, and provision of technical assistance and training from the contractor for the Iowa Parent Partner Program, Children and Families of Iowa. This includes email exchanges, conference calls, providing trainings and site visits, providing workshops and panel discussion, and invitation to attend Iowa's annual Parent Partner Summit.

Due to the consultation and interest from other states, in SFY 2023 HHS, CFI, and UN-L, worked together to establish a readiness and implementation checklist. This document is provided to states who express interest in the Iowa model to utilize as a mechanism for assessment of readiness by the state or jurisdiction and by Iowa that they are ready to move forward with implementation of the Iowa Parent Partner model.

The Parent Partner State Director has begun work with the Casey Family Programming and Children's Trust Alliance to hold a Parent Partner Learning Collaborative. This group meets with several sites across the nation to encourage conversations about peer mentoring programs.

To date, the Iowa Parent Partner Program has been provided training, planning and implementation of a peer mentoring program include Louisiana, Oklahoma, Colorado, Wisconsin, and Ohio. Other states have expressed interest in starting the planning process include New York State, Michigan, Indiana, South Carolina, Maine, Florida, and two sites in Minnesota. One of the two Minnesota sites includes a partnership with the Red Lake tribal nation.

Working with Ohio also brings a partnership with the University of Connecticut, QIC-R evaluation team. Ohio is growing their Parent Partner Program and is now implementing lead Parent Partners. Ohio is currently at program sustainability as they began taking referrals in November 2022. CFI will continue to provide technical assistance to the Ohio team through SFY 2025.

Cost Benefit Analysis
In SFY 2023, Casey Family Programming reached out to the Parent Partner Program to inquire about completing a cost benefit analysis on the Iowa program. Casey provided a draft of the analysis to HHS in February 2024 for review. The initial draft included analysis of net cost-benefit savings of $5.8 million to Iowa as identified through reducing expenditures to adoption subsidies by increasing reunifications based on 2019 program data and program costs for that year. Casey anticipates a final analysis will be shared with Iowa HHS later this spring.

Scope of Parent Partner Activities SFY 2020-2024
The types and number of supports provided to parents during the period of SFY 2020-SFY2024 by Parent Partners includes, but is not limited to:

- Mentoring Supports
- Meetings to support parents (ex., Solution Focused Meetings): 2531
- Support family in Court: 9506
- Support parent before/after visitation: 7692
- Face-to-face contact (not including the items above): 57026
- Outreach Activities
- Connect to community resources: 7519
- Access to needed services: 21,115
- Committees and meetings related to child welfare: state 598, local 1285
- Child welfare HHS new worker orientation: state 17. Local 7
- Community Partnership for Protecting Children: state 43, local 922
- Speaking engagements and program awareness: state 12, local 378
- Other meetings, trainings, and activities: state 78, local 987

At the conclusion of the third quarter of SFY 2024, there were approximately 94 Parent Partners (including Parent Partners in Training Mentoring) assigned to 547 individuals in 99 counties. Parent Partners continue to provide support for families involved in Family Treatment Court, and other types of inclusion court such as Safe Babies Court.

Building a Better Future Training (BABF)
BABF has always served as the core training for the Parent Partner Program. HHS child welfare staff attend BABF training alongside Parent Partners in training, and as a result develop

empathy and understanding of each other's experience within the child welfare system, creating new partnerships for collaborative efforts working with families. Approved trainers include both Parent Partners and HHS Social Workers to co-facilitate the BABF training to provide perspective and voice from their roles in the system. BABF trainings are offered minimally in each HHS service annually to ensure opportunity for new Parent Partners and HHS staff, in addition to foster parents and community members engaged in child welfare to attend.

Updates to the BABF curriculum were made in SFY 2023 and were piloted in SFY 2024. This included updated federal legislation and state child welfare practice changes, review of the curriculum materials to ensure they align with meeting the objectives of the learner and training outcomes, and opportunities to increases cultural responsiveness and an equity lens to the learning.

Policy and Practice Committee
The Parent Partners' Policy and Practice Recommendation Team was implemented in SFY2019 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. Annually, formal recommendations for child welfare policy and practice changes are submitted to the HHS Program Manager.

SFY2020-SFY2024
The Policy and Practice Committee developed and compiled results from a Parent Experience Survey, which was distributed to parents receiving support from a Parent Partner in Fall 2019. The survey asked questions around each parent's experience with frequency of contact with their HHS caseworker, their attorney, and other important team members, as well as understanding their case plan, feeling comfortable with self-advocacy to get their needs met to address challenges regarding their case, etc. In addition to evaluation of the findings by the team, the State Advisory Committee reviewed the findings of the surveys by service area. Communication concerns and comfort level in speaking to workers and professionals involved in their case were the most identified themes raised by the Parent Experience Survey. As a follow up, committee members led conversations with their local teams around how Parent Partners can support developing improved communication efforts and self-advocacy skills with the parents they mentor.

The parent survey was distributed to parents receiving support from a Parent Partner for a second round of distribution in August 2021. The second set of results of the survey showed a more positive relationship between those who had an open service case and all professional parties involved in child welfare. The data gathered from this survey was collected August 2021. A total of 414 surveys were collected in 73 of the 99 counties. It should be noted that of the 26 counties where surveys were not collected, the program was not mentoring in 15 of those counties.

Highlight outcomes from survey collections included:
- 47% of parents who were surveyed felt they were involved in their case planning
- 72% felt that they knew what needed to happen in their child welfare case to move forward.

- 73% felt that they had adequate legal representation and were able to meet with their attorney outside of the court room setting.
- 81% expressed being comfortable talking to their HHS worker.
- 56% saw their case workers once/twice per month

The second set of results of the survey showed a more positive relationship between those who had an open service case and all professional parties involved in child welfare. Between 2019 and 2021, there was a positive increase in contact with HHS and families being seen monthly by their caseworker, and a positive increase for the family's ability to contact attorneys when needed. As stated in the 2019 summary it appears that all participants can identify at least one person who they feel can support and assist them in their case. Eighty-one percent (81%) of all surveys collected identified the Parent Partner Program as one of those important supportive roles and connection to community resources.

Policy and Practice Committee annual recommendations to HHS state leadership have focused on key areas such as fair and accessible drug testing, clear case plans that support reunifications efforts, cross training opportunities for child welfare providers and partners with HHS, services and supports that are inclusive of race/ethnicity and gender roles. HHS has responded to the Policy and Practice Committee in ways such as follow up discussion on the recommendations from the Family Protection and Well-Being Division Administrator and the Child Welfare Policy Bureau Chief, presentation, and opportunity for Q&A with the HHS Program Manager for the Drug Testing contract, as well as written response to the committee from the Child Protection Services Director. Another example includes adding a Parent Partner representative from the committee to the case plan redesign workgroup that began in SFY 2023. This has provided both parent input to the redesign, as well as opportunity to report on progress and key changes to the case plan back to the committee.

In SFY 2024 in response to committee recommendations, a recorded training was provided by HHS to Parent Partners on the purpose and process for Bridge meetings, which Parent Partners can attend to provide support if invited by the parent. Additional cross training opportunities have included training with Family Treat Court Coordinators and Parent Partner Coordinators, Parent Partners and CPPC Coordinators on engagement and utilizing Parent Partner voice in CPPC, and Parent Partners and Family Centered Services providers. The committee is also being asked to review and provide feedback one the Juvenile Court Handbook for Children's Justice.

The following recommendations were submitted by the Policy and Practice Committee to HHS for SFY 2021-SFY 2023. Recommendations for SFY 2024 are in process of development by the team:

Mt. Pleasant Prison Project
In 2013, HHS and the Parent Partner Program collaborated to work with males who are incarcerated to help them get involved or re-involved with the open service case, as well as providing parent skill education. CFI has provided a volunteer four-week parenting group in the Mt. Pleasant Correctional Facility (MPCF). During the four weeks, topics covered included:

- I'm HHS involved, Now What?
- Healthy Communication
- Self-Advocacy
- Re-entry Programs

During the period of SFY 2020-SFY 2024, the Parent Partner contract, Children and Families of Iowa (CFI) has served 532 offenders and has impacted 1,225 children through the Mt. Pleasant Correctional Facility program. Of those offenders served, 225 were HHS involved, impacting at least 571 children.

Dads who participated in group gave the following summary feedback as learning opportunities in the four-weeks:

- Being aware that we have rights and that there are services for help.
- Effective communication
- Don't be afraid to ask questions.
- Knowing my rights as a father
- I can write HHS and thank them for their services and look for more opportunities for my son.
- Document things for HHS
- How to become a Parent Partner
- How to worker with your HHS worker
- Stand up and be assertive for my rights and responsibilities.
- There are people and resources out there to help parents in need.

Parent Partners and Diversity
Parent Partners address diversity, equity and inclusion through state/local meetings, training, recruitment of Parent Partners, referrals for parents to have peer mentors, presentations, and collaborations with other community partners. Coordinators and Service Area Coordinators are encouraged to develop a Plan Do Study Act (PDSA) to address DEI in their covered area. Parent Partners are included in county Equity teams across the state, monthly Parent Partner Courageous Conversations, and participate in learning exchanges such as Race: Power of Illusion and Understanding Implicit Bias.

The local Service Areas implemented their recruitment plans, with a result of increased participation by men and more diversity. At the conclusion of SFY 2023, there are 19 men currently serving as Parent Partners in the program, two of them identify as Latino. There are two African American Parent Partners; and two Parent Partners who identify as Native American. There continues to be an ongoing recruitment for Parent Partners who are culturally diverse and represent diverse race and ethnic backgrounds.

Meskwaki Family Services has made routine referrals into the Parent Partner Program. The pandemic created a gap in support between the Parent Partner Program and Meskwaki settlement. In SFY 2023, local coordinators, Parent Partners and the Parent Voice and Inclusion Coordinator have made more active efforts to participate in tribal court. Rebuilding this

relationship has shown strength in receiving additional referrals. Parent Partner Program will continue to engage the settlement to find recruit peer mentors and provide parent peer support.

The Parent Partner Program has increased their awareness, training, and recruitment of a more diverse team. In June 2020, the Parent Partner Program had Ana Clymer, Cultural Equity Statewide Coordinator provide a training to staff. The training included ways to address individual bias, being more inclusive to racial/ethnic backgrounds, and ways to have courageous conversations. The Parent Partner Program will work directly with Ana during SY 2023 to revise materials, with a cultural perspective to include the core Building a Better Future training and the Iowa Parent Partner Handbook.

In 2020, CFI participated in the United Way 21-day challenge. This was 21 days filled with DEI awareness, topics of discussion and education. Following the 21-day challenge, the Parent Partner Program as a collective wanted to continue with a brave space to continue conversations around DEI topics and efforts. From 2021-2024 the Parent Partner Program has continued to hold monthly Courageous Conversation meetings. These virtual meetings include all Parent Partner staff and two Parent Partners per service area. A planning committee has been established to include a Service Area Coordinator, two local Coordinators and three Parent Partners. This diverse team was formed to strategically identify monthly topics for the virtual meetings.

During SFY 2023, a local motivational speaker, trainer and survivor, Courageous Fire, presented on domestic violence and its impact on African American women. This training was highly impactful for those who attended as they were able to openly discuss strategies to become more culturally responsive when mentoring parents from diverse racial and ethnic communities.

In SFY 2024, monthly BIPOC meetings continue to be held for Parent Partners who are black, indigenous and people of color to support, recruit, and retain those that may face adversity. These meetings are supported by the state director, the parent voice and inclusion coordinator, a service area coordinator, and a local coordinator. The last Friday of each month a subcommittee made up of Parent Partners and staff engage in a DEI Courageous Conversation topic discussion. This conversation is inclusive of staff and Parent Partners from across the state. Meetings are held virtually to ensure all can participate and learn. At the end of the third quarter in SFY 2024 there were 16 parent partners who identified diverse racial/ethnic backgrounds statewide, and 23 male mentors.

Quality Assurance
Quality assurance is addressed through a variety of program responses such as updating the Parent Partner Program Handbook and associated materials, updating the core Building a Better Future Training for new parent partners and HHS staff, continuous fidelity monitoring by UNL through the Parent Partner Database, and feedback to policy and practice changes from the Parent Partner Policy and Practice Committee. Parent Partner feedback is utilized to review and provide input to changes in documents to ensure cleat and family friendly language for parents.

The Parent Partner Coordinators and Service Area Coordinators complete "cold calls" to parents current enrolled in the Parent Partner Program randomly monthly. The outcome of this call is documented in the parent participant's file. CFI indicates findings from these calls include:

- Some parents re-engage with the Parent Partner Program as a result of the call.
- Ability to capture exit paperwork, for those who disengaged with the program.
- Learn that the Parent Partner may not meeting with the participant, and opportunity to reassign the case to another Parent Partner.
- Connection with many parent participants who express their appreciation for the support of their Parent Partner. We always like to move the message forward and let the parent partner know.

Data collected from continuous reporting on the Parent Partner Program from CFI and from UNL in monitoring and analyzing the database regarding program fidelity measures drives next steps regarding adaptations needed to best meet the needs of parents entering the child welfare system for support and mentoring of a Parent Partner, such as continuing to build capacity to support parents as a prevention to family separation.

Flex Funding

HHS has allocated funding to the Parent Partner Program for flex funding. These funds assist parents who are actively engaged in their child welfare case to either prevent removal of a child or to assist with reunification. The money allocated each year is to be spent evenly across the state. Requests are submitted and reviewed by the Parent Partner Management Team monthly. Impact statements from individuals who have received the flex funding are provided in quarterly summaries to HHS. Below is an excerpt of the impact statements received from parents regarding the provision of flex funding:

- “These funds impacted me by getting my kids and I a new apartment. Without it, we wouldn’t be here right now. We greatly appreciate it and will continue to keep moving forward.”
- “The flex payment that was offered by my parent partner helped me meet the financial needs of rent to keep our home while I was in treatment. Now that I am out of treatment, my children and I can be reunified.”
- “I had such a large back bill that I could not afford. Without the help of parent partners, I would not have been to continue with my service and have lights for my family. It impacted my case because I am able to have kids with me in my home.”

CARES Act Funding for Communicative Technology Grants

Under the CARES Act, states were given the flexibility to fund efforts to ensure the welfare of children is protected and promoting safety, permanence, and well-being of children in foster care. As a result of COVID-19, in-person contacts in the Parent Partner Program, along with other family centered services within child welfare, were reduced to protect health and safety. Recognizing the need to support families’ ability to participate in virtual contacts for family meetings and/or interactions and virtually held therapeutic services, HHS made available Communicative Technology Grant funding available for contractors working with families served, including the Parent Partner Program. This one-time allocation of funding has been made available for Parent Partner Program for purchases expended between April 1, 2020 to June 30, 2021 for allowable devices for communicative technology for the purpose of parents to be able to participate in video and telephone conferencing interactions with their children and workers. Allowable devices for use of the grant funds include items such as laptops, tablets, pre-paid cell phones, iPad, Wi-Fi Hotspots, and cell phone minutes. The Parent Partner Program submitted monthly reporting documenting how funds were expended and tracking on all inventory. As of June 30, 2021, $4,656.37 of the allotted funds were expended.

SFY 2024 Summary Report

The Parent Partner Program contract between HHS and CFI identifies 1,400 individuals to be supported each fiscal year. There were 509 individuals who were being mentored going into SFY 2024, with 189 intakes for Quarter 1; 155 intakes for Quarter 2 and 197 intakes for Quarter 3. This brings the combined total to 1050 parents receiving mentoring support at year to date at the end of the third quarter, serving 75% of the overall population. There continues to be five lead Parent Partners in place throughout the state. At the end of Quarter 2, there were 94 parent partners mentoring and 22 new parent partners in training.

There was a total of five Building a Better Future trainings held statewide at the end of March. An updated BABF facilitator curriculum has been sent out to trained facilitators. This update included content updates regarding changes to policy, practice and realignment at the Department of Health and Human Services. CFI continues to recruit and onboard new HHS trainers throughout the state. There are currently three BABF trainings scheduled for the next April-June quarter of 2024.

The planning committee has been identified for the 2024 Parent Partner Summit and has begun the monthly planning calls with the state committee, which includes Parent Partners from across the state. The Parent Partner Summit will be held June 17-18, 2024. The theme of the summit this year is Making Connections as We Continue to Glow. Ronnie Cyrus-Jackson has been secured as the keynote speaker. She will assist the audience in understanding more about building a better self, rebuilding lives, and bringing encouragement to those who help support us.

Parent Partners are currently supporting 104 racially and ethnically diverse families who are involved in an open HHS child protection case, including four participants who identify as Native American. The first referral for a father who is Marshallese was made to the program for support. The Parent Partner Program have also received four referrals for individuals who were Spanish speaking only, and one for a family who speaks Swahili. The program has utilized language line and other translation and interpretive services to communicate and support parents who speak languages other than English.

The Parent Partner Program has continued to strengthen efforts with community relationships to support culturally diverse families. The program has partnered with agencies such as local food banks, churches, Community Action Agencies, NA/AA meetings, ALANON, domestic violence agencies, and assisted families in getting government assisted phones. The program also participated in presentations with the Monsoon community agency to connect with the Asian American Pacific Islander communities.

Collaboration and training opportunities for the Parent Partner Program have continued to develop throughout the year. the Parent Partner Program was invited to participate in a panel presentation for the All-Site Family Treatment Court conference. Representatives from the program also presented at the Polk County Zero to Three monthly meeting. Parent Partners have been asked to sit in on juvenile court and provide feedback on engagement of parents, youth, and overall experience in the courtroom. There continues to be program awareness through Parent Partner presentations at the new worker SW 020 training and CPW 200 trainings.

Parent Partners have been invited to co-train with the RRTS contract will participate in a trainer program to co-facilitate foster/adoptive parent pre-service training, to bring parent lived

experience to training new prospective foster and adoptive parents. Two Parent Partners are participating in the train the trainer program currently. Additional parents with lived experience will be identified and will attend future train the trainer.

Summary of Parent Partner Collaborative Efforts and System Impact

- Strengths:
  - Well trained Parent Partners successfully provide mentoring supports and engage in hundreds of committees and trainings locally and statewide.
  - Systemically there is an expectation that Parent Partners have a voice in policy and practice. Service Area Steering Parent Partner Committees meet regularly to review referral and intake data and set goals for implementation.
  - Parent Partner Management Team and the State Parent Partner Steering Committee regularly review outcome data and administrative data to determine impact. This data analysis serves as a feedback loop for program improvement.
  - Strong partnerships for referrals for both participants and Parent Partners
  - Promotion of professional and career development opportunities for Parent Partners
  - Beginning to broaden mentoring supports beyond the out-of-home placement (in-home and after case closes for substance abuse issues)
  - Increased mentoring supports for in-home cases and prevention approaches
  - Establish quality assurance protocol based on data and participant feedback
  - Parent Partner research published and submitted for evidence-based classification
  - Evidence based ratings designated as Promising by both the California Evidence Based Clearinghouse and the Federal Prevention Services Clearinghouse.
- Opportunities for Program Improvement:
  - Parent Partners' Policy and Practice Recommendation Team, Parent Partners will have a collective voice.
  - The evidence-based classifications could give Parent Partners new funding opportunities.
  - Develop a method for evaluating outcomes for Child Safety Conference Parent Partner Pilot Program, as we all as the on-going mentoring support program for parents who have experienced safe case closure.
  - Continue to monitor program data and utilize feedback to continually implement course corrections to strengthen model fidelity and outcomes.
  - Assess opportunities for additional evaluation to increase the evidence-based ratings of the Iowa Parent Partner Program, specifically evaluation of in-home prevention cases.
  - Continue to expand the Parent Partner Program that includes a more diverse support and inclusion of all groups.
  - Increased recruitment and engagement of Parent Partners will eliminate the wait list in specific areas in the state.

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.

Table 4mmm: SFY 2020-2024 Wrap Around Services Expenditures	
State Fiscal Year (SFY)	Statewide Expenditure Amount
2020	$ 34,175.00
2021	$ 41,747.00
2022	$134,256.00
2023	$ 49,695.20
2024 (Jul 23 – Mar 24)	$ 12,865.73

Family Support

Over the five-year period, HHS utilized PSSF Family Support funding (approximately 20-23% of the PSSF grant depending upon the year) for the Iowa Child Abuse Prevention Program (ICAPP). Please see *Child Abuse and Neglect Prevention, Early Intervention and Support Prevention Programs and Services, Iowa Child Abuse Prevention Program (ICAPP)* earlier in this section for more information.

Family Reunification

Iowa allocated approximately 22% to 28% over the five-year period of the PSSF dollars to Family Reunification Services. HHS central office staff removed some of the funding, usually allocated to the five HHS services areas, to include in the Family Centered Services (FCS) contracts. HHS utilized these funds, in addition to IV-B, subpart 1 funds, in the FCS contracts because the contracts included services to support reunification, such as facilitation of Solution Focused Meetings (SFM). Central office staff then allocated the balance to the service areas based upon historical allocations and service area needs. All services to children and their families remained traceable to the eligible child. Service areas determined utilization of the funds they received and sub-contracted with service providers. In some of the service areas, the service area's Decategorization (Decat) committee had responsibility for projects funded under Family Reunification Services. Table 4mmm shows how service areas utilized their allocation of Family Reunification funds.

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 4nnn: 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 Source: HHS; *Listed as Parent/Family Supports	------	2%	1%	1%	5%

Adoption Promotion and Support 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. These 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 high-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/adoptive parents. Licensure brings increased financial assistance, concrete supports and training that unlicensed caregivers do not receive. These additional supports make it more likely children will remain in placements in which they have strong meaningful connections. In the event a child becomes available for adoption, children in these situations are more likely to be in stable placements making adoption more likely and timely. The HHS does waive non-safety standards for relatives and fictive kin to promote licensing. HHS developed a process called Kinship Caregiver Payment which assists families with a $10 a day payment for up to 6 months to assist with the time frame of unlicensed placement until the family can become licensed/approved foster/adopt caregivers. The HHS continues to work in collaboration with RRTS contractor as well as Family Centered/Kinship Navigator contractors, to continue the process connecting families to the licensing process. It is hoped this process will assist in more quality and timely adoptions in the State of Iowa.

In January 2024, Iowa started the process to identify a workgroup of HHS staff to explore alternative title IV-E kinship foster care licensing and adoption approval. This demonstrates Iowa's commitment to valuing family relationships and kinship connections. It is hoped this process will result in families being supported in a timelier manner, which will then lead to more stable kinship placements and if needed stable adoptive placements.

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.

The highlighted new and improved services for post adoption and guardianship supports include:

- An outreach plan to provide awareness of available support and services to adoptive and subsidized guardianship families for community partners and families.
- Families will receive information at the time of adoption/guardianship finalization and at continued intervals until child is no longer eligible for service.
- Outreach will target Child Welfare system partner representatives, Public and Private Schools/Educational Facilities, Mental health facilities/clinics, Hospitals and medical clinics and Faith organizations.
- Centralized statewide referral and information system.
    - Centralized statewide referral and information specific to post adoption/guardianship system with electronic and phone access for referral, questions and problem solving will be developed.
    - The referral system will be accessible to the community and able to accept referrals 24 hours a day, 7 days a week.
- Intensive case management service, or crisis stabilization to families when needed.
    - Intensive Case management can be up to six (6) home visits lasting at least 45 minutes over a 6-week period, per year/per child and includes:
    - Service plan for support specific to an individual family's needs
- Information about post-adoption and subsidized guardianship services
    - Information about community services, including Medicaid, Waiver Services, food assistance, workforce opportunities, mental and behavioral health supports and other as needed by the family.
    - Stress management and problem solving
    - Parenting skill development including trauma informed parenting techniques when appropriate
    - Monitoring of safety in the home
    - Providing information on the role of the schools in providing appropriate education and resources including as determined by a child's IEP.
    - Staff providing service will complete the National Adoption Competency Mental Health Training Initiative (NTI)
    - Monthly support group meetings for all public and private adoptive and subsidized guardianship families.
    - Adoption specific training opportunities for all adoptive families in Iowa.
    - Subsidized adoptive and subsidized guardianship families will be provided 10 days of paid respite per calendar year.
    - $100 stability grant for subsidized adoptive and subsidized guardianship families
        - Monies can be made available for items such as weighed blankets, sensory items, equine and canine therapy, or emergency items needed for crisis stabilization within the adoption or guardianship home.

Engagement in post adoption/guardianship services over the last several years are reflected in the numbers below provided to HHS by its contractor Four Oaks/Family Connections. It is hoped the total number of engaged families in post adoption and guardianship services will continue to grow.

Table 4ooo: PAS Family Numbers 7/1/18-12/31/23	
SERVICE AREA	Total
1	92
2	906
3	643
4	1366
5	1220
Grand Total	4227

Iowa's adoption savings monies earmarked for post adoption and guardianship services are used to help pay for the increase in novel support services in this contract. This is assisting Iowa in meeting some of its adoption savings obligations.

The goal of adoption promotion and supportive services is to help strengthen families, prevent disruption, and achieve permanency. Iowa uses a minimum of 20% of PSSF dollars for adoption promotion and supportive services. It is hoped the increase in services as well as the outreach to adoptive and guardianship families will help reduce the number of children re-entering Iowa's child welfare system seeking congregate care settings for children. Iowa would like to reach families before they reach a crisis level and give them the supportive services, they need to be successful in a home setting, therefore reducing the number of children needing congregate care levels of service. The RRTS contract which went into effect on 7/1/23 has an unpaid performance measure which states: Adoptive and Subsidized Guardianship Families will receive supportive services: Thirty percent of the families will accept and participate in services offered during required contractor check-ins which is minimally every six months. This reflects Iowa active commitment to give adoptive and guardianship families support after finalization. Providing the information of available supports on a regular basis is the first step to preventing possible reentry into the child welfare system. Iowa also provides a flyer which outlines post adoption services in each new certified birth certificate sent to new adoptive parents regardless of the type of adoption.

Iowa has made improvements in the scope of post adoption supports and efforts to engage families in participating in the service in this reporting period. It is hoped the amount and quality of post adoption and guardianship services will continue to improve into the next reporting period.

Internal Agency Collaboration

Iowa HF 2578, adopted and signed in 2022, created the Iowa Department of Health and Human Services (HHS), which merged the Iowa Department of Human Services and the Iowa Department of Public Health.

The HHS adoption program manager held an "Adoption Summit" face to face with HHS adoption SWCM's and supervisors in October 2023 in Muscatine Iowa. The Summit included an exchange of information with statewide adoption SWCM's, supervisors, and the Iowa Attorney General's office. This assisted with providing the most accurate and current information to the persons working directly with families in order to support them in the most meaningful way possible. The summit also included worker collaboration and relationship building. Workers shared ideas and practices for difficult case situations. This was the third Iowa Adoption

Summit held in this CFSP reporting period. Feedback for this event was very positive from attendees and Iowa hopes to continue the event into the next reporting period.

The HHS adoption program manager holds bi-monthly virtual phone calls with adoption supervisors statewide to communicate about any latest information as well as communicate about any problematic situations.

Starting in 2023 the HHS adoption program manager began monthly virtual phone calls referred to as “office hours” with adoption SWCM’s and supervisors statewide in order to communicate directly regarding any adoption related issues, legislative information as well as general HHS information. This call provides the ability for adoption SWCM’s doing direct work to communicate regarding problematic cases, policy clarifications or any adoption related issues. The Iowa HHS adoption program manager also began to hold monthly meetings with Iowa’s “Adoption Subsidy” SWCM’s in 2023. These are HHS social workers whose positions are dedicated to assisting Iowa adoption and guardianship families after finalization. There are five of these positions statewide and their skill set, and duties are unique. Having an outlet for healthy discussion around consistent statewide practice has been a positive for these SWCM’s. Topics included continued eligibility for adoption subsidy approval, adoption subsidy suspension and termination, as well as other pertinent policy guidelines.

The HHS adoption program manager also participated in the quarterly meeting of the Iowa Association of Adoption Agencies. These meetings allow HHS to collaborate with Iowa’s private adoption agencies to discuss their needs and experiences with adoption.

During this reporting period, the HHS adoption program manager initiated statewide adoption worker training courses, referred to as “lunch and learns” for one hour time frames. There have been approximately twelve completed trainings for one hour as well as one additional all day adoption specific training. These trainings are recorded and available to workers on the HHS learning management system.

The shorter one-hour trainings were popular with Iowa adoption staff and will continue into the next reporting period. Subjects for the trainings were sought by the adoption program manager from adoption field staff and supervisors.

In March 2022 Iowa began requiring state adoption SWCM’s and supervisors to participate in the National Adoption Competency Mental Health Training Initiative (NTI). The NTI Child Welfare Professional curriculum is 20 hours and focuses on case work practices and professional skills for staff across the child welfare continuum to promote child well-being, permanency, and family stability for children in foster care and adoptive or guardianship families. Child Welfare Supervisors received an additional 5 hours of training and a Supervisor Coaching and Activity Guide to support staff transfer of learning in daily practice. This training was well received by HHS adoption staff.

In July 2023 the NTI training was included as a requirement for RRTS post adoption staff in the new contract. This training also was well received by RRTS post adoption staff.
During this reporting period the HHS adoption program manager worked with HHS staff, Iowa’s Attorney General office, community partners and stakeholders and assisted to develop a legal avenue for Tribal Customary Adoption (TCA) for Iowa’s Native American Families. TCA does not require a termination of parental rights but is a formal legal relationship, which is financially supported by the adoption subsidy program when eligibility requirements are met. There is a

process in place for some of Iowa's Native American tribes who have the option as part of their constitutions and laws. Iowa has finalized approximately nine TCAs to date with approximately another ten in process.

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 4I: Number of Children Receiving an Adoption Subsidy Payment by State Fiscal Year

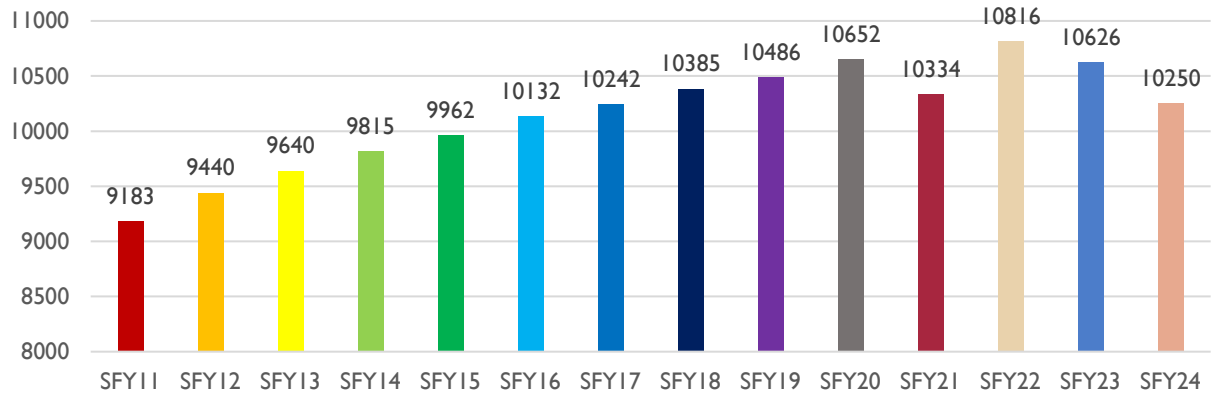


Table 4ppp: Adoption Subsidy by Status, Type and Service Area							
Adoption Subsidy by Status and Type		Western	Northern	Eastern	Cedar Rapids	Des Moines	Total
		Count	Count	Count	Count	Count	Count
Open	Financial	5	11	8	12	1	37
	Medical	2	20	89	7	1	119
	Fin & Med	2178	1719	1526	1746	2313	9482
	Future	365	366	316	390	217	1654
	No Subsidy	2	2	4	6	1	15
	Total	2552	2118	1943	2161	2533	11307

POPULATIONS AT GREATEST RISK OF MALTREATMENT

In 2019, Prevent Child Abuse Iowa (PCA Iowa), Iowa's Iowa Child Abuse Prevention Program (ICAPP) administration contractor, contracted with the Public Consulting Group, Inc. (PCG), to complete a data update to the statewide Iowa Child Maltreatment Prevention Needs Assessment conducted in 2017. The following information was from that Needs Assessment Data Update Report.

PCA Iowa and PCG developed a county-by-county index of need, which incorporated data regarding incidences of child maltreatment and associated known risk factors for child maltreatment. In completing the updated assessment, the following occurred:

- Examination of child maltreatment data in Iowa
  - 2018 child maltreatment data comprising:
    - confirmed and founded reports of physical and sexual abuse, and
    - confirmed reports of a registered sex offender allowed access to a child, neglect, mental injury, and presence of illegal drugs in a child's system.
- Examination of data on known child maltreatment indicators, which included the:
  - 2017 eight statistically correlated risk factors:
    - teen births
    - children living in poverty,
    - low birthweight births,
    - children living with domestic violence*,
    - children living with parents with 4+ ACEs*,
    - children living in households where rent is >35% of family income
    - children between ages 0 and 5, and
    - children living with mental illness in family*

    (*used data from 2017 assessment as no current data was available)
  - child abuse data
  - child neglect data

To determine the counties with the highest risk of child maltreatment, PCA Iowa and PCG calculated county rankings for each of the child maltreatment indicators, calculated a county-level composite score, and created a risk ranking. The table below shows the highest-risk counties identified in both the 2017 and 2019 assessments.

Table 4qqq: Highest-Risk Counties* for Child Maltreatment – 2017 and 2019

Rank	2017 County	2019 County
90	Clarke	Wayne
91	Lee	Lee
92	Pottawattamie	Woodbury
93	Union	Scott
94	Appanoose	Des Moines
95	Woodbury	Appanoose
96	Clinton	Decatur
97	Des Moines	Clinton
98	Wapello	Emmet
99	Montgomery	Wapello

*Highest-Risk counties were the bottom 10 counties
Source: Iowa Child Maltreatment Prevention, Needs Assessment Data Update, Prevent Child Abuse Iowa in collaboration with Public Consulting Group, Inc.

In response to the 2019 update to the Iowa Child Maltreatment Needs Assessment, HHS and the ICAPP Administrator released, in SFY 2020, a new competitive procurement for grantees for SFY 2021-2025. This request for proposal (RFP) identified 17 counties as a county with the

highest risk of child maltreatment (i.e., had a +5.00 or higher on the sum of standard deviations of all 10 Risk Factors). The counties, along with the HHS Service Area and standard deviation (SD) sum included:

Table 4rrr: Highest-Risk of Child Maltreatment Counties by DHS Service Area and Standard Deviation (SD) Sum

HHS Service Area	County	Sum SD
5-Des Moines	Adams	6.92
4-Cedar Rapids	Appanoose	10.21
2-Northern	Black Hawk	5.30
5-Des Moines	Clarke	7.89
3-Eastern	Clinton	12.49
5-Des Moines	Decatur	10.61
3-Eastern	Des Moines	9.91
1-Western	Emmet	12.80
3-Eastern	Lee	9.49
2-Northern	Marshall	6.73
1-Western	Montgomery	7.95
1-Western	Pottawattamie	6.59
3-Eastern	Scott	9.65
5-Des Moines	Union	6.63
4-Cedar Rapids	Wapello	12.95
5-Des Moines	Wayne	8.08
1-Western	Woodbury	9.60

Source: Request for Proposal (RFP), Iowa Child Abuse Prevention Program (ICAPP), Request for Grantee Project Proposals, ACFS 21-001

In addition to applying for ICAPP Core Services, these counties could apply to be one of four counties awarded a Resilient Communities Demonstration Project. This new project type modeled the Federal Community Collaborations to Strengthen and Preserve Families grant and was an attempt to address some of the community/systemic factors that may affect maltreatment rates. HHS limited Resilient Communities Project awards to bidders from these highest risk communities, with a maximum total annual award per county (including all funded proposals) ranging between $0 and $150,000 and varied depending upon risk level with higher risk counties eligible to apply for higher amounts of funding. These Demonstration Projects focused on the following:

- Community Development
- Community Needs Assessment and Strategic Plan Development, inclusive of Stakeholder Input
- Public Awareness and Messaging Campaign
- Strategic Plan Implementation

The new service contracts, which took effect July 1, 2020, included 50 new contracts covering 56 Iowa counties, including 14 of the 17 highest risk counties in the state, with an average award of approximately $35,000 annually. Over the five-year period, the number of projects,

including per project type, remained constant but the number of counties served declined from 56 to 44.

During the reporting period, there was an update to Iowa Code [232.2 35(A)] regarding the definition of neglect. The new definition specifies that neglect means the failure on the part of a person responsible for the care of a child to provide for adequate food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. Inclusion of language that specifies families who are financially able to care for their child or offered financial or other reasonable means to be able to provide necessary care was added to the definition. While poverty is a risk factor, it does not equate to neglect. This definition change addressed the connection between a family's ability to access concrete resources, in conjunction with state prevention efforts, should decrease the number of families entering the child welfare system due to poverty.

For more information, please see *Child Abuse and Neglect Prevention, Early Intervention and Support Prevention Programs and Services, Iowa Child Abuse Prevention Program*.

KINSHIP NAVIGATOR FUNDING

Research shows there are many benefits to placing child(ren) with kin or other kinship caregivers, including increased stability and safety, as well as the ability to maintain family connections and cultural traditions. Kinship navigator program goals include creating a safe and supportive home environment for children outside of stranger foster care, including early identification of needs for additional services such as therapy, counseling, educational and/or mental health services and to close the gaps and/or delays with service delivery to kinship caregivers. HHS focuses on providing a responsive strength-based supportive role to kinship caregiver families.

Iowa HHS received federal funds to develop, enhance, or evaluate kinship navigator programs. HHS entered into a contract with Families First Counseling Services, LLC (Families First) effective October 15, 2018. HHS renewed the contract each year funding was available. The most recent renewal to continue development of the kinship navigator program went into effect October 1, 2021 through September 30, 2022. After September 30, 2022, HHS rolled funding into the Kinship Navigator program, currently part of the Family Centered Services contract in the Cedar Rapids Service Area with Families First.

The funds allocated to this contract provide the necessary services and supports of kinship caregivers. Under this contract, the majority of the costs associated with this contract pay for the following positions:

- One (1) full-time Kinship Navigator Supervisor
- Three (3) full-time Kinship Navigator Specialists

In addition to payment of salaries of the supervisor and specialists, funds also purchase concrete goods, tangible items, and gift cards for the kinship caregivers. The contract requires the contractor to document the purpose and amount of funds provided to the kinship caregiver and obtain a signature for receipt and tracking of funds. The concrete supports provided may include items such as:

- Clothing allowance
- Beds, cribs, furniture, other items

- Gas cards to assist with transportation
- Gift cards for grocery/food items or other needed supplies

Included within the contract are any other costs associated with development of the necessary support network and provision of services to kinship caregivers referred by HHS.

The majority of services and supports provided to kinship caregivers during the reporting period included:

- Concrete supports, specifically around transportation and groceries in the form of gas/gift cards;
- Emotional Support;
- Info & Referral;
- Case Management;
- Local Resources; and
- Assessment of Needs

Additional services and supports provided include:

- Legal Services (information about types of court hearings and referrals for legal advice)
- Parent Education
- Entitlement Applications
- Med/Dental/Mental Health
- Support Groups

Payment is contingent on the contractor accepting referrals, providing services in accordance with the provisions of the contract, achieving contract performance targets, and submitting invoices for each month of the contract. Accompanying the invoices are documentation necessary to support the charges. The contractor receives payment in monthly installments of 1/12 of the total contract amount.

In the last two years, contractors took turns hosting quarterly meetings with all Kinship Navigator contractors. These meetings covered progress, barriers to progress, contract issues, topics for support group meetings/training for caregivers, referral processes, and documentation. At one of the meetings, contractors connected with Iowa's MCOs to learn about the services and supports available to children and kinship caregivers through the MCOs. These meetings have not occurred the last two quarters due to contractors focusing on other areas of the contract and overall stability of the Kinship Navigator program. HHS anticipates that these meetings will resume in the near future as Iowa works to align practice with IV-E claimable evidence-based interventions (EBIs).

As noted in earlier sections of this report, specific data on Kinship Navigator is not available due to limitations of HHS' current IT systems. Several testimonials gathered from kin and fictive kin caregivers point to increased placement stability and caregivers having their needs met. HHS began working with Sivic Solutions Group (SSG) in 2023 to review the Kinship Navigator Services program and to determine next steps to align Iowa's practices with IV-E claimable EBIs. SSG identified that Iowa's current practice most closely aligns with the Ohio Model for Kinship Navigator. Iowa continues to partner with SSG to work toward alignment with the Ohio Model.

MONTHLY CASEWORKER VISIT FORMULA GRANTS

Program goals: "To improve the quality of monthly caseworker visits with children who are in foster care under the responsibility of the State, with an emphasis on improving caseworker decision making on the safety, permanency, and well-being of foster children and on activities designed to increase retention, recruitment, and training of caseworkers."

Iowa Policy: Iowa defines a caseworker visit as face-to-face contact between the foster child and the caseworker. The caseworker's visit focuses on issues pertinent to child safety, case planning, service delivery, and goal attainment as it relates to that child's case. The visits occur at least monthly, with more frequent visits if determined necessary based upon the individual needs of the child. The majority of the time visits are in the "child's residence", which is defined as the home where the child is residing, whether in state or out-of-state, and includes the foster home, childcare institution, or the home from which the child was removed if the child is on a trial home visit. Caseworkers document the visit in Iowa's child welfare information system.

How the Monthly Caseworker Visit Grant is used to improve the quality of caseworker visits
Iowa HHS utilized the Monthly Caseworker Visit (MCV) grant over the five-year period in the following ways:

- Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs.
- 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 quality caseworker visits, which in turn affects caseworker's' assessment of safety, efforts to achieve timely reunification or other permanency goals, and efforts to achieve child and family well-being.
- CareMatch upgrades to help better support contracts.
- Exceptional payments to HHS mentors.

Table 4sss: Monthly Caseworker Visit (MCV) Grant Usage

SFY	MCV Grant Expenditures
2020	▪ Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs, and the JCS-HHS systems data matching to capture visits more accurately for juvenile justice children in foster care. ▪ Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. ▪ Purchased access to CultureVision™ for staff and service providers to utilize to engage children and families in a culturally responsive manner. CultureVision™ is a user-friendly database with information on a variety of racial, ethnic, and religious cultures. CultureVision™ assists caseworkers in providing culturally responsive services and supports. ▪ Annual fees for Federal Parent Locator Services (FPLS) for FFY2020.

Table 4sss: Monthly Caseworker Visit (MCV) Grant Usage	
SFY	**MCV Grant Expenditures**
2021	Same as 2020 with the exception of the Annual Fees for FPLS. HHS did not enter into a new contract due to low usage and utility as a resource for frontline staff.
2022	▪ Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs, and the JCS-HHS systems data matching to capture visits more accurately for juvenile justice children in foster care. ▪ Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc.
2023	▪ Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs, and the JCS-HHS systems data matching to capture visits more accurately for juvenile justice children in foster care. ▪ Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. ▪ CareMatch upgrades to help better support contracts. ▪ Exceptional Payments to HHS Mentors
2024	Same as 2023

Data Outcomes: The data in Table 4sss below shows some success in improving caseworker visits as there was a 2% improvement from FFY 2022 to 2023 and there has been another 2% improvement so far, this FFY 2024.

Table 4ttt: Monthly Caseworker Visits with Children in Foster Care (FFY 2020-2024)					
Reporting Requirement	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**FFY 2024 (10/2023-12/2023)**
The aggregate number of children served in foster care for at least one full calendar month	7,804	6,832	6,213	5,880	3,757
The total number of monthly caseworker visits for children who were in foster care	52,527	43,689	39,874	38,513	10,616
The total number of complete calendar months children spent in foster care	58,540	47,234	44,522	41,763	11,264
The total number of monthly caseworker visits with children in foster care in which at least one child visit occurred in the child's residence	42,994	37,558	32,872	31,351	8,163
The percentage of monthly visits by caseworkers with children in foster care under the responsibility and care of the state.	90%	93%	90%	92%	94%

Table 4ttt: Monthly Caseworker Visits with Children in Foster Care (FFY 2020-2024)					
Reporting Requirement	**FFY 2020**	**FFY 2021**	**FFY 2022**	**FFY 2023**	**FFY 2024 (10/2023-12/2023)**
The percentage of monthly visits that occurred in the residence of the child.	82%	86%	82%	81%	77%

Source: *Results Oriented Management (ROM); **AFCARS

Some of the main barriers to meeting the 95% frequency requirement over the last 5 years include increased staff turnover and worker shortages which resulted in much higher caseloads. Staff report limited time to document visits given the caseload and turnover issues. There also was an increased number of youths placed out of state and youths on the run.

HHS has taken multiple steps to improve compliance in meeting the frequency requirement. There has been more focus and conversations by managers and administrators on visits and ongoing visit data reports. Visit data has been provided with greater frequency to managers and staff, including sharing data across supervisor teams lending to healthy competition across teams. Service Area Supervisors have been collectively developing a standard approach across all supervisory teams regarding how to share visit related information ongoing. Service Areas are addressing lower performing staff, including suspending remote work from home for low performers until improvements are made. Supervisory teams are also reaching out more frequently across Service Areas to provide support and visit assistance.

ADOPTION AND LEGAL GUARDIANSHIP INCENTIVE PAYMENTS

During FFYs 2020-2024, Iowa spent its adoption and legal guardianship incentive payments on the following:

- Approximately $1.2 Million spent on Family Safety, Risk and Permanency (FSRP) services due to caseload growth;
- Approximately $5.3 Million spent on Family Centered Services due to caseload growth

ADOPTION SAVINGS

Adoption subsidy is a financial support provided to families who adopt special needs children. The funds assist families with the cost of raising a child and costs associated with the needs of the child. Reinvestment is the required use of state savings resulting from federal legislation that expanded eligibility for federal matching funds for children receiving an adoption subsidy. This additional federal funding reduced state expenditures. States are required to reinvest savings in specified qualified expenditures. Below is how Iowa has spent funds in the last year.

Iowa was obligated from 2016-2024 to spend approximately $41.9 million in three separate categories. The categories are post adopt/post guard services, adopt/post guard services or children at risk to enter foster care and all allowable services. The amounts with categories are as follows:

- Approximately $8.3 Million was required to be spent on adopt/post guard services of which $3.5 was expended on these services. Expenditures will continue to be met

through the RRTS contract obligations and increase in post adoption and guardianship services.

- Subsidized Guardianship
- RRTS Contract after 7/1/23
- Approximately $4.1 Million was required to be spent on adopt/post guard services at risk to enter foster care of which all was expended on these services.
    - Family Centered Services – including Non-Agency Solution Based Casework and Family Preservation
- Approximately $29.3 Million was required to be spent on all allowable services of which all was expended on these services:
    - TOP
    - Kinship Stipend Program
    - Kinship Navigator Program
    - Specialized ORTP Beds

HHS also has designated Adoption Reinvestment funds to help support our Subsidized Guardianship program. Five percent (5%) of expenditures are related to Iowa's Subsidized Guardianship program.

Iowa continues to increase the numbers of children in the Subsidized Guardianship program. Below is the number of children by Iowa's Service Areas in the program since its inception in 2019. These are cumulative totals of open Subsidized Guardianship cases for each service area. Demonstrating how many Subsidized Guardianship cases are averaging through each area as well statewide. As of March 22, 2024, Iowa has a statewide total of 182 subsidized guardianship cases. This is an increase of 43 subsidized guardianships from the previous fiscal year.

Table 4uuu: Subsidized Guardianships by Service Areas

	Western	Northern	Eastern	Cedar Rapids	Des Moines	Total
Open Cases	Count	Count	Count	Count	Count	Count
SFY 2024	61	21	35	27	38	182
SFY 2023	35	19	14	25	46	139
SFY 2022	28	14	8	21	27	98
SFY 2021	20	4	4	18	10	56
SFY 2020	7	3	3	5	6	24
SFY 2019	0	1	0	0		2

Data Source: HHS

HHS is also using available adoption savings money to increase the purchasing of Family Centered Services which include Safe Care 24.69% and Family Preservation 19.29%. Therefore 50% of Iowa Adoption Savings expenditures are related to family centered services.

As stated previously, Iowa's adoption savings monies earmarked for post adoption and guardianship services is being used to help pay for the increase in novel support services in the RRTS contract which began on July 1, 2023. This will assist Iowa in meeting its adoption savings obligations specially related to post adoption supports.

Family First programs represent 85% of Iowa's SFY 2023 Reinvestment funding.

FAMILY FIRST PREVENTION SERVICES ACT TRANSITION GRANTS

HHS used the Family First Transition Act (FFTA) funding for the purposes of IV-B, subpart I, to assist our Family Centered Services (FCS) contractors with developing capacity to provide the new FCS service packages. These implementation costs included training and certification in Solution Based Casework (SBC) and SafeCare® and IT costs associated with implementation. HHS also uses the funding for SBC licensing fees. SafeCare® is HHS' only Title IV-E Prevention Service implementing FFPSA, Part I. The table below provides a breakdown of how HHS utilized the FFTA funding.

Table 4vvv: FFTA Funding Utilization – 7/1/2019-3/31/2024

	Salaries & Wages	IT Technical Consultants	Educ & Training Supplies	Admin. Support	Other Licenses, Permits & Fees	Research	Training
IT COSTS	$79,337.80	$283,193.90	$0.00	$0.00	$0.00	$0.00	$0.00
Transition Funding	$0.00	$333,517.35	$0.00	$0.00	$132,512.43	$0.00	$0.00
FCS Costs	$0.00	$35,725.00	$539,983.00	$166,375.00	$54,345.82	$0.00	$24,000.00
Licensing Fees - SBC	$0.00	$9,600	$0.00	$22,000	$121,662.20	$0.00	$0.00
Program Manager	$36,150.09	$1,472.66	$0.00	$138.35	$185.00	$0.00	$0.00
IV-E Prevention Plan Manager	$95.65	$0.00	$0.00	$7.32	$0.00	$0.00	$0.00
FFTA allowable costs	$0.00	$0.00	$0.00	$0.00	$0.00	$95,000.00	$377,660.00
$2,312,961.57	$115,583.54	$663,508.91	$539,983.00	$188,520.67	$308,705.45	$95,000.00	$401,660.00

Characteristics of families and children served under FFPSA are families eligible for SBC and SafeCare® that have a confirmed child abuse assessment and their risk assessment indicated moderate or high risk for re-abuse, or a founded child abuse assessment. The children either remain in the parental home and are candidates for foster care or the children have been removed and their case plan goal is reunification.

SBC certification is a long process. Previously, only a couple of FCS workers applied for certification. All FCS contractors have workers trained in SBC; however, HHS does not have exact numbers at this time. Similarly, for SafeCare®, all FCS contractors have trained SafeCare® workers and all six contractors have certified coaches and certified trainers. It takes about six months for a SafeCare® worker to receive certification in SafeCare®, and then move toward coaching, etc. FCS contractors continue to work on staff development toward certification in SBC. Contractors are working with SBC developers to ensure a consistent supervisory process that leads to certification of additional staff. All contractors have certified SafeCare® staff currently.

For more information about FCS, please see *Family Centered Services (FCS)* earlier in this section.

HHS contracts with Georgia State University (GSU) Research Foundation to evaluate our SafeCare® implementation. The contract has been in place for two years now. HHS utilized FFTA funding for the SafeCare® evaluation, continued support of SBC and SafeCare® certification, coaching, and training, and FCS associated IT costs.

JOHN H. CHAFEE FOSTER CARE PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD (THE CHAFEE PROGRAM)

Program Description

The Iowa Department of Health and Human Services (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. HHS is the state agency that administers, supervises, and oversees all aspects of delivery and monitoring of services for transiting youth. Iowa efforts are supported by federal IVE 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.

Iowa ensures and will continue in federal fiscal years 2025 through 2029, that all political subdivisions implement the Chafee program in a youth driven, but statewide consistent manner, by relying on internal staff and the network of providers to ensure support and programming for Iowa youth. This means HHS has statewide contracts for services like the Iowa Aftercare Services Program (aftercare), the Iowa Foster Care Youth Council (known as AMP), and the Education and Training Voucher Program (ETV) so young people, including native youth, in different areas of 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.

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. 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 are provided by HHS caseworkers and Juvenile Court Officers for children in foster care and for eligible youth who have exited foster care, extend to the youth's age 23 in the Iowa Aftercare Services Program (Aftercare) and to age 26 if the youth is participating in the Chafee funded Education and Training Program (ETV). Iowa Aftercare and ETV are among the programs which will be described in this report.

In accordance with ACYF-CB-PI-18-06, HHS is operating a comparable program to serve youth up to age 23 through the state. ~~has an approved title IV-E plan amendment to serve youth in foster care up to age 23.~~ HHS contracts for a "comparable" state funded program for former foster care youth up to age 21. The Iowa Aftercare Services Program has been the primary case management service for youth at age 18 through 22, since 2020. HHS extended Chafee

education and training voucher (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 population served in federal fiscal year 2023/4 and which will be eligible in 2024/2025, 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.
(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).

Due to the HHS alignment activities which have been well publicized and addressed in this report, the legacy DHS combined with Iowa Department of Public Health, Human Rights, Volunteer Services Iowa and others. From the perspective of transition programs, this has created new opportunities to partner and align programs. For example, the NYTD program, which was administered in the Department of Human Rights, is now part of HHS. This eases communication and is more efficient. There have been no downsides to the alignment in this program.

Over the past five years, the number of youths in foster care (all types, including unlicensed relative and suitable other person placement) age 14 and older has decreased each year, which is a 37% decrease since 2019. We are projecting an even lower number of teens in foster care in federal fiscal year 2024, as the table below shows.

It is reasonable to assume that the Family First Act and Iowa efforts to comply with this federal law has had an impact on the number of children in care of all ages. Proponents of the Family First Act would say foster care is down due to newly created evidenced based interventions and to the restrictions on residential services claiming. Also, the new in 2021 Kinship Caregiver Payments, which allowed a time-limited payment specifically for kinship caregivers may help children reunify sooner. Others would argue, the reduced foster care numbers are less about the programs themselves and more about the "Family First" messaging and culture to keep children with family. Regardless, there is no arguing that the number of teenage youths in foster care is decreasing rapidly in Iowa, and by association, aftercare numbers are dropping as well.

Table 4www: Federal Fiscal Year Foster Care/Aftercare Breakdown and Total

	Youth aged 14 and older in foster care (FACS payment data)	Youth participating in Iowa Aftercare Services from monthly billing claims—Youth age 18-22 (some youth are duplicated in "core" and "extended")	Total
FFY 2024 (using Excel forecast function)	1702	776	2478
FFY 2023	2041	545+208=753	2794
FFY 2022	2260	574+237=811	3071

Table 4www: Federal Fiscal Year Foster Care/Aftercare Breakdown and Total			
	Youth aged 14 and older in foster care (FACS payment data)	Youth participating in Iowa Aftercare Services from monthly billing claims—Youth age 18-22 (some youth are duplicated in "core" and "extended")	Total
FFY 2021 (extended Jan 1, 2020)	2591	596+236=832	3423
FFY 2020 Family First Jan 1, 2020	2896	667+146=813	3709
FFY2019	3268	748+0=748	4016

Outcomes at a Glance

HHS is intentionally data informed in our child welfare efforts. The following data from Iowa's NYTD program hints at the trends over this reporting period. It is clear, while Iowa is doing well in many areas, there is still work to be done. There will be more NYTD data later in this report.

- Nearly 23% of youth have a part-time job, which is higher than the national average of 17%.
- Youth reporting two or more races had the highest rates of employment.
- The leading reason for youth not being employed was attending school.
- Of those who reported not working, 62% were currently living in congregate care, 36% in a family-like setting and 2% in Independent Living.
- Hispanic/ Latino youth and youth who reported two or more races were the most likely to receive employment-related skills training when compared to their peers.
- Iowa is above the national average for youth who have achieved their high school diploma or HiSET by the age of 17.
- About 80% of youth reported attending a regular high school, which is lower than the previous cohort year of 84% in FFY20.
- Nearly 97% of youth have at least one adult to go to for support, an increase from FFY 2020 (95.5%) and above the national average (93%).
- Most youth (56.9%) reported that their most trusting relationship is with a biological family member.
- The percentage of youth receiving substance abuse assessment or counseling increased by over 7 percentage points from FFY20.
- The percentage of youth reporting having a child by age 17 slightly increased and continues to stay below the national average.

Legislative Actions

In 2020, Iowa Governor Reynolds signed an HHS "pre-filed" bill to allow youth who age out of unlicensed relative foster care to receive the same PAL financial support as those who age out of state paid placements.

The Iowa General Assembly passed HF2252 in 2022, which created the option to extend licensed family foster care or Supervised Apartment Living (SAL) for a youth to age 21. The bill was drafted by HHS to improve outcomes for youth aging out of foster care. It was well supported by youth and was voted in unanimously by the Iowa General Assembly.

Based on a legislative proposal from Aftercare providers, the HHS anticipates an opportunity to increase the Preparation for Adult Living (PAL) payment to youth in Aftercare. The idea is to resolve a problem where staff and youth are selecting between the two options of remaining in foster care with SAL or exiting foster care to aftercare services supports (similar services), simply based on how much money they youth gets in the monthly stipend. Currently the aftercare stipend is $600 a month and the SAL stipend is $784.50.

Department of Health and Human Services Transition Staff

State Independent Living (IL) Coordinator
HHS maintains a full time Independent Living (IL) Coordinator. This state funded position will continue unchanged for the next five-year period. The IL Coordinator, within the recently renamed Division of Family Well-Being and Protection, is responsible for multiple programs and activities centered on the HHS services and supports for youth transitioning from foster care to adulthood. Responsibilities include:

- Ensuring projects, policies, and practices serve transitioning youth efficiently and effectively, resulting in positive outcomes for youth formerly in foster care; and
- Coordination duties for the Chafee funded Transition Planning Specialists as well as the regional Point of Contact (POC) for education and child welfare partnerships to implement Fostering Connections and Every Student Succeeds Act foster care stability provisions; and
- Managing contracts for the following programs:
    - The Iowa Aftercare Services Program, which utilizes combined state and federal funding to serve transitioning youth through a network of child welfare agencies.
    - The Education and Training Voucher program, which utilizes combined state and federal funding to support education attainment of current and former foster care recipients.
    - The Iowa Foster Care Youth Council Contract
    - The Foster Care Transportation for Education Stability Contract with the Iowa Department of Education.
    - Data sharing Memorandum with state and local education entities, for the purposes of education stability; and
    - The Iowa Finance Authority to administer the Rent Subsidy Program.

Transition Planning Specialists (TPS):
HHS employs one Transition Planning Specialist (TPS) in each of the five HHS service areas.

Transition Planning Specialist (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. HHS maintains one full time employee for each of the five service areas, who are responsible for understanding the programs, policies, and processes for foster care transition. 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 the supports they need to be successful. Because of the variety of eligibility criterion in the different programs, their working knowledge of the system is invaluable to HHS staff, as well as youth and public and private partners. TPS will continue in their current roles in coming years.

Naturally, permanency is also a big part of case practices addressed in the Chafee plan, such as within youth centered planning activities. TPS train and support staff at the local service area:

- Help staff understand transition planning requirements, including those around assessment of life skills, youth centered planning, and transition plans.
- Facilitate information sharing about transition services with HHS staff, tribes and other partners.
- Coordinate with Iowa Workforce, colleges and universities, and trade programs to highlight training opportunities available to meet the needs of youth.
- Assist management in assuring compliance with foster care transition indicators.

The TPS utilize the child welfare information system (specifically FACS) to check eligibility for ETV, Aftercare, and other services based upon foster care experience. TPS complete application forms or direct the case manager of a child in foster care on how to do so.

Each TPS tracks completion of transition plans for every youth in Local Transition Committees, flagging them for review at the child's age 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 have remained stable in their positions over the years, but due to retirements we have welcomed three new individuals to the TPS team. Teresa Jacobs (Cedar Rapids) and Michelle Cooper (Northern) have been a TPS for the full five years of this reporting period. Marsha Burke (Eastern), Brooke McCabe (Western), and Brian Speicher (Des Moines) have come on int the past five years, replacing Kai Brooks (2020), Kim Marks (2020), and Jan Huff (2022), respectively. It is a mixed feeling, that Brooke McCabe has taken a social worker position to work on complex cases in child welfare. It's a great innovation for child welfare at large, but it's hard to lose her on the TPS team. The position should be filled by the finalization of this report.

During the past five years, central office made limited funds available to HHS Service Areas for transition projects. "Project Transition" was a successful intervention that capitalizes on local passion and creative spirit. Typically, Project Transition funds are used for transition training and resource fairs in HHS service areas.

ETV Coordinator
The ETV Coordinator, employed through an HHS contract with Iowa College Aid, oversees college and career funding for foster care alumni. The coordinator provides a report of Federal Application for Financial Student Aid and ETV applicant status every two weeks for TPS. TPS provide suggestions to case managers to meet required dates and to keep youth informed of the application process.

Monitoring

Foster Care Transition Tracking System:
HHS maintains an electronic tracking system for transition planning activities to ensure youth get the support they need, and that HHS remains in compliance with all requirements for case planning of transition aged youth. Iowa Code § 232.2(4)(f) lays out the requirements.

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 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 of14. 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. The tracking system is an invaluable monitoring tool. As part of the work toward advancing the 2020-2024 Child and Family Services Plan (CFSP) goals, the TPS found ways to better use the tool by requesting additional sort features and to inform supervisors and engage them in the accountability of staff. In the coming five years, we hope to integrate more of the tracking and alerts into VISION, Iowa's comprehensive child welfare information system (CCWIS).

Internal Programs

Medicaid: The Support of Patients and Communities Act (Support Act) is a federal legislation that mandates that states provide Medicaid to former foster youth ages 18-26, who received Medicaid at the same time they aged out of foster care, regardless of the state they lived in at the time they aged out.

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.

Table 4xxx: MIYA and E-MIYA Expenditures/Enrollment

Calendar Year 2019						
		MIYA and E-MIYA Expenditures and Enrollment				
		Total $$	Federal $$	State $$		Enrollment
	Total	**$3,801,377**	**$2,293,613**	**$1,507,764**		**993**
Calendar Year 2020						
		MIYA and E-MIYA Expenditures and Enrollment				
		Total $$	Federal $$	State $$		Enrollment
	Total	**$4,357,263**	**$2,943,105**	**$1,414,158**		**1100**
Calendar Year 2021						
		MIYA and E-MIYA Expenditures and Enrollment				
		Total $$	Federal $$	State $$		Enrollment
	Total	**$4,501,861**	**$3,063,396**	**$1,438,465**		**1136**

Calendar Year 2022						
		MIYA and E-MIYA Expenditures and Enrollment				
		Total $$	Federal $$	State $$		Enrollment
	Total	**$4,926,736**	**$3,379,329**	**$1,547,407**		**1140**
Calendar Year 2023						
		MIYA and E-MIYA Expenditures and Enrollment				
		Total $$	Federal $$	State $$		Enrollment
	Total	**$4,789,153**	**$3,223,832**	**$1,565,321**		**1070**

Contracted Programs

SAL+: The Iowa General Assembly passed HF2252 in 2022, which created the option to extend licensed family foster care or Supervised Apartment Living (SAL) for a youth to age 21. The bill was drafted by HHS to improve outcomes for youth aging out of foster care. It was well supported by youth and was voted in unanimously by the Iowa General Assembly.

In 2023, the department amended the Aftercare contract to provide a new service called SAL +. SAL+ is a pilot program where Aftercare providers serve youth in Supervised Apartment Living (SAL) with the typical array of life skills training, assessments, and budgeting. This is the first-time Aftercare has been involved in delivering direct services to children who are still in foster care. HHS is piloting this in the Cedar Rapids Service area, because they don't have a SAL service provider under the new SAL contracts. It will be interesting to see the benefits of having aftercare connected before the youth exits foster care. The notion of having Aftercare involved for the youth in SAL is appealing, because when they youth age out of SAL, they shouldn't have to change Aftercare workers. This program will be observed over the time to evaluate participation and effectiveness. For the first eighteen months, we are limiting services for up to ten youth.

Achieving Maximum Potential (AMP)

Achieving Maximum Potential (AMP) is a youth engagement program for current and former foster and adoptive youth. Summarized by the motto "Nothing About Us, Without Us", AMP serves as Iowa's Foster Care Youth Council through a contract between YSS (AMP's lead agency) and the HHS.

HHS put out a public request for proposals in the fall of 2022 for the Iowa Foster Care Youth Council. An impartial evaluation committee selected YSS to continue the contract. State Fiscal Year 2024 represents the second year of a possible six-year contract between HHS and YSS. YSS has embraced the opportunity, and in fact, has initiated "AMP 2.0" with two new leaders who each possess high educational attainment and lived experience in foster care, among their many credits.

The primary purpose of AMP is to empower young people to become advocates for themselves and for system-level improvements to child welfare policies and practices in Iowa. When supported through productive partnerships with adults, youth can play a pivotal role in making the child welfare system more responsive to youth and families and more effective in achieving desired outcomes.

AMP offers leadership opportunities, service-learning projects, speaking opportunities, and educational or vocational assistance to youth ages 13-22 who have experienced foster care, adoption, or other out-of-home placements. AMP also offers opportunities to learn life skills and access to a variety of resources as young people transition from foster care to adulthood.

Under the YSS contract, including subcontracts, seven private, non-profit youth-serving agencies comprise the foster care youth council. During SFY 20223, AMP offered ten councils, each with a council facilitator employed for about 10 hours per week. The agencies involved in the Partnership and the location of the Councils they support are:

- YSS (Ames, Des Moines, Eldora State Training School (STS)
- American Home Finding Association (Ottumwa); Waterloo (tentative)
- Children's Square USA (Council Bluffs and Sioux City)
- Youth Shelter Care of North Central Iowa (Fort Dodge)
- Foundation 2 (Cedar Rapids)
- Hillcrest Family Services (Dubuque)

In SFY 2023, AMP served 891 unduplicated youth, with at least 2,352 connections. The annual reports in 2019 and 2021 show 903 and 641 unique youth served, respectively. The participation counts are based on youth sign in sheets, which has some weaknesses. Nonetheless, participation continues to be strong for the foster care youth council.

Since 2018 a lot has changed for AMP councils across the state. Reduction in the foster care population, cost increases and COVID have all challenged YSS and AMP subcontractors to serve as many or more than the year before, which is our goal. On the other hand, extension of the age limit from ~~20~~21 to ~~20~~23 in 2020 due to the flexibility of Chafee funding has expanded opportunities for youth to stay connected.

AMP has adapted to the changing needs of the community by creating mobile councils and offering virtual meeting options. Many AMP councils host meetings at various residential facilities in their areas, with some still holding community council meetings as well. The plan for this year is to have every council hosting at least one community meeting a month. AMP launched a virtual council that meets once a month to reach youth who are unable to attend in-person meetings. AMP has expanded their online and social media presence to engage youth and has employed youth in leadership positions to help recruit, retain, and mentor other AMP youth.

The department requires YSS to submit an annual program report. The SFY2023 report describes the statewide youth council serve provided to youth, including youth participation and results. The report, including AMP performance measures, has been approved by the department and is made part of this report by this reference:

AMP 22_23 Annual Report FINAL.pdf

Samanthya Marlatt, AMP Program Manager, was hired in September 2022. In addition to lived experience in Iowa's foster care system, she brings extensive knowledge and expertise in program management and authentic youth engagement. Laticia Aossey, MSW was hired in July 2022 as the AMP Council Coordinator and is also the AMP Council Facilitator of the Cedar

Rapids Council. In addition to lived experience in Iowa's foster care system, she brings extensive experience in child welfare and social work gained through a variety of roles. Armi Damken-Navarro was hired in March 2023 as the Des Moines AMP Facilitator following Atalie Ferring's transition from the role. Armi has lived experience in Iowa's foster care and juvenile justice systems. She also serves on the Iowa Department of Human Rights Youth Justice Council. Highly qualified AMP staff are effective leaders and great examples for youth. The future is bright for the Iowa's foster care youth council.

Iowa Aftercare Services Program (aftercare)

Iowa Administrative Code 441.187 establishes eligibility criteria for aftercare services, which allows youth to participate if they aged out of foster care (at least age 17.5), regardless of the licensure or payment status of the placement. Youth who exit a foster care placement to adoption or the Subsidized Guardianship Program are also welcome to participate. Participants can start the program at age 17 and may continue until they reach age 23. Youth who aged out of Iowa's detention centers or the State Training School (STS) also are eligible, and their services are 100% paid for with state funds.

Based on a competitive procurement released in 2022, HHS contracts for the Iowa Aftercare Services Program. Youth & Shelter Services (YSS), a child and family serving non-profit agency from Ames, Iowa. YSS is in their second year of a six-year contract. In addition to providing direct services through five of its central Iowa locations (Ames, Des Moines, Marshalltown, Mason City, Webster City), YSS subcontracts with seven other youth-serving agencies to provide aftercare services to eligible youth throughout the state. These partner agencies, and the location of the primary aftercare offices, include:

- American Home Finding Association (Ottumwa)
- Children's Square USA (Council Bluffs)
- Family Resources, Inc. (Davenport)
- Foundation 2 (Cedar Rapids)
- Four Oaks (Waterloo)
- Youth Homes of Mid-America (Des Moines)
- Young House Family Services (Burlington)

The Aftercare contract combines funding from federal and state sources. Over the years, legislative changes and increased funding have allowed aftercare to expand eligibility criteria so that more young Iowans can benefit from the program:

- Since January 1, 2020, "extended" services became available to 21 and 22-year-olds who had previously received "core" Aftercare services between the ages of 18 and 21. Extended services offer less structured services than core services and designed to be responsive to those young adults who want additional support as they continue a path towards self-sufficiency.
- In 2020, Iowa Governor Reynolds signed an HHS "pre-filed" bill to allow youth who age out of unlicensed relative foster care to receive the same PAL financial support as those who age out of state paid placements.
- Beginning in January 2020, Extended Aftercare became available to 21 and 22-year-olds who had previously received Core Aftercare between the ages of 18 and 21. Extended services are less structured than Core services and are designed to be responsive to those young adults who want additional support as they continue a path toward self-sufficiency.
- In 2022, Iowa Governor Reynolds signed HF2252, another HHS bill, which extended foster care to 21 and could indirectly impact aftercare participation.

- Beginning October 1, 2022, aftercare, in cooperation with the Department of Health and Human Services (HHS), implemented a formalized Pre-Aftercare referral process. Among other innovations, a new aftercare referral form included in the HHS employee manual.
- Anticipated: Increased flexibility to use state funds for transitioning youth programs and increased direct funds to youth is being considered by the Iowa Legislature in 2024.

Since July 1, 2023, YSS subcontracts with the Iowa State University (ISU) for coordination, training, and data collection. Dr. Jan Melby and her team at Iowa State ISU include a full-time Aftercare coordinator who receives questions from service providers and HHS, creates tools and documents, manages intake and referrals, and side by side assists HHS to audit the entire program. A highly skilled graphic designer continues her good work to keep documents for staff and the public looking clear, understandable, and “pretty”.

Each participant works individually with a Self-Sufficiency Advocate (SSA), assigned to them by their aftercare agency. These SSAs typically meet with participants, ideally at least twice per month, to assess their needs, help them set goals, identify action steps, and persist until they achieve those goals. SSAs offer support, guidance, and provide a range of information and services according to participants’ unique needs and interests.

Aftercare participants are either “Aftercare Basic” or “Aftercare Plus” status as determined by program eligibility criteria. Preparation for Adult Living (PAL) essentially means, in addition to case management supports that all participants receive, PAL participants receive up to $600 per month funding for living expenses. Because PAL eligibility requirements are more stringent than Aftercare requirements, some participants are eligible for Aftercare but ineligible for the PAL stipend. These participants have Aftercare Basic status. This status allows those who will never qualify for PAL benefits (i.e., monthly stipend) to receive aftercare case management services and support, as well as limited, short-term financial assistance in the form of vendor payments. Participants that could receive a PAL stipend depending on their education and work status receive designation as Aftercare Plus.

Youth have been increasingly vocal, that the amounts have not kept up with the cost of living. HHS has helped AMP youth identify online resources such as the Department of Labor Statistics cost of living reports to help them make an informed case for increased payment amounts to youth. HHS welcomes conversations with youth and lawmakers to “right size” payment amounts.

Over recent years HHS and Aftercare have worked hard to develop “pre-Aftercare” and an “extended” Aftercare service, to bolster the “core” Aftercare case management to expand the service to the point aftercare is now serving youth as young as age 17 up to the age of 23. The HHS is requesting additional funding and flexibility during the legislative session 2024 to better serve participants.

The number of young people aging out of foster care and other court-ordered placements in Iowa has declined over recent years, which has translated to a decreasing number of new entries into Aftercare services. Intakes to aftercare have been up and down in the past five years. For example, we saw 212 youth access core services in SFY 2022, compared to 177 in the previous year. In SFY 2023 it dropped again to 167 young people accessing the service for the first time. New participants represented 31.2% of the 535 young adults who received Core Aftercare services during the SFY23 year.

The department requires the Aftercare provider, YSS, to submit an annual program report. The SFY 2023 report describes the statewide aftercare service, youth participation and results. The report has been approved by the department and is made part of this report by this reference:

IASN_AnnualReport_SFY23_FINAL_12112023.pdf (iowaaftercare.org)

New Projects
The SAL+ component of the Aftercare, briefly mentioned above, helps youth in an Iowa Department of Health and Human Services (HHS), or Juvenile Court Services (JCS) Supervised Apartment Living Scattered Site placement learn skills and prepare for adulthood. The primary goal of the program is for youth to move toward self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood. This is a new pilot project in the HHS Cedar Rapids Service Area.

Therapeutic Foster Care
Therapeutic foster care is a new in 2023 pilot project in Cedar Rapids Service Area aimed at providing intensive, family-based support to youth in the child welfare system who have cooccurring behavior and mental health needs. Children in Therapeutic Foster Care (TFC) receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing a child's mental/behavioral health issues, facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or independent living), and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan.

TFC is a first of its kind program in Iowa, which was a joint project of Medicaid, child welfare, mental health and disability services and contracted providers. It has been a two-year project and a lot of effort, which will be totally worth it if it can prevent youth with this level of need from going deeper, staying longer, or not getting their needs met by the tradition foster care or mental health system.

Caring for children with severe mental health and behavioral challenges can be rewarding, but it does not come without its challenges. Caregivers need to be able to work in large teams, communicating often and effectively. It is necessary to train and support the family of origin beyond what would be expected in a traditional foster family situation. The trauma the child has experienced can result in secondary trauma to the caregiver and the team around the child. The flier below describes the service and eligibility. As of the writing of this report, there are three approved homes and two youth in placement. Both youths are succeeding.

Therapeutic Foster Care Flyer.pdf

Collaboration

This section provides an update on how HHS has collaborated with youth and other contributors and partners to improve foster care transition. Specific examples are intended to be representative of the kind of collaborate work we do, but this is not an exhaustive listing.

Activating Youth Engagement
Children's Bureau former Associate Commissioner Dr. Jerry Milner hosted Activating Youth Engagement (AYE) roundtables in 2019. Youth with lived experience in foster care expressed their opinions to Dr. Milner and his team; the importance of staying connected with caseworkers, and by association, being engaged in their own case planning, among other things. An Iowa team, including a youth member, the independent living coordinator and the ETV coordinator attended an event Washington DC to describe the roundtables and so Dr. Milner could help states imagine how much better our systems would be with input from those living it. After returning home, the Iowa team worked to establish an Iowa AYE group which began meeting in February 2021. The AYE involves youth with lived experience in foster care, policy staff, and youth advocates to genuinely discuss foster care matters and work side by side to make positive change.

HHS and AMP were key partners and wanted to keep the group small and connected, so AYE could take on actual policy issues and see them through. To this day, AYE intentionally brings the perspectives of youth and young adults with lived foster care experience into state level child welfare policy and practice decision-making. HHS leadership has worked out a plan with the AMP youth council to invite youth and convene the meetings. HHS policy staff, often including top child welfare leadership, attend the meetings to listen and to inform on progress. "Closing the loop" on efforts is very important. Youth want to know if their voices were heard, even if it did not result in the desired change. AMP staff prepare youth for meetings and mentor them on policy matters. AMP continues to convene the AYE meetings at least every quarter. AYE is expected to be an ongoing group and a core collaboration strategy. Among AYE's successes is an increased clothing allowance for children in foster care. Also, AYE is making useful contributions to the five-year child welfare plan, known as the Child and Family Services Plan.

AMP Legislative Agenda/Day on the Hill
Annually, AMP solicits input from youth around the state for AMP's legislative recommendations. For their Day on the Hill, January 30, 2024, AMP prepared and presented the 2023 AMP Legislative Agenda in an event and press conference at the Iowa Capitol called the AMP Day on the Hill. Director Garcia invited AMP youth to share their ideas with her leadership team again this year. AMP's ideas align with department efforts in many ways and the experience has given Iowa youth a chance to learn policy, HHS the ability to learn from youth, and potentially all youth in Iowa foster to benefit from any changes voted in by the Iowa General Assembly.

Over 40 AMP youth attended this year.

Youth presenters were very well prepared as they spoke to needs for kinship supports, increased funding for transition programs, and a youth bill of rights.

Several HHS leaders were present to support Iowa youth.

AMP's Legislative Agenda (as provided to HHS leadership and lawmakers) is below.

AMP 2024
Legislative Agenda (

Talking Wall

Iowa's NYTD will also work with the AMP foster care youth council to continue an innovative project, called the "Talking Wall", where young people in residential facilities, shelters, and other foster care settings use "sticky notes" on the wall to express the dreams improvements in their own case or in the system. Facilitated Talking Wall activities were conducted in the winter months of the 2023-2024 season. Input was compiled and used to inform the legislative and advocacy efforts. The Talking Wall always includes input-provoking questions, which never fail to get insights from youth. This year's questions were:

- What would you like to see happen to improve the foster care and/or juvenile justice system in Iowa?
- What do you and/ or other youth need that you're not currently getting?
- What is one thing that has helped you while being in the system?
- What things do you wish existed in your community that would help you?
- We are developing two bills of rights: one for youth in foster care and another for youth in juvenile justice. What do you think should be included?
- What do you wish people knew about how being placed in detention has impacted you emotionally, physically, and/ or mentally?

More information can be found at the following link:
The Talking Wall — AMPIOWA (weareampiowa.com)

Youth Engagement Survey

The Youth Engagement Survey was created in 2022 by the Department of Human Rights (DHR) with support from HHS to try to get a statewide assessment of whether youth in foster care feel authentically engaged to contact with family, youth rights, court and relationships with staff and workers. The Youth Justice Council worked on this survey and drew themes from the Talking Wall. The survey was conducted with youth who are residing in residential foster care program and detention centers. State Training School youth are being invited in this next round.

HHS and DHR partnered for the second year to conduct the survey in 2023. Several modifications were made based on lessons learned in the first round. These 2023 foster care youth survey results are the most recent available.

- 20% of youth reported being LGBTQ+ (DHR researchers determined the survey to be valid of youth in out of home placement since they surveyed a certain percentage of youth who were eligible to take the survey)
- 1 in 4 youth in out of home placement responded they do not know their rights as a youth in the system. 1 in 3 don't know how to exercise their rights. Black youth were the least likely to know their rights.
- Half (52%) of youth don't feel like they have enough phone calls with their families, 56% believe calls are too short.
- 1 in 2 youth in foster care do not meet with their attorney outside of court.
- Most youth (88%) said their judge treats them with respect.
- 85% of youth in foster care know they have the right to attend their own court hearings.
- 60% of youth believe they have a say in their case.
- 1 in 3 youth don't feel prepared for court and 1 in 3 youth don't feel comfortable speaking up in court. 53% of LGBTQ+ youth don't feel comfortable speaking up in the courtroom.
- 68% of youth believe staff in out of home placement care about them, 79% said staff tell them when they're doing a good job, and 57% feel listened to by staff.
- 66% of youth said their case manager responds when they reach out.
- 85% believe their cultural identity is respected.

DHR (now part of HHS) staff intend to continue the youth survey. This year's survey questions are as follows. The results will be reported in next year's APSR, if not sooner:

- What would you like to see happen to improve the foster care and/or juvenile justice system in Iowa?
- What do you and/ or other youth need that you're not currently getting?
- What is one thing that has helped you while being in the system?
- What things do you wish existed in your community that would help you?
- We are developing two bills of rights: one for youth in foster care and another for youth in juvenile justice. What do you think should be included?
- What do you wish people knew about how being placed in detention has impacted you emotionally, physically, and/ or mentally?

Vocational Rehabilitation

Iowa HHS and Chafee funded partners regularly collaborate with Iowa Vocational Rehabilitation (VR) and Iowa Workforce Development. For youth in foster care and transitioning to adulthood, Iowa Workforce is generally used for walk-in help with resumes, computer use, and resumes. Vocational Rehabilitation services are referred when the youth has a diagnosed mental health issue or disability.

The core Iowa Workforce services appealing to aftercare youth are as follows:

- Career services cover a broad range of activities, including skill assessments, staff assisted resume preparation and job development, the development of an individual employment plan, career counseling and career planning, financial literacy, adult basic education, pre-vocational activities, and work experience.
- Training services include occupational skills training, on-the-job training, incumbent worker training, and entrepreneurial training.

- Support services may be provided, when necessary, to enable individual participation in career or training services. Supportive services include dependent care assistance, transportation reimbursement, and required clothing and tools for work.

Local Transition Committees:
Iowa Administrative Code Chapter 202 describes the role of Local Transition Committees (mentioned earlier in this report), that have a purpose to ensure the needs of youth in foster care are addressed to assist them in preparing for adulthood. Every year, Local Transition Committees contribute to this report by sending in their local transition committee reports to HHS' central office. After a review of the last five years' reports, certain things stand out as ongoing concerns that should be addressed in our next Child and Family Services Plan. Readers will notice a push for more teens to receive Family Centered Services. HHS remains optimistic that the change from Solution Based Casework to Motivational Interviewing (set for July 1) will be a more appealing service and be more effective for teen interventions and supports.

Challenges identified by Local Transition Committees in state fiscal year 2023 are summarized by the following:

- 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 curriculums that could be taught to youth. Local communities sometimes have a financial literacy class offered a few times throughout the year for Aftercare youth.
- Academic Needs
  - 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 Solution Based Casework services for teens in care, so HHS workers have easier contact and ability to work with the teens' workers on their needs, areas to focus services on, and have close collaboration.
  - 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 Staffing's 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 and the Services They Need
  - 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 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 know 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.
  - 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 landlords willing to work with minors & 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.
  - 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. SAL providers are encouraged to work on establishing relationships with local landlords who are willing to work with youth in the program before or after they reach age 18.

- Other:
  - HHS has noticed an increasingly significant number of youths who return to court ordered care after having been adopted.

After review of the past five years of reports, the ongoing and reoccurring issues are:

- Housing options for youth who age out of foster care are very limited. This creates a risk of homelessness for youth who can't return to family. Furthermore, housing programs for youth needed a supervised independent living program are limited and hard to get into.
- 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.
- There continues to be some difficulties with the implementation of the Integrated Health Home Program in terms of identifying & defining roles. Many case managers are unaware of this service and/or are reluctant to refer. The ID Waiver waiting list continues to be approximately five years. The other waiver waitlists are equally as long.
- Iowa Vocational Rehabilitation Services 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.

Pandemic Response

HHS released the Division X Pandemic Relief for Iowa Foster Youth and Alumni effort May 10, 2021, and it concluded September 30, 2022. Major components included:

- Moratorium on Aging Out and Re-entry into Foster Care: HHS suspended the age restriction through September 30, 2021. Approximately 15 young people were permitted to remain or re-enter care during this time. The fact that some youth chose to remain in care, suggested Iowa needed to expand our foster care to 21 options. We did so in an HHS filed bill, HF2252, previously mentioned.
- Direct Payment to Foster Care Alumni: For young adults ages 18 through 26 who had aged out of foster care were directed to apply for a direct pandemic relief payment of $750 through June 2022 (youth aged 23-26 were not eligible after September 30, 2021). HHS then issued a Summer Pandemic Recovery Payment to qualifying youth who aged out of foster care, ages 18 through 22. Young adults began applying for the $900 payments on the fourth of July (July 4), 2022 through Labor Day (September 5), 2022. Aftercare administered the application process and made payments to eligible youth on behalf of HHS. Funds were provided through September 30, 2022, with no eligible youth denied support.
    - Phase 1, Initial Payments
      Dates: May 10, 2021 – June 30, 2022 (ages 18 – 26 until Sept 30, 2021; 18 – 23 beginning Oct 1, 2021)
      Amount: $750
      Applications: 1,994 (total received, not including duplicates)
      # Eligible: 1,599 (80%)
      $ Approved: $1,199,250
    - Phase 1, Round 2 Payments
      Dates: September – October 2021
      Amount: $500
      # Eligible: 1,130 (approximate; efts and confirmed address)
      $ Approved: $ 565,000
    - Phase 2, Summer of 2022 Payments
      Dates: July 4, 2022 – September 5, 2022
      Amount: $900
      Applications: 526 (total received through 8/7/2022)
      # Eligible: 440 (through 8/9/2022)
      $ Approved: $ 396,000 (distribution just getting started)

  TOTAL AMOUNT APPROVED: $2,160,250
  Note: These numbers are approximate and do not account for returned/uncashed checks, etc.
- Extra Support for Teens in Foster Care: HHS provided additional funds to support social, extracurricular, and cultural activities. Fo$ter Fund$ grants up to $600 per child were available to youth ages 14 and older who were in a foster care placement, including family foster care, group care, and supervised apartment living. Up to $300 per year was also available to relative caregivers through a similar program called Kinship Funds.
- Thanks to Children's Bureau and the Capacity Building Center, which helped through experienced program staff from Florida and Washington, Iowa created a "Removing Roadblocks" transportation assistance project, which funded up to $4000 per youth related to a transportation need. More on this is in coming pages.

  HHS created forms and fliers and a process by which TPS received and approved applications. HHS then contracted with a third-party vendor, Central Iowa Juvenile

Detention Center, to pay youth and caregivers reimbursement for any transportation costs that meet criteria. Examples of ways HHS was able to use Division X funds to help youth included payment for public transportation, private driving instruction to complete drive time requirement to obtain a driver's license, Department of Transportation (DOT) fees and registration, driver's ed fees that couldn't be waived, car insurance, car maintenance and repairs, and down payment or matching funds towards the purchase of a vehicle. Youth could use the form below to apply for transportation funds:

Removing Road Blocks Application.d

- Rent Subsidy: As mentioned earlier, the Rent Subsidy program, administered by Iowa Finance Authority, paid the full cost of rent to eligible youth ages 18 through 22 during the pandemic. Total funding was $233,370.24 and most certainly helped youth avoid homelessness. The funding per youth reverted the max $450 in October 2022.

  In state fiscal year 2023, expenditures totaled $152,278, which includes the pandemic funds. The number of youths served has been steadily dropping over time. We believe this due to increased eligibility for the aftercare PAL payment (those who receive PAL are not eligible for rent subsidy) and because of the FYI and other voucher programs. As the end of January 2024, there were five youth served statewide in the Rent Subsidy program. In February, the average monthly subsidy was $350.00 per month with total expenditures to date of approximately $22,000. This is stark contrast to SFY 2019, when an average of 44.5 participants utilized the Rent Subsidy program each month. The program distributed a total of $187,852.76 during the year, or an average of $15,654.40 a month. The department is going to have to make hard decisions in light of budget challenges. Rent Subsidy may have to be discontinued. If that happens, the department is committed to help the youth served find alternative housing supports.

- ETV: With the additional money provided through the Consolidated Appropriations Act ETV was able to help approximately 155 students in the amount of $697,415. The average additional award per student was $4,499. ETV did also have students who received funding the summer prior in the 2020-2021 school year. There were about 19 who received $25,208. We have not collected demographic information. There is no process to ask gender, race, ethnicity.

While services to youth were never halted due to the pandemic, formal notifications and modifications to contracts were necessary in 2020 through 2022 due to the pandemic. Typically, this meant the providers needed to follow public health guidance to ensure they were healthy, and their clients were healthy before meeting face-to-face. Public documents are available for review on the HHS website. HHS program managers regularly provided guidance from the Center for Disease Control and the Iowa Department of Public Health to be used by staff, contractors and youth. In June 2022, HHS notified providers, including Aftercare and AMP, that on July 1, 2022, contractors would be returning to pre-pandemic service delivery.

Aftercare, including Foundation 2, continues to support implementation of the Fostering Higher Education (FHE) pilot in Cedar Rapids. FHE is a research-informed program model to help older youth in foster care finish high school, make plans for continuing their education in college or career training and bridge the transition from high school to postsecondary education. The

research is being led by Dr. Amy Salazar and her team at Washington State University. The overarching goal of the study is to glean lessons learned from research on the FHE program to provide concrete strategies for helping youth-serving organizations overcome obstacles to implementing manualized interventions and participating in evaluation studies of their practice.

With the assistance of the HHS Cedar Rapids Service Area, Foundation 2 has enrolled nineteen young people in the pilot intervention. Thirteen youth from the Des Moines Service Area agreed to participate as a comparison group for the study. Foundation 2 found that seven out of nine participants who entered FHE as Seniors graduated high school and went onto post-secondary. One of those participants is still working on completing their high school diploma doing a hybrid of virtual and in-person. F2 reported that of the 19 youth, those who were already enrolled in Aftercare without their high school diploma still have not received it, but three are still enrolled. One of those who participated as an Aftercare participant did complete a CNA program. With this information, Foundation 2 will with Aftercare to apply lessons learned from the pilot and research to improve education support for all Aftercare participants. The project will end in June of 2024. HHS has been approached by Salazar to consider a similar grant project with the University of Nebraska.

A couple quotes from FHE participants are below:
"While I was going through the process of finishing high school and getting ready for what was after high school, I had no idea what i wanted to do. Nobody in my family had ever gone to college. I knew nothing about college. Until I met Clare. She helped me decide, she pushed me to do my best…She was there every step of the way. Always with the words of encouragement."

"My education advocate really helped me be more confident and comfortable during the transition from high school to college. By showing me many ways of adulting, as well as just being someone to lean on if I had anything I was questioning about."

CHAFEE IMPROVEMENT PLAN – PERFORMANCE ASSESSMENT UPDATE TO IMPROVING OUTCOMES
In 2019, HHS submitted the Chafee section of the CFSP, which received approval from the Children's Bureau. This is year five of a five-year plan.

To engage the field staff in the implementation of the CFSP, HHS held at least bi-monthly meetings to review CFSP status and activities. It was a regular topic of TPS meetings. New for the five-year reporting period, identifying TPS members as "Team leads" in the different goal areas is a great way to stay on track with goals and to build expertise in our TPS staff; HHS plans to continue to use team leads on goals in the new CFSP.

Each of the CFSP goals, objectives and benchmarks are restated below. This section provides a quick summary of accomplishments in the past year as well as a "lookback" over the past five years.

Goal 1: Meet the transition needs of youth in foster care, age 14 and older, for successful transition into adulthood.

Objective 1.1: Identify a reliable method to track, monitor, and follow up to ensure that youth age 14 and older in foster care have an individualized transition plan.
Benchmarks:

1. Implement and monitor revised transition plan (case plan Part C) in year one, and tweak as needed in year two, resulting in better quality & complete transition plans.
    a. TPS will train HHS staff at regional meetings by October 1, 2019.
2. Identify methods to track completion of quality transition plans in year one.
3. Identify method to track frequency and type of transition committee meetings in year two.
4. Systematically monitor that all transition plans are developed and reviewed by the HHS local transition committees no later than year 5.

Objective 1.2: Ensure youth aging out of foster care have a driver's license if they want one.
Benchmarks:

1. Research how many youth get their driver's license in year one.
2. In year one, use focus groups with youth in foster care to explore desire and need for a driver's license, auto, public transportation, and related.
3. No later than year two, use focus groups with youth and others to identify barriers to youth driving and driving their own car.
4. Address barriers in years four and five.

Objective 1.3: Assist youth acquiring state identification, birth certificate and social security card.
Benchmarks:

1. Identify baseline data elements regarding acquisition of documents (minimally required documents in Iowa Code 232.2) in year one.
2. Provide guidance to case managers on how to help youth acquire documents in year three.
3. No later than year four, institute a strategy to collect data (on each youth age 14 and older and aggregate) regarding acquisition of necessary documents.
4. Monitor accomplishments and resolve deficits in years four and ongoing.

Objective 1.4: Prevent & advocate for youth against identity theft.
Benchmarks:

1. Complete quarterly credit checks for every child in foster care age 14 and older, using all three credit reporting agencies (Transunion, Equifax, and Experian) in years 1-5.
2. Provide credit reports to case managers for them to share with youth age 14 and older annually for each youth.

Objective 1.5: Create a path to social and developmental opportunities for transition aged youth.

1. Engage youth to discuss their needs for social and developmental opportunities in year one.
2. Provide caseworkers serving children age 14 and older with a flier in year two, to be used in discussions with youth that suggests opportunities for positive youth development, including peer to peer opportunities.
3. Provide transition service tools to providers who work with teens in foster care in year two (Family Centered, SAL, RT, Foster Parents, etc.). Tools may include training materials and tools they may use in direct service (i.e., ecomap, permanency pact).

TPS continue to collaborate with new and ongoing workers to help them document quality transition plans. TPS offer to meet with case managers individually to help them develop a youth's plan if needed. TPS make themselves available through such things as office hours and

Microsoft Teams Meetings. The TPS also provide continuous input about how the transition plan can be improved or revised to ensure a thorough plan is in place.

TPS continue to attend staff/unit meetings throughout their service areas and provide ongoing training regarding the transition planning process with youth in foster care to case managers and supervisors.

TPS utilize a tracking tool that is updated monthly to identify all youth in out of home placements 14 and older. The TPS use this tool to identify where youth are in the transition planning process and have recently added columns to monitor driver's license status, pre-Aftercare referrals, need for adult services, graduation dates, in addition to the already tracked data of proof of foster care letter, completion of Casey Life Skills Assessment, Transition Committee Reviews, and other transitioning dates. This allows TPS to ensure youth are receiving the transitional planning services necessary.

To better track youth's driver's license status, a column has been added to the TPS tracking tool to document driving status. Choices listed include learners permit; school permit; driver license; suspended license; other; and none. Barriers to youth obtaining their License are problem solved with the youth and their team.

Funding available through the Consolidated Appropriations Act allowed HHS to develop a program called "Removing Roadblocks" (described earlier in this report) and although the program was temporary due to time-sensitive funding, many children were able to take advantage of the program. Over 400 thousand dollars was distributed to nearly 200 youth across the state for the purpose of transportation related expenses, to address transportation barriers such as the cost of driver's ed, auto repairs, insurance costs, purchasing a vehicle, bus passes, and bicycles. There was a limit of $4000 per youth. This was pivotal in promoting increased social, educational, and occupational opportunities and expanding self-sufficiency.

Should provisions be made to permanently fund Removing Roadblocks or a similar endeavor, HHS would reference the recommendations for improvement provided by Embrace Families and Paving the Way. These recommendations include goal definition and needs assessment within our served population, marketing efforts, sustainable funding, and data collection among other topics.

Although the pandemic enhancement to Kin$hip Fund$ have been exhausted at the $600 dollar level, Fo$ter Fund$ continue to be available for youth 14-21 years of age in foster care at up to $300/youth/year using Chafee funds.

Annual credit checks continue to occur for every youth in foster care 14 or older. If there is a hit on the youth's credit report the TPS work with the case manager to verify the information. If needed, the three credit reporting agencies are notified, and a request is made to have the information removed from the youth's report. Once this is resolved with the three credit reporting agencies, updated documentation is provided to the youth for their records. At the start FFY 2023, HHS realized Experian had changed their coding and it resulted in reports not being loaded. This issue was raised by TPS. HHS' information technology helpdesk quickly reached

out to Experian, and we have a solution for file transfers moving forward and to recover files that were missed.

Iowa HHS sent 3609 requests in calendar year 2023 through the three credit reporting agencies combined. No issues were reported for 3345 and 129 were “blank reports” meaning there was a record, but it had no issue. None were marked “invalid” this year due to the issue not being associated with the child. There are 133 “in process” where the worker is addressing the potential issue or has resolved it and has not entered the result in the system. Below is a history of results that goes back to the beginning of this five-year period.

Table 4yyy: History of Credit Reports – 2020 - 2023				
Calendar Year	**2020**	**2021**	**2022**	**2023**
Report Outcome	**Count**	**Count**	**Count**	**Count**
In Process	128	221	121	133
No Issues Reported	4106	2941	3573	3345
Invalid	1	0	2	0
Resolved with youth	21	10	2	2
Resolved with credit bureau	15	6	0	0
Resolved with creditor	0	0	0	0
Blank Report	295	650	169	129
Provided and assisted discharged child with report	0	0	0	0
Filed report for discharged child	0	0	0	0
Total Requests Sent 2020	4566	3828	3867	3609

The Transition Information Packet (TIP) is a compilation of various transition resources that we have found from many sources and are useful tools for youth who are transitioning to adulthood. TIPs continue to be provided to older youth in out of home placements. It has been used for the entirety of the five-year period. We’re looking at making some changes to make it more accessible for readers and to make it easier to update. HHS’ new communications team brings expertise to the work that we simply did not have five years ago. Recent conversations with youth, where they said we should use more social media and text messaging really aligns with the way we are going on the TIP book.

The TPS continue to share and utilize the Transition Planning Training Videos with HHS employees and other professionals, including Iowa College Aid, teachers and education professionals. The videos are readily available on the HHS Transition Planning website. These

videos continue to be utilized within the Iowa College & Career Readiness Academy courses as well.

In a joint effort between the Division of Family Well-Being and Protection (FWBP) and the Division of Public Health (DPH), a new one-step procedure to request an Iowa birth certificate was developed and implemented in March of 2022. The new procedure is believed to have decreased the processing time and eliminated application payments, that had been a barrier to getting documents for youth.

The IL Coordinator and TPS update and manage tools and resources to assist case managers and providers to assist them with Transition Planning with youth.

TPS continue to train and collaborate with new and ongoing workers to help them document quality transition plans, however, frequent turnover across the state creates significant barriers to achieving this goal. TPS continue to offer to meet with case managers and juvenile court officers individually to help them develop a youth's plan if needed. The TPS also provide continuous input about how the transition plan can be improved or revised to ensure a thorough plan is in place.

Each Service Area has Local Transition Committees that review every youth's Transition Plan by the time they turn age 17.5. TPS can check status of items including, but not limited to: vital documents, youth's participating in developing plan, education, employment, health, housing, supportive relationships, need for adult services, and referrals to supportive services.

HHS continues to explore ways to partner with the Social Security Administration and the Department of Transportation to ensure youth have their social security card and state issued photo ID before exiting care. At this point in time, HHS has been unable to establish a statewide process for obtaining important documents for youth. The Transition Planning Checklist provides a reminder to case managers to ensure youth have their necessary documents and this is documented in the youth's written transition plan. To assist in more accurate tracking of vital documents, the IL Coordinator has requested the addition of vital document tabs in the new Vision database system to accurately track and ensure these documents are obtained for youth.

An additional need that has been identified is when youth are lacking documents through immigration. It would be helpful to have a centralized process in place for cases involving immigration barriers.

TPS continue to explore ways to cover the cost of driver's education when it's not offered through the school. Resources utilized and explored to cover the cost may include Fo$ter Fund$, Vocational Rehabilitation, and the Managed Care Organizations.

There are several opportunities to engage youth on a statewide level such as AYE, statewide AMP meetings, and Engaging Youth Summit.

Resource fairs such as Future Fest continue to be offered statewide which provides information and opportunities for teens in foster care.

Clothing allowance for youth 13+ in foster care has been increased to $750.00 annually, which better aligns and supports basic needs for youth in foster care.

5-year look back:
Over the past five years, there has been increased emphasis to start transition planning earlier and having conversations with youth more often to better prepare them for adulthood. The transition plan has been revised and improved to include more details in the Fostering Connections Act areas of education, employment, health and health care coverage, housing and relationships.

Objective 1.1-Benchmark 1: A new transition plan has been developed. A webinar was held on 1/14/20 that provided training to social workers regarding the new transition plan as well as a Guidance tool. The webinar remains on the HHS training website. The new transition plan officially rolled out on 2/25/20. Each of the five Fostering Connections areas are separated into individual sections (Education, Employment and Workforce Supports, Health and Health Insurance, Housing, Supportive Relationships and Services). The new plan is more detailed and under each of the individual sections there are specific questions to be addressed to ensure a thorough plan is completed. In addition, the new plan tracks things like whether a youth has a bank account, if the youth plans to sign a Voluntary Placement Agreement to remain in foster care past age 18, the status of the youth's credit, and the status of the youth obtaining their important documents and driver's license. The IL Coordinator and TPS continue to hear positive comments from HHS staff about the revised transition plan. It is believed to be better aligned with the life skills assessment and more understandable for the youth and others on the youth's team.

Objective 1.2-Benchmark 2: In 2020 and 2021, HHS worked with AMP to survey youth placed in foster care as well as those who recently aged out. The goal of the survey was to explore what they need to help prepare them to transition to adulthood. They were asked if they have a driver's license, and if not, why not. The results from the survey were used to determine what the gaps are that need to be addressed to improve transition planning with youth. The survey is below:


Youth Needs Survey
Aged Out youth.doc

Objective 1.3-Benchmark 2:
In 2022, the HHS Service Help Desk released a new process for obtaining Birth Certificates to HHS case managers and staff, which was a joint effort between legacy DHS and public health. The email to all staff is pasted below:

Service Help Desk

Phone (866) 347-7782
Email Service HelpDesk

This material is current as of this date. If referring to this material in the future, check policy manuals for any updates.
Please contact the Service Help Desk if you have any service-related policy questions or issues, or visit us at the Service Information SharePoint.

New Process for Obtaining Iowa Birth and Death Certificates for Foster Care Youth

Effective March 1, 2022

This e-mail was sent to a field notification list including SAMs, SWAs, SW Supervisors, and SW staff. **Please share this message with other staff as appropriate.**

In a joint effort between DHS and IDPH, a new a one-step procedure to request an Iowa birth or death certificate has been developed and will go into effect March 1, 2022. The new **Application for a Search for an Iowa Vital Record** form (attached) will decrease processing time and eliminate current barriers for application payments. Staff must ensure all application fields are completed and accompanied with a court order before emailing them directly to IDPH at dhsrequests@idph.iowa.gov. Workers have the option to electronically sign the form or scan a signed physical copy when submitting to IDPH for processing.

If DHS has not been granted custody, guardianship, or supervision of the child, the worker will need to obtain a court order that authorizes the Iowa Department of Public Health to release the birth certificate. The court order establishes a "tangible interest" for DHS to request a vital record. DHS must have court ordered authorization, custody, guardianship, supervision of the child, or the decedent's child.

The Iowa Department of Public Health/Vital Statistics will waive the fee for the following:

- ✓ One free copy of a certified stamped, "Government Use Only" birth certificate for a minor in DHS custody or guardianship. (Accompanying court order is required.)
- ✓ One free copy of an unstamped, certified birth certificate for a foster youth aged 14 or older who will age out of foster care. (Accompanying court order is required.)
- ✓ One free copy of a death certificate for a legal parent of a minor in DHS custody or guardianship. (Accompanying court order is required.)
- ✓ One free copy of verification or birth/identity for any child involved with DHS. (Accompanying court order is NOT required.)
- ✓ One free copy of a death certificate for a dependent adult involved with DHS for services or via a protective action. (Accompanying court order is required.)
- ✓ Child in Need of Assistance/Placement (CINA) – DHS supervision. (Accompanying court order is required and an initial $15.00 fee will be charged.)

Additional copies of the above will require a payment of $15.00 per copy. When payment is required, IDPH will automatically invoice DHS Central Office based on the application field codes entered on the form. The Sub Org, Org Code, and State ID must be included on the application, or it will be returned.

- If the child's status (4E) (Org Code) has not been established, please wait to submit the application.
- If there is no current court order, please wait to submit the application. A court order, from the most recent hearing held, must accompany each application. The court order must indicate DHS has supervision, custody, or guardianship of the child, or child of the decedent.

If you have questions or experience issues regarding a specific application or this process in general, please contact Crawford L. Norwood Jr. (cnorwoo@dhs.state.ia.us) of the Service Help Desk.

Similarly, HHS addressed how to obtain a driver's permit/ID in the Removing Roadblocks Infographic. This was distributed by the help desk to all staff on May 13, 2022.

Removing Road Blocks Infographic.c

HHS updated Transition Information Packets that are given to transitioning youth. For example, there is an identity section that helps explain to youth the process of getting any vital documents that they need.

Objective 1.5-Benchmark 1:
This objective focused on obtaining meaningful feedback from youth in several ways:

- Through the NYTD Talking Wall.
- HHS has invited feedback from youth at Future Fests, asking questions about what would help support them in their transition to adulthood.
- Surveys and interviews for small and large projects. For example, in 2020 Linn County Community for Change Equity group created a survey for Transition Youth regarding their supports, cultural needs, and resources.

Objective 1.5-Benchmark 2: In 2020, HHS created and distributed a pandemic relief information sheet for case managers and caregivers for youth in care. A document called "Tips and Resources for Teens in Foster Care" was for caseworkers and focused on resources and suggestions to support a youth's social and emotional needs. Because HHS recognized youth needed to get out and enjoy social and cultural activities, a couple years later HHS created a pathway for additional funding to relative caregivers and licensed foster care placements. Two examples of the work are below:


DHS_COVID19_Tips & Resources for Tee


pandemic relief info one pager soci

These extra supports were funded through the Consolidated Appropriations Act. Feedback was very positive, and HHS continue to receive inquiries about whether these programs will be reinstated as they were very beneficial.

HHS has modified programs to better support needs of youth in care, for example: Fo$ter Fund$ have been increased $100 per fiscal year and clothing allowance was increased. Also, requirements have been revised to allow more youth to receive the PAL stipend through Aftercare, despite high school completion.

One of the lessons from the pandemic was that some youth prefer to or are better able to meet virtually. AMP is now offering a virtual council so youth can jump on a virtual call from anywhere in the state. This approach extends AMP's support to youth who would not otherwise be able to participate.

Goal 2: Increase appropriate housing opportunities for Transitioning Youth.
Objective 2.1: Ensure SAL is effectively meeting the needs of transition youth.
Benchmarks:

- Create a workgroup charter in year two, to establish a workgroup to study SAL.
- Convene the SAL workgroup no later than year three.
- Stakeholders shall include but not be limited to:
  a. Youth who have experienced transition programs
  b. SAL and RRTS service providers
  c. Homeless program service providers
  d. State level foster care policy staff
  e. Adult services
  f. Iowa Aftercare Services
- The workgroup will explore items including but not limited to:
  a. Performance measures.
  b. Capacity
  c. Assessment and services
  d. Appropriateness of referrals
  e. Alternatives to SAL
- Approve and implement practicable ideas from the workgroup no later than year five.

HHS awarded new contracts for Supervised Apartment Living, which began July 2023. The service areas that previously had SAL providers continued and one additional provider was added in the Eastern Service Area. For the Cedar Rapids Service Area, a SAL + skills service was added to serve youth in Supervised Apartment Living in Linn County where typical SAL services are not available.

HHS continue to identify barriers and challenges to the SAL program that prevent positive outcomes. For example, at times SAL ends up being a housing option pursued due to lack of other more appropriate programs. This puts additional strain on contractors that affects opportunities for other youth who could benefit from the program.

The HHS transition team and our Chafee funded partners continue to explore other housing options to connect youth to as needed, including Transition Housing Programs throughout the state. Among them is Pillars, United Action for Youth, Lighthouse, YSS, Winding Roads, and Steppingstones.

Housing partnership with Hatch Housing Development, Aftercare, and HHS to designate a certain number of apartments in their new apartment complex for youth at risk of homelessness. This has occurred in our two largest cities, Des Moines and Cedar Rapids.

As mentioned earlier, HHS approached the Iowa legislature and expanded eligibility for youth to be able to remain in or return to Voluntary Foster Care to age 21, regardless of education and employment status, when other housing options are not available or when the youth is still in need of the additional support.

HHS continues to support and explore kinship options for older youth in care to stabilize housing. Helping kinship placements know and connect to the resources that are available to the youth they are caring for (such as Kinship Caregiver Payments, Foster Funds, benefits through their MCO, Aftercare, etc.).

5-year look back:
HHS did not conduct a workgroup to address Supervised Apartment Living due to the pending request for proposals and new contracts that were being developed with the SAL providers at that time. Since the new SAL contracts, HHS has continued discussion on how to better serve youth in SAL. One idea that is being explored is surveying current youth in SAL and those who have aged out to gain their feedback on what they need. TPS continue to work with case managers with their youth in SAL and help them identify skills the youth need to develop and connect to resources available to them. HHS program managers also continue monthly provider calls and engage in discussions on best practices within the SAL program.

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.

Iowa 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 11 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 FUP and FYI where available for youth aging out of care and encouraging Public Housing Authorities to apply for FYI in areas 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 meetings with Missouri, Nebraska, and Kansas reps so we can break 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. Agreements have been made with 11 Public Housing Authorities or City Housing Authorities across the state to offer FYI Foster Youth Initiative Housing Vouchers.

In 2023, HHS expanded SAL contracts to 4 out of the 5 Service Areas and began a SAL-like Life Skills Service for one of the areas that does not have a SAL Provider.

Goal 3: Utilize NYTD and other existing data to improve service delivery.
Objective 3.1: Use data to inform caseworkers and providers, thereby creating data-driven practice.
Benchmarks:

1. Continue annual transition report in years 1-5 as planned and delivered for the CFSP 2014-2019.
2. Formalize and highlight data sharing between HHS, CJJP, and the Iowa Aftercare Services Program in year two.
3. Create and disseminate at least two infographics or educational tidbits in years three and five, which use data to inform and direct services.

The National Youth in Transition Database (NYTD) is a federal requirement that mandates HHS, as a recipient of Chafee funding, collect services and outcome information on youth in foster care or another out-of-home placement.

Objective 3.1 is all about how HHS used NYTD and other data to inform and motivate case managers and others who work directly with youth. This section will quickly describe NYTD and some of the vehicles we've used to get this data out.

Case managers are surveyed quarterly about the services provided to youth in foster care age 14 and older. Aftercare and Iowa College Aid Commission provides life skills and education services data, which adds to the casework data and is reported for NYTD services requirements.

Until HHS aligned with Iowa Department of Human Rights in 2023, HHS contracted with the Department of Human Rights (DHR) to collect the outcome information and conduct a survey of

youth in foster care or other out-of-home placement at age 17, also referred to as the baseline population. Now DHR and the NYTD project are part of the larger HHS system.

DHR surveys youth on outcomes required by the NYTD final rule, as they reach age 17, referred to as the “baseline population” and conducts a follow-up survey with a sample of youth at ages 19 and 21, referred to as the “follow-up population”. Essentially, outcomes derived from the survey includes over twenty-five questions that measure youth across six domains - educational attainment, financial self-sufficiency, access to health insurance, experience with homelessness, and positive connections with adults. Iowa adds several questions to the required items to inform program needs.

The outcomes data is collected directly from youth (and not administrative records). Iowa NYTD offers three methods for completing the survey: phone, mail, or online. All survey responses are voluntary, with youth having the option to decline a question, or the survey itself, at any time. Responses are confidential, and no individual youth are identified in this report or in any survey data analysis shared with provider agencies. Most participants chose to take the survey via the Internet. Youth were least likely to take the survey via mail.

Youth who complete the Iowa NYTD survey receive an incentive for participating. Survey participants receive incentives to increase the survey participation rate, as well as to show appreciation to NYTD participants for sharing their experiences. Iowa NYTD offers participants multiple options for their incentive. Youth participants receive gift cards from Wal-Mart, Casey’s General Store, Amazon, or Hy-Vee. Participants at age 17 and 19 are offered an additional gift card for providing names and contact information for individuals who will know how to contact the youth in two years to take the next survey.

To maintain contact with youth in the off years, the NYTD Coordinator mails birthday cards to participating youth on their 18th and 20th birthdays. In the exchange, contact information is updated and they are sent a $10 gift card with their birthday card for doing so. This has been a successful strategy to maintain contact with survey participants, as well as keep their contact information as current as possible which has been helpful when surveying them again at age 19 and 21.

On January 31, 2024, HHS and the NYD Coordinator proudly hosted the annual NYTD report release webinar featuring FFY 2023 National Youth in Transition data and calendar year 2023 Talking Wall data. These important data sets provide us a glimpse of how older youth are experiencing Iowa's foster care system. It was attended by nearly 100 individuals, including those from Iowa child welfare, service providers, state officials and even from interested individuals from outside of Iowa. The NYTD data collected for the FFY 2023 reports, including state and national comparisons on select NYTD outcomes was shared. The facilitators engaged the audience in dialogue about the meaning of the data and encouraged collaborations to address shared goals for better youth outcomes. The NYTD report in 2024 was far and away the most attended with well over 100 participants registering.

In addition to collecting survey results from the NYTD populations of youth, Iowa NYTD has also engaged youth through the several outreach activities:

- NYTD Ambassadors are young adults who have previously taken the NYTD survey and are between the ages of 17-26.
- The NYTD Creative Expressions Contest is an annual art contest that invites youth and young adults who have experienced foster care and/or juvenile justice to create a work of art that captures the given theme of the contest.
- Since 2018, Iowa NYTD has been hosting the Talking Wall in partnership with HHS, Achieving Maximum Potential (AMP) and Iowa's Juvenile Justice Advisory Council (JJAC).

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.

The department requires the DHR to submit an annual program report. The FFY2023 report describes efforts to locate and survey youth as well as outcomes for the FFY2023 Survey. "Creative Expressions" is a way DHR engages and celebrates youth voice and talent. The report has been approved by the department and is made part of this report by this reference:

FFY23 NYTD Annual Report_Final.pdf

NYTD data was used to create infographics to better inform case managers and encourage them to find ways to give youth a chance to get a permit, driver's license or a vehicle in a flier called "Removing Road Blocks".

HHS continues 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, used by the IL Coordinator and others to evaluate trends in the counts of teens in foster care and those aging out of foster care. The ROM data can be sorted and filtered for gender, race, and court jurisdiction, among other important categories. 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. ROM data is used frequently to monitor the Family First impact on transition aged youth participation.

Aftercare, AMP, ETV, and NYTD continue to be required to submit annual reports, which contribute to federal reports and drive data informed discussions about needed youth services. Contracts continue to include performance measures and associated payments, including but not limited to a youth's perceived financial stability, housing stability and connection to trusted adults. The AMP and Aftercare Reports will be linked later in this report.

TPS and the HHS training branch continue to educate using data in everyday work and contacts with youth, case managers, and community members about the needs of youth aging out of foster care. We share the foster care statistics (such as: graduation and employment rates, pregnancy, and homelessness) with youth and others to generate conversations about why

transition planning matters. Aftercare data is frequently used to show case managers and youth the benefits of youth connecting and working with Aftercare. Data suggests youth are better off when they participate in aftercare.

HHS maintains a foster care transition requirements tracking tool, updated monthly, to identify transition needs for all youth in out of home placements 14 and older. The TPS use this tool to identify where youth are in the transition planning process and have recently added columns to monitor driver's license status, pre-Aftercare referrals, need for adult services, graduation dates, in addition to the already tracked data of proof of foster care letter, completion of Casey Life Skills Assessment, Transition Committee Reviews, and other transitioning dates. This allows TPS to ensure youth are receiving the transitional planning services necessary.

HHS continues to use data from NYTD and Iowa Aftercare to help educate other community & work groups that TPS/HHS participate in to drive decisions where it impacts youth in Foster Care. This helps us better evaluate how we are serving transition-aged youth and where improvement is needed.

5-year look back:
Over the last 5 years, HHS has improved and increased the use of annual data reports to educate case managers and to look at what areas need improved for transitioning youth to adulthood. We've seen an increase in positive outcomes when transition planning is done often and done well.

HHS has increased the collection of data and what additional items need to be tracked to better plan with youth and case managers.

Data was used to create infographics to better inform case managers in the areas of Transportation "Removing Roadblocks" and Human Trafficking. Data was also used in the Transition Videos used for training.

The TPS utilized data from NYTD and Aftercare in the development of Transition Planning Training videos for Providers. These videos were originally distributed in April 2020; however, they continue to be available for use by HHS administrators, case managers, providers of residential treatment, SAL, shelter, foster parents, kinship caregivers, and family centered services. In 2022 these training videos became part of a class offered by Iowa College Aid to teachers and education professionals called, "Supporting College & Career Readiness for Systems-Involved Students" to help educate those working directly with the youth in foster care on the transition planning needs of the youth and how to better prepare them.

During this past five-year period, NYTD data exposed that many youths said they were unaware of Aftercare services. This was a shocking realization that we need to vary the approach to telling youth about programs and repeat it with each youth. Also, we need to monitor if referrals are being made prior to the youth's discharge. In 2022, a first ever formal referral process went into effect to refer youth to pre-Aftercare services and ensure all youth are receiving education about the support that is available to them through the Iowa Aftercare network. TPS are

collecting a monthly list of referrals completed. This allows TPS to follow up on youth who need a referral and identify any barriers.

Goal 4: Improve understanding of and align efforts to address human trafficking.
Objective 4.1: Ensure staff and contractors can identify signs of trafficking and refer for appropriate services.
Benchmark:

1. Continue to educate and train staff ongoing about human trafficking and the increase risk to children in foster care and alumni, urging those working with older youth to attend relevant training.
2. TPS will send out training opportunities starting in year one and ongoing.
3. TPS will develop training as needed to complement existing anti-trafficking training, as indicated.

Over the past five years, HHS has come a long way to better use SharePoint and blasts from the service helpdesk to provide case managers with information about topics like human trafficking. Among the great resources are a couple fliers created and distributed to remind staff and partners of the risks of Human Trafficking to children and youth in foster care. NYTD data was also used in the fliers and the Transition Videos on the HHS website. Human trafficking fliers were released to HHS staff and contracted partners in June and August of 2023, (the August release is below). The IL Coordinator presented an update on policy related to human trafficking and missing children on a CIDS supervisor training call in July 2023.

Service Training Help Desk

Email Service Training Help Desk

Please email the Service Training Help Desk if you have any Service Training Website questions or issues, or visit us at the **Service Training SharePoint** *for additional training related resources.*

Service Training Takeaways – Human Trafficking
This monthly installment of Service Training Takeaways covers Human Trafficking.

Human Trafficking is on the rise in Iowa and is the second-largest criminal industry in the world, generating billions of dollars each year. Of the cases reported to the Human Trafficking Hotline for Iowa, half are reports involving minors. In order to effectively combat Human Trafficking, HHS staff need to understand what it is and the best approach to handle Child Sex Trafficking cases. These cases are often difficult as traffickers are well-versed in tactics of coercion. Victims of Human Trafficking often do not identify as a victim and view their trafficker as an important person in their life.

August 2023 Service Training Takeaways

HHS continues to offer Human Trafficking trainings for all staff. Currently, SP 505 Child Sex Trafficking: Strategies for HHS is an upcoming half day training offered to HHS staff throughout the State of Iowa. Information about this training opportunity was provided to Supervisors, Social Workers, and Child Protection Workers. TPS are registered to attend this training opportunity as well.

Case managers need to continue to be aware about the higher risk of Human Trafficking of youth in foster care. Therefore, HHS continues to send out information about human trafficking trainings and resources.

5-year look back:
To improve collecting data about youth in foster care and sex trafficking, a box has been added to the records section of the transition plan that asks whether a youth has been a victim of sex trafficking.

Case managers are trained when a youth has been on run and returns, they are required to verify whether the youth has been a victim of trafficking. If they have, it gets reported to proper authorities. Manuals and forms were updated in the past five years to align and document efforts.

There are 3 Modules of human trafficking training available to case managers on the HHS Training Website. Additional human trafficking resources can be found on the Service Help Desk SharePoint.

The State of Iowa has also implemented requirements for in state lodging providers to complete human trafficking prevention training to receive public funds for state employee lodging. State employees are only allowed to use lodging providers who have gone through this training.

Goal 5: Increase career opportunities for transitioning youth.
Objective 2.1: Research varied options for employment, education, and career choices which may appeal to youth.
Benchmark:

1. Research the following in year one and two:
    a. Job Corps
    b. Military
    c. Apprenticeships, including but not limited to trade unions
    d. Direct employment opportunities
    e. Other educational or employment opportunities
2. In years two through five, distribute written information and create multiple presentations regarding promising opportunities for children in foster care and alumni participating in foster care.

HHS provides information and contacts at events such as Future Fest and AMP conferences for Job Corps, various military branches, Iowa Works, and other localized employment opportunities to youth in care.

HHS provides Job Corps pamphlets within the TIP binders and has distributed information from Job Corps website. HHS continues to share virtual tour videos created by Job Corps with youth interested in the program. Statewide transition conferences are occurring both in-person and virtual across the state.

5-year look back:
The HHS transition team welcomes opportunities to attend conferences and events hosted by our peers in workforce, to raise awareness of the needs of youth in foster care as well as to learn more about existing youth programs. Iowa's IL Coordinator has maintained active status on the Special Education Advisory Board to the Iowa Department of Education for the entirety of this reporting period for just this reason. Being on workgroups and councils with Iowa Workforce, Vocational Rehabilitation have made it easy to reach out with referrals, questions, or to collaborate on new projects.

TPS have actively participated in YTDM/YCPM's over the past 5 years to educate and encourage youth to take advantage of education and employment opportunities. TPS share information about FAFSA, ETV, AIOS, Last Dollar Scholarship, young adult programs through Iowa Works, Vocational Rehabilitation, Job Corps, and other vocational entities.

HHS distributes TIP binders with added local pamphlets to help increase knowledge about vocational supports to youth 14 and older.

TPS send out updates throughout the year to ensure workers are aware of applications timeframes and referrals that should be made. This can include Vocational Rehabilitation Services referrals, financial aid resources, workshops, career fairs, and other programs that become available.

In 2020 Job Corps' campuses closed due to Covid and remained closed for extended period, thus not allowing campus tours for TPS or teens. Job Corps developed virtual tour videos which TPS have continued to provide to SWCMs & JCOs to help them know more about their program and promote that interested youth view these informational video tours.

A Virtual Future Fest was held on June 11, 2021, that included presentations by Families Helping Families, Iowa College Aid, Amerigroup MCO, Planned Parenthood, Vocational Rehabilitation, IHH, AMP/Aftercare/SIYAC, HUD Housing, and Connect to Careers/WIOA.

Consultation and Coordination Between States and Tribes
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.

EDUCATION AND TRAINING VOUCHERS (ETV) PROGRAM (SECTION 477(I) OF THE ACT)

Program Service Description:
HHS partners with the Bureau of Iowa College Aid (Iowa College Aid) to administer the Education and Training Voucher (ETV) program. An intergovernmental contract, administered by HHS, ensures that all deliverables specified in the contract shall be provided by Iowa College Aid for an administrative cost that will not exceed the cost for one full-time employee.

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 an Iowa Financial Aid Application annually, and awards are made until available funds are depleted. Students are eligible for ETV up to the age of 26. Priority consideration is given to students who received ETV in the previous academic year, then to students who received ETV in any other previous academic year, then new applicants, and finally to students who are enrolled in a graduate program and have remaining ETV eligibility. All students who apply on or before July 1 are evaluated for priority consideration and awarded if funding allows. Applications received after July 1 are awarded as funding allows. Once all funds for a particular academic year are committed, a wait list is started. Students enrolled less than full-time receive a prorated ETV award. The college/university receives the awards directly, by term, and in most cases by Electronic Funds Transfer. Once tuition, fees, housing, meals and other direct charges are paid in full, the student then receives any remaining funds to assist in paying for additional costs of attendance.

During the 2022-23 academic year, two students were able to utilize ETV as a graduate student. This year there were initially 28 students on the waitlist. Additional re-allotment funds were requested and received, and awards were subsequently made to all students on the waitlist. Colleges/universities complete 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 all other eligibility rules, including but not limited to, Satisfactory Academic Progress (SAP), are being followed.

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 continued 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 is in attendance, they report the enrollment status and award amount in ICAPS, and a payment is generated.

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 former foster youth who have financial need and who have not yet attained age 26. Students who self-identify as a current or former foster youth are given priority for the AIOS. This scholarship is renewable for four years or until the recipient attains age 26, whichever happens first.

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)
- 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.

Accomplishments:
Goal 1: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.
Objective 1.1: Ensure data is being or will be collected is functional and useful to make data driven decisions on outreach opportunities, assistance through ETV process, and best practices for ETV administration.

Iowa College Aid has standardized a report that will be updated and produced annually. This report can be found **here**. The data will be useful as decisions are made for best practices in the administration of the ETV program.

Goal 2: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.
Objective 2.1: Use standardized data to analyze outreach methods, graduation rates, retention rates, and other student success measures.

Iowa College Aid has begun analyzing the education and employment outcomes for ETV recipients. The report mentioned in Objective 1.1 evaluates persistence and retention rates as well as several other factors. The findings of the report show the trend line for persistence is decreasing and illustrate that requiring submission of two separate applications may result in some students not being considered for ETV. Due to this, the recommendation is to remove barriers when applying for ETV. Iowa College Aid planned to only require the FAFSA and IFAA for new students entering the ETV program beginning with the 2024-25 application process. Students who have received ETV in the past will only be required to compete the FAFSA and will be awarded ETV without the need of an additional application. Unfortunately, the ICAPS system has not been updated to allow this as they have been updating code to prepare for the multitude of FAFSA changes for the 2024-2025 school year. There is still a ticket to have them update the system, and we are hopeful it will still happen during the 2024-2025 application cycle.

Five year look back - Education and Training Voucher Accomplishments:
Goal 1: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.
Objective 1.1: Ensure data is being or will be collected is functional and useful to make data driven decisions on outreach opportunities, assistance through ETV process, and best practices for ETV administration.

Goal 2: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.
Objective 2.1: Use standardized data to analyze outreach methods, graduation rates, retention rates, and other student success measures.

In Year 1, Iowa College Aid analyzed the information that was available on the ETV population and planned to start to collecting data on race and ethnicity to better understand the recipient population to meet their needs. This was originally intended to be done by adding an additional question to the Iowa Financial Aid Application for the 2020-21 school year. Doing this would allow Iowa College Aid to standardize data collection and utilize the information to make more data driven decisions on outreach opportunities, assisting students through the ETV process, and creating best practices for ETV administration.

During the 2019-20 academic year, one student was able to utilize ETV as a graduate student. The student reached the maximum lifetime eligibility of 5 years and will not receive ETV to finish her graduate degree. In addition, there was a wait list for the 2019-20 academic year and 33 eligible students did not receive ETV due to limited funding.

In Year 2, Iowa College Aid was able to get the question added to the Iowa Financial Aid Application for the 2021-2022 application cycle. Iowa College Aid started analyzing the education and employment outcomes for ETV and released a report that compared education and employment outcomes of ETV recipients and those students with similar attributes. It was determined both being eligible for and receiving an ETV award are associated with positive and significant postsecondary and employment outcomes. Consistent with previous research on scholarship eligibility, being eligible for an ETV award increased the likelihood of enrollment by eight percentage points. In addition, students who received an ETV award were 15 percentage points more likely to persist from year one to year two and three to six percentage points more likely to graduate.

During the 2020-21 academic year, three students were able to utilize ETV as a graduate student an increase from one student the year prior. In addition, no students were on the wait list for the 2020-21 academic year.

In Year 3, Iowa College Aid was able to add an additional question to the Iowa Financial Aid Application for the 2021-22 school year. Since the question was not a mandatory question on the application, we only received a response rate of 26.6%. Unfortunately, this was less than we were hoping for, but is a good start for standardizing data being collected. For 2022-23 school year, this question has been made mandatory. Once we have more race/ethnicity data we will be able to report on the success of students based on race/ethnicity as compared to their counterparts.

Due to the national pandemic, there was more targeted communication with youth and colleges regarding additional resources available to those youth who have aged out of foster care. Iowa College Aid closely monitored federal regulations regarding satisfactory academic progress and worked with colleges to ensure housing needs were met for all students living on campuses. After the passing of the Consolidated Appropriations Act, Iowa College Aid, with the help of HHS and student input, determined all funding would be used to pay ETV funds to students. An additional disbursement of $2,500 funding could be given to ETV recipients in the summer semester of the 2020-2021 academic year and the maximum ETV amount for the 2021-2022 school year could be $12,000. This additional funding allowed 19 students to receive additional funding to attend in the summer semester of 2021. It also allowed every recipient of ETV, 146, in the 2021-2022 academic year to receive additional funding. There was minimal funding remaining for use in the 2022-2023 school year; only 7 students received funding in fall 2022. Below is a table showing the amount of Consolidated Appropriations Act funding spent by fiscal year.

Table 4zzz: Funding Spent by FY

	Amount	Unduplicated Students
FY 21	25,208	19
FY22	659,825	146
FY23	12,382	7
Unduplicated	697,415	155

Iowa College Aid has begun analyzing the education and employment outcomes for ETV and released a report in 2020 that compared education and employment outcomes of ETV recipients and those students with similar attributes. The full report can be found **here**. Iowa College Aid is annually reviewing educational outcomes, and anticipates releasing a full report with education and employment outcome data every 4 years. This data is being utilized by the Opt-in College Access Network. They are currently working towards increasing the high school completion, postsecondary attendance, and postsecondary persistence rates among youth formerly in foster care. Opt-in was started through a Local College Access Network grant from Iowa College Aid and utilizes the collective impact framework to achieve goal.

During the 2021-22 academic year, no students were able to utilize ETV as a graduate student. Of the three recipients last year, 2 met their lifetime limit of 5 years receiving ETV and one recipient graduated. No students were on the wait list for the 2021-22 academic year.

In Year 4, Iowa College Aid has standardized a report that will be updated and produced annually. This report can be found here. The data will be useful as decisions are made for best practices in the administration of the ETV program. The report mentioned, evaluates persistence and retention rates as well as several other factors. The findings of the report showed the trend line for persistence is decreasing and illustrate the requiring submission of two separate applications may result in some students not being considered for ETV. Due to this, the recommendation is to remove barriers when applying for ETV. Beginning with the 2024-2025 school year, Iowa College Aid will only require the FAFSA and IFAA for new students entering the ETV program. Students who have received ETV in the past will only be required to compete the FAFSA and will be awarded ETV without the need of an additional application.

During the 2022-23 academic year, 1 student was able to utilize ETV as a graduate student and there were initially 8 students on our waitlist. To fund them we ceased paying administrative costs from ETV funding and utilized those funds to cover funding to students.

In Year 5, the Iowa College Aid Processing System has not been updated to allow a change for renewal applications. The system contractor has been updating code to prepare for the multitude of FAFSA changes for the 2024-2025 school year. There is still a ticket to have them update the system, and we are hopeful it will still happen during the 2024-2025 application cycle.

During the 2023-24 academic year, two student was able to utilize ETV as a graduate student. This year there were initially 28 students on the waitlist. Additional re-allotment funds were requested and received, and awards were subsequently made to all students on the waitlist.

Table 4aaaa: Annual Reporting of Education and Training Vouchers Awarded		
	Total ETVs Paid	**Number of New ETVs Paid**
2019-2020 School Year (July 1, 2019, to June 30, 2020)	159	67
2020-2021 School Year (July 1, 2020, to June 30, 2021)	137	76
2021-2022 School Year (July 1, 2021, to June 30, 2022)	146	72
2022-2023 School Year (July 1, 2022, to June 30, 2023)	140	82
2023-2024 School Year* (July 1, 2023, to June 30, 2024)	115	58

*Estimated

Section V: Consultation and Coordination Between States and Tribes

Describe the process used to gather input from Tribes since the submission of the last APSR and during the last five years, including the steps taken by the state to reach out to all federally recognized Tribes in the state.

The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation)
The Sac and Fox Tribe of the Mississippi in Iowa (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.

Over the last five years, the Iowa Department of Health and Human Services (HHS) gathered input from Meskwaki Nation through the following processes (examples of these processes are since the FFY 2024 APSR):

- Local case specific and systemic issue discussions, as needed, between MFS staff, HHS central office staff, and/or HHS service area leadership for Linn and Tama Counties and local frontline staff.
    - MFS staff shared continuing concerns regarding their local FCS providers, such as workers not showing up for scheduled appointments, not contacting the family about missing appointments, not being culturally appropriate, etc.

- Meetings between MFS staff and the Iowa ICWA/Tribal Relations program manager
- Quarterly discussions on the ICWA Training/Technical Assistance (TTA) contract
    - MFS staff continues to have capacity issues due to staff turnover for reviewing ICWA compliance. HHS and MFS continue to hold discussions to discuss how to overcome this barrier.
- MFS staff participation in statewide workgroups, such as the Cultural Equity Alliance Steering Committee quarterly meetings, Safe Sleep Initiative workgroup, and monthly Community Initiative for Native Children and Families (CINCF) meetings.

Tribes Not Federally Recognized as Domiciled in the State of Iowa
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, Rosebud, and Winnebago. CINCF also includes representatives from area service providers, the judiciary, housing, law enforcement, the Recruitment, Retention, Training, and Supports (RRTS) contractor Lutheran Services in Iowa (LSI), 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 staff 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 liaisons' role is to exchange cultural and case information between tribes, HHS and the Native families. HHS has created a Native Unit in the Des Moines Service Area (DMSA), as it was the 2nd largest Native populated area. The DMSA Native Unit includes an interim supervisor and one caseworker.

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 Director's, ICWA specialists, Tribal Caseworker's and Supervisors. Topics discussed include, but are not limited to, terminations of parental rights, customary adoptions, relative placements, transfer proceedings, and improving communication.

- Four times per year:
    - Winnebago Tribe of Nebraska:
        - These meetings include the Tribe's Attorney, Social Service Director, Tribal Social Service Supervisor, and ICWA Specialist.
        - During the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns. 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, Social Service Director, and ICWA Specialist. Often times, due to both the Winnebago and Omaha Tribes sharing the same attorney, both tribes and DHS meet together as one group.
    - 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. 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 programs operate to increase efficiency of services for children and families.
- Santee Sioux Tribe of Nebraska:
    - Attendance from these meetings vary between representatives of the Santee Sioux Tribe, such as the Social Services Director, Supervisor, and ICWA Specialist.
    - The topics of discussion included strengthening relationships, improved communication, and improved understanding of how each other's programs operate to increase efficiency of services for children and families.
- Ponca Tribe of Nebraska:
    - These meetings include the Social Services Director of the Ponca Tribe, ICWA staff, and others as needed.
    - The purpose of these meetings is to build relationships and communication with the Ponca Tribe. During meetings, participants discuss policy, services provided by the Ponca Tribe and Tribe's position on termination of parental rights hearings.
    - Iowa HHS has also discussed Tribal Customary Adoption (TCA) with the Ponca Tribe since it is part of their tribal law. Ponca is able to utilize their court as a service court for other Tribes that do not have TCA in their tribal law.

Also, the Native Liaisons provide monthly cultural training to the Woodbury Native Unit staff. These trainings include topics such as native ceremonies, star quilts, trauma, storytelling, musical instruments and their importance, tribal bands, etc.

Provide a final update, developed after consultation with Tribes, on the specific measures taken by the state to comply with ICWA since submission of the 2020-2024 CFSP.

HHS does not have a specific process to determine ICWA compliance, nor an automated mechanism to collect data to determine ICWA compliance. HHS has a contract in place with Meskwaki Family Services (MFS) for the ICWA Training and Technical Assistance (ICWA TTA). The ICWA TTA contract uses case reviewing to determine ICWA compliance and to develop training based on the case reading results. As stated above, following the COVID-19 pandemic, HHS and MFS had to halt case readings and continues to be paused at this time due to MFS capacity. HHS ICWA/Tribal Liaison and MFS continue to hold discussions about case readings for ICWA compliance.

HHS is in the process of developing our comprehensive child welfare information system (CCWIS). The HHS Federal Programs Program Manager met with CCWIS and IT staff to include several adoption and foster care analysis and reporting system (AFCARS) data elements and possibly additional elements related to ICWA compliance. HHS Federal Programs Program Manager continues to answer questions on reporting system data elements and compliance.

As part of Iowa's Child and Family Services Review (CFSR), program improvement plan (PIP), Iowa's Joint CQI workgroup decided its first project would be to apply the joint CQI process to ICWA. Clear gaps were identified, including not having enough data needed to measure performance on virtually any ICWA-related areas. Without documentation, we are unable to determine how we are currently performing. ICWA-related performance tracking is a significant gap for both HHS and MFS; the plan is to begin laying the foundation by focusing on the starting point of the process: exploration of tribal eligibility when a family intersects with the child welfare system, with a concurrent measure of a data gathering process that supports monitoring.

However, HHS continues to keep our staff informed. Bi-Monthly Service CIDS is a conference call occurring every other month that provides central office staff the opportunity to share with field HHS Service Area Managers, Social Work Administrators, and Social Work Supervisors important policy and practice information.

- November 2022 – HHS central office staff discussed information from the Intergovernmental Agreement with Meskwaki Nation and the Protocol with Meskwaki Nation as updates were made to the Agreement.

Section VI: Child Abuse Prevention and Treatment Act (CAPTA) State Plan Requirements and Update

Please see *Attachment 6A: CAPTA Update*

Section VII: Statistical and Supporting Information

CAPTA ANNUAL STATE DATA REPORT ITEMS

Please see *Attachment 6A: CAPTA Update* for the following information:

- Information on Child Protective Service Workforce – pp 116-120
- Juvenile Justice Transfers – pp 120-121

EDUCATION AND TRAINING VOUCHERS

Please see *Attachment D*.

INTER-COUNTRY ADOPTIONS

Report the number of children who were adopted from other countries and who entered into state custody in FY 2023 as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or the adoption, the plans for the child, and the reasons for the disruption or dissolution.

In the past year, there were no reports of children adopted from another country who experienced disruption or dissolution through HHS.