Iowa Evaluation Year 4 Report

July 1, 2021 – June 30, 2025

Georgia State University | National SafeCare Training and Research Center

Iowa Evaluation Year 2 Report

Contents

Introduction

The goal of this report is to present the results of the SafeCare program in Iowa from July 2021 through June 30,2025. Between 2016-2017, the National SafeCare Training and Research Center (NSTRC) at Georgia State University partnered with 5 agencies in Iowa to implement SafeCare® with funds from grants from the Agency for Healthcare Research and Quality (AHRQ), and the Patient-Centered Outcome Research Institute (PCORI). NSTRC trained SafeCare Providers, Coaches, and Trainers at each agency, and, in 2020, NSTRC trained SafeCare Providers and Coaches at an additional two agencies. This report summarizes the SafeCare cases who received services between July 1, 2021 and June 30, 2025.

About SafeCare

SafeCare is a home-delivered, behavioral parent training program that targets risk factors associated with child physical abuse and neglect. It is designated for families with children 0-5 years old and addresses three areas of concern related to child neglect and abuse: Parent-Child/Infant Interaction, Home Safety, and Child Health.

The *parent-child/infant interaction* (PCI/PII) module promotes positive parent-child interactions and teaches parents to structure their interactions with their child. There are separate protocols for infants, 0 to 18 months (parent-infant interactions or PII), and for toddlers and older children, 18 months through 5 years (PCI). Specific skills taught include behaviors such as talking, affectionate touching, use of attention, and positive reinforcers for desired behaviors. Parents are taught to use skills during routine daily activities such as mealtime, bathing, getting dressed, and free play; parents select activities for training that are the most problematic.

The *safety module* has a goal of improving environmental safety by reducing health hazards and promoting parental supervision. Parents are taught to make the home safer by eliminating or securing hazards, for example, by installing safety latches, removing trip or crush hazards, and cleaning bacterial hazards. Parents are also taught the importance of supervising children as some hazards may not be able to be eliminated and for when children are in different environments.

The *health module* focuses on teaching parents to (1) recognize symptoms and identify when children are sick or injured; (2) use a structured decision-making process to determine when to care for a child at home and monitor symptoms, see a doctor, or seek emergency services; and (3) take preventive action to keep their children healthy.

Past research on SafeCare

SafeCare was initially developed using methods of applied behavior analysis, which utilizes single-case research designs for the development and refinement of protocols.[1] Each of the SafeCare modules have had systematic expert validation of content and multiple single-case studies conducted to demonstrate its initial effectiveness. Uncontrolled group trials of SafeCare[2-4] demonstrated very large and clinically significant changes in the behaviors targeted by SafeCare, and quasi-experimental evaluations of SafeCare suggested that it prevented child maltreatment recidivism compared to comparison samples.[5,6]

Several randomized trials of SafeCare or variations have been completed, including a large statewide comparative effectiveness trial of SafeCare in the Oklahoma child welfare system that found a reduction

in child maltreatment recidivism favoring SafeCare.[7] Other randomized trial and quasi-experimental evaluations of SafeCare have shown positive impacts on parenting behaviors,[8-10] reductions in parental stress [10] and depression,[11] and improvements in children's adaptive functioning,[8] as well as key child welfare outcomes, including decreased maltreatment reports[5] and removals from the home.[12] Compared to other services, families receiving SafeCare reported higher levels of satisfaction, greater cultural relevance, and greater engagement and completion of service.[13,14] Finally, Providers trained to deliver SafeCare reported lower job burnout than non-trained peers[15] and, when coached, had lower job turnover than their peers.[16]

Roll out of SafeCare in Iowa

SafeCare has been disseminated formally since 2009 through the NSTRC and is currently being implemented in 24 U.S. states and 8 additional countries. SafeCare implementation in Iowa began in 2016 as part of a randomized trial of SafeCare that was funded by grants awarded to NSTRC from AHRQ and PCORI. As part of those research grants, five agencies in Iowa received training to begin SafeCare implementation that included training of Providers, Coaches, and Trainers to establish self-sustaining teams at each agency. The trial ended in 2018, and results found improvements in parenting skill and reductions in parenting stress among families receiving SafeCare compared to comparison families.[10] Two additional agencies (Boys Town and Lutheran Services of Iowa) adopted SafeCare in 2020. This report includes results from all seven agencies, although one agency (Lutheran Services of Iowa) stopped delivering SafeCare at the end of Year 2 (June 30th, 2023). The other six agencies are fully accredited.

Currently, SafeCare is offered to families receiving services through the Iowa Department of Human Services. Families are offered SafeCare when they:

- have children aged 0-5 who have experienced child abuse or neglect;
- have been identified as needing knowledge and skills related to child health, home safety, and/or parent-infant/parent-child interactions; and,
- were referred by the DHS caseworker to a family-centered services (FCS) contractor who delivers SafeCare for the SafeCare program.

Goals of the evaluation

In 2021, Iowa DHS contracted with NSTRC to conduct a 5-year evaluation of SafeCare activities in Iowa. The goals of the evaluation are to determine (1) whether SafeCare is implemented and delivered as intended (i.e. the effectiveness of implementation and fidelity to the SafeCare model) and (2) examine improvement in family outcomes, including immediate behavioral outcomes, child safety and permanency, and child and adult wellbeing outcomes.

The findings from this evaluation will serve to inform the Iowa Department of Human Services (DHS) whether the statewide implementation of SafeCare® is effective for reducing recurrence of child maltreatment and preventing foster care entry and/or re-entry in Iowa. Specifically, DHS aims to learn whether SafeCare increases parenting skills related to parent-infant/parent-child interactions, the child's health, and home safety among caregivers receiving SafeCare through DHS. This is the four-year evaluation of a five-year project, and includes data on the SafeCare workforce, provider fidelity, and family outcomes that are tracked as part of SafeCare delivery (completion, behavior change, satisfaction). For this Year 4 report, NSTRC did not receive new data from the Iowa DHS data system for cases in which

SafeCare was delivered to ascertain rates of recurrence with the Iowa child protection system. Thus, we have simply retained the summary of the data provided in the Year 3 report (note that no new data are included).

Methods

Data sources

The data from this evaluation comes from the SafeCare Implementation Data Network (SIDNe), which includes a web-based portal and mobile applications that are used for tracking staff implementation of SafeCare (Providers, Coaches, and Trainers), and the data provided to NSTRC by the Iowa DHS child welfare data system. SIDNe tracks SafeCare training and implementation outcomes, as well as family outcomes. Training and implementation outcomes are entered by Coaches and Trainers as Providers progress through training and coaching. Family data are entered by providers, typically via the mobile app in real time, as SafeCare is delivered. Family data can also be entered via the web-based portal if providers prefer to use paper forms during SafeCare delivery. It is important to note that NSTRC does not monitor entry of most provider data or family data into the app or portal; several large SafeCare sites have their own data systems and thus entry of family data into SIDNe is not strictly enforced. One agency in Iowa (Four Oaks) did not enter family assessment data, and thus, families served by Four Oaks are not included in this report.

Key data elements

Several data elements are used in this report. At the provider level, we use demographics, sessions completed, and session fidelity scores. For caregivers enrolled in SafeCare, we report data on demographics variables, risk factors identified by providers, sessions received, modules completed, assessments conducted as part of SafeCare, and satisfaction with services.

Provider demographics. When Providers are first enrolled in training, they are asked to complete a demographic profile, including information about age, sex, race and ethnicity, type of position, and prior experience with parenting programs and serving the identified population.

Session Fidelity. NSTRC requires that SafeCare sites engage in ongoing coaching, which consists of fidelity monitoring with performance feedback, to ensure implementation with fidelity. Fidelity is monitored by certified SafeCare Coaches or Trainers (who are also certified Coaches). Each agency in Iowa has its own Coach(es) and/or Trainer(s) who conduct this function. Four Oaks, who did not have a Coach throughout Year 3, trained a new Coach in August 2024. Their Coach has completed 4 out of 6 units towards their Coach certification by the date of this report. Active Certified Providers are expected to be monitored monthly. Sessions are scored by reviewing audio recordings of sessions made on the SafeCare App and uploaded to the web portal. Each session is scored for the key elements (27-32, depending on the session type), each of which is rated as being adequately performed or not. The fidelity score for the session is the percentage of items scored as adequately performed.

Family demographics and risk factors. For each new case, providers can enter a set of demographic information about the family, including demographic information (age, sex, race, marital status, age of targeted child, education, income, work status, etc.), as well as the presence of several key risk factors such as substance use, domestic violence, mental health concerns, disabilities, child behavior problems, and others.

Completion of SafeCare. Completion of SafeCare modules and of the SafeCare program is determined by provider reports on the final assessment for each module and information entered when a case is closed. More detail is provided in the Results section as data on each metric is provided.

Family behavior change. As part of SafeCare, providers complete behavioral assessments as the beginning (baseline) and end (end-of-module) of each module. Each behavioral assessment consists of observations of behaviors aligned with the skills targeted in training. For PCI and PII, providers observe a caregiver's interactions with their child in a range of everyday and play situations and count the number of SafeCare positive parenting target behaviors that caregivers use with their child during these interactions. For Safety, providers count safety hazards in three rooms in the home. For Health, providers present caregivers with common health scenarios in which their child may become sick or injured and score their responses for appropriate behaviors (care at home and monitor symptoms, call doctor, go to emergency room). More detail about each measure is given below in the Results section.

Family Satisfaction. At the end of each module, families are asked to complete a satisfaction survey consisting of 10 questions rated on a 5-point scale. Ratings are averaged to compute a satisfaction score for that module. Note that the satisfaction surveys are part of the SafeCare App; therefore, providers must allow families to enter them using the providers' device or must be collected on paper forms and entered later. Note that only about 40% of module satisfaction surveys were completed.

Data quality and completeness

As noted above, NSTRC does not typically monitor data entry across its many sites or enforce the use of the SafeCare Portal and App data entry features. One agency from Iowa (Four Oaks) did not enter family assessment data into the portal in Years 1-4. In addition, not all assessments were completed, and variations in numbers in the tables presented below are present because of small amounts of missing data.

Results

SafeCare workforce

Table 1 shows each of the seven agencies trained, when they began SafeCare, and the number of Providers, Coaches, and Trainers trained that are part of the current workforce. The table shows the number of Providers, Coaches, and Trainers that are considered inactive because they are not currently seeing families, on-leave, or are no longer conducting SafeCare as part of their position. The data does not include staff who have left the agency and were deactivated from the portal. Note that including temporarily inactive staff in the inactive count means that some staff labeled as inactive may currently be available to serve families.

The current active SafeCare workforce across the six active agencies includes 72 Providers, 15 Coaches, and 11 Trainers. The largest agencies are Families First and Family Access Center, which have SafeCare workforces including 37 and 26 active staff, respectively, in various roles.

Table 1. Current SafeCare Providers, Coaches and Trainers by agency

Agency	Date began SafeCare	Active (Inactive) Providers	Active (Inactive) Coaches	Active (Inactive) Trainers
Boys Town	6/20	1 (1)	1 (0)	1 (0)
Children & Families of Iowa	9/16	8 (18)	3 (0)	2 (0)
Families First	1/17	24 (24)	9 (1)	4 (0)
Family Access Center	8/16	23 (0)	0 (0)	3 (0)
Four Oaks	8/16	4 (2)	1 (0)	0 (0)
Lutheran Services of Iowa*	6/20	0 (0)	0 (0)	0 (0)
Mid-Iowa Family Therapy Center	6/16	12 (4)	1 (1)	1 (0)
Total		72 (49)	15 (2)	11 (0)

* Stopped delivery SafeCare as of June 30, 2023

When Providers are initially registered for SafeCare training, they are asked to complete a questionnaire to capture demographic data. Table 2 shows demographic characteristics of the entire SafeCare workforce trained in Iowa (not just the current workforce). Note that this questionnaire is not mandatory, so the sample size below reflects only those Providers who voluntarily completed the questionnaire; a significant portion of the data is missing. In addition, updating responses is not required; therefore, changes to work-status, education, etc. that occur after a provider is hired are not reflected in the data. As shown in Table 2, the SafeCare workforce in Iowa is primarily female (96%), white (90%), non-Hispanic (96%), and college educated (78% with BA or graduate degrees). Most of the workforce is employed full-time with their agency (95%), with just a few employed on a contractual basis or part-time.

Table 2. Demographic of all Iowa providers ever trained

Provider Demographic Summary	N (%)
Gender	
Male	3 (3%)
Female	96 (96%)
Other	1 (1%)
Race	
White	86 (90%)
African American/Black	6 (6%)
Unsure	4 (4%)
Ethnicity	
Hispanic	4 (4%)
Non-Hispanic	91 (96%)
Highest Degree Completed	
Less than bachelor's degree	23 (22%)
Bachelor's degree	74 (69%)
Graduate degree	10 (9%)
Employment Status	
Contractor	4 (4%)
Part-time	1 (1%)
Full-time	101 (95%)

Provider fidelity

A key part of the SafeCare implementation model is ongoing coaching of Providers to track and promote fidelity. Certified Providers who deliver SafeCare should be coached either monthly or quarterly, depending on their seniority as a Provider. Coaching includes fidelity scoring by a Coach or Trainer with a follow-up coaching session to review performance. Fidelity scores are entered into the SafeCare Portal for tracking.

Table 3 below shows for each agency the number of providers, the average number of sessions per provider on which fidelity was scored, the average fidelity score, and the percent of sessions scored below 85%, which is considered the threshold for a 'passing' session. Overall, 243 providers received some coaching sessions since July 1, 2021, and the mean number of sessions scored for fidelity was 10 per provider. The overall mean fidelity for all providers was 93.2%, well above the 85% threshold. The overall percent of failed sessions was 8.4%. There was some variation by agency in fidelity scores. Most notably, Lutheran Services and Boys Town had a larger percentage of sessions that did not meet the 85%

standard than other agencies. It is worth noting that Lutheran Services no longer implements SafeCare and no new data was entered in FY24 or FY25. In addition, the percentage of failed sessions at Boys Town has decreased since earlier iterations of this report. We caution against interpreting these data as an indicator of poorer quality at one agency versus another. Though coaches are trained to score sessions, the goal of coaching is to improve performance, thus coaches may have slightly different standards for rating particular items, and those that are more scrutinizing may score their providers lower overall.

Table 3. SafeCare fidelity by agency and overall

Agency	# providers*	# sessions scored Mean (sd)	Fidelity Mean (sd)	Percent failed sessions
Boys Town	13	16.8 (14.3)	89.8 (6.92)	25.8%
Children & Families of Iowa	38	13.3 (9.5)	93.6 (6.0)	5.9%
Families First	70	10.5 (7.7)	96.7 (5.0)	4.8%
Family Access Center	62	5.5 (3.9)	92.6 (6.5)	5.2%
Four Oaks	8	13.6 (12.3)	90.5 (6.3)	13.9%
Lutheran Services of Iowa	26	10.2 (6.05)	86.9 (11.8)	20.4%
Mid-Iowa Family Therapy Center	26	11.3 (6.4)	93.4 (4.9)	7.4%
All agencies	**243**	**10.1 (8.2)**	**93.2 (7.2)**	**8.4%**

*Includes all staff who received a fidelity sore and may include SafeCare Provider, Coach, and/or Trainer.

Family data and outcomes

A total of 2648 families were entered into the SafeCare Portal for FY22-25 (July 1, 2021 – June 30, 2025). Of the 2648 cases, 2514 are closed and 134 are active and ongoing at the time of writing (October 2025). For analyses, we included all families that had any SafeCare session during this period. For example, a family that began SafeCare in March 2021 and completed their last session in July 2021 would be included.

Table 4 shows families served for each agency including total families and active and closed cases. Note that Four Oaks did not enter any family assessment data in FY25 and are not represented. They are excluded from the tables below displaying family data.

Table 4. Active and closed cases by agency

Agency	Active cases	Closed cases	Total cases
Boys Town	3	308	311
Children & Families of Iowa	47	364	411
Families First	30	1018	1048
Family Access Center	7	206	213
Lutheran Services of Iowa	1*	46	47
Mid-Iowa Family Therapy Center	46	572	618
Total	134	2514	2648

Table 5 shows the demographic characteristics of SafeCare families. All families (active and closed) were included in this analysis. Note that because of missing data, the numbers in the table do not always sum to the full sample of 2648. Additionally, some of the data reported may not be known to the provider and thus would not be completed.

Caregivers served by SafeCare were largely female (75%), white (78%), non-Hispanic (90%), and had a mean age of 28. Virtually all caregivers were biological parents. Children were 1.64 years old on average (or about 19 months). Most clients were not married (83%), but over two-thirds had a romantic partner and about half lived with a romantic partner. Educational status was largely unknown, but of the reported data, about 77% of the sample had completed a high school degree and 23% had not. About half of the sample (45%) was not working, and the remaining participants were working either full- or part-time. Income data was also largely missing, but of the reported data 56% of the sample had an annual income of less than $15,000 per year.

Table 5. Family demographic overview

Variable	N (%) or M (sd)
Caregiver Average Age, years	M = 28.37 (*sd* =6.9), range = 15 – 63, n = 2038
Target child Age	M = 1.64 (*sd* = 1.7), range 0 – 10, n = 2216
Caregiver Sex	
Female	1684 (75%)
Male	552 (25%)
Caregiver Race	
White	1643 (78%)
Black	322 (15%)
Other/multiple races	137 (7%)
Caregiver Ethnicity	
Hispanic	195 (10%)
Non-Hispanic	1817 (90%)
Caregiver relationship to Target Child	
Biological parent	2161 (99%)
Not biological parent	22 (1%)
Caregiver Marital Status	
Married	222 (17%)
Unmarried	1136 (83%)
Caregiver has romantic partner	
Has partner	980 (69%)
Does not have partner	448 (31%)
Caregiver lives with partner	
Lives with partner	688 (46%)
Does not live with partner	799 (54%)
Caregiver highest level of education	
Has not completed high school	179 (23%)
Completed high school or GED	589 (77%)
Caregiver Employment Status	
Working part-time	244 (16%)
Working full-time	571 (38%)
Not working	673 (45%)
Household Annual Income	
Under $15,000	237 (56%)
$15-$30,000	104 (25%)
$30-$50,000	62 (15%)
$50,000 or higher	20 (5%)

Providers also reported common risk factors for families involved in child welfare systems. These are shown in Table 6 below. By far, the most commonly reported risk factor was parental substance abuse (49%). The next most common risk factor was the presence of violence between intimate partners (20%). Mental health issues (25%), including depression (8%), were also commonly reported. Caregiver intellectual disabilities (5%), homelessness (5%), and child behavior problems (4%), and former incarceration (3.4%), were all uncommonly reported. Note that some risk factors may not be apparent or reported to the provider; thus, these numbers may be underestimates of actual risk factors.

Table 6. Major risk factors for clients enrolled in SafeCare

Risk Factor	**N (%)**
Parent substance abuse	1298 (49%)
Domestic intimate partner violence	541 (20%)
Parental depression	227 (8%)
Other parental mental health problem	452 (17%)
Caregiver intellectual disability	141 (5%)
Homelessness	137 (5%)
Child behavior problems	112 (4%)
Formerly incarcerated	90 (3.4%)

Parent outcomes: Program completion and behavior change

Two primary outcomes available for analyses from the portal data are (1) caregiver completion of SafeCare and (2) uptake/acquisition of SafeCare skills (behavior change). In examining SafeCare completion data, analyses are restricted only to closed cases (n = 2430) as active cases may or may not complete SafeCare. In examining skill acquisition or behavior change, all cases (closed and active) are included because data are collected at the end of each module and available for any client that completed that particular module. We also examine client-rated satisfaction for each of the SafeCare modules.

Program completion

Program completion was computed in two ways that yield slightly different pictures of SafeCare completion. First, a measure of SafeCare completion was computed based provider's recording of the behavioral assessments at the beginning and end of each module ("module completion metrics"). All clients who had baseline and end-of-module assessments were considered to have completed the module, and we summed the number of modules completed to assess fully completing the program. Second, when closing a case, providers completed a single question that indicated a reason for closing the case, and one of the options is that the family completed SafeCare ("closed case metric").

Table 7 shows completion rates by agency and for all agencies based on module completion metric. Based on this metric, overall, 1065 of the 2430 cases (44%) completed the three modules of SafeCare, similar to the total of 45% from last year. The remaining 55% of cases (n = 1365)) did not complete three modules. The last column of Table 7 shows the mean number of sessions completed per family. Overall, the mean number of SafeCare sessions received was 12.3. Excluding Lutheran Services, which enrolled only 46 families, the remaining agencies had fairly similar completion rates (38% - 49%) and number of sessions completed (11.8– 12.5). The three largest agencies (Families First, Family Access Center, and Mid-Iowa) had the highest completion rates.

Table 7. SafeCare program completion based on module completion

Agency	**Number of closed cases**	**N (%) that completed SafeCare**	**sessions per family Mean (*sd*)**
Boys Town	308	116 (38%)	12.0 (6.4)
Children & Families of Iowa	364	139 (38%)	11.8 (6.9)
Families First	1018	474 (47%)	12.5 (7.0)
Family Access Center	206	102 (49%)	12.5 (7.1)
Lutheran Services of Iowa	46	3 (6%)	5.3 (3.8)
Mid-Iowa Family Therapy Center	572	254 (44%)	12.2 (7.1)
All agencies	**2514**	**1088 (43%)**	**12.3 (6.9)**

The module completion metric also allows us to examine the number of modules completed. This metric is important because even if families do not complete all three SafeCare modules, they may benefit from partial completion. Table 8 shows the number of modules completed by agency and for all agencies. The table shows that while 43% of families completed all three (or four) modules, another 14% completed two modules, and 19% completed one module. Thus, 76% of clients had completed at least one SafeCare module that may afford some benefit.

Table 8. Number of modules completed overall and by agency.

Agency	# of modules completed, N (%)			
	3 (or 4)	2	1	0
Boys Town	116 (38%)	50 (16%)	78 (25%)	64 (21%)
Children & Families of Iowa	139 (38%)	61 (17%)	60 (17%)	103 (28%)
Families First	474 (47%)	136 (13%)	180 (18%)	228 (22%)
Family Access Center	102 (49%)	23 (11%)	37 (18%)	44 (21%)
Lutheran Services of Iowa	3 (6%)	2 (4%)	14 (30%)	27 (59%)
Mid-Iowa Family Therapy Center	254 (44%)	80 (14%)	103 (18%)	135 (24%)
All agencies	**1088 (43%)**	**352 (14%)**	**473 (19%)**	**601 (24%)**

We also examined the completion rate for the three specific modules: PCI/PII, Safety, and Health. Table 9 below shows the completion rate for each module. The module most likely to be competed was Health (62%), followed by PCI/PII at 61%, and Safety (52%). Note that PCI and PII are considered together because families are offered either PCI or PII depending on the age of their child. We caution against overinterpretation of the differences in completion rates by module because it is likely that the variation in completion rates by module reflect the order in which the modules were offered rather than differences in engagement or interest in the content of the modules. Safety is often offered last as it is the most intrusive module, requiring providers to inspect the client's home, and thus, requires a great deal of trust between the provider and client.

Table 9. Completion rate for each module

Agency	N	PCI or PII	Safety	Health
Boys Town	308	179 (58%)	157 (51%)	187 (61%)
Children & Families of Iowa	364	197 (54%)	176 (48%)	214 (59%)
Families First	1018	687 (67%)	542 (53%)	609 (60%)
Family Access Center	206	135 (65%)	119 (58%)	133 (65%)
Lutheran Services of Iowa	46	7 (15%)	6 (13%)	14 (30%)
Mid-Iowa Family Therapy Center	572	316 (55%)	302 (53%)	398 (70%)
All agencies	**2514**	**1521 (61%)**	**1302 (52%)**	**1555 (62%)**

The second way we can determine program completion is via the "closed-case metric", a single question each provider completes when closing a case in the app/portal. When closing the case, providers select one of several options to indicate why the case was closed. As is shown in Table 10, the closed-case metric showed a higher completion rate for SafeCare – more than 53% -- compared to the module

completion metric's (which was 43%). Examining reasons for closed cases that did not complete SafeCare shows that the most common reasons were that the agency terminated the case for administrative reasons (42%) and that the agency terminated SafeCare because the client needed a different service (18%). Client refusal and loss of contact (excluding moving) accounted for 34% of non-completion.

Table 10. SafeCare completion and reasons for non-completion from closed cased metric

Variable	**N (%)**
SafeCare Completion	
Completed SafeCare	1327 (52.9%)
Did not complete SafeCare	1182 (47.1%)
Reasons for not completing SafeCare (n=1182)	
Agency terminated SafeCare for administrative reason (e.g., funding, closed child welfare case)	497 (42.0%)
Agency terminated because client needed a different service (e.g., substance use/domestic violence/mental health)	218 (18.4%)
Client refused services – said longer interested or did not need service	215 (18.2%)
Lost Contact with client (e.g., several messages left, disconnected phone)	189 (16.0%)
Client moved to an area that is not served	63 (5.3%)

Behavior change

The second outcome to be analyzed was skill acquisition or behavior change for each SafeCare module. Recall that each SafeCare module begins with a baseline skill assessment and ends with an end-of-module skill assessment. These baseline- and end-of-module assessments form the basis for gauging skill acquisition.

For PCI and PII modules, the skill assessments are observations of parent-child interactions across different scenarios including two daily activities and one play activity. For each activity, the provider observes and scores each of the desired behaviors as occurring or not. Using those scores, a percentage is computed representing the percent of positive parenting behaviors that occurred, and then those percentages are averaged across the different activities. The behavior change metric for PCI and PII thus represents the percentages of positive behaviors occurring across activities.

In PCI and PII, caregivers also complete the "Daily Activities Checklist" in which they review a set of normal daily activities (sleep time, feeding, bathing, shopping, etc.), and rate each on a 4-point scale to indicate the degree of problem with the activity, so higher numbers indicate more problems with the activity. (In-home activities rated as being more problematic are used in training sessions). We can

examine the overall mean from this scale at baseline and end-of-module to determine the extent to which PCI or PII has resulted in a reduction in perceived problems.

For the Safety module, the baseline and end-of-module assessment consists of an observational assessment conducted by the provider of safety hazards in the home. The provider chooses three rooms most commonly used by the child, typically the kitchen, living room, and bath or bedroom, and counts the safety hazards using the Home Accident Prevention Inventory (HAPI). The HAPI includes ten categories of home safety hazards (e.g., fall/activity restriction, fire, poison, drowning, sharp objects, projectile weapons), and rules for counting those hazards. The provider counts the hazards in three or more rooms, and the counts are averaged at baseline and at the end of the module. These metrics thus represent the average number of safety hazards per room at baseline and as end-of-module.

For the Health module, skill acquisition is assessed via a set of standardized health scenarios that assess the caregivers' knowledge and behaviors regarding how to address common instances of injury and illness. Parents are presented with selected health scenarios and asked to identify symptoms, state what actions they would take, and role play those actions (e.g., call the doctor, fill out the Health Recording Chart). Each scenario includes a predetermined number of correct steps for each scenario. The caregiver is credited with a 'check' for each correct step taken. Scores for each scenario are generated by computing the percentage of steps correctly taken, and then those percentages are averaged across the scenarios for baseline and for end-of-module.

Table 11 below shows the behavior change metrics across the SafeCare modules. The table displays scores at baseline and end-of-module, the percent increase or decrease in the targeted behaviors, and t-tests comparing baseline means and end-of-module. All metrics showed statistically significant changes in the expected direction, indicating uptake of SafeCare targeted behaviors.

For PCI, caregiver skill acquisition rose from 66.0% of target behaviors being performed in daily routine and play activities prior to service participation to 97.6% of behaviors performed, a 47.8% increase. A t-test confirmed this was a statistically significant change. Scores on the PCI daily activity checklist (DAC) decreased by 23.5%, indicating a reduced degree of caregiver perceived problems with their child across activities. For PII, an identical pattern was seen. Skill acquisition measures showed an increase in skills from 74.0% at baseline to 98.9% at the end of the module, representing a 33.6% increase in skills, which was statistically significant. The DAC for PII decreased by 25%, indicating fewer perceived problems for caregivers of infants. These findings suggest that parents were using more positive parenting skills and perceived fewer daily challenges during routine activities with their young children after completing the PCI/PII module.

Analysis of the safety metrics showed the mean number of hazards per room decreased from 11.9 to 2.6, a 78.2% decrease, which was statistically significant. This indicates that the homes environment was significantly safer for children and the risk for unintentional injury was lessened upon the completion of Safety.

Parent health decision making skills pertaining to child health showed substantial improvements, with scenario response correctness for appropriate ways to manage a sick or injured child increasing from 76.3 to 97.0%, a 27.1% increase in health skills, which was statistically significant.

Table 11. Behavior change metrics for SafeCare modules.

Module	Baseline Mean (*sd*)	End of Module Mean (*sd*)	% change*	t (df), p-value
PCI skill	66.0 (24.4), n = 958	97.6 (8.7) n = 745	↑ 47.8%	t (744) = 35.3, p < .01
PCI DAC	1.7 (0.6), n = 889	1.3 (0.49), n = 324	↓ 23.5%	t (302) = 13.7, p < .01
PII skill	74.0 (22.7), n = 1062	98.9 (4.7), n = 829	↑ 33.6%	t (828) = 29.9, p < .01
PII DAC	1.6 (0.6), n = 979	1.2 (0.4), n = 432	↓ 25.0%	t (404) = 13.3, p < .01
Safety hazards	11.9 (13.2), n = 1606	2.6 (5.6), n = 1259	↓ 78.2%	t (1258) = 27.7, p < .01
Health	76.3 (21.1), n = 1996	97.0 (8.1), n = 1568	↑ 27.1%	t (1567) = 38.5, p < .01

* Note: increased skills in PCI/PII and Health, and decreased hazards in Safety are the desirable direction.

For simple comparative purposes across agencies, Table 12 below shows the percent increase or decrease for each module for each agency. There was variation in the changes in skill acquisition by agency for each module. Increases in PCI skills range from 41% to 81%; PII skill increases range from 30% to 54%. Reductions in safety hazards range from 75%-94%. Finally, increases in health skills range from 16% to 38%. We caution in overinterpreting these apparent differences for several reasons. First, all agencies are showing changes in the desired direction. Second, there are large sample size differences between agencies and agencies with fewer clients are likely to have less precise estimates. Finally, scoring on the items may vary between agencies. Baseline scoring affects the change metrics provided below; agencies that tend to score clients lower at baseline have more room to improve than those who score clients higher at baseline.

Table 12. Skill acquisition changes by module for each agency.

Agency	PCI skills	PII skills	Safety (Hazards)	Health skills
Boys Town	↑ 66%	↑ 54%	↓ 76%	↑ 29%
Children & Families of Iowa	↑ 49%	↑ 31%	↓ 82%	↑ 39%
Families First	↑ 41%	↑ 30%	↓ 78%	↑ 16%
Family Access Center	↑ 43%	↑33%	↓ 80%	↑ 38%
Lutheran Services of Iowa	↑ 81%	↑ 45%	↓ 94%	↑ 25%
Mid-Iowa Family Therapy Center	↑ 54%	↑ 32%	↓ 75%	↑ 33%

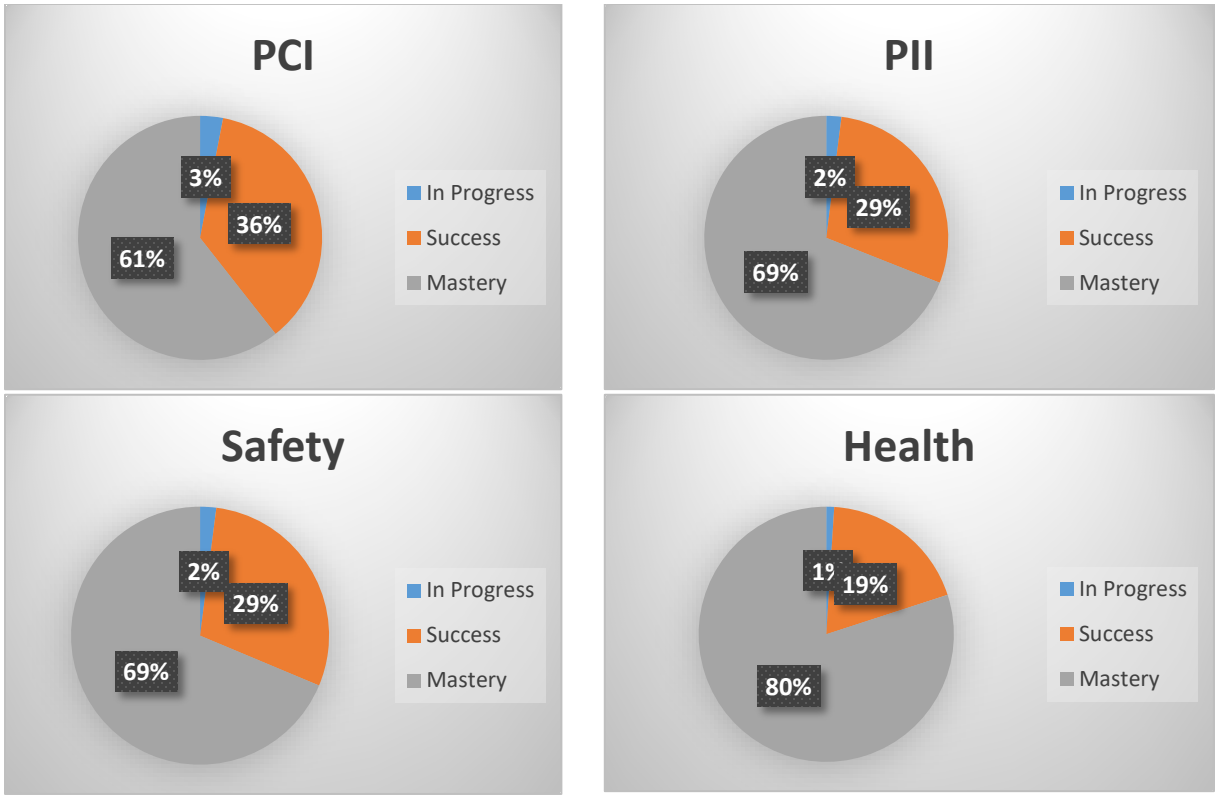
*Note increased skills in PCI/PII and Health, and decreased hazards in Safety are the desired direction.

At the completion of each module, providers indicate whether the caregiver's change in skills reached Mastery level, Success level, or were considered In-Progress. Mastery, Success, and In Progress ratings have specific definitions for each module but conceptually represent the providers' judgment about the

proficiency of ALL of the skills presented. For example, in PCI, caregivers rated for Mastery means that the caregiver demonstrated each skill consistently and with ease; Success is rated when the caregiver demonstrates each skill but not completely or not consistently. Typically, caregivers rated as In-Progress in Session 6 receive additional training in the module. However, this is not always possible.

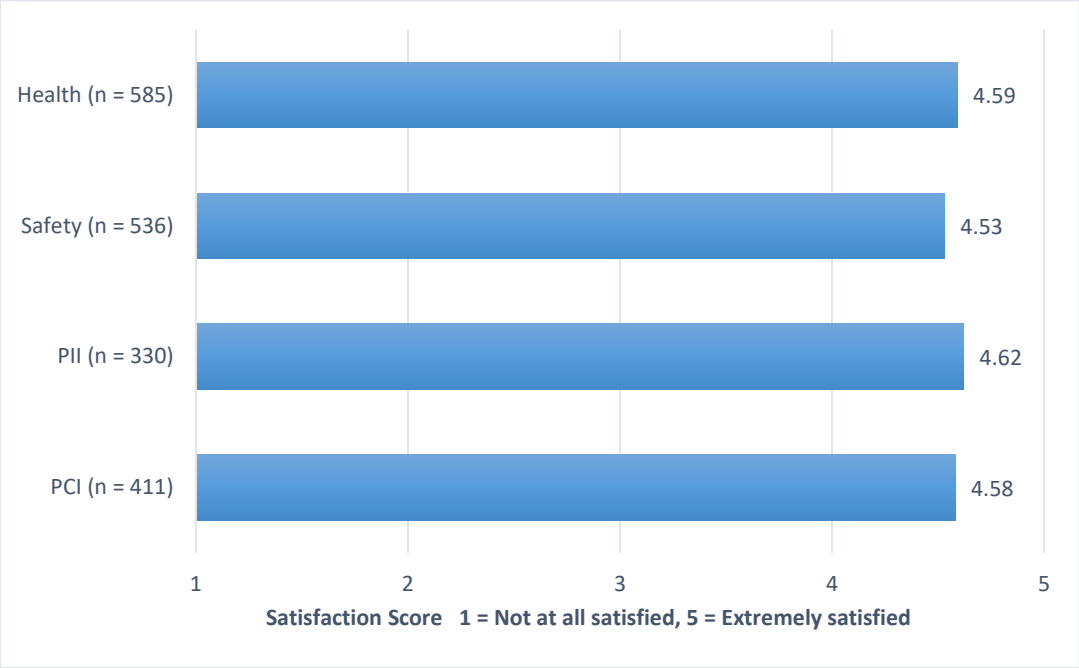
Figure 1 below shows the percent of caregivers rated for Mastery, Success, or In-Progress. Mastery ratings ranged from 61% of caregivers for PCI to 80% for Health, suggesting most caregivers achieved mastery of all the skills taught. Very few caregivers were rated as still In-Progress for each module, no higher than 3.5% for each module.

Figure 1. Caregiver status upon completion of the module



Lastly, caregiver satisfaction is assessed at the end of each module. Caregivers rate satisfaction with the module via the module Caregiver Satisfaction Survey on a scale of 1 to 5, with 5 indicating the highest level of satisfaction with services. Results are displayed in Figure 2. As shown, satisfaction was high for each module, with very little variation across modules. Note that less than half of the families that completed each module completed the satisfaction survey; they may have refused or not been offered the opportunity to complete it.

Figure 2. Caregiver rated satisfaction for each module.



Recurrence of services for SafeCare cases, FY 22-24

NOTE: THIS TEXT BELOW FOR SERVICE RECURRENCE WAS ADDED AFTER FY24 WHEN DATA WERE PROVIDED. THEY HAVE NOT BEEN UPDATED FOR THIS YEAR 4 REPORT AS RECURRENCE DATA ARE SCHEDULED TO BE ANALYZED AT THE END OF YEARS 3 AND 5.

Description

The State of Iowa provided data on the case recurrence for families who were referred for SafeCare services. The datafile included case identifiers, dates of original referrals, dates of SafeCare services, out of home placements and reunifications, whether the case was re-referred for services within the year after exiting SafeCare, and the type of services for which the case referred.

The data file received includes 1670 unique cases that received SafeCare between the dates of July 1, 2020 and June 30, 2023. There were a total of 1855 events in the dataset, but several of the events were for cases who had been referred to SafeCare services more than once. Thus, from the 1670 cases, there were a total of 1855 SafeCare events, for a mean number of events (SafeCare referrals) of 1.1 events per client (range of 1 to 4 events). Because some cases had multiple SafeCare events, we aggregated information for cases with multiple referrals for purposes of reporting. Specifically, we used the initial SafeCare start data, and the final SafeCare exit date for all date-related reports. We summed the total number of days in SafeCare across events and considered each event when determining whether any particular post-SafeCare recurrence happened.

The average number of days from the time of the Solution-Based Casework (SBC) to beginning SafeCare was 71.3 days (sd = 120.1, range = 0 to 765 days). The mean number of days spent in SafeCare was 147.9 days (sd = 91.3, Range = 0 to 604 days).

Among all 1670 cases, 43.89% (733) included some period in which the child was placed out of the home during the time that they were receiving SafeCare services (either SafeCare started when the child was out of the home or the child was removed during SafeCare delivery). Of those cases, 313 cases (18.74%) had the child removed from home while receiving SafeCare. There were 81 cases (4.85%) in which the child began out of the home and was reunified with the caregiver in the SafeCare period.

In the year following receipt of SafeCare (note, the data provided do not indicate whether SafeCare was completed or not), 35.99% (601 cases) had a new service recurrence within the subsequent year, and 64.01 did not have any service recurrence. Cases with recurrence spent more total days in SafeCare (*M* = 158.2, *sd* = 98.2) than cases with no recurrence (*M* = 142.1 *sd* = 86.7) and had more instances of starting SafeCare services (*M* = 1.20, *sd* = 0.47) than cases with no recurrence (*M* = 1.06, *sd* = .24). The types of services that occurred in the year after SafeCare are shown in Table 13. (Note that only 601 cases indicated a recurrence, but 617 cases include a post-SafeCare service.) The most common post-SafeCare service type was an out-of-home placement that was not a formal foster care, followed by SBC services, then adoption, and foster care placement.

Table 13. Service type for clients with recurring services within one year of SafeCare exit.

Type of service	N	%
Out of home placements, not formal foster care	189	30.6%
SBC Services	167	27.1%
Adoption	136	22.0%
Foster care placement	125	20.3%
Total	617	100%

The specific type of services received are displayed in Table 14. The most common services were pre-adoption subsidy, solution-based casework (SBC), relative placement, and family foster care.

Table 14. Specific services for clients with recurrent referral within one year of SafeCare exit.

Type of service	N	%
Pre-Adoption subsidy	104	16.86%
Solution-Based Casework (SBC)	95	15.40%
Relative Placement	93	15.07%
Family Foster care	88	14.26%
Supervision	67	10.86%
Subsidy	36	5.83%
Non-relative placement	30	4.86%
Shelter CA	28	4.54%
Detention	26	4.21%
Trial home	18	2.92%
Group care	15	2.43%
Runaway	14	2.27%
Hospital	12	1.94%
SafeCare	11	1.78%
State Institution of Mental Health	6	0.97%

In sum, about 36% of clients were referred for new services after exiting SafeCare, and among those referred, the most common referral types were out of home placement, SBC services, and formal foster care. A range of specific services was provided with the most common being pre-adoption subsidy, SBC services, and various types of placements.

Summary and conclusions

This report summarizes data from Years 1-4 (FY 22-25) of this 5-year evaluation. We can draw the following conclusions:

1. *Excellent SafeCare Workforce*. There is a strong and robust SafeCare workforce in Iowa. Six agencies in Iowa have certified SafeCare Providers and will continue to deliver SafeCare into FY25. Five out of six agencies have Trainers, so they can expand and sustain their workforce independently to meet demand.

   All six active agencies are fully accredited. Four Oaks had a Coach trained in August of 2024 to provide consistent fidelity requirement.

2. *High Quality SafeCare Implementation.* Fidelity to the SafeCare model is very good. Over all sessions scored for fidelity, mean scores were over 93%, indicating that almost all the key elements of SafeCare are delivered at each session. One agency showed lower than expected fidelity, but the low number of Providers and relatively short length of implementation at that agency suggest that their scores may be less stable than others. It is also possible that fidelity scoring is simply more rigorous at that agency.

3. *Average Family SafeCare Completion.* SafeCare completion rates were either 43% or 53% depending on the metric. In addition, 76% of families completed at least one SafeCare module, and may gain some benefit, even if not completing the entire program. It should also be noted that an overall completion rate of 43% is not atypically low. Many high performing SafeCare sites around the U.S. report completion rates lower than 50% and still demonstrate benefit. For example, the overall completion rate for SafeCare in the randomized trial in which five Iowa sites participated found improvements in parenting skill and reductions in parenting stress even though the completion rate for SafeCare was only 23%.[10] Likewise, the completion rate for the Colorado implementation of SafeCare that found reductions in out-of-home placements favoring SafeCare was just under 27%.[12] There are certainly system-level drivers of completion rates such as the rigor with which a mandate to services is enforced and whether a case is closed before the SafeCare program is completed. The statewide trial of SafeCare in Oklahoma that showed reduced recidivism favoring SafeCare to usual care had completion rates close to 90% for both SafeCare and usual care clients.

4. *Excellent Family SafeCare Skill Acquisition.* Behavior change metrics show excellent skill acquisition. Each of the behavior change metrics computed demonstrated large and statistically significant changes in the direction expected, indicating caregivers are able to demonstrate the skills taught during SafeCare. Provider's ratings of skill acquisition showed that the majority of caregivers that completed a module mastered the skills taught in the module. Those that did not showed success in improving their skills.

5. *High Family Satisfaction with SafeCare Services.* Families reported satisfaction with SafeCare modules is high for each module. All ratings were well above 4 on a 5-point scale.

Improvements for future reports

This report is the Year 4 report of a 5-year evaluation project. New versions of the SafeCare Portal and App were disseminated in September 2024. The dissemination process included thorough training on the new system for all Providers, Coaches, Trainers, and Administrators. NSTRC also encouraged updates to staff and family data as part of the dissemination process. NSTRC will continue to encourage Coaches and Trainers to closely review family assessment data completion as well as entering module completion and satisfaction which are frequently missing.

The migration and dissemination of both the SafeCare Portal and Apps introduced potential for data error. For example, it required staff to keep records on paper for a few weeks while data migrated from the old data server to the new when they had to enter them into the portal after the platform was disseminated. In addition, it took several months for data migrated errors to be corrected and technical issues on the platform to be resolved. NSTRC will conduct a survey across all sites asking about SafeCare Portal and App usage this fiscal year to further identify and address issues around data entry and platform usage. We anticipate that having consistently functioning web-based portal and mobile apps in addition to additional quality assurance measures will have a combined effect of improving the consistency and completeness of data entry.

With Iowa DHS permission, a summary of this evaluation report can be shared with agency leaders who will be encouraged to use these results to inform and strengthen their implementations. They will also be shared with NSTRC training, accreditation, and Trainer certification maintenance staff who can use the report to provide relevant support, especially as it relates to fidelity monitoring and missing data.

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