# FFY 2026 – Annual Progress and Services Report

June 30, 2025

IOWA Health and Human Services

# FFY 2026

# Annual Progress and Services Report (APSR)

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 2026 Annual Progress and Services Report (APSR), with attachments, to the Iowa Department of Health and Human Services' website, Child and Family Services Plan.

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# Section I: Update to the Vision and Collaboration

## COLLABORATION

### Collaboration with Families, Children, Youth, Tribes, and Other System Partners

Iowa utilizes the federal On-Site Review Instrument (OSRI) to conduct its case reviews and records the reviews in the federal OMS, Iowa CQI. Case reviews provide data on how Iowa's child welfare system is doing in the Child and Family Services Review (CFSR) seven outcomes. HHS reviewers engage children, parents, foster and adoptive parents, as applicable, and HHS caseworkers in these case reviews through case-related interviews. Their feedback is invaluable for HHS to understand their experience in Iowa's child welfare system and in identifying systemic barriers. For more information about these reviews, please see *Section II, Update to the Assessment of Current Performance in Improving Outcomes.*

For more information about HHS' collaboration with families, children, youth, tribes, and other partners, please see the following sections:

- *Section II, Update to the Assessment of Current Performance in Improving Outcomes, Agency Responsiveness to the Community*
- *Section III, Update to the Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Feedback Loop*
- *Section V, Update on the Service Descriptions – Early Intervention and Support Services (EIS); Parent Partners; Kinship Navigator; John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) (section 477 of the Act)*
- *Section VI, Consultation and Coordination Between Iowa and Tribes, Discussions with Meskwaki Nation and Discussions with Nebraska Tribes*

HHS plans to continue utilizing the collaborative venues mentioned above and throughout this APSR to engage stakeholders in the implementation of the goals and objectives and monitoring and reporting of APSR progress. HHS' Director Garcia and staff also engage and will continue to engage stakeholders, such as internal staff, service providers, judicial community, communities at large, etc., through Town Hall Meetings held every other month.

**Additional Collaboration:**

Child Welfare Partners Committee (CWPC): The Child Welfare Partners Committee (CWPC) exists because both public and private organizations recognize the need for a

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

Through collaborative public-private efforts, a more accountable, results-driven, high quality, integrated system of contracted services is created that achieves results consistent with federal and state mandates and the 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 now meets bi-monthly throughout the year.

During the time period of April 2024 through February 2025, committee members had conversations around system changes, capacity issues and ways to improve communication between HHS and providers. Members also discussed staff training and the importance of sharing this information in order to find opportunities for more alignment. Members received a high-level overview of the HHS new worker training process. JCS and providers also received an overview of their onboarding training.

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

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

Over the last year, members reviewed the CWPC membership guidelines and membership terms. The public and private co-chairs put together recommendations for membership changes including total number of members, permanent roles, term-limited provider representation, and a new application process. The committee reviewed and

approved these recommendations in February 2025. Information on the CWPC including the updated membership guidelines is available at https://hhs.iowa.gov/about/advisory-groups/cwpc.

### Collaboration with State Courts and Members of the Legal and Judicial Community, Including Court Improvement Program

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

- **Children's Justice State Council** - comprises representatives from organizations involved in the child welfare system. The primary focus of the council is to address matters that are overarching issues in the child welfare system. The council's chair is 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 Division Director of 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, director of a substance abuse treatment agency and a director from a provider agency.
- **Children's Justice Advisory Committee** - Federal regulations require the formation of a multi-disciplinary committee to provide recommendations and feedback to the Judicial Branch regarding the implementation of the Court Improvement Program (CIP) grants. Membership includes three 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, Court Appointed Special Advocate Administrator, two representatives from the Parent Partner Program, a representative for youths' voice, a representative from Drake Law School and the University of Iowa Law School, a representative from the Department of Education and two representatives from provider agencies.
- **Family Treatment Court Teams**- This collaboration occurs on a local level. Each Family Treatment Court has a judge led multidisciplinary team to deliver services needed for families in the program. Team members typically comprise HHS case managers, county attorneys, guardian ad litems, attorneys for parents, substance abuse treatment providers, and Parent Partners. Some teams also have mental health clinicians and domestic violence advocates.

- **Family Treatment Court Expansion Project, Infusion Court** - The Iowa Judicial Branch, along with HHS, continues to work towards expanding Family Treatment Court (FTC) services statewide through the Family Treatment Court Expansion Project (FTCEP). The project assesses needs, trains teams, and implements elements of FTC services in new areas that might not have the environment to support a full FTC.

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

- Pilot project for the new HHS Case Permanency Plan.
- Participation on the statewide team for the Sobriety Treatment and Recovery Teams (START) pilot project.
- Participation on the statewide team for the Safe Babies Court.
- Participation in the Youth and Family Engagement Statewide team and planning committee.
- Assist in reviewing and evaluating Youth Transition Plans.

HHS staff also met with CIP staff to review data and improvement activities related to the Case Review System (see *Section II, Update to the Assessment of Current Performance in Improving Outcomes, Case Review System*). CIP staff provided some of the data analysis. Ongoing collaboration will continue to support data collection, analysis, and the implementation of strategies for improvement.

HHS and ICJ will partner on Round 4 of the CFSR in FFY 2026, working together on key activities such as the Statewide Assessment, the On-Site Review, and the development of the Program Improvement Plan (PIP). Additionally, HHS will collaborate with ICJ in preparation for and throughout the Title IV-E On-Site Review, scheduled for September 2025. ICJ staff historically serve as reviewers during these On-Site Reviews, and HHS welcomes their continued involvement moving forward. ICJ and HHS also partnered to host a feedback session with judges focused on court ordered services.

Iowa does not have an active CFSR PIP or title IV-E PIP.

# Section II: Update to the Assessment of Current Performance in Improving Outcomes

## CHILD AND FAMILY OUTCOMES

### Case Reviews

Following Program Improvement Plan (PIP) completion on December 31, 2023, Iowa took time to evaluate different structures for reviews going forward and efficiencies that could be made. The most current data reported below reflects cases read between January 2024 and March 2025. During the evaluation of approaches to case reviews, the number of cases reviewed was not the focus, rather we were assessing process changes to more efficiently use limited resources to complete quality reviews; therefore, the number of cases reviewed in that period of time was less than will be completed when the structure is fully implemented. The data reflects performance on a total of 23 – 57 applicable cases (item-dependent) that were read during this period of transition. While we continue to assess and adjust the process, as of calendar year 2025, the capacity of the structure in place will be able to increase to 100 cases annually.

| Table 2a: Case Reviews | | |
|---|---|---|
| **Item** | **(1/1/2023 - 12/31/2023)** | **(1/1/2024- 3/31/2025)** |
| **Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.** | | |
| 1: Timeliness of Initiating Investigations of Reports of Child Maltreatment | 61% | 86% |
| **Safety Outcome 2: Children are safely maintained in their homes, whenever possible and appropriate.** | | |
| 2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care | 85% | 81% |
| 3: Risk and Safety Assessment and Management | 51% | 61% |
| **Permanency Outcome 1: Children have permanency and stability in their living situations.** | | |
| 4: Stability of Foster Care Placement | 68% | 72% |
| 5: Permanency Goal for Child | 95% | 87% |
| 6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement | 75% | 80% |

| Table 2a: Case Reviews | | |
|---|---|---|
| **Item** | **(1/1/2023 - 12/31/2023)** | **(1/1/2024-3/31/2025)** |
| **Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.** | | |
| 7: Placement with Siblings | 96% | 59% |
| 8: Visiting with Parents and Siblings in Foster Care | 82% | 80% |
| 9: Preserving Connections | 88% | 84% |
| 10: Relative Placement | 84% | 95% |
| 11: Relationship of Child in Care with Parents | 84% | 85% |
| **Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.** | | |
| 12: Needs and Services of Child, Parents, and Foster Parents | 62% | 67% |
| • 12A: Children | 77% | 86% |
| • 12B: Parents | 67% | 71% |
| • 12C: Foster Parents | 70% | 70% |
| 13: Child and Family Involvement in Case Planning | 80% | 75% |
| 14: Caseworker Visits with Child | 59% | 77% |
| 15: Caseworker Visits with Parents | 49% | 64% |
| **Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.** | | |
| 16: Educational Needs of the Child | 89% | 100% |
| **Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.** | | |
| 17: Physical Health of the Child | 52% | 74% |
| 18: Mental/Behavioral Health of the Child | 50% | 71% |
| Data Source: CFSR Portal OMS, State Summary OMS Statewide Summary Report | | |

Iowa implemented multiple strategies throughout the PIP period, targeting identified focus areas from the 2018 on-site review which resulted in improved performance. Below is an updated summary of current performance as compared to performance at the completion of the Round 3 PIP process (December 31, 2023).

**Safety Outcome 1**

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

As noted in the CFSP, a decrease in performance data in calendar year 2023 reflects increased expectations in practice and was not unexpected. As assessment staff and supervisors became more familiar with the guidance for assuring safety if a delay in timeframe for face to face was allowed, performance improved. Case review data

reflects overall performance at 86%; 23 of 28 visits were conducted within the initial timeframe assigned; of the 5 visits that did not meet the initial timeframe, 20% followed the protocol for approval of a delay to see a child. Statewide administrative data continues to report timely face to face visits at 100% utilizing approved delays in conjunction with meeting initial timeframes; approximately 70% of visits are conducted within the initial timeframe assigned and 30% of visits request and receive a supervisory approved delay. A primary difference in these data sources is that the case reviews assess the quality and necessity of delaying that contact whereas administrative data is looking at approval only. Iowa seeks to close the gap between case review data and administrative data around the process for delays.

**Table 2b: Administrative Data Compared to Case Review Data for Item 1 (January 2024 – March 2025)**

| | Administrative Data | Case Reviews |
|---|---|---|
| Initial Timeframe | 100% | 82% (23/28) |
| Approved Timeframe | 100% | 20% (1 of 5) |
| Overall Performance | 100% | 86% |
| Data Sources: | CWIS | CFSR Portal OMS, State Summary OMS Statewide Summary Report |

**Safety Outcome 2**

**Preventing entry to foster care (Item 2)**

Over the last year, Iowa transitioned to the definitions and guidance for Round 4 of the CFSR. Item 2 applicability criteria changed somewhat so the data does not line up precisely with the data from Round 3; however, their similarities do provide some context when looking at this area and performance is similar.

Iowa plans on focusing on this item specifically as part of the initial and second level QA of cases; information gathered will be used for inter-rater discussion of safety, risk, and targeted services. The ongoing quality monitoring check will be to work through specific case applicability, how it relates to other cases deemed applicable, and to establish key questions or identifiers that will assist in distinguishing between services addressed in this item versus other items throughout the OSRI. Given that Iowa did not successfully meet the Round 3 PIP goal for item 2, we recognize the need to focus on this item to assure ongoing communication and consistency between reviewers and federal partners.

**Risk and safety assessment (Item 3)**

Safety and risk assessments – initial and ongoing – continue to have a connection with multiple initiatives outlined in the recently completed CFSR PIP. The strategies outlined

there – Child Safety Conferences, consultation protocol, and the new assessment – continue to be embedded into practice. The trend continues to show consistently high-quality initial assessments but ongoing assessments show more variability. The primary issues that arose during the most recent case reviews concerned two areas:

- Worker did not regularly assess the entire home environment – either due to not meeting in the child's home regularly or not making a point of seeing all household areas utilized by the child/ren.
- Ongoing parental substance use was not identified, children remained in the home; not meeting privately with the child also exacerbated the issue as the worker was not able to elicit potentially helpful information from the child.

While performance showed a small increase in both initial and ongoing assessments, HHS scheduled follow up trainings – both within regular annual offerings and in a new format recently implemented called "Back 2 Basics" – that will reinforce practical application of safety and risk protocols. Back 2 Basics are training sessions that focus on key practice areas, are mandatory for all Child Protective Services staff, and are offered virtually monthly with a recorded training available ongoing.

| Table 2c: Item 3: Accurate assessment of all risk and safety concerns | | |
|---|---|---|
| **Timeframe of case reviews completed** | **Initial Assessment** | **Ongoing Assessment** |
| Jan 2023 – Dec 2023 | 90% | 59% |
| Jan 2024 – Mar 2025 | 91% | 74% |

Data Source: Practice Performance Report, CFSR Portal

### Permanency Outcomes

Relative and fictive kin placements continue to have a strong impact on placement stability as well as Permanency Outcome 2 indicators. There is a current initiative (April 2025) around development of an expedited licensing process for relatives and fictive kin. This came about as many relatives face financial constraints limiting their ability to open their home to care for additional children; in addition, the path to licensure for relatives resulted in unnecessary barriers. Through removal of barriers, Iowa hopes to increase the pool of families able to support children needing placement, open additional funding sources to support those placements through licensure and potentially create more stable placements for children. While Iowa works through Code changes for relative licensure, the structure for kinship care placements was modified to support unlicensed relatives earlier in the placement so financial limitations have less impact on caregiver decisions and ability to be involved. As of April 2025, information on specific financial funding available and process for use was disseminated statewide.

HHS anticipates that this focus on increasing opportunities for relatives and fictive kin to be engaged will have a broad impact on Permanency Outcomes 1 and 2 in general:

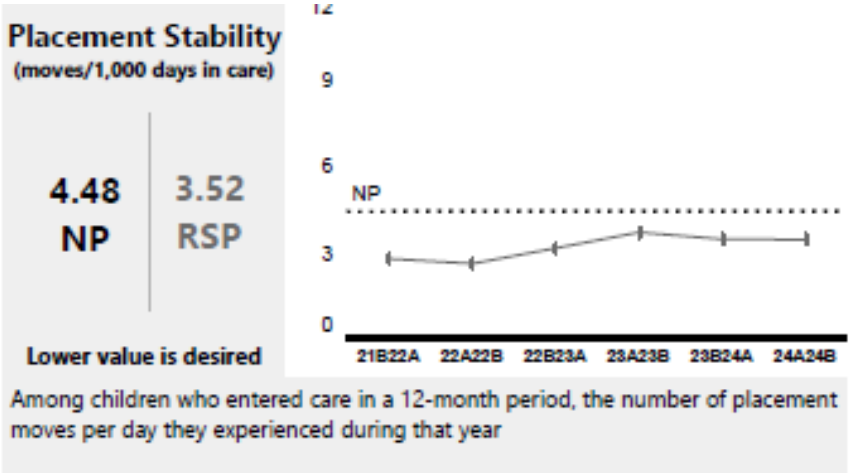
stability of placement, timely permanence, placement with siblings, frequent visits with parents, and preserving connections may all be enhanced by engaging and supporting relatives and fictive kin. Performance in these areas is related to the state's key performance measures and are routinely monitored, analyzed, and adjusted as needed.

**Permanency Outcome 1**

**Placement stability (Item 4)**

Federal placement stability data continues to validate that Iowa is consistently below the federal threshold of 4.1 moves per 1,000 days of foster care.

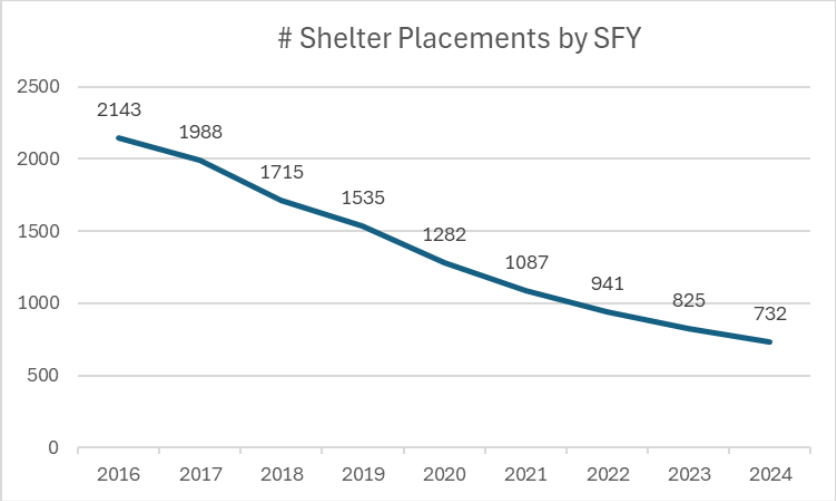
**Chart 2a: Placement Stability**




Data Source: Data Profile for Iowa, February 2025

The decrease in use of shelter as an initial short-term placement had a direct result on stability of placement for children. Since 2016 Iowa has consistently decreased the use of shelter, resulting in a 66% overall reduction between SFY 2016 and SFY 2024. HHS believes this to be a significant contributing factor resulting in Iowa's successful completion of the placement stability PIP target. Iowa is piloting a dedicated social worker officed at the shelters, working specifically toward services and placements that meet the needs of those children. This is still in process but early indications are positive.

**Chart 2b: Number of Shelter Placements by SFY**




Data Source: FACS

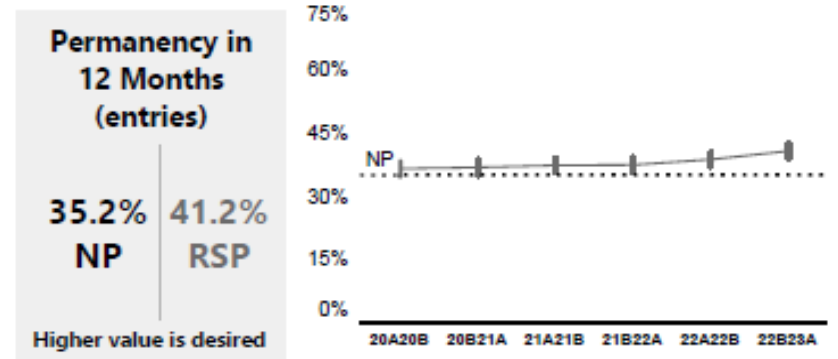
### Appropriate and Timely Permanency Goals (Item 5)

Iowa performs well with establishing timely and appropriate case permanency goals. Iowa does continue, however, to focus on instituting practice change around early identification of concurrent goals for children in care. Field representatives established a protocol that specifies when and how concurrent planning is incorporated into case planning. Monitoring of the practice revealed some barriers, which led to revisions in the monitoring system, clarifications, and streamlining the process. The QA&I bureau continues with planned oversight and support for successful implementation.

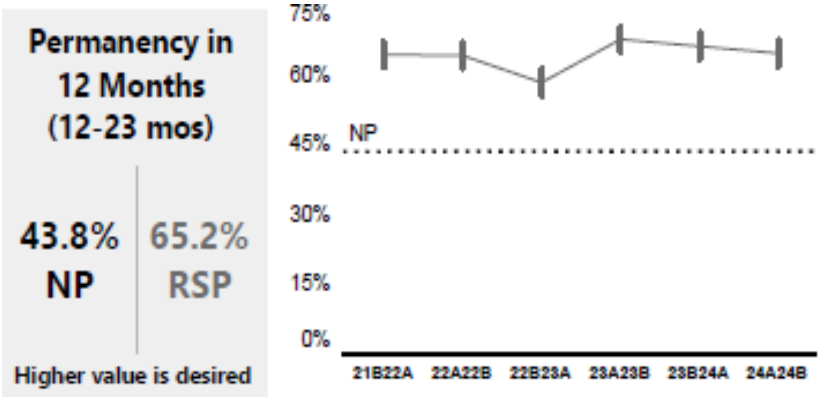
### Timely Permanency (Item 6)

Case review data indicates achieving permanency goals is a strength in Iowa, increasing to 80% in the most current review cycle. In addition to this data, Iowa's data profile continues to show Iowa performing in excess of the national targets regarding timeframes to reunification.

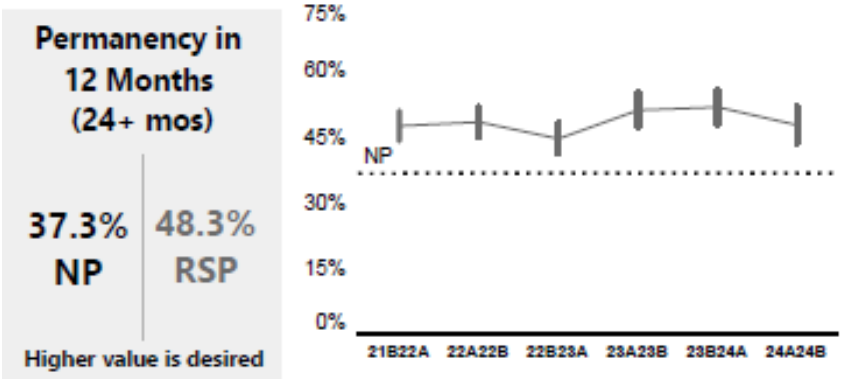
## Chart 2c: Permanency in 12 Months




Among children who entered foster care in a 12-month period, the percent who exited foster care to reunification, adoption, guardianship, or living with a relative within 12 months of their entry




Among children in foster care at the start of the 12-month period who had been in care for 12 to 23 months, the percent who exited to permanency in the subsequent 12 months




Among children in foster care at the start of the 12-month period who had been in care 24 months or more, the percent who exited to permanency in the subsequent 12 months

Data Source: Data Profile for Iowa, February 2025

Conversely, as reunification timeframes continue to meet standards, Iowa's re-entry to foster care performance has shown a decline. See *"National Safety and Permanency Data Indicators" section* for details.

### Permanency Outcome 2

### Placement with siblings (Item 7)

| Table 2d: Item 7: Placement with Siblings in Foster Care | | |
|---|---|---|
| | 1/2023 - 12/2023 | 1/2024 – 3/2025 |
| A. Placed with all siblings in foster care | 63% | 46% |
| B. If not placed together, there was a valid reason for the child's separation | 89% | 25% |

Data Source: Practice Performance Report, CFSR Portal

Iowa saw a sharp decrease in the area of placing siblings in foster care together in this last reporting cycle. Analysis of case review data indicates that placements were not generally available to take sibling groups; although there was no valid reason for children to be separated, this did occur due to lack of foster homes equipped to manage 3-4 children in a sibling group. In some cases, a child was placed with a relative, but each relative had limited capacity to extend beyond one child. Please see *Systemic Factors, Foster and Adoptive Parent Licensing, Recruitment and Retention* for more information.

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

As reflected in performance throughout the CFSR case review instrument, this item shows a maintenance of progress with father involvement following the CFSR PIP. Strategies included in the PIP continue through integration into practice. Ongoing monitoring of the involvement of all parents continues utilizing the case review data.

| Table 2e: Item 8: Visits between Parents and Child | | |
|---|---|---|
| | 1/2023- 12/2023 | 1/2024- 3/2025 |
| Frequency of visitation between mother and child | 90% | 79% |
| Frequency of visitation between father and child | 84% | 82% |
| Quality of interactions between mother and child | 93% | 84% |
| Quality of interactions between father and child | 89% | 91% |

Data Source: Practice Performance Report, CFSR Portal

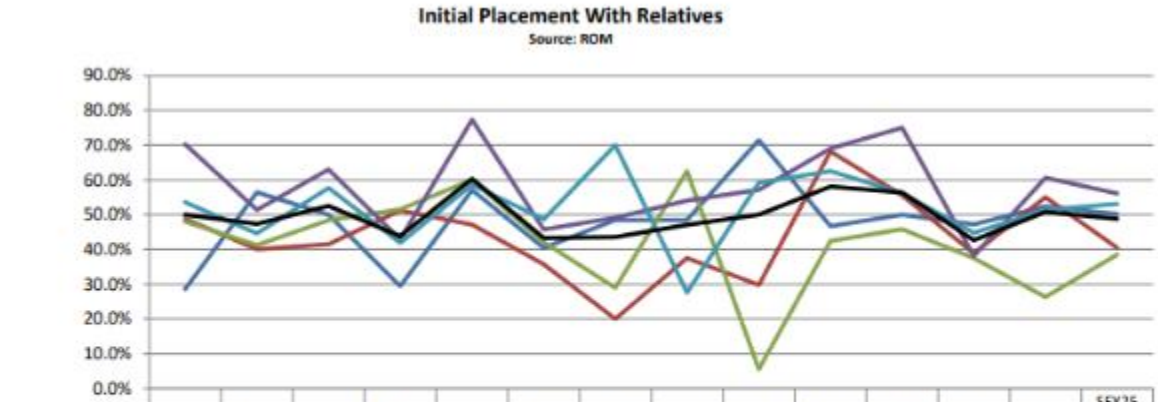
### Preserving Connections (Item 9)

Performance remains consistent across the most recent data collection period. The increased engagement of relatives and fictive kin also impacted the ability to maintain connections for the child and extended family members. In many relative/fictive kin placements, supervision of parent/child visits is by the placement; this allows for greater access and ability to maintain bonds.

### Relative placement (Item 10)

Iowa monitors many aspects of relative placements with a focus on the frequency with which children are placed with relatives or fictive kin at the time of entry to foster care. The graph below shows upward trending in this area even with the most current downturn (January 2023: 39%; January 2024: 57%; and January 2025: 43%); this is an ongoing focus that reflects the emphasis on involving non-resident parents in child welfare cases and the efforts to seek out relatives at the beginning of a foster care episode.

**Chart 2d: Initial Placement with Relatives**

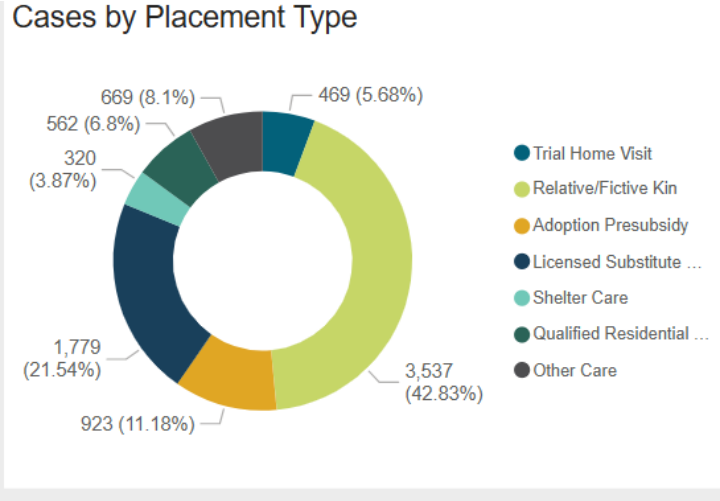



| | Feb24 | Mar24 | Apr24 | May24 | Jun24 | Jul24 | Aug24 | Sep24 | Oct24 | Nov24 | Dec24 | Jan25 | Feb25 | SFY25 Avg |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Western | 28.6% | 56.4% | 50.0% | 29.4% | 57.1% | 40.4% | 48.5% | 48.5% | 71.4% | 46.7% | 50.0% | 47.2% | 52.4% | 50.2% |
| Northern | 48.8% | 40.0% | 41.5% | 51.2% | 47.1% | 35.7% | 20.0% | 37.5% | 29.7% | 68.2% | 55.6% | 38.9% | 55.0% | 40.4% |
| Eastern | 48.0% | 41.2% | 48.4% | 51.5% | 60.0% | 42.1% | 28.9% | 62.5% | 5.6% | 42.4% | 45.8% | 37.5% | 26.3% | 38.5% |
| Cedar Rapids | 70.2% | 51.4% | 63.0% | 42.9% | 77.3% | 45.7% | 49.1% | 54.1% | 57.1% | 69.0% | 75.0% | 38.1% | 60.6% | 56.1% |
| Des Moines | 53.6% | 44.6% | 57.7% | 41.9% | 58.6% | 48.6% | 70.0% | 27.6% | 59.2% | 62.5% | 56.3% | 44.7% | 51.4% | 53.1% |
| State | 50.0% | 47.3% | 52.5% | 43.8% | 60.3% | 43.3% | 43.5% | 47.1% | 50.0% | 58.1% | 56.3% | 42.6% | 50.8% | 48.8% |

Data Source: Practice Performance Report, CFSR Portal

It's noteworthy that the data above does not include fictive kin. When evaluating point in time placements in family-like settings, regardless of whether it is the initial placement or subsequent, 67% of children are placed with a relative or fictive kin.

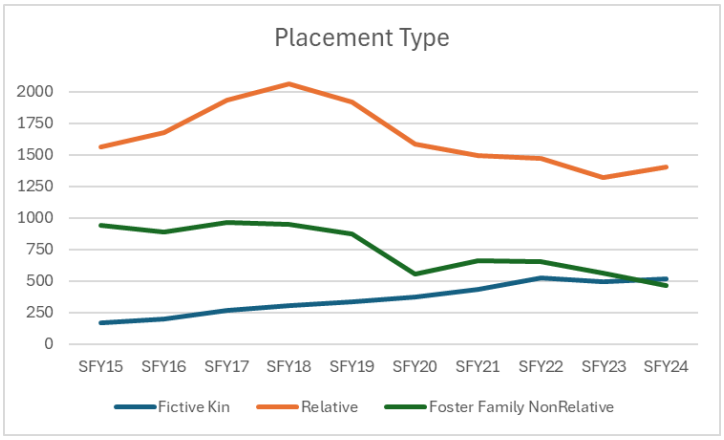
### Chart 2e: Calendar Year 2024




HHS Public Dashboard Placement Type

Also noteworthy in this area, data indicate an upward trend in fictive kin placement while showing a downward trend in stranger foster care. This reflects Iowa's efforts to support relatives and fictive kin.

### Chart 2f: Placement Type




Data Source: FACS

### Relationship of Child in Care with Parents (Item 11)

Data reflect stability in performance regarding this item. HHS anticipates that the ongoing emphasis on relatives and fictive kin placements allows for more involvement between the child in foster care and their parent(s). While family dynamics are a factor, additional access and communication while in a relative placement could positively impact the ongoing relationship and involvement between the parent and the child.

### Well-Being Outcome 1

This outcome was a primary target during Iowa's CFSR PIP period. Throughout WB1, performance with fathers was consistently lower than performance with mothers. Engaging with fathers became a strategic area for improvement as it identified a clear trend driving the overall performance; those targets were met and the summaries below now compare engagement across the various roles.

### Assessment and services (Item 12)

The data below represents performance for mothers, fathers, and children concerning assessment of needs and provision of services. While there's some minimal variation among the sub-questions, overall performance is at 67% which is a slight improvement from CY 2023 data (62%). Overall, performance remains steady; fathers continue to be a focus area throughout WB1 that we monitor individually so we do not lose ground, but the measure is examined more holistically as a "family" unit.

**Table 2f: Item 12: Needs Assessment and Services for Parents and Children January 2024 – March 2025**

| | Assessment | Services | Both |
|---|---|---|---|
| Mother | 85% | 80% | 76% |
| Father | 77% | 79% | 73% |
| Child | 97% | 74% | 86% |

Data Source: OMS Practice Performance Report, CFSR Portal

### Child and family involvement in case planning (Item 13)

As discussed in item 12 narrative, the focus of engagement is on the family unit; with the increased performance with fathers, this broader view allows for a reexamination of root cause around successful approaches to engagement as well as potential barriers.

**Table 2g: Item 13: Child and Family Involvement in Case Planning**

| | CY 2023 | 1/2024 - 3/2025 |
|---|---|---|
| Mother | 87% | 88% |
| Father | 80% | 80% |
| Child | 91% | 88% |
| Overall | 80% | 75% |

Data Source: OMS Practice Performance Report, CFSR Portal

### Social Worker Visits with Children (Item 14) and Parents (Item 15)

Social workers continue to show strong performance through the case reviews regarding the frequency of visits with children; quality of those visits continues to improve. Social worker visits with children and parents (Item 15) continue to be foundational to Iowa's practice. Ongoing discussions in the service areas, use of focus groups, and unit meetings continue to reinforce different techniques of engaging with families to promote rapport and open communication.

| Table 2h: Item 14: Social Worker Visits with Children | | |
|---|---|---|
| | 1/2023- 12/2023 | 1/2024 - 3/2025 |
| **Frequency** | 86% | 100% |
| **Quality** | 62% | 77% |

Data Source: OMS Practice Performance Report, CFSR Portal

| Table 2i: Item 15: Social Worker Visits with Parents | | |
|---|---|---|
| | 1/2023 – 12/2023 | 1/2024 - 3/2025 |
| Both the frequency and quality of caseworker visitation with the mother were sufficient. | 67% | 81% |
| Both the frequency and quality of caseworker visitation with the father were sufficient | 60% | 60% |

Data Source: OMS Practice Performance Report, CFSR Portal

The "goal section" of this report addresses more information about how Iowa will increase the frequency and quality of social worker visits with parents.

### Wellbeing Outcome 2

### Educational needs of the child (Item 16)

Assessment and provision of educational services continues to be a strength for Iowa, performing at 100% based on the most current CFSR case reviews.

### Wellbeing Outcome 3

### Physical health of the child (Item 17)

Over the past year, Iowa saw an improvement in the assessment of dental needs but Iowa continues to have capacity limitations for pediatric dental services which impact the ability to meet these needs. This is a known systemic issue for service array.

### Mental/Behavioral health of the child (Item 18)

Iowa has been actively developing enhanced mental and behavioral health care availability for children which is anticipated to have a direct impact on service array. On May 15, 2024, **House File 2673** was signed into law. Under this legislation, Iowa will:

- Combine the work and funding for mental health and addictive disorders into a Behavioral Health Service System, guided by a statewide plan, focused on ensuring equitable access to prevention, treatment, recovery, and crisis services.
- Transfer the management of disability services from the local Mental Health and Disability Services (MHDS) Regions to the Division of Aging & Disability Services. To focus on systems of support, care, and connection for all Iowans and families with disability-related needs, management activities will include identifying additional organizations to participate in the Aging and Disability Resource Center (ADRC) network and the creation of a disability services system.
- Strengthen important system connections to Medicaid, Public Health, and Child Protective Services by gathering meaningful feedback from Iowans to inform system planning.

Using a shared responsibility model between HHS and system stakeholders, Iowans will build a Behavioral Health Service System that:

- Is well-coordinated with clear access points throughout behavioral health districts,
- Ensures that individuals and families have access to person-centered services and supports no matter where they live,
- Reduces duplication by linking Federal, State and local governance and authority,
- Eliminates administrative red-tape, and the same efforts happening in multiple places, and
- Links funding to measurable outcomes.

Full implementation of the Behavioral Health Service System will start July 1, 2025.

### National Safety and Permanency Data Indicators

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

**Table 2j: Iowa Risk Standardized Performance on National Safety Data Indicators**

| Federal Measure | Federal Description | National Target | FY 2019 | FY 2020 | FY 2021 | FY 2022 | FY 2023 |
|---|---|---|---|---|---|---|---|
| Recurrence of Maltreatment | Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month period, what percent were | 9.70% | 20.0% | 19.3% | 21.8% | 21.2% | 19.1% |

| Table 2j: Iowa Risk Standardized Performance on National Safety Data Indicators | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Federal Measure** | **Federal Description** | **National Target** | **FY 2019** | **FY 2020** | **FY 2021** | **FY 2022** | **FY 2023** |
| | victims of another substantiated or indicated maltreatment report within 12 months of their initial report? | | | | | | |
| Maltreatment in Care | Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care? | 9.07 | 34.26 | 31.25 | 42.61 | 28.66 | -------- |
| Data Source: Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2025, provided by Children's Bureau; Data – AFCARS and NCANDS Submissions as of 12-17-24 | | | | | | | |

| Table 2k: Iowa Risk Standardized Performance on National Permanency Data Indicators | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Federal Measure** | **Federal Description** | **National Target** | **FFY 2019** | **FFY 2020** | **FFY 2021** | **FFY 2022** | **FFY 2023** | **FFY 2024** |
| Permanency within 12 months of entry | Of all children who enter foster care in a 12-month period, what percentage are discharged to permanency within 12 months of entering care? | 35.2% | 39.0% | 36.9% | 37.8% | 39.2% | -------- | -------- |
| Permanency in 12 months (12-23 months) | Of all children in foster care on the first day of a 12-month period who had been in care between 12 and 23 months, what percentage are discharged to permanency within | 43.8% | 67.7% | 68.5% | 67.3% | 64.7% | 68.2% | 65.2% |

| Table 2k: Iowa Risk Standardized Performance on National Permanency Data Indicators | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Federal Measure** | **Federal Description** | **National Target** | **FFY 2019** | **FFY 2020** | **FFY 2021** | **FFY 2022** | **FFY 2023** | **FFY 2024** |
| | 12 months of the first day? | | | | | | | |
| Permanency in 12 months (24+ months) | Of all children in foster care in the first day of a 12-month period who had been in foster care for 24 months or more, what percentage are discharged to permanency within 12 months of the first day? | 37.3% | 46.1% | 52.2% | 52.3% | 49.0% | 51.7% | 48.3% |
| Re-entry to foster care in 12 months | Of all children who enter foster care in a 123-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percentage reentered foster care within 12 months of discharge? | 5.6% | 8.9% | 8.2% | 8.1% | 11.5% | 11.5% | -------- |
| Data Source: Iowa, Child and Family Service Review (CFSR 4) Data Profile Context Data, February 2025, provided by Children's Bureau; Data – AFCARS and NCANDS Submissions as of 12-17-24 | | | | | | | | |

**Recurrence of Maltreatment**

Although Iowa demonstrated a decrease in recurrence of maltreatment since the last data profile was available, performance continues to significantly exceed the nationwide expectation; this has long been a focus area. Iowa reviewed data regarding types of

abuse for both initial and subsequent, age of victim, and circumstances surrounding the recurring incident. Analysis indicates that neglect and substance abuse continue to be the most frequent initial and subsequent categories of abuse.

Efforts to assess potential influencing factors are underway. One such focus is to establish protocols for open service cases when a safety or risk issue occurs to distinguish between a new child protective assessment versus service assessment to assure safety. Iowa believes current practice of broad definitions of what constitutes a traditional intake is one influencer that resulted in an artificially inflated recurrence of maltreatment figures.

Iowa is actively working with C!A to implement targeted recommendations from their previous assessment of Iowa's child welfare system. Recommendations included alternative, streamlined options for allegations deemed spurious or clearly not substantiated after an initial visit; other states have implemented an abbreviated process for this type of reports to quickly facilitate closure, thus efficiently freeing staff resources for where and when most needed.

Another partnership around assuring safety continues to be in place between Iowa and the National Partnership for Child Safety, a non-profit agency that worked with Tennessee to develop the standard Safe Systems Improvement Tool (SSIT) for the review of critical incidents. Iowa is actively working with consultants to implement a culture of safety for workers to promote greater exchange of information and identification of systemic trends and barriers affecting safety of children.

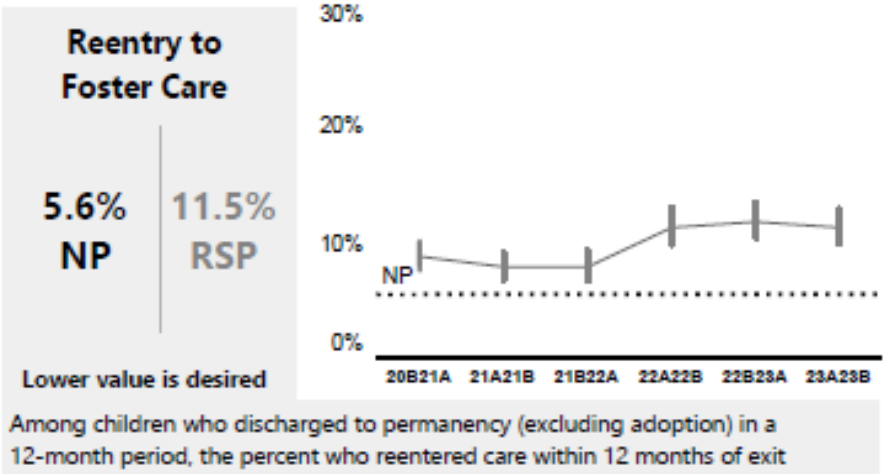
**Maltreatment in Foster Care**

Maltreatment in foster care has been a focus of continuous improvement over the last five years. After showing significant improvement following multiple sequential quality improvement reviews, performance continues to be inconsistent. Analysis indicates the most prevalent perpetrators in these founded reports continue to be "Parent" with the abuse occurring primarily while the child is on home visits. Iowa has prescriptive laws in place regarding when child exposure to parental substance use must be a substantiated abuse report. This is a driving factor not only in performance regarding maltreatment in foster care but also potentially for recurrence of maltreatment.

**Re-Entry to Foster Care**

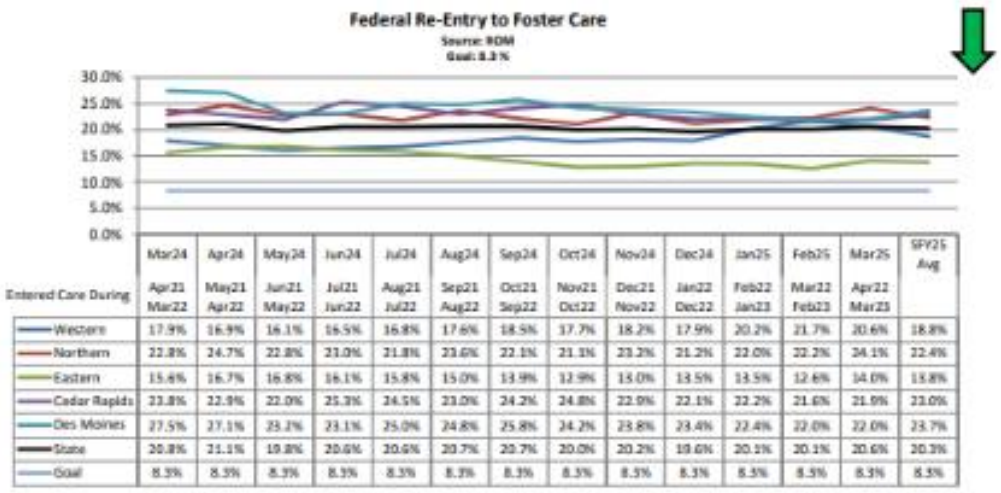
A change in practice implemented as of January 2021 discontinued the use of Trial Home Visits as a standard practice; this resulted in a definition change of "discharge from foster care"; this resulted in children with reunification episodes lasting less than 6 months being included in the re-entry population.

### Chart 2g: Reentry to Foster Care




Data Source: Data Profile for Iowa, February 2025

### Chart 2h: Federal Re-Entry to Foster Care




Data Source: ROM

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

| Table 2l: Re-Entry to Foster Care | | | | | |
|---|---|---|---|---|---|
| | June 2021 | June 2022 | June 2023 | February 2024 | February 2025 |
| **Re-Entry <6 Months** | 37% | 54% | 71% | 76% | 79% |

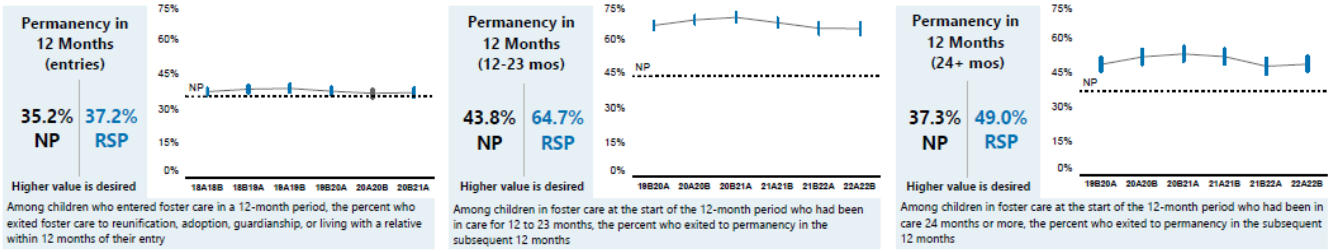
Data Source: ROM Federal Re-Entry

These cases previously did not impact re-entry rates but now play a defining role; while HHS anticipated an increase, this degree of change was not. To increase successful reunification, Iowa focused on steps to prepare both the child and parent(s) through a process to guide planning prior to a child's return from care. Recent focus on concurrent planning has also built on this concept, reinforcing the thoughtful preparation for reunification.

HHS' QA&I Bureau identified this area as a priority and will develop an approach to identify root causes and engage stakeholders in improvement efforts as part of Iowa's CFSP. See Goals section.

**Permanence**

**Chart 2i: Permanency in 12 Months**




Data Source: Data Profile for Iowa, February 2025

Performance on timely reunification for families continues to be a strength for Iowa. National goals continue to be exceeded for achieving permanence for children in all three of the federal measures.

## SYSTEMIC FACTORS

### Statewide Information System

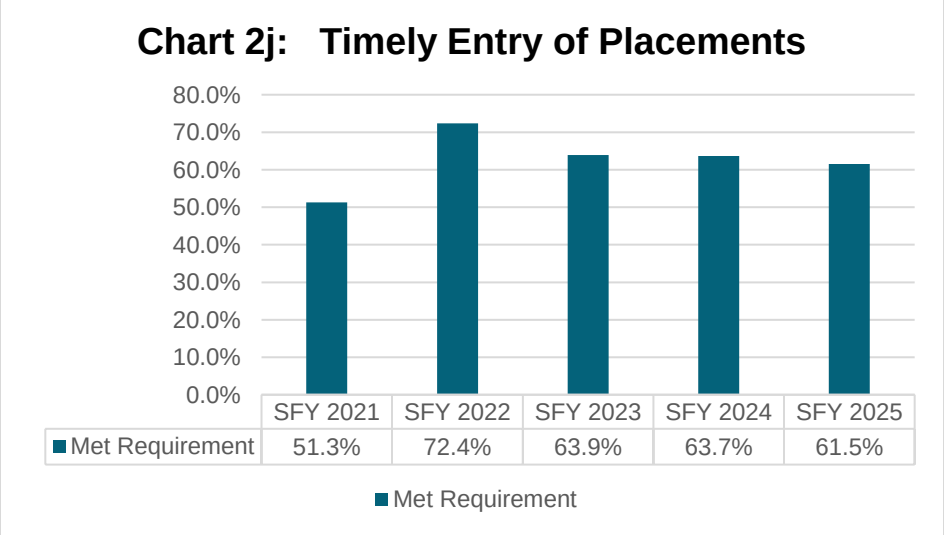
**Item 19: Statewide Information System**

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

Iowa's statewide information system also includes components to increase data quality, such as interfacing with income maintenance programs (e.g., food assistance, Temporary Assistance to Needy Families (TANF), Medicaid, etc.) and child support

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

441 Iowa Administrative Code (IAC) 130.6(4) and (5) requires HHS staff to enter case information into the reporting system and to monitor the case to ensure the information in the reporting system is correct. The information to be entered includes but is not limited to: the status, demographics, location, and permanency goals for children in foster care. Employee's Manual 18C(2): Case Management, Foster Care Placement, requires staff to complete placement entries in FACS within three business days from the date the child initially enters foster care and the date of any foster care placement changes. The data in the chart below shows that performance to meet this requirement declined from SFY 2022 but has remained relatively consistent since then, with almost 62% of the entries meeting the timeliness requirement in SFY 2025.




Data Source: FACS; Note: SFY 2025 data is from July 2024-February 2025

In addition to monitoring timeliness of placement entries, HHS' Bureau of Quality Assurance and Improvement (QA&I) staff examine data accuracy for 100 cases randomly selected from all children served in out of home care. This process compares FACS/AFCARS data with case narrative and file documentation from sources other than FACS/AFCARS (i.e., court orders and narratives, social history, case plan narratives, etc.). The process explores basic demographics (race, sex, and ethnicity),

foster care placement data (latest removal, manner of removal, current setting, discharge date, discharge reason), and case plan goal, etc. For the FACS/AFCARS review, data counts as “accurate” when it is consistent with case file documentation. Data counts as “inaccurate” when there is clearly an inconsistency between FACS/AFCARS and case file documentation. Individual data counts as “unable to verify” when data comparison cannot occur because there is no independent paper file source for comparison. Reviewers communicate with case managers when an inconsistency is found; case managers follow up and correct or clarify information as needed. Annually, HHS generates and distributes a statewide report, as well as service area-specific reports, with reviewing of these reports occurring at leadership and staff meetings to identify any trends that may need additional action.

While a standard process is in place, there was no review in 2023; in 2024 the sample doubled to assure ongoing monitoring and reporting of accuracy. Performance on the AFCARS reviews remains high overall, with notable improvement in accurate entries of race and ethnicity.

**Table 2m: AFCARS Data Validation Review**

| Element | Item Description | CY 2020 Data Not Available | CY 2021 | CY 2022 | CY 2023 Data Not Available | CY 2024 |
|---|---|---|---|---|---|---|
| FC-06 | Does the child's DOB in FACS accurately reflect what is listed in paper file documentation? | ----- | 100% | 99% | ----- | 98% |
| FC-07 | Does the child's Gender in FACS accurately reflect what is listed in paper file documentation? | ----- | 99% | 100% | ----- | 100% |
| FC-08 | Does the child's Race in FACS accurately reflect what is listed in paper file documentation? | ----- | 51% | 83% | ----- | 95% |
| FC-09 | Does the child's Hispanic or Latino Ethnicity in FACS accurately reflect what is listed in paper file documentation? | ----- | 41% | 65% | ----- | 98% |
| FC-21 | Does the child's Date of Latest Removal in FACS accurately | ----- | 91% | 96% | ----- | 97% |

| Table 2m: AFCARS Data Validation Review | | | | | | |
|---|---|---|---|---|---|---|
| **Element** | **Item Description** | **CY 2020 Data Not Available** | **CY 2021** | **CY 2022** | **CY 2023 Data Not Available** | **CY 2024** |
| | reflect what is listed in paper file documentation? | | | | | |
| FC-25 | Does the child's Manner of Removal in FACS accurately reflect what is listed in paper file documentation? | ----- | 100% | 100% | ----- | 100% |
| FC-41 | Does the child's Current Setting in FACS accurately reflect what is listed in paper file documentation? | ----- | 99% | 99% | ----- | 97% |
| FC-43 | Does the child's Case Plan Goal in FACS accurately reflect what is listed in paper file documentation? | ----- | 96% | 96% | ----- | 91% |
| FC-56 | Does the child's Discharge Date in FACS accurately reflect what is listed in paper file documentation? | ----- | 91% | 94% | ----- | 90% |

Data Source: AFCARS Review

Comprehensive Child Welfare Information System (CCWIS) Development

Effective July 2024, HHS placed the VISION project on pause, including solutions design and software development, to comprehensively assess our overall strategy for internal design and development. This pause enabled a thorough review of the project's direction, design, and approach. By doing so, HHS intended to enhance the overall efficiency, effectiveness, and long-term success of the project. After careful consideration of our options, HHS determined to pursue a commercial-off-the-shelf (COTS) CCWIS solution and to cease further investment in a customized, in-house developed solution. HHS contracted with BerryDunn to do the following:

- Requirements gathering
- Translating state processes, and state and federal regulations into technical system requirements.

- Turning requirements into a Requirement Traceability Matrix (RTM)
- Developing an RFI that vendors working in the CCWIS space will respond to, allowing us to identify from the response pool vendors that meet our requirements and are accessible through an existing master agreement.
- Assistance in developing selection criteria for CCWIS vendors.

At this time, HHS anticipates having a pool of vendors to select from in December 2025. If we determine a specific vendor meets our criteria, we anticipate developing a contract with them through an existing master agreement and potentially ready to initiate design and development work in the Spring/early Summer of 2026.

Current or Planned Activities to Improve Performance: See CCWIS Development above

## Case Review System

### Item 20: Written Case Plan

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

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

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

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

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

HHS designed The Family Case Plan to use the anticipated VISION system functionality. However, in the summer of 2024, HHS placed the VISION system build on hold. HHS is currently incorporating the Family Case Plan into the JARVIS system.

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

Table 2n shows performance data for CY 2023 while Table 2o shows performance data for January 2024 through March 2025. Overall, performance data shows consistent performance.

**Table 2n: Item 13: Parents Involvement in Case Planning by Case Type CY 2023**

| Practice Description | Foster Care – Performance of Applicable Cases | In-Home Services – Performance of Applicable Cases | All Case Types – Performance of Applicable Cases |
|---|---|---|---|
| (Question 13B) The agency made concerted efforts to actively involve the mother in the case planning process. | 87.5% (28 of 32) | 86.95% (20 of 23) | 87.27% (48 of 55) |
| (Question 13C) The agency made concerted efforts to actively involve the father in the case planning process. | 81.8% (18 of 22) | 77.78% (14 of 18) | 80% (32) of 40 |

Data Source: OMS Practice Performance Report

**Table 2o: Item 13: Parents Involvement in Case Planning by Case Type (January 2024 – March 2025)**

| Practice Description | Foster Care – Performance of Applicable Cases | In-Home Services – Performance of Applicable Cases | All Case Types – Performance of Applicable Cases |
|---|---|---|---|
| (Question 13B) The agency made concerted efforts to actively involve the mother in the case planning process. | 83.33% (20 of 24) | 82.35% (14 of 17) | 82.93% (34 of 41) |
| (Question 13C) The agency made concerted efforts to actively involve the | 73.33% (11 of 15) | 86.67% (13 of 15) | 80% (24 of 30) |

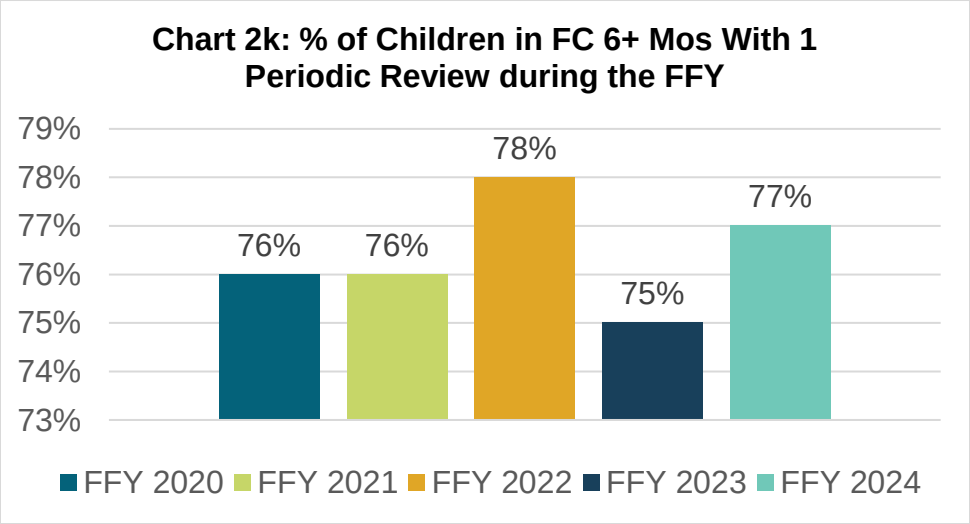
| Table 2o: Item 13: Parents Involvement in Case Planning by Case Type (January 2024 – March 2025) | | | |
|---|---|---|---|
| **Practice Description** | **Foster Care – Performance of Applicable Cases** | **In-Home Services – Performance of Applicable Cases** | **All Case Types – Performance of Applicable Cases** |
| father in the case planning process. | | | |

Data Source: OMS Practice Performance Report

### Item 21: Periodic Reviews

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

The following chart answers the question: Of all children in foster care 6 months or more during an FFY, how many children had at least one court review? Performance has been consistent over the last four FFYs.




Data Source: AFCARS

### Item 22: Permanency Hearings

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

Table 2p represents data collected by Iowa Children's Justice (ICJ). Charts 2l and 2m represent the timeliness of permanency and subsequent permanency hearings from 2019 through the end of March 2025.

Generic court order templates continue to be used across jurisdictions. Some judges and clerks still utilize a default "Order" heading that does not specify the type of hearing, making it difficult for clerks to determine the nature of the hearing without reviewing the entire order. This led to occasional data entry errors.

There are juvenile court order templates for the different types of hearings in Child in Need of Assistance (CINA) cases. We continue to discourage the practice of combining permanency and termination hearings. Progress continues to be made in this area, with a noticeable increase in separately held permanency hearings.

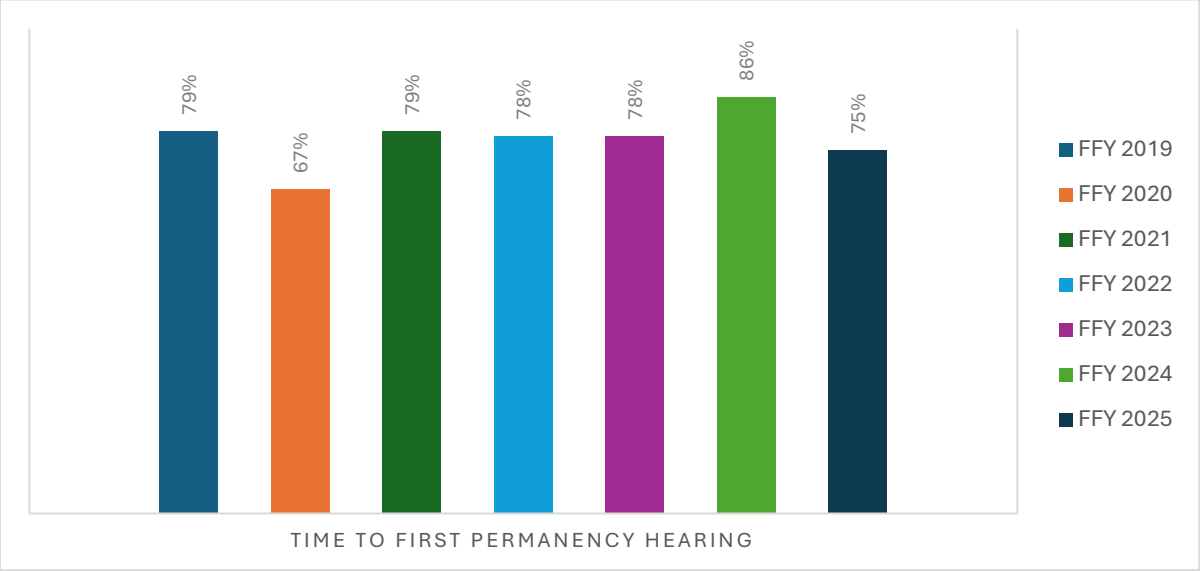
Additionally, there were several judicial vacancies due to medical issues, retirement and promotions. This has left some districts shorthanded, and cases are then assigned to other judges who already have a full docket.

**Table 2p: Timeliness of Initial and Subsequent Permanency Hearings**

| **Court Function Indicator** ***[Specific, observable, and measurable]*** **Timeliness Permanencies** | **Previous Year Baseline Rate (FY2024)** | **Initial Baseline Rate or Level (FY2025)** | | **Target** | **Difference From Baseline** *[Difference in the annual level from the baseline.]* |
|---|---|---|---|---|---|
| **Time to First Permanency Hearing*** | 86% | 75% | | 100% | -11% |
| **Time to Subsequent Permanency Hearing**** | 98% | 99% | | 100% | 1% |

Data Source: Iowa Children's Justice

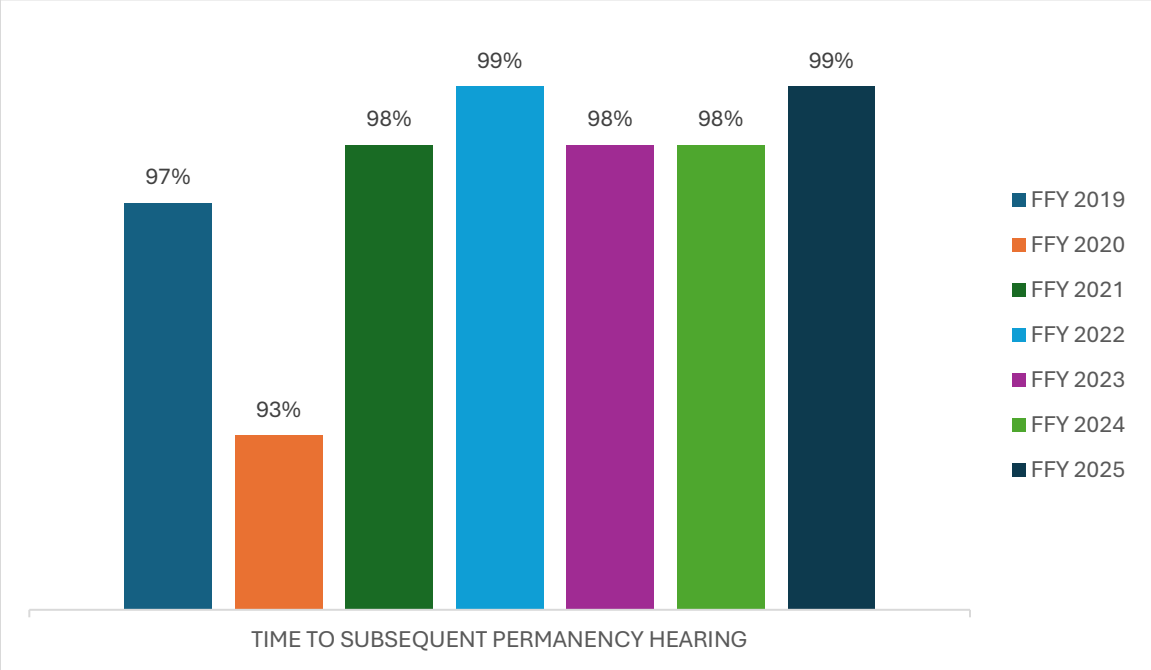
## Chart 2l




Data Source: Iowa Children's Justice; October 2019- March 2025

*From DHHS Placement Date to Issuance of the Permanency Hearing Order in 365 days

## Chart 2m




Data Source: Iowa Children's Justice; October 2019- March 2025

**From Permanency Order File Date to the Date of the Last Permanency Review Hearing in 365 days.

### Item 23: Termination of Parental Rights

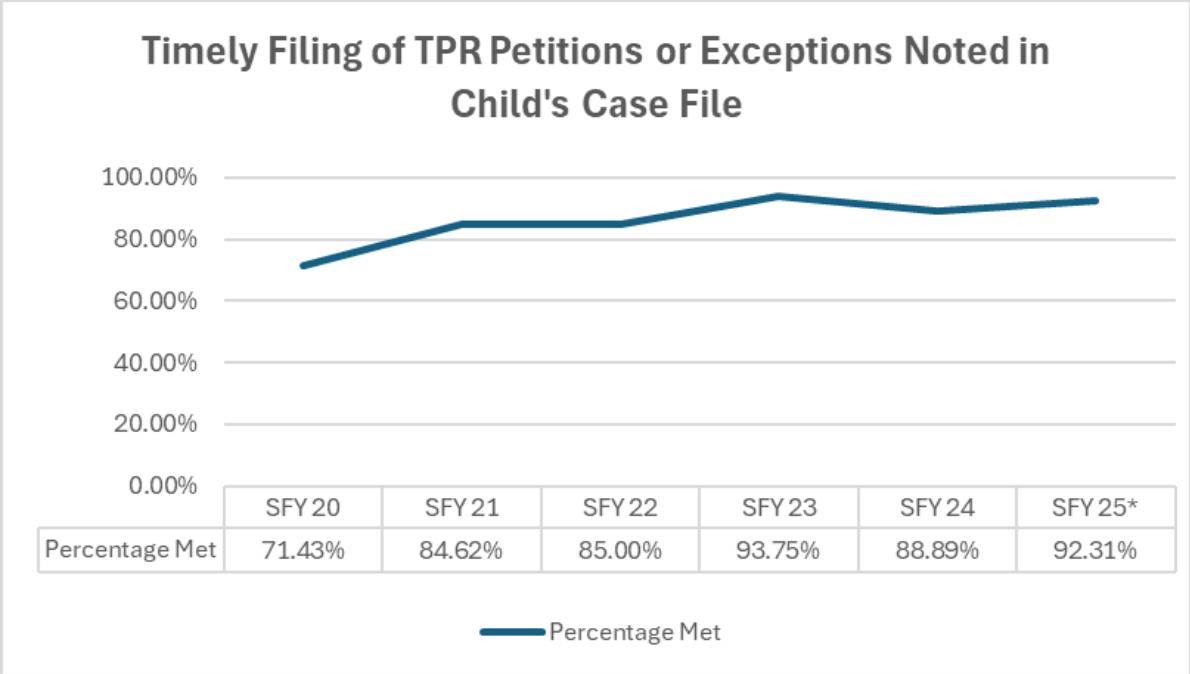
When a child is in foster care under the responsibility of HHS for 15 of the most recent 22 months, HHS staff follows local protocols to initiate a petition to terminate parental rights unless:

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

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

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

**Chart 2n: Timely Filing of TPR Petitions or Exceptions Noted**




Data Source: CFSR OMS, CFSR Portal; * SFY 25 – July 2024 - March 2025

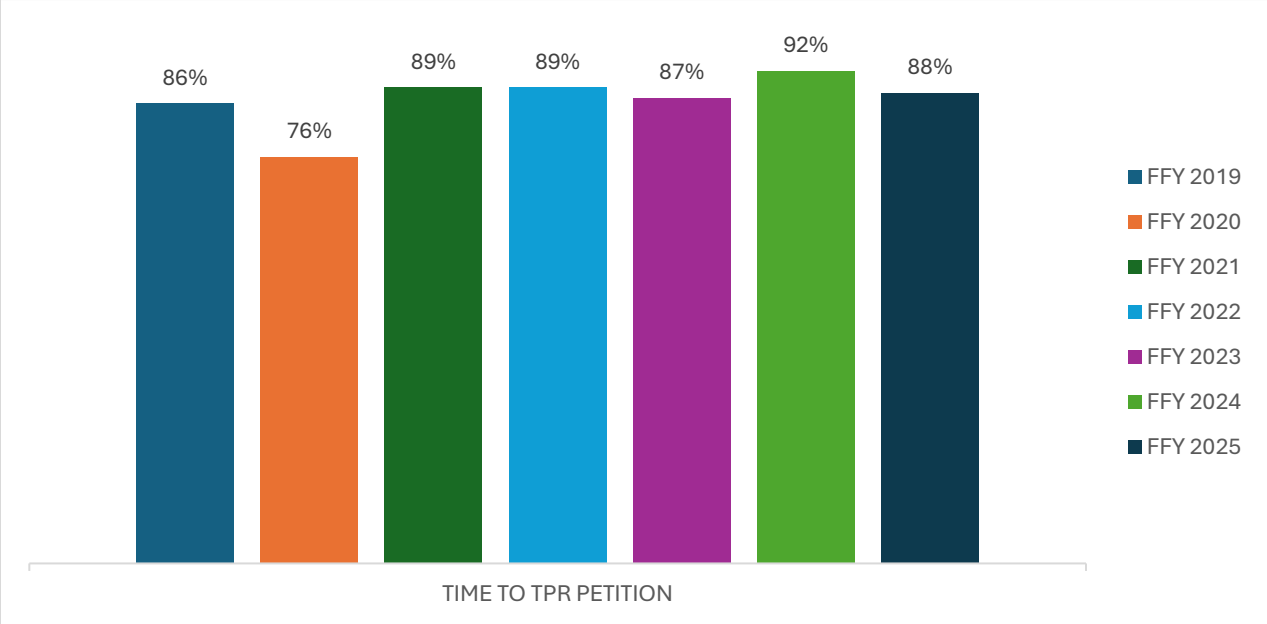
There is typically one petition filed for each parent. The county attorney, acting on behalf of HHS staff or by order of the court, usually files the petitions, which must occur by the end of the child's fifteenth month in foster care, unless exceptions or compelling reasons exist as noted above. However,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

Table 2q represents data collected by Iowa Children's Justice (ICJ). The data represents TPR petitions filed from across the state. There are no known limitations for the TPR petitions data. Charts 2o and 2p represent the timeliness of termination parental rights petition and termination order from 2019 through the end of March 2025.

| Table 2q: Timeliness of Termination of Parental Rights (TPR) Petitions | | | | | |
|---|---|---|---|---|---|
| **Court Function Indicator *[Specific, observable, and measurable]* Timeliness of Permanency Hearings** | **Previous Year Baseline Rate (FY2024)** | **Initial Baseline Rate or Level (FY2025)** | | **Target** | **Difference From Baseline** *[Difference in the annual level from the baseline.]* |
| **Time to TPR Petition** | 92% | 88% | | 100% | -4% |

Data Source: Iowa Children's Justice

**Chart 2o**

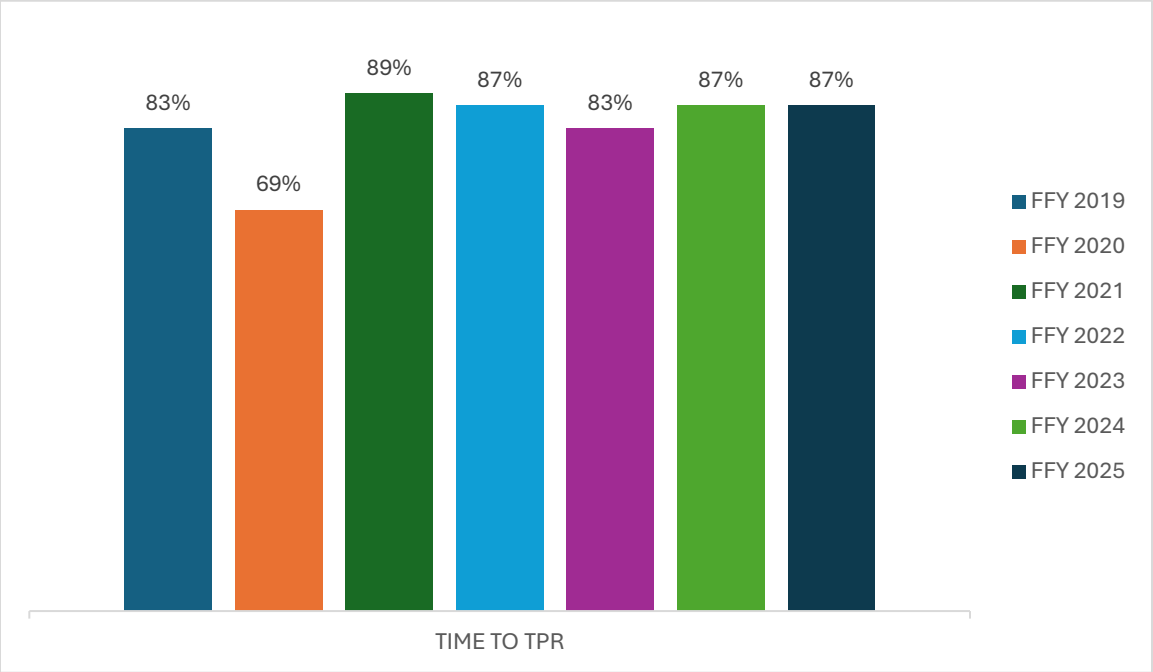



Data Source: Iowa Children's Justice, October 2019- March 2025

* Target is 100% of the cases will meet this measure

*From CINA Petition Filing to Termination Petition Filing in 455 days.

**Chart 2p**




Source: Iowa Children's Justice, October 2019- March 2025

* Target is 100% of the cases will meet this measure

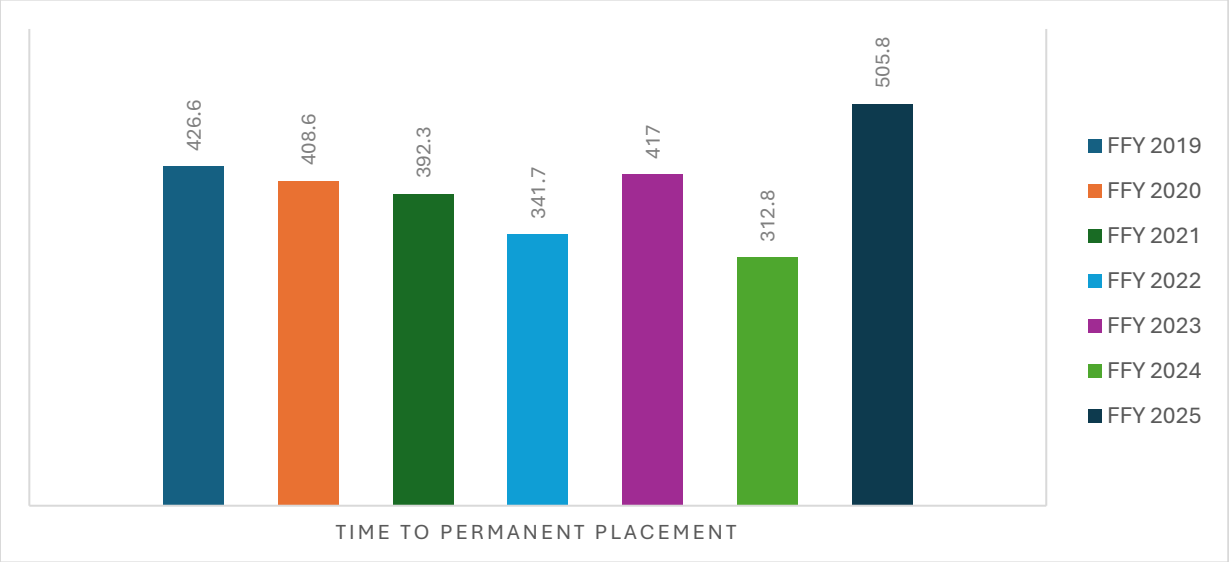
*From CINA Petition Filing to Termination Petition Order in 545 days.

Chart 2q represents the number of days to achieve final permanency for a child from FFY 2019 through the end of March FFY 2025.

As mentioned previously, there were several judicial vacancies due to medical issues, retirement and promotions. This has left some districts shorthanded, and cases are then assigned to other judges who already have a full docket. We also have a shortage of attorneys which had an impact on cases.

An additional observation made during ICJ case assessments is an increase in the number of cases where termination of parental rights occurred and a permanency plan was not finalized for a child.

**Chart 2q**




Data Source: Iowa Children's Justice, October 2019- March 2025

### Item 24: Notice of Hearings and Reviews to Caregivers

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

<u>Current or Planned Activities to Improve Performance on Case Review System:</u>

- Item 20: Written Case Plan – Continue integration of case plan into JARVIS
- Item 21: Periodic Reviews – No planned activity at this time.
- Item 22: Permanency Hearings – Continue to work on conducting timely initial permanency hearings
- Item 23: Termination of Parental Rights – No planned activity at this time.
- Item 24: Notice of Hearings and Reviews to Caregivers – No planned activity at this time

## Quality Assurance System

### Item 25: Quality Assurance System

The mission of the QA&I Bureau centers on the collection and analysis of performance data on which HHS can base decisions. Key performance measures, federal statewide indicators, and CFSR case review data are reviewed monthly with supervisory units in each of the service areas and in leadership meetings, such as the Service Business Team. This ongoing analysis of performance may also lead to targeted data collection to uncover additional information as well as to dig into root causes. The QA&I Bureau provides data weekly, monthly, quarterly for both public and internal users; from there members of the QA&I team disseminate data and analysis through existing structures within their service areas across the state. This allows for regional decision-making regarding the highest priority improvement areas, while a statewide review of data occurs to determine consistent statewide target areas and strategic approaches.

While the QA&I Bureau has this developed structure for disseminating identified information, staff use other sources and formats to gather additional information for purposes of program improvement.

The QA&I Bureau collects and reports on data at established intervals in the form of Key Performance Measures identified by CPS Leadership and analyzed routinely in joint efforts between the QA&I bureau and service area leadership teams.

This collaborative approach allows for broad consideration of continuous improvement opportunities including: service area foci, initiatives, and data; statewide performance and trends; lessons learned through improvement efforts; and new skills/knowledge gained through training in which others in the bureau may benefit. We strive to openly communicate to learn from each other, assure everyone stays informed of initiatives in order to prevent duplication of efforts, and to spread successful practices.

Communication is essential and is a primary goal for the QA&I bureau. There are multiple avenues of intersection between field staff and the QA&I bureau, primarily:

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

Iowa recognizes that quality assurance and improvement methodology must be built in throughout HHS. Multiple program areas and bureaus within the Division of Family Well-Being & Protection undertake efforts to assess satisfaction and gain feedback on the child welfare system. Central Office program staff, Service Area leadership, HHS Division Administrators, etc. may conduct these efforts, with results shared and incorporated into agency planning, contract focus, and problem-solving to assure children and families receive needed services. Regardless of who gathers the

information, HHS routing provides updates in the quarterly Town Hall meetings to keep all informed.

Iowa utilizes the federal Onsite Review Instrument (OSRI) for Round 4 for its case reviews and records the reviews in the OMS. Over the last year, Iowa used continuous improvement tools to refine the structure for completion of the CFSR case reviews. Focus groups occurred with stakeholders (reviewers, Social Work Administrators, etc.) to understand what they saw as strengths of the process and areas for improvement. Based on feedback regarding adequate sampling to represent actual performance, SBT established the goal of increasing the minimum number of reviews conducted from 65/year to 100/year; in order to achieve this, the QA&I bureau assessed the established process and led brainstorming activities to identify areas for streamlining. The QA&I bureau used Plan, do, check, act (PDCAs) to define, implement, and evaluate improvement ideas. Many improvements were identified, notably incorporating many of the federal approaches to reviews. Iowa is currently evaluating testing completed and developing standard operating procedures (SOPs). One area of significant change is the addition of a centralized scheduler of prep calls and interviews with participants. This process is working well overall but requires consistent, ongoing communication regarding availability; we continue to work through ways to promote communication and streamline the process. Within the next 6 months we expect to have foundational structures in place, supported by SOPs. Iowa plans to conduct a state-led CFSR in 2026; HHS anticipates final case review and reporting structures to be completed and submitted to our federal partners by the Fall of 2025.

**Comprehensive Child Welfare Information System:** Planning and designing of the new CCWIS continues. These efforts included not only update of AFCARS-required data points but also an evaluation of reporting elements needed. Due to system limitations, there were many data elements Iowa was to collect that we were unable to. The current system is limited not only in the data collected but in the data that can be retrieved. The new CCWIS will be a comprehensive system that can communicate with partner systems as well as merging separate reporting systems into one data source. This streamlined functionality will simplify the process of compiling needed data, increase consistency across reports both in data reported and interpreted. The availability of more data points and the ability to access the data for analysis will greatly expand the ability to understand performance and to make decisions based on data.

Data quality is assured in a number of ways. IT regularly cross checks system data when updates occur to assure data integrity, consistent rows, etc. At the time of each AFCARS submission, the Help Desk staff and case managers collaboratively identify and resolve errors.

**Foundational Data Collection and Use** The QA&I bureau generates, manages, and disseminates data regularly, promoting and supporting discussion of analysis, trends, potential impacts of practice, and process adjustments to improve performance. Staff

use the following data sources to generate the ongoing data to reflect Iowa's performance in key areas.

- CFSR Online Monitoring System (OMS): HHS utilizes OMS reports to share data on case reviews directly following individual reviews as well as trend data review quarterly in each of the service areas. The OMS provides several reports that are especially helpful and used routinely:
    - Statewide Performance Report – used throughout the review and continuous improvement process; this is core information regarding progress.
    - Multi-Item Data Analysis Tool – is especially helpful with analyzing performance and trends across multiple characteristics and items.
    - Practice Performance Report – provides summarized data specific to the scoring distribution among all sub-items; this also assists in the analysis of interactions between items and trends while providing a concise overview of performance on OSRI sub-items in one report.
    - Individual Ratings and Narratives by Case – provides all ratings and narratives for OSRI items and is distributed to social workers, supervisors, social work administrators, and review teams following finalization of each individual review.
- Data Dashboards: Dashboards are very user-friendly, featuring content and visuals selected through collaboration with the stakeholders who would be using the data. In some cases, the data content was based on the foundational purpose of an area (such as child protection) or through routinely asked questions from the public; the intent to make accessible the information stakeholders consider meaningful, indicative of how Iowa is performing. A variety of data are available to the following:
    - Public stakeholders to be aware of key indicators of how the child welfare system is functioning;
    - Service Contractors to monitor their performance on service-related expectations;
    - Internal HHS staff regarding current performance, both of HHS and service contractors; and
    - HHS Leadership for current performance and strategic planning purposes.
- Data Hub: This QA&I bureau-established data hub is accessible to all internal staff and include multiple ongoing reports generated weekly or monthly. These reports address key performance indicators that are shared and actively reviewed with field, policy, and leadership; they are maintained in one location on

SharePoint for ease of access to users. Internal reports contain detail so HHS has the ability to explore trends and root causes to inform decisions. A small example of reports housed here include:

- Pending and completed social worker visits with children
- Caseload data
- Initial placement with relatives
- QRTP/Shelter placements
- Recurrence of maltreatment
- Federal statewide indicators by service area

- Data Sources: Data sources utilized by QA&I routinely include AFCARS, NCANDS, and CWIS; utilizing this data allows for development of custom reports to inform data analysis, root causes, and trends.

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

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

## Staff and Provider Training

### Item 26: Initial Staff Training and Item 27: Ongoing Staff Training

Please see *IA Attachment 8D: Training Plan* for information on both items.

### Item 28: Foster and Adoptive Parent Training

Foster and Adoptive Parents: The Recruitment, Retention, Training and Support (RRTS) contractor, Four Oaks Family and Children's Services Iowa, completes pre-service and in-service training throughout the state. Pre-service training consists of the National Training and Development Curriculum for Foster and Adoptive Parents (NTDC). 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 experience trauma, separation, or loss. The use of the NTDC curriculum seems to result in resource families who have realistic expectations for foster care and adoption and who understand their role within the child welfare framework.

The NTDC curriculum provides ongoing development for parents who want to foster, adopt (child welfare, intercountry or private domestic), or those who provide kinship care. NTDC comprises three components: (1) Self-Assessment, (2) Classroom-Based

Training, and (3) Right-Time Training. The first component is a self-assessment which is a self-discovery tool to help prepare applicants by providing them 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. The themes of these trainings are specific to parents who are already fostering and adopting on a variety of topics to support them as families encounter new challenges.

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

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

CareMatch continues to be the data system HHS utilizes to manage foster and adoptive family licensing/approval activities and 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.

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

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

Four Oaks foster care and adoption staff, with the direction of HHS, emphasize the importance of training for skill development of resource families. Discussions with resource families regarding training topics/classes occur at every face-to-face visit and documented in the Progress Note. Four Oaks foster care and adoption trainers are also ready to assist resource families by providing resources or conducting training 1:1 with families to assist those families in parenting a child with needs/behaviors difficult for the placement family to navigate.

Tracking of the resource family's training plan is more consistent than in previous years and stored on the Resource Family licensing page for easy access and tracking of training completion. The training team works hard to ensure new topics are added consistently to assure resource families have a wide array of training opportunities. They adopted the use of non-traditional training schedules to accommodate resource families to the greatest extent possible. For example, during a recent four day "Training Palooza," the training team provided training to 451 individuals in a variety of topics, formats, and times. One training began as early as 5:00 am to accommodate very busy families.

All RRTS post adoption specialists receive training through the NTI, National Training Initiative: National Adoption Competency Mental Health Training Initiative. RRTS supervisors are also completing the NTI Child Welfare Curriculum which includes downloadable free resources featuring key information on child welfare and mental health that they are then able share with staff and resource families. As resource families enter into their foster care experiences, HHS believes placing value on training and development and by having staff who are also trained in these areas, families are better prepared to address the needs of the youth coming into care in Iowa. As a result, we found that RRTS staff have more confidence in their abilities to help resource families walk through their stability plans as well.

Four Oaks continues to pull a quarterly report that shows how many hours of training foster parents completed during that licensing year and provides this report to caseworkers so they can prompt their families. Four Oaks also began to do monthly random sampling quality reviews of contact/progress notes to make sure caseworkers document their discussions with families about training. (The random sample is 25% of all families in a service area.)

As reported in previous years, HHS and RRTS continue to collaborate with Five Points to develop an electronic tracking mechanism for foster parent trainings.

Staff of State Licensed or Approved Facilities: Iowa's out of home foster care contractors of emergency juvenile shelter (CWES), foster group care/QRTP, and

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

In addition, licensure standards require training for staff (with a designated staff person responsible for staff development). Internal training includes, but is not limited to, agency policies and procedures, mandatory reporter training and safe use of restraints.

The current contracts require that contractors provide all staff with appropriate and comprehensive training to deliver the services for which the individual is responsible and in a manner that teaches staff to promote the safety, permanency, and well-being for each child. HHS requires contractors to develop a training plan that includes both new staff onboarding training information and ongoing staff annual trainings and to submit this plan for HHS review and approval. They also must execute, adhere to, and provide training as required by Iowa Administrative Rule and their accreditation.

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

- The System of Care Guiding Principles, the Family-Centered Model of Practice, JCS's Model of Practice, and the Child Welfare Model of Practice;
- Crisis Interventions and Stabilizations including trauma-informed care, de-escalation techniques, and policies and procedures regarding critical incidents;
- Mandt or comparable training for appropriate physical restraints to ensure safety;
- Mental and behavioral health support, as appropriate to the staff person's role;
- Domestic violence prevention and support;
- Human trafficking identification, intervention, and prevention; and,
- Transition planning, including use of the Casey Life Skills Assessment tool.

Child Welfare Provider Training Academy: The Child Welfare Provider Training Academy (CWPTA or Training Academy) is a partnership with the Iowa Department of Health and Human Services (HHS) and the Coalition for Family and Children's Services in Iowa. The primary objective of this partnership is to research, develop, and deliver high-quality training programs for child welfare staff and supervisors across the state.

The overarching goal of the CWPTA is to enhance Iowa's child welfare system, focusing on safety, permanency, and well-being of families and children.

CWPTA is dedicated to enhancing the knowledge and skills of child welfare professionals across Iowa. Their mission is to provide high-quality, relevant, and accessible training opportunities that empower providers to deliver effective and compassionate services to children and families.

In the past year, CWPTA focused on aligning training offerings with workforce needs, strengthening stakeholder engagement, and promoting best practices in child welfare.

*Needs Assessment and Course Optimization:* In May 2024, the CWPTA team conducted meetings with child welfare providers to better understand their needs and challenges. Based on this feedback, the Training Academy streamlined its training catalog, reducing offerings to 66 courses for the next fiscal year. This strategic decision aimed to enhance the relevance and impact of their training programs, ensuring they effectively meet workforce demands.

*Special Initiatives:*

- Youth Team Decision Making (YTDM) and Child Safety Conferences (CSC): In partnership with Project Harmony, the CWPTA successfully transitioned the Youth Team Decision Making Meeting (YTDM) curriculum to an asynchronous format. This significant shift allows child welfare providers to access the training on-demand through the Relias platform, thereby eliminating the need to wait for scheduled in-person sessions. This change is expected to increase training accessibility and flexibility, enabling providers to complete the training at a time that best fits their schedules.

  Similarly, the curriculum for Child Safety Conferences (CSC) was converted to an asynchronous format and uploaded to Relias. This move aligns with the goal of offering more training options that cater to the diverse needs of the workforce, ensuring that critical training is accessible at any time.

- Motivational Interviewing (MI): HHS tasked the Coalition for Family & Children's Services in Iowa, in partnership with the CWPTA, with enhancing Motivational Interviewing (MI) practices among Family Centered Services (FCS) providers and state staff. This initiative supports efforts to improve service delivery and optimize federal recovery under Title IV-E and IV-B.

  To achieve this, the Coalition worked with the FCS workgroup to review MI training practices, fidelity monitoring tools, and continuous quality improvement processes. Based on this review, the Coalition and HHS identified the Lyssn Artificial Intelligence (AI) platform as the most comprehensive solution. Lyssn offers real-time feedback on MI techniques, helping providers and staff refine their skills and maintain fidelity to the MI model.

Lyssn enhances MI training through five skill-building modules, focusing on key areas such as listening to statements, exploring motivation, identifying change talk, and avoiding anti-MI approaches. By integrating this platform, CWPTA aims to strengthen workforce capacity, improve family engagement, and drive better outcomes across Iowa's child welfare system.

- Youth Intervention Programs Association (YIPA): During engagement with providers, the Training Academy kept hearing providers needed more on demand relevant training. This led the Training Academy to search for possible solutions. The Training Academy learned of YIPA. YIPA is a professional development organization dedicated to equipping youth service providers with the training, resources, and support needed to effectively engage and support young people. YIPA offers a wide range of high-quality, on-demand and live training opportunities designed to strengthen the skills of professionals working with at-risk youth. Their training curriculum covers essential topics such as trauma-informed care, de-escalation techniques, and youth engagement strategies. This valuable resource has been made available to CWES, QRTP, and SAL child welfare contract holders.

*Participation and Engagement:* During the current reporting period, April 2024 – March 2025, the Training Academy delivered a total of 57 in-person or live virtual trainings in various regions throughout the state. The Training Academy reached a total of 1,164 staff.

In-Person and Virtual Live Trainings: Trainings during the reporting period, April 2024 – March 2025, were a mix of in-person and live virtual trainings. This offered a variety of ways for participants to interact with trainers in real time. Hosting live virtual trainings also allowed for flexibility for the workforce to attend without travel. The courses offered were for all levels of child welfare staff, such as new workers, intermediate workers, advanced workers, and supervisory workers.

Family Focused Meetings Training (FFM): The Training Academy partnered with HHS to manage the delivery of FFM trainings. From April 2024- March 2025, 128 child welfare staff received training in FFMs.

On-line Learning: Relias is an online learning management system designed to provide healthcare related professional development opportunities to staff with 24/7 availability. Relias is a comprehensive system that provides opportunities for individualized training plans and compliance monitoring to track employee's compliance. The current Training Academy contract with Relias provides 700 user slots divided amongst the child welfare providers in Iowa interested in participating.

Providers utilize Relias to train new hires and ongoing professional development to retain current staff. During the reporting period, April 1, 2024 – March 1, 2025, 11 of the 15 active child welfare service contractors, currently utilizing the user seats through the

Training Academy, completed 8,294 courses (93 unique courses) for a total of 7,990.83 credit hours earned by 943 users. In comparison to the previous year's report, the total number of courses, unique courses, unique users, and credit hours slightly increased by 9.81%.

Lyssn is an online Motivational Interviewing Training Platform. Lyssn is provided to our Family Centered Service contract holders. Providers are using Lyssn for MI training and fidelity monitoring. Lyssn is a unique assessment platform which accurately assesses the use of evidence-based practices such as Motivational Interviewing and Cognitive Behavioral Therapy. With more than 54 metrics on everything from expressed empathy to open-ended questions to engagement and more, Lyssn will help FCS contractors and HHS staff hone their skills, as well as better support staff, and programs overall, thus improving family satisfaction and outcomes.

*Stakeholder Engagement and Collaboration:* CWPTA continued to strengthen its partnerships with child welfare providers, HHS, and other key stakeholders. By participating in monthly Coalition provider workgroup meetings, CWPTA gained valuable insight into providers' training needs while also keeping them informed about upcoming training opportunities. This ongoing engagement led to increased attendance and ensured that our offerings align with the workforce's needs.

Collaborative efforts with the Iowa Coalition Against Domestic Violence led to the introduction of the "Understanding Domestic Violence" course, enhancing providers' knowledge of abuse dynamics and intervention strategies.

Collaborative efforts with Meraki Institute of Learning led to the addition of four new courses based on provider requests, ensuring staff receive training on key topics relevant to their work. These new offerings reflect our commitment to supporting workforce development by addressing the specific learning needs identified by providers.

CWPTA continues to maintain a website that provides the most up-to-date information on trainings, including registration links, ensuring easy access for providers. This platform is the most effective way to communicate training opportunities, complemented by the monthly training newsletters and email blasts sent through the website.

*Feedback and Evaluation:*

- Training Evaluations: During the reporting period of April 2024 to March 2025, evaluation data from in-person and virtual trainings showed positive feedback from attendees. Among those who completed evaluations, 82.64% reported that the training content was relevant to their jobs, and 82.45% felt confident they could apply the knowledge gained. Additionally, 73.58% indicated that the content helped prepare them for their roles, while 90.38% found their trainers to be knowledgeable. Participants also highlighted the quality of instruction, with

86.04% rating it positively, and 82.45% stating that the materials provided were helpful and informative.

- Feedback Comments:
  - "Knowledgeable and presentation was well organized."
  - "Instructor was warm and easy to connect with"
  - "Any training that allows social workers the opportunity to develop and grow their understanding of and knowledge base of how to engage with others, how to speak to others to draw them in, and the do's and don'ts when it comes to building relationships with clients. Basically, getting back to the basics of social work 101, without being called 101 so that staff don't take offensive. There are so many directions workers are pulled now days that it is hard to stay the course and keep the focus or even know where to start sometimes."
  - "It was very educational to learn about the different causes of anxiety in our children"

*Future Plans and Goals:* Looking ahead, CWPTA is committed to expanding stakeholder engagement efforts to ensure ongoing alignment with workforce needs, fostering collaboration and responsiveness in training development. CWPTA plans to introduce new courses that address emerging issues in child welfare, equipping providers with the latest knowledge and best practices to support children and families effectively. Additionally, CWPTA will enhance their impact measurement tools to better assess training effectiveness, using data-driven insights to continuously improve our offerings. While CWPTA is committed to optimizing virtual training for accessibility and engagement, they also recognize the value of in-person learning. CWPTA's focus remains on delivering high-quality training opportunities that meet the needs of all providers.

To view the updated CWPTA Training Plan, please see IA Attachment 8D4.

Current or Planned Activities to Improve Performance on Staff and Provider Training:

Item 28: Foster and adoptive parent training (includes staff of state licensed or approved facilities): HHS will work with RRTS and CISR contractors to conduct the following improvement activities:

- Training Data:
  - In FFY 2025-2029, finalize implementation of a tracking mechanism to ensure completion of required training within specific timeframes.
- Training Content:
  - In FFY 2025-2029, in coordination with Cedar Rapids Service Area (CRSA) program of therapeutic family foster care:

- review existing initial and ongoing training requirements
- consider additional training needs as expressed through stakeholder interviews, surveys, forums, etc.
- revise initial and ongoing training requirements, if needed, based on identified needs
- develop additional training to meet identified needs

- In FFY 2025-2029, implement revised training and training requirements, if applicable

- In FFY 2025-2029, continue to monitor progress so that foster care providers, which include staff of state licensed or approved facilities, have the knowledge base and skills needed to carry out their duties regarding foster and adopted children.
- In FFY 2025-2029, continue to monitor progress regarding completion of NTI National Adoption Competency Mental Health Training for all adoption and post adoption staff to ensure they have the knowledge base and skills needed to carry out their duties regarding adopted children.

## Service Array and Resource Development

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

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

*Please see Section V: Update on the Services Description* of this report for information regarding Iowa's child welfare service array.

Current or Planned Activities to Improve Performance on Service Array:

- Revise Title IV-E Prevention Services and Programs Plan to add additional prevention services and include a community pathway
- Establish new Behavioral Health System effective July 1, 2025, which includes mental health, children's mental health, substance abuse, and disability services
  - For more information on this initiative, please utilize the following links:
    - Behavioral Health System Alignment
    - Behavioral Health System Bill Townhall
- Implement:
  - A workgroup to examine the issues surrounding providing Family Interactions

- Expedited licensing for relative and fictive kin caregivers
- Train HHS staff and contractors on MCOs and the services available through them

## Agency Responsiveness to the Community

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

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

- *Section I: Update to the Vision and Collaboration, Collaboration*
- *Section II: Update to the Current Performance in Improving Outcomes, Systemic Factors, Quality Assurance System*
- *Section III: Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Measure Progress and Implementation and Program Supports*
- *Section V: Update on the Services Description*
- *Section VI: Consultation and Coordination Between Iowa and Tribes*

### Item 32: Coordination of CFSP Services with Other Federal Programs

Coordination of services or benefits within HHS: HHS continues to be the agency that administers, in addition to child welfare, a variety of services, such as the Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid, child support, daycare assistance, etc. Child protective services (CPS) workers complete a comprehensive assessment of the family and their circumstances, including either current usage of these services or a need for a referral to these services. Social work case managers (SWCMs) work with the family and if needed HHS income maintenance, child support or other staff to ensure the family completes the necessary application and provides supportive paperwork for determining the family's eligibility for the services, child support payment amounts, coordination of case planning activities, etc.

HHS requires that daycare provided to children in foster care is a licensed or registered provider when:

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

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

cost of daycare so that foster care providers do not have to pay the difference between the actual cost of daycare and the rates allowed in the Child Care Assistance policy.

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

SWCMs submit a form to HHS' child support unit for their staff to conduct Parent Locator searches for them.

Please see *IA Attachment 8B – Health Care Oversight and Coordination Plan* for information on coordination with Medicaid.

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

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

*Collaboration with Foster Care Review Board:* In SFY 2024, Foster Care Review Board (FCRB) transitioned to HHS under the Division of Compliance, Internal Controls and Accountability. In Spring 2024, FCRB and the Court Appointed Special Advocate (CASA) programs separated and each program assigned dedicated staff. The FCRB team consists of five employees. This impacted the number of local review boards and number of volunteers that the FCRB could reasonably manage.

In SFY 2025, 22 local foster care review boards consolidated to 12 virtual local foster care review boards who meet monthly to review cases of children in paid foster care

placements. Staff facilitate local boards; contractors are no longer utilized for that role. In August 2024, the HHS service area managers along with management and staff from Internal Controls and Accountability/FCRB met to review the case selection plan of children to be reviewed by the 12 local boards. Not all local boards have the bandwidth to review all cases of children in paid foster care placements. Specialized populations were identified for two areas (4 of the 12 boards):

- Polk County - children aged 0-5 years who have been in foster care for at least one year. The board also continues subsequent reviews for any other children that were part of prior case selection plans until they return home or achieve permanency.
- Linn & Jones Counties - children aged 0-10 years (and their siblings).

The remaining review boards are able to review 100% of children in paid foster care placements. Although it should be noted that to avoid duplication, youth in Qualified Residential Treatment Programs (QRTP) are not reviewed by local boards. Children with termination of parental rights who are in their pre-adoptive home are no longer reviewed by local boards.

In SFY 2025, Q1-Q3, 12 local boards conducted a total of 604 case reviews that involved 919 children in paid foster care placements in 52 of Iowa's 99 counites. Some cases have more than one review in a year's time; there has been a total of 720 unduplicated children reviewed to date this fiscal year.

HHS social work case managers (SWCMs) continue to participate in local foster care reviews at a high percentage.

In SFY 2025, Q1-Q3, participation by HHS (SWCM, Adoption Specialist or Supervisor) was as follows:

- 72% actively participated
- 15% provided a recorded or written update
    - For a total of 87% HHS participation in foster care reviews
- 1% submitted a written update after the conclusion of the review
- 12% did not participate in any form

FCRB volunteers continue to receive six hours of continuing education each calendar year to stay up to date on current legislation and child welfare practices.

<u>Coordination of services or benefits with other state agencies and federally funded programs</u>

Please see *Section V: Update on the Services Description:*

- *Early Intervention and Support Prevention Programs and Services*;

- *Stephanie Tubbs Jones Child Welfare Services Program, Services for Children Under the Age of Five; and*
- *John H. Chafee Foster Care Program for Successful Transition to Adulthood*

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

## Foster and Adoptive Parent Licensing, Recruitment and Retention

**Item 33: Standards Applied Equally**

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

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

Non-relative applicants complete the 33 hours of pre-service training, background checks on all adult household members, and the home study. Non-relative foster family applicants may be given a variance to a non-safety standard when an alternative is presented that meets the requirement.

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


470-4873 waiver form.pdf

HHS strongly supports keeping children within their families and will continue to encourage more relative caregivers in becoming licensed foster parents. Four Oaks worked in collaboration with HHS to design and implement an expedited kinship approval process. This allowed for a smooth design process and implementation at the beginning of the next fiscal year, July 1, 2025. Currently, kin and fictive kin families must complete the general foster care licensing process which can take from 6-8 months. With the expedited licensing process for kin, the families will be approved within 60-90 days of placement, which brings increased financial assistance, concrete supports, and training that unlicensed caregivers do not currently receive. These approval standards for relative or kinship foster family homes are in response to ACYF-CB-PI-23-10.

The Kinship Caregiver and Kinship Navigator Programs continue to be very successful in supporting kin/fictive kin families. All relative/fictive kin placements are eligible for the Kinship Caregiver Program once a relative or fictive kin child is legally placed in their home. The kinship caregiver currently receives a payment of up to $310/month ($10/day) for a period of up to six months. During these six months, HHS works in collaboration with the RRTS contractor, to expedite the licensing process for the kinship caregiver while maintaining consistency in licensing standards for all foster families. Families do not have to participate in the licensing process to receive the kinship caregiver payment, but it is highly encouraged so that the family can receive the supports licensed foster parents receive such as clothing allowance, childcare, respite and support groups.

The Kinship Caregiver Program is currently funded by 100% state dollars. Effective April 1, 2025, this program will transition to TANF funding. Due to this change, the kin caregivers will receive an increase to the basic foster care rate based on the age of the child placed in their home for a period of four months. The rates are listed below:

**Table 2r: Iowa Rates as of July 1, 2024**

| Age of Child | Basic Daily Rate |
|---|---|
| 0 - 5 years | $17.62 |
| 6 -11 | $18.32 |
| 12 -15 | $20.06 |
| 16 - 20 | $20.32 |

Data Source: HHS

The Kinship Caregiver Program began July 1, 2021 and continues to provide financial assistance of $10/day for any relative/fictive kin who has a child court ordered to their care. With implementation of Family First, and the goal of keeping children with kin/fictive kin, HHS is committed to a process that will assist them financially until they can become licensed or approved foster parents. As stated above, HHS currently has a

process to waive non-safety standards tor relatives who apply to become foster parents for a child in their care which may include bedroom space, NTDC training, or siblings sharing a room to promote licensure.

In SFY 2024, Iowa licensing data for foster homes indicate that 0% of foster homes were approved without meeting full licensing standards. This may include families that had an approved exception to policy to allow licensure of a family pending a specific delay. All licensed foster family homes meet licensing standards as Iowa does not issue provisional licenses. If after licensure a licensed foster family is found to be out of compliance or no longer meets a licensing standard that was not waived or given an approved variance, a corrective action plan is put in place to correct the deficiencies. Failure to complete the corrective action plan may result in denial or revocation of the license.

Shelter and Group Facilities: HHS signed a Memorandum of Understanding (MOU) with the Department of Inspections, Appeals and Licensing (DIAL) for the initial licensure survey, annual and other periodically scheduled onsite visits, unannounced visits, complaint investigations, and re-licensure surveys of emergency juvenile shelter and group care facilities. HHS annually updates this MOU, which includes the monitoring of required federal fingerprint and background check requirements identified in Family First legislation. HHS is the licensing agent for these programs and uses the DIAL's written reports and recommendations to make all final licensing decisions before it issues licenses, certificates of approval, and Notices of Decision. HHS may grant exceptions to licensure policies for shelter and group care facilities by HHS when circumstances justify them, but this rarely occurs. Provisional licenses are not common but might occur temporarily in lieu of full licensure in order to give a facility time to correct licensing deficiencies. Not all identified deficiencies result in the need for provisional licensing or a formal corrective action plan. However, the licensee must correct all licensing deficiencies. Services continue under a provisional license when a determination occurred that there is no jeopardy to the safety of the youth in care. Provisional licenses require corrective action plans that generally last for about 30 days, which is usually sufficient to correct the deficiencies and for the DIAL to re-inspect the program.

Licensing data indicates that HHS issued one provisional license in calendar year (CY) 2024. This provisional license was issued due to licensing deficiencies surrounding a situation involving the death of a youth by suicide. This provisional license returned to full licensure status within 90 days.

**Item 34: Requirements for Criminal Background Checks**

Foster and Adoptive Parent Licensing: The foster and adoptive parent licensing contractor, under the current Recruitment, Retention, Training, and Support (RRTS) contract, prepares and submits licensing packets to service area field staff. Licensing packets include the following:

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

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

The RRTS contractor has an HHS approved checklist of all required documents that needs to be in a packet. HHS licensing staff review 100% of all packets and advise the RRTS contractor if a document is missing. HHS staff record missing documents and

dates requested on a tracking tool. A packet would be returned or the contractor notified if any document, especially a record check, was missing.

Caseworkers continue to make adaptations as needed to ensure that consultations with applicants do not delay licensure. RRTS struggled in past years due to staffing issues but in the past year made steady improvement in stabilizing their workforce which increased job satisfaction as well as retention.

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

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

HHS central office staff took all child welfare, facility contracts that were up for review from January 1, 2024, through March 31, 2025, and reviewed the contractors' DIAL licensing review and unannounced visit reports. For that period, there were 56 reports completed. Of these 56 reports, 48 indicated completion of the criminal background checks in accordance with the federal requirement. Five (5) of the 8 reports that did not meet requirements were lacking information regarding child abuse checks in states where new hires lived in the past five years. This continues to be a problematic process, as each state carries out these checks differently, and some states will not complete the checks for employment purposes.

### Item 35: Diligent Recruitment of Foster and Adoptive Homes

Please see *IA Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan* for information, accomplishments, and updates.

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

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

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

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

The report below is data provided from the National Electronic Interstate Compact Enterprise (NEICE). The Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) along with the American Public Health Service Association (APHSA)/Tetrus developed the availability of obtaining data regarding Iowa ICPC Cases by Type of Care for Calendar Year (CY) 2024; however, this is a "point of time" report and is unable to provide historical data. Iowa ICPC was able to use this report to request from NEICE/Tetrus to track completion of home studies as the case progressed to show Safe & Timeliness of the home studies completed in Iowa when home studies were requested from the receiving states.

Reports providing data for an overview of the timely completion of home studies are still not available in NEICE. The AAICPC along with the APHSA/Tetrus are continuing to discuss and develop additional reports. The primary focus of APHSA is onboarding additional states to NEICE and supporting those states already using NEICE. There is a report that states can use to track completed, pending and overdue home studies, but that is a "point in time" report and is unable to provide historical data. Iowa ICPC uses this report to track completion of home studies as the case progresses. Additionally, NEICE generates alerts/notices when the due date is approaching and then the case is flagged once the due date has passed so anytime the case is reviewed, it's clear the home study is overdue.

Below is information from the RRTS providers on timely completion of Iowa ICPC home studies for Calendar Year (CY) 2024. In reviewing the data, ICPC staff discovered an improvement since last calendar year on timeliness after meeting with the Foster Care Program Manager and RRTS Service Contract Specialist to discuss the timeliness of ICPC home studies.

In reviewing ongoing timeliness data, Iowa ICPC along with RRTS providers identified and implemented changes in processing home studies to assist and improve the process of 60 Day Safe and Timely home studies. RRTS providers submit the completed home study or preliminary home study to HHS Licensing staff within 55 days, so HHS Licensing staff has time to review before submitting to the ICPC office.

HHS staff also identified a strategy to improve the timeliness of the 60 Day Safe & Timely. If the potential placement had not completed all licensing requirements, a Preliminary Home Study would be submitted to update the receiving state of the reason for delay and an anticipated date for a decision regarding the request. This is not a new process; however, it was something we looked at from previous years to help improve timeliness data.

ICPC staff continue to be involved in ongoing discussions with program, contract specialists and providers to address the timeliness of ICPC home studies and areas for improvement. Additionally, we identified there were cases where timing of entries into NEICE impacted timeframes and timeliness outcomes. These are areas where the ICPC Unit is reviewing further. We are reviewing timeliness data for the 1st quarter of the calendar year to further assess timeliness and possible impacts.

**Table 2s: Timely Completion of Iowa ICPC Home Studies – CY 2024**

| Reg Type | Total Completed | Total Timely |
|---|---|---|
| Reg 1 & Reg 2 | 230 | 196 |
| Reg 7 | 26 | 17 |

Data Source: RRTS

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

| Table 2t: Children Placed into Iowa by State Fiscal Year (SFY) | | | | |
|---|---|---|---|---|
| **Type of Request** | **SFY 2021 – Number Placed in Iowa** | **SFY 2022 – Number Placed in Iowa** | **SFY 2023 - Number Placed in Iowa** | **SFY 2024 – Number Placed in Iowa** |
| Reg 1 | 5 | 10 | 5 | 5 |
| Reg 2 | 71 | 93 | 69 | 75 |
| Reg 4 | 9 | 6 | 3 | 7 |
| Reg 7 | 8 | 16 | 6 | 14 |
| Reg 12 | 11 | 11 | 18 | 14 |

Data Source: NEICE

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

| Table 2u: Children Placed Outside of Iowa by State Fiscal Year (SFY) | | | | |
|---|---|---|---|---|
| **Type of Request** | **SFY 2021 – Number Placed Outside of Iowa** | **SFY 2022 – Number Placed Outside of Iowa** | **SFY 2023 – Number Placed Outside of Iowa** | **SFY 2024 – Number Placed Outside of Iowa** |
| Reg 1 | 6 | 5 | 2 | 3 |
| Reg 2 | 74 | 74 | 75 | 73 |
| Reg 4 | 38 | 40 | 65 | 96 |
| Reg 7 | 13 | 19 | 18 | 31 |
| Reg 12 | 5 | 6 | 11 | 16 |

Data Source: NEICE

While a regular timeliness report regarding ICPC processing timeframes is still not readily available in the NEICE system, APHSA and Tetrus have been willing to provide Iowa ICPC with timeliness data when requested. Given resource limitations, the data may not be available immediately upon request. The following is timeliness data for Iowa ICPC's processing of outgoing requests based upon the date the request is sent to Iowa's ICPC unit from our local field staff to the date it is sent to the sending state. This processing time includes the review of the outgoing request and gathering of any additional information to ensure the request is complete. We identified that possible reasons for delays could be caused by the time data entries are made in NEICE from the processing time by our ICPC unit.

We intend to have further conversations with APHSA and Tetrus to help improve the timely completion of home studies for Iowa ICPC. APHSA reported at the AAICPC National Conference in May 2024 that Timely Completion of Iowa data will be soon available through NEICE that will be able to show real time data while it will compare to

the National data; however, no timeframe was provided on when that will be available for states. Iowa ICPC participated in the Data Committee that was formed after the AAICPC National Conference in May 2024, so we've provided input to NEICE/Tetrus on importance of having real time data available in NEICE.

Below are the ICPC performance measures for CY 2024. During that time frame, Iowa ICPC received incoming home study requests for 666 children and sent out home study requests for 713 children. Additionally, the ICPC unit processed 28 outgoing and 53 incoming adoption requests.

**Table 2v: Timeliness Data for Iowa ICPC Processing Outgoing Requests**

| Type of Request | SFY 2021 – Average Calendar Days | SFY 2022 – Average Calendar Days | SFY 2023 – Average Calendar Days | SFY 2024 – Average Calendar Days |
|---|---|---|---|---|
| Reg 1 | 2.3 | 3.7 | 14.5 | 0.3 |
| Reg 2 | 1.6 | 1.5 | 12.4 | 0.5 |
| Reg 4 | 2.5 | 2.4 | 3.4 | 1.5 |
| Reg 7 | 0.3 | 1.7 | 4.2 | 0.2 |
| Reg 12 | 0.5 | 0.7 | 1.2 | 1.2 |

Data Source: NEICE

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

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

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

Iowa, while collaborating with other states through discussion and involvement with National Office discussion through Kin Mobilization Learning Collaboration.

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

- Item 33: Standards Applied Equally & Item 34: Requirements for Criminal Background Checks – None noted except as described above.
- Item 35: See *IA Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan* for detailed information.
- Item 36:
    - Continue to work with field staff ICPC liaisons to ensure SW field staff have access to and utilize necessary information including required timeframes when working on an ICPC case, including both sending and receiving cases
    - Continue to work with contracted licensing agencies and licensing staff to help improve timeliness of home studies completed through ICPC
    - Continue discussions with Team Charter on Kinship Licensing in Iowa and the process for ICPC
    - Pursue possible border agreements with border states and review current border agreement in place for possible changes and improvements
    - Continue discussions within the ICPC community regarding use of TCA.

# Section III: Update to the Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes

## REVIEW AND UPDATE GOALS, OBJECTIVES, AND INTERVENTIONS

Iowa reviewed but did not revise its goals, objectives, and interventions. For more information, please see *Measure Progress* below.

Iowa does not have any current program improvement plans related to title IV-E, AFCARS or NYTD.

## MEASURE PROGRESS

To determine focus goals, current data were analyzed and prioritized based on HHS' vision: Individuals, families, and communities are safe, resilient and empowered to be

healthy and self-sufficient through delivery of high quality, equitable services. These principles are key to the HHS purpose and are the foundation for the improvement areas identified below.

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

**Objective:** Children abused or neglected are safe from re-abuse in their own homes.

**Strategy 1:** Ongoing assessments of safety and risk will be conducted and services provided accordingly to safely maintain children in their homes whenever possible.

**Strategy 2:** Evaluate the current practice and establish guidelines around the agency response to open service cases when a safety or risk issue is identified.

**Baseline:** Iowa's current rate of re-abuse is 16%.

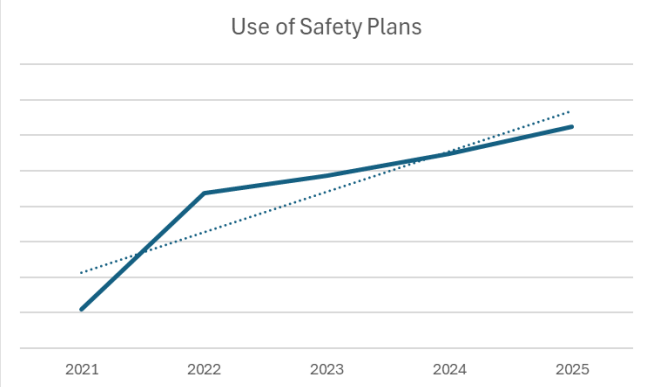
**Measurement:** Key Performance Measure based on ROM data, generated and evaluated monthly. Case review data for item 3b (ongoing assessment of safety/risk) and analysis of narratives to assess practice frequency, quality, and effectiveness.

**Expected Outcome:** Continued training and emphasis on ongoing assessment will decrease rates of re-abuse; defining an allegation in an open case may lead to increased understanding of administrative reasons Iowa's re-abuse rate appears high.

**Benchmark:** Iowa's rate of re-abuse will decrease by 1% each year throughout the duration of the CFSP (measured SFY 2027, 2028, 2029); interim measure, when developed, will provide information to assess performance trends.

**Strategy 1 Update April 2025:** Social workers receive initial and ongoing training; monitoring is ongoing through the case review data. Since 2021, there has been a consistent increase in the use of safety plans with families; this also coincides with a trend of decreased number of children placed in foster care. This may indicate additional use of informal supports and efforts to keep children safely in the home. This will be explored further to assess any correlation between the safety plan use and family outcomes regarding placement versus in-home services.

**Chart 3a: Use of Safety Plans**



**Strategy 2 Update April 2025:** The frequency of which child abuse assessments are completed on open service cases is leading to duplication of work among child protection workers (CPWs) and social work case managers (SWCMs) and a re-abuse rate that does not meet national targets. Participants from HHS across the state and contractors were identified to explore HHS' response to open service cases when a safety or risk issue is identified. The objective of this group is to develop decision point guidance to increase consistency, define factors of consideration, and identify responsibilities for addressing any safety or risk issues that arise. This group began work in April 2025.

**Goal 2: Children achieve permanence in their living situation.**

**Objective:** Children reunified with their parents upon discharge from foster care will successfully maintain that living situation without re-entering foster care.

**Strategy:** The QA&I bureau will conduct reviews on a sample of cases in which children reunified then returned to foster care within the most current six months; data collected will focus on the circumstances of re-entry to identify mitigation strategies.

**Baseline:** Performance from July 2023 through January 2024 indicated 20.3% of children re-entered care following discharge to reunification; data demonstrate 76% of children who re-enter care do so within 6 months of discharge.

**Measurement:** Reunification standard process tracking; QA&I will develop a tool to review cases based on the most current six months to measure improvement in real time.

**Expected Outcome**: Identification of trends that result in re-entry will inform needed practice changes to stabilize children and families upon reunification.

**Benchmark**: Iowa will reduce the percentage of children who re-enter foster care by 2% per SFY 2027, 2028 and 2029.

**Strategy Update April 2025:** As noted above, data continues to show an increase in re-entry of children to foster care; analysis demonstrates the same trend – approximately 79% of children who re-enter do so within 6 months following reunification. Currently a charter was drafted that outlines the scope of this project. Identification of the data elements and collection methodology are in process; implementation of the review is anticipated for the Fall of 2025.

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

**Objective 1**: Social workers conduct quality visits monthly with children receiving services in-home and in placement.

**Objective 2**: Social workers conduct quality visits monthly with parents involved in services.

(Quality= comprehensive assessment and management of safety; discussion of goals; progress; status; needs)

**Baseline:** For CY 2023, performance on social worker visits with parents was 49%; visits with children was at 59%.

**Measurement:** Iowa CQI case reviews will be used to measure performance on frequency and quality for social worker visits with parents and social worker visits with children.

**Expected Outcomes for Children & Families:** Routine contact and discussion of progress, barriers, needs provide opportunity to: engage parents and children, empowering them to drive planning; complete ongoing safety, strengths, and needs assessment; determine effectiveness of services and make changes as needed; build a trusting partnership with families.

**Benchmark:** Performance in this area fluctuated significantly during the PIP measurement period so milestones include increased consistency across each six-month period in SFY 2025-2029.

**Update April 2025:** Currently this is an area of ongoing monitoring and practice emphasis. A specific strategy has not yet been implemented but this remains an area of focus addressed in Town Halls, in Service Area meetings, and within supervisory units. Case review data shows an increase:

**Table 3a: Case Review Data – Items 14 and 15 (Caseworker Visits with Child; Caseworker Visits with Parents)**

| | 1/2023 – 12/2023 | 1/2024 – 3/2025 |
|---|---|---|
| Child | 59% | 77% |
| Parents | 49% | 64% |

Data Source: OMS

**Feedback Loop:** Iowa continued to add essential data to public dashboards available on the HHS website. These are interactive data centers that focus on measures at the core of services, such as safety of children, placement types, relative involvement, etc. The specific performance measures were chosen due to the frequency with which stakeholders historically had been requesting information from HHS; that is now accessible to them and updated quarterly. The link to the website, Agency Dashboards | Health & Human Services, is included in all email signatures, provided specifically to constituents requesting information that is available, and at the end of each community presentation (see below).

Data is regularly shared internally at HHS through routine Service Area meetings with supervisors and workers; reviewed with leadership teams, specifically as it relates to the Service Area Operational Plan; Service Area Managers (SAM) discuss data in their monthly meetings – reviewing performance as well as identifying gaps in data available; Social Work Administrators mirror the SAM effort in their meetings applying a different lens.

The HHS Director, the Family Well-Being & Protection Division Director, the Child Protective Services Director, Service Area Managers, and Social Work Administrators routinely share information during community presentations, such as: meetings with legislators; joint contractor meetings; ongoing advisory groups; foster parents; and more. These meetings promote discussions and feedback on data and practice issues of interest. While a variety of information is shared, ongoing data is included regarding performance in areas such as: supports to increase relative placements; progress on decreasing use of QRTP and shelter placements; and monthly worker visits with children. Additional information of interest to the specific group's focus is also routinely shared (for example, removal rate by county shared at a conference for Juvenile Judges).

Policy program managers recently held focus groups with contractors of Family Centered Services for the purposes of gathering their perspective on what's working, barriers they are encountering, and ideas for improving service delivery.

Information that results from any of these interactions is followed up on as needed and is routinely compiled, summarized, and shared within HHS as appropriate to the topic. These partnerships inform exploration, focus, and continuous improvement efforts to assure the most effective services are provided to children and families in Iowa.

## IMPLEMENTATION AND PROGRAM SUPPORTS

HHS front line staff and supervisors receive training and 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.

Over the last year, the Service Help Desk provided information to front line staff via Help Desk Releases on topics that included but were not limited to the following topics:

- Quick Guide for CINA Proceedings (Comm 542)
- New Statewide Concurrent Planning Process
- CPS Mentoring Program
- Process for Obtaining Iowa Birth and Death Certificates for Foster Care Youth

- Title IV-E Prevention Plan
- Pre-subsidy and Subsidy Applications
- Initial Family Focused Meetings (FFM)

The Bureau of Child Welfare and Community Services provides answers to policy questions that field staff have. HHS holds a bi-monthly meeting with policy staff and front-line supervisors to advise, inform and gather feedback regarding policy changes and their impacts on practice in Iowa.

Over the last year, these included:

- July 2024 – Intake Information and Quick Guide for CINA Proceedings
- September 2024 – Child Care Search – Linking Families to Quality Care, One Connection at a Time; Kinship Caregiver Payment Update
- November 2024 – Adoption Selection Process Update and Adoption Matching Clarification
- January 2025 – Canceled
- March 2025 – Kinship Caregiver Payment Update; JARVIS Documentation of Drug Testing; CFSR Round 4

Field leadership and policy staff collaborated to kick off a new training and technical assistance series entitled Back 2 Basics 2025. Back 2 Basics is a monthly series covering different topics. All CPS team members are to attend unless off for the day, in a court hearing or they were given approval by their supervisor to miss the meeting. Staff are required to inform their supervisor if they will miss a meeting. Meetings are recorded. Those who miss the live presentation are expected to go back and watch the recording. The table below shows the dates, topics, and content information for each presentation through the end of 2025. The 2026 series for Back 2 Basics has not been developed yet.

**Table 3b: 2025 CPS BACK TO THE BASICS SCHEDULE**

| DATE | Topic | Content |
|---|---|---|
| February 20, 2025 | Safe Care | Define Evidence Based Practice (EBP)<br>What makes Safe Care an Evidence Based Practice (EBP)<br>Eligibility for the Service<br>Structured curriculum- Pre-Test/Post Test<br>How to refer and Service Expectations<br>Talk about voluntary cases |

| Table 3b: 2025 CPS BACK TO THE BASICS SCHEDULE | | |
|---|---|---|
| **DATE** | **Topic** | **Content** |
| March 20, 2025 | Four Questions, Family Preservation and Child Safety Conferences (CSCs) | Review 4 questions and use with removal orders<br>Family Preservation - eligibility for services, length of service<br>CSCs- how do you determine risk of removal?<br>CSCs script and expectations |
| April 17, 2025 | Motivational Interviewing (During CPS Meeting) | Define Evidence Based Practice (EBP)<br>What makes Motivational Interviewing an EBP |
| May 15, 2025 | Kinship Navigator, Kinship Foster Care and Approval | Kinship Navigator payments and approvals<br>When and how to refer<br>When and how to process<br>Referral process and expectations for each |
| June 19, 2025 | Drug Testing and Behavioral Indicators | Contract Changes<br>Documentation of behavioral indicators |
| July 17, 2025 | Adoption Selection Staffing's | Process and new form<br>Importance of ongoing case manager<br>Communication<br>Critical Thinking |
| August 21, 2025 | Monthly Visits/Timely Reports | Tricks of the trade for being timely with visits and reports |
| September 18, 2025 | Family Interactions | Review general roles and responsibilities of Family Interactions Plans<br>Family Interaction Planning Tool |
| October 16, 2025 | Bridge Meetings/Comfort Calls | What are bridge meetings<br>Purpose of comfort-calls<br>Goals<br>What to expect |
| November 20, 2025 | Relative Notices, Kinship Specialist, Kin-first culture | Philosophy of kin 1st culture<br>Expectation of relative notices |

| Table 3b: 2025 CPS BACK TO THE BASICS SCHEDULE | | |
|---|---|---|
| **DATE** | **Topic** | **Content** |
| | | Kinship specialist expectations |
| December 18, 2025 | Reasonable Efforts vs Active Efforts | Reasonable efforts-citing code<br>Active efforts-citing code<br>How are they different<br>What to do about it |

In addition to the training and technical assistance mentioned above, the Bureau of Quality Assurance and Improvement (QA&I) conducts case reviews and provides statewide trend feedback to state and local leadership. In addition, they provide support for custom reports from the administrative data systems (CWIS) to assist staff in managing their workflow and caseloads. QA&I staff also facilitates program and process improvement sessions to assist frontline staff in identifying problems and developing specific solutions for implementation and monitoring. HHS reports monthly on a key set of performance measures that track the CFSR outcome measures and caseworker visits with children in foster care.

All of the activities mentioned above will continue in FFY 2026 as a way to assist our front-line staff in accomplishing the goals of safety, permanency and well-being for children and families of Iowa.

**Research, Evaluation or Management Information Systems**

Iowa re-engaged with Change and Innovation Agency (C!A) regarding implementation of some of their previous recommendations that were based on feedback from internal stakeholders as well as knowledge of nationwide best practices. In March 2025, C!A began working with HHS leadership and Field staff to lay the foundation for a central consult model to be incorporated with Intake and Assessment as well as follow up analysis on work processes, caseloads, and streamlining. C!A's assistance will help HHS to become more efficient thereby providing more time for front line staff to improve safety, permanency and well-being of the children and families they engage.

Iowa continues to carry out the evaluation and research activities related to the following:

- Parent Partner: Please see *Section V, Update on Services Description, MaryLee Allen Promoting Safe and Stable Families (PSSF)* for information on University of Nebraska-Lincoln's evaluation efforts for the Parent Partner program.
- SafeCare©: Iowa continues to coordinate with the National SafeCare Training and Research Center (NSTRC) to continue evaluation of the effectiveness of

SafeCare. The contract for ongoing evaluation continues through June 2026. For the most recent evaluation information please see the Iowa Evaluation Year 2 Report prepared by NSTRC.

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

- Sobriety Treatment and Recovery Teams (START): HHS is working with the University of Iowa to develop an evaluation plan for START as part of its efforts to include START in Iowa's Title IV-E Prevention Services and Programs Plan. HHS will include an update on these efforts in next year's Annual Progress and Services Report (APSR).

# Section IV: Quality Assurance System

Please see the following sections for information regarding the quality assurance system requirements:

- *Section II: Update to the Current Performance in Improving Outcomes, Systemic Factors, Quality Assurance System*
- *Section I: Update to the Vision and Collaboration, Collaboration*
- *Section III: Update to the Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes*

# Section V: Update on the Service Descriptions

### CHILD AND FAMILY SERVICES CONTINUUM

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

- Protect and promote the welfare of all children.
- Prevent the neglect, abuse, or exploitation of children.

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

HHS recently chose to initiate two separate consultation contracts that address major areas of the child and family services continuum, as well as a new way to capture the numerous system-changes occurring in the child welfare space.

HHS is working with C!A on a broad project to address the intake and assessment phases of child welfare, as well as some pieces related to adoption and ongoing case management. This work currently focuses on building out a Central Consult model, gaining efficiency in our statewide Intake unit, and aligning the dissemination of child abuse assessments with the rest of the nation. Below are some of C!A's recommendations:

- Intake:
    - Remove Preliminary Staffing of Rejected Intakes
    - Eliminate Supervisor Review of Accepted Reports
    - Create a Warmline
    - Allow Front Line Staff to Add/Adjust Allegations
    - Develop Standard Procedures to Send Information to Law Enforcement
    - Allow Warm Transfer to Out-of-State Child Welfare Agencies
    - Adjust County Phone Trees
- Assessment:
    - Design a Central Consultation Unit
    - Differential Documentation & Eliminate Duplicate Documentation
    - Implement Checkpoints and Huddles
    - Enhance Access to Prevention Services
    - Empower Staff with Real-Time Family Search
    - Streamline Case Record Distribution

The second consultative collaboration currently underway is with Sellers and Dorsey, which focuses on the Family Centered Services contract. This work centers on gathering a national scan of how other states are effectively providing this service to families. Focus areas include payment methodology to maintain a stable workforce and

identifying meaningful evidence-based approaches for family casework and family interactions. Below is a summary of the Sellers and Dorsey overall project plan.

Sellers and Dorsey Consultation on FCS

Finally, the Child Protective Services division of HHS also recently shifted to a new approach in order to outline and showcase the numerous initiatives that are in process. The SafeKids Portfolio is a grouping of many projects, divided into buckets, with an overall theme of reducing traumatic experiences so youth can heal. Many of these projects began out of feedback gathering done via listening sessions, surveys, and conversations with internal and external stakeholders. The Safekids Portfolio has both a governance structure led by Director Garcia, and a timeline to ensure projects are enacted and rolled out with intention. See IA Attachment 5A – APSR Safe Kids for a more expansive look at the SafeKids Portfolio.

## Child Abuse and Neglect Prevention

### Early Intervention and Support Prevention Programs and Services

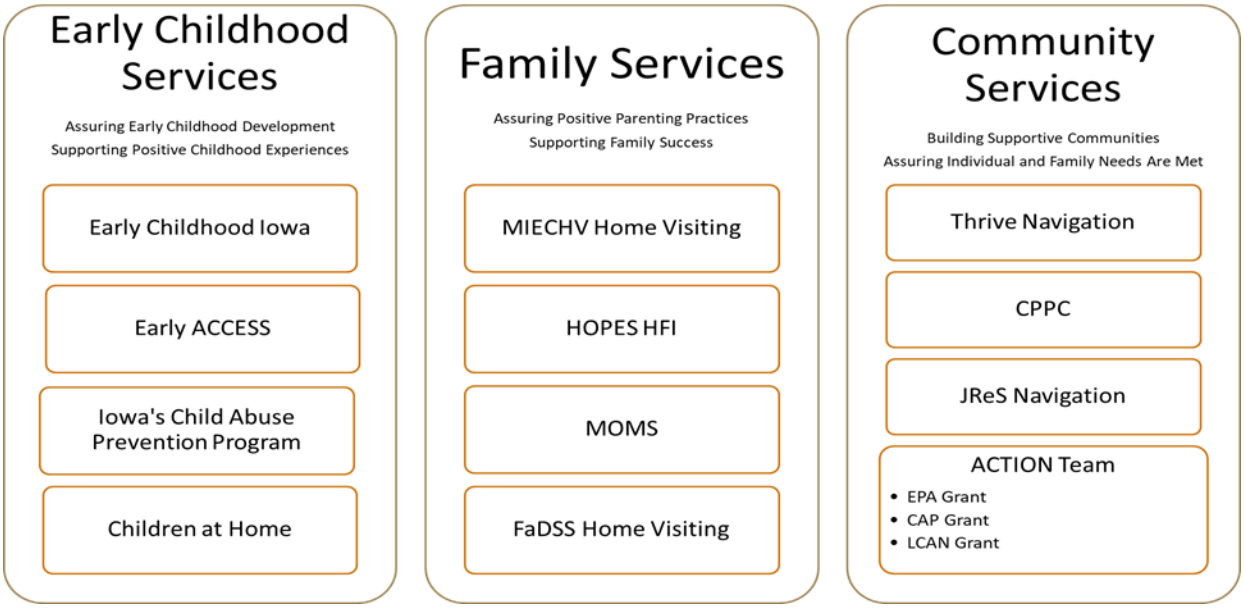
**Background:** The Early Intervention and Support (EIS) subdivision of the Family Wellbeing and Protection Division was established in February 2023 as part of the alignment of state agencies creating the Iowa Department of Health and Human Services (HHS). Each of the original programs were long-standing single programs from the former Public Health and Human Services agencies. They had collaborated but had not previously worked within the same team. There were 12 team members at that time. Additional team members from Human Rights were added in February 2024, May 2024, and July 2024.

Today, EIS has 27 team members from four legacy agencies and 3 vacant positions.

EIS programs provide primary and secondary prevention services for families with children 0-18. The subdivision is organized into three bureaus: Early Childhood Services, Family Services, and Community Services. These bureaus represent a continuum of prevention services. The graphic below highlights the programs and purposes of each Bureau. Since the launch of the subdivision, efforts have focused on ensuring existing programming continued, minimizing any negative impacts on funding requirements, service delivery, and outcomes for program participants. In addition, the team worked to create mission, vision, and north star statements. Those statements are:

- MISSION: We leverage resources and utilize data to customize services that meet the needs of families.
- VISION: Families have healthy and successful futures through connected systems and targeted programming.

- NORTH STAR: More Good Days for Families




**Prevention Budget:** The teams focused this year on making changes to existing programs while building new programs and services. Existing funding was considered while making these changes. We have many programs funded through state sources and, to a lesser extent, some are funded through federal sources. Here is the breakdown of EIS program funding:

**Table 5a: EIS Program Funding**

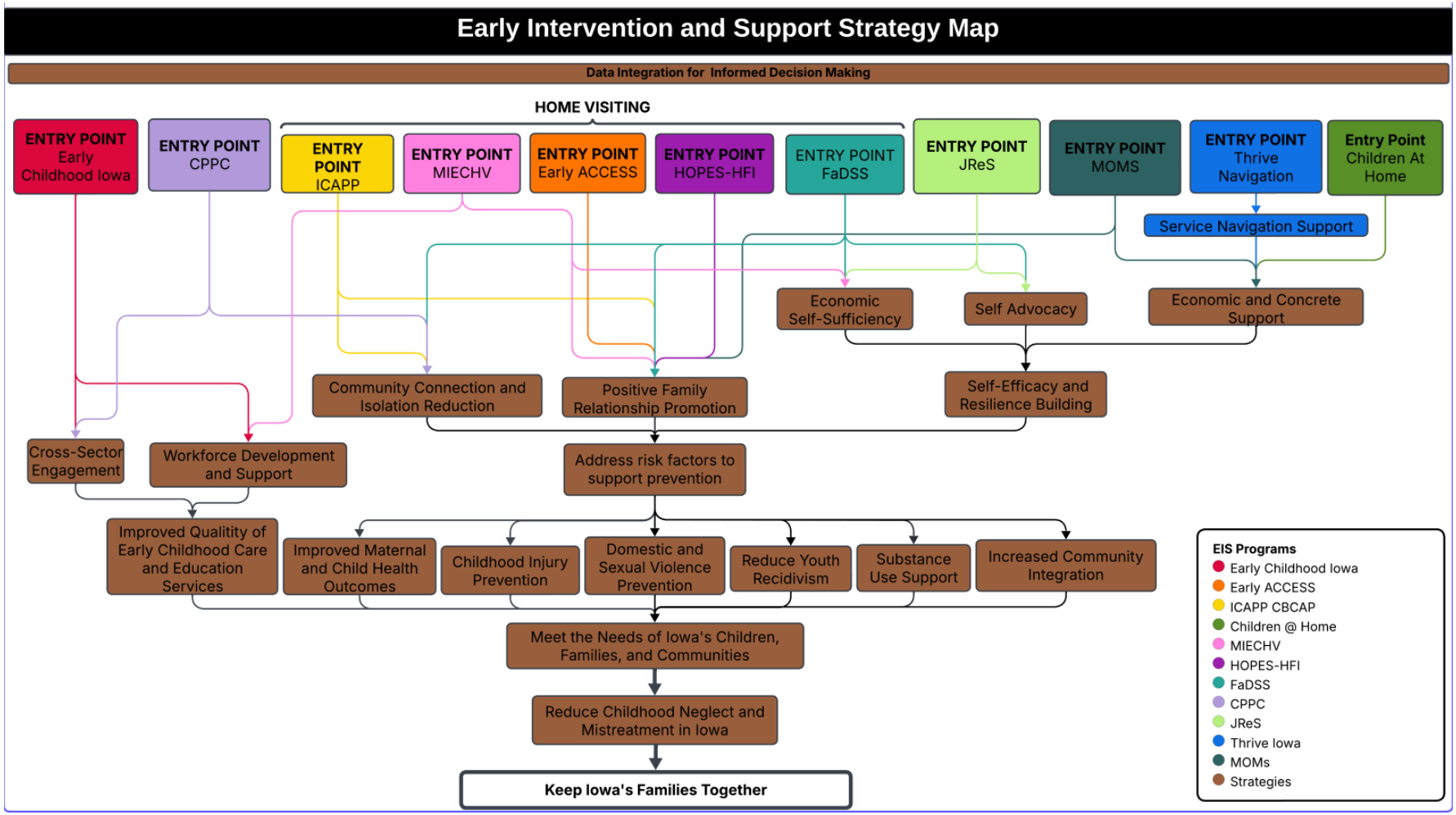
| Funding Source | Annual Amount | Number of Programs | Number of Positions Funded and Filled | Amount of Funding Dedicated to Positions | Amount of Funding Dedicated to Services or Programs |
|---|---|---|---|---|---|
| **HRSA** | $6,999,216.00 | 1 | 4.66 | $694,400 | $6,304,816.00 |
| **State Appropriations** | $38,196,975.00 | 9 | 11.95 | $1,013,028.24 | $37,183,946.76 |
| **TANF** | $3,013,980.00 | 2 | 1 | $184,401.28 | $2,829,578,72 |
| **CAPTA** | $100,000.00 | 1 | 0 | $0 | $100,000.00 |
| **PSSF** | $1,271,000.00 | 2 | 1 | $127,015.72 | $1,143,984.28 |
| **Environmental Protection** | $333,333.00 | 1 | 0.2 | $66,666 | $266,667.00 |

| Table 5a: EIS Program Funding | | | | | |
|---|---|---|---|---|---|
| **Funding Source** | **Annual Amount** | **Number of Programs** | **Number of Positions Funded and Filled** | **Amount of Funding Dedicated to Positions** | **Amount of Funding Dedicated to Services or Programs** |
| **Agency (ended April 2025)** | | | | | |
| **Rehabilitation Services Administration** | $128,865.00 | 1 | 1 | **$103,637.37 | $25,227.63 |
| **Iowa Department of Education** | $180,333.00 | 2 | 0.85 | **$90,265 | $90,068.00 |
| **Decategorization** | $60,709.62 | 1 | 0.5 | **$60,709.62 | $0 |
| **Iowa Vocational Rehabilitation** | $406,124.55 | | 3.5 | **$406,124.55 | $0 |
| **Juvenile Justice Federal Grant** | $15,600 | | 0.375 | **$15,600 | $0 |
| **CBCAP** | $631,910.00 | 1 | 0 | $0 | $631,910.00 |
| **Total** | $51,322,446.17 | 12 | 25.035 | $2,761,847.78 | $45,746,619.67 |

Data Source: HHS; **The service is the employee.

**Strategic Alignment:** An intern, obtaining her master's degree in public health from the University of Iowa, created the graphic below. This graphic is the result of her meta-analysis of annual reports, strategic plans, and assessments for each program in the subdivision. The goal was to discover the areas of alignment among the programs, their measures, and to depict their meaning within a prevention framework. You can see the culmination of the programs starts with their focus on addressing risk factors, filtered into meeting the needs of children and families and ultimately reducing abuse and neglect. The graphic will be used to assess strengths and weaknesses within the system we have in place as we enhance it over the next several years.

## Chart 5a: Early Intervention and Support Strategy Map



**Milestones:** Several plans were in the previous year's report. Progress occurred in each area. Here are updates on those plans:

- Enhancing the Early ACCESS system: A major planning event occurred in December of 2024. Expected outcomes included opportunities to increase family engagement in Early ACCESS services for children identified through Child Abuse and Prevention Treatment Act (CAPTA) referrals, advancing screening and service delivery to identified children including follow-up screening and assessment, and identification of programs and services that can support children and families who cannot or choose not to engage with Early ACCESS services (a safety net plan). A set of recommendations was produced, and those recommendations are under consideration by the Department of Education and Child Protective Services teams.
- FAST-LC (Families are Stronger Together Learning Community): In September of 2023, Iowa was one of ten states selected to participate in FAST-LC. This engagement ended in October of 2024. The FAST-LC Core Team comprised Family Well-Being and Protection Division team members and Community Access Division team members who worked collaboratively to benefit Iowa's families. The expected outcome was to continue to grow TANF and child welfare partnerships and infuse the voice of program participants, making these activities the expectation, not the exception. A family survey was deployed and over 130 families responded. We also engaged income maintenance and child protective staff in discussions about prevention. The results were presented to the Division Directors for consideration. We continue to use this data and the framework for the discussions as we plan future engagement with communities and stakeholders.
- Intake Data Analysis: A statistical analysis of 5 years of intake call data was analyzed and a more detailed understanding of those calls and callers was gathered. The results are in the process of compilation into a report that will be presented to our child protective services partners and the Division Director. Early Intervention and Support will use this information to plan future prevention programming and select our geographic focus areas. Some of the data will be used to learn more about the involvement of families in prevention programs either prior to or after an intake call.
- Iowa's Integrated Data System for Decision Making (I2D2): Throughout the year our university partners developed a new data collection survey via Qualtrics. We are working to transition data collection from an annual basis to a six-month cadence. The data collection process with the new approach had a focus on collecting performance measures and corresponding financial investments for the first six months of the SFY 2025. The data analysis is underway. It is the goal to connect new data visualizations via data dashboards to demonstrate county-level

investments and outcomes of services focused on supporting children, aged prenatal through age five, and their families. The primary goal is to be able to more readily utilize data to inform programmatic strategies based on awareness of service availability, capacity, outcomes, and enable more robust meaning-making, connecting the metrics to programmatic strategies and decision-making.

- Taking Steps to Standardizing Home Visiting practices: HHS secured Chapin Hall to assist in the development of an amendment to our IV-E Prevention Plan centered on our state investments in Healthy Families America and Parents as Teachers. In addition, the contractor will also complete an economic and concrete supports policy assessment that will be used to learn more about how we can incorporate the delivery of these supports to families. The Early Intervention and Support team has, in the meantime, taken the first steps toward standardizing home visiting practices across funding streams, using the MIECHV programs as the standard that will be met.
- Fatherhood System Coordination: Stakeholders convened over the course of last summer to discuss a coordinated Fatherhood Engagement model to increase collaboration, improve, and expand services, and optimally engage and support fathers, moving supports upstream to stem more significant interventions downstream. The results of that meeting revealed some services operating within HHS that were relatively mature and effective, such as those managed by the Child Support team. Other programs such as home visiting programs and WIC, identified they could serve fathers but there were no specific outreach strategies or programming in place. All stakeholders agreed that there should be more fatherhood-specific programming. Given this context, Early Intervention and Support decided to support fatherhood work first inside of our subdivision and then grow the collaborative work as a next step.

**Additional Milestones: A Year in Review:** The following list of milestones highlights the many changes that are in process or have been completed by the Early Intervention and Support team since the last report.

- Developing new ECI districts, moving from 34 to 7 to enable a more robust and streamlined prevention service delivery model.
- Built and deployed Thrive Navigation pilots and a replicable model with existing resources.
- Conducted listening sessions with child abuse prevention stakeholders across the state.
- Re-planned Iowa's Child Abuse Prevention program and delivered a request for proposal (RFP) incorporating changes that enhance outcomes for families while reducing administrative constraints.

- Began the process for planning our IV-E Community Pathway and wrote a preliminary plan. Hired a contractor to support the development of a successful strategy.
- Provided multiple internal and external presentations and enhanced or built new collaborations to promote our purpose and services.
- Launched the MOMS program through 2 RFPs as well as 2 RFPs for an Administrator contract.
- Began work on key performance measures and surveillance with a shared epidemiologist and an intern from University of Iowa.
- Adopted Hope Science, Third Spaces, Social Capital, and Building Better Childhoods as key tenants to apply to our work.

**Future Plans:** The work required to build a new team has taken time to complete. Monthly strategic planning activities produced a cohesive group with a shared vision. While building team identity and maintaining or bolstering our current assets, EIS also looked toward the future. We used other states as examples, participated in technical assistance opportunities, and sought educational opportunities to consider the effectiveness of our existing programs and funding and consider opportunities to assist families and children in new ways. Here are a few new initiatives that EIS will support over the next year, while also enhancing and increasing quality and capacity of the remaining service array:

- IV-E Community Pathway Development: This will increase the amount of flexible funds EIS has to bolster current programs and implement or invest in new programs. The work will be detailed and intensive and will depend on our technical readiness, our programmatic supports, and our capacity to support the process over time.
- Community Development: This work will involve exploring and deploying low- or no-cost opportunities or collaborative efforts that build support for families and infrastructure to collectively care for children. The economic mobility work in Community Access and Eligibility will be a close partner for building this strategy and set of activities. The outcome will be a collective, supportive mindset shared across communities, named in research as ‘collective parenting’.
- Maintaining and Expanding the Navigation Footprint of Thrive Iowa: We currently have a set of navigation strategies related to supporting children and families: those offered through our ICAPP contracts are the most basic level, serving families who may need a lighter touch service limited in scope; those offered through Thrive Iowa (after a sustainability plan is implemented) will act as an intermediate navigation service for all Iowans seeking an enhanced level of support as part of the Thrive Iowa service array; those offered through 100 Families will meet the needs of TANF or child welfare involved families. Mapping

the navigation networks across the state and convening them to enhance their collective impact is a final step in assuring all Iowans have an opportunity to be supported in finding resources to meet their needs.

- Restore Hope: 100 Families Iowa: This high-profile program will act as our most intensive navigation program, serving families involved with TANF and child welfare programs. The three-year engagement will produce 3 new sites each year for the first 2 years and 6 in the final year. This growing portfolio will need support from the EIS team to launch and sustain.
- Expanding the MOMS network and implementing Fatherhood programming: We plan to grow the MOMS (More Options for Maternal Support) network. This program offers local pregnancy support services through a range of providers. We will increase the capacity of MOMS providers by incorporating these entities into our navigation service array and providing the tools to enable their success.

**Thrive Iowa:** Thrive Iowa, a new resource through HHS, will create a network of navigators to help individuals find immediate support from community organizations, then support them over time helping them develop an individualized plan for self-sufficiency and long-term independence. Early Intervention and Support is piloting five programs through our existing Early Childhood Iowa system to explore how we can best:

- Implement an online system that facilitates the participation of churches, non-profits, and businesses.
- Establish a network of navigators to work with program participants.
- Establish a primary entry point for Iowans in need of help or referring organizations to engage with a navigator.

In each pilot, the Thrive navigator works with the Iowan to identify their needs. Navigators use a warm handoff approach as they connect the Iowan to resources including concrete goods and direct access to local programs. Coaching and navigation support are available as needed, ensuring connections are made and the needs of the caller are met.

Tracking the needs of those contacting Thrive, along with stress levels and a self-at-risk assessment, will help us better evaluate Iowa's programs and services to understand if we are meeting the needs of Iowans and whether they are aware of available services.

**Maternal, Infant and Early Childhood Home Visiting (MIECHV):** The Health Resources Services Administration (HRSA) provides funding to HHS for the Maternal, Infant and Early Childhood Home Visitation (MIECHV) program. Contractors providing in home family support programming to eligible families are required to use evidence-based home visiting models with fidelity and establish quantifiable, measurable

benchmarks that demonstrate improvements. Contractors do so by showing improvements in maternal and child health, childhood injury prevention, school readiness and achievement, crime or domestic violence prevention and intervention, family economic self-sufficiency, and coordination with community resources and supports. By providing supports to families, the MIECHV program aims to improve the overall health of mothers and children, get children ready to succeed in school, improve families' economic well-being and connect them to other resources in their community. The MIECHV program also works to prevent child injuries, abuse and neglect as well as crime and domestic violence.

The MIECHV program at HHS partners with eight local implementing agencies to offer Healthy Families America (HFA), Parents as Teachers (PAT), and/or Nurse Family Partnership (NFP) evidence-based in-home family support programming in 23 of the most at risk communities in Iowa. In fiscal year 2024, 970 families were served with MIECHV funding, and 14,760 home visits were provided. Of those 970 families, 98% of the children were receiving their well child exams by their medical provider. Eighty-seven percent (87%) of parents practiced early literacy skills with their child daily. Developmental screening results for children included that 87% were on track for communication while 88% were on track for fine and gross motor skills. Eighty-nine percent (89%) of the children served by MIECHV funding and seen by a family support professional offering evidence-based home visiting programming in fiscal year 2024 were on track for their personal and social development as well as for problem solving.

In additional to the incredible strides happening with children and families in the 23 communities in Iowa, MIECHV also supports several system building activities. Included is DAISEY, a single web-based data collection and reporting system offered to MIECHV, Early Childhood Iowa and other family support funded programs in the state. MIECHV helps to fund the Iowa Family Support Network that serves as Iowa's Statewide Coordinated Intake System for family support and early intervention services. Another system building activity is The Institute for the Advancement of Family Support Professionals, which is a web-based professional development system that includes the national credential for home visitors and is a requirement for MIECHV funded home visitors. I2D2, the Integrated Data System to determine specific activities that produce better results for families is supported by MIECHV, as well as a small portion of the Nine2Thrive coordinated intake which is co-located with prenatal health services. MIECHV supports the Performance Incentive for Home Visitors and their Supervisors (PAEYS) program and T.E.A.C.H., which provides comprehensive scholarships to family support professionals who wish to obtain college credits toward a degree relevant to their work in family support. The Phones4Families program, that provides smart devices and data plans for enrolled MIECHV families as well as Mental Health Consultation for home visiting supervisors and home visitors, designed to build their capacity to improve social, emotional and behavioral health and development of the young children and families they serve, are both supported through these system

building efforts. Iowa MIECHV is also working on a workforce evaluation that is doing a deep dive into what keeps home visitors engaged in the field.

MIECHV is planning for a small expansion into three additional Iowa counties, serving 60 additional families in the upcoming fiscal year.

**Family Development and Self-Sufficiency (FaDSS):** The 1988 Iowa General Assembly created the FaDSS program. FaDSS became part of the Family Well-Being and Protection division under Early Intervention and Support in 2024. Prior to that, the program was briefly administered in the Community Access & Eligibility division and before that it was administered by the Iowa Department of Human Rights. At present, HHS contracts with local agencies statewide to provide FaDSS services in all of Iowa's 99 counties. Participation in FaDSS is voluntary. The core components of the program are:

- Structured home visits conducted by skilled Family Development Specialists (referred to as Specialists)
- Assessments and screenings that support healthy self-exploration
- A science-informed process for goal pursuit
- A framework and process for skill building
- Connecting families to stabilizing supports and opportunities in their communities

FaDSS engages families in dynamic partnerships to address their basic needs, improve child well-being, and develop career opportunities that, in turn, improve lives, families, and communities. The program does this by:

- Reducing sources of stress that destabilize families. Specialists address the basic needs and emotional wellbeing of families through support and connection to resources such as housing, food, safety, and physical and mental conditions, among others.
- Strengthening core skills that are essential for work, school, and life. Specialists build the capabilities of families by teaching them goal-directed behaviors that strengthen life skills and improve family functioning and by connecting them to education and training opportunities that build career-related skills and health work and school-based habits.
- Creating responsive relationships that are safe and supportive. Specialists cultivate partnerships with families by building trust; holding parents accountable; and practicing unconditional, nonjudgemental positive regard. Specialists collaborate with community partners to address the needs and interests of families. They support healthy parent-child relationships that promote child wellness and development.

In SFY 2024, the FaDSS program served 2,252 families. Specialists conducted 14,809 visits and had an additional 79,818 contacts with families. This level of intensive support allows Specialists to develop a unique relationship with families built on trust and respect. FaDSS services are family-led, strength-based and provided in a trauma-informed manner. Economic stability is critical to the success of families participating in the FaDSS program. In SFY 2024, 68% of the 802 families that completed the program set an employment goal. The average wage change for heads of household employed at exit was an increase of $1,596 dollars per month. Not only do Specialists facilitate a goal-setting process with families, once a goal is set, Specialists provide activities during home visits designed to strengthen the skills needed to reach the goals.

The FaDSS program developed a skill-building framework for Specialists to utilize with families referred to as “FaDSS Forward”. The framework includes activities, tools and resources designed to support Specialists in their work with families and includes:

- Career development
- Economic supports
- Education and training
- Financial management
- Parenting and relationships
- Health and wellness

Staff are currently receiving training to provide career development support to families focused on career exploration, preparing for, getting and starting a job, maintaining a job and career advancement. Other strategies to support Specialists in their work with families to increase skill-building and goal-attainment focus on motivational interviewing, digital navigation, and increased financial literacy support. In the next year, the program will also begin developing and implementing community-based family events to increase social connection, support healthy parent-child interactions, and increase fatherhood focused programming.

**Iowa Child Abuse Prevention Program (ICAPP):** The Iowa Child Abuse Prevention Program (ICAPP) has a crucial role in HHS preventing child maltreatment in the state. The table below shows families served, children served, counties served, and the funds allocated to the ICAPP program for State Fiscal Years (SFY) 2020-2024.

**Table 5b: ICAPP Program**

| SFY | Families Served | Children Served | Counties Served | Total Funds |
|---|---|---|---|---|
| SFY 2020 | 2,003 | 9,931 | 56 | $1,562,638.00 |
| SFY 2021 | 1,428 | 5,698 | 43 | $1,748,109.00 |

| Table 5b: ICAPP Program | | | | |
|---|---|---|---|---|
| SFY | Families Served | Children Served | Counties Served | Total Funds |
| SFY 2022 | 1,326 | 6,258 | 44 | $1,730,632.00 |
| SFY 2023 | 1,276 | 5,622 | 44 | $1,753,177.00 |
| SFY 2024 | 1,128 | 7,382 | 42 | $1,667,788.00 |

Data Source: HHS

ICAPP is a part of the Early Childhood Services Bureau allowing close collaboration with Early Childhood Iowa, Early ACCESS and Children at Home. ICAPP programs are represented in many counties throughout the state. A stipulation of ICAPP is that the local community members establish a council or coalition to represent their specific strengths and challenges. The council or coalition applies for funding to implement child abuse prevention efforts in their communities. ICAPP receives both state and federal funding. The current ICAPP contracts fund Home Visitation, Parent Development, Sexual Abuse Prevention and the Resilient Communities across Iowa.

During the Spring of 2024 the ICAPP Program Manager and other staff from the EIS team traveled to six different regions of Iowa to conduct Listening Sessions with both providers and families. The data gathered during these sessions helped guide the Strategic Plan for ICAPP and the impending Request for Proposal (RFP). Community input was categorized by responses specific to strengths and needs areas. Responses were classified into one of the following categories: Health (e.g. Mental Health); Community Action and Collaboration (e.g., Service routes/communication); Critical (and/or Population Specific) (e.g. Housing, Basic Needs, Demographics); Political (e.g., Restrictions, Funding); and Education (e.g., Learning or progressive forward strategies).

Overall the themes in each community involved the following: there is a need for an efficient system to coordinate services to families and communicate efficiently between services; crisis programs and supports are in place and are necessary resources for all communities involved in the Listening Sessions; all communities expressed a deficit in providing basic needs and an increased need for concrete goods; all communities stated that there is a shortage of providers for critical health and mental health needs; and finally all communities voiced a desire for funding to support long-term growth in their communities and local control of services and funding.

ICAPP released a procurement intended to fund services to address the needs expressed during the Listening Sessions and other needs assessments conducted by HHS. The focus of the RFP includes the following seven goals:

- Reduce maltreatment by targeting services to families exhibiting risk factors that are most closely correlated with child abuse and neglect.

- Coordinate maltreatment prevention funding sources across multiple service sectors (e.g. public health, early childhood, human services) to use each source strategically in combatting child abuse and neglect.
- Balance funding between Primary and Secondary Prevention with a greater emphasis on reaching more vulnerable families.
- Embed practices that support prevention in a variety of ethnic areas.
- Increase the use of informal and non-stigmatizing supports for families and youth.
- Increase the use of Evidence-Based Practices (EBPS) in child maltreatment while introducing and evaluating innovative approaches; and
- Engage in a statewide evaluation of prevention services' effectiveness, monitoring protective and risk factors at the organization and community level.

**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.

CPPC efforts center around the following four key strategies:

- Shared Decision-Making
- Community & Neighborhood Networking
- Family and Youth-Centered Engagement
- Policy & Practice Change

The CPPC approach prioritizes community-based efforts in which community leaders, providers, youth, and caregivers come together to identify what families need to be successful. This involves ensuring resources are available, accessible and relevant to a variety of families in order to prevent abuse, promote safety, and support reunification

for families with child welfare involvement. The philosophy emphasizes that a single government agency can not solely be responsible for child safety and well-being, rather, it is the work of all members of a community.

Activities: Common CPPC initiatives include offering support for youth transitioning out of foster care, Parent Cafes, and awareness-building activities. Awareness building often occurs through collaborative activities, such as community resource fairs, hosting information tables during events, and publishing print or digital resource guides. CPPCs support a variety of programming, including parent education classes, youth literacy, and mentoring activities. Sites also work to connect families to concrete resources, such as household goods, food, housing, and transportation.

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

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

Data: Data captured from CPPC historically centered around community narrative. This includes data related to member representation and community outreach events promoting family engagement. Quantitative data is difficult to capture due to variability of projects across CPPC sites. As the program moves forward, HHS intends to align CPPC efforts more closely with Early Childhood system performance measures related to community capacity building.

Over the last several years increased use of the Parent Café model was utilized by CPPC as a strategy to connect with caregivers and foster the growth of informal support networks.

Parent Cafés is a model developed by Be Strong Families that facilitates small group conversations to build informal supportive relationships and connect caregivers with community resources. The model provides an opportunity for engaging parents, youth, community members, caregivers, the recovery community, refugee communities,

parents involved with HHS child protection, and others, in sharing safe spaces for conversation to strengthen protective factors. Parent Café has been growing in Iowa since 2018 and during SFY 2024, programs shifted to a consolidated evaluation and reporting system for Iowa programs. A limited number of responses (16) were collected in SFY 2024; however, more comprehensive data will be available going forward. SFY 2024 evaluation data is reflected in the following table.

| Table 5c: SFY 2024 Parent Café Evaluation Data | |
|---|---|
| **Survey statement** | **Percent responding "Agree" or "Strongly Agree"** |
| I felt safe sharing with other participants in the Café. | 94% |
| I learned something through somebody else's story/experience. | 94% |
| This experience helped me reflect on my strengths and challenges. | 94% |
| I learned a new way to handle stress or challenges in my life. | 81% |
| I met a person (or people) I plan to stay in touch with. | 75% |
| I learned that I can use the Protective Factors to keep my family strong. | 94% |
| As a result of my Café experience, I feel more comfortable going to a professional or using community resources for help. | 88% |
| I practiced ways to talk with others that will improve my relationships. | 88& |
| As a result of my Café experience, I want to get more involved with the host agency. | 69% |
| I see myself being able and willing to be part of a Parent Café team. | 81% |

Data Source: CPPC

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

The following table reflects the most common CPPC project types and number of CPPCs supporting each effort.

| Table 5d: Most Common CPPC Projects | |
|---|---|
| **Project Category** | **Number of CPPCs supporting** |
| Parent Education | 15 |

| Table 5d: Most Common CPPC Projects | |
|---|---|
| **Project Category** | **Number of CPPCs supporting** |
| Outreach Events/Awareness | 25 |
| Concrete Supports | 24 |
| Community Trainings/Workshops | 19 |
| Youth Development | 14 |
| Parent Café | 10 |
| Respite Care | 3 |
| Community and Cultural Events | 24 |

Data Source: CPPC

During SFY 2025, CPPC continued the process of transitioning to the Early Intervention and Support (EIS) area of the Family Well-Being and Protection Division. This process is ongoing, with an opportunity for CPPC to continue to align more directly with EIS programs and supports in this space. CPPC will benefit from continuing to center youth, parent, and caregiver voices with lived experience in the Child Protection System (CPS) to provide input to Shared Decision-Making and co-creation of community activities and policy and practice changes, as well as from families and young people experiencing community supports and resources intended to provide support and prevent CPS system involvement.

Alignment for Family Well Being and Protection programs are currently undergoing a phased approach, with Early Childhood Iowa (ECI) areas currently working to realign structure and geography along Behavioral Health regions. While currently in the planning stage, structural changes across phased implementation stages are anticipated to be implemented in SFY 2026. CPPC changes are anticipated to be implemented within the new ECI structure.

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

## Assessment and Intervention

### Child Protective Assessments

HHS is dedicated to ensuring the safety and well-being of all Iowa residents, particularly the most vulnerable among us—children and families. As outlined in the HHS Strategic Plan - digital (5).pdf, HHS is unwavering in its commitment to protecting children and strengthening families. Guided by principled leadership, we strive to foster a child welfare system built on compassionate engagement, research based decision-making, and systemic collaborations that address the complex challenges of child protection.

Child Protective Services (CPS) in Iowa works relentlessly to ensure the safety of children while supporting families in the creating of nurturing and stable environments. HHS believes that children thrive through healthy, supportive relationships. This is why we adhere to the Families First philosophy, which emphasizes strengthening and preserving family bonds whenever possible. Research demonstrates that when children maintain strong, positive connections with family, they experience better long-term emotional and developmental outcomes.

Additionally, HHS is committed to enhancing access to services through community coordination and development. By creating a welcoming and efficient “front door” for families in need, we simplify access to a range of programs and services, ensuring seamless connections to the support necessary for safety and well-being. Through strong collaborations across programs, warm referrals, and shared data, we can maximize expertise, improve communication, and increase the overall quality and efficiency of our services, providing families with the comprehensive support they deserve.

The following three goals are identified for the Child Protection Program:

**Goal 1: Prevention strategies that reduce unnecessary child welfare involvement and trauma**

- Promote Early Intervention and Support Services.
- Establish a prevention and support line.
- Consider the development of a Structured Decision-Making tool for intake.
- Family Assessment re-design

Promoting Early Intervention and Support Services: Early Intervention and Support (EIS) services are crucial in building connections between families and communities, helping to prevent abuse and neglect. By integrating Public Health and Human Services at HHS, we strengthened the link between prevention and intervention, with the goal of reducing unnecessary child welfare involvement and supporting Iowa families before crisis situations arise.

In the past year, HHS made significant strides in promoting EIS services by collaborating with both internal and external partners. For instance, our policy team participated in a Lean Kaizen event focused on improving the efficiency of Area Education Agency (AEA) referrals, which are automatically triggered through CPS-founded assessments. This initiative streamlined the referral process, improving access to vital services for families early in their involvement with the child welfare system.

Additionally, HHS engaged with the director of the Iowa Choices pilot program, a SAMHSA-funded initiative, to clarify eligibility criteria and establish referral pathways for this valuable program. This collaboration ensures that families who may benefit from these services are connected in a timely and effective manner.

Furthermore, Iowa's child protection workers (CPWs) continue to refer families to EIS services as part of their responsibilities. These referrals are a key part of our approach to providing early support and preventing the escalation of child welfare concerns.

These activities, along with other collaborative efforts, align with our goal to enhance service access, prevent unnecessary child welfare involvement, and reduce long-term trauma for children and families. These initiatives complement the work of our EIS team, which continues to focus on strengthening service delivery and ensuring that families receive the support they need as early as possible.

Establishment of a prevention and support line: As part of our ongoing commitment to prevention and strengthening families, HHS is working toward the goal of expanding the THRIVE Iowa program to become a statewide resource. THRIVE Iowa, currently being piloted in six counties, connects families with a network of "Navigators" who assist individuals in accessing immediate community resources and provide ongoing support. These Navigators work with families to help them build sustainable plans for self-sufficiency and independence.

Once THRIVE becomes a statewide program, it will serve as a dedicated prevention line for families in need, offering a proactive resource for guidance, referrals, and connection to EIS services. The warmline will provide families with assistance on a wide range of needs—such as utility assistance, support for fleeing domestic violence situations, transportation to essential appointments, and more—before these situations escalate into child welfare concerns.

The THRIVE Iowa program’s multi-level approach benefits the community, agencies, and families alike, ensuring that families receive the support they need to remain out of the child welfare system. It aligns with HHS’ broader goal of reducing unnecessary child welfare involvement and promoting positive outcomes for children. Information about THRIVE Iowa can be found at: https://hhs.iowa.gov/media/15519/download?inline

Consideration of the development of a Structured Decision-Making tool for intake: After careful consideration and discussion regarding the implementation of a Structured Decision-Making (SDM) tool for child abuse intake decisions, HHS decided not to move forward with obtaining and implementing this tool at this time. While SDM tools can provide consistency and support in the decision-making process, feedback indicates that the unique and complex nature of each child abuse intake case requires a more nuanced approach— one that prioritizes safety decisions made through critical thinking. This approach allows for a more individualized, flexible response to the varying circumstances of each case. However, we remain open to revisiting the possibility of utilizing an SDM tool in the future.

One of the key reasons for putting this plan on hold is the importance of intake staff utilizing critical thinking. Each call presents a unique situation, and no two cases are ever the same. While the category of abuse may be similar across cases, the household dynamics, support systems, child vulnerabilities, and intake histories can vary significantly and impact intake decisions. These elements require a level of professional judgment and flexibility that a tool may not be able to fully capture.

In addition, HHS has an established collaborative monthly meeting that includes administration, intake staff, field staff, policy staff, and intake training staff. During these meetings, we discuss intake decisions, review cases, and explore ways to enhance consistency in how decisions are made. This collaborative approach mirrors the purpose of an SDM tool but with the benefit of incorporating multiple perspectives, expertise, and experiences. It allows us to identify trends, share insights, and refine our decision-making processes in real-time, ensuring that we are aligned in our efforts to keep children safe while respecting the complexities of each case.

By combining our staff's ability to think critically with the guidance provided by our ongoing collaborative discussions and current policies, we believe we can ensure that decisions are made with the full context in mind—prioritizing the safety and well-being of children. This approach offers the flexibility to handle the diverse nature of each case while also striving for consistency and accountability in our decisions.

HHS acknowledges how useful SDM tools may be in some contexts, however we feel that our ongoing work to align intake decisions through collaborative discussions, supported by policies and experienced judgment, is the most effective and adaptive approach to ensuring that children receive the highest level of protection.

Family Assessment re-design: In 2014, Iowa HHS implemented a Differential Response (DR) System, which introduced two distinct pathways for child protective assessments: Family Assessments (FA's) and Child Abuse Assessments (CAA's). FAs are assigned when Denial of Critical Care is alleged, but there is no claim of imminent danger, death, or injury to a child. These cases typically involve less serious allegations and are aimed at addressing family functioning and child development without making a formal determination of abuse. In contrast, CAAs are used for more serious allegations

and involve a thorough investigation to determine whether abuse occurred, ending with a conclusion of confirmed, not confirmed, or founded.

After a decade of implementing the DR System, it became apparent that FAs were being conducted in a manner similar to CAAs. Despite the critical differences between these pathways, particularly in terms of the goals and outcomes of each assessment type, CPWs were approaching both assessments with similar practices. This overlap was a concern, as it potentially compromised the unique objectives of the FA process, which emphasizes family strengthening, safety, and prevention, rather than confirming abuse.

In response to this, HHS convened a focus group to examine the policies and practices surrounding FAs. The goal of this redesign was to distinguish the FA process more clearly from Child Abuse Assessments and ensure that policies and practices align with the true intent of each pathway. The group's efforts led to the refinement of the FA process, placing a stronger emphasis on family functioning, child development, and connecting families with both formal and informal supports.

A key enhancement in this redesign was the update to Iowa's child welfare information system (CWIS), JARVIS. The system now includes revisions to how FAs are documented and assessed. Previously, five family functioning domains were used, but these were streamlined into four focused assessment sections that better align with the goals of strengthening family supports, preventing future abuse, and improving child well-being. This update ensures that FAs are concentrated on family strengths and developmental needs, rather than on abuse investigations.

To further support this shift, HHS conducted in-person training for field staff across Iowa's five service areas. The training provided staff with the necessary knowledge and skills to effectively implement the redesigned FA process, ensuring consistency and clarity across the state.

The implementation of this redesigned process will be closely monitored by social work supervisors in the field, who will be responsible for overseeing the practice, identifying any issues, and providing feedback for continuous improvement. This will ensure that FAs remain focused on prevention and family well-being, with an emphasis on safety and the identification of support systems.

HHS implemented this redesign on March 1, 2025, with updates to the employee policy manual occurring to reflect the new distinctions between the pathways.

**Goal 2: Children remain safely in their homes whenever possible**

- Utilize Structured Decision-Making (SDM) tools to assess safety and risk
- Apply 4 questions to ensure reasonable and active efforts to prevent removal and service implementation
- Prioritize placement when removal is necessary

Structured Decision-Making (SDM) tools to assess safety and risk: HHS continues to utilize the Structured Decision-Making (SDM) Safety Assessment tool, which improved the consistency and accuracy of safety decisions in child welfare services. Since its statewide implementation in February 2022, the SDM Safety Assessment contributed to more standardized and reliable outcomes for child protective services.

Developed in collaboration with Evident Change (formerly NCCD) from 2020 to 2023, the SDM Safety Assessment tool and safety planning guide are integrated into JARVIS, supporting decision-making with evidence-based practices. This approach ensures that safety decisions are consistent, while still allowing for professional judgment and a family-centered practice.

HHS actively monitors the effectiveness of the SDM Safety Assessment by tracking completion rates, assessment findings, and the alignment of actions with policy. In March 2023, HHS released a memo to field staff, emphasizing the tool's importance in supporting consistent decision-making.

At this time, HHS is not planning to implement additional evaluation steps, such as a full evaluation study, staff surveys, or interviews, as the SDM Safety Assessment tool has performed well. Feedback and outcomes indicate that the tool is functioning as intended, and no significant concerns were raised by staff or stakeholders. HHS will continue to monitor its use and effectiveness through regular data review, and any future evaluation plans will be based on emerging needs or feedback

Apply 4 Questions to ensure reasonable efforts to prevent removal were taken: HHS continues to apply the 4 Questions to assess whether reasonable efforts were made to prevent removal, with the goal of keeping children safely in their homes whenever possible. The 4 Questions are as follows:

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

This approach did not change from the previous year and continues to guide CPWs in their efforts to prevent unnecessary removal. CPWs also remain encouraged to connect families to community-based resources, such as mental health services, housing support, and substance abuse treatment, to strengthen support systems and mitigate the need for removal. CPWs also make referrals to Family Preservation Services (FPS) and utilize Child Safety Conferences when appropriate.

The application of these questions and related interventions continues to be a key strategy in ensuring children's safety while promoting family unity whenever possible.

Prioritize Placement when removal is necessary: When removal is necessary due to one or more danger indicators, and despite our best efforts, it cannot be prevented, the focus shifts to ensuring that the child is placed in a setting where they have familiarity and support. Our priority is always to place the child with someone they know and trust, when possible, to reduce the trauma of the transition. HHS is committed to ensuring that any placement made is in the child's best interests, addressing their special needs, and providing a safe, least restrictive environment in close proximity to their home. Every reasonable effort is made to place the child with an adult relative or fictive kin, fostering continuity in their relationships and minimizing disruption.

Additionally, HHS works diligently to keep the child connected to their kin and community, recognizing that these ties are critical for the child's well-being. When removal is necessary, Iowa courts must first consider placing the child with the other parent, provided it is in the child's best interests. If that option is not deemed suitable, custody is transferred to HHS, which follows this order of priority for placement:

- An adult relative of the child (including but not limited to adult siblings and parents of siblings)
- Fictive kin (individuals with a close, familial-like relationship to the child)
- Other suitable placements identified by the child's relatives
- A licensed foster care provider
- A group care facility, shelter care facility, or other residential treatment facility

By focusing on placements that maintain continuity of familiar relationships, HHS strives to ensure the child's safety and well-being while minimizing trauma and preserving a sense of connection.

A breakdown of Iowa's removal rates and placement data can be found on HHS' website: Microsoft Power BI.

**Goal 3: Adequate services prevent repeat maltreatment**

- Complete Family Functioning Assessment to identify family strengths and needs
- Refer to services available in the community
- Create Safe Plans of Care for infants affected by substance use

Complete Family Functioning Assessment to identify family strengths and needs: HHS recently transitioned from utilizing five family functioning domains to a more refined approach with four Family Functioning Assessment sections. Previously, the five domains—child behavior, family safety, family interactions, parental capabilities, and home environment—provided a framework for gathering and analyzing information about children and families. While these domains helped guide the assessment process, the transition to the new sections allows for a more focused and holistic evaluation of family dynamics, better aligning with the evolving needs of Iowa families.

The new Family Functioning Assessment consists of the following sections:

- **Family Risk and Safety Concerns:** This section focuses on identifying potential danger indicators and assessing the risks present within the family environment. It examines factors that may compromise the safety and stability of the family unit.
- **Child Well-Being:** This section evaluates the child's strengths, needs, and vulnerabilities, specifically those that impact the child's safety, well-being, and long-term permanency. It provides a comprehensive understanding of the child's overall health and developmental needs.
- **Family Strengths, Services, and Supports:** Here, the family's strengths are identified, including protective factors, established support networks, and positive family dynamics. This section highlights the resources and supports that can be leveraged to help address challenges and promote family stability.
- **Recommendations for Services:** Based on the findings from the previous sections, this section outlines the formal and informal services and supports that are necessary to address the identified needs of the child, parents or caregivers, and the overall family unit. These recommendations focus on both immediate and long-term resources that will help strengthen the family and improve child safety and well-being.

By transitioning to these four sections, the Family Functioning Assessment has become a more comprehensive and individualized tool. It allows HHS to better address the unique needs of families while focusing on both the risks and strengths that will guide interventions and services. This refined approach ensures that assessments are more aligned with family-centered practices and supports the agency's goal of preventing maltreatment and promoting family well-being. Staff received training on this transition in early 2025 and updates to the employee manual occurred to reflect the information.

Refer to services available in the community: Repeat maltreatment is prevented through the timely and appropriate referral of services at the close of a child protective assessment, which includes both a FA and a CAA. CPWs complete FA reports within 10 business days when there is no finding of abuse, no consideration for placement on the Central Abuse Registry, and no recommendation for court involvement. A successful FA closure indicates that the children are safe, and no further intervention is required. For families with low risk, CPWs make referrals to community services, while moderate and high-risk families are offered non-agency voluntary (state-purchased) services. These services, in alignment with the Family First Prevention Services Act, encourage the use of Motivational Interviewing (MI) and require the completion of service plans for each case.

In 2024, after an assessment of Title IV-E claims for Child Protective Services, HHS identified opportunities to incorporate evidence-based programs through the federal

clearinghouse, expanding access to resources and enabling the use of federal IV-E funding. As a result, HHS transitioned from Solution-Based Casework (SBC) to Motivational Interviewing (MI) starting in 2024 and is in full implementation.

If, during a FA, a CPW determines that the family is ineligible for this pathway—such as when a child is deemed unsafe—the case is reassigned to the CAA pathway. In SFY 2024, over 2,400 family assessments were re-assigned to child abuse assessments. Throughout this process, the same CPW continues working with the family, ensuring continuity and stability in services.

Historical assessment outcomes data can be found on the Iowa HHS website at: Child Abuse Statistics | Health & Human Services

Assessment outcome data for the most recent year can be found on the "Agency Dashboards" page of our website at: Microsoft Power BI

Safe Plans of Care: Creating a Safe Plan of Care for infants affected by substance use is a key strategy in preventing repeat maltreatment. These plans address the health and substance use treatment needs of both the infant and the caregiver, ensuring necessary referrals and services are provided.

Further information on Safe Plans of Care and the implementation of the Comprehensive Addiction and Recovery Act (CARA) of 2016 in Iowa is available in the annual report for the Child Abuse Prevention and Treatment Act (CAPTA) State Grant.

For up-to-date data on repeat maltreatment and reentries to foster care, please refer to the "Repeat Maltreatment" dashboard on HHS' website, located at: Microsoft Power BI

### Child Advocacy Centers

A Child Advocacy Center (CAC), also known as a Child Protection Center (CPC), is a medically based, community-focused facility designed to provide a comprehensive, child-centered approach to addressing child abuse cases. CACs/CPCs operate within designated HHS service areas and facilitate a multidisciplinary collaboration among law enforcement, child protection professionals, mental health practitioners, prosecutors, and medical personnel to ensure the thorough and compassionate handling of child abuse cases.

CACs/CPCs are staffed by professionals with specialized expertise in addressing the emotional and physical needs of children who experienced sexual abuse, severe physical abuse, substance use-related maltreatment, or neglect. Key services provided include:

- Forensic Interviews: Conducted by trained specialists to gather information in a child-friendly, non-threatening environment.
- Medical Examinations: Comprehensive medical assessments to identify and document physical signs of abuse or neglect.

- Treatment Services: Provision of therapeutic support for child victims and non-offending family members to promote healing and resilience.
- Follow-Up Services: Ongoing coordination of care and support to ensure the safety and well-being of children and their families.

These services are structured to minimize trauma for child victims and their non-offending family members by providing a coordinated, streamlined approach to care.

Additionally, CACs/CPCs play a critical role in supporting HHS in the assessment and investigation of child abuse cases. They collaborate with law enforcement agencies and county attorneys to facilitate the prosecution of criminal cases involving child endangerment, child fatalities, sexual abuse, and human trafficking. CAC/CPC professionals frequently provide expert testimony in legal proceedings, including District Court and Juvenile Court cases where CAC/CPC services were utilized.

CACs/CPCs contribute to the broader child welfare system by offering multidisciplinary training programs for professionals involved in child protection services. These training initiatives aim to enhance the knowledge, skills, and coordination of all partners engaged in safeguarding the well-being of vulnerable children.

Through these comprehensive services and collaborative efforts, CACs/CPCs continue to provide essential support to HHS, the judicial system, and child welfare professionals dedicated to protecting and serving children across the state.

CAC/CPC Locations: 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 these sites, Project Harmony, a CAC/CPC located in Omaha, Nebraska, continues to play a pivotal role in addressing child abuse and neglect. Project Harmony operates under a nationally unique model featuring a centralized location that co-locates with multiple agencies, including the Omaha Police Department's Child Victim/Sexual Assault Unit and Domestic Violence Unit, Homeland Security, Omaha Fire Department, Nebraska Health & Human Services and the Child Saving Institute. This integrated approach fosters seamless communication and coordination among partners dedicated to protecting children and promoting their well-being.

Project Harmony also established a satellite location in Atlantic, Iowa, in partnership with Cass Health. The expansion of Project Harmony underscores its dedication to breaking the cycle of child abuse and neglect through effective collaboration and a multidisciplinary approach.

Project Harmony provides the following services:

- Children and Family Services, such as forensic interviews, medical examinations, family advocacy, and mental health services
- Multidisciplinary Team Coordination, includes two teams that serve 16 counties in Southwest Iowa
- Missing Youth Services, such as a thorough mental/behavioral health assessment, medical examination, forensic interview (if needed), advocacy, crisis counseling with the youth and caretaker, and connection to appropriate community services. These services are for non-system involved missing youth.
- Anti-Trafficking Youth Services, includes a specialist who builds rapport with the youth and helps the youth with basic needs, and a coordinator who works to identify available services in the community for trafficking survivors
- Triage Center, professionals greet children with a light meal, clothing, a medical examination and other items as needed

For more information about Project Harmony, please visit Home - Project Harmony.

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

**Goal 1: Increase collaboration between HHS & CAC/CPCs**

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

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

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

These goals and objectives are reflective and supported in the work and activities reported below.

Child Protection Center Grant Program: The Child Protection Center Grant Program was established in 2001 within the former Iowa Department of Public Health (IDPH) to support the development and sustainability of CPCs across Iowa. As outlined in Iowa Code Section 135.118, the program provides grants to eligible applicants for the purpose of establishing new CPCs and supporting the ongoing operation of existing centers.

Grant funding under this program is available to organizations that either meet or are actively working toward meeting the standards for Child Protection Centers established by the National Children's Alliance. These standards ensure the provision of high-quality, coordinated services to child abuse victims and their families referred to CPCs by HHS or law enforcement agencies.

It is important to note that funding provided through the CPC Grant Program is exclusively available to CACs/CPCs operating within the state of Iowa. Project Harmony, a CAC/CPC located in Nebraska, receives funding through a separate state appropriation.

The CPC Grant Program continues to play a critical role in enhancing the capacity of CACs/CPCs to deliver essential services to children and families impacted by abuse and neglect, thereby improving outcomes through effective collaboration, specialized care, and adherence to nationally recognized standards.

Historically, the funding component for the CPCs was managed by Iowa's legacy Department of Public Health. As the Department merged into one large umbrella agency, oversight of many duties is shifting to better align the work. As CPC's work is directly tied to the Division of Family Wellbeing and Protection, the oversight of the funding component will be shifting to reflect this. This will allow both the funding (contracts) and the Memorandum of Understanding (MOU) to be housed and managed under one division, for better oversight and efficiency. These grants are currently in the request for application period, with a new cycle beginning on July 1, 2025. After this process is complete, the shift to the new division will occur. No changes to the expectations or requirements of the funding are changing at this time.

CAC/CPC Contracts & MOUs: The six Iowa CAC/CPC operate under a nonmonetary agreement with HHS. This agreement is formalized through a collaborative MOU between HHS and each individual CAC/CPC. The MOU outlines the specific guidelines and services that the CACs/CPCs will provide to clients referred by HHS.

MOUs are renewed annually through a structured process involving either a Renewal Letter or an amendment issued to each CPC. For SFY 2025, there were no revisions or additions to the MOUs. As such, a Renewal Letter was provided to each CPC, extending the agreements through May 15, 2026.

In contrast, Project Harmony, a CAC/CPC located in Nebraska, operates under a formal contract with HHS. As an out-of-state provider, Project Harmony's funding is approved annually as part of the State's appropriations bill. The scope of work outlined in the Project Harmony contract mirrors that of the MOUs established with Iowa-based CACs/CPCs. The contract with Project Harmony will be extended through May 15, 2026.

These formalized agreements are essential in ensuring continuity of services, consistency in program standards, and effective collaboration between HHS and its partnering CACs/CPCs to meet the needs of children and families impacted by abuse and neglect.

CAC/CPC SFY 2024 Activities:

- Allen CPC served 737 children during SFY 2024. The largest demographic served consisted of white females up to age six. Parents were most commonly identified as the alleged responsible caretakers. The most frequent referral reason was an allegation of sexual abuse. Assessments most often resulted in an unfounded outcome.
- Blank Children's STAR Center served 1,149 children. The primary population served was white females between the ages of 11 and 17. Parents were most commonly identified as the alleged responsible caretakers followed by other relatives. Sexual abuse was the most common reason for a referral to the CPC. Founded or reason to be believe was the most common outcome. There were no prosecutions reported.
- The Child Protection Response Center served 296 children. The primary population served included white females between the ages of 7 and 12. Parents were most commonly identified as the alleged responsible caretakers. Assessments most frequently concluded with an unfounded outcome.
- Mercy One served 810 children. The predominant population served consisted of white females up to age six. Parents were most commonly identified as the alleged responsible caretakers. Assessments most frequently resulted in an unfounded outcome.

- Mercy One Child Advocacy Center served 601 children. White females aged 7 to 12 were most commonly referred. Sexual abuse was by far the most common allegation and the assessment outcome was most commonly unfounded. There were 33 alleged responsible caretakers who were criminally charged.

CAC/CPC Annual Report: The Iowa Chapter of Children's Advocacy Centers prepares a comprehensive Annual Report each year. The 2024 Annual Report provides detailed data and information regarding the services delivered by Iowa's six CAC/CPCs) and Project Harmony.

In addition to providing essential background information, the report includes:

- The total number of children served,
- The types of cases addressed,
- The funding sources supporting Iowa's Centers, and
- The number of professional trainings conducted throughout the past year.

The 2024 Annual Report is available for review at: www.iowacacs.org.

### HHS Drug Testing Services

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

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

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

Drug Testing Data: The following data tables reflect the Drug Testing Collections under each of the three funding sources from April 2023 through March 2025. 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 5e: Statewide Drug Testing Collections (April 2023 - March 2024)**

| Service Area | Child Abuse Registry 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% |

Data Source: HHS

**Table 5f: Statewide Drug Testing Collections (April 2024 - March 2025)**

| Service Area | Child Abuse Registry Funding | Child Welfare Funding | Court Ordered Funding | Total | Percentage of Court Ordered to Testing Total |
|---|---|---|---|---|---|
| Western | 831 | 1,305 | 1,269 | 3,405 | 37.27% |
| Northern | 270 | 766 | 674 | 1,710 | 39.42% |
| Eastern | 546 | 1,864 | 105 | 2,515 | 4.17% |
| Cedar Rapids | 579 | 624 | 5,560 | 6,763 | 82.21% |
| Des Moines | 664 | 1,677 | 717 | 3,058 | 23.45% |
| **TOTAL** | 2,890 | 6,236 | 8,325 | 17,451 | 47.71% |

Data Source: HHS

Upon review, the Statewide Drug Testing Collections data tables indicate an overall decrease in drug testing since March 2024. In looking at the percentage of court ordered testing to the testing total, the tables reflect that court ordered testing remains about half of the testing total. Cedar Rapids Service Area continues to reflect the highest percentage of court ordered testing at 82.21%. Testing under child welfare funding during the same time period increased slightly from 5,693 in 2023 to 6,236 in 2024.

FFY 2025-2026 Drug Testing Activities: On June 30, 2025 the current HHS Drug Testing Collection Contract and the HHS Drug Testing Laboratory Services Contract will end. In preparation for new drug testing contracts to begin in 2025, an HHS workgroup began meeting to discuss the future needs of the drug testing program and the RFP process that will be followed. HHS decided to enter into an Intergovernmental (IGA) Contract with Central Iowa Juvenile Detention Center (CIJDC) for both collections and laboratory services. Contract negotiations are underway to develop the contract. The new contract will begin on July 1, 2025.

New supports for the drug testing program in the coming year will include assistance from Dr Kruse, HHS Medical Director. Dr Kruse expressed an interest in learning more about the Drug Testing program based on his previous work as a Certified Medical Review Officer for workplace drug testing. Dr Kruse will work with the Drug Testing Policy Program Manager and the Drug Testing Contract Specialist to learn about the program and offer his expertise in this area. Dr. Kruse has put together recommendations based on industry standards on how HHS should handle drug testing collections. HHS is also in the process of updating our Drug Testing Protocol Manual to better reflect SAMHSA (Substance Abuse and Mental Health Services Administration) and START (Sobriety Treatment and Recovery Teams) guidelines around drug testing.

**FFY 2025-2029 Drug Testing Goals & Objectives:** Based on the list of opportunities for improvement in drug testing outlined in Iowa's FFY 2025-2029 CFSP, HHS identified the following Drug Testing Program goals and objectives for 2025-2029.

**Goal 1: Accessibility to drug testing services.**

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

The new contract includes changes to the Fixed Sites. This includes changing some of the locations, times and days of operation for the sites. HHS is considering expanding in-home testing in some service areas due to elimination of sites with low volume.

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

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

Iowa will implement the START (Sobriety Treatment and Recovery Teams) model in two pilot sites this year. HHS expects to expand the program to other areas throughout the state over the next several years. The START model aims to mitigate systems issues that result in barriers to families being able to access services in a timely manner. The model uses a variety of strategies to promote collaboration and systems-level change within and between child welfare agencies and substance use treatment providers.

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

- Judicial partners
- HHS contracted providers
- HHS field staff

HHS will provide Drug Testing training to judicial partners, contracted providers and field staff in June and July 2025. Training will include information on SAMHSA (Substance Abuse and Mental Health Services Administration) guidelines and changes to the contract and policy manual.

## Treatment Services and Foster Care

### Connect And Protect (CAP) Teams and Consultations

Connect and Protect (CAP) Teams are multi-disciplinary and have membership from the Iowa Department of Health and Human Services (HHS), Family Centered Services providers, Parent Partners, and Domestic Violence advocates. CAP teams are the content experts on Safe & Together™ - the model for domestic violence child welfare cases that HHS is responsible for serving. Teams are designed to meet to provide case consultation on domestic violence cases in the style of Safe & Together™ to promote best practice and to assist child welfare partners in working through cases through a domestic violence-informed lens. The Safe and Together model is a perpetrator pattern-based, child-centered, and survivor strengths approach to working with domestic violence 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.

The CAP Teams continued to provide consultation to child protection workers and ongoing case managers on child welfare cases which intersect with domestic violence

and are referred for CAP consultation in each of the five service areas during SFY 2025. CAP teams continue to receive ongoing learning and development through available virtual trainings from the Safe and Together Institute and the CAP Team bi-annual seminars.

| Table 5g: CAP Team Consults by Service for SFY 2025 | |
|---|---|
| **Service Areas** | **SFY 2025 (July – April 2025)** |
| Des Moines | 19 |
| Eastern | 1 |
| Western | 3 |
| Northern | 5 |
| Cedar Rapids | 12 |
| **Totals** | **40** |

Data Source: HHS

On January 9, 2025, the CAP Team seminar occurred virtually and featured presentations on the CAP Team 30 Day Follow Up Survey, explained in more detail below, and Choose to Change: Your Behavior, Your Choice. David Mandel from Safe and Together Institute presented a virtual recording on How a Perpetrator Pattern Based Approach Changes Our Language in Domestic Violence Cases, followed by CAP Team breakaways to discuss key learning points and takeaways. Lastly, presentations on the updates to the Iowa Domestic Abuse Program referral process and eligibility requirements occurred.

On May 8 and 9, 2025, the Safe and Together Institute will provide a two-day seminar focused on an overview and the core concepts of the Safe and Together Model. Day 1 of the seminar will focus on creating domestic abuse-informed systems, the principles and components of the Safe & Together Model and information about the framework behind competency-building and collaboration in child welfare around domestic abuse. Day 2 of the seminar will be focused on four core concepts including: interviewing perpetrators, case planning with perpetrators, intersections and cross cutting themes, and mapping perpetrator patterns. The seminar will be in person in Des Moines, Iowa and will be available for all CAP Team members to participate.

A workgroup representative of CAP team members, and the HHS service trainer and program manager who provide training support to the teams, came together to explore additional strategies to track and evaluate the outcomes of cases who participate in CAP team consultation. The workgroup developed a case consultation survey distributed to the HHS social work case manager (SWCM) and their supervisor 30 days following the case presented to the CAP Team for consultation. The goal of the survey is to learn how the information and guidance provided in consultations are applied to the case, as well as if the mapping tool and key concepts from the Safe and Together Model were utilized during the consultation. The survey further asks the respondent if they will refer a case to the CAP Team for consultation in the future.

HHS implemented the CAP Team survey following the January 9th CAP Team seminar, as the survey was shared and presented to the teams for awareness and time was given for each CAP Team to develop a plan for survey distribution to the presenting SWCM and supervisor 30 days post-consultation. The HHS program manager tracks the data from the surveys and will provide the data to the teams for their area every 6 months for review and analysis.

HHS is also adding dedicated HHS staff time to support the CAP teams through providing observation and feedback to the CAP team consultations. In March 2025, one of the HHS service trainers offered individualized support and coaching to each of the Connect and Protect Teams. The teams requested additional guidance surrounding use of the Perpetrator Pattern Mapping Tool which assists with comprehensive assessments, interventions, and outcomes through a perpetrator pattern-based approach. The tool allows practitioners to apply the Model's critical concepts and principles to their cases. In addition, the tool helps identify the primary perpetrator and their patterns of coercive control and violence, assess harm to children and documents protective parenting efforts. The tool includes a place for workers to consider the implications for their practice and next steps.

### Family-Centered Services (FCS)

The goal of Family Centered Services (FCS) is that through collaboration between the family and public and private agencies, children and families in Iowa will be safe, secure, healthy, and well in their communities.

Iowa implemented FCS in July 2020. These services are targeted toward intact families (in-home), families with children placed with kin/fictive kin caregivers, and families whose children are placed in stranger foster care. The interventions selected for the FCS service array are a direct response to federal Family First legislation. FCS focuses on addressing identified safety concerns, enhancing caregiver capacities, and reducing risk so that children can remain in their homes as often as possible or return home quickly if out of home placement is necessary.

FCS contracts began July 1, 2020, after a competitive procurement process. There are nine active contracts with six contractors across the state. Each contractor provides services in specific counties, with 18 counties covered by a single contractor and 81 counties covered by two contractors with alternating assignment of cases.

The current agencies who hold contracts for FCS in Iowa are:

- Father Flanagan's Boys Home (Boys Town)
- Children and Families of Iowa
- Families First
- Family Access Center

- Four Oaks
- Mid-Iowa Family Therapy Clinic

On November 11, 2024, Iowa released a Notice of Intent to Release a Request for Proposals (RFP) for the contract cycle beginning July 1, 2026. Listening sessions occurred with multiple partner groups, including frontline staff, supervisors, and leadership from HHS and FCS, judicial partners, and Iowa's Parent Partners in December 2024 and January 2025. These listening sessions provided insight into the strengths and challenges of the current FCS contract. Iowa also contracted with Sellers Dorsey who will provide additional insight into quality service delivery and monitoring as work continues on the RFP. HHS anticipates releasing the RFP mid-summer 2025.

Under the current Family Centered Services contracts, contractors provide the following services:

- Family Casework (FMCW), incorporating Family Focused Meeting facilitation and Youth Transition Decision-Making (YTDM) meetings,
- SafeCare (including Non-Agency SafeCare),
- Family Preservation Services (FPS) with Child Safety Conferences (CSCs),
- Family Interactions,
- Non-Agency Services, and
- Kinship Navigator Services (provided to kin/fictive kin who are caring for children placed in their care)

A family is eligible for FCS on an Open Agency (HHS) case when:

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

FPS are also available during a Child Abuse Assessment when it is determined that there is an immediate safety concern that would otherwise require out-of-home placement and the family is agreeable to working with providers to address the immediate safety concern.

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

*Practice Standards:* The Practice Standards for Family Centered Services Contractors were developed jointly between HHS and representatives from each of the current FCS contractors. The Practice Standards provide additional guidance and clarification of expectations and best practices for provision of Family Centered Services. The current edition of the Practice Standards published in June 2024 and is available at https://hhs.iowa.gov/programs/CPS/cps-contracts under Family Centered Services.

FCS contractors and the HHS program manager meet monthly to discuss continuous quality improvement, barriers to progress, and strategies to overcome barriers. In addition to these statewide meetings, contract leaders meet regularly with the HHS field leadership teams in their local areas. While the practice expectations for FCS are consistent statewide, there are local nuances that respond to the needs of the families in those areas and these conversations at the local level are critical to ensuring success.

**Descriptions of Family Centered Services and Performance Measure Data:**

Family Casework (FMCW): Family Casework is designed to support families in building skills to provide safety and stability for the children. This is primarily accomplished through direct services in the home which assess family functioning, identify specific deficits/barriers to child safety, and work with parents to remedy them.

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

There are three Performance Measures associated with FMCW:

**Performance Measure 1:** Children served by the contractor are safe from abuse for 12 consecutive months following the conclusion of their case. The target is to achieve 90% on all cases served.

**Performance Measure 2:** Children served by the contractor are safely maintained in their own homes or with kin/fictive kin caregivers during the case. The target is to achieve 90% on all cases served.

**Performance Measure 3:** Children served by the contractor who are reunified or exit foster care do not experience reentry into care within 12 consecutive months of their reunification date. The target is to achieve 90% on all cases served.

Iowa transitioned to FMCW with MI in July 2024. Performance Measure data for measures 1 and 3 will not be available until at least July 2025 as these measures evaluate whether a child/family return to the child welfare system in the 12 months following case closure.

Performance Measure 2 evaluates whether children remained in their home or with kin/fictive kin during their FMCW case. The data for this measure covers the time period of July 1, 2024-March 31, 2025. The data below reflects that over 93% of families whose children are in the home or with a kin/fictive kin caregiver throughout their open Agency (HHS) case. While providers in the Cedar Rapids Service Area have not met this measure, they are extremely close and it is likely that the minor difference with other contractors is the result of variance in judicial practices.

# Table 5h: Family Casework – Performance Measure 2

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

## Family Casework - Performance Measure 2

Children served by the contractor are safely maintained in their own homes or with kin/fictive kin caregivers during the case. The target is to achieve 90% on all cases served to receive payment.

**OVERVIEW:** Includes cases that have received Family Casework (FMCW) and only includes cases that have a Service End Date entered that is within the selected date range. In order to meet this performance measure the child/children must be safely maintained in their own home or with kin/fictive kin caregivers during the entire span of the case. 'Safely maintained' means the child was not removed from their home or from a kin/fictive kin placement and placed in a disqualifying licensed foster care or other out of home placement during the case.

In the event that there are multiple children in the case, the case is assigned to the youngest child victim in FACS, so if there is an identified child in the home under the age of 18, the case would be included in the measure calculation.

**GENERATED ON:** 4/18/2025 5:51:50 PM

**DATE RANGE:** 7/1/2024-3/31/2025

**CASEWORK TYPE:** Agency and Non-Agency

**SERVICE AREA:**

- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**

- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number of Cases Referred to FMCW | Number Of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Father Flanagan's Boys' Home | 356 | 330 | 92.70% |
| Children & Families of Iowa | 68 | 60 | 88.24% |
| Southwest Iowa Family Access Center | 386 | 360 | 93.26% |
| **Western Service Area Total** | **810** | **750** | **92.59%** |
| **2 - Northern Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 358 | 334 | 93.30% |
| Families First Counseling Services of Iowa | 307 | 290 | 94.46% |
| **Northern Service Area Total** | **665** | **624** | **93.83%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 783 | 739 | 94.38% |
| Mid-Iowa Family Therapy Clinic | 56 | 54 | 96.43% |
| **Eastern Service Area Total** | **839** | **793** | **94.52%** |
| **4 - Cedar Rapids Service Area** | | | |
| Families First Counseling Services of Iowa | 301 | 269 | 89.37% |
| Four Oaks Family and Children's Services | 296 | 265 | 89.53% |
| **Cedar Rapids Service Area Total** | **597** | **534** | **89.45%** |
| **5 - Des Moines Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 292 | 277 | 94.86% |
| Children & Families of Iowa | 316 | 299 | 94.62% |
| **Des Moines Service Area Total** | **608** | **576** | **94.74%** |
| **Statewide Total** | **3,519** | **3,277** | **93.12%** |

Family Focused Meetings: Iowa uses Family Focused Meetings (FFMs) within Family Casework to provide consistent opportunities for the family, their supports, and professionals involved in the case to come together for case planning. Beginning in July 2024, Iowa implemented a two-phase process for FFMs. The first phase is the initial FFM, which occurs at the beginning of the case. This meeting is between the referring HHS worker, FCS provider assigned to the case, and the family. It serves as the warm handoff between HHS and providers. While no specific data is available, reports across the state indicate that when initial FFMs occur, the case gets off to a better start and families engage in services more quickly

The second phase of FFMs includes the first and subsequent comprehensive FFMs. Planning for the first comprehensive FFM begins at the initial FFM and continues with information being passed from the FCS provider to the FFM meeting facilitator. The first comprehensive FFM occurs 45-60 days into the case, with follow up FFMs occurring every 6 months after, at the family's request, or when substantial changes to the case occur. The comprehensive FFMs are opportunities for the family to invite their supports and any professionals involved in the case to come together for additional case planning. Reports from these meetings inform both goal development and identified progress and/or barriers to progress for the HHS case plan and FCS service plan.

Youth Transition Decision-Making Meetings (YTDMs) are for youth transitioning into adulthood. YTDMs are offered to youth when the family has an open Family Casework case. 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 to support youth and young adults who are at risk of homelessness, unemployment, and poor health is an effective means to address the factors that threaten a successful transition.

Under the current contract, FCS contractors provide trained FFM and YTDM meeting facilitators. The responsibility for providing comprehensive FFM and YTDM meeting facilitation training courses is that of the Child Welfare Provider Training Academy (CWPTA). (For additional information on FFM and YTDM meeting facilitation training and approved trainers, refer to the Child Welfare Provider Training Academy (CWPTA) section of this report). HHS and CWPTA jointly developed an initial FFM training webinar, which CWPTA provides to FCS staff.

SafeCare: SafeCare is the evidence-based behavioral parenting intervention selected by HHS to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 years in at-risk families. It is a home visitation-based parent training program conducted over 18 sessions. Parents receive instruction on how to have positive parent-child and parent-infant interactions (PCI/PII), keep homes safe, and improve child health. SafeCare is available on open HHS service cases in addition to Family Casework or may be provided as a standalone service. HHS may also refer families for Non-Agency SafeCare when the family is eligible for Non-Agency Services.

It is not required that Non-Agency Services be open to open Non-Agency SafeCare. FCS contractors receive compensation for provision of SafeCare separately from other services in the FCS service array. The delivery of SafeCare is identical for Agency (HHS) and Non-Agency cases.

SafeCare was shown to be effective with families involved in Iowa's child welfare system. Iowa continues to contract with Georgia State University and the National SafeCare Training and Research Center (NSTRC) to complete annual evaluations of Iowa's SafeCare program. Please see the SafeCare Iowa Evaluation Year 3 Report under the SafeCare section found at the following link: https://hhs.iowa.gov/programs/CPS.

There are two Performance Measures for SafeCare:

**Performance Measure 1:** 65% of parents in contractor's cases receiving SafeCare will complete and graduate from all three modules.

**Performance Measure 2:** 85% of parents in contractor's cases receiving SafeCare will complete the Parent-Child/Parent-Infant Interactions module.

## Table 5i: SafeCare - Performance Measure 1

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

### SafeCare® - Performance Measure 1 - Graduated SafeCare® Modules

65% of parents in contractor's cases receiving SafeCare® will complete and graduate from all three modules.

**OVERVIEW:** Includes cases that have received SafeCare® and only includes cases that have a Service End Date entered that are within the selected date range. In order to meet this performance measure ***ALL*** boxes need to be checked in all three modules, not just if the Post Test has been checked in each module.

**GENERATED ON:** 4/20/2025 8:58:46 PM

**DATE RANGE:** 7/1/2024-3/31/2025

**SERVICE AREA:**

- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**

- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number of Cases Completed All 3 Modules | Number of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Father Flanagan's Boys' Home | 39 | 77 | 50.65% |
| Children & Families of Iowa | 6 | 14 | 42.86% |
| Southwest Iowa Family Access Center | 18 | 57 | 31.58% |
| **Western Service Area Total** | **63** | **148** | **42.57%** |
| **2 - Northern Service Area** | | | |
| Families First Counseling Services of Iowa | 11 | 41 | 26.83% |
| Mid-Iowa Family Therapy Clinic | 7 | 36 | 19.44% |
| **Northern Service Area Total** | **18** | **77** | **23.38%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 44 | 139 | 31.65% |
| Mid-Iowa Family Therapy Clinic | 3 | 10 | 30.00% |
| **Eastern Service Area Total** | **47** | **149** | **31.54%** |
| **4 - Cedar Rapids Service Area** | | | |
| Families First Counseling Services of Iowa | 23 | 42 | 54.76% |
| Four Oaks Family and Children's Services | 16 | 44 | 36.36% |
| **Cedar Rapids Service Area Total** | **39** | **86** | **45.35%** |
| **5 - Des Moines Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 23 | 65 | 35.38% |
| Children & Families of Iowa | 42 | 87 | 48.28% |
| **Des Moines Service Area Total** | **65** | **152** | **42.76%** |
| **Statewide Total** | **232** | **612** | **37.91%** |

No contractors have met the performance measure in this fiscal year. Challenges include courts closing cases prior to parents completing SafeCare and parents

disengaging from services prior to completion. Through conversations with NSTRC, it appears these challenges, especially parents disengaging from services, are not uncommon with other SafeCare providers across the nation.

### Table 5j: SafeCare – Performance Measure 2

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

## SafeCare® - Performance Measure 2 - Completed PCI/PII Module

85% of parents in Contractor's Cases receiving SafeCare® will complete the Parent-Child/Parent-Infant Interactions module.

**OVERVIEW:** Includes cases that have received SafeCare® and only includes cases that have a Service End Date entered that are within the selected date range. In order to meet this performance measure ***ALL*** boxes need to be checked in the Parent-Child/Parent-Infant Interactions (PCI/PII) module, not just if the Post Test has been checked.

**GENERATED ON:** 4/20/2025 9:17:37 PM

**DATE RANGE:** 7/1/2024-3/31/2025

**SERVICE AREA:**
- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**
- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number of Cases Completed PCI/PII | Number of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Father Flanagan's Boys' Home | 48 | 77 | 62.34% |
| Children & Families of Iowa | 10 | 14 | 71.43% |
| Southwest Iowa Family Access Center | 22 | 57 | 38.60% |
| **Western Service Area Total** | **80** | **148** | **54.05%** |
| **2 - Northern Service Area** | | | |
| Families First Counseling Services of Iowa | 32 | 41 | 78.05% |
| Mid-Iowa Family Therapy Clinic | 11 | 36 | 30.56% |
| **Northern Service Area Total** | **43** | **77** | **55.84%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 90 | 139 | 64.75% |
| Mid-Iowa Family Therapy Clinic | 5 | 10 | 50.00% |
| **Eastern Service Area Total** | **95** | **149** | **63.76%** |
| **4 - Cedar Rapids Service Area** | | | |
| Families First Counseling Services of Iowa | 30 | 42 | 71.43% |
| Four Oaks Family and Children's Services | 20 | 44 | 45.45% |
| **Cedar Rapids Service Area Total** | **50** | **86** | **58.14%** |
| **5 - Des Moines Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 25 | 65 | 38.46% |
| Children & Families of Iowa | 57 | 87 | 65.52% |
| **Des Moines Service Area Total** | **82** | **152** | **53.95%** |
| **Statewide Total** | **350** | **612** | **57.19%** |

Again, no contractors met the performance measure for this reporting period. Similar challenges were identified, with the added difficulty of HHS staff continuing to refer for a

single module. Reports of this occurring have decreased but still continue. Additionally, if families disengage while participating in one of the other two modules, families miss the opportunity to engage with this module. On a positive note, the statewide total improved from 55.65% the previous year.

HHS plans to meet with NSTRC leadership in spring 2025 to further discuss national trends in SafeCare and how these trends might impact Iowa's plans for ongoing SafeCare performance monitoring and expectations. The SafeCare evaluation data from NSTRC continues to indicate that, for the families who participate in SafeCare, there is a positive benefit to the family's long-term success. HHS expanded referral criteria for SafeCare in July 2024, expanding access to utilize SafeCare as a standalone service and to provide SafeCare for Non-Agency cases. HHS anticipates next year's data will provide a more accurate reflection of the success of this expansion.

Family Preservation Services with Child Safety Conferences: 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 support and skills needed to remain together safely or make informal arrangements for the child to stay with kin/fictive kin while the immediate safety issue is resolved, preventing out-of-home placement of children whenever possible. Services focus on assisting in crisis management, restoring the family to an acceptable level of functioning, and gaining 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 stranger foster care. FPS are available during a child abuse assessment, a CINA Assessment, and anytime during an open HHS service case. Delivery of FPS is in 10 calendar day units and a worker may not refer a family for more than three consecutive units of FPS. In the event that additional units are necessary, approval by the Social Work Administrator (SWA) is required.

HHS utilizes Child Safety Conferences (CSCs) during provision of FPS for children at risk of removal and placement in foster care. HHS invites parents to attend an initial 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 placement of the children occurs with kin or fictive kin caregivers rather than in a stranger foster care placement.

CSCs gather family members and their supports 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 the CSC direct the blend of FPS and supports provided to maintain children safely in the home or with kin/fictive kin caregivers. The focus is development of solutions that remove the risks placing children at imminent risk of removal.

There are two performance measures associated with 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 5k: Family Preservation Services – Performance Measure 1

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

## Family Preservation Services - Performance Measure 1

Children served by the Contractor during a CPS Child Abuse Assessment will **not** be removed from their homes and placed in foster care during provision of Family Preservation Services and for three months following the end date of this service.

**OVERVIEW:** Includes cases that have received Family Preservation Services and only includes cases that have a Service End Date entered that is within the selected date range. In order to meet this performance measure the child/children must remain in their home and not placed in Foster Care during the provision of Family Preservation services and for 90 days after the service has ended.

**Note:** For the purpose of this measure, it was decided that multiple Family Preservation Service cases within a 5 day gap of each other will be consolidated into a single service span using the start date of the first Family Preservation Service case and the Service End Date of the last Family Preservation Service case.

**GENERATED ON:** 4/20/2025 11:23:38 PM

**DATE RANGE:** 7/1/2024-12/31/2024

**SERVICE AREA:**
- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**
- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number Of Cases Not Removed And Placed In Foster Care | Number Of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Father Flanagan's Boys' Home | 22 | 27 | 81.48% |
| Southwest Iowa Family Access Center | 31 | 32 | 96.88% |
| **Western Service Area Total** | **53** | **59** | **89.83%** |
| **2 - Northern Service Area** | | | |
| Families First Counseling Services of Iowa | 35 | 38 | 92.11% |
| Mid-Iowa Family Therapy Clinic | 34 | 40 | 85.00% |
| **Northern Service Area Total** | **69** | **78** | **88.46%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 59 | 69 | 85.51% |
| Mid-Iowa Family Therapy Clinic | 5 | 6 | 83.33% |
| **Eastern Service Area Total** | **64** | **75** | **85.33%** |
| **4 - Cedar Rapids Service Area** | | | |
| Families First Counseling Services of Iowa | 29 | 32 | 90.63% |
| Four Oaks Family and Children's Services | 40 | 41 | 97.56% |
| **Cedar Rapids Service Area Total** | **69** | **73** | **94.52%** |
| **5 - Des Moines Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 17 | 20 | 85.00% |
| Children & Families of Iowa | 16 | 18 | 88.89% |
| **Des Moines Service Area Total** | **33** | **38** | **86.84%** |
| **Statewide Total** | **288** | **323** | **89.16%** |

Data indicates that, in nearly 90% of cases, children are able to remain in their home or with kin/fictive kin caregivers during FPS and for three months following the closure of the service. The lowest score was 81.5%, indicating that overall success of the service is quite high. HHS has not set a specific data marker for this measure, as the goal is for no child to require removal and placement into foster care. Providers continue to engage families in services and support activities that prevent foster care placement at a high level.

## Table 5l: Family Preservation Services – Performance Measure 2

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

### Family Preservation Services - Performance Measure 2

80% of Children served by the Contractor during the CPS Child Abuse Assessment will not suffer maltreatment during provision of Family Preservation Services and for three months following the end date of this service.

**OVERVIEW:** Includes cases that have received Family Preservation Services and only includes cases that have a Service End Date entered that is within the selected date range. In order to meet this performance measure 80% of the children will not suffer maltreatment during provision of Family Preservation Services and for 90 days after the service has ended.

**Note:** For the purpose of this measure, it was decided that multiple Family Preservation Service cases within a 5 day gap of each other will be consolidated into a single service span using the start date of the first Family Preservation Service case and

**GENERATED ON:** 4/20/2025 11:33:01 PM

**DATE RANGE:** 7/1/2024-12/31/2024

**SERVICE AREA:**
- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**
- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number Of Cases Did Not Suffer Maltreatment | Number Of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Father Flanagan's Boys' Home | 27 | 27 | 100.00% |
| Southwest Iowa Family Access Center | 30 | 33 | 90.91% |
| **Western Service Area Total** | **57** | **60** | **95.00%** |
| **2 - Northern Service Area** | | | |
| Families First Counseling Services of Iowa | 35 | 38 | 92.11% |
| Mid-Iowa Family Therapy Clinic | 34 | 47 | 72.34% |
| **Northern Service Area Total** | **69** | **85** | **81.18%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 64 | 80 | 80.00% |
| Mid-Iowa Family Therapy Clinic | 5 | 7 | 71.43% |
| **Eastern Service Area Total** | **69** | **87** | **79.31%** |
| **4 - Cedar Rapids Service Area** | | | |
| Families First Counseling Services of Iowa | 30 | 33 | 90.91% |
| Four Oaks Family and Children's Services | 36 | 44 | 81.82% |
| **Cedar Rapids Service Area Total** | **66** | **77** | **85.71%** |
| **5 - Des Moines Service Area** | | | |
| Mid-Iowa Family Therapy Clinic | 18 | 22 | 81.82% |
| Children & Families of Iowa | 16 | 19 | 84.21% |
| **Des Moines Service Area Total** | **34** | **41** | **82.93%** |
| **Statewide Total** | **295** | **350** | **84.29%** |

Statewide, contractors meet and exceed this performance measure. On average, nearly 85% of cases do not see incidents of further maltreatment during provision of FPS or for 3 months after service closure. The low number of cases for one contractor in the Eastern Service Area disproportionately impacts their percentage, as they were successful on this measure in 5 out of the 7 cases they served during the reporting period. It is possible that this data set is also impacted by how Iowa counts new incidents of maltreatment, as Iowa's data considers additional information gathered during the course of the assessment as re-abuse due to data analysis limitations.

Data regarding CSCs is hand tracked and reported via spreadsheets. While no specific data is available, informal reporting, including feedback elicited through various listening sessions with HHS, providers, families, Parent Partners, and the public, indicate that CSCs are highly effective and families have a clear understanding of the immediate safety concern and what steps they need to take to prevent removal of their children. Follow up CSCs, which bring the team back together to discuss progress and next steps, are highly effective tools for families to know that others see their successes and develop a "next steps" plan for ongoing safety.

Family Interactions: Ensuring children see their parents on a consistent basis while placed out of the home is a critical part of ensuring child well-being. Family Interactions provide a sense of normalcy for children in foster care. When ongoing safety concerns place children at higher risk, supervised Family Interactions provide safety while parents practice new skills and demonstrate the ability to provide appropriate care for their children.

When making a referral for Family Interactions, HHS staff must complete a Family Interaction Plan (FIP) detailing the circumstances that have led to the need for supervised family interactions, what the parent should be working on during family interactions, and what other opportunities parents and children have to engage with each other outside of supervised family interactions (e.g. attending medical appointments, school/sporting events, spending time with the child at extended family gatherings, etc.) The FIP also includes a description of the frequency and duration of supervised family interactions (family visit time).

FCS providers are a critical part of ensuring safety during interactions. Providers supervise up to 10 interactions per month or 20 hours of interaction per month, whichever comes first. Supervision can also be provided by natural supports. HHS and FCS continue to work on plans to expand supervision of family interactions by the family's supports, though ongoing work with legal partners is needed to ensure this can be successful.

No specific data is collected regarding Family Interactions. HHS is currently developing improved data collection which will allow for data reporting on the frequency of family interactions and whether providers are compliant with what is requested in the FIP and that children and parents have regular opportunities to spend time together.

Non-Agency Services: In addition to open HHS service cases, services are available to families at the conclusion of a CPS child abuse assessment or CPS family assessment when the case will not be referred for ongoing services. A Non-Agency case means no one in the household is involved with an HHS assigned social work case manager (SWCM). Case management and decision-making responsibility is with the FCS contractor, not HHS. Authorization for Non-Agency voluntary services is for a maximum of four months.

The outcome of the CPS child abuse assessment or CPS family assessment as well as the identified level of risk determines service eligibility. The completed standardized HHS family risk assessment identifies the level of risk. The family risk assessment examines factors known to be associated with the likelihood of abuse or neglect occurring at some point in the future. Identification of risks also assists in identifying the need for individualized services. Services strive to keep children safe, keep the family intact, and prevent the need for further or future intervention by HHS, including removal of the children from the home. As in Family Casework, contractors use Motivational Interviewing (MI) to support the family in identifying strengths, needs, and how they plan to improve their connections with community supports. The shift to using MI as the primary intervention occurred concurrently with Family Casework on July 1, 2024.

A family is eligible for Non-Agency voluntary services based on the following criteria:

- Outcome of the child abuse assessment when there is:
  - A confirmed but not placed report, moderate to high risk; or
  - A not confirmed report, moderate to high risk; or
- Outcome of the family assessment when there is:
  - Moderate to high risk; *and*
  - The family voluntarily agreed to the referral.

The following cases are not eligible for Non-Agency voluntary services:

- Any child in the household has an open HHS service case.
- Any child in the household adjudicated as a Child in Need of Assistance (CINA) or has a filed or pending CINA petition, or any child adjudicated delinquent/informal adjustment or involved with Juvenile Court Services (JCS).
- The abuse occurred outside of the home. (i.e., any abuse that occurs in an out-of-home setting which includes any alleged abuse that occurs while the child is under the supervision of any caretaker other than the child's parent or guardian or in a childcare setting).

In addition to the three reasons above for not referring to Non-Agency voluntary services, referrals may not occur for families who meet the eligibility requirements if any of the following exception reasons exist:

- Parent not willing to accept Non-Agency voluntary services;
- Family already engaged in Non-Agency voluntary services;
- Family does not need additional supports beyond current formal/informal systems; or
- Family resides out of state.

As a part of the current contract, there are two performance measures implemented to evaluate effectiveness of the services (these are identical to the performance measures for Family 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.

Note: These are the same performance measures as those on open HHS service cases.

The only measure currently available under Non-Agency Services is Performance Measure 2.

# Table 5m: Non-Agency Case – Family Casework – Performance Measure 2

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

## Family Casework - Performance Measure 2

Children served by the contractor are safely maintained in their own homes or with kin/fictive kin caregivers during the case. The target is to achieve 90% on all cases served to receive payment.

**OVERVIEW:** Includes cases that have received Family Casework (FMCW) and only includes cases that have a Service End Date entered that is within the selected date range. In order to meet this performance measure the child/children must be safely maintained in their own home or with kin/fictive kin caregivers during the entire span of the case. 'Safely maintained' means the child was not removed from their home or from a kin/fictive kin placement and placed in a disqualifying licensed foster care or other out of home placement during the case.

In the event that there are multiple children in the case, the case is assigned to the youngest child victim in FACS, so if there is an identified child in the home under the age of 18, the case would be included in the measure calculation.

**GENERATED ON:** 4/21/2025 12:59:08 AM

**DATE RANGE:** 7/1/2024-3/31/2025

**CASEWORK TYPE:** Non-Agency Only

**SERVICE AREA:**

- 1 - Western
- 2 - Northern
- 3 - Eastern
- 4 - Cedar Rapids
- 5 - Des Moines

**PROVIDER AGENCY (CONTRACTOR):**

- Four Oaks Family and Children's Services | 2957005
- Children & Families of Iowa | 2977008
- Father Flanagan's Boys' Home | 2978009
- Families First Counseling Services of Iowa | 2907021
- Southwest Iowa Family Access Center | 2978043
- Mid-Iowa Family Therapy Clinic | 2908001

| | Number of Cases Referred to FMCW | Number Of Eligible Cases | Performance Measure % |
|---|---|---|---|
| **1 - Western Service Area** | | | |
| Southwest Iowa Family Access Center | 101 | 101 | 100.00% |
| Children & Families of Iowa | 8 | 8 | 100.00% |
| Father Flanagan's Boys' Home | 100 | 100 | 100.00% |
| **Western Service Area Total** | **209** | **209** | **100.00%** |
| **2 - Northern Service Area** | | | |
| Families First Counseling Services of Iowa | 68 | 68 | 100.00% |
| Mid-Iowa Family Therapy Clinic | 67 | 67 | 100.00% |
| **Northern Service Area Total** | **135** | **135** | **100.00%** |
| **3 - Eastern Service Area** | | | |
| Families First Counseling Services of Iowa | 95 | 94 | 98.95% |
| Mid-Iowa Family Therapy Clinic | 4 | 4 | 100.00% |
| **Eastern Service Area Total** | **99** | **98** | **98.99%** |
| **4 - Cedar Rapids Service Area** | | | |
| Four Oaks Family and Children's Services | 63 | 63 | 100.00% |
| Families First Counseling Services of Iowa | 65 | 65 | 100.00% |
| **Cedar Rapids Service Area Total** | **128** | **128** | **100.00%** |
| **5 - Des Moines Service Area** | | | |
| Children & Families of Iowa | 95 | 95 | 100.00% |
| Mid-Iowa Family Therapy Clinic | 84 | 84 | 100.00% |
| **Des Moines Service Area Total** | **179** | **179** | **100.00%** |
| **Statewide Total** | **750** | **749** | **99.87%** |

Contractors are highly successful in this measure. Generally, families involved in Non-Agency Services do not experience removal from the home during the case. As there is no direct HHS involvement during Non-Agency Services, removal from the home occurs if a new report of suspected abuse was reported and the ensuing investigation indicates the children are unsafe. That this does not happen is a strong indicator of the effectiveness of Non-Agency Services.

It is noteworthy that case numbers for Non-Agency Services are small in some areas. This may result from geographic coverage area differences between contractors or from families electing not to participate in Non-Agency Services after initially agreeing to the referral.

**Collaboration:** During the reporting period, the HHS FCS program manager and the current FCS contractors met monthly to discuss progress in service implementation, barriers to progress, and collaborate on solutions to challenges. Over the past year, this included transitioning to Motivational Interviewing (MI) as the primary evidence-based intervention utilized within FCS.

Providers worked with HHS and one another to develop a consistent method of implementation, training and development, fidelity monitoring, and continuous quality improvement. While researching methods of training and fidelity monitoring, the CWPTA identified the Lyssn platform as the primary method of training, fidelity monitoring, and continuous quality improvement. The Lyssn platform can also be used with HHS staff. The CWPTA currently holds the contract with Lyssn for training seats for both FCS providers and HHS staff. Lyssn's data is broken down by contractor so that each agency is aware of their staff's performance and areas of ongoing need.

In addition to monthly meetings between the FCS program manager and FCS contractors, each contractor participates in regular meetings with the leadership of their Service Area to discuss needs specific to the counties they jointly serve. The FCS program manager routinely attends these meetings in most service areas and attends when requested in others. These meetings provide additional insight into particular activities that are working and may be considered for statewide rollout and insight into unique challenges of each Service Area that need specific solutions.

Each Service Area holds at least quarterly meetings with contractors across CPS to discuss HHS and contractor needs and provide additional opportunities to understand what is happening in other parts of CPS. The FCS program manager attends these meetings throughout the year to share information about FCS with contractors in other parts of CPS and to learn about opportunities for deeper collaboration.

Regular email correspondence between the FCS program manager and the contract specialists who oversee day-to-day contract management ensures timely payments to contractors, consistent messaging when questions arise and builds trust with the contractors who interact with their contract specialists on a more frequent basis.

Incidence of Brain Injuries in parents involved with CPS: Over the past year and a half, the FCS program manager worked with the Brain Injury Grant Manager in the Division of Public Health at HHS on several projects surrounding the intersectionality of child welfare involvement and parental brain injuries. The Brain Injury Grant Manager worked with the Eastern Service Area, the Brain Injury Alliance of Iowa, the Consortium for Substance Abuse Research and Evaluation, the Traumatic Brain Injury State Partnership Program, and the University of Iowa to develop a pilot project in which CPWs complete a high-level screening for potential lifetime history of brain injury during assessments. If parents screen positive for potential lifetime history of brain injury, the CPW talks with the parents about a referral for a more in-depth screening through the Brain Injury Alliance of Iowa and possible NeuroResource facilitation. The NeuroResource facilitator coordinates with the parents to provide individualized planning and skill building with reasonable accommodations to support the parent's needs. The NeuroResource facilitator and FCS provider coordinate to ensure that case planning and service planning includes accommodations for the parents to set them up for success.

While the number of screenings was lower than expected, each parent screened has screened positive for a lifetime history of brain injury. Not all parents screened positive for a lifetime history of brain injury accepted NeuroResource facilitation. Of those who have, reports from HHS and FCS field staff indicate a positive impact to working with families. The NeuroResource facilitators are especially helpful when attending Family Focused Meetings, as they are able to provide insight into needed accommodations that will aid the parents in meeting case plan goals. Limited data is available as the pilot began in July 2024. The report from the University of Iowa below provides the most up-to-date information (February 2025).


NeuroResource Child Welfare Collaborative

In addition to working with the Brain Injury Grant Manager on this pilot, the FCS program manager also participates in the National Association of State Head Injury Administrators (NASHIA) Leading Practices Academy as part of a team which includes the Brain Injury Grant Manager, the Brain Injury Alliance of Iowa, the director of Iowa ACES 360, the training coordinator from the CWPTA, the researchers from the University of Iowa, and HHS leadership. The focus of Iowa's team is raising brain injury awareness among child welfare staff with the goal of improved case planning that provides accommodations to parents who experienced a brain injury. The team is working to develop a plan for Iowa's CPS system, including FCS providers, to be brain injury informed such that all parents who experienced a brain injury in their lifetime are offered supports and accommodations that aid in keeping children safe and in their own homes. Ongoing work will occur in SFY 2026 to continue developing a training plan.

**Planned Activities for SFY 2026:** In SFY 2026, HHS will be completing the RFP process for the next contract cycle of FCS. HHS anticipates the RFP will be released in late summer for bidders to review and submit bids. Once HHS identifies successful bidders, contract negotiations will be completed with the goal of the next contract cycle beginning July 1, 2027.

Multiple challenges with consistent provision of Family Interactions were identified over the last several years. HHS and FCS providers began working together to evaluate potential options for reworking Family Interactions with an eye on improving consistency. Iowa continues to value children and parents spending quality time together during periods of separation to reduce harm to the children and family. The vision of a reworked program is for families to have as much time together as possible while also targeting the challenges a family faces so that problem areas are addressed and the length of time children are in out-of-home care is reduced.

The FCS program manager and Brain Injury Grant Manager will continue to work with our partners and NASHIA on building a sustainable plan for infusing brain injury awareness into the child welfare system with the goal of becoming a brain injury informed system that responds to the unique needs of individuals who experienced brain injury. HHS anticipates this work will support FCS staff in developing their skills around individualized case planning that meets the unique needs of each family who comes into the child welfare system, whether or not a member of the family experienced a brain injury.

### Fatherhood Services

**Caring Dads™:** Caring Dads™ is a voluntary program for fathers to develop healthy coping, life, and parenting skills. The program targets fathers currently involved in the child welfare system due to child physical/emotional abuse, neglect, or child exposure to domestic violence. The curriculum addresses awareness of controlling behaviors, abuse, and neglectful attitudes. Participants receive ways to strengthen their father-child relationships, while maintaining a child-centered approach. Caring Dads™ is a unique opportunity for men to connect as fathers. This interactive learning environment is a combination of active group discussions, exercises, and homework.

Caring Dads™ is a weekly two-hour session for 17 weeks. There are collaboration opportunities between HHS and Children and Families of Iowa (CFI). These efforts include CFI's Fatherhood Coordinator presents to HHS about the Caring Dads program to further communication and build relationships. The State Parent Partner Director discusses the program at HHS new worker 020 and 200 training, for ongoing case workers and child protection workers, on a quarterly basis. 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 must have a minimum of 10 referred participants, with a maximum capacity of 12-15 attending the cohort. CFI

holds three groups each fiscal year, two in the Des Moines Service Area (DSMA) and one in the Northern Service Area.

In SFY 2025, there were a total of 51 dads referred to group, with 20 of them starting a group. To date, one cohort completed in its entirety in the DMSA. Eight dads completed successfully and received a certification of completion. Each group has at least one trained facilitator and/or one licensed independent social worker (LISW).

Data is collected on any dad who agrees to participate in group. Prior to the start date each dad signs a confidentiality agreement, completes a pre-test and fills out an extensive demographic questionnaire. Those who successfully complete the 17-week cohort then fill out a post-test. With the information collected, CFI can look at whether there was an improvement in attitude, parenting style or relationships. This information is collected and based on information taught and discussed during the cohort sessions.

CFI collected a small sample of pre/post-test as it was from the DMSA cohort that completed in the fall. In most of the questions, the dads improved their score by one point from the pretest to the post-test. This result indicates that the perception of fathering changed over the 17 weeks. Many of the responses showed a positive increase related to the mother of the child(ren) and the ability to co-parent and/or the father's attitude towards mom's parenting ability. HHS will receive a full evaluation in the August 15, 2025, annual report.

By the end of the 17 weeks, most fathers want to continue with the group as it became their therapeutic weekly support group. They rely on their peer support. At the conclusion of the group, the fathers receive encouragement to reach out to one another for support, if appropriate. The greatest incentive is the improved relationships with all involved in the case and within their respective family systems. An unforeseen positive outcome includes dads who successfully complete group and move into mentoring spaces for other dads. Some graduates became Parent Partners, completed 24/7 Dads' group or Dads with a Purpose, and became peer facilitators of Caring Dads.

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

### Parent Support

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

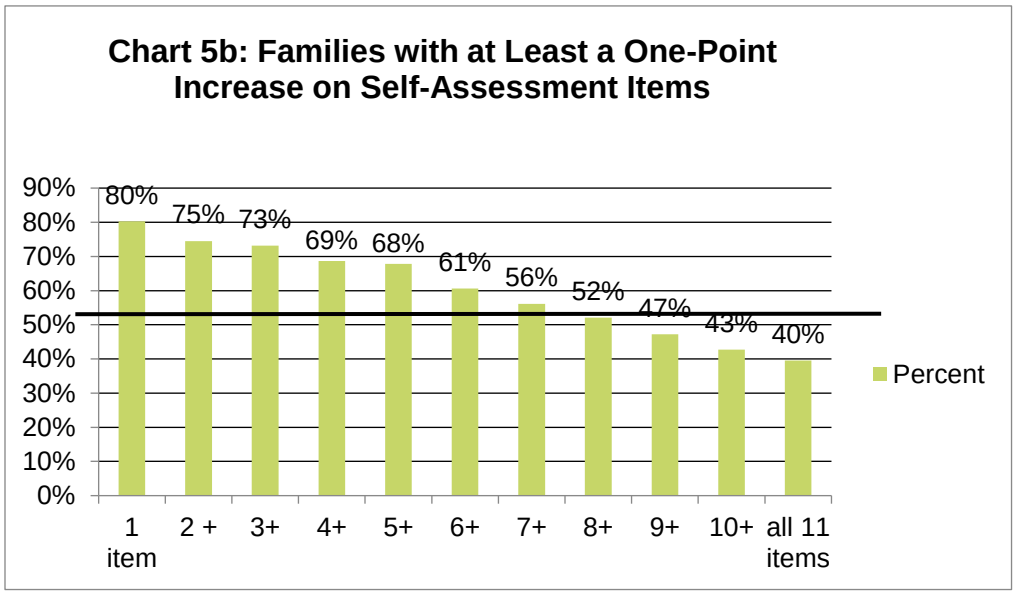
Parent Partners share experiences and offer recommendations through a variety of opportunities such as foster/adoptive parent training; HHS child protection services training for new and ongoing case managers; local and statewide planning/steering committees and conferences; and Community Partnerships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

Parent Partners are available in all 99 counties. Children and Families of Iowa (CFI), manages the statewide Parent Partner Program through a contract with HHS. In SFY 2025, there are currently fifteen local coordinators, five service area coordinators, three parent partner specialists, one parent voice coordinator, one operational coordinator, one quality assurance specialist, and a state director who are employed by CFI for the statewide Parent Partner Program. Currently, there are six Lead Parent Partners, 86 Parent Partners, and 28 new Parent Partners in training status across the state.

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. Parent Partner Program staff enter the outcome data into the web-based Parent Partner database.

**UN-L Bi-Annual Iowa Parent Partner Database Data Report:** The following information reflects analysis from the Parent Partner Database bi-annual report for the first half of SFY 2025, July – December 2024, and can be referenced in the charts below.

Percentage of Families with At Least 1-point Increase from Retro to Exit on At Least Three Measures: Two-hundred-twenty-three (223) parents fully completed both an exit self-assessment and a retrospective self-assessment between July 1st, 2024 and December 31st, 2024. 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 measures/items. About 73% of parents with complete data met this performance measure during this reporting period. The pattern of results was similar to recent annual reports in the number of self-assessment items with at least a one-point increase from retro to exit, when compared to previous reporting periods.




Data Source: UN-L Iowa Parent Partner Online Database Data Summary July 1- December 2024 Report

Family Feedback: Fidelity Checklist and Family Outcomes: Parent Partners entered data for 226 Family Feedback forms for families exiting the Parent Partner program between July 1st, 2024 and December 31st, 2024. Parents with missing data or who responded "I don't know" were excluded from the following analyses. Average scores were largely comparable to the previous fiscal year, and the overall pattern of results remained consistent when compared with the prior fiscal year. These results indicate families report a similar level of improvement in their outcomes and parent partner fidelity as they did during the previous annual reporting period

Parent Partner: Fidelity Checklist and Family Outcomes: Parent Partners completed 362 fidelity checklists between July 1st, 2024, and December 31st, 2024. If the Parent Partner did not respond or responded, "I don't know," the data was excluded in the analyses. In total there were 339 Fidelity Checklists completed in their entirety. The majority of parent partners indicated they often or always completed activities listed in the fidelity checklist with their parents.

Parent Partners completed a total of 396 Parent Partner: Family Outcome surveys. The number of respondents for each statement ranged from 288 to 350, but only 277 had responses for every item. In general, parent partners rated similar levels of improvements across family outcomes. The pattern of ratings for family outcomes were similar to the previous fiscal year's report.

Family Feedback and Parent Partner Comparisons: Pairwise comparisons occurred to compare parents' responses on the fidelity checklist and family outcomes measures to Parent Partners' responses. Only parents with responses for both the family feedback and the fidelity checklist were included in the following analyses. Differences in reports of fidelity behaviors this reporting period generally followed the trend of parents

reporting more fidelity behaviors than Parent Partners. The difference in scores was statistically significant for eight of the ten items, as well as for the difference in total scores. Scores that are not significantly different indicate a higher level of agreement between Parent Partners and parents scoring.

| Table 5n: Fidelity Checklist | | | | |
|---|---|---|---|---|
| **Statement**<br>**Rated on a scale of 1 (*never*) to 5 (*always*)** | | **Parent Partner Average** | **Participant Average** | **Number of responses** |
| 1 | Encouraged the participant to fulfill case plan activities. | 4.8 | 4.8 | 214 |
| 2* | Regular face to face visits. | 4.5 | 4.6 | 214 |
| 3* | Other communication and contact. | 4.4 | 4.7 | 214 |
| 4* | Advocated for needed resources. | 4.5 | 4.7 | 212 |
| 5* | Encouraged the participant. | 4.8 | 4.9 | 214 |
| 6* | Connected with community resources. | 4.3 | 4.5 | 207 |
| 7* | Helped connect with the community. | 4.1 | 4.5 | 206 |
| 8* | Coached on communication strategies. | 4.4 | 4.5 | 210 |
| 9* | Supported at FTM, court, treatment, and other gatherings. | 4.3 | 4.6 | 206 |
| 10 | Coached on what to expect throughout this process. | 4.7 | 4.8 | 213 |
| | Total * (out of a possible score of 50) | 44.5 | 46.5 | 196 |

Source: UN-L Iowa Parent Partner Online Database Data Summary Report July 1-December 2024

Parents reported greater improvement than Parent Partners on eleven of the eleven family outcome measures. The difference in ratings was statistically significant for nine of the eleven items. Items with an asterisk in the table below identify statistically significant differences between participant and Parent Partner ratings. The difference in total scores was also statistically significant. The overall pattern of results is consistent with the results reported in the previous report.

| Table 5o: Family Outcomes: Level of Improvement | | | | |
|---|---|---|---|---|
| **Statement**<br>**Rated on a scale of 1 (*decreased*) to 4 (*significant improvement*)** | | **Parent Partner Average** | **Participant Average** | **Number of responses** |
| 1 | Relationship with people who are able to connect with resources. | 3 | 3.2 | 206 |
| 2* | Relationship with people who support positive changes. | 3 | 3.3 | 207 |
| 3* | Level of communication with DHS worker. | 3 | 3.1 | 201 |
| 4* | Level of communication with attorney(s). | 2.9 | 3.1 | 164 |
| 5* | Ability to advocate appropriately. | 3.3 | 3.4 | 208 |
| 6* | Knowledge of what needs to be done for custody of children. | 3.1 | 3.4 | 207 |
| 7* | Ability to get to appointments on time. | 2.9 | 3.2 | 203 |
| 8* | Ability to find community resources. | 3 | 3.3 | 205 |
| 9 | Knowledge of who to contact with needs or concerns regarding the case. | 3.1 | 3.3 | 208 |
| 10* | Level of personal responsibility and accountability. | 3 | 3.4 | 210 |
| 11* | Willingness to make changes. | 3 | 3.4 | 209 |
| | Total* (out of a possible score of 44) | 33.3 | 36.3 | 156 |

Source: UN-L Iowa Parent Partner Online Database Data Summary Report July 1- December 2024

Relationship between Fidelity Checklist and Family Outcomes: For each parent, the Parent Partner completed a Fidelity Checklist and a Family Outcomes measure. The parent also completed a Fidelity Checklist and a Family Outcomes measure. There are six correlations to examine:

| Table 5p: Fidelity Checklist and Family Outcomes Correlations | | |
|---|---|---|
| **Measure 1** | **Measure 2** | **What the relationship tells us** |
| Parent Partner report of Fidelity Checklist | Parent Partner report of Family Outcomes | Whether Parent Partners' reports of fidelity to the model relate to Parent Partners' reports of improvement on the family outcomes |
| | | |
| | Parent report of Fidelity Checklist | Whether Parent Partners and parents agree on fidelity to the model |
| | Parent report of Family Outcomes | How Parent Partners' reports of fidelity to the model relate to parents' reports of improvement on the family outcomes |
| Parent Partner report of Family Outcomes | Parent report of Fidelity Checklist | How Parent Partners' reports of improvement on family outcomes relate to parents' reports of fidelity to the model |
| | Parent report of Family Outcomes | Whether Parent Partners and parents agree on parents' improvement on family outcomes |
| Parent report of Fidelity Checklist | Parent report of Family Outcomes | How parents' reports of fidelity to the model relate to parent's reports of improvement on the family outcomes |

Source: UN-L Iowa Parent Partner Online Database Data Summary Report July 1 – December 2024.

The highlighted box above (relationship between Parent Partners' reports of family outcomes and parents' reports of fidelity) provides the most important information. The strength of this relationship provides an indication of how closely parent's views of the treatment they received relate to their Parent Partner's assessment of the family's improvement. The table below includes the relationships between each measure. Values with an asterisk (*) are statistically significant.

| Table 5q: Relationships Between Each Measure | | |
|---|---|---|
| **Measure 1** | **Measure 2** | **Correlation** |
| Parent Partner report of Fidelity Checklist | Parent Partner report of Family Outcomes | +.28* |
| | Parent report of Fidelity Checklist | +.47* |
| | Parent report of Family Outcomes | +.17* |
| Parent Partner report of Family Outcomes | Parent report of Fidelity Checklist | +0.08 |
| | Parent report of Family Outcomes | +.17* |

| Table 5q: Relationships Between Each Measure | | |
|---|---|---|
| **Measure 1** | **Measure 2** | **Correlation** |
| Parent report of Fidelity Checklist | Parent report of Family Outcomes | +.343* |

Source: UN-L Iowa Parent Partner Online Database Data Summary Report July 1 – December 2024.

From this table, we found that:

- With higher Parent Partner perceptions of fidelity to the Parent Partner model, there are improved family outcomes as reported by the Parent Partners.
- Parent Partners and parents strongly agree in their perceptions of fidelity to the model.
- Parent Partner report of fidelity was significantly related to family report of outcomes, but family report of fidelity was not significantly related to Parent Partner report on family outcomes. However, this finding should be interpreted with caution given the smaller response rate. The annual report will provide a better indicator for the relationship between these two measures.
- Parent Partners and parents' perceptions of family outcomes are highly correlated.
- Overall, the correlation analysis shows that Parent Partners and parents provide similar reports of both family outcomes and Parent Partner fidelity.

Number of parents served in the Parent Partner Program: In SFY 2024, HHS staff made a total of 2,109 referrals to the Parent Partner Program during the fiscal year. The number of referrals increased from last year by nine referrals statewide. The Parent Partner Program provided mentoring support to 1,229 parents throughout Iowa during this fiscal year. This was an increase from SFY 2023 to SFY 2024 of 189 supported participants.

In SFY 2025, 508 individuals continued to be mentored going into the fiscal year, with 174 program intakes for Quarter 1, 181 program intakes for Quarter 2, and 213 program intakes for Quarter 3. The combined total of parents supported at the end of the third quarter is 1,080, serving 77% of the overall population for the year as required in the Parent Partner Program contract. Intakes into the program include both in-home prevention cases (child and parent remain intact), and out of home cases (child has been placed out of home).

**In-Home Prevention/Child Safety Conferences:** The Parent Partner Program is one of the engagement strategies to support families during the Child Safety Conference (CSC) process and through the journey of the child welfare process. CSCs are a key component of Iowa's implementation of Family First and provide a conference facilitated opportunity for parents of children at imminent risk of removal and placement in foster care. Parent Partner support at the CSC focuses on families who are at risk for abuse if appropriate supports and/or resources are not provided and will participate in a CSC as

a result of participation in Family Preservation Services (FPS). These families will potentially remain intact through the CSC process with appropriate resources and the ongoing support of a Parent Partner.

On July 1st, 2024, the Parent Partner Program added five Parent Partner Specialist positions to enhance the provision of timely support to parents at CSCs through FPS referrals in areas identified to have higher number of referrals. The Parent Partner Program engages with the referred parent to set up a meeting as quickly as possible. During this initial meeting, the Parent Partner, or the Parent Partner Specialist, share their role and about the Parent Partner Program. If the parent agrees to receive mentoring support, the Parent Partner or Specialist assigned to the parent will help the parent prepare for the CSC. The goal of timely engagement is to make contact quickly, engage parents within a few hours of referral to support the parent to prepare for the CSC, and to help connect the parent to community resources if needed.

**In-Home Prevention Support Evaluation:** HHS is 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 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 participate 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 choose to decline Parent Partner program support. The evaluation will draw 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 increased, the ability to pull an appropriate sample size for evaluation got closer. In SFY 2025, UN-L began data analysis for this evaluation.

HHS explored with UN-L additional fidelity measures of Parent Partner support for parents whose children remain at home in preventing subsequent removal. This included a 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. However, new fidelity measures will likely not be implemented for in home prevention support until completion of the evaluation to determine outcomes of the Parent Partner Program as a prevention measure to subsequent of out of home removal.

**Collaboration and Community Outreach:** Parent Partners collaborate with HHS CPS staff to promote parent engagement though the life of a child protection case. Parent

Partners also engage with the community to increase awareness regarding the protection of children, work with community-based organizations to provide resources, and strive to develop community partnerships. Parent Partners participate in a variety of local and state committees geared to policy and practice changes in child protection directed at improving the well-being of families. Parent Partners collaborate with the judicial/juvenile justice system, community providers focused on domestic violence, mental health and substance use providers, community organizations providing resources to meet concrete needs such as food assistance, transportation, childcare, and housing stability, and inclusion courts such as Family Treatment Court and Safe Babies Court. In these spaces, Parent Partners bring lived expertise through their own experiences, in addition to the voices of parents with whom they provide mentoring support.

In SFY 2025, the Parent Partner Program participated in several community outreach opportunities. Parent Partners attend committee meetings related to child welfare, community meetings/events attended by parent partners, and provide program awareness presentations. Examples of activities include a meet-n-greet with Meskwaki Family Services, meeting with a family court judge, and program presentations at unit meetings for HHS.

The Parent Partner Program continues to partner with Four Oaks for Parent Partners to co-train with Four Oaks' NTDC pre-service training for prospective foster and adoptive parents. Parent Partners in the Cedar Rapids Service Area and the Des Moines Service Area increased the number of trainings they are co-training throughout the year. In February, the Parent Partner Coordinators had a second cross-training opportunity with the staff from Iowa Children's Justice. The training focused on better ways to engage parents and empower those with lived experience.

Throughout SFY 2025, the Parent Partner Program continued to attend new SW 020 training and new CPW 200 training on a quarterly basis. This allows workers to have exposure to the Parent Partner Program, to understand how to make referrals and the importance of family engagement. These learning opportunities are invaluable as Parent Partners share their experience, hope, and inspiration with front line state staff workers.

The annual Parent Partner Summit is an opportunity for Parent Partners, program staff, HHS, community partners, and guests from out of state agencies implementing Parent Partner programs to come together for learning, networking and to celebrate the successes of the program. The summit also recognizes the Parent Partners and their years of service to the Parent Partner Program. The planning committee for the summit consists of several Parent Partners from across the state and coordinated by the Parent Partner Program Quality Assurance Specialist. The theme of the 2024 summit focused on building a better self, instilling confidence, and being an example of courage and hope to parents supported in the program. Participants attended sessions on stigma

and mental health, supporting recovery and responding to addiction, maintaining self-care while supporting others, and dynamics of domestic violence and supporting survivors of trauma. The next Parent Partner Summit will be held June 23-24, 2025.

**Parent Partners Policy and Practice Committee:** The Parent Partners' Policy and Practice Recommendation Team, implemented in SFY 2019, incorporates 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 comprises Parent Partners with representatives from each of the service areas and meets quarterly to discuss and compile recommendations. HHS Child Protection Services (CPS) leadership also attends these meetings to dialogue with the committee and share system changes and updates. Annually, the Team submits formal recommendations for child protection policy and practice changes to the HHS program manager.

In SFY 2025, the Policy and Practice Committee submitted the following recommendations to Family Well-Being and Protection (FWBP) Leadership to consider:

- HHS increase monthly visits for fathers who are involved in child welfare.
    - The purpose of this recommendation is to increase father engagement and increase percentage of monthly caseworker contacts with fathers of children who are involved in a child welfare case.
- HHS enhance consistent communication with families.
    - Parent Partners often learn of inconsistencies in frequency and level of communication to the parents they support. The committee recommends expectations of clear and consistent communication to parents, including ample support to parents to meet case plan goals. The committee further recommended HHS CPS staff complete Motivational Interviewing training and demonstrate competency in this area. In response to this recommendation, FWBP leadership provided information on the Safe Kids portfolios, which includes effective communication, and a well-trained workforce as identified projects.
- HHS move forward the "no wrong door policy" by providing prevention parent education, mental health support, economic assistance, and access to quality childcare.
    - The committee learned from a presentation by the Division Director of Early Intervention and Support (EIS) around the goal to implement a "warm line" for families who need additional support but do not reach the level of assessment or intervention from child protections services. The committee further recommends implementation of an online resource platform to help further assist identified needs of families in communities.

Additionally, the committee recommends prevention programs and community-based resources be available specific to fathers.

- EIS Division reached out to the Parent Partner Program and Children and Families of Iowa through the 24/7 Dads program in late 2024 to explore opportunities to engage fathers in listening sessions who experienced the child welfare system, through community-based services and supports, and from fathers seeking opportunities for community connection with other dads. Listening sessions will focus on learning more about what fathers want for connections and support in their communities, as well as how HHS can better support fathers through programs and services available.
- Parent Partners receive a checklist for file review audits to ensure standard of practice occurred during the life of the case.
    - The committee recommended opportunity for Parent Partners to anonymously review cases and provide feedback to HHS relative to the case. This feedback would include strengths as well as better ways to engage families. FWBP leadership considered this recommendation, however there were some concerns about how this could be arranged logistically, considering time commitment of CFSR case reviews, and de-identification of cases for review.

As mentioned above, additional response to the Parent Partner Policy and Practice Committee recommendations included FWBP Division Director presentation to the committee on the Safe Kids portfolio, and the addition of Parent Partners to the Safe Kids Advisory Panel. The Parent Partner representatives on the panel provided updates on the progress of the Safe Kids initiative to the Committee at quarterly meetings. The next upcoming quarterly committee meeting will focus on presentation and discussion with the Family Centered Services program manager at HHS on the contract expectations for Family Centered Services providers, with a specific focus on contractor expectations around family interactions. The committee will focus the remainder of their time in SFY 2025 selecting their top three recommendations to FWBP leadership for submission in July.

**BABF trainings:** The Building a Better Future (BABF) training is a key component of the Iowa Parent Partner Model, bringing new Parent Partners, HHS staff, and other key partners from the community together. The BABF three-day training focuses on learning more about the Parent Partner Program and the child welfare system, hearing from parent and social worker perspectives and their experiences with the child welfare system, and provides opportunity for building empathy, trust and hope to develop meaningful partnerships to better support families. The Parent Partner Program contract requires seven BABF Trainings annually. In SFY 2025, 7 BABF trainings occurred across the state, and three additional trainings scheduled between April and June 2025.

The increased number of trainings are a result of additional statewide recruitment and the need for additional Parent Partners.

All current approved trainers and master trainers received an updated BABF facilitator curriculum in SFY 2024. In SFY 2025, there is one new HHS worker and two new Parent Partners who started the training process to become approved trainers.

**Success/Opportunities for growth:** The current Parent Partner Program contract will expire on June 30, 2025. A notice of intent to award was issued to Children and Families of Iowa, who holds the current contract, to begin July 1, 2025, for statewide management of the Parent Partner Program.

The Parent Partner Program continues growth on a local, state, and national level. There is continued increase in requests for Parent Partners involvement in local and state level committees, workgroups, and focus groups to lift parent voice. The addition of the Parent Partner Specialist position provides opportunity to employ Parent Partners and the dedicated positions provides opportunity for immediate support to parents referred for Family Preservations Services and to help support the parent to address safety concerns that may help prevent out of home removal of their child.

On a national level, the Parent Partner State Director began work with the Casey Family Programming and Children's Trust Alliance to host the Parent Partner Learning Collaborative. This group meets with several sites across the nation to encourage conversations about peer mentoring programs. Also on a national level, the Parent Partner Program is working to either implement or provide support for the following states regarding the Iowa Parent Partner model: Louisiana, Ohio, Oklahoma, Florida, South Carolina, and Arkansas. From an international level, an organization from Australia has also reached out to Iowa to discuss potential implementation of the Iowa Parent Partner Model.

**SFY 2025 Progress on CFSP Goals:** The Parent Partner Program has set a standard in Iowa and on the national stage for successful implementation of a statewide peer mentoring program to support parents involved in the child protection system. Parent Partners are available in all 99 counties in Iowa to provide mentoring support to parents. Fully trained Parent Partners can mentor a range of 5-15 parents, depending on their availability and experience with mentoring. As the Parent Partner Program is both a career development opportunity and a steppingstone for parents as they enter or re-enter the workforce, Parent Partners often move on from the program to new career opportunities, secondary education, or due to other life changes.

The Parent Partner Program must then continuously partner with HHS to engage with new prospective Parent Partners who experienced successful case closure to maintain capacity to match parents with Parent Partners across the state to provide mentoring supports. The following is a summary of progress for SFY 2025 program goals:

**Goal 1: Referrals to the program will be consistent statewide for parents who meet criteria to receive Parent Partner support.**

**Objective:** Parents will be consistently referred to the Parent Partner Program early in their child protection case for support and mentoring by a Parent Partner. This includes at the time of removal and during family preservation services through the Child Safety Conference.

In SFY 2025, the Parent Partner Program continues to partner with HHS through various avenues to ensure that referrals to the program are consistent across the state. As the HHS workforce changes, the Parent Partner Program continues to provide ongoing communication and guidance via new worker training, meeting participation, email, and other methods with HHS CPS staff regarding the process for referral of a parent to the Parent Partner Program. This includes referral to the program for the Parent Partner to participate in a Child Safety Conference.

Parent Partner Program staff enhanced efforts this year to increase effective communication with HHS referring staff to the program to ensure closed loop referrals with HHS on intake status and parent engagement into the program, as well as to ensure communication around case closure. The program increased email communication with the referring HHS worker to provide status updates on referrals, by attending HHS unit meetings to promote clear bi-directional communication between HHS and local coordinators of the program, and by troubleshooting challenges with HHS Service Area leaders in steering committee meetings. CFI also created centralized email addresses for all referrals to the Parent Partner Program in each service area to help alleviate confusion in lieu of emailing individual Parent Partner Coordinators directly to make a referral to the program.

Referrals to the Parent Partner Program by type of support are reported in the tables below. Referrals listed include both types of supports (in-home referral through referral of Family Preservation Services and scheduling a CSC, and out of home support referral after a removal occurred) for the period of July 1 - December 2024.

**Table 5r: New Referrals by Service Area: July 1st, 2024 – December 31st, 2024**

| Service Area | New In-Home Referrals | New Out-of-Home Referrals | Total Referrals |
|---|---|---|---|
| Des Moines | 16 | 51 | 67 |
| Cedar Rapids | 49 | 132 | 181 |
| Western | 30 | 79 | 304 |
| Northern | 23 | 77 | 100 |
| Eastern | 81 | 105 | 186 |
| **Statewide** | **199** | **444** | **643** |

Source: UN-L Iowa Parent Partner Online Database Data Summary July 1 - December 2024 Report

**Goal 2: Increase timely peer support to parents referred to the Parent Partner Program.**

**Objective 1:** In partnership with HHS, the Parent Partner Program will increase the number of available Parent Partners to provide timely support to parents and decrease waitlist times.

In SFY 2025, the Parent Partner Program continues to provide education on the Parent Partner Program to new HHS child protection staff through new worker training, in addition to marketing the program to HHS local teams through attending unit meetings, organizing meet and greets, and maintaining ongoing communication between the program and local HHS staff. HHS case managers and supervisors participate in Parent Partner service area steering committees, the statewide advisory committee, and attend the annual Parent Partner Summitt. New child protection workers and social worker case managers also attend Building a Better Future (BABF) Training, a three-day experiential training for new Parent Partners and child protection staff to learn more about each other's experiences and roles in the child welfare system.

The Parent Partner Program also continues to partner with HHS to engage with parents at successful case closure to consider becoming a Parent Partner. HHS staff can help support recruitment efforts by talking with parents about this opportunity prior to case closure, particularly with parents who received Parent Partner support during their case. The Parent Partner Program also continues to educate HHS staff on recruitment needs for the program through the previously mentioned spaces that HHS and Parent Partners participate.

The Parent Partner Program added the Parent Partner Specialist position to the program in SFY 2025. Parent Partner Specialists have personal experience of involvement in the child welfare system and previously served as a Parent Partner. The Parent Partner Specialists assist with strengthening capacity to provide Parent Partner support at Child Safety Conferences (CSCs). CSCs are offered during Family Preservation Services and frequently occur in a short turnaround time. Parent Partner Specialists fill gaps to ensure parents have support at the CSC and engaged to continue to have peer support during the life of the case. The Parent Partner Specialist role also provides an avenue for existing Parent Partners to move into staff positions, while continuing to utilize their experience and an ability to provide support to parents in the program. The role further provides training and insight about being a Parent Partner to new mentors through providing additional training and shadowing opportunities. To date, a total of three Parent Partner Specialist positions have been filled, with the goal to hire a total of five Specialists by the end of the year.

Of the FPS referrals directed to the Parent Partner Specialists, 60% of parents referred had a Parent Partner Specialist attend the first CSC with the parent. Of those parents who had support at the CSC, 68% entered the Parent Partner Program to receive

ongoing support from the Parent Partner Specialist after FPS ended while their child(ren) remained in the home during their child welfare case.

**Objective 2:** The Parent Partner Program will increase engagement of parents referred to the program and will increase the number of completed intakes by 10%.

As the Parent Partner Program is voluntary for parents, a variety of factors contribute into intake into the program such as parents disinterested in participating, parents who disengage, who are still actively using substances, etc. The goal for the Parent Partner Program during the five-year CFSP plan period is to increase engagement of parents into the program through improving timely communication to parents, continued coaching and support to Parent Partners on engagement of parents into the program, and by building on the capacity of available Parent Partners to support parents.

The chart below provides the number of intakes into the program for the reporting period of July 1, 2024 - December 30, 2024, in comparison with the percentage of referrals to completed intakes from the previous five-year reporting period. Three of the five HHS Service Areas demonstrated growth in the number of referrals to completed intakes in comparison to the previous five-year average.

**Table 5s: Parent Partner Program New Intakes by HHS Service Area SFY 2025: July 1-December 2024**

| Service Area | Number of New Intakes In-Home Prevention Support (no removal) | Number of New Intakes Out-of-Home Support (removal cases) | Total Number of Completed Intakes | Percent of Referrals with Completed Intake July 1-December 2024 | *Percent of Referrals with Completed Intake SFY2020-SFY 2024 (through 12/31/23) |
|---|---|---|---|---|---|
| Des Moines | 21 | 50 | 71 | 51.4% ↑ | 49% |
| Western | 17 | 68 | 85 | 43.8% ↑ | 39.7% |
| Cedar Rapids | 16 | 61 | 77 | 29.8% | 42.1% |
| Northern | 4 | 27 | 31 | 23.6% | 32.6% |
| Eastern | 27 | 75 | 102 | 35.4% ↑ | 33.6% |
| **Statewide** | **85** | **281** | **366** | **36.3%** | **39.1%** |

Source: UN-L Iowa Parent Partner Online Database Data Summary July 1 - December 2024 Report

*UN-L Iowa Parent Partner Online Database Data Summary SFY20-24 Report

As mentioned previously, a new contract for the Parent Partner Program was awarded to Children and Families of Iowa and will go into effect July 1, 2025. The following Performance Measure addressing benchmarks for percentage of referrals resulting in a program intake is included in this upcoming contract:

- PM 1: Contractor shall provide Parent Partner mentoring supports that conform to following contractual requirements:
    - A minimum of 1,240 parents statewide will be provided Parent Partner mentoring supports each year of the contract. This will be measured by the program providing support to a minimum of 310 parents per quarter.
    - A minimum of 150 new Parent Partner Program Intakes of parents into the program will be completed each quarter.
    - A minimum of 40% of the contract referrals must proceed to Parent Partner Program Intakes of parents each quarter.

In addition, the Parent Partner Program contract expectation to complete an intake of a parent into the program will decrease from 90 days to 60 days after receiving the referral. The purpose of this reduced timeframe to complete an intake from the time of referral is to promote increased level of engagement between the program and the parents to complete the intake process sooner and with the goal of less attrition of parent involvement due to delayed contacts or participation in the process.

**Goal 3: Parents who receive peer support by a Parent Partner will help prevent out of home placement.**

**Objective:** HHS will partner with the University of Nebraska-Lincoln to evaluate outcomes of the Parent Partner Program to provide peer mentoring and support to parents as a prevention to out of home placement.

As mentioned previously, HHS is 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 who participated in a 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.

Beginning in SFY 2025, HHS entered into a data sharing agreement with UN-L to provide child welfare case data for comparison with data entered in the Parent Partner Database regarding parents who received support from a Parent Partner at their CSC and then received ongoing support from the Parent Partner throughout the remainder of their open child welfare case. UN-L will analyze data beginning in SFY 2021 when the pilot program began for support by a Parent Partner initiated through Family Preservation Services and attending a CSC.

**Goal 4: Parent Partners will be representative of parents they provide mentoring and support to.**

**Revised Objective:** Parent Partner Program will recruit and engage with parents who are reflective of the parents referred to support to become Parent Partners. The program will recruit males to become Parent Partners to increase available support to fathers.

At the end of March 2025, there were 86 Parent Partners mentoring and 28 new Parent Partners in training. Currently, there are 12 males mentoring dads, and 6 lead Parent Partners across the state. The Parent Partner Program increased communication efforts with HHS regarding Parent Partner recruitment needs through presentations at HHS unit meetings. Parent Partner program staff collaborated with the HHS EIS to develop a plan to engage dads in listening sessions to learn more about what dads believe would reinforce available supports and resources to them in the community, as well as increasing community spaces that will engage dads for interacting with their families and children, experience connection to their community, and to connect with other dads. This is an opportunity to not only recruit dads who may be interested in becoming Parent Partners, but also to provide current male Parent Partners additional ways to lift their voice around needs for father centered programming and activities.

To further increase the number of Parent Partners available for mentors, the program includes experienced Parent Partners to recruit and coach new mentors. The population of parents represented in each service area are further considered when recruiting new Parent Partners, as well as the unique challenges and needs of each area. Statewide recruitment plans for Parent Partners will be submitted to HHS under the new Parent Partner Contract with Children and Families of Iowa starting July 1st 2025. The plans will be used to not only increase the number of parent partners statewide but will also focus on expanded retention efforts and engagement opportunities.

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

Please see the following for information on RRTS:

- *Section II: Update to the Current Performance in Improving Outcomes, Systemic Factors:*
    - *Staff and Provider Training, Item 28: Foster and Adoptive Parent Training*
    - *Foster and Adoptive Parent Licensing, Recruitment and Retention*
- *IA Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan*

### Crisis Intervention, Stabilization, and Reunification (CISR)

In FFY 2025 and in FFY 2026, HHS continues/will continue to focus on the over-arching mission of family connections are always strengthened and preserved. The role of the

Crisis Intervention, Stabilization, and Reunification (CISR) contracts will continue in this system.

CISR services represents HHS' intent to provide and support child welfare services and juvenile justice services that:

- are family focused
- are designed to build on family strengths
- enhance parents' or other caregivers' capacity to protect and safely care for children
- connect families to community resources and informal support systems
- ensure children who age out of foster care have the skills and connections to successfully transition to adulthood
- are consistent with the principles of the Child and Family Services Review (CFSR) of child safety, permanency and well-being while encouraging flexibility, innovation, and use of evidence-based practice strategies to build a comprehensive continuity of care system.
- address the Risk Need Responsivity Principles
- utilize research driven practices informed by the review of Iowa specific data

CISR services comprise three of Iowa's child welfare services. They are Child Welfare Emergency Services (CWES), Foster Group Care Services (FGCS), and Supervised Apartment Living (SAL). The intent of continuing to combine these three services into a single RFP is to encourage Iowa's child welfare service provider community to begin thinking systematically about better coordination of services and combining efforts to better meet the needs of Iowa children and families.

HHS may annually renew these contracts for up to a six-year period before required to conduct new competitive bidding. The six-year period takes these contracts through June 30, 2029, unless HHS decides to pursue a new procurement.

The CISR services' general scopes of work will continue to focus services to achieve the desired outcomes of safety, permanency, and well-being for children. To that end, these contracts require collaboration between the CISR contractors, HHS, JCS, other child welfare and community services providers, and relevant stakeholders. Strong collaboration will strengthen services, identify gaps or needs, promote best practice, and avoid service duplication. HHS encourages contractors to collaborate with entities such as, but not limited to, the following:

- All other CWES, FGCS/Qualified Residential Treatment Program (QRTP), and SAL Contractors in all Service Areas

- Family Centered Services (FCS) Contractors, including the facilitators of Family Focused Meetings
- Recruitment, Retention, Training, and Support (RRTS) of Resource Families Contractors
- Parent Partners
- Youth Transition Decision Making (YTDM) or Youth Centered Planning Meeting (YCPM) Facilitators and Contractors
- Providers of mental health and substance abuse services
- Churches and faith-based community organizations
- The judicial system including judges, county attorneys, and guardians ad litem
- State child welfare and JCS justice initiatives
- Schools or other education entities (AEA)

Efforts concentrate on families and building on their strengths. The parameters of each contracted service (including performance measures) address needs related to maintaining or achieving permanence, keeping children safe, and assuring well-being. Performance incentives allow contractors to earn additional funding if meeting outcome targets. The performance measures and practice of placing children in their communities of origin (or at least as close to home as possible) by contracting with providers of the services in each of HHS' five Service Areas remains a core tenant of these contracts. Preserving children's connections to their families, home communities, schools, and positive support systems while placed outside their home, and assurances that children who age-out of foster care have the skills and connections needed to successfully transition to young adulthood directly address attention to safety, permanence, and well-being. The program-level goals identified in each of the following sections (CWES, FGCS/QRTP, and SAL) align closely to Iowa's Goal 2: Children achieve permanence in their living situation.

Iowa implemented the use of Critical Case Managers (SW4's) in each field service area, to address youth with high acuity needs and assist in getting these youth the right level of services and supports. These positions will continue to be evaluated and built out in order to meet the unique needs of our most acute and vulnerable youth. This work touches youth in all three arms of the CISR umbrella: CWES, FGCS/QRTP, and SAL.

Another cross-collaborative initiative that continues to be evaluated is the Children's SWAT. This meeting allows for HHS to staff our highest need youth with all different manner of providers in the child welfare, Medicaid, and behavioral health spaces. The primary objective of this meeting is to facilitate urgent placement needs for individuals in Iowa.

To do this, all participants commit to:

- Open conversations about what it will take to get to a “yes”
- Being flexible to change and extending beyond established comfort zones
- Doing all we can, collectively, to make incremental changes in the system to support serving Iowans within this state in the least restrictive setting that is appropriate.

**Child Welfare Emergency Services (CWES):** CWES are short term and temporary child welfare placements provided through the child welfare system that focus on a child’s safety, permanency, and well-being. CWES emphasizes HHS’ goal that placement is temporary and is less than fourteen days. CWES contracts stabilize and support the child and child’s family such that a return to CWES is unnecessary. The purpose of CWES is to immediately respond to the needs of the eligible target population defined for the contract. CWES approaches include temporary informal placements to formal court-ordered Emergency Juvenile Shelter Care (as permitted by the Iowa Code). CWES must be coordinated with other child welfare and juvenile justice services and with other domains of a child’s life, including but not limited to, education, family relationships, recreation, health care, and mental or behavioral health care. Contractors access available services that youth in their care may need, including accessing Medicaid-covered behavioral support services.

CWES serves children requiring placement in shelter referred to CWES with court orders for immediate placement into shelter care or children with or without court involvement referred to CWES for whom it has been agreed upon between the contractor and HHS/JCS/Law Enforcement that temporary informal placement into a shelter bed is the most appropriate service.

CWES addresses the child welfare/juvenile justice needs of children and families as they relate to safety, permanency, and well-being. Children and families may be involved with CWES for a matter of hours, or perhaps days or weeks if a shelter bed was ordered, whereas mental health-related treatment may be available as long as needed in order to stabilize psychiatric crises. The contract does not address mental health crisis services.

Delivery of CWES includes collaborating with entities at the local and state levels, decision-making with the families to include their informal supports and the child’s positive support system, and ensuring no child is ever refused services or discharged from service except in HHS approved cases per the Admission and Discharge Protocol. Each CWES contractor has a written plan for disaster response consistent with state, federal and local guidelines. CWES contractors ensure that each child receives services that address any special needs they may have.

CWES contractors respond to temporary informal shelter care referrals from HHS/JCS/Law Enforcement within one hour and coordinate the placement. If a youth

does not meet the criteria for the placement, the contractor provides resources to assist with meeting the needs of the individual. The children can stay in a temporary informal placement for up to 47 hours. The contractor develops a crisis plan for the child and connects the family to resources and makes referrals as needed. Temporary informal shelter care is available in identified coverage counties only.

Desired outcome: Whenever possible, to prevent children from being placed out of home while keeping them safe or to provide a safe and temporary environment when children need a place to stay as they await final disposition of their case by the court.

HHS implemented a pilot program in one of the five service areas to add a HHS staff member, called a shelter liaison. This shelter liaison's primary duties are to go into the shelters in the service area to meet with the children and youth placed in the shelter, to assist with communication between the children and their assigned social work case manager (SWCM) as needed, act as a communication liaison between the shelter and the SWCM's as needed, and to help track down any missing items needed for successful discharge. Often these items include personal items that did not make it with the child to the shelter or missing pieces of the necessary paperwork the shelter needs for the child. Both HHS and the shelters who participated identified this pilot program as beneficial and steps are in place to expand having a shelter liaison position in each of the service areas where there are shelters geographically located.

Another added beneficial cross-collaborative partnership is between RRTS and CWES providers. RRTS matching staff, who search for foster homes for the youth, visit the shelters to interact with the youth and get to know them in order to better inform matching to potential foster homes.

Performance measures: The overall goal for CWES is ensuring short-term use of shelter as a very time-limited intervention while family/fictive kin is located. The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing youth's needs being adequately met (PM2), keeping youth from advancing further in the system (PM1), and wraparound planning for all youth (PM3).

**Performance Measure 1 –** For eligible children placed in (47 hour stay) temporary informal shelter care, that are not subsequently placed in emergency juvenile shelter care, Foster Group Care/QRTP, or family foster care placement within 90 days of discharge, the contractor will receive $100.00 per child who does not enter the specified placements.

| Table 5t: CWES Performance Measures and Data for SFY 2025 (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Divert from Foster Care | 75.6% |
| Number of children not admitted to shelter, Foster Group Care/QRTP or Family Foster Care within 90 days of Temporary Informal Shelter | 68 |

| Table 5t: CWES Performance Measures and Data for SFY 2025 (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Number of children who received Temporary Information Shelter services | 90 |

Data Source: HHS JARVIS Reporting System; Data pulled on 3/27/2025

**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 who does not incur criminal charges or placement in detention during their shelter stay.

| Table 5u: CWES Performance Measures and Data for SFY 2025 - (Q1, Q2: 7/1/2024-12/31/2024) | |
|---|---|
| No criminal charges with stay over 30 days | 73.5% |
| Number of children with no charge or detention<br>Number of children > 30-day shelter stay | 119<br>162 |

Data Source: Contractor Self Reports

This specific data is dependent on many factors outside of the actual contractor's control at this time, including the local law enforcement, local JCS and even at times the county attorney and judges. Regardless of whether or not any charges are incurred for the behaviors, the contractors provide the structure and support to manage behaviors so that it does not escalate to the level of needing to involve law enforcement.

**Performance Measure 3 (no payment incentive) -** The contractor shall create a discharge plan with family to include future identified services needed by the family including both system (only if situation meets criteria) and non-system involved services. Discharge planning to also include crisis planning and recommendations. Services focus on mental health, substance abuse and physical health needs. Monitored via Contract Specialist review.

| Table 5v: CWES Performance Measures and Data for SFY 2025 - (Q1, Q2: 7/1/2024-12/31/2024) | |
|---|---|
| Discharge Planning | 79.7% |
| Number of Discharge Summaries that identify needed services<br>Number of Discharge Summaries Reviewed | 51<br>64 |

Data Source: HHS Contract Specialist

CWES Contractors and HHS continue to struggle with longer than desirable lengths of stay in shelter. A process is currently in place to review those youth who are in shelter for longer periods of time. A collaborative approach between HHS and the shelter continues to identify additional opportunities to find alternative places for the youth to live.

There were at least four of the shelter contractors that took part in a shelter exchange in CY 2024. One of the identified "swaps" took place between two of the shelters that are actually part of the same company but did have separate contracts and were located in different parts of the state. The other took place between two shelters that are located several hours away from each other and were located in different service areas. In both situations, this was a better solution for the youth and open communication and collaboration occurred with HHS prior to the swaps taking place.

In CY 2025, CWES contractors submitted proposals for additional funding allocated by the Governor to enhance the Safety and Security of their shelter environment. Examples of enhancements include installation of security cameras, delayed locks, alarms, a security gate around the perimeter of the property, communication system, key card entry locks, etc. These projects are underway currently.

Anticipated for CWES FFY 2025-2026:

HHS will continue to work on the overall mission of shortening the length of stay in shelter for youth and to have youth placed in the most family-like setting possible. Other strategies that will continue to be explored and built out are:

- Shelter Exchange Proposal-an effort to utilize a "swap" of youth between shelter contractors to best suit the youth's needs. Based on a youth's circumstances, there may be times that a better fit exists in another shelter. This process allows for this swap to happen in collaboration with HHS. This was implemented by some shelter contractors and will continue to be utilized when it appears to be in the youth's best interest.
- Shelter Intercept Proposal-an effort to staff current youth in shelter identified as needing a higher level of care (QRTP or Psychiatric Medical Institute for Children (PMIC)). This process will allow QRTP and PMIC providers to hear information about youth currently in shelter and make the best match possible between a youth's needs and the individual providers' openings, in collaboration with HHS. This concept will continue to be explored.
- Quarterly meetings continue between contractors, HHS and JCS field representatives and policy staff. These meetings allow an opportunity to discuss progress or barriers in the programs overall, discuss any changes and to have collaborative conversations about any topics group members wish to discuss.
- Safety and Security Enhancements for those that chose to submit proposals will be completed by the end of CY 2025.

**Foster Group Care Services (FGCS):** FGCS/QRTP are a part of the child welfare service array that offers a structured living environment for eligible children in foster care who are considered unable to live in a family situation due to social, emotional, behavioral, or physical disabilities or community safety issues. All current FGCS settings in Iowa are QRTPs. Expectations regarding FGCS settings meeting the requirements and definition of QRTP remain and will continue to do so in the future. The contracted service requirements are to:

- Offer a safe, structured, and stable living environment for children who are considered unable to live in a family situation due to social, emotional, behavioral, physical disabilities, or community safety issues, but are able to interact in a community environment with varying degrees of supervision.
- Maintain all required licensures, certifications, or approvals.
- Accept HHS and JCS referrals within one (1) hour and to plan with the referral worker to have the child placed within 72 hours. In limited cases, additional time to place a child (up to no more than 5 days from the referral date) may be allowable for the contractor to best accommodate a referral. The additional time will require prior approval from the respective referral authority, i.e., the SAM or designee for HHS referrals or the Chief Juvenile Court Officer or designee for JCS referrals. At no time shall the total number of placements exceed the number specified in a contractor's license.
- Provide contracted services on a No Reject, No Eject basis. Each provider, based on number of guaranteed beds, will have a designated number of rejections that can be used in a calendar year when the contractor chooses to enact them. Other admission/discharge disputes shall be handled following an HHS/JCS Protocol.
- Facilitate the reduction of multiple placements by increasing youth engagement in treatment and targeting high-risk criminogenic areas.
- Facilitate child development and the acquisition of age-appropriate life skills.
- Help each child develop and maintain relationships with the child's family and community and ensure each child stays connected to their kin and community.
- Support 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.
- Provide some combination of general QRTP and/or Specialized Programs, as follows:
    - Currently under the FGCS/QRTP umbrella, three (3) specialized programs are available - Problematic Sexualized Behavior (PSB), Neurodevelopmental and Co-Morbid Conditions (NACC), and Specialized Delinquency Program (SDP).

- FGCS/QRTP help a child with high needs thrive and develop the skills necessary to return home. Through the delivery of FGCS/QRTP, the contractor shall meet the needs of the child in out-of-home placement and promote safety, permanency, and well-being. The contractor shall: Utilize a service delivery approach that conforms to QRTP standards and Guiding Principles, the HHS' Family-Centered Model of Practice, Child Welfare Model of Practice, Juvenile Court Services' Model of Practice (as applicable), the Federal Child and Family Services Review, the Family Focused Meeting and the Youth Transition Decision Making Meeting, and Youth Centered Planning Meeting models.

- Provide the minimum service requirements including the implementation of each child's service plan, monitor and record the child's behavior daily, plan and supervise the daily living activities and provide oversight of their general health and well-being, coordination and participation in internal and external activities and maintain communication with the referring worker. Also, facilitate the participation of the child in other necessary programs and services to ensure the child's overall needs are met, including medical, mental health or substance abuse treatment, educational, criminogenic need reduction services and other community-based services. Contractors also provide, discipline, guidance, development of peer relationships, and delivery of recreational programs. Community resources in both the location of the contractor (i.e., where the child may be placed) and the location of a child's family may be used for education, recreation, medical, social, and rehabilitation services.
- Within one (1) hour accept all referrals made when there is a vacancy in the program and plan with the referral worker to have the child placed within 72 hours. In limited cases, additional time to place a child (up to no more than 5 days from the referral date) may be allowable for the contractor to best accommodate a referral (for reasons like, but not necessarily limited to, preparing for placement into the most suitable milieu, unique needs of a child, or arranging for proper staffing needs). The additional time will require prior approval from the respective referral authority, i.e., the SAM or designee for HHS referrals or the Chief Juvenile Court Officer or designee for JCS referrals. At no time shall the total number of placements exceed the number specified in a contractor's license.
- All Specialized Delinquency Program (SDP) referrals must be reviewed and approved by the Interagency Placement Review Committee (IPRC). The IPRC utilizes a multi-faceted approach to review all referrals to confirm they meet the program's entry criteria and ensure appropriate programming is available. Following review and approval of a referral by the IPRC, CareMatch shall be updated.

- Administer the FGCS/QRTP program following the Reasonable and Prudent Parent Standards. Each child engaged in care shall be provided services that address any special language needs, reinforce positive social practices, and acknowledge and build upon their unique strengths. Utilize the HHS' Treatment Outcome Package (TOP). Follow all TOP instructions including adherence to the timeframes contained therein.
- Provide programs that ensure child welfare and juvenile justice children are not co-mingled whenever possible. In addition, ensure children reside and interact with persons within their own age group and with common treatment needs whenever possible. The behavioral, psychological, emotional, and developmental levels of children shall be considered in the determination of appropriate groupings.
- Methodologies include using the "One Caseworker Model" and assign an "education specialist" to each child, implementing service plans for each child in care that address identified needs, family and community connections, crisis and stabilization, reintegration planning, education, physical and mental and behavioral health needs and supports, medication management, and discharge. While in care, children shall be taught age-appropriate skills and/or skills to reduce criminogenic risk factors if applicable, to help prepare them to return to their communities or to transition to adulthood or future self-sufficiency.

Desired outcome: Stabilize the situations of the children in care and reunite them with their family or other lesser restrictive family-like setting at the earliest possible time.

In CY 2025, QRTP contractors submitted proposals for additional funding allocated by the Governor to enhance the Safety and Security of their QRTP environment. Examples of enhancements include installation of security cameras, delayed locks, alarms, a security gate around the perimeter of the property, communication system, key card entry locks, etc.

Performance measures: The overall goal for HHS and FGCS/QRTP is to increase quality individualized programming to ensure youth are gaining necessary skills and returning to family-like settings whenever possible. The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing discharge to family-like settings and adequate programming to keep youth out of further QRTP placements (HHS) and reduce instances of Recidivism (JCS).

**Performance Measure 1** – Return to Group Care for CINA Youth - In alignment with the HHS' 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. HHS 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.

| **Table 5w: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025)** | |
|---|---|
| Number of children not re-admitted to FGCS<br>Number of children who exited | 55<br>83 |
| Performance measure | 66.3% |

Data Source: HHS JARVIS Reporting System; Data Pulled: 4/14/2025

**Performance Measure 2 – Recidivism of Children Adjudicated for Delinquent Acts (SJDP) -** In alignment with JCS's Model of Practice, the contractor shall help a youth develop the skills necessary to reduce recidivism (any misdemeanor or felony level offense filed in/referred to Juvenile Court, the adult corrections system, or both, within a twelve-month period after date of discharge from service). Accordingly, recidivism in children who have been referred to and placed in a bed designated for Specialized Delinquency Program (SDP) will be monitored, and the contractor may earn additional payment based upon low levels of recidivism.

- 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.

| **Table 5x: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025)** | |
|---|---|
| Number of children did not recidivate | 14 |

| Table 5x: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Number of children who exited SJDP | 37 |
| Performance measure | 38% |

Data Source: JCS

**Performance Measure 3 – Discharge to a Family-Like Setting -** In alignment with the HHS' 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.

| Table 5y: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| **NACC Only** | |
| Number of children who exited to a family or family like setting | 3 |
| Number of children who exited | 7 |
| Performance Measure | 42.9% |
| **SJDP Only** | |
| Number of children who exited to a family or family like setting | 28 |
| Number of children who exited | |

| Table 5y: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Performance Measure | 34<br>82.4% |
| **QRTP Only**<br>Number of children who exited to a family or family like setting<br>Number of children who exited<br>Performance Measure | <br>129<br>269<br>48% |
| **Combined**<br>Number of children who exited to a family or family like setting<br>Number of children who exited<br>Performance Measure | <br>160<br>310<br>51.6% |

Data Source: HHS Jarvis Reporting System Data Pulled: 4/14/2025

**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.

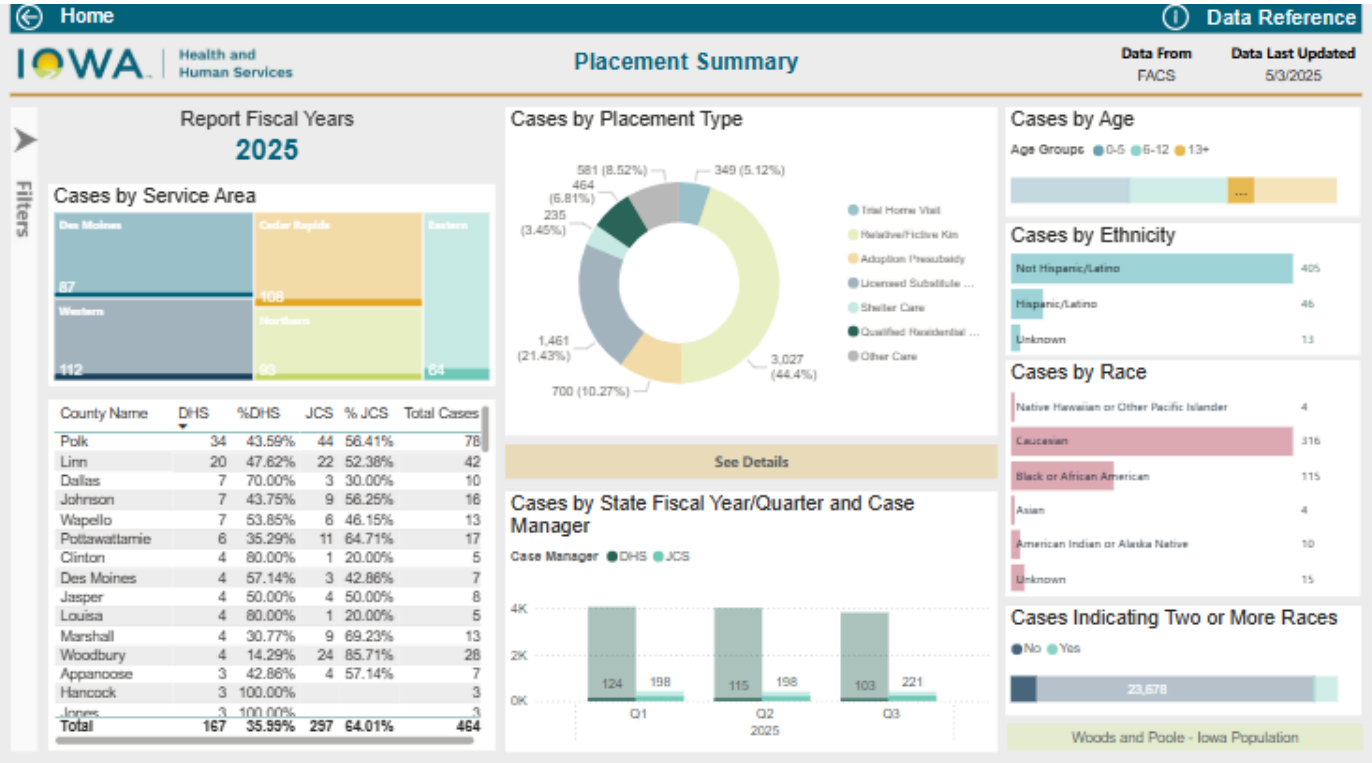
| Table 5z: QRTP Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Number of children did not recidivate<br><br>Number of JCS General children who exited FGCS | 75<br><br>149 |
| Performance measure | 50% |

Data Source: JCS

Anticipated for FGCS/QRTP FFY 2025-2026:

- Continue to evaluate the need for congregate out of home placements in light of declining HHS group care populations. As of 2025, Iowa is contracting for approximately 345 beds statewide, as compared to 660 beds in 2016. Iowa continues to explore alternative ways to meet the needs of youth outside of the "historical" congregate care settings. Iowa will continue to lean heavily on the expertise of our partners at Casey Family Programs and their work around "ending the need for group care" to help inform this work.
- The contracts that went into effect July 2023 designated a specific number of beds for JCS youth and a specified number of beds for HHS. Currently there are 98 Guaranteed Beds for HHS, 141 Guaranteed Beds for JCS, 80 PSB beds, 10 NACC beds and 26 Non-Guaranteed Beds. The specialized programming beds (PSB and NACC) are utilized by both JCS and HHS. The breakdown of QRTP placements remained stable with a usage of 60% JCS and 40% HHS. Ongoing data analysis will continue to determine if any changes to bed structure need to be effectuated.

  See below for a snapshot of SFY 2024 (July 1, 2024-March 31, 2025) QRTP data from the HHS Family First Dashboard.




| County Name | DHS | %DHS | JCS | % JCS | Total Cases |
|---|---|---|---|---|---|
| Polk | 34 | 43.59% | 44 | 56.41% | 78 |
| Linn | 20 | 47.62% | 22 | 52.38% | 42 |
| Dallas | 7 | 70.00% | 3 | 30.00% | 10 |
| Johnson | 7 | 43.75% | 9 | 56.25% | 16 |
| Wapello | 7 | 53.85% | 6 | 46.15% | 13 |
| Pottawattamie | 6 | 35.29% | 11 | 64.71% | 17 |
| Clinton | 4 | 80.00% | 1 | 20.00% | 5 |
| Des Moines | 4 | 57.14% | 3 | 42.86% | 7 |
| Jasper | 4 | 50.00% | 4 | 50.00% | 8 |
| Louisa | 4 | 80.00% | 1 | 20.00% | 5 |
| Marshall | 4 | 30.77% | 9 | 69.23% | 13 |
| Woodbury | 4 | 14.29% | 24 | 85.71% | 28 |
| Appanoose | 3 | 42.86% | 4 | 57.14% | 7 |
| Hancock | 3 | 100.00% | | | 3 |
| Jones | 3 | 100.00% | | | 3 |
| Total | 167 | 35.99% | 257 | 64.01% | 464 |

Data Source: HHS Family First Dashboard

- Evaluate QRTP as a level of care to ensure quality services that meet the needs of all Iowa youth. There may be an opportunity in Iowa for current QRTP providers to transition to PMIC (PRTF-like) services, which allow for braided Medicaid-funding and a more suitable array of services for youth.
    - HHS has been utilizing a consulting group, SSG, to research and identify the strengths of the current Iowa QRTP and PMIC services and what opportunities there may be to transition the QRTP to PRTF services. This will be a 12–18-month project that will provide recommendations to HHS.
- Continue evolution of QRTP Exchange process - an effort to utilize a “swap” of youth between QRTP providers to best suit the youth’s needs. Based on a youth’s circumstances, there may be times that a better fit exists in another QRTP. This process allows for this to swap happen in collaboration with HHS.
    - While this process was identified as a possibility in certain situations, it has not yet been utilized to its full potential for various reasons. There were some opportunities for collaborative conversations between QRTP contractors and HHS to identify how to best meet the treatment needs of the youth.

- Explore the creation of specialized beds to serve females at high risk of human trafficking. HHS and current contractors are currently researching potential sites and models for this population.
    - Work will continue with HHS and current contractors to research programming options and to identify if additional QRTP beds should be added to serve this very specific population.
- Technical Assistance will be provided to QRTPs through the use of an outside contractor and transition to an internal team developed under the State-Operated Specialty Care Division. This Technical Assistance will provide insight into increasing the quality of programming provided by the current QRTP's to meet the intense needs of youth in their care. Initially contractors will volunteer, but then a rotation will be identified and implemented. Additionally, criteria for what would be an emergent need for the use of the Technical Assistance will be identified.
- To better identify and anticipate providers who may be struggling, or to highlight strong performers, additional critical incident types will be tracked within the HHS provider system. This tracking will assist in identifying providers who may need additional technical assistance as described above.

**Supervised Apartment Living (SAL):** SAL is the least restrictive type of foster care placement in Iowa; eligibility begins at age 16½ years old. These living arrangements provide youth an environment in which they experience living in the community with less supervision than that provided by a foster family or foster group care setting. The goal of the supports and services is to prepare the youth for self-sufficiency.

Supplemented by life skills training and staff guidance and supports, youth in the SAL program attend school, prepare their own budgets, pay their own bills, shop for their own food, prepare their own meals, do their own laundry and cleaning, and engage with the community.

Scope of the service: SAL contractors provide two types of SAL setting; they are cluster sites and scattered sites. Cluster sites allow a maximum of six children to be located in the same building (such as apartments located in one building or private housing or their own rooms in a shared unit). Contractor staff must be on-site and available at any time when more than one youth is present. Scattered sites (e.g., an individual youth's apartment unit in a community) also provide access to SAL staff 24 hours a day, seven days a week and they must be available as needed. Staff supervision and guidance is flexible to meet the needs and behaviors of each individual in the program.

Desired outcome: Youth self-sufficiency and the development of interdependence with their community and the systems that support daily living on one's own.

SAL services and methodologies: The staff accept all referrals within one (1) hour when there is a vacancy in the program and arrange to have the child placed within 48 hours.

Contractors accept referrals and provide services on a No Reject, No Eject basis. Throughout the delivery of SAL services, contractors support each youth's development of necessary skills, tools, and abilities to attain self-sufficiency while ensuring their safety and well-being and working toward permanency. The contractor utilizes real life learning opportunities within the structured SAL community in order to help the child develop life skills needed for successful transition to adulthood. Youth in the SAL program are expected to learn new skills such as preparing their own budget and paying bills, shopping for their own food and preparing their own meals, doing their own laundry and cleaning and utilizing public transportation. The youth practice these skills in the program and demonstrate competency. The HHS' and SAL contractor staff are responsible for promoting each child's relationships with family members and other persons in the child's positive support system. Protection of children occurs in the least restrictive setting necessary, and the HHS and the contractors are obligated to provide a nurturing environment where children can thrive, and through SAL prepare themselves for their transition to young adulthood.

Performance Measures: The overall goal for HHS and SAL is to ensure SAL youth gain necessary skills and supports to transition to adulthood successfully. The objectives to meet this goal are captured via the Performance Measures of the contract. These include incentivizing stability, connection to necessary resources, skill-building and building a positive informal support network.

**Performance Measure 1 – Stability** - In accordance with HHS' 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.

| **Table 5aa: SAL Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025)** | |
|---|---|
| Number of youths who aged out or exited to family/family like setting<br><br>Youth who exited the SAL program | 53<br><br>44 |
| Performance measure | 83.02% |

Data Source: HHS Jarvis Reporting System; Data Pulled - 4/3/2025

**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.

| Table 5bb: SAL Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Number of youths engaged in Aftercare for 3 months<br>Youth who exited the SAL program | 1<br>23 |
| Performance measure | 4.35% |

Data Source: Contractor Self Reports; Data Pulled - 4/3/2025

**Performance Measure 3 – Life Skills Attainment -** In accordance with HHS' 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 HHS' online reporting system.

| Table 5cc: SAL Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Increased Life Skills<br>Youth who exited the SAL program | 11<br>27 |
| Performance measure | 40.74% |

Data Source: Contractor Self Reports Data Pulled: 4/3/2025

**Performance Measure 4 – Increase in Positive Informal Supports (no payment incentive) -** In accordance with HHS' 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 HHS 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 HHS' online reporting system.

| Table 5dd: SAL Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Discovery Tool | 3.85% |

| Table 5dd: SAL Performance Measures and Data for SFY 2025 - (Q1, Q2, Q3: 7/1/2024-3/31/2025) | |
|---|---|
| Number of files with Discovery Tool increase | 1 |
| Number of Files Reviewed | 26 |

Data Source: HHS Contract Specialist Data Pulled: 4/3/2025

The contractors reported that the youth refuse to fill out the Discovery Tool. They reluctantly do one when they first come into SAL, but they do not like talking about it during their stay and they do not like doing it when they are discharged. The tool recently underwent some changes in addition to intentional planning with SAL contractors during the quarterly meetings about how to try to encourage and increase youth utilization of the Discovery Tool.

Anticipated for SAL FFY 2025-2026:

- With the introduction of both Positive Youth Development and Motivational Interviewing on July 1, 2024, HHS and SAL contractors will be monitoring and analyzing how these evidence-informed practices are impacting overall outcomes for SAL youth.
- Two of the four SAL contractors recently prioritized updating the physical spaces where SAL youth reside. HHS is encouraged and excited about the high-quality spaces that these contractors are providing for SAL youth. In years 2025-2029, it is a goal for all SAL spaces to receive updating.
    - One of the SAL contractors built stand-alone “tiny homes” on their property and held a ribbon cutting in late summer of 2024. This was much anticipated by the youth that could see the construction occurring from the previous SAL space and the new space was a widely celebrated addition amongst contractors and HHS. Another of the SAL contractors offer very nice and modern living spaces for their clustered site that some commented is nicer than some apartments in the area. Both of these newly updated living spaces are not only providing a safe place for the SAL youth to live but also providing them a sense of pride as they are learning the skills needed to eventually transition into living independently.

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

### Description of Program Design and Delivery (section 477(b)(2)(A) of the Act)

The Iowa Department of Health and Human Services (HHS) is the state agency that administers, supervises, and oversees all aspects of delivery and monitoring of services for transition aged youth. Iowa efforts are supported by federal title IV-E funding, Chafee funding and state funding, among other sources. Chafee provides a framework for the

services and limited, but flexible, financial support to states which fund programs for youth in foster care and those who have aged out of the foster care system, to age 26.

Iowa ensures that implementation of the Chafee program will continue in a youth driven, but statewide consistent manner, by relying on internal staff who are Transition Specialists, and the network of providers to ensure support and programming for Iowa youth. In accordance with ACYF-CB-PI-18-06, HHS is operating a comparable program to serve youth up to age 23 through the state. HHS has statewide contracts for services like the Iowa Aftercare Services Program (aftercare), the Iowa Foster Care Youth Council (known as Achieving Maximum Potential (AMP)), and the Education and Training Voucher Program (ETV) so young people, including Native youth, in different areas of the state have equal opportunities and receive similar support. Individuals receive youth centered planning, voluntary services and support services, depending on their desire and the youth's assessment of life skills. Individuals receive services tailored to their unique needs. 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.

The eligible population served continues to include the following:

- Is currently in foster care and is 14 years of age or older.
- Is under the age of 23 and was adopted from foster care at 16 years of age or older.
- Is under the age of 23 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.
- 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.
- 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).

The number of youths served in SFY 2024 was 2,477 which is a decrease from 2,794 in SFY 2023.

| Table 5ee: Youth Served by Iowa Chafee | | | |
|---|---|---|---|
| | Youth aged 14 and older in foster care (FACS payment data) | Youth participating in Iowa Aftercare Services from monthly billing claims—Youth aged 18-22 (some youths are duplicated in "core" and "extended" | Total |
| FFY 2024 | 1770 | 510 +197=707 | 2,477 |
| FFY 2023 | 2041 | 545+208=753 | 2,794 |

Data Source: HHS

HHS is aware many of the youth who age out of foster care do so without the family support that acts as a safety net. The mental and social health needs of our transitioning youth can be a barrier. These are among the reasons HHS has a host of supports and services in place for anyone who ages out of foster care, up to age 23 for case management services. Additionally, college funding and Medicaid are available until the age of 26. To avoid the inclination of caring adults to keep a child in care just to get the services and financial support, we also provide transition supports to youth who enter subsidized guardianship or adoption from foster care at age 16 or older. The host of services are federally funded. State funding increased over the years building upon the federal funds to the point where the state funding has surpassed and doubled federal funding.

A full time Independent Living (IL) Coordinator, within the Division of Family Well-Being and Protection, oversees Iowa's Statewide Foster Care Transition Program. This state funded position experienced a staff change in the past year. While the coordinator is continuing to learn all that this position encompasses, contract oversight and renewals continue without disruption in services to youth.

The IL Coordinator is responsible for the following:

- Ensuring projects, policies, and practices serve transitioning youth efficiently and effectively, resulting in positive outcomes for youth formerly in foster care.
- Coordination duties for the Chafee funded Transition Planning Specialists (TPSs) 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, monitored as follows:
    - Regional supervisors
    - Regional administrator oversight
    - "Lead" administrators

  - Central office activity monitoring
  - Performance tracking and monitoring
- Managing contracts for the following programs:
  - Iowa Aftercare Services Program, which utilizes combined state and federal funding to serve transitioning youth through a network of child welfare agencies.
  - Iowa Foster Care Youth Council, for children in foster care.
  - Foster Care Transportation for Education Stability Contract with the Iowa Department of Education (DE).
- Advocating for children in foster care and alumni on committees and groups:
  - Juvenile Justice Advisory Council
  - Juvenile Justice Re-entry Grant Project
  - Activating Youth Engagement
  - Opt-In Post Secondary Workgroup
  - Iowa Collaboration for Youth Development

**Chafee Transition Specialized Staff:** 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. 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 the coming years.

The TPS utilize the child welfare information system (specifically FACS) to check eligibility for education and training voucher (ETV), Iowa Aftercare, and other services relying upon foster care experience for eligibility. TPS complete application forms, as needed, or assist and train the case manager of a child in foster care on how to do so.

Iowa has a tracking system for transition planning activities to ensure youth aged 14 and older in foster care as well as young adult foster care alumni get the support they need, and that HHS remains in compliance with all requirements for case planning of transition aged youth. TPS are responsible to record such things as: completion of 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 of 14. The intention of these emails is to ensure all youth have a viable plan whether the youth are leaving at age 18 or whenever they leave foster care.

A tracking system is an invaluable monitoring tool. 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)(g) lays out the requirements.

TPS engage providers in their local areas though face-to-face and video training. TPS provide case consultation daily, via phone and email for providers or HHS. TPS attend youth centered planning meetings, as requested, to share information on all procedures, polices, and programs regarding transition planning and required activities. It is important for TPS to be involved in cases where permanency is uncertain, because they know all the “ins and outs” of eligibility for key transition programs (ETV, All Iowa, Aftercare, and PAL).

Case managers ensure youth complete the Casey Life Skills Assessment (CLSA) at age 14 and older. After the assessment is complete, the case manager works with the youth and their team to develop the Transition Plan section of the case permanency plan, which lays out goals and action steps for the youth and those who will assist and may occur around the first youth centered planning meeting. The case manager, the youth, and their team update the Transition Plans every six months or more often as needed.

A necessary prerequisite to the development of the Transition Plan section of the case permanency plan (also known as Part C) is a convening of the youth centered team. The team is intentionally created by the case manager, with input from the youth, so the youth have a group of people who can provide support and help youth reach their dreams. The team comprises persons selected by the youth, service providers, and others. Some youth centered planning meetings are formal through our Family Centered Services Program and others are less formal, conducted by a case manager or other HHS identified person, depending on the family and the needs of the child. The case manager and the youth may engage team members to review and update the plan at a minimum of every 6 months. TPS are available to assist in specific transition planning for youth who is expected to have a challenging transition, such as a youth who will need adult disability services, youth who experienced a number of placement disruptions, youth who have substance abuse issues, etc. The case manager documents the transition team, dates, and membership in the Transition Plan section of the case permanency plan (also known as Part C).

The Casey Life Skills Assessment (CLSA) is the required assessment for teens in foster care. The assessment was recently added to the Iowa Aftercare Services Contract, so all youth in aftercare will be assessed for life skills prior to setting goals and action steps in the Self-Sufficiency Plan. One of the reasons for selecting the CLSA is because it is

touted by the developers as sensitive and appropriate for every individual regardless of their living arrangement.

HHS ensures that the Chafee program serves all of Iowa by having a TPS in each HHS Service Area, designated coverage in the Iowa Aftercare program by county and local youth councils in every HHS service area. The result is that we glean information from the data specific to each area and can provide a familiar level, quality, and quantity of services across the state while maintaining flexibility in response to poor outcomes or other needed changes.

**Local Transition Committee Reviews:** Iowa Code 235.7 requires HHS to establish and maintain local transition committees to address the transition needs of those children receiving child welfare services age 16 or older and have a case permanency plan as defined in Iowa Code Section 232.2. HHS has rules establishing criteria for transition committee membership, operating policies, and basic functions.

Each Service Area has Local Transition Committees that review every transition plan by the time the youth reach age 17.5. TPS and a team of HHS staff and partners (Aftercare, MCO, VR, etc.) are able to check status of items including, but not limited to vital documents, youth participation, education status and referrals, employment skills and services, health care coverage, housing plan and a backup plan, relationships, and need/referrals for adult services.

In SFY 2024, Local Transition Committees reviewed and approved 296 transition plans. Of the plans reviewed, 11 were not approved the first round. Two-hundred-eighty-five (285) or 96% of plans are approved in the first round. When a plan is not initially approved, there is a recommendation for workers to address certain deficits in the plan and a requirement to return for a final review. Each HHS service area submits a report to central office with total reviews completed, description of the committees including membership, barriers to transition, and possible solutions. A statewide summary is below that outlines some strengths and challenges in delivery of service to older youth.

- Normalcy and Youth Voice: 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. HHS is exploring contracting for Youth Transition Decision Meetings to assist with ensuring more meetings for the youth.

  Foster care youth often lack financial literacy training or modeling of how to budget, pay bills, etc. Explore basic living skills training curricula that could be taught to youth. One local Aftercare developed a relationship with Dupaco in Cedar Rapids to have a financial literacy class offered a few times throughout the year for Aftercare youth. Dupaco also extended the offer to provide financial literacy education to SAL locations throughout Central and Eastern Iowa for additional support for youth aging out. Opportunity Passport continues to be

available in the Des Moines Area for youth. TPS on the Western side of the state are searching for financial institutions to partner with in an effort to educate all youth on financial matters across the state.

Transportation barriers continue to be huge for youth. There are not enough resources available to assist youth with getting their driver's licenses and getting vehicles. Youth in foster care placement or QRTP frequently do not have the opportunity for behind the wheel opportunities which leads to the ability to get their license. HHS does not have a solution to this barrier. Exploration of creative ways to meet this need will continue.

Youth in QRTP settings typically do not have the opportunity to seek or maintain employment. For those youth moving from a QRTP setting to a Supervised Apartment setting, the ability to work and gain job skills is crucial. Due to the limitations of QRTP, this will likely continue to be a barrier for the foreseeable future.

- Collaboration: Better collaboration between the systems including the school. It would be beneficial to have a centralized state database through the Iowa Department of Education where transcripts of all 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. In each service area there are child welfare points of contact (POC) to assist with the delivery of ESSA protections to youth in foster care. Additionally, the IL coordinator is also the Statewide POC. There is good collaboration between the Department of Education and HHS at the state level. There needs to be better collaboration at the local levels. Ongoing conversations with the local child welfare POCs regarding joint training with their local school districts continued. Recently the ABA Center on Children and the Law released videos to assist with educating points of contact both in the school districts and child welfare. Educational Stability in Focus (Video #1) - Zoom

  Warm hand-offs between the HHS worker and the Aftercare worker also aid the youth in feeling comfortable with Aftercare. While this would be best practice, this would be difficult to coordinate and mandate.

  Better collaboration between the HHS social workers, TPS and placements such as QRTP, SAL and shelter can make a better transition for youth. TPS workers made a greater effort to be present on local campuses in their areas for meetings and support.

- Connecting to Existing Services: Another strong suggestion continues to be using Family Centered Services for youth in care, so HHS workers have an ally in the transition work with youth and so service providers and youth have close collaboration. At this time, FCS does not have the capacity to provide this

service. There are ongoing discussions with Aftercare regarding increasing the availability of pre-aftercare work to include more interactions with youth starting at age 17. This would give the youth the ability to work more on transition goals and assist with better preparation for the transition to adulthood.

Iowa Vocational Rehabilitation Services (IVRS) is a valuable service available to youth, yet very few workers seem to be aware of the service or what they have to offer. IVRS helps those with disabilities gain, keep, and advance in their employment. IVRS advocates for and increases the opportunities for youth to gain job experience and skills through job shadowing and volunteer opportunities regardless of type of foster care placement. Currently, IVRS is available through the school system in Iowa. Members of the AEA participate in the local transition committee meetings and make recommendations regarding youth that may benefit from IVRS. Greater focus needs to be put on connecting field staff with their local AEA point of contact to strengthen the relationship in this area.

Not all youth are 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 occur. Better collaboration between case managers and AMP can assist in bridging this gap. A collaborative is forming at this time to help bridge this gap. Members from RRTS (foster care recruitment and retention), Kinship Navigators, Aftercare, TPS and AMP hope to begin meeting in May 2025 to start breaking down the barriers that exist and ultimately serve more youth.

- Youth with Disabilities Transitioning to Adult Services: While the number of older youths aging out of care is decreasing, there is a greater percentage of the youth aging out with significant needs that require additional support into adulthood. There is not a good resource for youth to obtain guardians, when needed, when they do not have anyone willing to do it voluntarily. Another gap that causes problems is the youth's SSI, meaning it can take some time for SSI to switch payee from HHS to the new payee or the youth themselves. Many youths lack understanding of the significance of their mental health needs and the importance of remaining in treatment after leaving HHS and court supervision. At times SSI is the only funding a youth has available for living expenses. If forms are not completed for a payee change prior to the youth exiting care, there may not be any funds available to the youth upon exiting care. Waiver waitlists continue to be long and not readily available to youth aging out.

  Making referrals earlier to Maximus and continuing to educate staff on the services Maximus provides can help with some of the SSI issues. Maximus staff have been able to attend many transition meetings which helped with service delivery.

Having youth access centers and creating a central provider system to identify services such as HAB housing for youth with disabilities would be beneficial.

- Housing: It is very hard to find property owners willing to work with minors and young adults, who may have one or more of the following barriers: no rental history, lack of financial resources, no one to cosign, no references, and criminal histories. This makes it difficult for transitioning youth to find an apartment. The amount of funds available to a youth in Aftercare is not enough to secure housing that is safe and affordable. This frequently results in the youth being in unstable housing situations or becoming homeless.

  Iowa has access to FYI vouchers, however many of the Housing Authorities do not access these. A better partnership and further education on how to access and utilize FYI vouchers would be beneficial. Iowa requested assistance with this mission from our federal partners. The hope is that these conversations can continue in the future.

**Foster Care Transition-Contracted Programs and Services:** About 25% of the annual Chafee appropriation goes to our dedicated TPS staff and the rest goes to contracted direct services for youth. This section describes core contracted services. HHS is proud to have private child welfare agencies joining in this important work.

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 HHS. 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.

Much of the AMP information in this report comes from the annual AMP report, required by contract. AMP offers leadership opportunities, service-learning projects, speaking opportunities, and educational or vocational assistance to youth ages 13-21 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.

The agencies involved in the Partnership and the location of the Councils they support are:

- YSS (Ames, Des Moines, Eldora (STS))
- American Home Finding Association (Ottumwa)
- Foundation 2 (Cedar Rapids)

- Hillcrest Family Services (Dubuque)
- Youth Shelter Care of North Central Iowa (Fort Dodge)
- Virtual AMP

In SFY 2024 AMP staffing remained stable. Samanthya Marlatt, MPA was promoted to Director of Youth Empowerment & Advocacy in October 2024. Laticia Aossey, MSW was promoted to AMP Programs Operations Manager in October 2024.

Despite dwindling AMP locations over the last few years, AMP staff and leadership remain open to new, fresh ideas regarding reaching more youth. AMP reports making 1,910 connections with youth over SFY 2024 and engaging 396 new youth.

Youth attendance reported in meeting summaries ranged from 1 youth to 24 youth. This size group is conducive to youth development programming, allowing each youth to be engaged in discussion and activities. Often, one or two community members, presenters, or volunteers (in addition to the facilitator) were also present for the meetings.

AMP facilitators often lead multiple activities during each council meeting. Meetings included a wide range of guest speakers, including representatives from HHS, Iowa Aftercare, community organizations, law enforcement, health care providers, among others. Several council meetings involved the “Talking Wall” activity to gather input from foster youth. The Talking Wall activities in which AMP participated generated thousands of comments and reflections from youth across the state about Iowa’s child welfare and juvenile justice systems.

Facilitators also categorize the primary topic they address at each council meeting from a list of options. Categories selected included: AMP Day on the Hill Preparation, Talking Wall, Dream Seed applications, AMP 101, life skills and educational presentations, holiday activities and parties, resilience training, back to school bash, summer games and team building are just a sample of activities.

Among the expectations in the AMP contract is that they utilize positive youth development practices. This means youth should have social activities, leadership opportunities and skill building exercises, among other developmental and character-building activities.

All AMP activities and events promote social and recreational opportunities for participants. AMP staff and facilitators are encouraged to plan and provide fun and engaging activities that promote normalcy and developmentally appropriate engagement with peers and communities. Some examples of fun activities provided in SFY 2024 included game nights, movie nights, bowling, pumpkin carving, trips to the zoo and farms, Living History Farms, Adventureland and several mini camps that included canoeing and bonfires, and college campus tours.

*Opportunities for improvement:*

- Current data indicates an evaluation of AMP recruitment strategies needs to be conducted to better engage youth in foster and adoptive placements in community settings.
- Current data indicates that current program elements need to be evaluated to ensure we are including youth residing in all placement types and providing equal opportunities to connect with peers, communities, and programming that supports strengthening of life skills.

The HHS Program manager for the AMP contract began these discussions with AMP leadership. As noted above, a collaborative was formed to assist with recruitment in many placement settings. The first meeting of the collaborative is May 2nd, 2025.

*AMP Events & Celebrations:*

June 2024: The AMP Annual Conference occurred at Grand View University on June 5th, 2024. Councils participated from across the state, and it was an engaging opportunity to showcase all the community support available to students who experienced foster care. In addition to a campus tour and a presentation from the admissions staff, youth also engaged with community partners ranging from postsecondary institutions to supportive services like IowaWORKS and Aftercare. The keynote speaker was a young author and entrepreneur with lived expertise in both the child welfare and juvenile justice systems.

*AMP Legislative Agenda/Day on the Hill:* AMP partnered with Iowa's NYTD Coordinator, Kayla Powell, to utilize a "Talking Wall" to solicit input from youth around the state for AMP's legislative recommendations. Kayla Powell facilitated either in-person or virtually the Talking Wall activity with most AMP Councils in the winter of 2024. Input was compiled and used to inform the legislative and advocacy efforts.

As of the writing of this report, Iowa is in its legislative session for 2025. AMP Day on the Hill took place January 30th, 2025. AMP prepared the 2025 AMP Legislative Agenda and distributed to legislators via email with an invite to the day's event. Issues prioritized this year included all of the following:

- Access to appropriate hygiene products
- Better relationships with caseworkers
- Increased participation in court proceedings
- Maintaining family connections
- Reduced wait times for placements
- Increased rates for QRTP and Shelter (in collaboration with the Coalition for Family and Children's Services in Iowa).


**Iowa Aftercare Services Program:** 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. 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, paid for with state funds.

HHS contracts for the Iowa Aftercare Services Program (Aftercare). Youth & Shelter Services (YSS), a child and family serving non-profit agency from Ames, Iowa, holds the Aftercare 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)
- Ellipsis (Des Moines)
- Young House Family Services (Burlington)

Further information about these agencies, including the counties they serve as part of Aftercare, is available at www.iowaaftercare.org.

Contracted staff provide case management, life skills training, and financial supports for housing, transportation, clothing, food, and other costs related to the participant's self-sufficiency plan. 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.

YSS subcontracts with Iowa State University (ISU) to provide statewide coordination, policy development, quality assurance, and evaluation services for the program. Dr. Jan Melby and her team at Iowa State bring a research orientation. Coordination through ISU includes the full-time Aftercare Coordinator, Joanie Havel, 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.

The Iowa Aftercare Services website includes very readable annual reports with trend information from intake interviews with youth when they first access aftercare services; participant satisfaction survey reports; demographic and other characteristics of all participants served by aftercare each year; and outcomes of participants who exit services. Program results are in the link: https://iowaaftercare.org/program-results/.

The Iowa Aftercare Services contract combines funding from federal and state sources. Over the years, legislative changes and increased funding allowed Aftercare to expand eligibility criteria so that more young Iowans benefit from the program. Due to realigning the service areas in Iowa and a new contracting cycle for Supervised Apartment Living Services (SAL), a need for SAL services in the Cedar Rapids Service Area was identified. On January 1st, 2024 the Aftercare contract was amended to include SAL + Life Skills Services. Youth must reside in Linn County, Iowa which is home base for the Cedar Rapids Service Area. There must be a court order or a voluntary placement agreement for a youth to be placed in SAL. The youth must be between the ages of 17-20 and residing in a scattered-site Supervised Apartment Living Placement. If this criterion is met, Aftercare can be contracted to provide case management that includes life skills to youth.

The most recent update to the program took effect July 1, 2024, with an increase in funding to the PAL stipend. The maximum monthly PAL stipend increased from $600 to $800 for youth aged 18, from $500 to $600 for youth aged 19, and from $400 to $500 for youth aged 20.

Nearly all Aftercare participants received budget and financial management services and mentoring services. This reflects the emphasis on budgeting and financial issues in

the program and the mentoring relationship SSAs work to establish with participants. In addition to assessing and helping youth meet basic needs with financial assistance, SSAs also work with youth on housing, health, postsecondary education, career preparation, and family support issues.

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 support that all participants receive, PAL participants receive up to $800 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.

Over recent years Iowa has worked hard to develop “pre-Aftercare” and an “extended” Aftercare service, to bolster the “core” Aftercare case management. The frequency of meetings, plans and budgets are less for pre and extended participants. On the front end, pre-Aftercare helps introduce the program to the youth still in foster care to build trust and get “buy in”, so the likelihood of later participation is high. On the “back end” extended Aftercare allows youth to have a less intensive service at age 21 and 22, to meet participants’ waning support needs and to “step down” services, as they are older and presumably more skilled.

The number of young people aging out of foster care and other court-ordered placements in Iowa declined over recent years, which translated to a decreasing number of new entries into Aftercare services.

**Table 5ff: Youth Served in Aftercare – SFY 2022-2024**

| Core Participation | SFY 2022 Total | SFY 2023 Total | SFY 2024 Total |
|---|---|---|---|
| New Initial Intakes | 212 | 167 | 156 |
| Unduplicated Number Served | 587 | 535 | 510 |
| Avg Number Served/Month | 353 | 347 | 339 |
| Avg Number Received PAL/Month | 168 | 200 | 197 |

Data Source: Iowa State University (ISU)

*SFY2024 Participation Data – Aftercare:* Aftercare begins services with a youth by having the youth complete a survey. Information is gathered regarding employment, resources, housing, education, relationships, parenting, physical and mental health,

high risk behaviors and essential documents. This same survey is administered to the youth exiting the program. As evidenced by the outcome measures within the report, young individuals engaging in Aftercare services demonstrate notable improvements across various domains. The SFY 2024 unduplicated "outcomes group" includes 129 participants. The results of this report can be found here: https://iowaaftercare.org/wp-content/uploads/2024/10/SFY24-Annual-Outcomes-Report_Final.pdf.

A total of 510 young people ages 18, 19, and 20 received "Core Services" during SFY 2024, with an average of 339 served per month. We served 48 youth at STS between July 2023 - June 2024. Thirty-two youth exited during that time frame, fifteen of which engaged in Pre-Aftercare and/or Core Aftercare to date (47%).

Extended services, which were first available in January 2020, are less structured than Core services and are designed to be responsive to those young adults who want or need additional support as they continue on a path towards self-sufficiency. There are two primary differences between Core and Extended services:

- Expectations for meeting regularly with an Aftercare Advocate are relaxed. There is no predetermined minimum contact for young people to remain eligible. Participants in Extended services are able to determine the frequency of meetings based on their needs and interest; and
- Participants in Extended services are not eligible for a monthly PAL stipend. Rather, they may receive limited financial support for approved uses in the form of "Extended Aftercare Supportive Payments" on a case-by-case basis. Supportive payments may not exceed $300 per quarter.

Most young people who elected Extended services had Aftercare PLUS status as Core participants (88.3%). Compared to youth exiting Core services, Extended participants were somewhat more likely to be female (58.9% versus 48.8% of Core exits) and to be parenting (36.3% versus 22.5% of Core exits). Ten (10) of those who received Extended services aged out of the STS or detention.

Participants taking advantage of the Extended services in SFY 2024 met with an Advocate for an average of five months during SFY 2024 and ranged from one to twelve months. In addition, 25% of the SFY 2024 participants engaged and met anywhere from 13-24 months within their two years of eligibility for Extended Aftercare

**Table 5gg: Extended Aftercare Participation – SFY 2022 - 2024**

| Extended Participation | SFY 2022 Total | SFY 2023 Total | SFY 2024 Total |
|---|---|---|---|
| Unduplicated Number Served | 235 | 168 | 197 |
| Avg Number Served/Month | 78 | 76 | 76 |

| Table 5gg: Extended Aftercare Participation – SFY 2022 - 2024 | | | |
|---|---|---|---|
| **Extended Participation** | **SFY 2022 Total** | **SFY 2023 Total** | **SFY 2024 Total** |
| Avg Number received $/Month | 38 | 41 | 39 |
| Avg Amount Support Payment | $212 | $200 | $238 |

Data Source: Iowa State University (ISU)

Aftercare and PAL are voluntary programs, so eligible young adults can initiate and discontinue services as they choose if they meet eligibility requirements. As they move around the state, they may transfer from one Aftercare agency to another. In some cases, services may be discontinued when young people fail to meet the participant responsibilities established by the program. These young people may re-enter services when they are ready.

In compliance with reporting requirements for the National Youth in Transition Database (NYTD), the Network tracks the provision of specific services to participants and submits monthly reports to HHS. The table shows the number of youths who received each of the NYTD-defined services at least once during SFY 2024. Because NYTD service definitions are very specific, this data is not an exhaustive list of the services provided by Aftercare Advocates.

| Table 5hh: Participation in NYTD Defined Services through Aftercare | | |
|---|---|---|
| **NYTD Defined Services** | **#** | **%** |
| Mentoring | 483 | 94.7% |
| Budget and financial management | 469 | 92.0% |
| Housing and home management education | 397 | 77.8% |
| Career preparation | 355 | 69.6% |
| Other financial assistance | 385 | 75.5% |
| Health education and risk prevention | 366 | 71.8% |
| Independent living assessment | 348 | 68.2% |
| Family support and healthy marriage education | 326 | 63.9% |
| Post-Secondary educational support | 221 | 43.3% |

| Table 5hh: Participation in NYTD Defined Services through Aftercare | | |
|---|---|---|
| **NYTD Defined Services** | **#** | **%** |
| Academic support | 153 | 30.0% |
| Employment programs or vocational training | 145 | 28.4% |
| Room and board financial assistance | 91 | 17.8% |
| Education financial assistance | 64 | 12.5% |

Data Source: Iowa State University (ISU)

Among Core participants in SFY 2024, nearly all received "mentoring" services (94.7%) and assistance with "budget and financial management" (92.0%) from their IASN Advocate during SFY 2024. This reflects the mentoring relationship SSAs establish with their clients, as well as the program's emphasis on financial capability (particularly monthly budgeting). Advocates also supported participants in a variety of other areas, including housing, assessing needs, career preparation, and health education. Any participant receiving a PAL stipend or Aftercare vendor payment is recorded as receiving "other financial assistance." The NYTD "Room and board financial assistance" category includes vendor payments used specifically for housing and the Chafee-funded Rent Subsidy program.

### National Youth in Transition Database (NYTD) Data

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 other out-of-home placement.

HHS and JCS case managers are contacted quarterly to survey the services provided to youth in foster care age 14 and older. The Iowa Aftercare program and Iowa College Aid Commission provides life skills and education services data, respectively.

HHS previously 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. DHR would track these youth as they age and conduct a follow-up survey with a sample of youth at ages 19 and 21, referred to as the follow-up population. Outcomes derived from the survey included 24-27 questions that measured youth across six domains - educational attainment, financial self-sufficiency, access to health insurance, experience with homelessness, and positive connections with adults.

Most recently HHS aligned multiple executive branch agencies, among them DHR. Due to the alignment, HHS created a data sharing agreement in lieu of the previous NYTD Contract. There was effectively no change to the activities or the staff delivering the service, which includes surveying youth in the baseline population, surveying youth in

the follow up population, creating reports, and presenting the data to appropriate HHS staff. HHS is currently working through the process of moving the NYTD work to the TPS. This would include the survey of youth and ongoing contact with youth. HHS is currently looking at options to improve our current CWIS system to collect NYTD data into the system. This would aid in generating reports and data. As of the writing of this report, a decision was made regarding the updates to the system but these updates have not begun. The HHS program manager would still be responsible for the submission of the reports through the NYTD portal and maintaining the dashboard.

The survey 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. Collected responses are confidential, and no individual youth are identified in the report or in any survey data analysis shared with provider agencies. The majority of 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 a VISA gift card delivered electronically through Giftogram. 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.

The current NYTD Coordinator and IL Coordinator are working on a Power Bi Dashboard to present the NYTD data. Power BI, which stands for Power Business Intelligence, is a data visualization platform developed by Microsoft that allows users to connect to various data sources and model the data, create interactive reports and dashboards to gain actionable insights. The TPS and the IL Coordinator can use this dashboard to help guide state and local decision-making. This dashboard would also be available to supervisors, JCS districts and service area leaders to aid in service delivery specific to their parts of the state.

In addition to collecting survey results from the NYTD populations of youth, Iowa NYTD also engaged youth through several outreach activities:

- NYTD Ambassadors are young adults who have previously taken the NYTD survey and are between the ages of 17-26. This partnership serves as an opportunity for young adults and state agencies to collaborate using survey data to inform, empower, and advance positive youth and community outcomes. This originally started as an advisory council and transformed into state agency positions. We currently have one NYTD Ambassador.

- The NYTD Creative Expressions Contest is an annual art contest that invites youth and young adults who experienced foster care and/or juvenile justice to create a work of art that captures the given theme of the contest. In 2023, the 7th Annual Creative Expressions Contest went themeless to empower creative vision. A total of 102 young people submitted 106 pieces of art into the contest. Youth from across the state in a variety of settings including group care, shelter, Psychiatric Mental Institutions for Children, foster homes, juvenile detention centers, and youth who aged out of the system submitted artwork. To date, 309 youth participated in this contest. Unfortunately, due to staffing and time constraints, this contest was not offered again in 2024 or to date in 2025.
- In 2018, Iowa NYTD began hosting the Talking Wall in partnership with HHS, Youth Justice Council Achieving Maximum Potential (AMP) and Iowa's Juvenile Justice Advisory Council (JJAC). JJAC provides oversight and guidance to departments and the judicial branch on services and monitoring pertaining to the Juvenile Justice and Delinquency Prevention Act of 1974. Through the Talking Wall, youth are empowered to lend their voices to the decision-making process by answering questions, sharing their experiences, and expressing their visions for change. The Talking Wall provides decision-makers an opportunity to align their action to what youth are saying they need. Talking Wall responses are shared with youth advocates, stakeholders, and state leaders.

  This year's questions included:

  - 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 are the do's and don'ts of the adults who work with you?
  - Who or what helps you feel safe when you're in placement?
  - While you're in placement, what do you need to successfully return home?
  - How has being placed in group homes/shelters impacted you emotionally, physically, and/or mentally?
  - What is one thing you would like to be different about court?

  In FFY 2025, 38 organizations participated leading to 3,401 sticky notes uplifting the voices of 480 youth. More than 15 state-level stakeholder groups will review the Talking Wall data and host discussions on how to translate the ideas into actions. The feedback is also used to inform the development of youth representation standards for juvenile attorneys.

  Outcomes of the Talking Wall include:

- Modified pending administrative rules to ensure youth have access to the period products they need while in out-of-home placement
- Modified administrative rules to increase the clothing allowance for youth in foster care
- Creation and pilot of a Youth Report to the Court
- Workgroup to create a pathway for youth in detention to work on their HiSET
- Development of a Juvenile Justice Bill of Rights
- Creation of a Guide to Court for youth in child welfare and another for youth in juvenile justice
- Capacity building work around healing-centered engagement
- Inspired the Family and Youth Engagement Summit
- Development of a youth-created toolkit on how schools can partner with youth to address the school-to-prison pipeline
- Presented at over 40 state and national events/conferences/webinars

- During the Talking Wall project, we also administer a survey to youth in out-of-home placement, primarily QRTP, Detention, State Training School, Shelter and SAL placements. The Talking Wall was also facilitated at local AMP councils. The goal is to assess to what extent is authentic engagement and well-being evident in their daily lives. This survey was co-created with the Youth Justice Council and questions were informed by past themes of the Talking Wall. In FFY 2024, 392 youth in out-of-home placement took the survey. Notable results include:
  - Family Engagement
    - 57% of youth believe they have a say in their case
    - 85% of youth believe their families want to be involved in their case and 58% reported their family has a say in their case
    - The majority of youth reported having too few and too short of phone calls (69% and 69% respectively)
  - Court
    - 1 in 3 youth see their attorney's outside of court (34%)
    - 90% of youth want to attend their court hearings
    - 57% of youth feel comfortable speaking up in the courtroom
  - Youth Agency and Rights

- While 81% of youth know how to make a grievance, just 47% of youth believe their grievances are taken seriously
- 56% of youth believe something will happen if they raise concerns

- Relationships with Workers and Staff
  - 65% of youth said their workers include them in decisions about their case
  - 82% of youth said their workers treated them with respect

These results were shared with the Bureau of Child Welfare and Community Supports to help educate program managers regarding youth wants and needs. These results will be shared at the upcoming Judges Conference. Additionally, the information is shared at the Youth Engagement Summitt in August to help direct and drive practice.

### Serving Youth/Young Adults Across the State (section 477(b)(2)(B) of the Act)

Under Iowa's Transition Planning Program, services are available to all youth in foster care who are 14 years of age and older in Iowa and to all youth adopted or who enter Subsidized Guardianship from foster care at age 16 or older, regardless of whether they resided in Iowa or another state when they existed foster care.

The eligible population served continues to include the following:

(1) Is currently in foster care and is 14 years of age or older.

(2) Is under the age of 23 and was adopted from foster care at 16 years of age or older.

(3) Is under the age of 23 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.

(4) Was formerly in foster care and eligible for and participating in Iowa's aftercare services program as described at 441 Iowa Administrative Code (IAC) § 187. Services are to age 23.

(5) Was formerly in foster care and eligible for and participating in Iowa's postsecondary education and training voucher (ETV) program as described at 42 U.S.C. § 677(a) (6-7). Services are for five years or to age 26, whichever comes first. Services are available on a statewide basis.

Please see the previous section for information regarding Iowa's Chafee program and its structure, which ensures that the program is available in all political subdivisions in Iowa.

### Serving Youth of Various Ages and Stages of Achieving Independence (section 477(b)(2)(C) of the Act)

Iowa continues to not take the option to extend foster care to 21. However, HHS submitted certification of a "comparable" program in IA Attachment C of Iowa's FFY 2025-2029 Child and Family Services Plan (CFSP), dated June 2024, which the federal

Children's Bureau approved. HHS contracts for a "comparable" state funded program, Iowa Aftercare Services Program, for former foster care youth who have not attained the age of 23. For more information, please see Iowa's Aftercare Services program mentioned earlier in this report. HHS also continues to work with Iowa College Aid to provide Chafee ETV for youth up to age 26. For more information, please see the ETV section later in this report.

HHS believes young people develop at different ages and in different stages. It is for this reason, for teens in foster care of any type, Iowa utilizes the Casey Life Skills Assessment (CLSA), described earlier in this section, and youth centered planning meetings, such as the Youth Transition Decision-Making (YTDM) meetings. A youth driven model ensures young people express their dreams, receive help to engage trusted adults and formal and informal connections, and help to realize their dreams. Social work case managers (SWCMs)/juvenile court officers (JCO)s and transition planning specialists (TPSs) constantly monitor the process. Iowa convenes and conducts reviews of final transition plans in Local Transition Committees across the state.

The Iowa Foster Care Youth Council (AMP) is a contracted service intended to offer fun social and developmental activities to youth in all kinds of foster care. AMP has lots of fun things to do such as an annual camp, game nights, movies, hikes, and chances for youth to engage in civic opportunities and volunteering. AMP is totally voluntary, so the youth get to select activities that fit their interest and ability. AMP reports are available online at AMPIOWA (weareampiowa.com). Their services are mentioned throughout this section of the report.

### Collaboration with Other Private and Public Agencies (section 477(b)(2)(D) of the Act)

**Medicaid:** The Support of Patients and Communities Act (Support Act) is 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.

The table below shows that over the past four years enrollment remained stable.

| Table 5ii: MIYA and E-MIYA Expenditures and Enrollment | | | | |
|---|---|---|---|---|
| **Calendar Year** | **Federal $** | **State $** | **Total $** | **Enrollment** |
| 2024 | $3,086,771 | $1,741,841 | $4,828,612 | 969 |
| 2023 | $3,223,832 | $1,565,321 | $4,789,153 | 1070 |
| 2022 | $3,379,329 | $1,547,407 | $4,926,736 | 1140 |
| 2021 | $3,063,396 | $1,438,465 | $4,501,861 | 1136 |

Data Source: HHS - Medicaid

**Regional Housing Authority:** 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.

As was mentioned previously in this report, 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. 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 representatives so we can break barriers and get ideas. Amy Hance is working on pulling in HUD representatives and has even agreed to facilitate getting meetings with local housing authorities in communities where we can have a large impact.

Progress toward FYI grants has slowed and remains unchanged at 26 communities.

**State Education Agency:** Since 2017, HHS maintains a contract with the Iowa Department of Education (DE) to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. HHS wrote the contract with a maximum of $300,000 per year since it is expensive to transport children when they are out of their school-bussing zone.

Getting children to and from school continues to be a challenging task. Bus drivers are just not available. It is not uncommon to see hiring bonuses for drivers and $300 per day cost of transportation in providing transportation services. HHS' regional specialists continue to educate staff on the federal requirements. Workers initiate best interest meetings and do what they can to emphasize that it is the role of the school district where the child attended to bus the child from the foster care placement to the provider. Workers are often frustrated when busing is delayed or simply unavailable. Foster parents, teachers, and family members try to fill the gaps.

The number of children being bussed is usually 20-30 in a quarter statewide. HHS and DE began to improve data sharing and the claims process to make it easier to do what is required and to be able to track progress.

Additional guidance was issued in November 2024 titled Ensuring Educational Stability and Success for Students in Foster Care. This very clearly lays out the requirements of child welfare agencies and school districts regarding the education of youth in foster care. The ABA Center on Children and the Law created a point of contact (POC) community for information sharing across states. They also created a video series to assist with educating and breaking down the barriers to the regulations.

HHS and DE are members of the POC community and consistently meet to work through issues, including seeking local technical assistance as needed.

**Collaboration with the Iowa Judicial Branch:** Juvenile Court Services (JCS) and HHS continue to partner in the work to provide better outcomes for youth. JCS continues its work to promote and support youth and family engagement through its Annual Youth and Family Engagement Summit. JCS held its 4th annual summit in September 2024. This event provided a venue to further the collective pursuit of integrating authentic engagement into all levels of child welfare and juvenile justice practice, policy, and research. In addition, following the summit, district teams met to continue work on their local strategies for expanding youth and family engagement. TPS typically serve as members of the district teams. The IL coordinator alongside JCS serve on the planning team for the Youth and Family Engagement Summitt.

In October 2024, HHS in partnership with Juvenile Court Services and Iowa Workforce Development hosted over 200 guests at our inaugural Building Bridges Convening. The convening was designed to facilitate connections and resource sharing among professionals dedicated to supporting older youth in the child welfare and juvenile justice systems. The convening featured panels of professionals working to support older youth. Panel topics included Reentry and Transition planning; Workforce and Education; Housing and Concrete Supports; Health and Wellbeing; Leadership and Court which included youth with lived experience. Feedback from the convening noted that most people met someone new, deepened their knowledge of resources for youth, and would attend another one in the future. The keynote speaker was a nationally sought after speaker with lived experience which helped to center guests in the conversations. Plans for a 2nd summit are underway. The team added a Department of Education representative to the collaboration.

Previously, JCS and HHS partnered to create specialized delinquency qualified residential treatment program (QRTP) for females, starting with the new contracts on July 1, 2023. HHS is also specializing more of the residential services for adjudicated delinquent youth. This approach promises to reduce contagion of delinquent behaviors, makes it more convenient to provide high quality services to address the criminogenic needs of delinquent youth, and could be safer for youth and staff alike.

**State of Iowa Youth Advisory Council (SIYAC):** The purpose of SIYAC, as stated in Iowa Code §216A.140(8), is to “foster communication among a group of engaged youth and the Governor, the General Assembly, and state and local policymakers regarding

programs, policies, and practices affecting youth and families; and to advocate for youth on important issues affecting youth."

Originally established in 2001, SIYAC was formalized in the Iowa Code in 2009 as an avenue for youth to inform state leaders and local communities on issues important to young people. SIYAC consists of 21 youth aged 14 to 20 who reside in Iowa. Membership includes youth with lived experience in the foster care system. Members serve two-year staggered terms that begin in July.

SIYAC members meet monthly online and quarterly in-person to collaborate on projects, advise various policymakers, conduct service projects and discuss committee updates. Every two years, they administer a statewide survey to identify the top concerns that youth in Iowa have. Based on the latest findings, SIYAC is currently focused on:

- Community Engagement
- Education
- Science, Technology, Education and Math (STEM)
- Mental Health
- Youth Policy

SIYAC splits into committees to focus on each of these priority areas. Each committee develops advocacy, service, and public awareness strategies to address these priorities. In addition, SIYAC members complete both a group and individual service project each year to make a direct impact in their communities.

Each year, SIYAC creates position statements that outline legislative solutions to issues affecting youth. They dedicate time to researching the problem, examining various approaches to address it, explaining the reasoning behind their chosen solution, and formulating an official position. For the 2025 legislative session, SIYAC authored three position statements that were introduced as legislative bills:

- SF86: Authorizes student liaisons on school boards to bridge communication between students and school leaders
- SF88: Requires schools to excuse at least one absence per year for high school students to attend civic or political events
- SF100 and HF223: Mandates schools to publish mental health resources on school websites and collaborate with students to improve awareness of mental health resources

Five More Ways SIYAC Is Making an Impact:

- Reducing Food Waste: Created a Food Waste Guide to help schools manage and recycle food waste more effectively

- Expanding STEM Opportunities: Advocating for the availability of STEM kits in public libraries to ignite an early interest in science and technology
- Improving Access to Services: Developing a tip sheet to help youth providers understand how they can ensure their resources are accessible to youth
- Youth Shadow Week: In February 2025, SIYAC members shadowed state leaders, including Attorney General Brenna Bird, Secretary of State Paul Pate, HHS Director Kelly Garcia, and legislators, gaining insights into day-to-day government operations and highlighting the importance of engaging youth in decision-making
- Giving Back: Collected and donated 98 pounds of food to a local food bank during their winter meeting

### Determining Eligibility for Benefits and Services (section 477(b)(2)(E) of the Act)

Since the submission of the 2025-2029 CFSP, there has been no change in HHS' objective criteria for determining eligibility for benefits and services under the programs and for ensuring fair and equitable treatment of benefit recipients.

### Chafee Training

Every new case manager receives training through the HHS Bureau of Service Support & Training on how to complete the transition planning process and receive contact information for their local Transition Planning Specialist (TPS), for support and guidance, and they receive basic eligibility information on all the key transition programs, including how to make a referral. The Independent Living (IL) Coordinator conducts the current training for new workers and includes requirements around the five primary components of transition planning: 1) housing; 2) positive support system; 3) education; 4) employment; and 5) health care and access to health care. A representative from Achieving Maximum Potential (AMP) is also a trainer for all new workers.

TPS share information on all state and federal laws regarding transition planning and requirements including:

- Role of TPS as support to ongoing workers
- Youth-centered planning
- Planning inclusive of the five primary components mentioned above
- Ensuring smooth access for youth who need services and supports from the adult disability system
- A written transition plan for each youth in foster care age 14 or older
- Required documents
- Services available, including AMP and Iowa Aftercare Services Program

No caseworker starts their job without knowing there are certain laws and procedures for all of the following:

- youth-centered planning, including referrals for services, inclusive of the five primary transition domains: housing; positive support system; education; employment; health care/access to health care coverage;
- a written transition plan for each youth in foster care age 14 or older;
- an update transition plan completed at each six-month case review (or more often if needed), within 90 days of a youth turning 18 years of age, and within 90 days of departure for a youth who elects to stay in voluntary foster care past 18 years of age to complete a high school diploma or obtain their high school equivalency
- requirements to obtain a birth certificate or state ID for every youth prior to aging out of foster care, and assisting them to obtain a social security card;
- local transition committee review process - one way Iowa reviews all cases of children planning to age out of foster care;
- Credit checks are completed through credit reporting agencies annually for children in foster care age 14 and older. Caseworkers receive alerts when there is a credit issue and they work with the youth, directly. TPS also provide support.

IL coordinator and TPS hosted online training regarding National Youth in Transition Database (NYTD) services surveys and how to complete them. IL and TPS are working on an updated online refresher training course regarding transition planning for ongoing workers. This training will assist workers with completing the transition plans in the child welfare information system (CWIS) thoroughly as well as reminders of services available to older youth.

In addition to face-to-face training provided by the HHS training branch and local HHS, online training is available. Transition planning webinars, training videos, and NYTD data are available to those who login at: Transitioning Into Adulthood | Health & Human Services. HHS periodically reviews the webinar for relevancy.

Below is a list of the “go to” documents TPS use on a frequent basis to educate and inform their communities:

- Samples of transition plans/guidelines that caseworkers may use to supplement the HHS transition plan within the case permanency plan;
- Specifics for caseworkers on how to electronically send a Casey Life Skills Assessment (CLSA) for children in family like foster care settings;
- Monthly transition topic conversations to have with youth;
- Information about what a Power of Attorney for Health Care is and why it is important for youth aging out of foster care to understand this process;

- Resources available to youth aging out of care;
- Transition eligibility scenarios;
- Ways in which the TPS may assist the caseworker with difficult cases regarding transition; and
- A thorough checklist by ages 16, 17, 17 ½, and 18 and what specific required transition processes occur during each of these ages. The checklist is in each youth's case file as a measure to track progress during one-on-one meetings between the caseworker and their supervisor

To reach foster and relative care families, training is available using various approaches. In addition to the available webinar described above, the recruitment and retention contractor (RRTS) staff provide pre-service and ongoing trainings (currently through video conferencing), including foster family support groups. Training topics include attachment, trauma informed parenting, crisis management, child and youth mental health, self-care, and other localized areas of interest. RRTS caseworkers help families find training that will enhance their skills and that are relevant to children in their home.

**CHAFEE IMPROVEMENT PLAN (CFSP REPORT) – PERFORMANCE ASSESSMENT UPDATE TO IMPROVING OUTCOMES**

In 2024, HHS submitted the Chafee section of the CFSP, which received approval from the Children's Bureau. This is year one of a five-year plan. This section provides a quick summary of accomplishments in the past year and any next steps.

**FFY 2025-2029 CFSP Goals, Objectives, and Benchmarks are as follows:**

**Objective 1.1:** Identify a reliable method to track, monitor, and follow up to ensure that youth aged 14 and older in foster care have an individualized transition plan.

**Objective 1.2:** Promote youth centered planning meetings.

**Benchmark:** All youth in foster care age 14 and older for at least six months will have a transition plan.

**Benchmark:** In year one, create a visual for youth, staff and contractors that describes services for youth transitioning from foster care to adulthood, that includes the application process and how to apply.

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. The IL coordinator meets with new social workers during their initial training to

introduce them to transition planning and provide the framework for thorough, quality transition planning.

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.

The Transition Information Packet (TIP) is a visual compilation of various transition resources for youth, staff and contractors that describes services for youth transitioning from foster care to adulthood. The TIP binder continues to be provided for older youth in out-of-home placements. HHS has reimagined the packet to make it more accessible for readers and to make it easier to update. The 360-page binder will now be broken into smaller magazines ranging from 10-20 pages based on content. Feedback from young people indicates this will be an easier format for them to digest the information. The binder was overwhelming and therefore likely underutilized. HHS' new communications team brings expertise to the work to aid in bringing this project to fruition. The information will also be readily available to youth online.

In the past year, our Juvenile Court partners have worked to ensure youth have transition plans and planning meetings. They focused on training and seeking new tools to aid in better plans for youth.

During SFY 2024, all Juvenile Court Officers (JCO) participated in training on the Out of Home, Transition, and Reentry JCS Policy and then again on a yearly basis. The training is also a part of the new JCO academy offered twice a year to provide education to new JCO's. This training offers a standardized approach to transition and reentry aftercare for youth involved with Juvenile Court Services (JCS). It outlines specific requirements to ensure compliance with federal and state regulations, guaranteeing that youth aged 14 and older receive the necessary services, support, and opportunities. The training equips JCO's with the tools to offer all youth a Youth Center Planning Meeting (YCPM) before discharge from a court-ordered placement. This also provides a shared ownership between JCO's, community providers, and youth to ensure that we are meeting the youths needs and wants as they transition back to their home, school, and community.

The purpose of the YCPM is to help young adults transitioning back to their communities from out-of-home placements develop meaningful, long-lasting community connections. These meetings are voluntary, youth-led, and facilitated by the youth, empowering them throughout the process. During the YCPM preparatory phase, youth create an individualized action plan, which becomes part of their transition plan. They set goals in the following eight domains; education, employment, housing, health, relationships, self-sufficiency, civic engagement, and interpersonal skills and behaviors.

JCS team members contribute to expanding the transition plan, which is tracked through a web application. This system allows easy monitoring of youth who received a

YCPM and transition plan while in out-of-home placements. The YCPM provider has access to a domain and benchmark assessment tool, which supports the creation of the action and transition plans. JCOs can view and update these plans regularly, ensuring they remain living documents. Additionally, the system sends reminders to both the JCO and YCPM facilitator to schedule discharge YCPM meetings within 45 to 60 days, allowing adequate time to finalize the youth's transition plan.

JCS focused on increasing education and training around federal and state requirements for transitioning youth, as well as YCPM expectations for contractors and providers. A PowerPoint presentation was created to visually illustrate the transition and reentry process, as well as the YCPM process. Families and youth receive a brochure outlining the process, but Iowa has yet to develop a visual aid that explains the application process for adult services.

**Objective 1.3:** Ensure youth who age out of foster care have state identification, birth certificate and social security card. Youth should receive assistance getting a driver's license or permit if they want one.

**Benchmark:** Increase percentage of youth who enter Iowa Aftercare Services Program with documentation, from 40% to 60% by 2029, based on Iowa Aftercare Services intake data.

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 are adding columns to monitor the receipt of vital documents, such as social security card and birth certificate. Previously added columns were 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 receive the necessary transitional planning services.

According to Aftercare data, most youth enter Aftercare in possession of their essential personal documents. In SFY 2024, most new participants reported possessing a birth certificate (83.3%), Social Security card (81.4%), and government-issued identification, such as a State ID, driver's license, or Permanent Resident Card (88.5%). In addition, 80.8% indicated they had written verification of their time in foster care or out-of-home placement, a relatively new federal requirement that States are mandated to provide to older youth exiting foster care to facilitate access to other resources for which prior foster care involvement is a criterion (e.g., college financial aid).

To better track youth's driver's license status, a column was added to the TPS tracking tool to document driving status. Choices listed include learner's 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.

**Objective 1.4:** Utilize NYTD and other existing data to improve service delivery.

**Benchmark:** Engage fifty or more staff and colleagues to participate in each of the NYTD Annual Outcomes Report Out webinars.

As of the writing of this report, the NYTD Outcomes webinar is scheduled for June 5th, 2025. As previously noted, the team is working on a new system. The team would like to be able to present the Power BI on the webinar as well as provide information on how to use the system and filter the results.

**Objective 1.5:** Increase employment, education, and career choices which may appeal to youth.

**Benchmark:** Initiate a formal relationship with AmeriCorps and Iowa Works Programs, including but not limited to Vocational Rehabilitation, to create options for paid work experience no later than year three.

**Benchmark:** Monitor percent of youth aged 14 and older in foster care who elect to participate in a volunteer work experience, with an initial goal of at least ten percent of youth over age 16 and older volunteering.

In SFY 2024 a collaboration formed between Iowa Workforce Development, JCS, HHS, and the Department of Education. The team hosted a convening in October 2024 designed to facilitate connections and resource sharing among professionals dedicated to supporting older youth in the child welfare and juvenile justice systems. Included in the panel of experts was Iowa Works, AmeriCorps, Job Corps and Vocational Rehabilitation.

**Goal 2:** Ensure youth transitioning from foster care have reliable housing and a services plan prior to exit.

**Objective 2.1:** Make referrals for adult services in advance of age eighteen, for youth expected to age out of foster care. Referrals are expected to be made six months before aging out or later date if directed by the facility.

**Benchmark:** The percentage of transition plans approved by Local Transition Committees will exceed 90%.

As previously noted, in SFY 2024, Local Transition Committees reviewed and approved 296 transition plans. Of the plans reviewed, 11 were not approved the first round. Two-hundred-eighty-five (285) or 96% of plans are approved in the first round. When a plan is not initially approved, there is a recommendation for workers to address certain deficits in the plan and a requirement to return for a final review.

For all teens who have SSI or mental health diagnoses, TPS make sure to discuss Integrated Health Home Services (IHH) with their workers. This information is typically shared during their first Youth Transition Decision Making Meeting (YTDM) when they

are 16. Currently there is no clear tracking mechanism for data collection to ensure this is happening.

**Objective 2.2:** Utilize Medicaid funded services to bridge service support as youth transition from foster care to adulthood, including securing case management and residential programs for those who need them.

**Benchmark:** HHS will work with adult services providers to develop clear procedures for making referrals timely. This may include pre-approving youth, so when the youth leaves care, they are approved to enter.

As previously noted, HHS makes referrals to an Integrated Health Home (IHH). This is a team of professionals, including family and peer support services, that coordinates care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). This includes individuals currently receiving Targeted Case Management (TCM) and Case Management through Medicaid funded Habilitation. Care coordination is provided for all aspects of the individual's life and for transitions of care the individual may experience. The IHH is required to assist individuals with their paperwork and guide them through the application process for benefits for which they qualify. The IHH is required to coordinate all services for an individual, including medical, behavioral and community services regardless of the funding sources for those services. A youth typically receives two YTDMs between the ages of 16-17.5. The team and youth together review what the plan may look like for them at/after age 18 and if services such as HAB, waivers, payee, guardianship, etc. are needed, with referrals made if needed. It is also helpful to have the Mental Health and Disability Region (MHDS) representative on the Transition Committee Review board so they can discuss the need for adult services early and be aware of teens who might be coming back to their area. Further relationship building is needed to ensure smoother transitions for young people. In many cases there is a delay from the youth turning 18 to acceptance and entry into adult services.

### Consultation with Tribes (section 477(b)(3)(G))

The only federally recognized Tribe in Iowa, the Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) has a settlement in Tama County, Iowa (northeast part of Iowa). Additionally, there is a concentration of Native families in northwest Iowa (primarily Woodbury County). All child welfare agencies, including tribal ones, are continuously in the loop concerning the Chafee purposes and programs funded under Chafee (including the ETV program). The HHS Transition Planning Specialist (TPS) is the point of contact for Chafee services and transition process questions.

Meskwaki Nation has Meskwaki Family Services (MFS) located within the settlement in Tama County. The TPS for the HHS service area in which Tama County is located, offers to meet with the MFS staff to train on transition practices. The MFS staff is in the loop concerning Iowa’s transition planning protocol, practices, and resources for youth

still in care and aftercare resources, including the ETV program, for youth who age out of care.

The TPS in the Cedar Rapids Service area is available to visit/staff cases virtually with the MFS case manager to assist with resource ideas and to help develop transition plans for Meskwaki youth. Case plans for Native youth are also reviewed in the transition committee meetings.

HHS includes MFS in distribution of information about resources for older youth in foster care and youth transitioning to adulthood. HHS' TPS in the Cedar Rapids Service Area notifies the MFS case manager when they have a youth who is on the list needing to do their Casey Life Skills Assessment, is within 90 days of turning 18 and needs to review their transition plan with the youth, and when they have a youth who needs to be reviewed by the Transition Committee. TPS also encourage and help facilitate older youth in connecting to Pre-Aftercare and Aftercare services.

Contact with MFS continued to be limited this past year, due to a low number of Meskwaki youths in care. MFS only had a few youths who showed up on the HHS tracking as being 14 and older in out of home placement. HHS continues to offer to meet with MFS to provide information and resources or training regarding transition planning.

Native Youth Standing Strong (NYSS) - Native youth in Woodbury County receive encouragement to participate in cultural and recreational activities. NYSS is a collaborative effort between the Native communities, Sioux City School District, Four Directions Community Center, Juvenile Court Services, HHS, Goodwill Industries, Big Brothers Big Sisters and counseling and support services. NYSS' Winter Gathering was December 6, 2024. It was by far the biggest event yet. They had over 550 people who came out.

HHS works with tribal partners to ensure tribal youth have similar opportunities for engagement in transition planning (including assessments and planning activities) and the same array of services provided for non-Native teens in foster care/alumni. Tribal children in Iowa foster care typically have a state caseworker (through either HHS or JCS) due to no tribe requesting to develop an agreement to administer, supervise, or oversee the Chafee program with respect to Indian children.

Native youth eligible for Chafee benefits and supports have their transition plan reviewed beyond court and agency review by a local transition committee prior to turning 17.5 years of age (or if entering foster care after the age of 18, within 30 days of completion of the transition plan).

The Tribal/State Agreement with Meskwaki Nation states HHS is responsible for contracting and payment for foster care and Chafee transition services accessed by Meskwaki children. MFS has all case management responsibilities, which includes

activities such as life skills assessments and youth centered meetings. Aftercare services and AMP are available through HHS contracted services.

During this last reporting period, none of the Nebraska tribes requested to develop an agreement to administer, supervise, or oversee the Chafee or an ETV program with respect to eligible Indian children and to receive an appropriate portion of the state's allotment for such administration or supervision.

### Education and Training Vouchers (ETV) Program

The Iowa Department Health and Human Services (HHS) partners with the Department of Education through 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.

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 (FAFSA) and ETV applicant status every two weeks for Transition Planning Specialist (TPS). TPS provide suggestions to case managers to meet required dates and to keep youth informed of the application process.

Typically, each year Iowa's ETV application is available online beginning in October, to coincide with the FAFSA release. During the 2024-2025 school year, there was a delay in releasing the FAFSA, but Iowa released their application on October 1. New students must submit both a FAFSA and an Iowa Financial Aid Application their initial year of receiving ETV. Beginning in 2024-2025 returning students are only required to complete the FAFSA. This was a direct result in reviewing the data and determining some students were losing eligibility due to the additional barrier of an extra application.

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.

As of right now, Iowa has five graduate students who received ETV in the 2024-2025 academic year. With the additional allotment funding received in 2024-2025, Iowa was able to award everyone who applied through October 25. Unfortunately, there were still twelve students, who applied after October 25, who did not receive funding due to lack of funding.

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 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. Please see IA Attachment C for the number of youth/young adults (unduplicated count) who received ETV awards for the 2023-2024 and 2024-2025 school years.

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 first priority for the AIOS. This scholarship is renewable for four years or until the recipient attains age 26, whichever happens first.

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

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.

**ETV IMPROVEMENT PLAN – PERFORMANCE ASSESSMENT UPDATE TO IMPROVING OUTCOMES**

**Goal 1:** Collaborate with institutions of higher education (schools) and provider partners to ensure foster care alumni are supported in their pursuit of higher education.

**Objective 1.1:** Capitalize on key partnerships to identify needed services and supports for students.

**Objective 1.2:** Attend FutureFest and other events to share information about best practices, new programs, and timelines for scholarship and grant applications.

**Objective 1.3:** Ensure data is available to schools and service providers, including but not limited to applications, enrollment, and outcomes.

Iowa College Aid staff attended Iowa Aftercare Services meetings to train workers on ETV and other financial aid related topics. This began the process of determining what was needed for training in order for training to be effective in the future.

Iowa College Aid staff attended multiple FutureFest events throughout the state. Meeting the youth where they are empowers them to reach out when they have questions about ETV and the financial aid process.

Iowa College Aid attends staff meetings throughout the year to train and assist with questions about financial aid and ETV. Iowa College Aid staff work very closely with college financial aid staff to ensure youth are supported through the ETV program. They also work closely with other college access entities throughout the state helping with the completion of the FAFSA such as ICAN and TRIO. AmeriCorps students also assist with completion.

Iowa College Aid staff continues to evaluate trends in ETV recipients and releases that data annually.

## STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM (TITLE IV-B, SUBPART 1)

HHS will utilize title IV-B, subpart 1, funding as indicated on the CFS-101 for:

- Crisis Intervention (Family Preservation): Family Preservation Services, which is part of the Family-Centered Services (FCS) package;
- Family Reunification Services:

  - Family-Centered Services (FCS) package, except for Family Preservation Services covered above;
- Parent Partner program, which also includes title IV-B, subpart 2 Family Preservation and planning funding;
- Foster Care Maintenance:
  - Foster Family & Relative Foster Care
  - Group/Institutional Care

For more information on these services, please see the *Child and Family Services Continuum* earlier in this section, as noted below:

- Family Centered-Services, pp 107-126
- Parent Partner program, pp 127-143
- Recruitment, Retention, Training, and Supportive Services (RRTS), page 143
- Foster Group Care Services/QRTP, pp 150-158

### Services and Data on Children Adopted from Other Countries

Families who adopt children internationally have the ability to access training and support groups through Iowa's RRTS contractor. 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 internationally. Limited resources and diverse racial and cultural needs are significant barriers to expanding post-adoption services for families who adopt from other countries. Resources are not limited to available funds, but staff time to develop an array of post-adoption services that can be available to any family. However, HHS will continue to do the following over the next year:

- Work collaboratively with private adoption agencies to identify gaps in services by engaging the Iowa Association of Adoption Agencies in gathering information from families who adopt from other countries and identifying gaps in services.
- Work collaboratively with private adoption agencies to explore creatively how services and supports can assist families who adopt from other countries within current funding and service provision constraints.

Should additional funds become available, HHS will work collaboratively with private adoption agencies to prioritize, develop, and implement services and supports to assist families who adopt from other countries.

**Number of children adopted from other countries and entered into state custody in FY 2024**

Iowa's child welfare information system (CWIS) tracks:

- The number of children adopted from other countries who enter into State custody because of the disruption of a placement for adoption or the dissolution of an adoption;
- The agencies that handled the placement or the adoption;
- The plans for the child; and
- The reasons for the disruption or dissolution.

In the past year, no children adopted from another country experienced disruption or dissolution through HHS.

## Services for Children Under the Age of Five

Iowa utilizes its child welfare service array to meet the unique needs of children and families served, which includes children under the age of five remaining in the home or in foster care. These services include but are not limited to Family Centered Services (FCS), referrals to Early ACCESS (described below), referral of parents to mental health, substance abuse, domestic violence, employment, and disability services, etc. Another public service available to families is Head Start and Early Head Start. Social work case managers (SWCMs) discuss Head Start and Early Head Start services with families, with the families accessing services through direct application to the programs.

Please see this section, *Child and Family Services Continuum, Family Centered Services* for more information about these services.

The HHS' child protective workers (CPWs), as part of their assessment of child abuse allegations, inclusive of safety and risk assessments, assess the strengths and needs of the children and the family. The HHS' SWCMs build upon the initial assessment of the CPW by:

- working with the family to continually assess the strengths and needs of the children and family;
- connecting the children and family to the appropriate services; and
- monitoring the effectiveness of those services to meet their needs.

The goal is to achieve safety and permanency for these children, in accordance with the Adoption and Safe Families Act (ASFA, P.L. 105-89) guidelines, and achieve child and family well-being. Through clinical case consultation with SWCMs, supervisors provide oversight of the SWCMs' assessment of and provision of age-appropriate services to

children. Please see discussions of *Child Protective Assessments* earlier in this section.

**Early ACCESS (EA):** Iowa's Early Intervention services program, or Early ACCESS (EA), is housed in the Iowa Department of Education (DE). Local Area Education Agencies (AEAs) and Child Health Specialty clinics provide the services. AEA services are available statewide, offering both Part C and Part B services. Child Health Specialty Clinics' services have partial state coverage and support families with service coordination, health assessments, and nutrition services. HHS is a signatory partner with two staff who participate as members of the state leadership team. HHS offers support to EA by completing Child Abuse and Prevention Treatment Act (CAPTA) referrals and facilitating contact with families, providing support, Medicaid, and acting as a liaison between DE and HHS programs, namely across Early Childhood programming, Maternal and Child Health, 1st Five, Child Care and Mental Health and Disability service areas. HHS staff facilitate communication among departments to ensure local programs are aware of EA services and encourage local partnership. HHS staff provide training and professional development efforts within EA programs and support policy and infrastructure building efforts for the program. The CAPTA program coordinator was previously a part time contract position. In SFY 2024, HHS hired a full-time position to be housed within Early Intervention and Support bureau of Early Childhood Services. This enables wide collaboration with other early childhood programs, including Early Childhood Iowa, the Iowa Child Abuse Prevention Program to work closely with home visitation and other local family support and community building initiatives.

Data: CAPTA referrals for EA generate through an automated system via an email to the EA CAPTA program coordinator. Review of the referral information occurs to ensure information is accurate and complete, then submitted electronically via a web portal which directs the referral to the appropriate AEA based on the child's address. Children with existing open referrals or are already served are not re-referred. The following tables reflect the number of eligible CAPTA referrals, children in foster care, and children served by year for EA services:

**Table 5jj: Children under age 3 eligible for CAPTA referral, by State Fiscal Year**

| State Fiscal Year | Number of children |
|---|---|
| 2024 | 2,429 |
| 2023 | 2,446 |
| 2022 | 2,581 |
| 2021 | 2,483 |
| 2020 | 2,452 |

Data Source: HHS

| Table 5kk: Number of children under age three in foster care, by State Fiscal Year | |
|---|---|
| **State Fiscal Year** | **Number of children** |
| 2024 | 1,328 |
| 2023 | 1,415 |
| 2022 | 1,494 |
| 2021 | 1,574 |
| 2020 | 1,835 |

Data Source: HHS

The following table reflects children with a confirmed or founded child maltreatment case that received EA services in each SFY. Numbers are provided for each HHS service area.

| Table 5ll: CAPTA referrals on IFSPs by HHS Service Area | | | | | | | |
|---|---|---|---|---|---|---|---|
| **State Fiscal Year** | **Service Areas** | | | | | | |
| | **CR** | **DSM** | **East** | **North** | **West** | **Other** | **Total** |
| 2024 | 34 | 23 | 47 | 36 | 36 | 1 | **177** |
| 2023 | 44 | 47 | 47 | 36 | 32 | 3 | **209** |
| 2022 | 49 | 72 | 73 | 38 | 81 | 1 | **314** |
| 2021 | 46 | 59 | 54 | 50 | 32 | 0 | **241** |
| 2020 | 61 | 99 | 65 | 72 | 36 | 0 | **333** |

Data Source: HHS

The following table reflects children under the age of three in foster care that received EA services by fiscal year.

| Table 5mm: Children in Foster Care on IFSPs by HHS Service Area | | | | | | | |
|---|---|---|---|---|---|---|---|
| **State Fiscal Year** | **Service Area** | | | | | | |
| | **CR** | **DSM** | **East** | **North** | **West** | **Other** | **Total** |
| 2024 | 25 | 18 | 31 | 24 | 31 | 1 | **130** |
| 2023 | 37 | 27 | 39 | 28 | 31 | 0 | **162** |
| 2022 | 42 | 69 | 34 | 37 | 53 | 4 | **239** |
| 2021 | 36 | 64 | 35 | 52 | 40 | 0 | **227** |
| 2020 | 67 | 112 | 47 | 74 | 62 | 0 | **362** |

Data Source: HHS

Data narrative: Referrals for children 0-3 with substantiated maltreatment reports remained relatively consistent over the past five years. However, the number of children 0-3 residing in foster care decreased over time. The decline of foster care coincides with the implementation of Family First. CAPTA referrals remained fairly steady, the number

of children referred through CAPTA that go on to receive services through an IFSP declined. Children in foster care receiving IFSP services also declined, and at a rate disproportionate to the decline in foster care utilization.

During SFY 2024, HHS staff continued to be a part of the state team supporting EA infrastructure. Due to vacancies at the DE, additional support occurred through monitoring and CQI efforts as well as with training and professional development. Additionally, the CAPTA program manager captured data related to referrals and service uptake to better understand characteristics of families accepting services, those choosing not to participate, as well as families who engage, but whose children are identified through evaluation as ineligible due to not showing developmental delays. Trend data over the last 5 years reflects a general downward trend of families engaging in services. Referral data shows the vast majority of CAPTA referrals ending due to families declining services or unable to be reached. One of the main goals in 2024 was to collect and better understand this data in order to boost enrollments for eligible children. Planning occurred in 2024 for a Kaizen event which occurred in December 2024. This event involved detailed mapping of the CAPTA referral process, from a case being founded/confirmed, through the end of a referral, either through enrollment or referral closure. HHS anticipates additional information in the SFY 2025 report to provide a more detailed look at this project and the outcomes of the effort, in particular, changes to the referral process, training, IT resources, and family engagement protocols.

**Early Childhood Iowa:** The premise of Early Childhood Iowa (ECI) is that communities and state government can work together to improve the well-being of our youngest children. ECI promotes evidence-based programs that increase quality of services to children and families. ECI was legislated to prioritize children, prenatal through age five, to increase their positive early childhood experiences along the pathways aligned with the five legislated result areas: healthy children, safe and supportive communities, secure and nurturing families, secure and nurturing early learning environments, and children ready to succeed in school.

In SFY 2024, investments occurred with state allocated funds to support eligible families through family support home visitation services and navigation services to provide intentional support in connecting families to available concrete goods and resources. ECI piloted five community-based service navigation resources, known as Thrive Iowa. We found success with linking navigation resources to services with well prepared, local navigators who are known in the community to be a family support home visitation professional. In SFY 2024, ECI state funded family support home visitation services served 4,543 families with children, prenatal through age five. A priority focus was reaching families as early as possible to strengthen child and family outcomes. In SFY 2024, 39.9% of families enrolled in an ECI funded family support home visitation program were first time moms (first time parenting children). In Iowa we currently have

over 70 evidence-based family support home visitation services funded across the state through ECI, closely serving almost all of our 99 counties. Home visitation is a statewide collaborative effort across ECI state funding and federally funded initiatives such as CBCAP and Maternal Infant and Early Childhood Home Visitation (MIECHV). Through the collaborative funding efforts, Iowa is able to provide a home visitation service model in each of our 99 counties. The models vary from Parents as Teachers (PAT), Healthy Families America (HFA), or the Iowa Family Support Credential (IFSC) earned by promising practice programs.

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.

**Infant and Early Childhood Mental Health Consultation/Young Child Wellness Council:** The relationships and attachment that infants and toddlers experience with their primary caregivers heavily influences mental health outcomes across the lifespan. HHS is committed to fostering healthy relationships between children and their caregivers, especially for those children in out-of-home placement. HHS strategies for promoting healthy parent/child relationships are below:

- Strategy 1: Implement Visit Host Approach - To support infant and early childhood mental health, HHS began building infrastructure to implement a "Visit Host" approach for families participating in Iowa's Infant Toddler Court Program (ITCP) as a way of supporting positive relationships and healthy attachment for families with children in out-of-home placement. The design of this approach is to engage families' natural supports (extended family, friends, neighbors, clergy, etc.) who have a positive relationship with the family and are committed to supporting safe, stable and nurturing relationships among the family unit. Visit Hosts are identified, vetted, and will work in partnership with child welfare staff to ensure that Family Time (family interactions) occur frequently, consistently, and authentically, thereby reducing trauma and moving families more quickly towards reunification and permanency. Additionally, this approach will reduce the workload for child welfare staff and other professional supports.
    - Goal 1: By 12/31/2024, a Family Time Coordinator will be subcontracted under the Infant Toddler Court grant, and policies and procedures for identifying, vetting and training Visit Hosts will be in place.
        - Progress: A Family Time Coordinator was hired by the Visit Host contractor (Children and Families in Iowa) in September 2024. The full-time coordinator developed program policies, procedures and training practices that will build infrastructure for this approach. The contractor meets monthly with HHS staff to discuss progress, challenges and programmatic changes. Materials developed to date include a Family Time Facilitator agreement, a family support

interview template, a process map, an orientation process, and a facilitator report to record family interaction data.

- Goal 2: By 6/30/2025, at least 8 Visit Host facilitators will be vetted and actively supervising frequent and consistent family interactions for infants and toddlers enrolled in Iowa's Infant Toddler Court program.
  - Progress: Referrals for six families were received, and two families participated in an intake interview; however, identifying Visit Host facilitators proved more difficult than anticipated. Barriers identified by the contractor include:
    - Misunderstandings about what the internal referral process looks like (who is responsible for making referrals, whose responsibility it is to identify appropriate supports and process for completing background checks)
    - Finding volunteers for families who do not identify natural supports
    - Effectively engaging natural supports (the coordinator reports that, despite numerous attempts to reach natural supports, they are not returning phone calls.)
  - Although difficulties happened in getting this approach developed, the contractor and HHS staff continue to move forward, recognizing that launching new initiatives often takes time and patience. The primary goal for this work is to first engage a family's natural supports; when a family does not identify natural supports, the next step would be to engage a community volunteer. The coordinator is actively pursuing partnerships with local volunteer organizations as well as the faith community to establish the volunteer base.
- Goal 3: By 6/30/2029, at least 40 Visit Host facilitators will be vetted and actively engaged to supervise frequent and consistent family interactions for infants and toddlers enrolled in Iowa's Infant Toddler Court program.
  - Progress: As mentioned above, six referrals were made to the Visit Host/Family Time initiative. Two families completed interviews and provided information on natural supports. Those identified as natural supports have not yet been engaged to become Visit Host facilitators, citing the challenges referenced above. The coordinator is actively seeking to engage a volunteer base for families without identified supports.
- Goal 4: By 6/30/2029, reunification rates for infants and toddlers enrolled in the Infant Toddler Court program will increase by 5%.

        - Progress: Baseline reunification rate for Safe Babies for the reporting period 9/30/2023 – 9/29/2024 was 20%. The goal is to increase this each year of the CFSP.

- Strategy 2: Provide training to Iowa child welfare staff regarding how relationships, attachment and trauma in early childhood impact child development and well-being, as well as strategies for fostering safe, supportive, and nurturing relationships: HHS recognizes the value of both personal and professional development and strives to connect staff with opportunities that promote individual competencies and growth. The Bureau of Child Welfare and Community Services works closely with the HHS Service Help Desk to identify and develop appropriate training opportunities, addressing gaps in knowledge and expertise.
    - Goal 1: By 12/31/2024, a structure and plan for supporting HHS staff training on the topic of infant and early childhood mental health will be developed and ready for implementation.
        - Progress: Staff from the Bureau of Child Welfare and Community Services meets monthly with staff from the Service Help Desk to discuss training updates and identified needs. Development of the training plan occurs through a collaborative process. The Project Director for the Infant Toddler Court Program attends all meetings, with a goal of identifying training needs related to infant and early childhood mental health. The Service Help Desk team is welcoming of all suggestions and recommendations and is willing to work together to best meet the needs of staff.
    - Goal 2: By 6/30/2029, at least 8 voluntary lunch and learn sessions on topics related to infant and early childhood mental health will be offered to HHS staff virtually.
        - Progress: In 2025, a two-part training series on the topic of infant and early childhood mental health will occur as an optional “Lunch and Learn” for HHS child welfare staff. The presenter, Kristi Armstrong, will provide a training titled, “Infant and Early Childhood Mental Health: Its Importance for Children and Families” on April 4th. She will provide the second training, titled “Infant and Early Childhood Mental Health: Protective Factors, Red Flags, and Your Role” on May 9th. The presenter is a clinician trained in working with infants, toddlers and very young children, and has a background as an investigative worker in child welfare.

- Goal 3: By 6/30/2029, at least 80% of survey participants will agree or strongly agree that the content of the training events increased their capacity to serve families more effectively.
    - Not applicable at this time.

**Sobriety, Treatment, and Recovery Teams (START):** In 2024, HHS executed a contract with Children and Family Futures (CFF) to implement the evidence-based Sobriety, Treatment and Recovery Teams (START) approach to child welfare delivery. START is a specialized model shown, when implemented with fidelity, to improve outcomes for very young children and their families impacted by both parental substance use and child maltreatment. This model emphasizes the importance of collaboration and systems change to better support vulnerable families by engaging partners from child welfare, the court system and mental health (MH) and substance use disorder (SUD) treatment.

The START model serves families involved in the child welfare system with at least one child aged 5 or younger, and one parent diagnosed with a SUD. Overarching goals of START are to ensure child safety and well-being, prevent and/or decrease out-of-home placements, increase parental recovery, increase parenting capacity and family stability, reduce repeat child maltreatment, and improve system capacity for addressing parental substance use and child maltreatment, aligning very closely with the goals identified in the CFSP.

HHS leadership determined that START meets the needs of Iowa's child welfare system based upon the following criteria:

- START is an evidence-based practice model that is listed on the Title IV-E Prevention Services Clearinghouse, which would allow Iowa to draw down federal prevention funds to sustain and expand this work.
- A significant percentage of Iowa's open service cases include families with at least one child age birth through five, and many of those cases involve a caregiver with substance use concerns.
- START has a focus on preventing/decreasing out-of-home placement.

<u>Progress This Reporting Period:</u> HHS executed a contract with Children and Family Futures (CFF) on July 8, 2024 as the provider of training and technical assistance to support installation and implementation of the START model. CFF is the proprietary owner of START materials, and is the only entity approved to provide these services. Since execution of this contract, CFF partnered very closely with HHS to begin building infrastructure to implement services in Iowa.

- In August 2024, CFF began facilitating monthly meetings of the Statewide Steering Committee. The Steering Committee's role is to address issues related to programming, evaluation, continuous quality improvement and sustainability.

The focus of the first few meetings was to develop recommendations for selecting two pilot sites to initiate implementation.

- CFF also facilitated monthly project management meetings with the HHS Project Director and Transformation Coordinator to begin planning and coordinating the work. Project management meetings are used to develop agendas for the Steering Committee, discuss contract reporting requirements, explore staffing needs, discuss funding opportunities, address challenges and opportunities, and begin discussing the plan for evaluation.
- CFF and an internal HHS team worked collaboratively to develop the START Toolkit, which will be used to ensure consistent implementation across sites. The Toolkit includes items related to eligibility criteria, START timeline requirements, a Minimum Work Guidelines document which outlines expectations for each staff role, a general PowerPoint on START for use by HHS staff, a program handout, and a Family Mentor co-supervision plan. In addition, CFF met with HHS staff to discuss how START intersects with Family Centered Services (FCS). A matrix document was developed that identifies which services will be provided under the START initiative and which services will be referred to FCS.
- HHS selected two sites in October 2024 to serve as pilot sites for START. They are Clinton/Scott counties in northeast Iowa, and Woodbury County in northwest Iowa. The Steering Committee reviewed relevant data and provided recommendations to HHS leadership. Leadership made the decision to engage these two regions of the state. Since selection, representatives from both pilot sites participated in an orientation training and actively engaged in regular conversations about implementation. Both sites identified a START supervisor and started having conversations with staff about case manager roles.
    - CFF assists the selected pilot sites with determining staffing needs. The decision was made to implement a full team at each site. A full team includes four Social Work Case Manager/Family Mentor dyads, and one full-time supervisor. HHS' Director Garcia is supportive of this approach and signed a Decision Memo allowing the hiring of nine additional staff to support implementation.
    - Monthly meetings with the selected pilot sites began in late 2024. These meetings occurred individually for each site and designed to engage local level leadership, and to provide an open forum for questions or concerns to be discussed. Joint monthly meetings began in the spring of 2025 at the request of the sites as a way of facilitating increased communication and collaboration across the pilot sites.
    - Family Mentors serve a key role in START. Family Mentors are individuals in long-term recovery with experiences that makes them

sensitive them to child welfare. All families in START will receive a Social Work Case Manager and Family Mentor dyad, offering a team approach to supporting families. Family Mentors will be employed by an external agency. Due to the similarity in scope of work, HHS decided to embed Family Mentor positions in the Parent Partner contract. The contractor was selected and contract negotiations are underway.

- A webinar occurred in early March 2025 for all staff located in the two pilot sites to provide a high-level overview of the START initiative and respond to any questions or concerns. A total of 42 staff members joined the meeting.

- CFF coordinated three national webinars to assist affiliate states with specific topics. The first addressed harm reduction, and how it fits into the START model, the second addressed claiming and reimbursement for the Family First Prevention Services Act, and the third addressed trauma informed drug testing. These webinars were available to all affiliate states and their partners.
- HHS selected an evaluation lead, the University of Iowa's National Resource Center for Family Centered Practice, to serve as the entity responsible for overseeing the evaluation process. The lead evaluator met with CFF and the Project Director to begin discussions regarding what the evaluation plan should look like. Regular monthly meetings will occur going forward.

Alignment with CFSP: Each element of START is designed to promote child safety, permanency and well-being. The model places an emphasis on keeping children safely with their family whenever possible and works to reunify the family once parental recovery is stable and safety factors were remediated.

START provides opportunity for parent voice, utilizing a shared decision-making process, as well as a family-centered approach through the Social Work Case Manager/Family Mentor dyad. The Family Mentor brings their own lived experiences to the team and is able to identify both progress in recovery as well as potential relapse behaviors. A dedicated and unified dyad is important to provide consistent messaging, oversight, family contacts, and service delivery. Both partners bring their unique perspectives, complement each other, and evolve as a team.

**FFY 2025-2029 Goals:** HHS is on track for meeting projected goals as described below:

**Goal 1:** By 6/30/2025, at least six trainings shall be provided to key staff and stakeholders regarding the START model and relevant topics (such as safety and risk assessment, language, etc.)

**Progress:** During this reporting period, CFF offered the following START training opportunities:

- Overview presentation about START for Clinton/Scott counties HHS leadership
- Overview presentation about START for Woodbury County HHS leadership
- Overview presentation about START for all HHS staff in Clinton, Scott and Woodbury counties and Central Office
- Webinar training on Harm Reduction
- Webinar training on Claiming and Reimbursement for the Family First Prevention Services Act
- Webinar training on Trauma Informed Drug Testing
- Additional trainings are scheduled, including an in-person site visit

**Goal 2:** By 6/30/2026, an Iowa START Toolkit shall be developed and distributed, based on national START standards.

**Progress:** The Iowa START Toolkit was developed and will be finalized in April 2025. Once finalized and approved by HHS leadership, it will be made available to the pilot sites to ensure consistency in implementation.

**Goal 3:** By 6/30/2029, at least three local implementation sites will be fully trained and directly implementing the START model.

**Progress:** Two local implementation sites were identified and working to develop infrastructure to begin implementation in the summer of 2025. After implementation begins, the Steering Committee will explore additional areas of the state for possible expansion.

**Goal 4:** By 6/30/2029, evaluation data will indicate that rates of out of home placement for children in START will decrease by 5% over baseline.

**Progress:** Not applicable at this time.

## Efforts to Track and Prevent Child Maltreatment Deaths

**Steps Iowa Is Taking to Track Child Maltreatment Deaths:** In FFY 2024, Iowa reported 13 child fatalities resulting from abuse, neglect, or in which abuse or neglect was a contributing factor. A manual review of these cases revealed the following distribution of causes:

- Category of Abuse:
    - Physical Abuse:
        - Physical abuse: 23% (3 cases)
        - Homicide: 14% (2 cases, both involved physical abuse)
    - Denial of Critical Care:
        - Supervision:

- Unsafe sleep: 23% (3 cases)
- Inadequate medical care: 8% (1 case)
- Suicide: 8% (1 case)
- Motor vehicle accident: 8% (1 case)
- Alcohol-involved incident: 8% (1 case)
- Asphyxiation: 8% (1 case)

These findings underscore the importance of continued efforts to address preventable causes of child fatalities, such as unsafe sleep practices and physical abuse, as well as the need for interventions in areas like medical care and suicide prevention.

For context, the 2023 Child Maltreatment Report (ChildMaltreatmentAR2023_FINAL) from the Children's Bureau found that physical abuse accounted for 41% of national child maltreatment fatalities. In FFY 2024, Iowa reported 38% (5 out of 13) of its fatalities resulting from physical abuse, aligning closely with national trends. Similarly, medical neglect represented about 7.8% of national fatalities, while Iowa's rate was 8%, further reflecting consistency with national data.

Of the reported child maltreatment deaths, eight families had prior contact with child protective services, either through assessments, ongoing services, or both, while five families had no prior involvement with CPS in Iowa.

**Steps Iowa Is Taking to Prevent Child Maltreatment Deaths:** Iowa's commitment to preventing child maltreatment fatalities is supported by the work of the Iowa Child Death Review Team (CDRT), a multidisciplinary body established by Iowa Code Section 135.43. Since its inception, the team plays a pivotal role in identifying preventable child fatalities by reviewing deaths linked to abuse or neglect. Comprised of professionals from 14 different disciplines, the CDRT's collaborative approach enables it to analyze child deaths with expertise from medicine, mental health, social work, law enforcement, and other critical fields.

The primary function of the CDRT is to conduct in-depth reviews of child fatalities, identify contributing factors, and make recommendations for preventing future deaths. The team reviews cases of child abuse and neglect, accidents, suicides, homicides, and undetermined deaths—many of which may be preventable through improved intervention and systemic changes. By collaborating with key stakeholders and utilizing data collected from various sources, including the Iowa's Child Welfare Information System (JARVIS), the team made significant strides in both case-specific and broader policy-level interventions aimed at improving child welfare across the state.

One key theme emerging from the CDRT's reviews was the identification of unsafe sleep environments and physical abuse as leading contributors to preventable child deaths. The team's findings and recommendations inform targeted prevention efforts,

including statewide education campaigns and the development of protocols for child fatality review committees.

Safe Sleep Efforts and Progress: In particular, the CCC Review team observed that Child Protection Workers (CPWs) statewide are doing a great job of discussing safe sleep practices with families and consistently documenting these discussions in case records. This positive trend is a direct result of ongoing efforts related to safe sleep education and awareness campaigns. HHS policy is an active participant in the Safe Sleep Workgroup, which collaborates with stakeholders to develop and promote safe sleep practices to prevent sleep-related fatalities. These efforts are contributing to improved outcomes and more effective safety interventions for Iowa's children.

The Iowa Child Death Review Team's annual report, which reviews fatalities from previous years, highlights risk factors such as sleep-related deaths and suicides. These areas were identified as opportunities for intervention to significantly reduce the number of child deaths. Through its recommendations and the dissemination of findings, the CDRT continues to be a cornerstone of Iowa's approach to improving child safety and preventing maltreatment fatalities.

Additionally, Iowa has a Critical Case Coordinated Review Team (CCC Review), an internal group tasked with reviewing critical incidents involving children who were subjects of abuse assessments, experienced rejected intakes, or were involved in ongoing services cases, including child fatalities. This team consists of experienced HHS social workers from policy, help desk, field social work administrators, and leadership, including division directors.

The CCC Review team conducts comprehensive case reviews, analyzing all relevant case records within HHS, such as assessments, rejected intakes, monthly case notes, and criminal and civil histories for family members. The team also reviews cases involving children in foster homes or daycare settings. Additional cases are reviewed at the discretion of the Director or division administrator.

In alignment with Safety Science principles, the CCC Review team works closely with a partner from the National Partnership for Child Safety (NPCS). Recently, NPCS conducted an observation of the team's review practices and provided valuable feedback, which the team is already implementing to enhance case review processes. Previously, the team would individually review case histories (including case notes, criminal history, etc.) and then input the information into a standard review form before discussing the case. NPCS suggested that the team input this information into the form prior to meetings, allowing more time for discussing systemic issues and fostering a more collaborative review process.

This change in practice is helping the team focus better on identifying patterns and systemic issues, ultimately contributing to more effective and comprehensive reviews that support the goal of preventing child maltreatment fatalities.

The CCC Review team is also taking steps to track internal data on child deaths to identify trends and assess whether adjustments in practice can occur to further prevent maltreatment fatalities.

Finally, as part of ongoing efforts to reduce child maltreatment fatalities, Iowa's Child Protection Policy team reviewed, studied and analyzed the "Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities report, drafted by the Commission to Eliminate Child Abuse and Neglect Fatalities. The insights from this report sparked important discussions with Iowa's Early Intervention Support unit about prioritizing home visiting programs for children under age 5 with prior CPS involvement. This proactive approach further aligns with the state's commitment to preventing child maltreatment and enhancing the safety and well-being of Iowa's children.

## MARYLEE ALLEN PROMOTING SAFE AND STABLE FAMILIES (PSSF) (TITLE IV-B, SUBPART 2)

### Family Preservation Services

Iowa received approval from the federal Children's Bureau in 2007 to allocate less than 20% of Promoting Safe and Stable Families (PSSF) funding for family preservation services. Iowa's family preservation services are currently our Family Centered Services (FCS) available statewide. Iowa utilizes a combination of state and federal IV-B, subpart 1 and subpart 2 (Family Preservation), SSBG, TANF, and Medicaid funds for FCS.

For more information about FCS, please see *Family Centered Services* earlier in this section.

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. In SFY 2024, service areas spent $6,606 for wrap-around services.

### Family Support Services

Iowa utilizes PSSF Family Support Services funding for the Iowa Child Abuse Prevention Program (ICAPP). For more information on ICAPP, please see *Early Intervention and Support Prevention Programs and Services, Iowa Child Abuse Prevention Program (ICAPP)*.

### Family Reunification Services

Iowa allocates PSSF dollars to Family Reunification Services. HHS central office staff removes some of the funding, usually allocated to the five HHS services areas, to

include in the Family Centered Services (FCS) contracts. HHS utilizes these funds, in addition to IV-B, subpart 1 funds, in the FCS contracts because the contracts include services to support reunification, such as facilitation of Family Focused Meetings (FFM). Central office staff then allocates the balance to the service areas based upon historical allocations and service area needs. All services to children and their families remain traceable to the eligible child. Service areas determine utilization of the funds they receive and sub-contract with service providers. In some of the service areas, the service area's Decategorization (Decat) committee has responsibility for projects funded under Family Reunification Services.

Services from the following menu are available to children and families, including relative caregivers, during the child's foster care stay and up to 15 months after the child reunifies with the parents or relatives. These services promote the program goal of safe and timely reunification of the child with the family and prevention of foster care re-entry.

**Iowa's Family Reunification Services "Menu":** Due to service area usage, the menu changed to reflect those services utilized the most over the past three SFYs:

- 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.
- All Other Counseling (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.
- 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.

- 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.

**Table 5nn: PSSF Family Reunification Services Usage**

| Services | SFY 2021 | SFY 2022 | SFY 2023 | SFY 2024 | SFY 2025 (7/1/24 – 3/31/25) |
|---|---|---|---|---|---|
| Access and Visitation Services | 28% | 45% | 27% | 49% | 38.62% |
| All Other Counseling | 26% | 10% | 15% | 12% | 21.86% |
| Substance Abuse (SA) Services | 3% | 3% | 1% | 1% | 0.0% |
| Mental Health (MH) Services | 28% | 31% | 43% | 35% | 30.20% |
| Transportation | 1% | ------ | 1% | 0.0% | 9.32% |
| Domestic Violence Assistance | ------ | ------ | 1% | ----- | 0.0% |
| Fatherhood Programs* | 2% | 9% | ------ | 0.0% | 0.0% |
| Motherhood Programs* | 9% | 1% | ------ | 0.0% | 0.0% |
| Daycare, Respite Care, and Therapeutic Camps | 2% | 1% | 1% | 3% | 0.0% |

Data Source: HHS; *These programs were not utilized over the last three SFYs and are eliminated from the menu of services.

HHS plans over the next fiscal year to conduct a robust analysis of how HHS can better utilize the funding to provide services to achieve safe, timely and permanent reunification for children and families.

### Adoption Promotion and Supportive Services

Iowa's Recruitment, Retention, Training, and Supports (RRTS) contractor, Four Oaks Family & Children Services continues to engage Iowa foster, adoptive and kinship providers by providing direct service in their homes for licensing and support, having monthly contact at a minimum for all licensed foster and adoptive homes when a child is placed in the home. A new contract went into effect on July 1, 2023. The contacts include face-to-face meetings in their homes, as well as additional face-to-face contacts at support group meetings and trainings. Support caseworkers assist adoptive families in connecting with needed supports and services. The support caseworkers also maintain contact with providers and HHS workers as needed for updates or to problem

solve a situation and assist the family through the adoption process. These supports remain in place until an adoption is finalized.

RRTS support caseworkers also meet every other month with approved adoptive families even when a child is not placed in the home to discuss opportunities to take placement of children and sibling groups currently available for adoption. It is hoped this will result in timelier and higher-quality adoption matches.

HHS strongly supports keeping children within their families and communities of origin. HHS continues to encourage more relative and fictive kin caregivers to become licensed foster or adoptive parents. Licensure brings increased financial assistance, concrete supports and training that unlicensed caregivers do not receive. Iowa plans to implement a kinship licensure process on July 1, 2025. HHS worked with Four Oaks and collaborated to develop a path to licensure that will work for Iowa kinship families.

Iowa will continue to support quality post adoption and guardianship services through the RRTS contract. Once a pre-adoptive youth is placed in a foster or adoptive home, RRTS offers pre and 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. Families are eligible for services who receive future or special needs adoption subsidy as well as families who received a subsidized guardianship subsidy. Currently, there are 1,021 adoptive families receiving adoption support services.

**Collaboration:** Iowa began a relationship with Reel Hope, a private non-profit agency, in February 2024 to add additional adoption recruitment services to match Iowa's awaiting children. The Reel Hope Project's goal is to create a video for all youth in Iowa who experience foster care and awaiting an adoptive family. Each reel is specific to the child and shows what makes each child waiting unique. These videos are used as active recruitment by Iowa HHS workers to seek out permanent families and connections for these children.

Since initiation, six children were matched with their forever family due to their Reels. Iowa will continue into this reporting period with active efforts to seek out and find quality adoptive homes for children to minimize the length of stay in foster care. It is also important that the match for children is a good one to prevent re-entry into the child welfare system after adoption.

**Internal Agency Collaboration:** The HHS adoption program manager will continue to collaborate with agency staff through "Adoption Summits." The Summit is intended to be an exchange of information with statewide adoption SWCM's, supervisors, as well as the Iowa Attorney General's office. These summits assist with providing the most

accurate and current information to the persons working directly with families. The summit also includes worker collaboration and relationship building. Workers share ideas and practices for difficult case situations. Iowa has had four Adoption Summits. Feedback for these events was very positive from attendees and Iowa hopes to continue these events into the next reporting period.

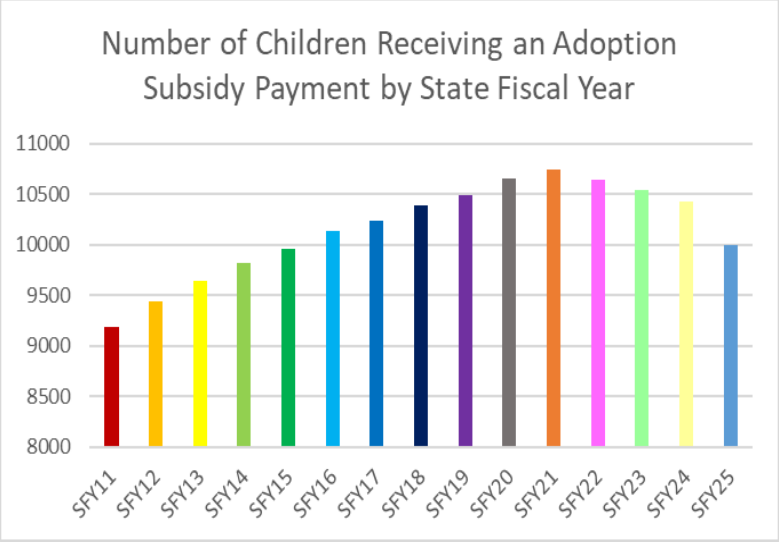
The HHS adoption program manager will continue to hold regular communication with Iowa's HHS adoption workers and supervisors into the next reporting period.

For more information on *Recruitment, Retention, Training, and Supports (RRTS)*, please see:

- *Section II: Update to the Current Performance in Improving Outcomes, Systemic Factors, Foster and Adoptive Parent Licensing, Recruitment and Retention*
- *IA Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan*

**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 5c: Number of Children Receiving Adoption Subsidy by SFY**




Data Source: HHS

## POPULATIONS AT GREATEST RISK OF MALTREATMENT

Intentional planning for understanding populations with the greatest risk of maltreatment was an ongoing need, now made possible as Iowa continues to strengthen our Integrated Data System for Decision-Making (I2D2) via our state and university partnership with Iowa State University. Based on 2023 year-end, statewide data, we

know cumulative birth risks from I2D2 data analysis of Iowa birth records. Birth risk factors are poverty, low birth weight, parenting alone (single parent), low maternal education, inadequate prenatal care, teen mother, tobacco used during pregnancy, and preterm birth. In 2023, there were 38.9% of children born with no identified risk factors. There were 21.7% born with at least one risk factor and 39.4% were born with two or more risk factors.

As our state continues to grow in understanding county-level data we can better respond to family needs with a prevention and community capacity building approach. In SFY 2024, Iowa prepared a request for proposals (RFP) for the Iowa Child Abuse Prevention Program (ICAPP). When we conducted statewide listening sessions in spring and summer 2024, we gained insightful information.

All six communities identified strengths and empowerment with the understanding and commitment to one another through collaborative efforts. There was consensus in understanding that community programs working together creates the recipe for full support to families and children. All six communities identified the importance of partnership programming, and the strength in commitment to one another. Continued initiatives to grow capacity with community partnerships, communicative efforts to collaborate efficiently and build systems, which foster the smooth delivery of services through collaborative efforts, was a key component in trends to build upon collaborative strengths of partnerships.

To begin, we established a requirement for local volunteer Child Abuse Prevention Council to agree to meet at least once per year with the local Early Childhood Iowa (ECI) Area Board. A mutually signed agreement letter was required in the ICAPP RFP. The core of funding has historically been 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 the new RFP, there were three project options provided to applicants to choose to apply for within their Council and ECI area geography. These project opportunities focused on evidence-based home visitation services, community-based collaboration, and sexual abuse prevention.

- Evidence-Based Home Visitation Services: Home visitation services are designed to support families by providing education, resources and health services directly in the family home. In the RFP, applicants were asked to submit documentation that they were affiliated with either Parents as Teachers (PAT) or Healthy Families America (HFA). If applicants were in the process of becoming affiliated/accredited, they have 12 months from contract start date to complete the affiliation or accreditation process. They were asked to identify the number of families projected to be served per family support professional, aligned with model fidelity. Family support professionals are required to complete on-going

documentation within the Family Support Statewide Database (FSSD) DAISEY. Programs will also develop and issue a parent satisfaction survey to be distributed to families annually.

- Community Capacity Building: Community capacity building may involve establishment or support for Family Resource Centers or resource hubs as a way to reach families in need. Community capacity services shall be paired with the distribution of "concrete goods" to improve family health, well-being, and/or self-sufficiency. Concrete goods shall be paired with any of the following three activities. This pairing will help families establish a network of supportive relationships and connect them to essential goods to help them along a pathway to economic stability and family well-being.

  Community capacity efforts shall include one or more of the following activities:

  - Group-Based Parent Programming. This includes programs that facilitate the development of informal caregiver/guardian/parent networks. Examples may include but are not limited to parent and coffee groups with supervised child play options and social gathering with the guided purpose of parent engagement with connections to on-going service options to meet developing needs. Gatherings should include a parent education component to increase skill building, while social networks are encouraged. The use of the Parent Cafe model may also be used.
  - Parent Development. These services include, but are not limited to parenting instruction, parent-child interaction programs, social support programs, and parent leadership services. These services may be delivered in group settings or public locations. This service may also be targeted toward specific populations at greater risk, for example young parents, parents of children with disabilities, or other special populations.
  - Resource Navigation. Resource navigation will align with HHS' developing approach to partner with families to complete resource applications, establish relevant referrals to programs or resources in the community, and actively engage with community members equipped to help families participate in on-going services.
  - Resource navigators will actively collaborate with HHS team members to simplify access to services and capture our core value of "Iowans helping Iowans to be healthy and successful."

  Applicants for these components are required to submit quarterly service reports including number of participants served, services offered, and project narrative.

- Sexual Abuse Prevention: Applicants were given curricula to choose from that is focused on teaching skills to adults to understand how to protect children, is adult-focused, and trauma informed from the following list of options:

- Darkness to Light
- Stewards of Children
- Prevent Child Abuse Vermont
- Brain Development and Learning Consent During Childhood
- CARING Adults (Child Anti-trafficking Resources, Instruction, and Norms Growth)
- Everything Everyone Needs to Know About Sexual Abuse
- Keeping Adolescent Youth Safe on the Internet
- Nurturing and Safe Environments for Children with Disabilities
- Nurturing Healthy Sexual Development
- Overcoming Barriers to Protecting Children from Sexual Abuse
- Technicool: Keeping Kids Safe on the Internet
- Understanding and Responding to the Sexual Behaviors of Adolescents
- Understanding and Responding to the Sexual Behaviors of Children
- Understand, Recognize, and Respond to Grooming Behaviors

Instruction may be delivered to adult audiences via a certified trainer. Instruction may occur in an in-person, virtual, or asynchronous setting. This may include training with adult audiences such as parents, caregivers, law enforcement, educators, childcare providers, social workers, and employees or volunteers of child-serving organizations. Allowable activities may also include consultation with decision makers and/or child serving entities responsible for services involving children and youth aged 0-17 for development or enhancement of policy, protocol, and practice procedures for sexual abuse prevention.

Applicants for this component must train at a minimum 75% of the identified populations who engage with adults who serve and/or interact with children and youth, provide on-going attendance lists and collect and report their training session evaluation data aligned with the delivered curriculum.

## KINSHIP NAVIGATOR FUNDING (TITLE IV-B, SUBPART 2)

When safety cannot be assured in the home and a removal must occur, HHS first looks to kin and fictive kin caregivers who may be able to care for the child. When a child is placed with kin or fictive kin, the Kinship Navigator Program provides immediate support to the caregiver family. This can take the form of assisting kin or fictive kin in obtaining any items necessary to care for the child, connecting the caregiver with community resources to meet the child's needs or the caregiver's needs, and helping the caregiver process the change in relationship dynamics with the child and parents. Iowa is working

toward aligning practice with an established Kinship Navigator program to better support kin and fictive kin caregivers, assure needs are identified and addressed in a timely manner, and that kin and fictive kin caregivers have ready access to information about community supports.

Through this array of services available under the Family Centered Services contracts, families involved with Iowa's child welfare system receive support and empowerment to keep their children safe and, in their homes, whenever possible. The focus of all services under FCS is to drive positive behavioral change, which results in better long-term outcomes for children as they are less likely to re-enter the child welfare system. Parents and caregivers are empowered to identify and make choices that work best for their family, resulting in increased confidence of decision-making. Through empowerment and positive behavioral change, parents are better equipped to identify stressors early on and seek out community supports in the future, thereby avoiding a return to the child welfare system. There were a total of 912 separate cases of Kinship Navigator Services in service between the period of July 1, 2024 and April 30, 2025.

In SFY 2025, HHS utilized FY 2024 title IV-B, subpart 2 funds to partner with Kinship Navigator providers to align Kinship Navigator Services with the HHS selected evidenced based model, ProtectOhio Kinship Supports Intervention (KSI). Aligning with the KSI model listed as Promising on the Preventions Services Clearinghouse allows HHS to add the model to the state's title IV-E State Plan and drawdown federal IV-E funds.

The HHS Kinship Program Manager and the Kinship Navigator Services providers began meeting monthly August 2024 to work on KSI model alignment efforts, as well as to discuss strengths and challenges occurring in the Kinship Navigator program and to troubleshoot areas of concern in providing services. HHS maintains close communication with this provider group on other upcoming changes impacting kinship caregivers, such as on the changes to the Kinship Caregiver Payment program (KCP) and the upcoming implementation of the expedited Kinship Foster Care approval process.

HHS consulted with Sivic Solutions Group (SSG) to complete a review and comparison of Iowa's existing Kinship Navigator Program with the ProtectOHIO KSI model. Though Iowa's program already included many of the ProtectOHIO KSI model program components, SSG identified implementation steps to align Iowa's current program with the ProtectOHIO KSI model. In addition, representatives from HHS and Kinship Navigator Service Providers consulted with the Ohio Department of Children and Youth regarding KSI model requirements and Iowa implementation, and with Franklin County Children Services in Ohio about their practical implementation and daily practice of the KSI model to assist Iowa in learning about the model and to inform implementation efforts.

The aligned implementation of the Kinship Navigator Services program with the ProtectOHIO Kinship Supports Intervention (KSI) will be primarily implemented through the Kinship Navigator Services program, which is a contracted service through the Family Centered Services contracts with providers. HHS' Child Protective Services caseworkers will also support implementation of the KSI model through their role in completing components of the KSI model through their work with the kinship caregiver.

Iowa's Kinship Navigator Services program currently meets the requirements per the Title IV-E Handbook of Standards and Procedures regarding provision of services to kinship caregivers for the purpose of:

- Case coordination
- Financial supports
- Training and education
- Support groups
- Referrals to social, behavioral, and health services
- Assistance with navigating government programs
- Other types of assistance, financial or otherwise
- Concrete supports

Training for Kinship Navigator staff on the Ohio KSI model changes occurred in March 2025 by the Child Welfare Provider Training Academy in collaboration with Families First, a Family Centered Services (FCS) contract provider and pilot provider for Kinship Navigator Services in the initial roll-out in 2018. HHS staff received an overview of the Kinship Navigator Services changes also in March 2025. The Kinship Navigator Services Program will fully implement the tools and processes from the ProtectOhio KSI Model to be effective May 1, 2025, to align current services with the KSI model.

**Collaboration:** Kinship Navigator Services provides an opportunity to connect Kinship Caregivers with supports and resources to meet their needs at both local and state levels. Kinship Specialists are knowledgeable of available community resources through connection to community partnership coalitions, knowledge of services providers and organizations and the resources available, and through accessing online platforms that provide directory and hub information, such as 211. Kinship Specialists and FCS providers are expected to coordinate regularly to ensure family needs are met and to communicate with HHS regarding concurrent planning and family finding efforts and connection of identified natural supports that will be important to the child and the family.

Kinship Navigator Specialists connect with community organizations that support kin and fictive kin, including Achieving Maximum Potential (AMP), Area Agencies on Aging (AAA), mental health organizations and other related community resources that can

enhance community connections and promote available supports to kinship caregivers. These connections allow for better coordination of services and meeting the unique needs of each caregiver family.

Iowa's Foster Squad is a program to provide resources to Iowa foster families. Foster Squad developed a program called "Equip Hub". The program connects technology that drives action for local children and families in crisis. Equip Hub enables care-sharing: a method of collaboration that empowers people to share the responsibility of caring for people in need by providing something they need to care for a child in their home. This program is anticipated to go live in May 2025 in the HHS Des Moines Service Area, including the community of Ames. Foster/adoptive and kinship caregivers can access the portal if they need baby gear, clothing, or any other tangible item to take care of the children in their home, such as a bed, dresser, crib, etc. The community can access the portal and choose to provide requested items. Similar online resource hubs are available in scattered communities across the state.

In development are plans to connect with youth with lived experience in kinship care through AMP (Achieving Maximum Potential) and with kinship caregivers to develop additional engagement opportunities for youth and families to advocate and inform continued development of Kinship Navigator Services. Representatives from Kinship Navigator Services will begin meeting with AMP monthly to discuss how to increase access to youth in kinship placements to participate in local AMP chapters. The HHS Kinship Program Manager further requested Kinship Navigator Services partner to identify potential kinship caregivers to participate in a statewide advisory committee to provide input and feedback to how they are experiencing or have experienced the supportive services available or being implemented for kinship care through the child welfare system in Iowa. Kinship caregiver feedback, along with input from Kinship Specialists providing Kinship Navigator Services, were further utilized to determine the information and resources instrumental to include in development of the Kinship Caregiver Handbook.

## MONTHLY CASEWORKER VISIT STANDARDS AND FORMULA GRANTS

Iowa utilized the funds over the past year on the following:

- Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. The CareMatch system:
    - Tracks beds in group care, shelter and supervised apartment living and
    - Tracks and matches licensed foster parents and children in foster care. The license agreement contract includes system enhancements, data conversion, training, and an annual licensing fee. The tracking system assists caseworkers in determining the closest and most appropriate placement for the child. Research suggests that children placed closer to

home receive more frequent, quality caseworker visits, which in turn impacts caseworkers' assessment of safety, efforts to achieve timely reunification or other permanency goals, and efforts to achieve child and family well-being.

- CareMatch upgrades to help better support contracts.

Focus groups occurred earlier this year with SWCM's and supervisors to find out the barriers to completing monthly visits. Two of the main barriers reported were travel time, distance across the state and large sibling groups placed across the state. CareMatch helps to locate the closest, most appropriate placement for the child. Iowa's monthly caseworker visit (MCV) numbers increased over the last several fiscal years and HHS believes that using CareMatch to locate closer placements assisted in this increase.

**Continued action steps to ensure that statutory performance standards are met.**

| Table 5oo: FFY 2024 – Monthly Caseworker Visit Grant Reporting | | |
|---|---|---|
| **Reporting Requirement** | **Data** | **Type of Data** |
| The aggregate number of children served in foster care for at least one full calendar month | 5,477 | SACWIS |
| The total number of monthly caseworker visits for children who were in foster care | 43,066 | SACWIS |
| The total number of complete calendar months children spent in foster care | 44,983 | SACWIS |
| 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 | 32,942 | SACWIS |
| The percentage of monthly visits by caseworkers with children in foster care under the responsibility and care of the state. | 96% | SACWIS |
| The percentage of monthly visits that occurred in the residence of the child. | 77% | SACWIS |

Data Source: HHS' SACWIS

Iowa made significant improvement over the last several fiscal years. Iowa was at 96% this past FFY, an increase of 3% from FFY 2023. HHS took multiple steps to increase compliance in meeting the frequency requirement. The Bureau of Quality Assurance and Improvement pulls a Not Met Visits report just after the 20th of each month as all visits for the prior month must be entered by then. Supervisors review the report and report back to the Social Work Administrator (SWA) on any missed visits. Supervisors are also reviewing the reports with their staff during monthly supervision towards the end of the month. SWAs are sending an email to supervisors, bringing to their attention any workers who are not at 95%. Service Areas partner with each other for visits with youth placed in state, but out of their service area. They ensure the youth has a relationship with both workers for a quality/comfortable visit. For youth placed out of state, the Iowa social worker joins the visit virtually when the receiving state is at an in-person visit. Iowa also ensures there is good communication with the receiving state to

gather visit narrative for timely entry. The SWAs send appreciative emails to staff when visits are at 100%. The child visit performance is also a part of the supervisor and social worker's annual performance evaluation.

## PROGRESS REPORTING FOR OTHER GRANTS AND REQUIREMENTS COORDINATED THROUGH THE CFSP/APSR

### Adoption and Legal Guardianship Incentive Payments

Iowa spent $1,360,500 in Adoption and Legal Guardianship Incentive Payments in SFY 2024. The state plans to spend $1,343,500 in Adoption and Legal Guardianship Incentive Payments by June 30, 2025. In SFY 2026, the funds will be utilized in Family Centered Services expenditures. Iowa utilized the FFY 2021 funding in SFY 2024 and will be utilizing FFY 2022 funding in SFY 2025. Iowa has not encountered any changes, issues or challenges to the plan outlined in the 2025-2029 CFSP for timely expenditure of the funds

### 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 specific qualified expenditures. Below is how Iowa has spent funds in the last year. Iowa expects expenditures to be the same over the next year.

HHS continues to fund the Treatment Outcome Package (TOP), created by Outcome Referrals, which is used to:

- assess a child's current treatment needs within 12 domains;
- track a child's improvement or deterioration;
- identify data trends around stronger/better performing providers and foster parents; and
- identify other data points that would impact practice decisions made by HHS' and Juvenile Court Services' staff.

TOP provides another avenue to empower individuals involved in a child's care, including parents and the children themselves, to have a voice in the assessment and placement process through entering information into the same system. Sixteen percent (16%) of Iowa Adoption Savings Expenditures are TOP related.

HHS also designated Adoption Reinvestment funds to help support our Subsidized Guardianship program. Twenty-one percent (21%) 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. The numbers represent the total number of all open subsidized guardianship cases for the fiscal year in each of Iowa's five service areas, which are cumulative over the time period represented. The "currently open" number represents a point-in-time number of open subsidized guardianship case. Thus far in SFY 2025, 6 cases closed.

**Table 5pp: Number of Children in Subsidized Guardianship by Service Area**

| | Service Area | | | | | |
|---|---|---|---|---|---|---|
| | Western | Northern | Eastern | Cedar Rapids | Des Moines | Total |
| | Count | Count | Count | Count | Count | Count |
| SFY 2024 | 73 | 25 | 49 | 35 | 43 | 225 |
| Currently Open | 65 | 27 | 50 | 31 | 58 | 231 |

Data Source: HHS

HHS is also using available adoption savings money to increase the purchasing of Family Centered Services which include SafeCare (0%), Family Casework (10%), and Family Preservation Services (11%). Therefore, 21% of Iowa Adoption Savings expenditures are related to family centered services.

HHS estimates $4.6 million in unspent funds from previous years, primarily in the category of amounts required for post-adopt/post-guardianship services. HHS is actively addressing this through the creation of new programs and targeted expansion of existing efforts. This includes allocating more funding to the RRTS post-adopt contract as of SFY 2024, as well as the creation and ongoing expansion of the subsidized guardianship program since SFY 2020. These steps are part of our strategy to ensure the remaining funds are effectively utilized to support the intended populations.

## Family First Prevention Services Act Transition Grants

**HHS:** 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 FCS service packages. These implementation costs included the following:

- Training and certification in Solution Based Casework (SBC) (now Family Casework) and SafeCare, including coaching

- Training in Motivational Interviewing through a contract with the Child Welfare Provider Training Academy, which also included HHS staff
- IT costs associated with implementation.
- SBC licensing fees.
- SafeCare and Motivational Interviewing are the currently approved Title IV-E Prevention Services implementing FFPSA, Part I.
- SafeCare evaluation with Georgia State University (GSU) Research Foundation

HHS also utilized the FFTA funding for HHS staff costs, specifically for a Program Manager and the IV-E Prevention Plan Manager.

The table below provides a breakdown of how HHS utilized the FFTA funding.

**Table 5qq: FFTA Funding Utilization**

| | Salaries & Wages | IT Technical Consultants | Education & Training Supplies | Administrative Support | Other Licenses, Permits & Fees | Research | Training |
|---|---|---|---|---|---|---|---|
| **IT COSTS** | $79,337.80 | $311,710.72 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **Transition Funding** | **$0.00** | $333,517.35 | $0.00 | $3,500.00 | $132,512.43 | $0.00 | $666,275.71 |
| **FCS Costs** | **$0.00** | $35,725.00 | $539,983.00 | $185,600.00 | $54,345.82 | $0.00 | $150,284.88 |
| **Licensing Fees - SBC** | **$0.00** | $9,600.00 | $0.00 | $22,000.00 | $130,662.20 | $0.00 | $0.00 |
| **Program Manager** | **$127,228.98** | $1,472.66 | $0.00 | $138.35 | $185.00 | $0.00 | $0.00 |
| **IV-E Prevention Plan Manager** | **$9,708.22** | $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 |
| **$3,266,455.44** | $216,275.00 | $692,025.73 | $539,983.00 | $211,245.67 | $317,705.45 | $95,000.00 | $1,194,220.59 |

Characteristics of families and children served under FFPSA are families eligible for SBC (As of July 1, 2024, Family Casework with Motivational Interviewing), SafeCare, and Family Preservation Services with Motivational Interviewing. These services are targeted toward intact families (in-home), families with children placed with kin/fictive kin caregivers, and families whose children are placed in stranger foster care.

For more information about these services:

- Please see *Family Centered Services (FCS)* earlier in this section.

- Please see *Section III, Update to the Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Implementation and Program Supports, Research and Evaluation, SafeCare*

HHS plans to fully obligate the balance of the funds by September 30, 2025. Specifically, HHS plans to utilize the remaining funds on the following:

- SafeCare eligible expenditures
- FCS eligible expenditures
- Lyssn user seats for Motivational Interviewing (MI)
- START costs
- IT costs

**Juvenile Court Services (JCS):** JCS received $425,000 of the $5.1M of Transition Grant funds awarded to Iowa. Because JCS had not previously participated in any Title IV-E activities or funding initiatives, these implementation activities focused primarily on establishing an infrastructure to deliver FFPSA across the state as well as training of staff. Since JCS utilized their portion of the FFPSA grant for staff salaries related to the implementation and activities of the Family First Prevention Services Act, funds were not used for direct services for children and families served.

In addition to the training costs incurred by JCS for Title IV-E implementation, there was also an expense associated with the implementation of a Continuous Quality Improvement (CQI) process, including the hiring of a CQI manager. Prior to its participation in FFPSA, JCS did not have a CQI process. To ensure JCS was able to meet Title IV-E requirements and begin a systematic effort at system improvement, JCS employed a CQI manager on June 1, 2021.

# Section VI: Consultation and Coordination Between Iowa and Tribes

**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.

Since the submission of the 2025-2029 CFSP, the Iowa Department of Health and Human Services (HHS) gathered input from the Meskwaki Nation through the following processes:

- Local case-specific and systemic issue discussions, as needed, between MFS staff (Mylene Wanatee – MFS Director and Carrie Welton – MFS caseworker),

HHS central office staff, and/or HHS service area leadership for Linn and Tama Counties and local frontline staff.

- Meetings between MFS staff and the Iowa ICWA program manager continue to go well. At this time, there are no concerns with MFS and HHS.
- MFS continues to work on recruiting more native foster homes for their area in hopes of getting more families licensed. This remains a continued partnership between MFS and Four Oaks.
- MFS continues to provide training to other counties regarding ICWA and how the case process works with their agency.
    - MFS recently provided training to the Black Hawk County service area.

In cooperation and consultation with the Tribe(s):

- MFS Director Mylene Wanatee and the Iowa ICWA program manager meet annually to discuss the Intergovernmental Agreement executed in November 2022 between Iowa and the Meskwaki Nation. This is still ongoing, and at this time, there have been no added changes to the IV-E agreement. However, HHS had a few conversations regarding IV-E Prevention that may allow additional funding for Meskwaki. HHS and Meskwaki will begin those conversations this year.
- HHS' ICWA program manager met with MFS staff monthly to address any questions or concerns. Although in the past there were FCS concerns, at this time there are no noted concerns.
    - HHS developed a quarterly meeting with MFS to include FCS providers, but also to include counties such as Polk and Linn to ensure MFS is staying as up to date as possible with new HHS initiatives. This meeting also addresses any potential questions or concerns MFS may have.
        - This meeting also includes HHS staff responsible for foster care payments to alleviate any confusion moving forward.
    - The ICWA program manager developed a new ICWA training that will be implemented in August; this training will be at least 4-6 hours. It will be offered to all HHS staff, tribes and FCS providers. This will assist with the understanding of ICWA, active efforts, and how to work ICWA cases effectively.

**Coordination and Consultation with Tribes Domiciled in Nebraska**

- The HHS ICWA program manager meets with tribes in Nebraska, including Santee Sioux, Winnebago, Ponca, and Omaha, on a monthly basis to discuss ICWA cases. At this time, there are no concerns with cases between the tribes and HHS.

- The HHS ICWA program manager is working on an MOU process to ensure that children placed in Iowa through the tribes have Medicaid coverage. This project is underway, and we hope to have it completed by the end of 2025.
    - This project will also include establishing a database that will allow the tribes to notify HHS on a need-to-know basis of children placed in Iowa. This will assist in coverage of services but also will alleviate any confusion with children being placed in Iowa foster homes.
- The HHS ICWA program manager assisted on an issue between tribes in Nebraska and Woodbury County with missing youth since there is a gap in services regarding assistance from law enforcement. HHS and the ICWA program manager assisted in mending this issue and hope to find a solution.

**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 Support (RRTS) subcontractor 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 also 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 Roz Kobb/Diane Smith, Social Service Director Miskoo Petite, Tribal Social Service Supervisor, and ICWA Specialist Elexa Mollet.
  - 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 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. Fernando Claren is covering everything at this time while they fill positions. Often times, due to both the Winnebago and Omaha Tribes sharing the same attorney, both tribes and HHS 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 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 Danielle LaPointe, Supervisor Clarissa LaPlante, and ICWA Specialist Renae Helper.

- 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 Penny Lingle, ICWA staff Faye Langdeaux, 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.
  - HHS 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.

**Description of the state's plan for ongoing coordination and collaboration with tribes in the implementation and assessment of the CFSP/APSR.**

HHS will include tribal representatives in the ongoing Service Area meetings, which continue throughout the year to address local interests.

- Meskwaki Nation – quarterly meetings with HHS staff
- Winnebago, Omaha, and Santee Tribes of Nebraska – quarterly meetings with HHS
- Ponca Tribe of Nebraska –quarterly meetings with HHS
- Monthly CINCF meetings attended by the various tribes.

**Arrangements jointly developed with tribes as to roles and responsibilities for providing child welfare services and the protections delineated in section 422(b)(8) of the Act to Tribal children, whether under state or tribal jurisdiction.**

As noted above, Meskwaki Nation is the only federally recognized tribe domiciled in Iowa. The State/Tribal Agreement states HHS will be responsible for payment for foster care or other child welfare services accessed by Meskwaki Nation children under tribal court jurisdiction. MFS has all case management responsibilities. Children under tribal court jurisdiction may access any service available to a child under state court jurisdiction as long as the child is eligible for HHS services.

The Agreement also states the cases of children under tribal court jurisdiction, but for whom HHS pays for services, may be subject to federal review through a Title IV-E Eligibility Review or through a Child and Family Services Review. MFS provides all required Title IV-E documentation including court orders and family household

composition, income and resources, and ongoing documentation to HHS in order to determine initial and continued eligibility for Title IV-E claiming.

MFS has responsibility for the management of cases under tribal court jurisdiction and meeting the law of their nation regarding case requirements and a case review system. Tribal law explains case planning requirements including required federal language in case plans. Tribal law also includes periodic review and reporting requirements by MFS. Tribal law addresses case requirements to prevent children's removal from their home, to achieve reunification, and to achieve permanency.

HHS performs all case review requirements for Meskwaki Nation children under state court jurisdiction, which includes providing credit reports to children aged 14 or older in foster care.

There are several tribes domiciled in Nebraska and South Dakota who have a presence in the northwest part of Iowa. At this time, HHS does not have agreements to pay for services for children under the jurisdiction of the tribal courts of these tribes. HHS, in consultation with the federal Children's Bureau and the Tribes, plans to establish agreements with as many of these tribes as possible. The Omaha Tribe, from Nebraska, has started conversations with the HHS ICWA program manager in creating an agreement between the Omaha Tribe and HHS. The primary focus of the agreement will include information sharing between the Tribe and HHS. Discussions continue as of the date of this report.

Children under state court jurisdiction are eligible for all child welfare services. HHS pays for these services and manages these cases in collaboration with the child's Tribe. Children under the jurisdiction of a tribal court in another state receive services by that Tribe or state.

Currently, Meskwaki and HHS are looking to incorporate another avenue of services within the IV-E agreement that will allow prevention work. Although conversations are still ongoing, this is something HHS and MFS have discussed. This will include prevention work MFS can work on with their community to assist in the prevention of child abuse.

**Description of the specific measures taken by the state to comply with ICWA. (See section 422(b)(9) of the Act.).**

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 MFS for the ICWA Training and Technical Assistance (ICWA TTA). At this time, this has been put on pause since HHS converted its files to electronic only; MFS has no way of accessing ICWA case files to audit. The HHS ICWA program manager is working on a solution for this issue.

HHS is in the process of developing our comprehensive child welfare information system (CCWIS) and will include ICWA data elements to track performance. Please

see *Section II: Update to the Current Performance in Improving Outcomes, Systemic Factors, Statewide Information System* for more information.

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.

**Description of the state's consultation with each Indian tribe in the state regarding eligibility for Chafee and ETV benefits and services**

Please see ***Error! Reference source not found.***, Consultation with Tribes (section 477(b)(3)(G)), of this report.

**Exchange copies of APSRs (45 CFR 1357.15(v) and 1357.16(d)).**

HHS will provide the FFY 2026 APSR directly to MFS and to the Four Directions in Sioux City. Additionally, the HHS will explore other avenues of exchanging subsequent APSRs directly with the tribes in the northwest area of the state.

# Section VII: Child Abuse Prevention and Treatment Act (CAPTA) State Plan Requirements and Updates

Please see *IA Attachment 7: CAPTA State Plan Update*.

# Section VIII: Updates to Targeted Plans within the 2025-2029 CFSP

### FOSTER AND ADOPTIVE PARENT DILIGENT RECRUITMENT PLAN

Please see *IA Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan* for progress and accomplishments and updates to the plan.

### HEALTH CARE OVERSIGHT AND COORDINATION PLAN

Please see *IA Attachment 8B: Health Care Oversight and Coordination Plan* for progress and accomplishments and updates to the plan.

### DISASTER PLAN

Please see the following attachments for progress and accomplishments and updates to the plan:

- *IA Attachment 8C: Disaster Plan*
- *IA Attachment 8C1: HHS Continuity of Government Plan*
- *IA Attachment 8C2: Family Well-Being EMAC TO*

### TRAINING PLAN

Please see the following attachments for progress and accomplishments and updates to the plan:

- *IA Attachment 8D: Training Plan*
- *IA Attachment 8D1: SWCM and SWCM Supervisors, New Worker Training*
- *IA Attachment 8D2: CPW and CPW Supervisors, New Worker Training*
- *IA Attachment 8D3: HHS - FFY 2025-2029 Training Plan*
- *IA Attachment 8D4: Child Welfare Provider Training Academy (CWPTA) – FFY 2025-2029 Training Plan*

# Section IX: Financial Information

### PAYMENT LIMITATIONS

#### Title IV-B, Subpart 1

In FFY 2005, Iowa expended $724,000 under title IV-B, subpart 1, for foster care maintenance. Iowa will allocate the same amount for foster care maintenance in FFY 2026. Iowa did not and does not use title IV-B, subpart 1, funds for childcare or adoption assistance payments.

In FFY 2005, Iowa utilized $241,334 state expenditures, non-federal funds, for foster care maintenance payments as state match for title IV-B, subpart 1. Iowa will apply the same amount of non-federal funds expended for foster care maintenance payments as state match in FFY 2026.

#### Title IV-B, Subpart 2

Iowa does not utilize 20% of the PSSF funds for the Family Preservation category. Iowa utilizes federal Temporary Assistance for Needy Families (TANF) and Social Services Block Grant (SSBG) as well as state appropriations to fund Iowa's main family preservation service, Family Centered Services. Iowa secured authorization from the

Children's Bureau Region VII office in 2007 to utilize less than 20% of PSSF funds for the Family Preservation category.

Table 9 below shows financial information comparing FFY 2023 state and local share spending for subpart 2 programs against the 1992 base year amount as required to meet the non-supplantation requirements in section 432(a)(7)(A) of the Act.

**Table 9: Comparison of FFY 2023 State/Local Spending and 1992 Base Year Spending**

| Category | FFY 2023 | FFY 1992 |
|---|---|---|
| Family Preservation | 61,183 | - |
| Family Support | 731,000 | 581,841 |
| Family Reunification | 132,156 | - |
| Adoption Promotion | 1,447,824 | - |
| Other Service-Related Activities | 690,653 | - |
| Total Administration | 272,857 | - |
| Total | 3,335,673 | 581,841 |

Data Source: HHS

In FY 2007, Iowa began targeting the adoption promotion portion of PSSF funds to provide adoption support services to adoptive families via the statewide Resource and Recruitment contract, which became the Resource, Recruitment, Training and Support of Resource Families (RRTS) contract effective July 1, 2017. Iowa updated the FY 1992 baseline to reflect that change in the use of these funds.