ADMINISTRATION FOR CHILDREN & FAMILIES
Children's Bureau | 330 C Street, S.W., Washington, DC 20201
www.acf.gov/cb

August 27, 2026

Larry Johnson
Director
Iowa Health and Human Services
1305 East Walnut Street
Des Moines, Iowa 50319

Dear Director Johnson:

Thank you for submitting Iowa's amendment to the agency's approved title IV-E prevention program five-year plan.

Plan Amendment Approval

Iowa submitted an amendment to the agency's approved title IV-E prevention program five-year plan (five-year plan) to the Children's Bureau (CB) to add Healthy Families America and Parents as Teachers. Iowa also submitted a request to waive the evaluation requirement for Healthy Families America and Parents as Teachers. We are pleased to notify you that Iowa's five-year plan amendment has been found to be in compliance with applicable federal statutory and regulatory requirements. Iowa's five-year plan amendment is approved as outlined below.

Iowa's five-year plan amendment is effective from January 1, 2026. Please maintain this approval letter as a part of the final, approved plan.

Approval of Services under the Title IV-E Prevention Program
Pursuant to Sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, states may claim reimbursement for services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse) and continuously monitored. Based on this amendment, CB has approved the following additional allowable programs and services under this program:

Healthy Families America
Parents as Teachers

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than

payments for provision of prevention services directly to program recipients must be identified in an approved cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative and training costs in accordance with applicable regulations at §95.509(a)(3). We encourage the state to review its previously submitted/approved PACAP to determine if updates are required as a result of this amendment to the IV-E Prevention plan.

Approval of Request for Waiver of Evaluation Requirements
Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of Section 471(e)(5)(B)(iii)(II) are met. CB approves Iowa's request for waiver of the evaluation requirement for the following approved services:

Healthy Families America
Parents as Teachers

Data Collection and Reporting Requirements
Pursuant to Section 471(e)(4)(E) of the Act, states electing the title IV-E prevention program are required to collect and report on child-specific data to HHS for each child who receives title IV-E prevention services. In the initial five-year plan, Iowa has provided an assurance that the state will collect and submit information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures. Data element details are provided in Revised Technical Bulletin #1. For amendments, agencies must begin reporting data in the period after the agency's title IV-E amendment is approved. Title IV-E Prevention Program Data submission timelines are provided in Technical Bulletin #2.

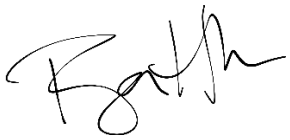
Payer of Last Resort
In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

The title IV-E prevention program is part of the Children's Bureau's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please email the Children's Bureau at ivepreventionprogram@acf.hhs.gov

We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,



Ryan Hanlon
Associate Commissioner
Children's Bureau

Enclosures: Plan Submission Certification, Request for Waivers of the Evaluation Requirement, State Assurance of Trauma-Informed Service Delivery

cc: Title IV-E Prevention Program Resource Mailbox, ivepreventionprogram@acf.hhs.gov;
Regional Office Resource Mailbox, cbregion7@acf.hhs.gov;
Janice Realeza, ACF Office of Grants Management;
Sona Cook, ACF Office of Grants Management.

OMB Approval No: 0970-0433
Expiration Date: 07/31/2025

Title IV-E Plan – State of Iowa

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I, Janee Harvey, hereby certify that I am authorized to submit the title IV-E Plan on behalf of the State of Iowa. I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date_____ Janee Harvey Digitally signed by Janee Harvey Date: 2026.02.27 09:27:52 -06'00'

(Signature)

(Title)

APPROVAL DATE: 8.27.2026

EFFECTIVE DATE: 1/1/2026

(Signature, Associate Commissioner, Children's Bureau)

Attachment 1: Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2026-2030

Amendment 3

February 2026

IOWA Health and Human Services

Table of Contents

Iowa received approval of its *Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024* (Prevention Plan), effective October 1, 2020 (FFY 2021). On December 2, 2025, Iowa received approval for its *Title IV-E Prevention Program Five-Year Plan Renewal Assurance: FFY 2026-2030* (Prevention Plan). Therefore, the Prevention Plan is updated to reflect FFY 2026-2030.

Effective July 1, 2023, the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) merged to become the Iowa Department of Health and Human Services (HHS). Therefore, references to DHS and IDPH have been replaced with HHS.

PART A – CHILD WELFARE

The information provided in this part of Iowa's *Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2021-2025* (Prevention Plan) pertains to Iowa's child welfare system. Part B addresses Iowa's juvenile justice system, with whom the Iowa Department of Health and Human Services (HHS) has an IV-E Agreement. Part C provides assurances and attachments applicable to the overall Prevention Plan.

INTRODUCTION

In calendar year (CY) 2019, Iowa's population of children ages 0 – 17 was 730,767[1]. During that same year, HHS assessed 33,004 reports of suspected child abuse and neglect. Of those assessed reports, HHS staff conducted:

- 6,543 (20%) family assessments, which involved 8,560 children; and
- 26,461 (80%) child abuse assessments, with assessment dispositions of:
  - 17,947 (68%) of child abuse assessments resulted in a finding of "not confirmed" (aka not substantiated), which involved 18,113 children;
  - 6,891 (26%) of child abuse assessments resulted in a finding of "founded" (aka substantiated) abuse, which involved 9,532 children; and
  - 1,623 (6%) of child abuse assessments resulted in a finding of "confirmed" (aka substantiated) abuse, which involved 1,936 children. "Confirmed" abuse means that the abuse was minor, isolated, and not likely to re-occur; and the perpetrator was not placed on the child abuse registry.[2]

Of the total number of abused or neglected children, 5,323 (46%) were 5 years of age or younger, 3,055 (27%) were between 6-10 years, and the remaining 3,085 (27%) were older than 11 years. Of all substantiated child abuse or neglect:

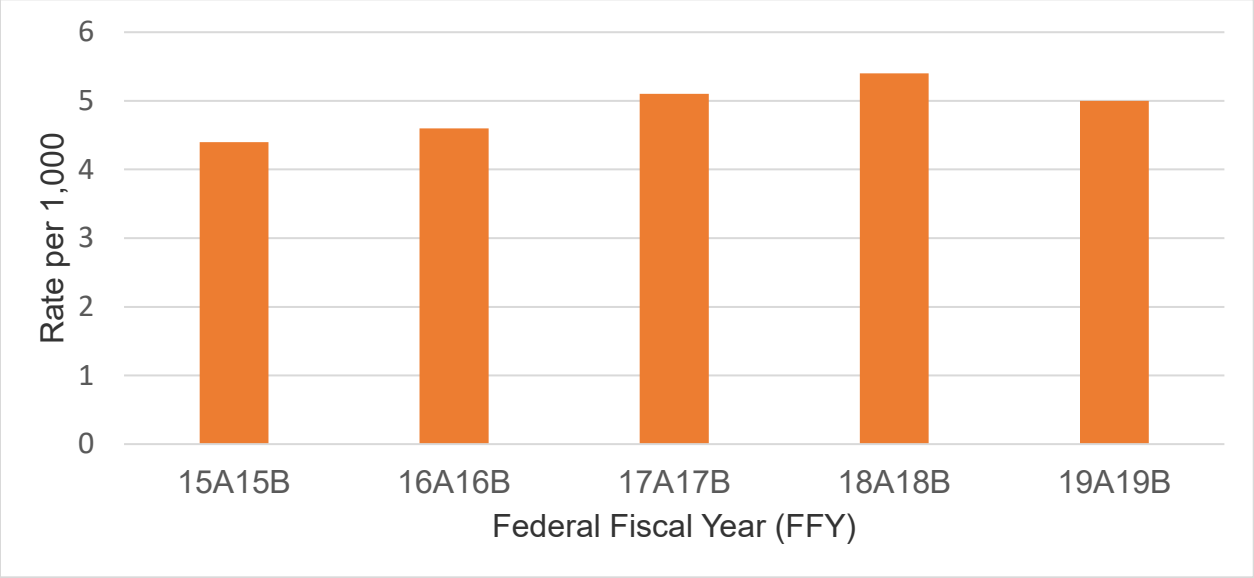
- 54% was neglect (denial of critical care);

[1] Iowa, Child and Family Service Review (CFSR 3) Data Profile, Context Data, dated February 2020; population estimate 2018 utilized for 2019
[2] HHS, 2019 Child Welfare By The Numbers, available at https://hhs.iowa.gov/media/9283/download?inline=

- 27% was dangerous substance;
- 7% was physical abuse;
- 7% was presence of illegal drugs in a child's body;
- 4% was sexual abuse; and
- the categories of allows access by a registered sex offender, allows access to obscene materials, mental injury, child sex trafficking, prostitution of a child, and bestiality in the presence of a minor each made up less than 1% of the total substantiated child abuse or neglect.[3]

Chart A1 below shows increases of foster care entries for Iowa's abused or neglected children from federal fiscal year (FFY) 2015 through 2018, but a decline from FFY 2018 to FFY 2019.

Chart A1: Iowa Foster Care Entry Rates per 1,000 (FFY 2015-2019)



Source: Child and Family Service Review (CFSR 3) Data Profile (Context Data), February 2020

The Family First Prevention Services Act (Family First) (Public Law 115-123) provides an opportunity for Iowa to utilize title IV-E funding to improve its service to children and their families. Family First authorizes funding for time-limited mental health and substance abuse prevention and treatment services and for in-home parent skills-based services. Children, who are candidates for foster care or pregnant or parenting youth in foster care, and their parents or kin caregivers, may receive these evidence-based prevention services. The goal of the title IV-E Prevention Services and Programs is to strengthen families by preventing child abuse or neglect and the unnecessary removal of children from their families, including the resultant trauma of unnecessary parent-child separation. Iowa's Family First, Blueprint for Iowa's Future Child Welfare System,

[3] Ibid.

"Family Connections are Always Strengthened and Preserved" (Attachment A1), reinforces Iowa's commitment to prevent foster care entry.

HHS decided to implement the title IV-E Prevention Services and Programs as authorized by Family First. In accordance with ACYF-CB-PI-18-09, herein is Iowa's Prevention Plan. HHS may expand the services and applicable population in this Prevention Plan, through plan amendments, as additional evidence-based services receive approval through the Title IV-E Prevention Services Clearinghouse or through additional independent systematic reviews as part of the transitional payment review process authorized by the Children's Bureau through ACYF-CB-PI-19-06.

ACRONYMS AND ABBREVIATIONS

Table A1: Acronyms and Abbreviations	
AMP	Achieving Maximum Potential
CBOs	Community-Based Organizations
CWSG	Annie E. Casey Foundation's Child Welfare Strategy Group
CY	Calendar Year
IECMHC	Infant and Early Childhood Mental Health Consultation
CAA	Child Abuse Assessment
CINA	Child in Need of Assistance
CPW	Child Protection Worker
CWIS	Child Welfare Information System
CWPC	Child Welfare Partners Committee
CWG	Child Welfare Policy and Practice Group
CINAA	CINA Assessment
CCWIS	Comprehensive Child Welfare Information System
CQI	Continuous Quality Improvement
CHEA	Council for Higher Education Accreditation
COA	Council on Accreditation
CARF	Council on Accreditation for Rehabilitation Services
DAISEY	Data Application and Integration Solutions for the Early Years
DAS	Department of Administrative Services

Table A1: Acronyms and Abbreviations	
DoE	Department of Education
ECI	Early Childhood Iowa
FA	Family Assessment
FCS	Family Centered Services
Family First	Family First Prevention Services Act (Public Law 115-123)
FFM	Family Focused Meeting
FSLG	Family Support Leadership Group
FSP	Family Support Professional
FSS	Family Support Specialist
FFY	Federal Fiscal Year
IS	Intervention Specialist
ICJ	Iowa Children's Justice
HFA	Healthy Families America
HHS	Iowa Department of Health and Human Services
PAT	Parents as Teachers
Prevention Plan	Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2021-2025
MIECHV	Maternal Infant Early Childhood Home Visitation
NSTRC	National SafeCare® Training and Research Center
PIP	Program Improvement Plan
QA	Quality Assurance
RFP	Request for Proposal
SWCM	Social Work Case Manager
SFY	State Fiscal Year
START	Sobriety Treatment and Recovery Teams
YTDM	Youth Transition Decision-Making

SECTION I: TITLE IV-E PREVENTION SERVICES AND PROGRAMS

Child and Family Eligibility for the Title IV-E Prevention Program

For purposes of the title IV-E prevention services program, a child is:
1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).
2. A child in foster care who is a pregnant or parenting foster youth.

Definition of Child: The Iowa Department of Health and Human Services (HHS) considers a child or youth to be "…either a person less than eighteen years of age or a person eighteen, nineteen, or twenty years of age who meets any of the following conditions:

a. The person was placed by court order issued pursuant to chapter 232 in foster care or in an institution listed in section 218.1 and either of the following situations apply to the person:

(1) After reaching eighteen years of age, the person has remained continuously and voluntarily under the care of an individual, as defined in section 237.1, licensed to provide foster care pursuant to chapter 237 or in a supervised apartment living arrangement, in this state.

(2) The person aged out of foster care after reaching eighteen years of age and subsequently voluntarily applied for placement with an individual, as defined in section 237.1, licensed to provide foster care pursuant to chapter 237 or for placement in a supervised apartment living arrangement, in this state.

b. The person has demonstrated a willingness to participate in case planning and to complete the responsibilities prescribed in the person's case permanency plan.

c. The department has made an application for the person for adult services upon a determination that it is likely the person will need or be eligible for services or other support from the adult services system." (Iowa Code § 234.1(1)).

A child in foster care, who turns 18 and meets the conditions above, signs a Voluntary Placement Agreement with HHS to continue their foster care placement.

Candidate for Foster Care: A child/youth, formally determined to be at imminent risk of entering out-of-home care, but who can remain safely in their home or in a kinship placement with evidence-based prevention services delivered by/through community-based service agencies, HHS, or a public or tribal services agency with whom HHS has an IV-E Agreement. HHS makes the candidacy determination, except for those with

whom HHS has an IV-E Agreement. Those agencies with whom HHS has an IV-E Agreement make their own determinations for candidacy.

A child/youth may be at imminent risk of entering out-of-home care based on alleged maltreatment and/or circumstances and characteristics of the family unit, individual parents, and/or children or the children's physical environment that poses a threat of maltreatment affecting the parents' ability to safely care for and nurture their child in their own home.

Circumstances or characteristics of the child, parent, or kin caregiver that could put children at imminent risk of entering out-of-home care include, but may not be limited to, the following:

- Household income is at or below 200% of the Federal Poverty guidelines
- Household has someone who is pregnant and under age 21
- Household has a history of child abuse or neglect or has had interactions with child welfare services
- Household has a history of substance use or addiction or there is a need for substance use treatment
- Household has a history of mental illness or there is a need for mental health treatment
- Someone in the household has attained low student achievement or has a child with low student achievement
- Household has a child with developmental delays or disabilities
- Household includes individuals who are serving or formerly served in the US armed forces
- Substance exposed newborns
- Children who are victims of trafficking
- Open Child Abuse Assessment or Child in Need of Assistance (CINA) Assessment
- Confirmed or Founded child maltreatment
- Open HHS agency child welfare case
- Open non-HHS voluntary family-centered services case
- Reunification, adoption or guardianship arrangements that are at risk of disruption

Pregnant or Parenting Youth in Foster Care: Youth in foster care who are pregnant or parenting are also eligible if the youth has been assessed to need a specific evidence-based practice (EBP) and:

- The EBP is approved on the Title IV-E Prevention Services Clearinghouse,
- The EBP is included in Iowa's approved Title IV-E Prevention Services and Programs Plan, and
- The EBP is listed in the child's specific prevention plan, which is included in the child's foster care case plan.

The state must describe how it will assess children and their parents or kin caregivers to determine eligibility for title IV-E prevention services. (471(e)(5)(B)(v))).

PATHWAYS TO PREVENTION SERVICES

HHS will utilize two pathways to determine eligibility and access Iowa's title IV-E prevention services: community pathway and child protective services (CPS).

Community Pathway

The community pathway is an avenue in which children, youth and families can receive

Healthy Families America (HFA) and Parents as Teachers (PAT), Iowa's evidence-based home visiting services, absent current formal child welfare involvement. This pathway is appropriate for families who require support to manage risk and safety concerns but do not rise to the level of requiring child welfare involvement. This community pathway to services reflects an instrumental strategy in Iowa's overall approach to keeping families together, by allowing families with serious risk factors to engage in services before a crisis occurs. Offering the prevention services absent a formal child welfare case removes the stigma of working directly with HHS, thus removing a key deterrent to families getting the support they need to stay together and keep their children safe.

Through the community pathway, families can self-refer or be referred by a public or private entity such as a school, healthcare provider, or local organization to avoid putting children at imminent risk of entering out-of-home care. An HHS child protection worker (CPW) also may refer families to the community pathway if the CPW determines a family is eligible for prevention services to mitigate the family's risk and safety concerns, but a non-HHS voluntary case will not be opened. These referrals can identify for families the local community-based organization (CBO) contracted for prevention services.

Information necessary to determine title IV-E prevention service eligibility will be collected using a standard 8-item scale directly reflecting a subset of Iowa's previously approved title IV-E prevention eligibility criteria, which is listed above in the "Candidate for Foster Care" definition. The scale will be completed and documented upon intake to the home visiting program by the home visiting staff. Families must exhibit one or more of the 8 prevention eligibility criteria to receive Iowa's Healthy Families America (HFA) and Parents as Teachers (PAT) programs funded through the title IV-E prevention program.

Results of this eligibility assessment will be documented in HHS' **D**ata **A**pplication and **I**ntegration **S**olutions for the **E**arly **Y**ears (DAISEY) data base system, where they will be visible to HHS staff to determine eligibility. Although family information to inform the eligibility determination will be gathered by the home visiting staff, HHS will remain

solely responsible for determining eligibility for title IV-E prevention services offered through the community pathway through accessing eligibility results in DAISEY.

The child's prevention plan start date will be determined by HHS, reflecting the date when:

(1) HHS has determined eligibility,

(2) a child specific prevention plan has been developed, and

(3) the services will be documented in DAISEY. This date will be documented in DAISEY. It will be used to determine the 12-month time limit for service eligibility and will be tracked electronically by HHS.

Following eligibility determination, the CBO must begin prevention planning with the family. The CBO providing the title IV-E home visiting service will document the child specific prevention plan in DAISEY. If more than one service is to be provided, HHS will determine the roles of care coordination and how the agencies ensure that community-based prevention services are provided to support the family's unique needs.

Child Protective Services (CPS) Pathway

Assessment Process: Child Protective Services (CPS) is Iowa's formal child welfare system for child abuse and neglect. The CPS assessment process begins with Iowa's child abuse hotline, which receives reports of suspected child abuse. When the allegation meets the three criteria for abuse or neglect in Iowa (i.e., the victim is under the age of 18; the allegation involves a caretaker for most abuse types; and the allegation meets the Code of Iowa definition for child abuse), staff accept the report for a CPS assessment. Staff assigns accepted reports to one of two pathways for assessment, a Family Assessment (FA), or a Child Abuse Assessment (CAA). If a report of suspected child abuse does not meet the criteria for acceptance, staff rejects the report. Staff screen rejected reports to determine if the report meets the criteria for the child to be adjudicated a Child in Need of Assistance (CINA) in accordance with Iowa Code § 232.2(6). If rejected reports meet CINA criteria, staff assigns the report for a CINA Assessment (CINAA). The Family Assessment, Child Abuse Assessment, and CINA Assessment comprise Iowa's CPS assessments for title IV-E prevention services.

During the CPS assessment, the HHS child protection worker (CPW):

- Visits the home and speaks with individual family members to gather an understanding of the concerns reported, what the family is experiencing, and engages collateral contacts in order to get a holistic view;

- Evaluates safety and risk for the child(ren), including completion of *Form 470-4132, Safety Assessment* and *Form 470-4133, Family Risk Assessment* (Attachments A2 and A3 respectively);
- Engages the family to assess family strengths and needs through a full family functioning assessment;
- Identifies appropriate services or supports for the family; and
- Connects the family to any needed voluntary services.

The CPW determines if the child is a candidate for foster care or a pregnant or parenting youth in foster care, if applicable, as follows:

- For Child Abuse Assessments and CINA Assessments: The CPW makes the candidacy determination and documents it in Iowa's child welfare information system (CWIS), prevention plan tab in the STAR module, prior to the provision of services.
- For Family Assessments, the CPW determines the child is a candidate for foster care and sends the determination to the Family Centered Services (FCS) contractor through the referral process for non-HHS voluntary FCS by completing and sending *Form 470-3055, Referral and Authorization for Child Welfare Services*.

Family Assessment (FA): The FA is Iowa's differential response to reports of suspected child abuse or neglect. There is no finding of abuse or neglect. By the end of 10 business days, the CPW utilizes the risk level to determine whether the family receives information only, information and referral, or non-HHS voluntary FCS.

- Low risk – Based on identified service needs, the CPW may recommend and refer the family to community services or to non-HHS voluntary, state-purchased family-centered services.
- Moderate or High risk – The CPW recommends and refers the family to non-HHS voluntary, state-purchased family-centered services.

Child Abuse Assessment (CAA): The CAA is Iowa's traditional path of assessing reports of suspected child abuse. By the end of 20 business days, the CPW must make a finding of whether abuse occurred, consider whether a perpetrator's name meets criteria to be placed on the Iowa Central Abuse Registry, and determine whether to request court intervention.

Findings include:

- "Founded" means that a preponderance (more than half) of credible evidence supports that child abuse occurred and the circumstances meet the criteria for placement on the Iowa Central Abuse Registry.
- "Confirmed" means that a preponderance (more than half) of credible evidence supports that child abuse occurred, but the circumstances did not

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

The finding and risk level determine whether the family will receive services and at what level.

- "Not Confirmed" and "Confirmed" low risk – The CPW makes recommendations to the family for services available in the community.
- "Confirmed" moderate risk and "Founded" low risk – The CPW offers the family non-HHS voluntary, state-purchased family-centered services.
- "Confirmed" high risk and "Founded" moderate and high risk – The CPW transfers the case to an ongoing SWCM for formal HHS family-centered services.

Child in Need of Assistance (CINA) Assessment (CINAA): CPWs conduct a CINAA to examine the family's strengths and needs in order to support the families' efforts to provide a safe and stable home environment for their children and to determine the necessity of juvenile court intervention.

At the conclusion of the CINAA, the CPW determines the disposition of the case:

- If CINA criteria are met, the CPW may refer the case for a CINA petition according to local protocols. The CPW refers the case to the SWCM or supervisor and provides transfer information.
- If during the CINAA the circumstances constitute an abuse allegation on any child in the house, the CPW refers the child for child protective services intake.
- If the CINA criteria are not met and there are no circumstances that constitute an abuse allegation, the CPW may provide information on services available to the family in the community.

The CINAA risk level determines service availability to the family:

- Low risk – The CPW makes recommendations to the family for community services.
- Moderate risk – The CPW offers the family non-HHS voluntary, state-purchased family-centered services.
- High risk – The CPW works with their supervisor and a SWCM to provide formal HHS family-centered services to the family.

At the conclusion of the CPS assessment process, the CPS Assessment Summaries (*Child Protective Services Family Assessment Summary, Form 470-5371; Child Protective Services Child Abuse Assessment Summary, Form 470-3240*, or *CINA*

Services Assessment Summary, Form 470-4135) (Attachments A4, A5, and A6 respectively) reflects the CPW's work with the family to develop a plan of action moving forward. For Child Abuse Assessments and CINA Assessments, the CPW documents the child's prevention plan on the prevention tab in CWIS' STAR module. The child's specific prevention plan includes the following plan requirements, prior to the provision of any prevention services:

- Identifies the child as a candidate for foster care or a pregnant or parenting youth in foster care;
- Candidate for foster care:
    - Identifies the strategy to prevent the child's entry into foster care so that the child may safely: remain at home, live temporarily with a kin caregiver, or live permanently with a kin caregiver; and
    - Identifies the services to be provided to the child, the parents, and the kin caregiver (if applicable) that will ensure success of the identified foster care prevention strategy.
- Pregnant or parenting youth in foster care:
    - Describes the foster care prevention strategy for any child born to the youth;
    - Lists the services to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent; and
    - Is included in the youth's foster care case plan.

The child's specific prevention plan will automatically populate to the Prevention Plan tab in the Child Services module for social work case managers (SWCMs).

For Family Assessments, the CPW documents their candidate for foster care determination and sends it to the FCS contractor through the referral process. The FCS contractor utilizes the referral information from HHS, including the CPW's assessments and summary findings, to develop a baseline understanding of family functioning, safety and risk factors. The contractor engages the family to identify appropriate services to meet the child and caregivers needs and utilizing this information identifies the foster care prevention strategy. The FCS contractor will enter the child's specific prevention plan through the provider portal in CWIS prior to opening up any non-HHS voluntary, family-centered services. The child's specific prevention plan includes all required prevention plan elements as indicated above under candidate for foster care and includes the identification of the child as a candidate for foster care as previously determined by the CPW. The provider portal will require the provider to enter the child's specific prevention plan before the provider can enter the non-HHS voluntary, family-centered services. The FCS contractor has case management and decision-making responsibility for non-HHS voluntary, family-centered services cases.

HHS Case Management: If during ongoing case management the HHS' SWCM determines that the child would meet the definition of a candidate for foster care or a pregnant or parenting youth in foster care and there is not currently a prevention plan in effect for the child/youth, the SWCM will document the child's prevention plan on the Prevention Plan tab in the Child Services module in Iowa's CWIS prior to the provision of prevention services. Depending upon the prevention services needed, the SWCM may refer the child and family to a community-based organization (CBO) for prevention services provided in the community.

Please see Monitoring Child Safety in this section for information on processes utilized to re-determine eligibility for title IV-E prevention services.

Services Description and Oversight

Describe the HHS approved services the state will provide, including:

- *whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the title IV-E Prevention Services Clearinghouse*
- *the target population for the services or programs*
- *an assurance that each HHS approved title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III)*
- *how providing the services is expected to improve specific outcomes for children and families*

The Iowa Department of Health and Human Services (HHS) will provide services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregivers' needs for the services or programs directly relate to the child's safety, permanence, or well-being to prevent the child from experiencing maltreatment or entering foster care. Services for the child and the parents or kin caregivers of the child will only be provided after the determination has been made that the child is a candidate for foster care or a pregnant or parenting youth in foster care and the child's specific prevention plan has already been established.

As reflected in Table A2, HHS will implement five evidence-based programs (EBPs), Motivational Interviewing (MI), SafeCare®, Sobriety Treatment and Recovery Teams (START), Healthy Families America (HFA) and Parents as Teachers (PAT). HHS' family centered services (FCS) contractors will continue to utilize MI to provide Family Preservation Services (FPS) and Family Casework services. HHS will continue our existing in-home parent skill-based program, SafeCare®, which is available in both open HHS child welfare service cases as well as non-HHS voluntary, family-centered services cases. HHS will use START to serve families with an open HHS child welfare case, where at least one child is age 5 or younger and the primary reason for

involvement is a caregiver's substance use. Through its community pathway, HHS has an opportunity to broaden its investment in the home visiting programs that include Healthy Families America (HFA) and Parents as Teachers (PAT) at this time. HHS identified that these services meet or will meet the needs of our children and families.

Family Preservation Services (FPS): FPS are available during a child protective services (CPS) Child Abuse Assessment, Child in Need of Assistance (CINA) Assessment, and anytime during an open HHS child welfare service case. FPS can be purchased as an additional service under family-centered services.

FPS are short-term, intensive, home-based, crisis interventions targeted to families who have children at imminent risk of removal and placement in foster care. 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 alternative of remaining together safely, averting out-of-home placement of children whenever possible. FPS function is to modify the home environment and/or family behavior so that the child may remain safely in the parental household or with kin or fictive kin caregivers. Services are focused on assisting in crisis management, restoring the family to an acceptable level of functioning, and gaining support within their community to remain safely together.

Family Casework (FC): FC is available in both open HHS child welfare cases and non-HHS voluntary, state-purchased FCS cases. FC is a family-centered model of child welfare practice involving ongoing assessment, case planning, and direct services to families which assists families in building the skills necessary to provide a permanent, safe, and stable environment for their children. Direct services include any interventions to ameliorate barriers/deficits which would otherwise result in removal.

> *Motivational Interviewing (MI) – used in FPS and FC:* Motivational Interviewing (MI) is an evidence-based, client-centered method designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through the stages of change. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals.
>
> MI is required in the provision of FPS and FC. During FPS and FC, the Family Support Specialist (FSS) uses MI with clients to help clients identify reasons to change their behavior and reinforce that behavior change is possible. MI has been shown to be an effective intervention when used by itself or together with a combination of other treatments to reduce risk of maltreatment and placement into out of home care.

For information on how all other requirements are being met during the provision of IV-E prevention services, e.g. monitoring child safety requirements, please see the subsections that follow in this section.

Table A2: Iowa's Evidence-Based Programs (EBPs) [4]			
Evidence-Based Program Name, Description, including Target Population and Manual	**Type of Service**	**Targeted Outcomes/Program Goals**	**Evidence Rating**
Motivational Interviewing (MI) is a method of counseling clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible. MI can be used to promote behavior change with a range of target populations and for a variety of problem areas. MI is typically delivered over one to three sessions. Each session typically lasts for 30 to 50 minutes. The dosage may vary if MI is delivered in conjunction with other treatment(s).	Mental Health and Substance Abuse Prevention & Treatment Services[5]	▪ Improve parent/caregiver well-being ▪ Reduce future incidents of child maltreatment ▪ Reduce entries and re-entries into foster care	Well-Supported

[4] Please see Attachment III, which provides assurance that the EBPs meet the trauma-informed service delivery requirements.
[5] Although Title IV-E Prevention Services Clearinghouse lists this EBP under Mental Health and Substance Abuse Prevention & Treatment Services, the EBP is applicable for a range of target populations and a variety of problem areas, which lends itself to in-home parent skill-based and cross-cutting case management applications.

Table A2: Iowa's Evidence-Based Programs (EBPs) [4]			
Evidence-Based Program Name, Description, including Target Population and Manual	**Type of Service**	**Targeted Outcomes/Program Goals**	**Evidence Rating**
Manual: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.			
SafeCare® is a trauma-informed, supported behavioral parenting model shown to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 in at-risk families. It is a home visitation-based parent-training program conducted over 18 sessions, with each session one to one-and-a-half hours in length. Parents whose children, ages 0-5, are at-risk for neglect or physical abuse receive instruction in three modules. These modules address three risk factors that can lead to child abuse and neglect: 1) the parent-child relationship, 2) home safety, and 3) caring for the health of young children. Each module includes a baseline assessment, intervention (training sessions), and a follow-up assessment to monitor progress over the course of the program. *Manual:* Lutzker, J. R. (2016). *SafeCare provider manual* (version 4.1.1).	In-Home Parent Skill-Based	▪ Reduce future incidents of child maltreatment. ▪ Reduce entries and re-entries into foster care. ▪ Increase positive parent-child interaction. ▪ Improve how parents care for their children's health. ▪ Enhance home safety and parent supervision.	Supported
Sobriety Treatment and Recovery Teams (START) serves families, where there is at least one child age 5 or younger and substance use is determined to be the primary child safety risk factor. To be eligible, the	In-Home Parent Skill Based; Substance	▪ Prevent out-of-home placements, keeping children in the home	Supported

Table A2: Iowa's Evidence-Based Programs (EBPs) [4]			
Evidence-Based Program Name, Description, including Target Population and Manual	**Type of Service**	**Targeted Outcomes/Program Goals**	**Evidence Rating**
parent and/or family cannot have an ongoing case at the time of accepted intake. START is used to recruit, engage, and retain parents in SUD treatment and to improve outcomes for families that are involved in the child welfare system. The model was designed to keep children safe. START allows families to be involved with the decision-making team during treatment and case planning. The intervention activities include: (1) intensive SUD recovery services, (2) coaching to help parents with parenting and life skills, (3) intensive Child Protective Services (CPS) case management services provided by a dyad which includes a Social Work Case Manager and a Family Mentor, and (4) individual, group, and/or family counseling and other relevant services for parents, children, and other family members as needed. Teams are responsible for monitoring families' progress and coordinating their care across agencies and providers, including CPS, family mentors, SUD treatment providers, the judicial system, and family	Use Programs & Services	with the parent when safe and possible. ▪ Promote child safety and well-being. ▪ Encourage parental SUD recovery, to care for children and to engage in essential life tasks. ▪ Improve family stability and self-sufficiency.	

Table A2: Iowa's Evidence-Based Programs (EBPs) [4]			
Evidence-Based Program Name, Description, including Target Population and Manual	**Type of Service**	**Targeted Outcomes/Program Goals**	**Evidence Rating**
service agencies. Family mentors also provide peer support to families. *Manual: Willauer, T., Posze, L., & Huebner, R. A. (Eds.). (2018). The Sobriety Treatment and Recovery Teams (START) model: Implementation manual. Children and Family Futures.*			
Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Each HFA site determines which family and parent characteristics it targets. Community Pathway enrollment begins at birth and typically continues up to three months after birth. Most families are offered services for a minimum of three years, receiving weekly home visits at the start. After six months, families receive visits less frequently depending on their needs and progress. Manual*: Healthy Families America. (2018) Best practice standards. Prevent Child Abuse America.*	In-Home Parent Skill-Based	▪ Cultivate and strengthen nurturing parent-child relationships ▪ Promote healthy childhood growth and development ▪ Enhance family functioning by reducing risk and building protective factors ▪ Prevent child abuse and neglect	Well-Supported

Table A2: Iowa's Evidence-Based Programs (EBPs) [4]			
Evidence-Based Program Name, Description, including Target Population and Manual	**Type of Service**	**Targeted Outcomes/Program Goals**	**Evidence Rating**
Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Community Pathway enrollment begins at birth and continues through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Manuals: ▪ *Parents as Teachers National Center, Inc. (2016). Foundational curriculum.* ▪ *Parents as Teachers National Center, Inc. (2014). Foundational 2 curriculum: 3 years through kindergarten.*	In-Home Parent Skill-Based	▪ Increase parent knowledge of early childhood development ▪ Improve parenting practices ▪ Promote early detection of developmental delays and health issues ▪ Prevent child abuse and neglect ▪ Increase school readiness	Well-Supported

How the state selected the services (471(e)(5)(B)(iii)(III))

In 2016, HHS began implementing SafeCare as part of the SafeCare research project conducted by Georgia State/National SafeCare Training and Research Center (NSTRC). Five of HHS' contracted child welfare, service organizations implemented SafeCare through their existing contracts. In order to provide SafeCare to parents, one must be a certified home visitor. Each of these five organizations have certified home visitors, coaches, and trainers. Some of the contractors also have "train the trainers", who provide training within their own respective organizations. Contractors are also SafeCare accredited, renewable on an annual basis, through the NSTRC.

As part of the research project, recruitment of families continued through September 30, 2017 within the specific counties identified and selected by Georgia State. Due to the research component of the project, not all of Iowa's counties implemented SafeCare. Once the research project ended, which included expectations of the contractors, HHS staff explored and decided to expand SafeCare statewide. HHS reviewed the SafeCare research, which included family survey results. Survey results showed that caregivers had a high rate of satisfaction, as did the providers delivering the model, which was a specific area of evaluation by NSTRC.

In the fall of 2018, HHS enlisted the assistance of Annie E. Casey Foundation's Child Welfare Strategy Group (CWSG) to assess Iowa's current child welfare practice, to make recommendations, and to assist Iowa in strategically prioritizing Iowa's improvement strategies[6]. Specifically, the CWSG:

- Assessed the needs of children and families served by Iowa's child welfare system and Iowa's child welfare, service array to see if services provided met identified needs.
    - Analyzed data:
        - Analyzed both state and regional/county level data to understand priority issues (i.e. prior victimization, in-home services, and out of home care)
        - Review of prior analyses completed by state data personnel
    - Reviewed policies, documents, and contracts, such as:
        - Internal policies
        - Key legislation including task force reports, HHS' and Children's Bureau visions
        - Communications materials
        - Provider request for proposal (RFP)
        - Achieving Maximum Potential's (AMP's) Youth Voice Project
    - Conducted focus groups with:

[6] The Annie E. Casey Foundation (AECF) Iowa Needs Assessment 2019, (March 26, 2019), Available at https://hhs.iowa.gov/media/9253/download?inline=

        - HHS Social Worker IIs (social work case managers (SWCMs)) and IIIs (child protective workers (CPWs)) (34)
        - HHS Supervisors (26)
        - Parent Partners[7] (30)
        - Parents (28)
        - Youth (25)
    - Conducted interviews with:
        - HHS' Family First Oversight Team
        - HHS Regional Managers
        - External stakeholder interviews: Judges, Legal Aid Attorney
        - IT and QA staff
- Recommended service models for foster care prevention services.
- Assisted HHS in planning to support Family First implementation, including fiscal analysis, foster care prevention model selection, and implementation strategies.

CWSG's assessment noted some key challenges in Iowa's child welfare system, such as unnecessary placements in foster care, teenagers with challenging behaviors, and parents with substance abuse issues. CWSG noted systemic issues that undergird these challenges are lack of individualization of services, lack of role clarity between HHS and contracted service providers, lack of experienced workforce capacity, and lack of efficacious accountability. In response, CWSG recommended the following:

- Implement a clear case management model with defined roles. "Case management can be a prevention service that requires skilled workers, reasonable caseloads and clearly defined activities.
    - Working with the family to develop a family service plan (family team meetings)
    - Helping the family connect to needed services (referrals, assistance at appointments)
    - Aiding the family in accessing services (transportation planning or support)
    - Assessing the parents' protective capacities and behavior changes over time
    - Monitoring the child's safety and addressing any new safety or risk concerns"[8]
- Establish an array of evidence-based interventions, e.g. SafeCare
- Institute stronger accountability for HHS and child welfare services' contractors

Iowa will continue working with CWSG to guide Family First implementation efforts.

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[7] Parent Partners are parents who previously had their children removed by HHS but achieved and maintained reunification for at least one year. Parent Partners provide peer-to-peer mentoring support to parents whose children have been removed from their care.

[8] The Annie E. Casey Foundation (AECF). Iowa Needs Assessment 2019. (March 26, 2019). Slide 12. Available at https://hhs.iowa.gov/media/9253/download?inline=

In June 2019, the Child Welfare Policy and Practice Group facilitated 10 Provider Partnership Forums[9] across the state, which was a way for HHS to collect service providers' voices regarding the future of child welfare in Iowa. These forums included open conversation in a safe space designated for providers. These small group conversations provided an opportunity to share cross-area perspectives with the guidance of a neutral facilitator, sharing of success and themes of concern, and an initial discussion of Family First. The topics included but were not limited to the following:

- Implementation of evidence-based services
- Financing services, including incentives
- Caseload size
- Workforce (turnover, compensation, and staff retention strategies)
- Transportation

In 2024, HHS also considered several criteria for selecting evidence-based programs (EBPs) rated as promising, supported or well-supported on the Title IV-E Prevention Services Clearinghouse to add to Iowa's title IV-E Prevention Services and Programs plan (Prevention Plan), including:

- whether the EBP would meet the needs of Iowa's children and families to prevent child maltreatment or foster care entry,
- the extent to which the EBP was currently being implemented in Iowa,
- the qualifications of those who would be delivering the EBP,
- the eligibility requirements of the EBP,
- the rating of the EBP by the Title IV-E Prevention Services Clearinghouse, and
- whether the EBP required an evaluation.

Motivational Interviewing (MI): HHS decided to add MI to its Prevention Plan after considering the criteria above. MI has been shown to be effective as a standalone service and in conjunction with other interventions. Statewide, family-centered services (FCS) contractors' Family Support Specialist (FSS) already utilize MI in conjunction with providing Family Preservation Services (FPS) and will also begin to utilize MI in conjunction with providing Family Casework (FC) starting July 1, 2024. Many of HHS' FCS contractors have staff trained and proficient in the delivery of MI and those staff not trained and proficient in MI will be. FFPSA requires that states implement services that are rated either promising, supported or well-supported. MI is a well-supported EBP rated by the Title IV-E Prevention Services Clearinghouse and will not require an evaluation if the Children's Bureau approves Iowa's waiver request.

[9] The Child Welfare Policy and Practice Group. (June 11, 2019). Iowa Department of Human Services Provider Forums Report. Available at https://hhs.iowa.gov/media/9250/download?inline=

Sobriety Treatment and Recovery Teams (START): HHS would like to initiate START and add it to the Prevention Plan because it is shown to be an effective service that will meet the needs of children and families who are impacted by substance use disorders (SUDS). The START model has been proven effective due to specific fidelity standards that require rapid (almost immediate) access to recovery services, including intensive case management as well as treatment for substance use and mental health disorders. START affiliates in other states report that staff in START have less turnover and that the model is family-centered, team-centric, and uses motivational enhancement. START is a supported EBP rated by the Title IV-E Prevention Services Clearinghouse and will require an evaluation.

Community Pathway Home Visiting Programs: HHS will implement Healthy Families America (HFA) and Parents as Teachers (PAT) through contracts with grantees throughout the state. Some Iowa counties have implemented these EBPs for more than a decade, especially in urban counties. The programs consistently maintain high utilization and yield positive results for the communities they serve. These EBPs are currently being delivered through state funds. Iowa's home visiting programs are well coordinated at the state level, with all programs reporting data into a centralized system, the DAISEY system.

HFA and PAT are both rated well-supported EBPs by the Title IV-E Prevention Services Clearinghouse and will not require an evaluation if the Children's Bureau approves Iowa's waiver request.

How the state plans to implement the services or programs (471(e)(5)(B)(iii)(II))

HHS considered the feasibility of implementation including trauma-informed service delivery models and evaluation considerations. The table below details implementation strategies of each EBP.

Table A3: Implementation Plans of Evidence-Based Programs (EBPs)

Evidence-Based Program (EBP)	Strategies for Implementation	Trauma-Informed Service Delivery
Motivational Interviewing (MI)	HHS will implement MI statewide through its family-centered services (FCS) contractors, whose staff will provide MI in conjunction with Family Preservation Services (FPS) and Family Casework (FC). The FCS contractors' Family Support Specialist (FSS) provides MI as follows:	All providers of MI are or will be trained in trauma-informed care.

Table A3: Implementation Plans of Evidence-Based Programs (EBPs)		
Evidence-Based Program (EBP)	**Strategies for Implementation**	**Trauma-Informed Service Delivery**
	▪ FPS: The FSS provides MI through eight contacts in each 10-day referral period, with all contacts at least 60 minutes in length. At least five of the contacts occur in the child's home of origin. ▪ FC: The FSS provides MI through four contacts in each full calendar month, with all contacts at least 45 minutes in length. At least two of the contacts occur in the child's home of origin. The FSS provides a summary of services delivered each service month to the HHS worker for open HHS cases. The FSS also provides a service termination summary when the services are terminated. Contractors must demonstrate the ability to provide MI with fidelity to the model.	
SafeCare®	HHS implemented SafeCare statewide through its FCS contractors, whose staff are accredited by the National SafeCare Training and Research Center (NSTRC) and maintain their accreditation. The contractor's Intervention Specialist (IS) provides SafeCare® at least three sessions per month, no more than twice per week and no less than every 2 weeks. The sessions are 60 minutes in length. SafeCare® occurs in the family home unless there is a specific reason the service cannot be delivered in the home. The IS provides the HHS caseworker with a casework contact note for each SafeCare® contact with the family. The IS	Service model includes trauma affected youth and training on trauma informed care.

Table A3: Implementation Plans of Evidence-Based Programs (EBPs)		
Evidence-Based Program (EBP)	**Strategies for Implementation**	**Trauma-Informed Service Delivery**
	also provides a service termination summary when the services are terminated.	
Sobriety Treatment and Recovery Teams (START)	HHS has selected Woodbury County in northwest Iowa and Scott and Clinton counties in northeast Iowa to serve as pilot sites to begin implementing START, prior to implementing statewide. These counties will reflect a mix of urban and rural populations. Each site will have a full team consisting of four (4) HHS Social Work Case Manager (SWCM)/Family Mentor dyads and one full-time supervisor who has been thoroughly trained in the model. The national START model identifies eleven Essential Components and Fidelity Standards for achieving model fidelity and certification; five (5) of these Essential Components pertain to program structure while six (6) of these Essential Components pertain to practice. Unlike other initiatives, the entire family unit is identified as the "client" (not the individual caregivers). The model requires START caseloads to be capped at a maximum of 12 shared cases per dyad due to the intensity of the intervention; therefore, adequate staffing is an essential component to achieving program outcomes. The number of dyads selected for each pilot site is proportionate to the number of open service cases for children aged 0-5 with a parent's substance use identified as the primary concern. The capped caseload allows staff to provide direct support to families by ensuring there are more intensive services made available than those provided in traditional child	Service model requires trauma informed training

Table A3: Implementation Plans of Evidence-Based Programs (EBPs)		
Evidence-Based Program (EBP)	**Strategies for Implementation**	**Trauma-Informed Service Delivery**
	welfare, such as home visits occurring at least once each week. Children and Family Futures (CFF) is the provider of the intensive training and technical assistance and has extensive experience in helping sites develop capacity to implement START. CFF will provide support to both pilot sites to ensure that staff are well trained and ready to implement with full fidelity.	
Healthy Families America (HFA)	HHS will implement HFA through contracts with grantees throughout the state. HHS will examine the possibility of HFA expansion in subsequent years through a phased implementation approach. Grantees and potential grantees must demonstrate the ability to provide HFA services with fiscal responsibility and fidelity to the model. Grantees will collaborate with the National Office for training and support. Contracts will require that preventive agencies deliver services in a trauma-informed manner. The HFA program model and training are designed to provide services to families and children affected by trauma and chronic hardship. HHS will monitor and oversee home visiting contracts to ensure compliance with contractual requirements and high-quality service delivery. Key mechanisms for contract oversight are annual site visits by HHS to each provider and quarterly data reviews.	The HFA program model and training are designed to provide services to families and children affected by trauma and chronic hardship.
Parents as Teachers (PAT)	HHS will implement PAT through contracts with grantees throughout the state. HHS will	The PAT program model and training

Table A3: Implementation Plans of Evidence-Based Programs (EBPs)		
Evidence-Based Program (EBP)	**Strategies for Implementation**	**Trauma-Informed Service Delivery**
	examine the possibility of PAT expansion in subsequent years through a phased implementation approach. Grantees and potential grantees must demonstrate the ability to provide PAT services with fiscal responsibility and fidelity to the model. Grantees will collaborate with the Parents as Teachers National Center for training and support. Contracts will require that preventive agencies delivery to all preventive services staff and deliver services in a trauma-informed manner. HHS will monitor and oversee home visiting contracts to ensure compliance with contractual requirements and high-quality service delivery. Key mechanisms for contract oversight are annual site visits by HHS to each provider and quarterly data reviews.	are designed to provide services to families and children affected by trauma and chronic hardship.

Continuous Quality Improvement (CQI) Activities

- *How implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved (471(e)(5)(B)(iii)(II))*
- *How information learned from the monitoring will assist in refining and improving practices*

Community Pathway

Healthy Families America (HFA) and Parents as Teachers (PAT). Iowa HHS will leverage two key strategies to ensure that title IV-E home visiting services are delivered to fidelity and yield the intended program outcomes. These include: 1) requiring and overseeing model accreditation (HFA) and/or affiliation (PAT) and 2) leveraging Iowa HHS's home visiting assessment and reporting requirements captured in DAISEY, which fuel both state and local monitoring and improvement activities.

Model Accreditation and Affiliation Requirements and Documentation:

Model-specific accreditation (HFA) and affiliation (PAT) processes entail rigorous assurance of **quality and fidelity**. All HFA and PAT programs that provide title IV-E prevention services will be required to achieve and maintain model accreditation or affiliation. Attaining and maintaining accreditation or affiliation requires providers to engage in robust ongoing quality improvement processes and yields documentation to meet Family First fidelity monitoring requirements. HHS will collect and maintain fidelity-related reports generated by the model purveyors and other key documentation specific to the accreditation or affiliation process. For example, PAT and HFA programs are required to report on the model's Essential Requirements and Quality Standards annually as the basis for the PAT Annual Performance Report (APR), and for the HFA Site Profile Report (SPR), demonstrating high-quality and adherence to the model. HFA accreditation requires collection of programmatic and administrative data for a self-study in addition to a site visit and direct technical assistance from purveyor staff. Both processes are designed to capture and elevate data on program quality and fidelity, ensure that programs adhere to model standards, and promote program-level CQI.

Required Data Collection and Reporting in HHS's DAISEY System:

Iowa HHS's existing assessment and data reporting requirements for home visiting programs, captured in DAISEY, provide another core source of data to monitor fidelity and outcomes. This data is routinely updated, as home visiting providers are required to complete assessment activities at specific intervals throughout service delivery and to document information gathered during assessment activities. For state-level users, data can be aggregated within and across program models and provider sites and used to monitor key aspects of model fidelity and model-specific outcomes regionally or statewide. DAISEY-generated data reports and dashboards are easily accessible to both local programs and HHS administrators in DAISEY, providing an ongoing mechanism to support statewide and local improvement efforts.

Data needed to monitor key **fidelity** metrics related to staffing qualifications and service delivery are gathered during required assessment activities and captured and reported in DAISEY.

- *Staffing Qualifications:* Adherence to program-specific staffing qualification requirements can be monitored using information captured in the Iowa Staff Profile. Supervisors are required to complete the Staff Profile within ten days of a staffing change and must regularly update all fields in real time. Data entered in DAISEY reflect the core staffing requirements of each evidence-based home-visiting model.
- *Service Delivery Requirements:* Timely completion of key service delivery requirements for each model are captured in DAISEY as follows:
  - *Timely Completion of Required Visits (HFA)*: CBO is tracking the percentage of families who receive the first home visit within three months of the child's

birth using the Home Visit Report Form, completed within 48 hours of each home visit.

- *Timely Completion of Developmental Screening (HFA and PAT):* CBO will track the percentage of children who receive a complete developmental screening within 90 days of enrollment or birth and the percentage of children who receive a complete annual developmental screening within the program year using the Ages and Stages Questionnaire (ASQ-3). Home visitors are required to administer the ASQ-3 at the following intervals across service delivery: 4 months, 9 months, 12 months, 18 months, 24 months, 30 months, 36 months, 48 months, 60 months.

Plans to determine outcomes achieved through HFA and PAT:

DAISEY also captures and generates reports reflecting key home visiting (HFA and PAT) program ***outcomes*** aligned with EBP-specific outcome measures. Specifically, Iowa tracks and monitors outcomes in six benchmark areas across all HFA and PAT provider sites, inclusive of key EBP-specific outcomes, as shown below. For purposes of Title IV-E prevention, these instruments and/or benchmarks will be implemented only after a child's eligibility has been determined (i.e., after birth).

Benchmark 1: Maternal and Newborn Health

- Infants born pre-term (fewer than 37 week's gestation). Iowa will track improved pregnancy outcomes by monitoring the percentage of infants who are born preterm following program enrollment. This information is captured in the Caregiver (Adult) Profile, completed upon program enrollment, and the Child Profile, created upon the child's birth.
- Breastfeeding: Infants born to mothers who were breastfed any amount at 6 months of age. This will be assessed using the Home Visit Review Form.
- Depression Screening: Iowa will track improvements in maternal health by monitoring: a) the percentage of primary caregivers enrolled in home visiting for at least 3 months who were screened for depression within 3 months of enrollment and b) the percentage of primary caregivers with a positive screen for depression who receive one or more service contacts.
- Well Child Visit: Iowa will track improvements in newborn health by monitoring: The percentage of target children who received the last recommended well-child visit based on the American Academy of Pediatrics (AAP) schedule. This will be assessed using the EAR Annual Report - Target Child
- Postpartum Care: Iowa will track improvements in maternal health by monitoring: the percentage of mothers who enrolled within 30 days of giving birth who received a

postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery. This will be assessed using the EAR annual report – Caregiver.

Benchmark 2: Child Injury

- Safe Sleep: Iowa will track safe sleep outcomes by monitoring the percentage of primary caregivers who report infants less than 1 year are always placed to sleep on their backs and without bed-sharing or soft bedding. This will be monitored using the Home Visiting Report form.
- Child Injury: Iowa will track child injury outcomes by monitoring the percentage of target children with injury-related visits to the Emergency Department since enrollment. This will be monitored using the Home Visit Report form.

Benchmark 3: School Readiness

- Parent-Child Interactions: Iowa will track improvements in parenting practices by monitoring the percentage of caregivers with children in the target level age range who receive an observation of caregiver-child interaction by the home visitor using a validated tool. In Iowa, home visitors assess parent-child interaction using the PICCOLO, CHEERS, or DANCE. Parent-child interaction is measured twice per year until the child reaches 36 months.
- Early Language and Literacy: Iowa will track improvements in early language and literacy by monitoring the percentage of target children who had family members read, tell stories, and/or sing songs to the target child every day during a typical week. This will be assessed using the Enrollment and Annual Report – Target Child.
- Developmental Screening: Iowa will track improvements in child health and development by monitoring: a) the percentage of children enrolled in home visiting who receive timely developmental screening using a validated tool.

Benchmark 4: Domestic Violence

- Domestic Violence: Iowa will track improvements in domestic violence by monitoring the percentage of primary caregivers who are screened for intimate partner violence (IPV) using a validated tool. This will be assessed using the Futures without Violence Relationship Assessment Tool.

Benchmark 5: Economic Self-Sufficiency

- Primary Caregiver Education: Iowa will track improvements in economic self-sufficiency by monitoring the percentage of primary caregivers without a middle/high school degree or equivalent at enrollment who subsequently enrolled in, maintained continuous enrollment in, or completed middle/high school or equivalent during their participation in home visiting. This will be assessed using the Enrollment and Annual Report – Caregiver.
- Continuity of Insurance Coverage: Iowa will track improvements in economic self-sufficiency by monitoring the percentage of primary caregivers who had continuous health insurance coverage for at least 6 consecutive months in the reporting year. This will be assessed using the Enrollment and Annual Report – Caregiver.

Benchmark 6: Coordination and Referrals

- Complete depression referrals: Iowa will track improvements in coordination and referral by monitoring the percentage of primary caregivers with a positive screen for depression who receive one or more service contacts. Improvements in maternal health will be assessed using the Postnatal Depression Screening. The Edinburgh is completed within three months of enrollment for families who enroll postnatally.
- Completed Developmental Referrals: Iowa will track improvements in coordination and referral by monitoring the percentage of children with positive screens for a developmental delay who receive timely services. This information is captured using the Ages and Stages Questionnaire (ASQ-3) at specific intervals.
- Intimate Partner Violence (IPV) Referrals: Iowa will track improvements in coordination and referral by monitoring the percentage of primary caregivers with positive screens on the relationship assessment tool who receive referral information to IPV resources. This will be assessed using the Futures without Violence Relationship Assessment Tool.

Child Protective Services (CPS) Pathway

Social work case managers (SWCMs) oversee HHS cases on a day-to-day basis. Family-centered services (FCS) contractors oversee non-HHS voluntary FCS cases on a day-to-day basis. Both SWCMs and FCS staff participate in case consultation with their supervisor to discuss their cases. Additionally, both HHS and FCS contractors conduct CQI activities for prevention services as outlined below reflecting HHS and non-HHS, voluntary FCS cases.

Motivational Interviewing (MI): HHS' FCS contractors will access required trainings through third-party vendors, Relias and Lyssn. For more information about the training requirements, please see *Section III: Child Welfare Workforce, Training*.

FCS contractors will implement a five-tiered approach to maximize maintaining fidelity to the MI model. FCS contractors will utilize the 1st quarter of implementation to determine a baseline for performance and to set a proficiency percentage for staff to meet.

- Tier 1 – Lyssn Liaison (Admin)
  - Each contractor is required to designate at least one Lyssn Liaison. These liaisons will be pivotal in ensuring smooth communication and implementation.
    - Liaisons are enthusiastic, trusted by their peers, and have backgrounds in training, CQI, or IT.
  - Liaisons will add the following people from their agency to the Lyssn Platform to complete the five modules for the specified virtual client assigned:
    - MI Specialist(s)
    - MI Coach(s)
    - Supervisors
    - Users (Direct-line staff)
- Tier 2 - MI Specialist
  - MI Specialists will complete the introduction training through Relias, the five Lyssn modules for all four virtual clients, the MI Coach training and the MI Specialist training.
    - If a MI Practice Specialist is a Motivational Interviewing Network of Trainers (MINT) and is in good standing with MINT, the person is deemed to meet the qualifications of MI Specialist in Iowa.
  - The MI Specialist will need to demonstrate proficiency in MI.
  - MI Practice Specialists will have access to the Lyssn Dashboard.
  - The MI Practice Specialists will meet quarterly to share how MI Practice is working and develop topics for MI booster sessions.
- Tier 3 – MI Coach
  - The MI Coach will complete the introduction training through Relias, the five Lyssn modules for all four virtual clients and the MI Coach training.
  - The MI Coach will demonstrate proficiency in MI.
  - MI Coaches will have access to the agency's Lyssn Dashboard, which provides metrics, on a monthly basis, related to staff's performance on the five MI modules.
    - The MI Coach will be responsible for fidelity monitoring at the FCS Contractor level to ensure integration of results into supervision.
- Tier 4 – Supervisors
  - Supervisors are individuals that each FCS Contractor designated as a supervisor in the Lyssn System and they are the direct line supervisor of the user.

    - Supervisors will complete the introduction training through Relias and the five Lyssn modules for Gabriella and Jeanette.
    - Supervisors will review and discuss how their frontline staff are using MI with families during supervision. At a minimum, supervisors are expected to discuss each case on the frontline staff's caseload at least once per month.
- Tier 5 – Users (Direct-Line Staff)
    - These are the individuals that each FCS Contractor identified as a User in the Lyssn System.
    - Users will complete the required introduction training through Relias and then the required five Lyssn MI modules for Gabriella.
    - Users will implement MI with their families.

Additionally, Tier 2 through Tier 5 staff will complete a Lyssn MI vignette on a quarterly basis.

Plans to determine outcomes achieved: HHS has the following contract performance measures in contracts with the FCS contractors for Family Preservation Services (FPS) and Family Casework (FC), which requires the contractor's utilization of MI to provide the 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. The target is to achieve 90% on all cases served.
    - 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.
- Family Casework:
    - 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.

Safecare®: HHS' Family-Centered Services (FCS) contractors providing SafeCare must receive certification by the National SafeCare Training and Research Center (NSTRC). The NSTRC provides training, observation, and guidance to FCS contractors to ensure their certification attainment, ongoing fidelity monitoring, and annual

recertification. To become a SafeCare provider, individuals must first attend the four-day workshop conducted by certified SafeCare trainers from the NSTRC. The workshop uses a combination of instructional presentations, skills observation, and role-play sessions with training specialists to teach service providers about implementation of the three core modules, i.e. Health Module, Home Safety Module, and Parent-Child/-Infant Interactions Module, as well as communication and structured problem-solving skills. After attending the workshop, certified SafeCare coaches must observe and rate the individual's fidelity in at least nine sessions until staff obtain sufficient proficiency in SafeCare skills (measured by at least 85% or greater on the fidelity assessment) to attain certification. Fidelity monitoring for providers includes a review of session audio by coaches, who use standardized fidelity checklists to evaluate provider's competency and accuracy in conducting each session. Coaches give session feedback to providers to support their SafeCare practice. During provider certification, this occurs as often as needed until the provider is certified. After certification, providers continue fidelity monitoring once a month for two years, at which point they move to quarterly fidelity monitoring. NSTRC requires fidelity to consistently be at 85% or greater for continued SafeCare implementation.

FCS contractor SafeCare coaches periodically conduct recordings or observations of SafeCare sessions for quality assurance purposes. SafeCare Trainers and NSTRC Specialists check coaches' quality assurance. Each year, FCS contractor SafeCare trainers demonstrate their accuracy in assessing fidelity of provider and coach support sessions and workshop training skills.

Once certified, individuals can receive additional training to become a SafeCare coach or trainer. The NSTRC requires onsite SafeCare coaching. To become a SafeCare coach, certified individuals participate in a two-day workshop to learn the role of a coach, including how to coach and provide constructive feedback to the SafeCare provider. After attending the workshop, a SafeCare trainer observes and rates the coach on demonstration of coaching skills and mastery in fidelity monitoring for certification as a coach.

After individuals complete the required trainings and receive certification as a SafeCare provider and SafeCare coach, individuals may attend a two-day workshop that teaches SafeCare training methods, how to teach adult learners, how to set up role-play, how to provide feedback to trainees, and how to support SafeCare coaches. Becoming a SafeCare trainer is a commitment to the NSTRC to adhere to their requirements regarding distribution of materials, supporting SafeCare coaches and providers, and reporting data to NSTRC through the SafeCare Implementation Data Network (SIDN), https://safecareportal.nstrc.org/SafeCare/WebApp/Account/Login. After the workshop, the NSTRC observes SafeCare trainer trainees during their first provider workshop to ensure fidelity to the training model. To become fully certified, the NSTRC Trainer must rate the SafeCare trainer trainee as having achieved mastery in the delivery of a provider workshop.

The NSTRC requires FCS contractors to obtain annual recertification to ensure model fidelity of SafeCare. The NSTRC conducts annual accreditation, in which organizations accredited in SafeCare, provide documentation of compliance with the SafeCare Implementation Standards. Accreditation standards are on the core program criteria that promotes a high-quality service delivery to maximize the effectiveness of SafeCare for families. These standards require that organizations: (1) implement the SafeCare model as prescribed to maintain fundamental structural, measurement, and mastery criteria; (2) conduct ongoing quality assurance of worker's SafeCare responsibilities; and (3) have a minimum number of providers actively delivering SafeCare at the time of accreditation. NSTRC will also consider details pulled from the SafeCare Portal such as frequency of SafeCare visits, module and program completion, and program satisfaction. The contractor organizations submit information about their SafeCare implementation through an online accreditation survey. The NSTRC Accreditation Manager schedules a phone interview to ensure organizations maintain high quality implementation and fidelity to the model. If an implementation has not met SafeCare standards, that organization has a corrective action plan. In addition to this once a year check in, organizations can reach out to NSTRC at any time and the NSTRC will provide local sites technical assistance with implementation and quality assurance. The NSTRC's accreditation process also provides opportunities to obtain SafeCare program and technology updates, the latest research findings regarding SafeCare and its implementation, as well as an opportunity to highlight the strengths of an organization's implementations and to obtain consultation about challenges or concerns. NSTRC requires ongoing coaching to keep the contractors' certifications active.

Through its contracts with FCS contractors, HHS provides funding for contractors not already certified in SafeCare to attain their certification. All contractors are currently certified. HHS contractual expectations are that FCS contractors will attain and maintain SafeCare certification throughout the contract period.

Plans to determine outcomes achieved: HHS has the following SafeCare performance measures in contracts with the FCS contractors:

- 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.

FCS CQI Processes for SafeCare and Motivational Interviewing (MI): In addition to FCS contractors fidelity monitoring noted above, FCS contractors complete self-assessments of 50 cases (randomly selected by HHS) in the spring and fall. These assessments review elements of contract compliance as well as reviewing the quality-of-service provision. HHS' service contract specialist reviews 20% of cases selected for contractor self-assessments. Contractors will be expected to agree on the cases the

service contract specialist reviews. See HHS' CQI Processes below for more information.

HHS' CQI Processes for SafeCare and Motivational Interviewing (MI): As part of HHS' activities for SafeCare and MI provided during FPS and FC, HHS' feedback loop utilizes stakeholder group processes and contract monitoring to refine and improve practices. Stakeholder group processes, which usually occur at a local level but roll-up to a state level, include but are not limited to:

- Service Area Contractor Meeting – Held in each Service Area, contractor leadership, i.e. director level of organizations that hold contracts with HHS and HHS leadership, attend these meetings. This group comes together quarterly to share agency updates, performance data, as well as the current focus of the state resulting from upcoming policy and/or contract changes. This allows everyone to have a voice and provide feedback regarding upcoming changes. Often this is a time for stakeholders to communicate regarding any barriers that they are experiencing and begin problem-solving issues.
- Joint Supervisor Meetings – These will occur quarterly between HHS, FCS contractors, and foster care supervisors. This is time to partner and problem solve regarding service-related issues that staff are experiencing. The supervisors also receive information derived from other contractor meetings. Supervisors often jointly develop topics for staff meetings, as needed, for field staff.
- Joint Quality Assurance (QA) Meetings – These occur in some Service Areas quarterly between HHS QA staff and QA staff from the contractors in the Service Areas. This is an opportunity for QA staff to share what they have been focusing on and offer any assistance. This is a partner and learner opportunity to share across organizations for continuous quality improvement (CQI).

Twice a year, via phone call, teleconference, or webinar, the HHS' family-centered services (FCS) program manager and assigned service contract specialist plans to meet with the FCS contractors to discuss a set agenda shared with the contractors prior to the call. At the conclusion of the meeting/call, the FCS program manager will create a one-page document summarizing the key points and overview of the discussion and will share the one-page document with contractor representatives, HHS service area managers, service contract specialists, child welfare bureau chief, and division administrator.

The FCS program manager also regularly attends the local in-person meetings (Service Area Contractor Meetings) scheduled in each of the Service Areas in an effort to increase understanding of the challenges contractors face and support program development, performance, and improvement. By attending the local service area meetings, the FCS program manager gains understanding regarding the systemic challenges between contractors and field operations. In addition, the information

discussed during the local service area meetings build upon the information discussed during the semi-annual meetings/calls. The in-person meetings also help facilitate discussion about training, program development and improvement, and best practices.

The FCS program manager (aka contract manager), in collaboration with the assigned service contract specialists, oversees the contracts for FCS, which includes SafeCare and MI through FPS and FC. The contract manager determines compliance with general contract terms, conditions, and requirements and assesses compliance with the contract deliverables, performance measures, or other associated requirements based on information received from the service contract specialist for the contract. Service contract specialist activities include but are not limited to:

- Responding to day-to-day questions from the contractor.
- Resolving contract issues and disputes between HHS and the contractor to the extent possible.
- Monitoring data on a monthly basis regarding any incentive payments the contractor is eligible to obtain.
- Conducting onsite reviews of contractor records, including the records of subcontractors as necessary, to validate the contractor's monthly service reporting and compliance with the service requirements. HHS reserves the right to set the frequency of onsite reviews.
- For Family Casework, the service contract specialist will read a minimum of 25 randomly selected records semi-annually. Of the 25 records, Family Casework services provided will be reviewed, as well as records that include Kinship Navigator, SafeCare®, and Family Preservation Services. This sample will also include non-HHS voluntary FCS case records. The records will be selected through a random sampling methodology to be reviewed as part of the contractor's quality assurance review. If there is a significant error rate of service of more than 10%, HHS reserves the right to increase the sample size. Results of each semi-annual review will be compiled into a Contract Compliance Review Report and provided to the HHS contract owner and service area manager upon completion of each review.
- Monitoring program improvement plans (PIP) that the contractor is required to develop to improve their performance in meeting the service requirements.
- Conduct onsite reviews of the contractor's overall quality assurance system to validate that the contractor is implementing a quality assurance system as described in their proposal. Quality assurance reviews by the service contract specialist will occur periodically throughout the contract period. The first review will take place within the first nine months of the contract. Further review, as needed, will ensure that the service contract specialist maintains an understanding of the contractor's quality assurance processes. During the subsequent reviews, the service contract specialist will review 10 staff files including newly hired staff and on-going staff, and five subcontractor staff if there

are any subcontractors, to check on the compliance with records checks and qualifications. Based on service contract specialist's or contractor's preference, these reviews may be scheduled prior to or concurrent with the contract compliance review.

Sobriety Treatment and Recovery Teams (START) - In July 2024, HHS executed a training and technical assistance contract for implementation of the Sobriety, Treatment and Recovery Teams (START) approach to child welfare. START is an evidence-based practice model that is rated on the Title IV-E Prevention Services Clearinghouse as "Supported". START is a specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for both parents and children impacted by child maltreatment and substance use, and to successfully keep children in the home, avoiding out-of- home placement.

Outcomes associated with implementation of the model include[10]:

- Mothers in START had higher rates of sobriety and early recovery than a matched comparison group (66% vs. 37%).
- Children in START entered out-of-home placement at half the rate of children from a matched comparison group (21% vs. 42%).
- At case closure, more than 75% of children in START remained with or were reunified with their parent(s).
- At 12 months post-intervention, more children in START remained free from both out-of-home placement and child abuse/neglect as compared to children served in treatment as usual (68.5% vs. 56%).

General Implementation Information:

- A project director has been identified at HHS to lead implementation. The implementation occurs utilizing a dyad approach consisting of one HHS social work case manager (SWCM) and one family mentor for each family. Together, the dyad provides intensive case management services. The family mentor is someone in long-term recovery with experiences that sensitize them to child welfare and works closely with the SWCM as a part of the child welfare team. Eligible families will receive immediate access to mental health and SUD assessment and treatment. START has a very rapid timeline for caregivers to be referred and to access services. The number of days between initial report to child welfare and START referral must not exceed 10 business days or 14 calendar days.
- Staff support from CFF includes two leadership staff, a change liaison specifically assigned to Iowa to move the work forward, and a national evaluation technical assistance (TA) lead to help direct the evaluation plan. Each pilot site will have a

[10] https://www.cffutures.org/start-outcomes/

local steering committee that includes child welfare staff, judicial representation, treatment providers and other community stakeholders. This committee will drive local implementation. The statewide steering committee has been formed and meets bi-monthly, led by staff from CFF. Initially, the committee met once per month, but as implementation has progressed and local steering committees are formed, there is less need for monthly meetings. These meetings inform implementation by focusing on topics such as site selection, programmatic issues, evaluation, continuous quality improvement, sustainability, certification, alignment with other Iowa initiatives, and site visit planning.

HHS' CQI Information and Processes for START:

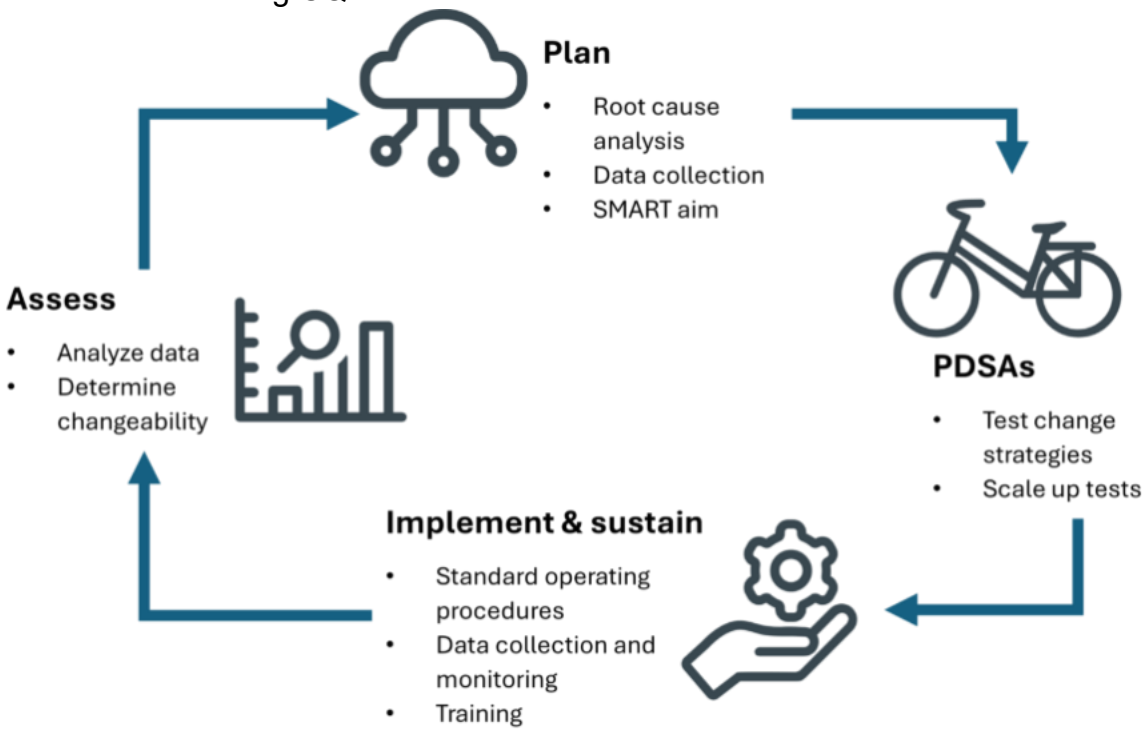
- As identified in the fidelity standards, CQI strategies include analysis of program data, sharing/discussing results in a user-friendly format, and using information to improve START implementation, outcomes, and to foster a learning organization. Children and Family Futures (CFF) staff will meet monthly with each pilot site individually, and once per month with both pilot sites in a joint meeting. CFF leads a project management meeting twice per month to ensure implementation to fidelity. The evaluator and project director will meet monthly with the national evaluation TA lead to discuss evaluation progress and address challenges. Additionally, the evaluator will meet regularly with the pilot sites, CFF and the project director to gather feedback and suggestions regarding data collection and evaluation. This will be an ongoing CQI process.
- A virtual visit to engage with Kentucky and Ohio START sites is planned for Jan/Feb 2026 to allow HHS staff and family mentors, as well as leadership, to meet with established sites to learn how they approach the work.
- Training is required for HHS staff, child welfare teams, family mentors and treatment providers. Training schedule is listed below:
    - Foundations I was offered to all interested HHS staff in early June,
    - Foundations II is specific to the family mentor hiring agency and was offered in mid-June,
    - Foundations III is specific to treatment providers, and will be offered once those providers have been identified and engaged (early winter),
    - Foundations IV is targeted to the child welfare teams, and
    - Other trainings will be offered as appropriate.

HHS' CQI Processes for HFA and PAT:

Iowa will employ several strategies to leverage insights that emerge from the monitoring process to improve service delivery, as follows.

- Iowa will leverage a cycle of improvement to monitor and improve service delivery across title IV-E home visiting providers. Iowa's current home visiting CQI framework, visualized below, will be utilized to monitor and improve the delivery of title IV-E home visiting services.

Iowa's Home Visiting CQI framework



- HHS will host peer-to-peer CQI meetings for all title IV-E home visiting providers. A representative from each title IV-E home visiting sites will be required to attend meetings and to share information with their program staff for implementation and monitoring of a quality improvement project. The group will collaboratively select a statewide area of focus for improvement based on performance data, and each provider site must develop and implement a quality improvement topic project around the selected focus area. Title IV-E home visiting providers may leverage Plan-Do-Study-Act (PDSA) cycles as the primary mechanisms for assessing progress on the CQI statewide topic of emphasis. PDSA is a cycle of activities, focused on a common change strategy, to monitor and improve an identified aspect of service delivery. Insights generated from each cycle of testing are used to refine the change strategy being tested, until implementation challenges have been

addressed, or the desired changes or implementation outcomes are achieved. During CQI meetings, site representatives review key performance metrics, report on their quality improvement topic project, and share implementation successes, milestones, or challenges. CQI meetings provide a collaborative forum to discuss site-specific quality improvement projects with peers and to receive feedback from colleagues who have had similar experiences.

- Provider sites have access to data collection and reporting tools via the DAISEY data system. DAISEY allows for near real time collection of data and visualization of the corresponding measures. Visualizations include both process measures, such as completeness of data entry, and outcome measures for variables collected in the system. DAISEY is a central entry point that allows for a streamlined and timely data collection process allowing CQI training and technical assistance staff to have a single point of access to assist each provider site with project or data concerns.
- EBP-specific outcomes are currently monitored through the course of existing practice across Iowa's home visiting system, via the completion of required assessment activities. For example, the following outcomes are tracked and monitored across HFA and PAT provider sites:
    - Improved pregnancy outcomes: Iowa will track improved pregnancy outcomes by monitoring the percentage of infants who are born preterm following program enrollment. This information is captured in the Caregiver (Adult) Profile, completed upon program enrollment, and the Child Profile, created upon the child's birth.
    - Improved child health and development: Iowa will track improvements in child health and development by monitoring: a) the percentage of children enrolled in home visiting who receive timely developmental screening using a validated tool and b) the percentage of children with positive screens for a developmental delay who receive timely services. This information is captured using the Ages and Stages Questionnaire (ASQ-3) at specific intervals.
    - Improved positive parenting practices: Iowa will track improvements in parenting practices by monitoring the percentage of caregivers with children in the target level age range who receive an observation of caregiver-child interaction by the home visitor using a validated tool. In Iowa, home visitors assess parent-child interaction using the PICCOLO, CHEERS, or DANCE. Parent-child interaction is measured twice per year until the child reaches 36 months.
    - Improved maternal health: Iowa will track improvements in maternal health by monitoring: a) the percentage of primary caregivers enrolled in home visiting for at least 3 months who were screened for depression within 3 months of enrollment and b) the percentage of primary caregivers with a positive screen for depression who receive one or more service contacts. Improvements in maternal health will be assessed using the Edinburgh Postnatal Depression Screening.

The Edinburgh is completed within three months of enrollment for families who enroll postnatally.

- Home visiting providers across the state of Iowa are required to document assessment activities in DAISEY, (Data Application and Integration Solutions for the Early Years), Iowa's web-based outcome reporting system. Providers can utilize DAISEY to generate reports with outcomes aggregated across sites, an additional mechanism for ongoing monitoring and CQI processes.

How each service or program provided will be evaluated. - See Evaluation Strategy and Waiver Request below.

Evaluation Strategy and Waiver Request

Evaluation Strategy: The state must include a well-designed and rigorous evaluation strategy for each service, which may include a cross-site evaluation approved by ACF.

Family First requires that each approvable service listed in Iowa's Prevention Plan have a well-designed and rigorous evaluation strategy, unless granted a waiver for a well-supported intervention.

Iowa HHS' evaluation strategy for SafeCare® is to contract with an evaluator to conduct the well-designed and rigorous evaluation (please see Attachment A: Iowa SafeCare Evaluation Plan).

The HHS evaluation strategy for Sobriety Treatment and Recovery Teams (START) is to contract with an evaluation team at the University of Iowa to conduct the rigorous evaluation (please see Attachment A17: Iowa Sobriety Treatment and Recovery Teams (START) Evaluation Plan).

Evaluation Waiver Request: Consistent with section 471(e)(5)(C)(ii) of the Act, the Children's Bureau may waive this requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state may request this waiver using Attachment II to the five-year plan and must demonstrate the effectiveness of the practice.

Please see Attachment II (c): State Request for Waiver of Evaluation Requirement for a Well-Supported Practice for Motivational Interviewing (MI), Healthy Families America (HFA) and Parents as Teachers (PAT).

Evidence of Effectiveness of Evidence-Based Programs (EBPs)

Healthy Families America (HFA): The Title IV-E Prevention Services Clearinghouse rated HFA as "well-supported" based on research evidence demonstrating effectiveness in the following areas:

- *Child safety – reduced self-report of maltreatment.* Participation in HFA has resulted in a reduction in child neglect, frequency of minor physical aggression, frequency of psychological aggression, frequency of severe and very severe physical abuse, severe physical abuse, and neglectful parenting behaviors (Duggan, 2004; Mitchell-Herzfeld, 2005).
- *Child well-being – improved behavioral and emotional functioning*. HFA has been shown to reduce both internalizing and externalizing behaviors (Caldera, 2007).
- Child well-being – Improved cognitive functions and abilities. HFA has been shown to increase scores on an infant mental health development index (Caldera, 2007).
- *Child well-being – reduced delinquent behavior*. One study showed that HFA resulted in a reduction in children skipping school (DuMont, 2010).
- *Child well-being – improved educational achievement and attainment.* One study showed that HFA resulted in increased retention in 1st grade (Kirkland, 2012).
- *Adult well-being – improved positive parenting practices*. HFA has resulted in improved positive parenting practices demonstrated through observations of three distinct parenting tasks. (DuMont, 2008).
- *Adult well-being – improved parent/caregiver mental or emotional health*. Studies show that HFA participation has resulted in improved parental mental health and decreased stress (Duggan, 2004; Duggan, 2007; McFarlane, 2013).
- *Adult well-being – improved family functioning*. HFA has demonstrated positive outcomes in family functioning through reductions in maternal intimate partner domestic violence victimization and perpetration rates. (Bair-Merritt, 2010).

HHS is confident that these favorable outcomes will be seen in Iowa's title IV-E funded services. First, Iowa's HFA target population will be the same population for which the program is designed and found to have positive outcomes. Second, HHS has already begun to see positive results from its implementation of HFA to date under both the ECI and MIECHV-funded programs. For example, in FY25, 95% of the 3,282 families served through ECI home visiting programs (inclusive of PAT and HFA) were able to improve or maintain their healthy functioning, problem solving, or communication skills.[11] Additionally, 89% of families report increased or maintained levels of social

[11] Iowa Department of Health and Human Services (2025). *2024 Early Childhood Iowa Annual Report* https://publications.iowa.gov/52222/1/2024%20ECI%20Annual%20Report.pdf

supports. Of the children screened in FY25, 19% were identified with having a developmental concern and 97% of those were referred for evaluation or service.

Motivational Interviewing (MI): As mentioned earlier in this section, Motivational Interviewing (MI) is an evidence-based, client-centered method designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through the stages of change. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible.

MI is a cross-cutting intervention which has demonstrated flexibility and favorable outcomes to promote behavior change with a range of target populations, backgrounds and for a variety of problem areas.

The Title IV-E Prevention Services Clearinghouse lists parent/caregiver substance use as significant impact area for MI, which is supported by the extensive list of studies provided as sources on the clearinghouse. In summary, “Adult well-being: Parent/caregiver substance use” showed an effect size of 0.16 and implied percentile effect of 6. Six individual studies detailed on the Title IV-E Prevention Services Clearinghouse showed positive statistically significant effect sizes in at least one outcome area.[12]

According to a 2018 narrative review of 16 articles discussing the use and effectiveness of MI in child welfare, 12 studies suggested MI’s “value in parenting skills, parent/child mental health, retention in services, parent/child mental health, substance use, and CW [child welfare] recidivism.”[13] These studies point to MI’s potential to address head-on the risk factors of substance-use and mental health, and to enhance the likelihood of success of conjunctive services such as those aiming to reduce domestic violence. A study published in 2008 further demonstrates MI’s positive impacts on behavior change in domestic violence offenders.[14]

MI has been shown to be an effective intervention when used by itself or together with a combination of other treatments to reduce risk of abuse/neglect and placement into out of home care. Iowa intends to capitalize on the benefit of being able to use MI in

[12] Title IV-E Prevention Services Clearinghouse. Accessed 1/25/2024. https://preventionservices.acf.hhs.gov/programs/256/show

[13] Shah A, Jeffries S, Cheatham LP, et al. Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society. 2019;100(1):52-67. doi:10.1177/1044389418803455

[14] Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. Violence and victims, 23(5), 558-570.

conjunction with our Family Preservation Services (FPS) and Family Casework (FC), as previously described in this Title IV-E Prevention Plan.

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Parents as Teachers (PAT): The Prevention Services Clearinghouse rated PAT as "well-supported" based on the following favorable research outcomes:

- *Child safety – child welfare administrative reports*. One study showed that PAT resulted in reduced substantiated maltreatment reports and reduced substantiated neglect. reducing the occurrence of substantiated incidents of abuse and neglect. (Chaiyachati, 2018).
- *Child well-being – social functioning*. Findings from one study demonstrate that PAT participation led to improved social development and self-help development according to the Developmental Profile scale (Wagner, 1999).
- *Child well-being – improved cognitive functioning and abilities*. Research shows that participation in PAT contributes to improved child cognitive development and expressive language (Neuhauser, 2018; Wagner, 1999).

As with HFA (described above), HHS is confident that these favorable research outcomes will also be seen in Iowa's title IV-E funded PAT services. First, Iowa's HFA target population will be the same population for which the program is designed and found to have favorable outcomes. Second, PAT already has a successful track record in Iowa. As noted above, in FY25, 95% of the 3,282 families served through ECI home visiting programs (inclusive of PAT and HFA) were able to improve or maintain their healthy functioning, problem solving, or communication skills.[15] Additionally, 89% of families report increased or maintained levels of social supports. Of the children screened in FY25, 19% were identified with having a developmental concern and 97% of those were referred for evaluation or service.

Please see above, *Services Description and Oversight, Continuous Quality Improvement (CQI)* activities for information regarding CQI processes for HFA, MI, and PAT.

Monitoring Child Safety

The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for

[15] Iowa Department of Health and Human Services (2025). *2024 Early Childhood Iowa Annual Report* https://publications.iowa.gov/52222/1/2024%20ECI%20Annual%20Report.pdf

the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.

Community Pathway - Safety and Risk Assessment

Healthy Families America (HFA) and Parents as Teachers (PAT) practitioners will use a combination of both formal and informal risk assessment tools and processes throughout their involvement with a family. All service providers will complete a suite of formal assessments on a regular basis: the ASQ3 and ASQ:SE2, the Edinburg Postnatal Depression Screening, and the Life Skills Progression (every six months). Results from these assessment tools captures family dynamics, risks, and protective factors in detail, thus providing a rigorous basis for informal risk assessment. Each child will receive an informal assessment of risk by HFA or PAT staff on a regular basis during each in-person and virtual home visit. Assessment results will be monitored alongside progress toward service goals by the responsible home visiting staff. The child-specific prevention plan or service plan will be updated if additional risks or needs are identified throughout the course of service delivery.

All home visitors are mandated reporters and receive training on mandated reporting as well as child abuse and neglect. HHS requires that all sites establish a clear procedure requiring suspected cases of child abuse and neglect be reported to CPS. See Attachment A19: 2025 Home Visiting and Family Support Operations Manual, page 9, which is inclusive of child abuse and neglect indicators and reporting requirements. HHS tracks and monitors child safety throughout the course of services by reviewing safety performance measures collected at each home visit and stored in the DAISEY data system. This data is viewed by HHS staff in a quarterly CQI effort and is discussed with the CBOs at the quarterly contract manager meeting.

Child Protective Services (CPS) Pathway

Both HHS and its family-centered services (FCS) contractors will monitor and oversee the safety of children who receive prevention services. HHS staff oversee HHS cases on a day-to-day basis while FCS contractors oversee non-HHS voluntary FCS cases on a day-to-day basis. Additionally, FCS contractors monitor the safety of the children and families they serve throughout the provision of services regardless of whether the case is an HHS case or a non-HHS voluntary FCS case.

Safety Monitoring and Oversight

HHS – Safety and Risk Assessments

Safety Assessment - HHS staff utilize safety and risk assessments, including risk reassessments, to oversee the safety of children receiving HHS child welfare services, including prevention services. The safety assessment is a decision-making and documentation process that evaluates safety threats, present danger, child vulnerability, and family protective capacities to determine the safety response. Specifically, the assessment looks at child safety using three constructs:

- The threats of maltreatment that are present at this time (i.e., aggravating factors that combine to produce a potentially dangerous situation).
- The child's vulnerability to maltreatment (i.e., the degree that a child cannot on the child's own avoid, negate, or minimize the impact of present or impending danger).
- The caretaker's protective capacities (i.e., the family strengths, or resources that reduce, control or prevent threats of maltreatment from arising as well as factors and deficiencies that have a negative impact on child safety).

Since safety assessment is an ongoing process, HHS staff, child protective workers (CPWs) and social work case managers (SWCMs), conduct a safety assessment, utilizing *Form 470-4132, Safety Assessment*, with supervisory consultation, at the following critical junctures throughout the course of the family's involvement with HHS:

- Within 24 hours of first contact with the child during a child protective assessment (CPW)
- At completion of the child protective assessment (CPW)
- Whenever circumstances suggest the child is in an unsafe situation (SWCM)
- Before the decision to recommend unsupervised visitation (SWCM)
- Before the decision to recommend reunification (SWCM)
- Before the decision to recommend closure of protective services (SWCM)

If the child is conditionally safe, HHS staff initiate controlling safety interventions, which may include the parent arranging informal temporary care of the child, through a safety plan. If the child is unsafe, HHS staff may pursue a kinship care placement or pursue removal of the child from the parental home, sanctioned by a court order or voluntary agreement, for foster care placement.

Risk Assessment: Risk refers to the probability or likelihood that a child will suffer maltreatment in the future. The identification of risk looks at the conditions within a family that may put the child at risk of maltreatment. Risk is not static; it changes and needs re-evaluated throughout the life of the case. Risk factors indicate child welfare threats that if left unattended could result in a safety concern. Some risk factors identify what needs to change within the family so that the child will remain safe.

HHS intake staff assess risk during intake in terms of the type and severity of the risk with respect to the allegations. Risk factors exist on a continuum from low to high that indicate the likelihood that any form of maltreatment will occur or reoccur.

HHS' CPW completes *Form 470-4133, Family Risk Assessment*, before the completion of the child protective assessment. This tool in combination with clinical judgment helps to focus on the needs of the family. The Family Risk Assessment:

- Evaluates personal, physical, and environmental factors in families that are associated with repeat maltreatment,
- Documents risks related to abuse and neglect, and
- Assigns a score of low, moderate, or high risk for the family within each category. The family risk score is a factor in determining case referral for services.

CPWs record the results of the risk assessment in the *Child Protective Services Family Assessment Summary, Form 470-5371, Child Protective Services Child Abuse Assessment Summary, Form 470-3240*, or in the *CINA Services Assessment Summary, Form 470-4135*, in the section entitled, "Summary and Analysis of Safety/Risk Assessments." The information gathered from the risk assessment becomes part of the case information given to the SWCM for an ongoing services case. The SWCM uses this information when conducting case planning activities with the family.

HHS' SWCMs reassess risk formally and informally periodically throughout the life of the case. The results of the risk reassessments and the assessment of the family's functioning gauge progress and determine appropriate services. Staff conduct formal risk reassessments by using *Form 470-4134, Risk Reassessment* (Attachment A7), during case and prevention plan reviews (discussed below) and before case closure. SWCMs conduct informal risk reassessments, without the use of a tool, at the following points during the life of a case:

- At family focused meetings (FFMs),
- In unsafe situations,
- During any contact with child, caregiver, or future caregiver,
- After review of reports,
- In clinical case consultations with the supervisor and other professionals,
- Before unsupervised family interactions or visits,
- Before reunification, and
- Whenever circumstances suggest.

Client Contacts: HHS' SWCMs conduct face-to-face visits with each child receiving services in the home and those in out-of-home placements. At a minimum, face-to-face visits occur once every calendar month but can be more frequent based upon the needs of the child. The majority of the visits take place in the child's place of residence, with the visit being of sufficient length to focus on the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case

permanency plan's goals. Documentation of the visits occurs in HHS' child welfare information system (CWIS), contact note.

The Sobriety Treatment and Recovery Teams (START) model requires HHS SWCMs to conduct face-to-face visits in the home with the family weekly for at least the first 60 days. The family mentor is required to conduct weekly home visits with the family for at least the first 90 days. The SWCM and the family mentor will be physically co-located in the same office space and will communicate daily to share updates, coordinate service delivery, and respond to any safety/risk concerns and/or needs that families receiving START may have.

Family-Centered Services (FCS) contractors – Safety and Risk Assessments

FCS contractors utilize referral information from HHS, including safety plans and child protection worker (CPW) assessments and summary findings to develop a baseline understanding of family functioning, safety and risk factors. FCS contractors assess child safety, during home visits with clients, throughout provision of SafeCare and Motivational Interviewing (MI) provided during Family Preservation Services and Family Casework, by identifying, documenting, and reporting the three elements of safety constructs: threats of maltreatment, child vulnerability, and caretaker's protective capacities. This occurs for both HHS cases and non-HHS voluntary FCS cases.

During any home visit, the FCS contractor must include an assessment of the child's safety and well-being. The contractor considers the home environment (including a walk-through of the home), the child's physical condition, interactions between the child and caregivers, the child's ability to communicate and self-protect, and the parent's ability to meet the child's basic needs. The contractor documents all observations related to the safety and well-being of the child at each home visit in their contact note. While HHS does not contractually require FCS contractors to utilize certain standardized tools to evaluate safety and risk, tools utilized by FCS contractors include, but are not limited to, the following:

- Basic Household Necessities Checklist;
- Iowa State University Home Safety Checklist;
- Signs of Safety Assessment tool;
- Substance use screening tools: CAGE-AID, CRAFTT, UNCOPE;
- Quick Risk and Assets for Family Triage (QRAFT) housing stability screening tool;
- Adverse Childhood Experiences (ACES) Assessment;
- Hurt, Insulted, Threatened with Harm and Screamed (HITS) intimate partner violence screening tool

For HHS cases, FCS contractors provide their evaluation of safety and risk to HHS through monthly progress reports. For non-HHS voluntary FCS cases, because FCS

contractors have case management and decision-making responsibility, the contractors' documentation of each home visit, which includes their evaluation of child safety and risk, remains in the case file. Please see *Continuous Quality Improvement (CQI) Activities* earlier in this section for information on HHS oversight of HHS and non-HHS voluntary FCS cases.

Regardless of whether the case is an HHS case or a non-HHS voluntary FCS case, if a child is in imminent danger while meeting with the family, the FCS contractor does not leave the child in the home without a safe caregiver present. The contractor develops a plan with the family to keep the child safe at least until the next day, using resources within their agency. If the safety concern rises to the level of suspected abuse, the contractor makes a report to HHS' Centralized Intake Unit. If the family is unable or unwilling to develop a plan to keep the child safe, the contractor contacts law enforcement.

Additionally, for HHS cases, the contractor contacts the HHS worker immediately; leaving a message for the HHS worker if they are unavailable. If the family is unable or unwilling to develop a safety plan and the HHS worker cannot be reached, the contractor contacts law enforcement.

Prevention Plan Review

Community Pathway

Home visitors document the child's specific prevention plan in HHS's DAISEY database system during family intake, which is a site visit. Local home visitor staff, or supervisor determine eligibility based on 8-item scale prior to enrollment. A child's candidacy status is initially determined at intake and is reassessed annually. HHS reviews information submitted by home visitors and makes the official determination of each child's eligibility. This annual determination assesses the child's age and the family's level of need, ensuring continued compliance with—and fidelity to—the evidence-based home visitation model.

Intake and assessment data is reflected in the Enrollment and Annual Report for the caregiver and child. HHS requires this report be completed within 15 days of enrollment in home visiting services. Ongoing home visitation logs and required assessments are collected in DAISEY.

Each subsequent 12-month prevention plan period will be determined by HHS. Continued eligibility will be dependent on:

- After initial determination by HHS, the child's candidacy status is formerly reassessed, and eligibility is redetermined on an annual basis.
- The family's ongoing need for home visiting services
- The family's continued model eligibility based on program standards

- The child remaining within the eligible age range as shown in DAISEY, and
- Continued participation consistent with EBP expectations

HHS oversees home visiting programs and ensures their fidelity to the EBP model, including criteria for families to remain eligible. Contractually required program standards clearly guide providers to discharge families from the programs in DAISEY when families are no longer benefiting or participation lags. HHS enforces these contract expectations through compliance checks during regular site visits.

Child Protective Services (CPS) Pathway

HHS

CPWs document the child's specific prevention plan in HHS' CWIS during the child protective services (CPS) assessment process, which is reflected in the Child Protective Services assessment summaries. HHS requires SWCMs to develop an initial case permanency plan on all HHS cases, in-home and out-of-home, in partnership with the child and family, within 25 days of the date the HHS opens a service case or the child's entry into foster care, whichever occurs first. SWCMs will incorporate the prevention plan created by the CPW into the child's initial case plan, if applicable.

SWCMs will utilize family focused meetings (FFMs), with the child (if age appropriate), the family, the family's supports, professionals, etc. to review the initial case permanency plan, inclusive of the prevention plan, and develop a more robust plan. Facilitation of these meetings occur through the FCS contractors. Subsequent case and prevention plan reviews occur as part of FFMs according to the following schedule:

- Initial (within 45 calendar days from the date of referral),
- Six months from the date of referral to services,
- 12 months from the date of referral to services and every six months the case remains open, and
- Prior to case closure if referred by the HHS SWCM.

HHS staff also utilize youth transition decision-making (YTDM) meetings to review the case permanency plan, inclusive of the youth's transition plan, for youth in foster care who are 16 years of age and older. HHS staff may utilize these meetings for pregnant or parenting youth in foster care in addition to any applicable FFMs. YTDM meetings occur on or after the youth's 16th birthday and within 90 days prior to the youth's 18th birthday, if applicable. FCS contractors also facilitate these meetings.

If the child was not determined a candidate for foster care or a pregnant or parenting youth in foster care during the CPS assessment process, the SWCM may determine later that the child is a candidate for foster care or a pregnant or parenting youth in foster care based on eligibility criteria discussed earlier in this section. When this occurs, the SWCM will document the child's prevention plan in CWIS prior to the

provision of prevention services. The SWCM will incorporate the child's prevention plan in the next case permanency plan, if applicable. Prevention plan reviews would then occur as outlined above.

FCS Contractors

Non-HHS voluntary FCS cases are typically limited to four months of services. If for some reason services extend beyond four months, the FCS contractor will review and update the child's specific prevention plan and will communicate such to HHS no less than every six months.

SECTION II: CONSULTATION AND COORDINATION

The state must: Engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers

The Iowa Department of Health and Human Services (HHS) is responsible for administering mental health and substance abuse prevention and treatment services. HHS consults with other public and private agencies with experience in administering mental health and substance abuse prevention and treatment services as well as child and family services to foster a continuum of care for children and their caregivers.

Mental Health and Substance Abuse Prevention and Treatment Services

Iowa struggles with a fragmented mental health system and a shortage of psychiatrists. Iowa often ranks as one of the lowest states in the nation when it comes to mental health treatment services and accessibility. This is, at least in part, due to our geography and the increasing decline in population in many of our rural areas. Understanding what we know now about mental health and the correlation between childhood trauma and chronic disease, we know that perhaps the best way to prevent mental illness in adults is to screen for and treat mental health concerns in early childhood. However, as noted, providers and services are sometimes scarce in certain parts of the state. One way Iowa addresses this is through the promotion and development of Infant and Early Childhood Mental Health Consultation (IECMHC) services as part of a continuum of services related to children's mental health.

Infant and Early Childhood Mental Health Consultation (IECMHC) – Based on the 2022 statewide needs assessment, Early Childhood Iowa (ECI) local areas increased their investments to provide mental health consultation to enhance the quality and capacity of

Iowa's early childhood professionals providing family support home visitation services and/or childcare. The goal is to enhance the early childhood workforce's response to better meet the social, emotional, and behavioral needs of young children and their families. To increase a formal workforce preparedness pathway there are two separate credentials that can be earned by anyone working with, or on behalf of, very young children and their families. These credentials focus on strengthening and supporting early relationships that are crucial to a child's social and emotional development. These endorsements, Infant Mental Health Endorsement ® (IMH-E ®) and Early Childhood Mental Health Endorsement ® (ECMH-E ®) signify an early childhood provider has acquired knowledge to promote the delivery of high quality, relationship-focused services to infants, toddlers, parents, and other caregivers and families. Establishing an infrastructure of early childhood workforce development opportunities to recognize and infuse the endorsement into preservice and in-service professional development has been a struggle. In 2023 there were 36 individuals who participated in direct endorsement application assistance from the ECI funded endorsement coordinator. The participation in training opportunities is utilized but applying for a full endorsement and completing associated requirements is not as highly sought out.

To further address children's mental health, in 2019, Iowa's Governor Reynolds signed into law House File 690, which established requirements for the Children's Behavioral Health System after receiving the Strategic Plan for the Children's System State Board as ordered by Executive Order No. 2 signed April 23, 2018. The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need. The Children's Board comprises 17 voting members appointed by the Governor. The HHS and DoE director's co-chair the Children's Board. The basis for the selection of the members of the Children's Board were their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.[16] However, the Children's Board ended in 2024 due to enactment of a law establishing a Behavioral Health System in Iowa.

Behavioral Health System[17] – On May 15, 2024, Iowa Governor Kim Reynolds signed House File 2673 into law. Under this legislation, Iowa will:

- Unite the work of the 13 Mental Health and Disability Services (MHDS) Regions, 19 Integrated Provider Network service areas and 37 Tobacco Community Partnerships together into a connected system to support mental health and addictive disorders' efforts in Iowa.

[16] For more information about the Children's Behavioral Health System State Board, please go to https://hhs.iowa.gov/about/advisory-groups/cbhs-state-board.
[17] For more information about the Behavioral Health System, please go to https://hhs.iowa.gov/initiatives/system-alignment/ibhss.

- Improve its focus on systems of support, care and connection for all Iowans and families with disability-related needs through Iowa HHS' Aging and Disability Services' enhancement of Aging and Disability Resource Center (ADRC) and connection to disability-serving networks.
- Combine the work and the funding for mental health and addictive disorders into a behavioral health service system guided by a statewide plan focused on ensuring equitable access to a full continuum of prevention, treatment, recovery and crisis care.
- Strengthen important system connections to Medicaid, Public Health, and Child Protective Services by gathering meaningful feedback from Iowans to inform system planning.

Iowa will hire local administrative service organizations (ASOs) to manage services in each of seven behavioral health districts. The alignment requires the new behavioral health districts to be set up by August 1, with organizations selected by December 31 to manage services. These districts will handle prevention, education, early intervention, treatment, recovery and crisis services for mental health and substance use disorders. Funding will operate like block grants, aiming to target measurable outcomes rather than specific services. Each district will have an advisory board made up of local providers and government officials to identify opportunities, tackle challenges and advise the ASOs.

The new system will be effective by July 1, 2025.

Additional Information - HHS' child welfare staff are currently working with:

- FCS contractors to ascertain the specific evidence-based mental and substance abuse prevention and treatment services they provide, and
- HHS' Iowa Medicaid Enterprise (IME) to identify a coding structure that will work with Medicaid for payment and provide specific data points for these services for child welfare involved families.

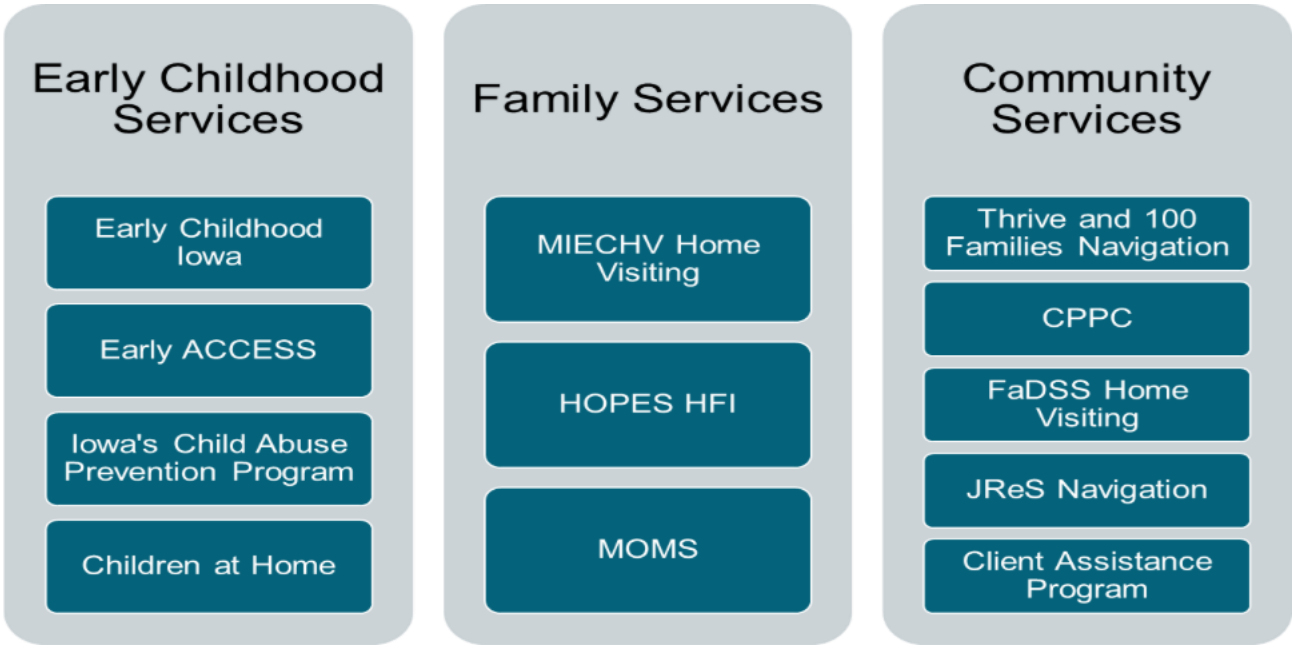
After the passage of Family First, HHS worked with substance use disorder providers to explore implementation of the placement of children with parents in a licensed residential family-based treatment facility for substance abuse. At this time, HHS decided not to move forward but may reconsider this in the future. In addition, HHS staff are working to map services available for families.

Family Support

The Early Intervention and Support (EIS) subdivision of the Family Well-Being and Protection Division was established in February 2023 as part of the alignment of state agencies creating the Iowa Department of Health and Human Services (HHS). Each of the programs within the new Early Intervention and Support subdivision were long-standing single programs from four legacy agencies. They had collaborated but had not previously worked within the same team. Most programs are steeped in primary

prevention or secondary prevention, focusing on overwhelmed families and children aged 0-5, with some variation.

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



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

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.

Goal:

- Iowa's communities will be supported and connected through access to programming, resources, quality education, and strong relationships.

Objectives:

- Increase access, awareness, knowledge and understanding of services and resources.
- Ensure quality and access to maximize opportunity and outcomes.

North Star:

- More Good Days for Families

Guiding Frameworks:

- Hope Science: Do our interventions and services increase hope?
- Social Capital: Do our interventions and services increase relationships that provide value?
- Third Spaces: Do our interventions and services emphasize stress reduction and reduce isolation?
- Building Better Childhoods: Do our interventions and services promote positive childhood experiences and minimize adverse childhood experiences?

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

Key partnership development activities have been focused on:

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

Family First Implementation

HHS staff engaged stakeholders to develop the Family First, Blueprint for Iowa's Future Child Welfare System (Attachment A1). After finalization of the Blueprint, HHS staff discussed the Blueprint with a multitude of stakeholders, which included Achieving Maximum Potential (AMP) (foster care youth councils in Iowa), Parent Partners, child welfare services contractors, courts, tribes, etc.

Child Welfare Policy and Practice Group (CWG): CWG, a nonprofit technical assistance organization, has extensive experience in conducting evaluations in more than two dozen states. CWG focuses on system evaluation, constructing effective implementation strategies, and strengthening the quality of front-line practice through training and coaching. In 2019, the CWG elicited feedback from the provider community regarding current processes and practices, including recommendations for improved outcomes for children and families; greater fiscal efficiency and, any questions or concerns about Iowa's vision for practice and technical implementation of Family First. CWG facilitated 10 provider forums throughout the state, which included provider directors and administrators, Family Safety Risk and Permanency (FSRP) Care Coordinators and supervisors, other child welfare service providers, and court appointed special advocates (CASAs). While HHS central office staff managed the venues, invitations, and scheduling, there were no HHS employees present at any of the forums.

Annual HHS/Child Welfare Services Contractors Meetings: In 2018 and 2019, HHS conducted a statewide meeting that included representation from current child welfare service contractors, HHS field and central office staff, and other external partners. The purpose of the statewide meeting was to bring HHS and current child welfare services contractors together to continue strengthening relationships and identifying ways to work together across the entire service array to improve our child welfare outcomes. A small number of public and private Child Welfare Partners Committee (CWPC) members volunteered to participate in a planning committee to prepare and plan for the statewide meeting.

The meetings included but were not limited to:

- a presentation on Family First;
- a keynote presentation that focused on inspiration, transformation, and strategic planning;

- a presentation by Kerri Smith with the Annie E. Casey Foundation (AECF) regarding their assessment findings and recommendations on steps HHS needs to take to improve services in Iowa[18]; and
- pre-implementation activities associated with Family First.

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 keeps the focus on child welfare outcomes. The CWPC unites individuals from Iowa HHS and private organizations to create better outcomes for Iowa's children and families.

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

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

With completion of their three-year strategic plan, the primary focus of the CWPC shifted to support HHS with implementation of Family First.

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, active workgroups, and products developed out of the workgroups. More information on the CWPC is available at https://hhs.iowa.gov/about/advisory-groups/cwpc.

[18] AECF PowerPoint Presentation regarding assessment is available at https://hhs.iowa.gov/media/9253/download?inline=

Oversight and Implementation Workgroups (Attachment A8): HHS developed a Family First Oversight Group that oversees five workgroups, comprising internal and external stakeholders, including social service organizations, to implement Family First. The five workgroups include:

- Communication and Marketing
- Training
- Information and Technology/Systems
- Practice and Forms
- Data

Dr. Amelia Frank Meyer, LISW, APSW: In September and October 2019, Dr. Frank Meyer presented six trainings on the "Human Need for Belonging" throughout the state (one training in each service area) for HHS staff. External stakeholders, such as judges and attorneys, also attended. The trainings explored the life-long impact of out-of-home placement on children and the importance of safely connecting children to their family. These trainings occurred to prepare the HHS workforce and stakeholders for Family First implementation and necessary shifts in practice. One of the sessions was recorded and available at https://www.youtube.com/watch?v=i0y4yvkpAI8&feature=youtu.be.

Iowa Children's Justice: HHS staff also remains active in the Iowa Children's Justice State Council, as well as Iowa Children's Justice (ICJ) Advisory Committee, and other taskforces and workgroups. The ICJ State Council and ICJ Advisory Committee meet quarterly, with members representing all state level child welfare partners. Council and committee members discuss policy issues, changes in practice, updates of child welfare relevance, and legislative issues. For example, within the last couple of years, Iowa's Supreme Court directed establishment of a taskforce to consider what actions the judiciary needs to take in light of Family First implementation. The group reviewed a variety of materials, discussed practice in Iowa, developed a report with recommendations, and provided the report to the Iowa Supreme Court. The Iowa Supreme Court decided to continue the taskforce for several more years as Iowa implements Family First.

Describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.

HHS will coordinate services provided for or on behalf of a child and the parents or kin caregivers of the child with services provided under Title IV-B, subparts I and II, of the Social Security Act. HHS utilizes Title IV-B subpart I (aka The Stephanie Tubbs Jones Child Welfare Services Program) funds for crisis intervention (family preservation services) and family reunification services. HHS utilizes Title IV-B subpart II funds (aka MaryLee Allen Promoting Safe and Stable Families (PSSF)) funding to provide services

such as Family Preservation (e.g. Wrap-Around, Caring Dads and Parent Partners), Family Support (Iowa Child Abuse Prevention Program (ICAPP), Family Reunification (e.g. access and visitation services), and Adoption Promotion and Support Services. Family Preservation services provide additional resources beyond evidence-based interventions, e.g. wrap around services to meet the family's concrete needs, such as assistance with rent, utilities, or other one-time costs, and two programs to provide support to parents in crisis. Family Support funds provide approximately 31% of the funding for our child abuse prevention programs, which provide primary and secondary child abuse prevention services in local communities according to local need. HHS utilizes Family Reunification funds primarily for access and visitation services, which are not IV-E prevention services. Lastly, HHS may utilize our Adoption Promotion and Support Services to provide robust post-adoption services to adoptive families to prevent re-entry into foster care.

For additional information related to service coordination, please see the Services Coordination section in Iowa's FFY 2025-2029 Child and Family Services Plan.[19]

SECTION III: CHILD WELFARE WORKFORCE

Support

The state must describe the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including:

- *ensuring that staff is qualified to provide services that are consistent with the promising, supported, or well-supported practice models selected; and*
- *developing appropriate prevention plans and conducting risk assessments for children receiving prevention services.*

Community Pathway

All evidence-based programs selected as part of Iowa's title IV-E Prevention Plan will be administered with a trauma-informed framework through local providers. HFA and PAT providers are required to conduct background checks at the hiring of all staff and ensure that requirements for essential trainings are met at each annual site visit. Because title IV-E funded home visiting services will be affiliated (PAT) or accredited (HFA), all program staff will meet education and training requirements established by purveyors to ensure high-quality service delivery. According to the title IV-E Clearinghouse, these requirements include:

HFA: "HFA home visiting staff must have at least a high school diploma or equivalent, experience providing services to families, and knowledge of child development.

[19] Available at https://hhs.iowa.gov/media/15201/download?inline

Supervisors and Program Managers must have at least a bachelor's degree with three years prior experience. All HFA staff are encouraged to seek Infant Mental Health endorsement. The National Office offers several trainings for HFA staff. All staff are required to attend a four-day core training that is specialized based on role (assessors, home visitors, and supervisors). Supervisors attend one additional day for the core training and an optional three days of training that focuses on building reflective supervision skills. Program managers are required to attend core training plus three days of training focused on how to implement the model to fidelity using HFA's Best Practice Standards. HFA also offers supplemental online training, advanced trainings, and on-site technical assistance."[20]

PAT: "Parent educators must have a high school degree or GED with two or more years of experience working with children and parents. In order to receive their PAT certification, all parent educators must attend a three-day foundational training. They must also attend a two-day model implementation training that covers strategies used to implement PAT. The PAT National Center also offers technical assistance and certification renewal sessions."[21]

HFA home visitors are required to receive regular observations of home visits to ensure effective practices. All home visitors shall receive weekly individual supervision (1.5 to 2 hours per week) that includes administrative, clinical, and reflective components. Similarly, PAT home visitors are required to receive the same trainings and background checks. However, the slight differences are shown in the frequency and duration of supervision. The supervision is 2 hours a month for over .5 FTE and 2 hours for staff meeting. Parent Educator's working less than .5 FTE get 1 hour of supervision and 2 hours for team meetings. CBO's receive model specific technical assistance training quarterly and bi-weekly technical assistance to both visitation models.

Child Protective Services (CPS) Pathway

Iowa is a state administered and state supervised child welfare system. The Department of Health and Human Services (HHS) is the state agency that purchases trauma-informed and evidence-based services from contracted child welfare, service organizations, who provide Iowa's family-centered services (FCS), inclusive of SafeCare® and Motivational Interviewing (MI), to families. Additionally, HHS contracts with a child welfare service organization to provide family mentors for Sobriety Treatment and Recovery Teams (START).

FCS Contractors

Below are the contractor staff qualifications required to provide SafeCare® and MI, which is required as part of Family Preservation Services and Family Casework.

[20] Title IV-E Prevention Services Clearinghouse. Accessed 12/19/2025.
[21] Title IV-E Prevention Services Clearinghouse. Accessed 12/19/2025.

SafeCare was effective July 1, 2020 while MI requirements began July 1, 2024 with full implementation occurring by January 1, 2025.

- Any staff delivering a service intervention for which a professional licensure is required by state statutes will possess the current appropriate professional licensure.
- SafeCare has no minimal educational requirements. However, the Intervention Specialist (IS) providing SafeCare will be trained and certified in SafeCare or working toward certification.
    - The IS shall possess a minimum of one year of full-time experience in human services or a related field.
        - Staff employed as Intervention Specialists on or prior to June 30, 2024, are exempt from this requirement.
- MI has no minimum educational requirements. However, HHS has requirements for staff who provide MI.
    - The Family Support Specialist (FSS) will possess a bachelor's degree or master's degree from an accredited four-year college recognized by the Council for Higher Education Accreditation (CHEA); or an associate of arts degree in human services or related field from an accredited college or university plus the equivalent of two years of full-time experience in human services or a related field.
        - The FSS providing MI will be trained and proficient in MI or working towards training and proficiency.

Additionally, there are requirements for MI Coaches and MI Specialists.

- A MI Coach will have one year of child welfare experience.
- A MI Specialist will have a minimum of two years of child welfare experience, demonstrated training background, and experience implementing an evidence-based practice.
    - If a MI Specialist is a Motivational Interviewing Network of Trainers (MINT) and is in good standing with MINT, the person is deemed to meet the qualifications of MI Specialist in Iowa.

IS and FSS staff providing SafeCare® and MI, respectively, as well as MI Coaches and Specialists will meet training requirements as outlined below in *Training*.

<u>Training and support for FCS staff for developing prevention plans for non-HHS, voluntary FCS cases:</u> For non-HHS voluntary FCS cases, HHS' CPW determines the child is a candidate for foster care and sends the determination to the FCS contractor through the referral process by completing and sending *Form 470-3055, Referral and Authorization for Child Welfare Services*. Utilizing referral information and information gained through family engagement, the IS and/or FSS identifies the foster care prevention strategy and services that will be provided to the family. The IS and/or FSS receives support from their supervisor in completing their work and assisting them in answering any questions they may have related to service identification, foster care

prevention strategy, etc. The IS and/or FSS develops the child's prevention plan and documents the prevention plan on a prevention plan tab in the Provider Portal of Iowa's CWIS prior to the provision of services. FCS contractor staff utilize training as outlined below in *Training* to help them develop the prevention plan, and review and revise the prevention plan, if applicable. HHS will provide training to FCS contractors on documentation of the prevention plan on the Provider Portal.

FCS contractors also assess for safety and risk throughout their provision of SafeCare and MI through contract requirements related to contacts with the family. Please see *Section I, subsection Monitoring Child Safety*, for more information on FCS contractors' staff conducting safety and risk assessments.

START Contractor

- The contractor will hire family mentors who meet the following requirements per the START model: Family mentors must be in long-term recovery from a substance use disorder (SUD), with a minimum of two years of sustained recovery.
- Family mentors must have experiences that sensitize them to child abuse and neglect and/or understand how SUDs affect families.

The contractor will utilize the START Family Mentor Hiring Guide, which includes a questionnaire, two interviews, and role play, in the hiring process. The family mentor will be supported through co-supervision by the contractor and the HHS START supervisor. The HHS START supervisor will provide direct day-to-day, case-related, and individual supervision to support the family mentor's recovery and performance. The contractor and HHS supervisor will meet at least monthly to discuss the co-supervision plan and the family mentor's performance.

Family mentors will complete all of the contractor's mandatory training in accordance with their onboarding and training plan as well as START specific training prior to serving families. Family mentors will also receive training and/or become certified as peer recovery specialists.

HHS

HHS' child protective workers (CPWs) conduct child protective assessments, which include developing appropriate prevention plans, if applicable, and conducting initial safety and risk assessments. HHS' social work case managers (SWCMs) may develop a prevention plan, if not already done by the CPW, review and revise appropriate prevention plans and conduct ongoing safety and risk assessments. Please see *Section I, subsection Monitoring Child Safety*, for more information on HHS staff conducting safety and risk assessments.

HHS, as an executive branch agency, must hire staff through the Iowa Department of Administrative Services (DAS). DAS will not certify individuals as meeting the minimum position requirements for CPWs and SWCMs, and send their information to HHS, unless they meet the required qualifications below:

- CPWs (aka Social Worker 3s):
  - Graduation from an accredited college or university with a bachelor's degree and the equivalent of three years of full-time experience in a social work capacity in a public or private agency; or
  - graduation from an accredited college or university with a bachelor's degree in social work and the equivalent of two years of full-time experience in a social work capacity in a public or private agency; or
  - a master's degree in social work from an accredited college or university; or
  - an equivalent combination of graduate education in the social or behavioral sciences from an accredited college or university and qualifying experience up to a maximum of thirty semester hours for one year of the required experience; or
  - employees with current continuous experience in the state executive branch that includes the equivalent of one year of full-time experience as a Social Worker 2 shall be considered as qualified.
- SWCMs (aka Social Worker 2s):
  - Graduation from an accredited four-year college or university; or
  - the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; or
  - an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

<u>Training and support for HHS staff for developing prevention plans:</u> HHS CPWs, SWCMs, and supervisors will receive training on the prevention plan and corresponding services' changes made to the CAA and CINAA documents through a recorded training posted in June 2020. Supervisors will ensure that their staff complete the training prior to July 1, 2020. The recorded training will remain posted on the SharePoint site for staff to review at will. When the CAA and CINAA documents' changes go into production, HHS' child welfare information system (CWIS) Help Desk (HD) will send an email notice to all field staff with basic overview and instruction.

Beginning July 2024, documentation of the child's specific prevention plan occurs in the CWIS (STAR module for CPWs or Child Services module for SWCMs). The CWIS HD sent out an email notice to all field staff with basic overview and instruction about the change. These prevention plan tabs automatically populate the FA, CAA, and CINAA

with the applicable information. HHS also will add corresponding guidance to the JARVIS User Manual.

HHS training staff are currently in the process of updating the materials for new worker training (SW020 and CP200) in regard to developing prevention plans (SW3) and revising prevention plans as needed (SW2). These updates to the new worker courses will occur by January 2021.

Supports provided to staff to develop prevention plans is multifaceted and includes but is not limited to:

- The trainers discuss the participants' experiences in the second part of their new worker trainings, which includes the safety and risk assessments as well as identification of service needs initially and ongoing.
- The trainers hold office hours for staff on a regular basis to address staff questions.
- Coordination occurs with the Service Help Desk when a worker requests a case consultation for how best to support a family.
- Supervisors support their staff in work completion and assist staff with any questions they may have related to service identification, foster care prevention strategy, etc.
- Mentoring: A multidisciplinary focus group convened to develop a standardized mentoring program for new CPWs and SWCMs during their first six months of employment. This framework formalized an informal system that was already in place in an effort to improve statewide consistency. The mentoring program aims to build the confidence level of a new worker as well as their competency in doing casework in the counties they serve. With this goal in mind, the design of the program is around experiential learning opportunities in the field that reinforce classroom learning. The desired outcome of the program is increased employee satisfaction and retention.
    - To infuse the formalized mentoring program into the onboarding culture, the Bureau of Service Support and Training conducted a webinar required for supervisors providing an overview of the program and outlining responsibilities for supervisors, mentors, and mentees.
    - The documents in the mentoring toolkit support the goals and objectives of the program and track required field learning experiences. The multidisciplinary group updated the Field Learner Experience Guides, essential tools for staff, this fiscal year to ensure they align with the core job duties of each position.
    - The next step in the process in the coming fiscal year is to survey folks who participated in the mentoring program. The results will serve as feedback for evaluating and enhancing the mentoring program.

Training

The state must describe how it will provide training and support for caseworkers in assessing what children and their families need; connecting to the families served; knowing how to access and deliver the needed trauma-informed and evidence-based services; and overseeing and evaluating the continuing appropriateness of the services.

Community Pathway

HFA and PAT are provided by community-based organizations (CBO) that receive training either from the developer of the EBP or someone officially trained as a trainer. Although HHS is not the direct purveyor of training to providers, through the contracting and oversight process, HHS will continue partnering with state program intermediaries to ensure that all local EBP providers for Family First are certified to deliver the selected EBPs with fidelity to the model, and capable of providing the required data elements for each child to meet the eligibility, CQI, and data reporting requirements. Contract language will incorporate Family First Prevention Services Act services quality, fidelity monitoring, and data collection requirements.

HHS and CBO's are committed to having a prepared, well-trained workforce., and anyone overseeing a prevention plan must complete required trainings. HHS provides ongoing training and support for caseworkers to help them assess what children and their families need, engaging and connecting to the families served, access and deliver trauma-informed and evidence-based services, while ensuring services remain appropriate in accordance with federal requirements, as listed in the table below:

Training specific to prevention services: Contracts will require that preventive agencies attend training on the following:

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
Institute for the Advancement of Family Support Professionals trainings: The Institute provides engaging online training modules that cover a wide range of topics essential for family support professionals. These trainings are designed to help professionals learn new skills, grow their careers, and prepare for the National Family Support Certification Exam.	✓	✓		Both
Mandatory Reporter training: Required prior to working with families, and must be renewed every three years. Topis covered Definitions of child and dependent adult abuse under Iowa law. Physical, psychological, behavioral, and environmental indicators of abuse. Procedures for reporting suspected abuse, including oral reports within **24 hours.** Review of Iowa Code and Administrative Code relevant to abuse reporting . Assessment protocols used by the Department of Human Services and other investigative agencies. Resources for prevention and support for affected individuals and families	✓	✓		Both
National Family Support Certification which tests knowledge across domains outlined in the National Family Support Competency Framework for Direct Service Professionals.	✓	✓	✓	Both
DAISEY trainings are specific to the DAISEY data collection tool required by HHS for home visiting programs. DAISEY specific trainings are updated annually and are required for all staff using the DAISEY database.	✓	✓	✓	Both

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
Annual benchmark/outcomes training: Annual training in performance measures, benchmarks and evaluation for all staff working with families. This may be combined with the DAISEY annual trainings or may be provided separately. This training is required for funders as well as providers and is facilitated by IHHS staff	✓	✓		Both
Training for assessment & screening tool fidelity: All staff receiving funding for home visitation and using DAISEY will be trained to administer all required screening and assessment tools with fidelity. This includes comprehensive training on the ASQ-3, ASQ:SE-2, Alcohol and Drug Screening Tool, Relationship Assessment Tool, and the Edinburgh Postnatal Depression Scale (EPDS). Staff will be expected to implement each tool according to established protocols to ensure accuracy, consistency, and high-quality data collection across programs.	✓	✓	✓	Both
Trauma-informed service delivery for all staff: trauma-informed service training will equip all staff with the knowledge and skills needed to recognize the signs and impacts of trauma, respond in ways that promote safety and trust, and integrate trauma-sensitive approaches into all interactions. Training will include understanding the principles of trauma-informed care, strategies for fostering emotional and physical safety, promoting empowerment and choice, practicing cultural humility, and reducing the risk of re-traumatization. Staff will also learn effective communication techniques, grounding strategies, and			✓	Both

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
approaches to building strong, supportive relationships with families. This training ensures that all services are delivered with compassion, consistency, and an awareness of how trauma may shape client experiences and needs. Trauma informed training is a build in component for HFA and PAT model training. IHHS will be providing additional training to support all staff within our Early Child and family service system- inclusive of funds, community providers and other agencies supporting families and children.				
HFA Foundations for Family Support (FFS) Core Training for Direct Staff/Home Visitors (**Taken within 6 months of hire**): Outlines duties of HFA Home Visitors: trauma-informed practice; communication skills; assessing, addressing, and promoting positive parent-child relationships; creating a trusting alliance with families; goal setting; strategies to enhance family functioning, address difficult situations, and ensure healthy childhood development.	✓	✓	✓	HFA
HFA FROG Scale Training for Direct Staff/Home Visitors: Structured tool for learning family stories, recognizing strengths/challenges, setting the stage for a family's entry by building supportive relationships.	✓	✓	✓	HFA
HFA Supervisor Core Training & FFS (**Taken within 6 months of hire**): Supervisors receive core training as Direct Staff plus Relationships & Reflection: supervision and documentation practice that applies the foundational concepts that are introduced in FFS to the Supervisor role via the parallel process. Supervisors develop skills to support	✓	✓	✓	HFA

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
Direct staff through reflective supervision and use of HFA Reflective Strategies to understand the expectations and responsibilities of the Supervisor role as expressed in the HFA Best Practice Standards. Training begins with the HFA Advantage and the four components of attachment and apply them to the development of healthy supervisory relationships that build staff skills and hold space for staff feelings and reflections on the impact of this work. Supervisors practice documentation, respond to supervisory scenarios, and have hands-on practice implementing skills.				
HFA FROG Scale Training for Supervisor: Supervisors learn skills to support staff using the FROG scale.	✓	✓	✓	HFA
HFA Program Manager Training (**Taken within 6 months of hire**) includes FFS, Supervisor Core, Implementation: ▪ Foundations for Family Support (FFS) Core Training. ▪ Supervisor Core Relationships and Reflections Training. ▪ Implementation Training: Intensely immersed in HFA, the expectations of the model, and the responsibilities of an HFA leader, developing relationships with national office staff and a network of support from other program manager colleagues throughout the country.	✓	✓	✓	HFA
PAT Core Trainings for Direct Service Staff (**Taken within 3 months of hire**): Foundations & Model Implementation Training: Outlines specific duties of the home visitor in their role within	✓	✓	✓	PAT

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
PAT and is required prior to working with families. Training includes the Foundational Curriculum and offers implementation strategies. Topics include, but are not limited to trauma-informed practice, approaches to learning, neuroscience, child development, developmental concerns, transitions to early care and education and family engagement.				
PAT Core Training: Foundations 2 (Optional): Outlines specific duties of the home visitor in their role within PAT. Supports parent educators who intend to use PAT curriculum and approach when working with families whose children are between ages 3–6.	✓	✓	✓	PAT
PAT Core Trainings for Supervisor (**Taken within 3 months of hire**): Model Foundations + Model Implementation: Required before supervising PAT direct service staff.	✓	✓	✓	PAT
PAT New Supervisor Institute (**Taken within 3 months of hire**): New Supervisor's Institute Virtual provides an opportunity for new supervisors to dive deeper into the tools and processes for implementing a quality PAT affiliate. ▪ gain knowledge about the PAT resources necessary for service delivery, program implementation, and quality assurance as introduced by PAT National Center staff ▪ understand real life application of tools and processes through engagement in group discussion	✓	✓	✓	PAT

Table A4: Federal Training Requirements and HFA & PAT Provider Training Courses				
Training (with descriptions)	**Assessing what children and their families need**	**Connecting to the families served**	**Knowing how to access and deliver the needed trauma-informed and evidence-based services**	**HFA/PAT**
▪ establish peer networks with supervisors around the country ▪ connect with PAT National Center staff.				

Child Protective Services (CPS) Pathway

HHS and FCS contractors are committed to having a prepared, well-trained workforce. The organizations provide training and support for caseworkers in assessing what children and their families need, connecting to families served, knowing how to access and deliver needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services. Iowa's Family First, Blueprint for Iowa's Future Child Welfare System, "Family Connections are Always Strengthened and Preserved" (Attachment A1) guides staffs' work with families and the training and supports staffs receive.

HHS

HHS requires newly hired social work staff to complete the New Worker Training Plans by the timeframes specified for each course (Attachment A9 for SW2/SW2 Supervisors and Attachment A10 for SW3/SW3 Supervisors). The New Worker Training Plans serve as a roadmap of the training requirements within the first year of hire. These documents also detail the learning modality and number of credit hours associated with each course.

The following shows the federal requirements and training courses that meet the requirements for HHS staff.

Table A5: Federal Training Requirements and HHS' New Worker Training Courses		
Federal Requirement	**New Worker Training Course**	**Training Course Description**
Assessing what children and their families need	Both CPWs and SWCMs take the following courses: ▪ Within 3 months of hire: ○ CC 387 Assessing and Planning Around Safety ○ SP 102 Virtual Home Simulation (VHS) ▪ Within 6 months of hire: ○ SP 316 Quality Visits and Documentation CPWs also take within 3 months of hire: ▪ CP 200 Foundations of Child Protection Worker Practice SWCMs also take within 3 months of hire: ▪ SW 020 Foundations of Social Work Case Manager Practice	▪ CC 387 – This training provides learners with information about observation timeframes for seeing kids, including some new practice guidance, how to assess danger vs. risk, how to assure safety for children and families, and how to safety plan with a family if a child is conditionally safe. ▪ CP 200 - This course is an introduction to the purpose, expectations, and methods used by CPWs. Participants learn how to apply HHS policy and the Iowa Code to effectively interview and engage families, conduct thorough and accurate assessments, make a determination of abuse, and appropriately plan next steps. Course also includes information on HHS' family centered services (FCS), how to make referrals to FCS, etc. ▪ SW 020 - This training provides learners with the knowledge and skills necessary to provide quality case management. This includes aligning SWCM work with HHS policies and procedures, identifying supports to meet family needs, utilizing effective engagement skills, assessing for danger and risk, and planning for safe case closure. Course also includes information on HHS' family centered services (FCS), referrals to FCS, working with FCS professionals, etc. ▪ SP 102 - VHS provides users with the opportunity to practice identifying a possible risk to the safety of children as well as protective factors and capacities of the caregivers considering the case scenario. Workers are provided with immediate feedback on what the "best" assessment decisions are based on an expert consensus profile, given the specific scenario provided. This software was developed by The University of Utah College of Social Work. New SWCMs, CPWs and

Table A5: Federal Training Requirements and HHS' New Worker Training Courses		
Federal Requirement	**New Worker Training Course**	**Training Course Description**
		Supervisors are required to complete the Simmons case in VHS using the coaching mode during their month-long field experience learning between Part 1 and Part 2 of SW 020 Foundations of Social Worker Case Management Practice or CP 200 Foundations of Child Protection Worker Practice. ▪ SP 316 - This training reviews the elements of a quality home visit and related documentation. Topics covered include: assessing safety, well-being, and permanency for families; strategies to ensure a worker's safety during home visits; and the importance of quality documentation.
Connecting to the families served	Both CPWs and SWCMs take within 6 months of hire: ▪ SP 314 Engagement Fundamentals Both CP 200 and SW 020 described earlier cover family engagement.	▪ SP 314 - This course provides an interactive learning platform where workers explore different engagement skills while recognizing the benefits, impacts, and barriers of engaging children, families and professionals. Participants have the opportunity to practice their engagement skills through the use of role-play and other training activities. This course also helps workers identify what their role is in developing partnerships with families and providers during a case. During the training, the participants hear from children, parents, and professionals regarding their recommendations for how to best engage with all parties during a case.
Knowing how to access and deliver the needed trauma-informed and evidence-based services	Both CPWs and SWCMs take the following courses: ▪ Within 6 months of hire: ○ SP 504 SafeCare ○ SP 537 Using Motivational Interviewing in Everyday Practice (Florida Board of	▪ SP 504 – During this course, learners explore the goals of SafeCare, including reducing future incidents of child maltreatment, increasing positive parent-child interactions, improving how parents care for their children's health, and enhancing home safety with special emphasis on parent supervision. Learners also review the eligibility requirements and the referral process while measuring readiness for participation in the program.

Table A5: Federal Training Requirements and HHS' New Worker Training Courses		
Federal Requirement	**New Worker Training Course**	**Training Course Description**
	Certification Coursework) ○ SP 538 Motivational Interviewing Fundamentals Both CP 200 and SW 020 described earlier cover HHS' family-centered services (FCS), how to access those services, etc.	▪ SP 537 - This eLearning course is offered through FADAA, a subsidiary of the Florida Department of Children and Families. The course teaches the use of Motivational Interviewing (MI) – a widely used evidence-based practice for helping people to resolve ambivalence about change by evoking motivation and commitment. Engagement methods and strategies are taught, stressing the critical aspects of motivating and empowering individuals to recognize their own needs, strengths, and resources for taking an active role in changing their lives for the better. This course is a prerequisite to the Lyssn Motivational Interviewing. ▪ SP 538 - During this course, learners practice the client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence. SP 537 Using Motivational Interviewing in Everyday Practice (Florida Board of Certification Coursework) is a required training or a prerequisite for SP 538 Motivational Interviewing Fundamentals.

Table A5: Federal Training Requirements and HHS' New Worker Training Courses		
Federal Requirement	**New Worker Training Course**	**Training Course Description**
Overseeing and evaluating the continuing appropriateness of the services	SWCMs take the following courses: ▪ Within 3 months of hire: ○ SW 020 Foundations of Social Work Case Manager Practice ▪ Within 12 months of hire: ○ SP 535 Assessing throughout the Case	▪ SW 020 – This training also covers content related to overseeing and evaluating the continued appropriateness of services. Breakout sessions during the training engage learners in discussions around the development of the plan for the family and ensuring that the services are appropriate for families. ▪ SP 535 - This course builds on the information learned in SW 020 Foundations of Social Worker Case Manager Practice with an in-depth case study. Trainees articulate the importance, including legal requirements, of initial and ongoing assessment at critical case junctures; document relevant information used to substantiate critical decision making throughout the life of the case; and demonstrate the ability to use critical thinking to extract key information regarding trauma, substance abuse, mental health, domestic violence, and family functioning necessary for good decision making.

Motivational Interviewing (MI): In addition to SP 537 and SP 538 noted above, CPWs, SWCMs, and Supervisors will take Motivational Interviewing through Lyssn. HHS staff will complete one vignette, which will be the same vignette for staff, every 6 months, with the option of completing Advance Child Welfare vignettes to further hone their skill in using MI. Please see Child Welfare Provider Training Academy below for more information.

Supports provided to staff includes but is not limited to:

- The trainers discuss the participants' experiences in the second part of their new worker trainings.
- The trainers hold office hours for staff on a regular basis to address staff questions.
- Coordination occurs with the Service Help Desk when a worker requests a case consultation for how best to support a family.

- Supervisors support their staff in work completion and assist staff with any questions they may have related to determining appropriateness of services, service sequencing, etc.
  Mentoring: A multidisciplinary focus group convened to develop a standardized mentoring program for new CPWs and SWCMs during their first six months of employment. This framework formalized an informal system that was already in place in an effort to improve statewide consistency. The mentoring program aims to build the confidence level of a new worker as well as their competency in doing casework in the counties they serve. With this goal in mind, the design of the program is around experiential learning opportunities in the field that reinforce classroom learning. The desired outcome of the program is increased employee satisfaction and retention.
    - To infuse the formalized mentoring program into the onboarding culture, the Bureau of Service Support and Training conducted a webinar required for supervisors providing an overview of the program and outlining responsibilities for supervisors, mentors, and mentees.
    - The documents in the mentoring toolkit support the goals and objectives of the program and track required field learning experiences. The multidisciplinary group updated the Field Learner Experience Guides, essential tools for staff, this fiscal year to ensure they align with the core job duties of each position.
    - The next step in the process in the coming fiscal year is to survey folks who participated in the mentoring program. The results will serve as feedback for evaluating and enhancing the mentoring program.

Training specific to prevention services: Since Iowa's FCS, which includes SafeCare and Family Preservation Services (FPS), will begin July 1, 2020, HHS and contractor staff will participate in joint service implementation training in June 2020, which will cover the new services, referral process, and other pertinent contract requirements. A similar training occurred in June 2024 regarding the incorporation of Motivational Interviewing into Family Preservation Services and Family Casework as prevention services.

Sobriety Treatment and Recovery Teams (START): Please see *Section I, Title IV-E Prevention Services and Programs, Services Description and Oversight, Continuous Quality Improvement (CQI) Activities, Sobriety Treatment and Recovery Teams (START)*, for a description of training in START.

START Contractor

In addition to the START training, the START contractor also requires family mentors to complete the following mandatory contractor training:

- Mandatory Child Abuse Training

- Core Trainings: Mental Health, Domestic Violence, Sexual Abuse, Substance Abuse, Human Trafficking
- Special Populations 1 and 2
- Trauma Informed Care Level 1
- De-escalation with a Trauma Informed Care Approach
- Safety/Business Emergency Guide Review
- Personnel related trainings: New Employee Orientation, 3 Month Training and Education Checklist; Antiharassment; Defense Drivers Training; Distracted Drivers

Training FCS Contractors

Each FCS contractor has their own onboarding and initial and ongoing training requirements required of their staff. Contractual requirements related to training in the new contracts, effective July 1, 2020, are:

- Develop a training plan tailoring it to the needs of the workers and target populations for the services. Submit the training plan to HHS for review within 30 days after the contract start date. Submit a final training plan, which incorporated any changes requested by HHS, to HHS within 30 days after the first submission of the plan. The contractor shall execute, adhere to, and provide training set forth in the HHS-approved training plan. Changes to the plan must receive prior approval from HHS, and the contractor shall make any updates. The training plan shall include initial and ongoing training provided for all contractor or subcontractor staff on children and family identified needs, including but not limited to:
    - Domestic violence,
    - Mental health,
    - Substance use/abuse, and
    - Trauma informed care.

FCS contractors' staff receive training in multifaceted ways, e.g. through online asynchronous learning platforms, in-person group supervision and external experts in the field. Skills are then reinforced and practiced through individual and group supervision.

Below is information regarding how FCS contractors meet the federal training requirements.

- Assessing what children and their families need:
    - FCS contractors' staff receive training on the use of evidence informed screening and assessment tools and the critical skills necessary to evaluate root causation, contributing factors to underlying family issues, and family change and growth during provision of services.
        - Examples of training on tools include but are not limited to:

- SafeCare assessment tools
- Motivational Interviewing assessment tools
- Adverse Childhood Experiences (ACEs) Questionnaire – used to evaluate past trauma
- Home Safety Checklists – used to assess for concerns in the home environment
- Developmental stages of children

    - Topics included in standard training for FCS staff may include but not be limited to:
        - Child welfare system of care
        - Reading and review of referral documents, case plans and working collaboratively with HHS for ongoing focus of care
        - Behavioral outcomes
        - Threats of maltreatment; Child strengths and vulnerabilities; Caregiver protective capacities
- Connecting to the families served:
    - Family engagement trainings include but may not be limited to:
        - Motivational Interviewing
        - SafeCare
        - Children's Bureau' family engagement inventory, which outlines evidence informed best practices for family engagement.
        - Topics that relate to family engagement.
    - Some FCS contractors have:
        - Certified Trauma Trainers who provide regular and ongoing trauma training to employees throughout each calendar year
        - Certified HOPE Trainers who provide training on how to help engage and drive change for families
- Knowing how to access and deliver the needed trauma-informed and evidence-based services
    - FCS contractors not currently trained and certified to provide SafeCare® will work with the National SafeCare Training and Research Center (NSTRC) to begin training and the accreditation process.
    - Please see Child Welfare Provider Training Academy below for information regarding FCS contractors training related to Motivational Interviewing (MI), which is required in their delivery of FPS and Family Casework.
    - FCS staff also may access other trainings through the Child Welfare Provider Training Academy (see below).
    - Some FCS contractors have:
        - Designated learning platforms where all employee resources and tools are housed for ease of access and continued learning.

        - Agency employees are trained on these organizational elements within the first 90 days of employment and then reinforced through individual and group supervision and annual training.
- Overseeing and evaluating the continuing appropriateness of the services
    - SafeCare and Motivational Interviewing trainings as well as trainings mentioned under the first 2 bullets above help train FCS contractors in overseeing and evaluating whether continuing the services are appropriate.

FCS contractors also may access training for their staff through the Child Welfare Provider Training Academy. Please see below for more information about these trainings.

Supports provided to FCS contractor staff includes but is not limited to:

- Comm. 660, Practice Standards for Family-Centered Services Contractors (Attachment A11)
- Supervisors support their staff in work completion and assist staff with any questions they may have related to determining appropriateness of services, service sequencing, etc.
- FCS contractors' in-house training staff answer questions that front line staff may have

Child Welfare Provider Training Academy (Training Academy)

The Child Welfare Provider Training Academy (Training Academy) is a partnership between HHS and the Coalition for Family and Children's Services in Iowa. The purpose of the partnership is to research, create, and deliver quality trainings supportive to child welfare services frontline workers and supervisors throughout the state to help improve Iowa's child welfare system to achieve safety, permanency, and family and child well-being. The Training Academy provides accessible, relevant, skill-based training throughout the state of Iowa using a strength based and family centered approach. The Training Academy continues to improve the infrastructure to support private child welfare social service organizations and HHS in their efforts to train and retain child welfare workers and positively affect job performance that is in the best interest of children and families.

The Training Academy coordinates curriculum development and oversight with guidance and support from the Training Academy Workgroup and the HHS Training Committee. The Training Academy Coordinator leads the Training Academy Workgroup and is an active member of the HHS Training Committee.

Trainings that pertain to the federal requirements that the Training Academy offers, includes but are not limited to, the following:

- Assessing what children and their families need:
    - Understanding & Supporting Child Development as a Child Welfare Worker - Child welfare workers will support and engage with children of all different ages. It is important for workers to understand the basics of children's social, emotional, and physical development and what children need from adults within each stage. Additionally, it is often the role of child welfare workers to support parents or caretakers in developing the knowledge and skills to engage in healthy relationships and respond to behaviors in developmentally appropriate ways. In this workshop, workers learn the key stages of child development based on observations of a child's social, emotional, and physical abilities. They also learn how to support caretakers in establishing developmentally appropriate relationships, routines, and responses to behavior (discipline).
    - See SafeCare and Motivational Interviewing Training (MI) below
- Connecting to the families served:
    - Enhancing Family/Provider Relationships Through Trauma Informed Care Practices - This workshop is focused on using trauma informed relationship practices with family/support systems. Programs, providers, and staff will enhance relationship building with families to increase overall engagement and integration of caretakers and support systems during services and episodes of care.
    - Skills for Effective Communication - The purpose of this course is to familiarize the learner with techniques and skills for communicating with others and to enhance listening skills. Information on barriers to communication, active listening, and how to talk with professionals and families is presented. The course engages learners in learning how to resolve conflicts.
    - See SafeCare and Motivational Interviewing Training (MI) below
- Knowing how to access and deliver the needed trauma-informed and evidence-based services
    - See SafeCare and Motivational Interviewing Training (MI) below
- Overseeing and evaluating the continuing appropriateness of the services
    - See SafeCare and Motivational Interviewing Training (MI) below

SafeCare: Please see *Section I, Title IV-E Prevention Services and Programs, Services Description and Oversight, Continuous Quality Improvement (CQI) Activities, SafeCare*, for a description of training in SafeCare.

Motivational Interviewing Training (MI): HHS' family-centered services (FCS) contractors will access required MI training through third-party vendors, Relias and Lyssn, contracted by the Training Academy. Relias is a learning management system (LMS) housing a plethora of virtual trainings from leading experts in a variety of fields and on a variety of topics. Contractors will take the *Motivational Interviewing: An Introduction* in Relias before moving on to Lyssn training.

Utilizing artificial intelligence (AI) Lyssn's training incorporates training from leading experts in the field and simulated interactions and then evaluates responses providing immediate tips and feedback. There are five Motivational Interviewing Skills Modules:

- Ambivalence and Listening Statements - Learn to identify and address ambivalence in conversations, using listening statements to foster connection and guide individuals toward resolution.
- Existing Motivation and Exploring Questions - Uncover and enhance motivation by asking exploring questions that inspire action and deepen collaboration.
- Identifying Change Talk and Lifting Language - Recognize "change talk" and learn to amplify it through supportive and strategic responses that drive progress.
- Refraining from Anti-MI Approaches - Avoid communication pitfalls by recognizing and refraining from anti-Motivational Interviewing techniques that hinder change or damage rapport.
- Identifying Strengths - Empower individuals by identifying and leveraging their strengths, fostering confidence, growth, and resilience.

FCS' staff will complete the five Lyssn modules every quarter with one vignette. They also will complete booster sessions as needed, which will be developed through the Training Academy. Depending upon performance, they also may complete advanced level MI trainings.

In addition to completing the Lyssn modules, MI Coaches will complete a MI Coach training and MI Specialists will complete the MI Coach training plus a MI Specialist training. These additional trainings will be provided through the Training Academy. MI Coaches and MI Specialists will also complete Lyssn advanced level MI trainings.

Any booster sessions developed will be based on the results from CQI activities. Please see *Section I: Title IV-E Prevention Services and Programs, Services Description and Oversight, Continuous Quality Improvement (CQI) Activities* for more information.

For more information, please see The Coalition for Family and Children's Services in Iowa website, https://www.iachild.org/, CWPTA Training tab.

Prevention Caseloads

The state must describe how the caseload size and type for prevention caseworkers will be determined, managed, and overseen.

Community Pathway

Caseloads for Iowa's HFA and PAT programs will adhere to model-specific standards and are limited to ensure that home visitors have sufficient time and resources to deliver the models with fidelity and to serve families most effectively. Iowa home visitors have limited caseloads with caseload size determined by the number of hours worked, the

experience and skill level of the home visitor, the number of families served at each level, and any additional resource requirements of the family (e.g., families involved with child welfare, families with multiple births, etc.). Typical caseloads range between 10 to 20 families, with an average caseload size of 15 families.

Child Protective Services (CPS) Pathway

HHS

As mentioned in *Section I, Title IV-E Prevention Services and Programs, Child and Family Eligibility for the Title IV-E Prevention Program*, HHS' child protective workers (CPWs) conduct child protective assessments, e.g. Family Assessments (FAs), Child Abuse Assessments (CAAs) and Child in Need of Assistance (CINA) Assessments (CINAAs). During these assessments, CPWs conduct safety and risk assessments. At the conclusion of the assessment process, the CPW's *Child Protective Services Family Assessment Summary, Form 470-5371, Child Protective Services Child Abuse Assessment Summary, Form 470-3240*, or *CINA Services Assessment Summary, Form 470-4135*, (Attachments A4, A5 and A6 respectively) reflects the CPW's work with the family to develop a plan of action moving forward. For CAAs and CINAAs, the CPW documents the child's prevention plan in CWIS for HHS child welfare cases. For FAs, the CPW documents the candidate for foster care determination and sends that information to the family-centered services (FCS) contractor for the contractor to complete the child's prevention plan in the provider portal for non-HHS, voluntary FCS cases.

For HHS child welfare cases, the CPW then meets with the family, HHS' social work case manager (SWCM), and the FCS contractor to transfer the case to the SWCM for ongoing case management. Throughout the rest of the case, the SWCM conducts informal and formal safety and risk assessments and risk reassessments, including through monthly caseworker visits with the child and family, and reviews and revises the child's prevention plan, as outlined in *Section I, Title IV-E Prevention Services and Programs, Monitoring Child Safety.* These activities occur through engagement and collaboration with the family and the FCS contractor.

For non-HHS voluntary FCS cases, the CPW also meets with the family and the FCS contractor to transfer the case to the FCS contractor for ongoing case management. Throughout the rest of the case, the FCS contractor monitors the child's safety and reviews and revises the child's prevention plan, if applicable, as outlined in *Section I, Title IV-E Prevention Services and Programs, Monitoring Child Safety*. These activities occur through engagement and collaboration with the family.

HHS supervisors assign cases to the CPW or SWCM. In assigning cases, supervisors may consider the worker's caseload size. CPW cases typically vary by the type of assessment, e.g. CAA, CINAA, and Family Assessment (Iowa's differential response).

The type of cases SWCMs have varies across the state. In some of HHS' five service areas, there are dedicated units, e.g. Native Unit in Woodbury County, another planned permanent living arrangement (APPLA) unit in the Cedar Rapids Service Area, etc. However, the majority of SWCMs have a variety of case types, i.e. foster care and in-home services cases. HHS does not have caseload size limits for its workers. In its 2019 Child Welfare by the Numbers report, HHS reported the following for calendar year 2019:

- 199 HHS child protective workers were assigned an average of 15 cases a month, including cases alleging adult abuse.
- 310 HHS case managers (SWCMs) had an average child welfare caseload of 33

CPW and SWCM supervisors continue to manage and oversee the workers' caseloads through clinical case consultations between the supervisor and the worker and supervisory monitoring of caseload sizes across all their workers in their unit. Service area leadership, e.g. the social work administrator (SWA), also keeps track of caseloads and may send some cases to another county if one county is overloaded.

While HHS acknowledges the roles and activities its CPWs and SWCMs have related to the prevention plan, as noted above during the assessment and ongoing case management processes, including referring families to FCS contractors, HHS does not consider its CPWs or SWCMs to be "prevention caseworkers". Instead, HHS defines "prevention caseworkers" as the entity providing the prevention service, e.g. FCS contractor staff, the Intervention Specialist (IS), who provides SafeCare, and the Family Support Specialist (FSS) who provides Motivational Interviewing (MI) in Family Preservation Services and Family Casework (FC). Since the Children's Bureau has not defined "prevention caseworkers", HHS will apply its definition of "prevention caseworkers", as discussed below.

However, for the Sobriety Treatment and Recovery Teams (START) model, HHS recognizes that the SWCM is a prevention caseworker along with the family mentor who comprise the START dyad. The START dyad works as a team and shares a dedicated capped caseload that is either at or below 12 cases. Dyads are assigned no more than one new case per week to allow for completion of timeline activities. The START supervisor manages and oversees the dyad's caseload through clinical consultations between the supervisor and the dyad and through individual supervision with the SWCM and family mentor. The START supervisor has a system to track and reinforce the START model's minimum work guidelines (MWGs) for each member of the dyad. The supervisor uses professional judgement and/or team consultation to increase or modify the intensity of service provision to address the ongoing safety and needs of families receiving START.

FCS

HHS program management contractually determined the caseload size for each prevention service:

- MI as provided in:
    - Family Casework (FC) - The FSS shall not have more than 14 families assigned to their caseload at one time.
    - Family Preservation Services (FPS) - The FSS shall not have more than four families assigned for this service to their caseload at one time.
- SafeCare - The IS shall not have more than 15 families assigned to their caseload at one time.

The contractors will provide these services on open HHS child welfare cases, which includes intact families on in-home cases, when children are in kin caregiver placements, or when in foster care placements. The contractors also will provide SafeCare and MI provided during FC on open non-HHS voluntary, state-purchased FCS cases for up to four months, or longer with HHS prior approval.

Supervision and oversight of prevention caseworkers' caseload size and type occurs through case consultations between the FCS contractors' supervisors and their FSS and IS. Supervisors will have case consultations with their staff in accordance with their accreditation requirements and in accordance with any oversight required by the services' models. HHS contracts require the contractors to maintain accreditation at all times in accordance with their respective accrediting body. The contractors also must utilize their quality assurance system. Quality assurance means the procedures established and activities undertaken by the contractor to ensure service delivery occurs in accordance with requirements established by HHS and to improve the quality of services to achieve safety, permanency, and well-being. HHS also requires contractors to submit a HHS developed staffing report on a quarterly basis.

HHS' service contract specialists will conduct monitoring and oversight activities, outlined above under *Section I, Service Description and Oversight, Continuous Quality Improvement (CQI) Activities, HHS*, to oversee execution of the contracts and the contractors' compliance with the requirements. This includes developing a quarterly compliance review report for review by HHS' contract owner and service area managers, conducting site reviews to ensure compliance with quality assurance requirements, etc.

ATTACHMENTS

- Attachment A: Iowa SafeCare Evaluation Plan
- Attachment A1: Comm. 534, Family Connections are Always Strengthened and Preserved
- Attachment A2: Form 470-4132, Safety Assessment
- Attachment A3: Form 470-4133, Family Risk Assessment
- Attachment A4: Form 470-5371, Child Protective Services Family Assessment Summary
- Attachment A5: Form 470-3240, Child Protective Services Child Abuse Assessment Summary
- Attachment A6: Form 470-4135, CINA Services Assessment Summary
- Attachment A7: Form 470-4134, Risk Reassessment
- Attachment A8: Family First Implementation Workgroups and Teams
- Attachment A9: New Worker Training Plan – SW2s and SW2 Supervisors
- Attachment A10: New Worker Training Plan – SW3s and SW3 Supervisors
- Attachment A11: Comm.660, Practice Standards for Family-Centered Services Contractors
- Attachment A12: Family-Centered Services Contract Example
- Attachment A13: Employee's Manual 18-C(3): Family-Centered Services
- Attachment A14: Iowa Code §234.1(1)
- Attachment A15: 441 Iowa Administrative Code 172.1(234) (Candidate for Foster Care)
- Attachment A16: 18-Family Services Appendix, pp 56, 77 and 132
- Attachment A17: Iowa Sobriety Treatment and Recovery Teams (START) Evaluation Plan
- Attachment A18: Employee's Manual 18-C(2): Case Management
- Attachment A19: 2025 Home Visiting and Family Support Operations Manual

PART B – JUVENILE JUSTICE

INTRODUCTION

In 2017, Iowa's juvenile population for youth ages 10-17 years old was 331,434.[22] During that same year, Iowa's Juvenile Court received 14,003 juvenile complaints, which was a 17.4% reduction for all race and gender categories from 2013-2017.[23] Because of those complaints, 3,420 juveniles received informal probation, 798 received consent decrees, 255 received waiver to adult court, 946 youth received delinquent adjudication and 683 received formal probation[24]. The average recidivism rate for the eight highest populated counties; Polk, Linn, Woodbury, Pottawattamie, Scott, Dubuque, Black Hawk and Johnson, was 35.78%.[25] In addition to the financial costs associated with processing and supervising these complaints, there are significant expenses incurred when youth require out-of-home placement. For example, in 2016, Iowa spent $7,158,068 in federal funds and $23,449,698 in state funds on residential placement for youth.[26]

The monetary expenses of the court process are not the only costs associated with juvenile delinquency. Families and communities experience significant losses, as well, especially when removal of youth from their homes occurs. However, community-based supervision programs for youth both cost less than confinement and provide increased rehabilitative benefits for youth.[27] These programs show recidivism reduction by up to 22%, at a cost significantly lower than imprisonment, places an emphasis on behavior change, decision-making, and the development of social skills among different groups.[28] The best programs tend to be those that focus on developmentally and empirically based family-centered interventions. Without services, such as these, youth frequently re-offend, dropout of school, become homeless, use drugs and alcohol, are unemployed and fail to seek appropriate medical care. As youth's difficulties in these areas increase, so do the social and economic costs to the community.

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[22] OOJDP, 2019. *Easy Access to Juvenile Populations: 1990-2018*. Retrieved https://www.ojjdp.gov/ojstatbb/ezapop/asp/comparison_selection.asp?selState=0

[23] CJJP, 2018. *Iowa's 3-Year Plan Program Narrative: Juvenile/Needs Analysis Data Elements*. Retrieved https://humanrights.iowa.gov/sites/default/files/media/2018_Juvenile_Needs_Analysis_Data_Elements.pdf

[24] CJJP, 2017. *State of Iowa Juvenile Delinquency Annual Statistical Report*. https://humanrights.iowa.gov/sites/default/files/media/2017%20State%20Annual%20Report%20for%20JCS.pdf

[25] Ibid.

[26] Child Trends, 2016. *Child Welfare Spending SFY 2016: Iowa*. (The Annie E. Casey Foundation). https:/www.childtrends.org/wp-content/uploads/2018/12/Iowa_SFY2016-CWFS_12.13.2018.pdf

[27] Richard A. Mendel, *No Place for Kids: The Case for Reducing Juvenile Incarceration* (Baltimore: The Annie E. Casey Foundation, 2011), www.aecf.org/noplaceforkids.

[28] National Mental Health Association, 2004

The purpose of Iowa's juvenile justice system is holding youth accountable for their delinquent acts, providing treatment to correct their behavior, and promoting public safety. To accomplish this purpose, Iowa's Juvenile Court Services (JCS) began utilizing evidence-based practices in 1997, when it implemented standardized case planning and motivational interviewing. By 2004, all juvenile court officers received training in evidence-based practice. By 2007, JCS had developed and implemented the Iowa Delinquency Assessment (IDA).

The IDA is a standardized risk assessment tool that predicts the likelihood a youth will recidivate and directs treatment and services by identifying a youth's criminogenic risk and need areas. Risk refers to the likelihood a youth will reoffend and prediction of risk occurs by conducting an actuarial assessment of the characteristics or "risk" factors identified by research as correlated to future delinquent behavior. There are two types of risk factors – static and dynamic. Static risk factors are those that are unchangeable due to their historical context. Dynamic risk factors, however, are those characteristics that change over time through treatment or the normal developmental process.

Criminogenic needs are variables related to dynamic risk factors that predict recidivism and when treated are associated with reductions in the risk of reoffending. Research shows there are four "Big" criminogenic factors that when targeted generate the greatest decrease in risk, i.e. antisocial attitudes, antisocial peers, antisocial personality and antisocial behavior/thinking.[29] Substance abuse, mental health issues and deficits in parenting skills and family relationships, areas of focus identified by Family First, are also criminogenic risk factors. These risk factors, identified by the IDA and targeted by juvenile court officers (JCOs), are a part of comprehensive approach to treatment.

Table B1: Iowa Delinquency Assessment (IDA) - Criminogenic Risk Factor Domains Scoring Items	
Record Complaints	12
Demographics	1
School History	4
Current School Status	11
Free Time Historic Use	2
Free Time Current Use	3
Employment History	4
Employment Current	4
Relationships History	2
Relationships Current	6
Family History	5
Family Current Living Arrangements	16
Alcohol & Drug History	6

19 Andrews, D.A. and Bonta, J. (1994). *The Psychology of Criminal Conduct*. Anderson Publishing Co.

Table B1: Iowa Delinquency Assessment (IDA) - Criminogenic Risk Factor Domains Scoring Items	
Alcohol and Drug Current Use	4
Mental Health History	8
Mental Health Current	5
Attitudes and Behaviors	11
Aggression	6
Skills	11

Source: Juvenile Court Services

In 2012, Iowa was one of three states selected by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to be a demonstration site for their Juvenile Justice Reform and Reinvestment Initiative (JJRRI). The goal was the implementation of an evidence-based assessment and guide for program improvement. As a result, Iowa implemented the Standardized Program Evaluation Protocol system SPEP™ in five districts to assess the treatment services of residential programs statewide and community-based services locally. This afforded JCS a standardized method to assess services, enhance placement and programming recommendations, and guarantee the fidelity and quality of services. [30]

Since 2012, Iowa has maintained its commitment to providing quality services and programming for youth and their families by implementing, to varying degrees, numerous EBP services across its eight judicial districts. Contracts for these services are according to each district's needs and budgetary limitations. The passage of Family First provides Iowa's JCS a viable funding mechanism for the expansion and consistent use of EBP services for delinquents across the state.

ACRONYMS AND ABBREVIATIONS

Table B2: Acronyms and Abbreviations	
ART	Aggression Replacement Training
CJCO	Chief Juvenile Court Officer
CJJP	Criminal and Juvenile Justice Planning
CQI	Continuous Quality Improvement
CSG	Council State Government
CST	Candidacy Screening Tool
DOJCS	Director of Juvenile Court Services
EPICS	Effective Practices in Community Supervision
Family First	Family First Prevention Services Act
FFT	Functional Family Therapy

[30] Husseman, J. and Liberman, A. (2017). *Implementing Evidence Based Juvenile Justice Reforms.* https://www.urban.org/sites/default/files/publication/90381/implementing_evidence-based-juvenile-justice-reforms.pdf

Table B2: Acronyms and Abbreviations	
HHS	Department of Health and Human Services
ICIS	Iowa Court Information System
IDA	Iowa Delinquency Assessment
Prevention Plan	Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2021-2025
JCO	Juvenile Court Officer
JCS	Juvenile Court Services
JJSI	Juvenile Justice System Improvement
MDFT	Multi-dimensional Family Therapy
MST	Multisystemic Family Therapy
NCSC	National Center State Courts
NYSA	National Youth Screening Assessment
PSP	Prevention Services Plan
SAMHSA	Substance Abuse and Mental Health Services Administration
SCA	State Court Administration
SPEP	Standardized Program Evaluation Protocol

SECTION I: TITLE IV-E PREVENTION SERVICES AND PROGRAMS

Child and Family Eligibility for the Title IV-E Prevention Program

On June 26, 2020, HHS entered into a IV-E Agreement with JCS pursuant to section 472(a)(2)(B)(ii) of the Social Security Act, which replaced any prior IV-E agreement HHS had with JCS. In accordance with the Agreement, JCS alone determines Title IV-E Prevention Services program eligibility for the children and families they serve.

For purposes of the title IV-E prevention services program, a child is:

1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).

2. A child in foster care who is a pregnant or parenting foster youth.

Research shows there are several factors that increase a youth's risk of foster care placement. These factors include parental risk factors associated with substance abuse, mental illness, deficits in parenting skills, lack of social supports and connections and child maltreatment. Factors related directly to the child include previous out-of-home placements, developmental delays and physical or intellectual disabilities.[31] The Center for the Study of Social Policy and the Administration on Children, Youth and Families also indicated protective factors, resilience, social connectedness and the cognitive and

[31] English, D. et al (2015). *Predicting Risk of Entry into Foster Care from Early Childhood Experiences: A Survival Analysis using LongScan Data*. Child Abuse and Neglect 45: 57-67.

social/emotional competence of youth could directly affect a youth's risk of out-of-home placement.[32]

JCS based its definition of a "child who is a candidate for foster care" on Family First's definition, research, and Iowa Code sections 232.2 and 234.1, which provide a definition for "child" and a "child in need of assistance". JCS defines a "child who is a candidate for foster care" as a child whose involvement with JCS is for the specific purpose of either removing the child from the home or providing prevention services, such that if the services are unsuccessful, the plan is to remove the child from the home and place him/her in foster care. JCS' involvement with the child may be informal or formal, and the child may not be an eligible candidate. However, if a substantial change occurs or safety issues emerge that places the child at imminent or serious risk of removal from the home and placement in foster care, a child may become an eligible Title IV-E candidate for foster care. A child is not a candidate for foster care if the planned out-of-home placement is an arrangement other than foster care, such as placement in a detention, state training school, or psychiatric facility.

The state must describe how it will assess children and their parents or kin caregivers to determine eligibility for title IV-E prevention services.

At the initial intake for each youth for whom JCS receives a complaint, JCS will utilize a structured method to determine eligibility, based on the following:

1. Completion of the Iowa Delinquency Assessment (IDA) (Attachment B1) to identify the child's risk and protective factors. The IDA contains assessments in eleven domains, including family factors related to maltreatment, substance abuse and mental health. Based on the Ecological Model[33], the IDA takes into consideration the complex interactions between individual, relationship, community, and societal factors and identifies the scope of characteristics that put youth at risk of perpetrating or experiencing violence. The IDA detects areas of need across multiple levels of the ecological model, which is necessary for long-term prevention. For youth who score as moderate or high risk to reoffend, JCOs will complete the Title IV-E Candidacy for Foster Care Screening Tool (CFST) (Attachment B2).
2. Completion of Title IV-E CFST. The CFST provides a structured methodology for JCOs to accurately identify Family First candidates based on whether a child meets the candidacy threshold score, which is a composite tally of the family's and child's identified risk factors associated with foster care placement.
3. Completion of the JCS child prevention plan, which clearly states that absent prevention services or should preventative services fail, the JCO will remove the

[32] Harper Browne, C. (2014). *The Strengthening Families Approach and Protective Factors Framework*. https://cssp.org/wp-content/uploads/2018/11/Branching-Out-and-Reaching-Deeper.pdf
[33] Center for Disease Control (2020). *The Social-Ecological Model: A Framework for Prevention.* https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

youth from the home and placed in foster/group care. The prevention plan requires JCOs to:

a. identify the foster care prevention strategy required for the child to remain safely in the home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver, and
b. list the services to be provided to or on behalf of the child to ensure the success of that prevention strategy.

For those youth who are pregnant or parenting, the prevention plan will:

a. be in the youth's foster care case plan;
b. list the services to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of parenting foster youth) to be a parent; and
c. describe the foster care prevention strategy for any child born to the youth.

The JCS prevention plan also includes youth and family strengths, objectives and related services and the date the youth became an eligible candidate. Prevention plans are progressive documents with a requirement to update and modify the plan as the needs of the child and family change.

4. Evaluation of eligibility occurs every six-months or when changes in circumstances occur and a new prevention plan is developed.

Service Description and Oversight

Describe the HHS approved services the state will provide, including:

- *whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse;*
- *how the state plans to implement the services, including how implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;*
- *how the state selected the services;*
- *the target population for the services;*
- *an assurance that each HHS approved title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III); and*
- *how providing the services is expected to improve specific outcomes for children and families.*

Services: The driving philosophy for Iowa's Juvenile Court Services (JCS) has been the least proscriptive intervention for children and families is the best approach. Consequently, JCS has strived to implement a wide spectrum of treatment and prevention services to meet the multi-faceted needs of the children and families it

serves.[34] Recognizing the need for standardized policies and practices to enhance the quality and breadth of services and supports, JCS recently worked cooperatively with Criminal Juvenile Justice Planning (CJJP) to initiate this process. Subsequently, in October 2019, Iowa finalized its Juvenile Justice System Improvement (JJSI) plan, which provides a structured strategy to accomplish this goal.

A child and the parents or kin caregivers of the child may receive services, when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. JCS provides the following services or programs throughout the state.

- Aggression Replacement Training (ART),
- Multi-Dimensional Family Therapy (MDFT),
- Functional Family Therapy (FFT),
- Multisystemic Therapy (MST),
- In-Home Family Services,
- Strong African American Families,
- Love & Logic Parenting,
- Juvenile Court School Liaison Support,
- Standardized Case Management,
- Tracking and Monitoring,
- Mentoring,
- Substance Abuse Assessment and Treatment,
- Mental Health Assessment and Treatment,
- Adolescent Sexual Offender Treatment, and
- Day Treatment Programming.

In addition to these services, all Juvenile Court Officers (JCOs) in Iowa received training in Motivational Interviewing and use it regularly in client interactions. JCOs also utilize Effective Practices in Community Supervision (EPICS), which employs a cognitive behavior therapy and motivational interviewing approach to structure client interactions. The JCO documents the type and dosage of each EPICS intervention in case notes. Tables B3 and B4 summarizes the services JCS provides and their evidence-based ratings, outcomes and population served.

[34] US Congress, (1988). *HR 1801 to Reauthorize the Juvenile Justice Delinquency Prevention Act*.

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Aggression Replacement Training (ART)[35]	Utilizes cognitive behavior therapy approach to teach youth social skills, anger control and moral reasoning.	Thirty sessions over 10 weeks	Moderate and high-risk juvenile delinquents ages 11 to 18	CEBC – Promising NIJ - Effective	▪ Increased social program solving ▪ Increased anger management ▪ Reduced physical aggression ▪ Reduced trait anger levels ▪ Reduced problem behaviors	No
Cognitive Behavior Intervention – Core Youth (CBI-CY)[36]	Uses cognitive behavioral strategies to teach youth methods to control risk factors in a way that is developmentally appropriate. Skill building activities are	Forty-seven 1-hour sessions	Moderate and high-risk juvenile delinquents ages 11 to 18	Not yet rated	▪ Reduced anti-social behaviors ▪ Reduced recidivism	No

[35] National Institute Justice (2012). *Program Profile*. https://www.crimesolutions.gov/ProgramDetails.aspx?ID=256
[36] University of Cincinnati Corrections Institute. *Cognitive-Behavioral Interventions*. https://cech.uc.edu/about/centers/ucci/products/interventions/group-interventions.html

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	strongly emphasized to assist with cognitive, social, emotional, and coping skill development. The program includes modifications to meet the needs of youth with mental illness.					
Cognitive Behavior Intervention – Substance Abuse (CBI-SA)[37]	Employs cognitive behavioral strategies to teach youth methods to avoid substance abuse. Skill building activities are strongly emphasized to assist with cognitive, social, emotional, and coping skill development	Thirty-nine 1-hour sessions	Youth ages 11-18 with moderate to high needs in the area of substance abuse	Not yet rated	▪ Reduced substance use ▪ Reduced recidivism	No
Decision Points[38]	A cognitive behavior structured program constructed on the tenet "Strategy of Choices." It teaches youth different	Minimum of five 90-minutes sessions	Juvenile justice involved youth ages 11-18.	Not yet rated	▪ Increased problem-solving skills ▪ Reduced anti-social behaviors	No

[37] Ibid
[38] Decision Points Program Overview. www.decisionpointsprogram.com/

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	methods to analyze their negative thinking and behaviors. The program can be utilized as brief intervention or an extended service.				▪ Reduced recidivism	
Effective Practices in Community Supervision (EPICS)[39]	Integrates the Risk-Need-Responsivity (RNR) principle with cognitive behavior therapy techniques to structure interactions between juvenile court officers and youth that are based on the eight evidence-based principles of effective interventions and youth learning styles, motivation levels, abilities and strengths.	One to two weekly sessions over 12 months	Moderate and high-risk juvenile delinquents ages 11 to 18	NIJ - Promising	▪ Increased problem-solving skills ▪ Increased relationship skills ▪ Reduced recidivism	No
Effective Practices in Community Supervision	An extension of EPICS that enables pro-social supports to structure	One to two weekly sessions over 12 months	Moderate and high-risk juvenile	Not yet rated	▪ Increased problem-solving skills	No

[39]Blasko, B., et. Al. *Performance Measures in Community Corrections: Measuring Effective Supervision Practices with Existing Agency Data* (2016). https://www.uscourts.gov/sites/default/files/80_3_3_0.pdf

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Influencers (EPICS-I)[40]	everyday interactions with youth based on evidence-based practices to increase youths' ability to identify risky situations and practice skills to manage successfully these challenges.		delinquents ages 11 to 18		▪ Increased relationship skills ▪ Reduced recidivism	
Functional Family Therapy (FFT)[41][42]	Family-based prevention and intervention program that treats complex and multidimensional family issues using a flexible clinical approach. Focuses on reducing risk factors and on improving protective factors that directly affect youth.	Twelve to fourteen sessions over 3-5 months	Youth 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral and/or emotional problems and their parents/caregivers	IV-E PSC – Well Supported CEBC – Supported NIJ - Effective	▪ Improved family interactions ▪ Increased parental involvement ▪ Improved family functioning ▪ Reduced negative youth behaviors ▪ Reduced youth out of	Yes

[40] Latessa, E. (2015). *Understanding the Principles of Effective Intervention and the Importance of Using and Applying Risk Assessment*.
[41] Alexander, J.F., Waldron, H.B., Robbins, M.S., & Neeb, A.A. (2013). *Functional Family Therapy for adolescent behavior problems.* American Psychological Association
[42] Sexton, T. L. (2010). *Functional Family Therapy in clinical practice: An evidence based treatment model for at risk adolescents.* Routledge.

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
					home placements ▪ Reduced youth recidivism ▪ Reduced youth substance abuse	
Mentoring[43]	A structured relationship between a youth involved in the juvenile justice system and an adult with the objective of developing the skills and abilities of the youth.	One to three hours per week for a minimum of 12 months	Youth ages 11 to 18 who are juvenile justice involved and moderate to high risk.	Not yet rated	▪ Reduced substance use ▪ Reduced anti-social behavior ▪ Improved family relationships ▪ Improved academic performance	No
Motivational Interviewing (MI)[44]	Youth focused and structured approached to increase motivation to change behavior. It focuses on discovering	Two to three 30-50-minute sessions	Youth 11 to 18 at-risk of delinquency with behavioral and/or conduct problems	IV-E PSC – Well Supported CEBC –	▪ Increased motivation to change behavior	No

[43] National Institute Justice. (2019). *Practice Profile: Mentoring*. https://www.crimesolutions.gov/PracticeDetails.aspx?ID=15
[44] IV-E Prevention Services Clearinghouse. (2019). https://preventionservices.abtsites.com/programs/142/show

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	and resolving ambivalence by advancing intrinsic motivation to make change.		and/or substance abuse issues	Well Supported NIJ - Effective	▪ Increased engagement in treatment	
Multi-dimensional Family Therapy (MDFT)[45]	Family-based treatment that focuses on four domains - the adolescent, the parents, the family, and the community to enhance motivation and facilitate behavior and relational changes.	One to three sessions a week for 3-6 months	Youth 11 to 18 with substance use, delinquency, and/or other behavioral and emotional problems and their parents	IV-E PSC – Next to be rated CEBC – Well Supported NIJ - Effective	▪ Reduced delinquent behavior ▪ Reduced substance abuse ▪ Reduced out of home placements ▪ Improved family functioning	No
Multisystemic Therapy (MST)[46][47]	Intensive community-based family treatment that utilizes an empirically based clinical approach to change a youth's criminal behavior,	One to several sessions per week dependent upon the family's needs. Averaging 3-5	Youth 12 to 17 at-risk of out of home placement due to anti-social or delinquent behaviors and substance abuse	IV-E PSC – Well Supported CEBC – Well Supported	▪ Reduced youth recidivism ▪ Reduced out of home placements for	Yes

[45] Multi-dimensional Family Therapy. (2019). http://www.mdft.org/Effectiveness/Family-functioning
[46] Multisystemic Family Therapy (2019). https://preventionservices.abtsites.com/programs/121/show
[47] MST Manual Version - Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for antisocial behavior in children and adolescents (2nd ed.). Guilford Press.

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	reduce family risk factors and empower parents.	months. Therapists are on call 24/7	issues and their parents	NIJ - Effective	serious offenders ▪ Improved family functioning ▪ Decreased youth problem behaviors ▪ Decreased youth mental health problems	
Thinking for a Change (T4C)[48]	An integrated, cognitive behavioral change program for individuals that includes cognitive restructuring, social skills development, and development of problem-solving skills.	Two 90-120 minutes sessions weekly for 13 weeks	Juvenile justice involved youth ages 11-18.	IV-E PSC – Not yet rated CEBC – Not yet rated NIJ - Promising	▪ Increased problem-solving skills ▪ Increased Positive social interactions ▪ Decreased negative behaviors ▪ Decreased anti-social attitudes ▪ Decreased recidivism	No

[48] Justice Research Center. (2019). *What Works Curriculum: Thinking for a Change (T4C)*. http://thejrc.com/wwi-curriculum.asp

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)[49]	A cognitive-behavioral, family focused psychotherapy approach to decreasing emotional and/or behavioral problems stemming from traumatic life events.	Twelve to eighteen weeks. Separate weekly sessions for the child and parent during initial phase of treatment; then joint sessions with parent and child	Youth 3 to 18 and parents/caregivers of youth 3 to 18, exposed to traumatic life events and are experiencing PTSD symptoms and/or depression, anxiety or shame related to their trauma.	IV-E PSC – Promising CEBC – Well Supported NIJ - Effective	▪ Improved trauma symptoms and responses ▪ Increased parent effective coping skills ▪ Increased positive parenting skills ▪ Increased effective family communication ▪ Increased parent ability to manage stress ▪ Increased parent behavior	No

[49] Child Welfare Information Gateway (2018). *Trauma-Focused Cognitive Behavioral Therapy: A Primer for Child Welfare Professionals.* https://www.childwelfare.gov/pubPDFs/trauma.pdf

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
					management skills	

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
Common Sense Parenting[50]	Parenting class that focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior.	One 2-hour weekly session for 6 weeks	Parents and other caregivers of children ages 6 - 16 years	CEBC – Supported	▪ Increased positive parental strategies for managing negative behaviors ▪ Increased positive behaviors ▪ Increased positive parent-child communication	No

[50] California Evidence Based Clearinghouse (2019). *Common Sense Parenting*. https://www.cebc4cw.org/program/common-sense-parenting/detailed

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
Homebuilders[51]	A home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning.	Three to five 2-hour sessions contacts per week; an average of 8 to 10 hours per week of face to face contact, with telephone contact between sessions.	Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities	Title IV-E Clearinghouse – Well Supported CEBC – 2 Supported	▪ Reduced child abuse and neglect, family conflict, and child behavior problems. ▪ Increased parenting skills.	No

[51] Title IV-E Prevention Services Clearinghouse (2020). Homebuilders. https://preventionservices.abtsites.com/programs/176/show

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
Love and Logic Parenting[52]	Parenting class that teaches caregivers how to decrease stress while teaching youth necessary life skills. Based on the concept that children learn the best when allowed to make their own choices and failure it met with love and empathy.	Minimum of one 8-hour training. Can be up to six 8-hour training days.	Parents, grandparents, teachers, and other caretakers working with children 0 – 18	CEBC – Not able to be rated	▪ Improved decision-making skills ▪ Improved problem-solving skills ▪ Increased positive parenting strategies ▪ Improved family relationships	No
On the Way Home[53]	Integration of three interventions: Check & Connect, Common Sense Parenting, and homework support to meet the educational and family-based transition needs of youth. Primary goal is to foster stability of	Two-hour weekly sessions over 12 months.	Youth ages 12-18 at-risk for, emotional and behavioral disorders transitioning from residential placements back into the home and community school	CEBC - Promising	▪ Increased academic performance ▪ Increased school engagement ▪ Decreased out-of-home placements	No

[52] Fay, C. Love and Logic Curriculum Research: Effects of Becoming a Love and Logic Parent. https://www.blottcom.com/love-and-logic-research.html

[53] California Evidence Based Clearinghouse (2019). *On the Way Home*. https://www.cebc4cw.org/program/on-the-way-home-otwh/detailed

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
	youth in home and school.		settings and their caregivers		▪ Improved family relationships	

At this time, JCS does not have the infrastructure or financial capacity required to implement multiple Family First prevention services. In addition, JCS is currently working with Georgetown University and the University of Cincinnati to complete an evidentiary review and evaluation of services in Iowa. Upon completion of that review, JCS will have a broader knowledge base to identify and select the programming and services best suited to meet the needs of the youth and families it serves. Until this review is completed and JCS has identified viable funding mechanisms, JCS is requesting that only Functional Family Therapy (FFT) and Multisystemic Therapy (MST) be included as an approved Family First prevention service.

Outcomes: Iowa's JCS commitment to improving youth and family outcomes are visible through its long-term goals to expand and improve mental health and substance abuse services and improve treatment services to produce positive youth outcomes and reduce recidivism.[54]

In addition, JCS's participation in the Juvenile Justice System Improvement Project (JJSI) provided an opportunity for JCS to collaborate with nationwide experts, e.g. the Council of State Governments Justice Center (CSG), National Youth Screening and Assessment Partners (NYSAP), and the Center for Juvenile Justice Reform at Georgetown (CJJR). The purpose of the collaboration was to perform a comprehensive evaluation of Iowa's juvenile justice system. This evaluation, which identified

[54] CJJP (2018). *2018 Iowa Criminal and Juvenile Justice Annual Plan Update.* https://humanrights.iowa.gov/sites/default/files/media/2018%20Iowa%20Criminal%20and%20Juvenile%20Justice%20Annual%20Plan%20Update.pdf

strengths and areas for improvement for JCS, resulted in the development of a comprehensive statewide plan to standardize policies and practices and ensure the quality and effectiveness of services that youth receive.[55]

1. *Selected Services and Evidence-Base Rating* – JCS selected only two Mental Health Services, FFT and MST, for inclusion in Iowa's Family First Five-Year plan. The Title IV-E Prevention Services Clearinghouse rated both of these services as "well-supported". In addition, FFT received a level "2 supported" rating and MST a level "1 well supported" rating from the California Clearinghouse.

   Research on FFT, conducted throughout the United States, has shown FFT produces improvement in family relations and statistically significant decreases in recidivism.[56]

   FFT is a prevention and intervention program that treats complicated and multi-dimensional family problems using a flexible clinical approach. Trained therapists spend twelve to fourteen sessions over 3-5 months working with youth and their families to reduce risk factors and improve protective factors. The program has three distinct intervention phases, engagement and motivation, behavior change, and generalization, with each phase having specific goals and assessment objectives.

   The expected proximal outcomes for FFT include improved family functioning, reduced delinquent behavior, improved mental health, reduced youth substance use, fewer out-of-home placements and higher treatment completion rates. Distal outcomes anticipated include reductions in recidivism, increased family stability, decreased trauma and improvement in overall life outcomes for youth.[57]

   MST is an intensive community-based therapy for high-risk juvenile delinquents ages 12-17 with possible substance abuse issues and their families. A master's level therapist provides services in the home for youth at times when it is convenient for the family. Treatment typically lasts three to five months with the therapists "on-call" 24/7. There is a broad base of research on the effectiveness of MST. Results, replicated through numerous independent studies, show 54% fewer arrests for juvenile offenders and 54% fewer out-of-home placements. Communities with MST offered saw reductions in incarceration rates, mental health services and crime rates.[58] MST treatment has two primary goals, to reduce delinquent behavior and to decrease out-of-home placements. Critical components of MST include (a)

[55] Iowa Department of Human Rights (2018). *Juvenile Justice System Improvement (SMART) Project*. https://humanrights.iowa.gov/juvenile-justice-system-improvement-smart-project
[56] Blueprints for Healthy Youth Development. (2020). *Functional Family Therapy*. https://www.blueprintsprograms.org/programs/28999999/functional-family-therapy-fft/
[57] EPIS Center. (2014). *FFT Logic Model*. Penn State University. http://www.episcenter.psu.edu/sites/default/files/ebp/Functional-Family-Therapy-Logic-Model-REV%204-2014.pdf
[58] MST Services (2020). *MST's Juvenile Delinquency Prevention Program.* https://www.mstservices.com/mst-juvenile-delinquency-prevention-program

incorporation of evidence-based treatment methods to target complex risk factors found across environments (family, friends, education and community); (b) empowering caregivers and changing a youth's behavior within the community context; and (c) meticulous quality assurance procedures that concentrate on accomplishing outcomes through preserving program fidelity and creating approaches to surmount obstacles to behavior change.

Proximal outcomes associated with MST include reductions in delinquent behavior and out-of-home placements, improvements in family functioning, and decreased behavior and mental health problems for high-risk juvenile offenders. Long-term outcomes of MST show improvements in child-parent relationships, improvement in youth-peer relationships, reductions in youth substance abuse, and reductions in child maltreatment.[59]

2. *Implementation and Monitoring of Fidelity*

   a. Implementation:

   Functional Family Therapy (FFT) - FFT requires completion of a three-phase training process, clinical, supervision and maintenance, and site certification prior to provision of services. Clinical training consists of a five-day in-person training followed by weekly phone consultations provided by an FFT expert trainer. Individuals selected to be site supervisors attend a two-day in-person training supported by monthly phone supervision. During phase II of FFT training, all therapists receive a one-day on-site training or a regional training. Phase III of the training process includes a review of Clinical Supervision System (CSS) to evaluate an agency's adherence, service delivery and outcomes. Therapists also receive a one-day continuing education training.

   Multisystemic Therapy (MST) - MST requires a pre-implementation assessment of an agency to identify the organizational, clinical and financial resources needed to implement MST. Upon completion of this assessment, the agency identifies a team of qualified clinicians. This team of clinicians attends a five-day intensive training, followed by weekly telephone consultation, and quarterly on-site booster trainings to monitor treatment fidelity and adherence to the model. Any agency providing MST must complete a certification process to ensure it meets the training, program management, performance, and adherence requirements set forth by MST.

   Through a competitive process, JCS selected qualified service providers who successfully completed the required FFT and MST training and site certification. JCS established a contract with the providers that included allowable expenses, scope of service, rates of payment and billing codes, process evaluation criteria,

[59] Zajac K, Randall J, Swenson CC. *Multisystemic Therapy for Externalizing Youth. Child Adolescent Psychiatry Clin N Am*. 2015;24(3):601–616. doi:10.1016/j.chc.2015.02.007

administrative reporting and required training/certification protocols. JCS also required providers to report on data related to adherence, exposure, quality of delivery and participant responsiveness semi-annually.[60]

JCS districts worked cooperatively to develop and distribute information packets to JCOs, support staff and additional referral sources to provide an overview of FFT and MST, including program objectives, structure, outcomes and eligibility guidelines. In addition, JCS will train staff on the referral processes respective of both. Districts have also collaborated with service providers to develop and provide program training and updates to JCS staff.

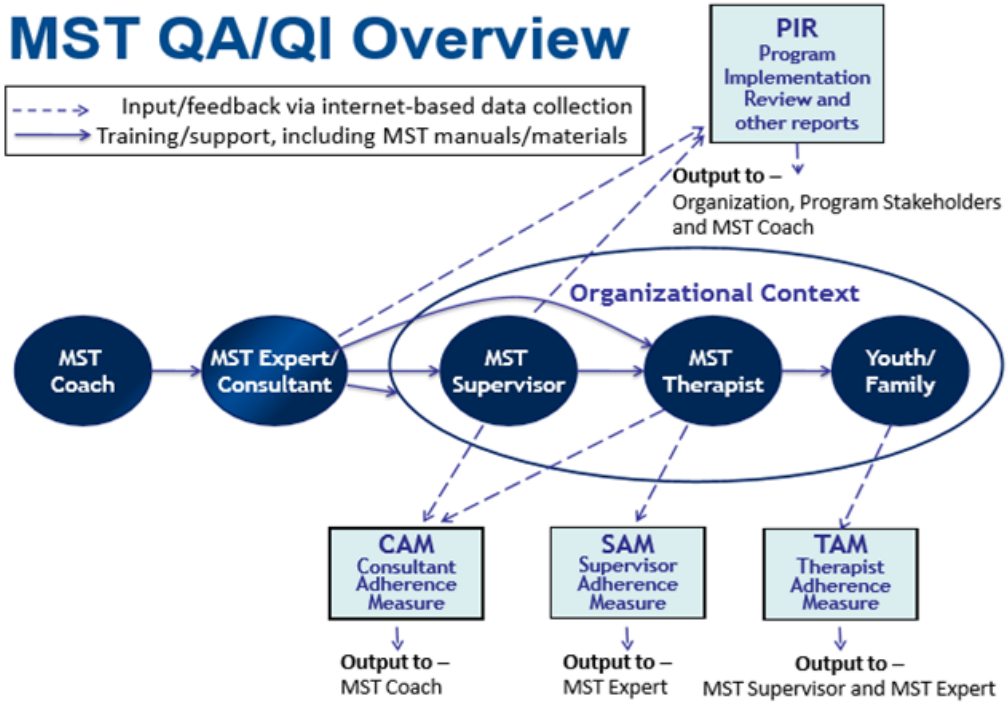
b. FFT and MST outcomes, data, and fidelity (how outcomes will be identified, how data collected regarding these outcomes will occur, and how fidelity will be monitored to ensure fidelity to the practice model):

Functional Family Therapy (FFT) - FFT has a systematic approach to training and program implementation, as well as a comprehensive system of client, process, and outcome assessment. This has allowed FFT to establish a fidelity model that ensures strong adherence to and high competency in the provision of FFT. To ensure continued fidelity, the organization responsible for providing FFT training, FFT LLC, developed the Clinical Services System (CSS), which gathers data input from FFT therapists. This system is used to track both individual and agency fidelity measures.

Multisystemic Therapy (MST) - MST has a rigorous qualify assurance/improvement program that evaluates elements on four levels – therapist, supervisor, expert/consultant and program – to ensure fidelity of and adherence to the MST treatment model. The MST Institute oversees the MST QA/QI program, who is responsible for setting quality assurance standards and measuring and monitoring program implementation. Through MST, agencies offering MST receive various tiers of training, support, and feedback (see Figure B1).[61]

[60] Bell, James (2009). *Measuring Implementation Fidelity*. https://www.acf.hhs.gov/sites/default/files/cb/measuring_implementation_fidelity.pdf
[61] MST Institute.

Figure B1. MST QA/QI Overview



a. Outcome Identification: Using the Theory of Change model, outcomes will be identified based on the following:
   1. Juvenile Court Service's purpose (to rehabilitate or habilitate youth and ensure public safety)
   2. Published research
   3. Historical data analysis
   4. Evaluations
   5. Program model standards

   Measures will be on two levels – outcome and process. Outcome measures will be specific to the youth and family will be specific to the youth and family and focus on measuring the effect of the treatment/service. Process measures, which will monitor fidelity, will examine the specific steps in the service process. Tables B4(a) and B4(b) illustrate at a minimum the outcome and process measures that may be collected by JCS.

Table B4(a) Key Outcome Measures	
Functional Family Therapy (FFT)	▪ Percentage of participants who report improved family functioning as measured by the Client Outcomes Measure

Table B4(a) Key Outcome Measures	
	(COM) administered at the completion of the program - (Annual) ▪ Percentage of parents/guardians who report a reduction in the level of family conflict post-therapy, as indicated by a score of 3 or higher on the Client Outcome Measure ▪ Percentage of parents/guardians reporting improvement in their parenting skills, as indicated by a score of 3 or higher on the COM-P - (Annual) ▪ Percentage of parents/guardians who report improvement in their child's behavior as measured by the Youth Outcome Questionnaire (Y-OQ 2.01) pre to post - (Annual) ▪ Number of youths with decreased recidivism ▪ Number of youths not placed outside of the home at 6, 12, 18, and 24 months
Multisystemic Therapy (MST)	▪ Number of youths with decreased recidivism ▪ Number of youths not placed outside of the home at 6, 12, 18, and 24 months. ▪ Number of youths in school or working

Table B4(b): Key Process (Fidelity) Measures	
Functional Family Therapy (FFT)	▪ Therapists will meet the model developer required staff qualifications ▪ Therapist will complete the required certified model training prior to serving clients ▪ Therapists will carry the recommended caseload of 10-12 families at any given time ▪ Therapists will meet the model developer's standards for dosage (number and duration) of client contacts. ▪ Therapist will meet the supervision/consultation program model requirements ▪ Providers delivering the model will be site affiliates as required by the model developer ▪ Providers will meet the model developer metrics requirements for fidelity and quality assurance ▪ Cases will be completed within the model developer's recommended timeframe of 3 to 4 months ▪ Clients will be from the target population ▪ Number of clients served
Multisystemic Therapy (MST)	▪ Therapist Adherence Measure score ▪ Supervisor Adherence Measure score ▪ Therapists will meet the model developer required staff qualifications ▪ Therapists will complete the required certified model training prior to serving clients

Table B4(b): Key Process (Fidelity) Measures	
	▪ Therapists will serve a maximum of 6 families per year ▪ Therapists will meet the model developer's standards for dosage (number and duration) of client contacts. ▪ Therapist will meet the supervision/consultation program model requirements ▪ Providers delivering the model will be site affiliates as required by the model developer ▪ Providers will meet the model developer metrics requirements for fidelity and quality assurance ▪ Cases will be completed within the model developer's recommended timeframe of 4 to 6 months ▪ Clients will be from the target population ▪ Number of clients served

b. Data Collection: For each outcome, JCS will generate a data collection plan. This plan will include the following:
   1. Data (variable)
   2. Operational Definition
   3. Input or Output data
   4. Unit of measurement
   5. Data Type
   6. Data Sources
   7. Collection Method/Instruments
   8. Historical Data References
   9. Operational Definition
   10. Sample
   11. Data Collector
   12. Collection Date/Time

   JCS will collect both qualitative and quantitative data. Process outcome data will derive from service provider reports. These reports are from three sources, provider completion of a quarterly fidelity questionnaire, a yearly service provider audit conducted by the JCS Contract Administrators, and each service's respective case management system (FFT - Clinical Services System and MST – MSTI Enhanced System). Data from these systems is based on client questionnaires and therapist observations.

   Outcome data collection will come directly from the Juvenile Court Service's Case Management (CM) system or reports from the Criminal and Juvenile Justice Planning (CJJP) agency. The CJJP reports derive from the Justice Data Warehouse (JDW), a central repository of key criminal and juvenile justice information from the Judicial Branch Case

Management System[62]. Data collected within CM can be on an individual or aggregate level. JCS is also currently working with the Judicial Branch Information Technology (JBIT) department to develop and implement forms in the Case Management system specific to FFPSA that will assist in collecting and aggregating data accurately.

As JCS enhances its CQI infrastructure, additional data will be collected from youth/parent surveys and case file reviews and analyzed to ensure a comprehensive evaluation of all programs and practices.

c. Fidelity Monitoring: JCS will monitor fidelity in four ways:
   1. Data related to the service outcomes identified by the program model and JCS will be collected through quarterly service provider reports and yearly audits of service provider contracts. A standardize quarterly reporting form will be developed to ensure all districts are collecting and reporting the same data. The CQI teams will then analyze this data, with statewide reporting.
   2. The Contract Administrator/Accountant (CA/As) will review service provider contracts in all districts and develop standard contract language for use statewide to ensure service providers are reporting outcomes directly related to program fidelity.
   3. The Standardized Program Evaluation Protocol (SPEP™) will occur yearly for eligible SPEP services.
   4. Data collected from other CQI processes will be used to augment the above three methods to ensure a comprehensive approach to fidelity

   In addition to the identified fidelity measures for FFT and MST, JCS will monitor and enhance fidelity by taking the following actions:

   - Conduct yearly meetings with providers to review progress, identify strengths and address any process and/or delivery issues.
   - Participate in joint learning opportunities with providers, when feasible

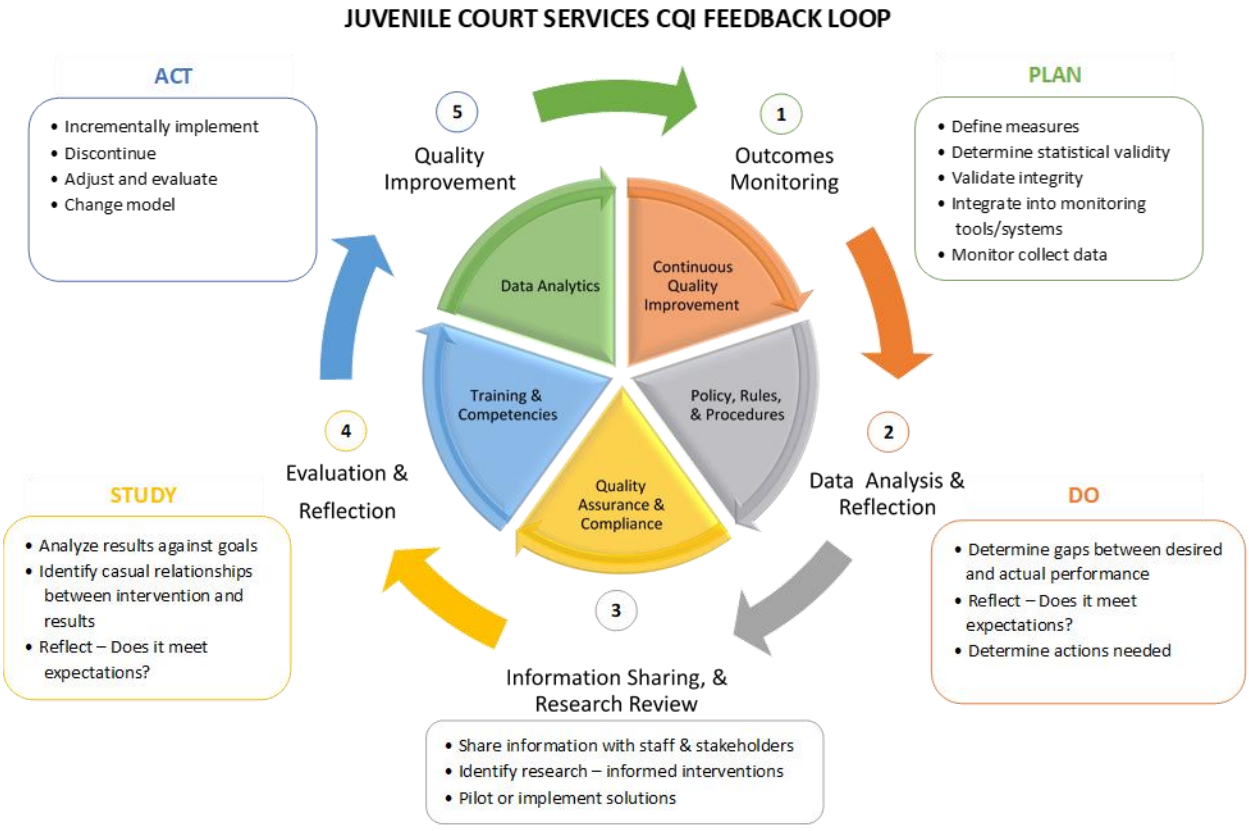
c. How information learned from CQI for FFT and MST refines and improves practices: JCS will utilize the feedback loop (Figure. B2) to ensure a structured approach to Continuous Quality Improvement. This feedback loop will give JCS the opportunity to use the information learned from the CQI process for FFT and MST to refine and improve practices by providing JCS with a data-driven and informed approach to decision-making. This approach will allow JCS to enhance and ameliorate its services and practices by using CQI results to guide the agency in:

   - Identifying which services/programs to maintain, expand, or terminate

[62] CJJP (2020). *Justice Data Warehouse*. https://humanrights.iowa.gov/cjjp/justice-data-warehouse

- Modifying services that do not meet expectations
- Implementing new services that are more conducive to achieving desired outcomes
- Improving delivery of services
- Improving internal processes (i.e. changes in policies, procedures, and training)
- Improving external relationships
- Addressing barriers to service delivery
- Identifying and addressing gaps in programming
- Understanding underlying conditions
- Identifying solutions
- Identifying if Technical Assistance is needed
- Identifying if there are collection, communication, or technology issues
- Identifying trends
- Addressing performance issues

Figure B2. JCS CQI FEEDBACK LOOP



3. *Service Selection*

JCS utilized a comprehensive and longitudinal process to select its services. The process identified programs for their effectiveness in reducing criminogenic risk and ameliorating criminogenic needs, which are the overriding factors that contribute to a juvenile justice youth being a candidate for group foster care. This process included the following actions:

- Chief Juvenile Court Officers (CJCO) identified individual district needs and budgetary constraints through a detailed analysis of data obtained from the Iowa Court Information System (ICIS), the Iowa Delinquency Assessment (IDA) and research initiatives, such as the SMART project.

    - The SMART project was a result of Iowa receiving one of three OJJDP planning grants for system improvement. Iowa used this grant to initiate the Juvenile Justice System Improvement Project (SMART). The SMART project allowed Iowa the opportunity to collaborate with experts from the Council of State Governments Justice Center (CSG), National Youth Screening and Assessment Partners (NYSAP), and the Center for Juvenile Justice Reform at Georgetown (CJJR). The purpose of the collaboration was to perform a comprehensive evaluation of Iowa's juvenile justice system for identifying strengths and deficit areas in Iowa's juvenile justice system. The long-term outcomes for the SMART project were to reduce reoffending, enhance outcomes for youth and families, improve community safety, and decrease disproportionate minority contact. Because of the project, the development of a comprehensive plan occurred that included recommendations to systematize policies and procedures and assure the quality and efficacy of services that youth receive. The SMART leadership team, which comprised juvenile justice participants from all three branches of government, worked collaboratively with expert advisors and local consultants to reach agreement on priorities for improvement, ascertain essential stakeholders, and generate a plan for Iowa's juvenile justice system that was progressive and realistic.

- CJCOs consulted with a variety of experts in the juvenile justice field, such as Dr. Edward Latessa (Director and Professor of the University of Cincinnati School of Criminal Justice); Dr. Robert Macy (founder and president of the International Trauma Center in Boston); Dr. Mark Lipsey (Research Professor at Vanderbilt Peabody College); and Diana Wavra, Orbis (consultant and trainer for evidence-based services in juvenile justice). The purpose of the consultation was to identify evidence-based services and programs best suited to the identified needs of Iowa's youth and families.

- Assessment of funding and resources needed to implement each selected service or program occurred to evaluate its feasibility.
- Services and programs were selected based on overall assessment of criteria related to the service or program's evidence-base, level of suitability, outcomes, availability and required time, resources and costs associated with delivery and administration.

  To continue the process of service selection, JCS is currently working with Georgetown University and the University of Cincinnati to complete an evidentiary review of programs/services in Iowa.

4. *Target Population*

   The target population for FFT are youth age 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral and/or emotional problems and their parents/caregivers. The target population for MST are youth age 12 to 17 at-risk of out of home placement due to anti-social or delinquent behaviors and substance abuse issues and their parents. The target population for other services currently offered by JCS but not included in the Family First Prevention Plan is in Tables B3 and B4.

5. *Trauma Informed Delivery Assurance*

   Iowa Juvenile Court Services recognizes the importance of trauma-informed approach to service delivery and evaluates all service/program delivery based on SAMHSA's six key principles of a trauma-informed approach.

6. *Service/Program Evaluation - Services and Programs Eligible for Waiver of Evaluation Requirements (Well-Supported Practice)*

   The Title IV-E Prevention Services Clearinghouse designated both FFT and MST as "Well-Supported." In addition, both models have highly structured processes for program evaluation that providers are required to meet on a yearly basis. JCS has also established measures for program evaluation of FFT and MST, based on CQI and the Standardized Program Evaluation Protocol (SPEP) that includes semi-annual provider reporting of outcome and process measures, quarterly provider meetings, yearly audits and semi-annual provider trainings. Due to this, JCS is requesting a Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation for FFT.

Evaluation Strategy and Waiver Request

- *The state must include a well-designed and rigorous evaluation strategy for each service, which may include a cross-site evaluation approved by ACF.*
- *Consistent with section 471(e)(5)(C)(ii) of the Act, the Children's Bureau may waive this requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous*

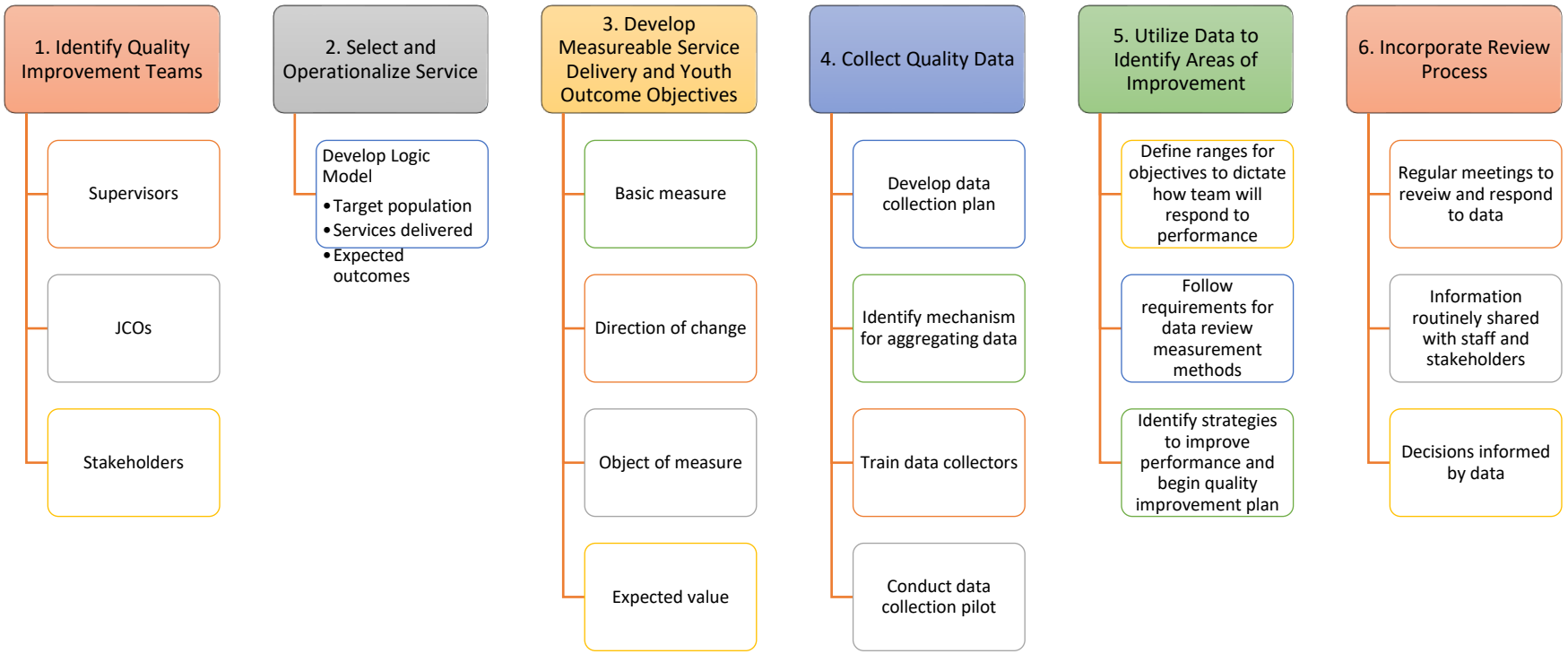
quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state may request this waiver using Attachment II to the five-year plan and must demonstrate the effectiveness of the practice.

JCS bases its evaluation strategy on Theory of Change, which provides a coherent framework for evaluating programs, processes and practices to determine if an intervention is working as planned and how to improve it. As part of this strategy, JCS will also use the Continuous Quality Improvement[63] (CQI) process to develop individual assessment practices for each selected Family First service or program. The evaluation plan for each service selected for Family First implementation will contain the below listed CQI components. If a service or program, such as Functional Family Therapy (FFT) or Multisystemic Therapy (MST) has already identified an appropriate evaluation strategy, JCS will follow the requirements of that strategy to complete an evaluation of the service/program.

- Identify CQI teams in each district comprising Supervisors, JCOs and service providers. Connection of these teams will occur to form a larger statewide CQI team.
- Teams will operationalize the service or program by developing a logic model that includes target population, services delivered, and expected outcomes.
- Develop measurable proximal and distal service delivery and youth outcome objectives, including fidelity to the model
- Collect quality data, in particular, outcomes related to recidivism and out-of-home placement, by developing a data collection plan, identifying mechanisms for aggregating data, training data collectors and conducting a data collection pilot.
- Analyze and utilize data to identify areas of program improvement
- Incorporate a review process by holding regular meetings to review and respond to data, sharing information routinely with staff and stakeholders, and making data-driven decisions.

[63] National Center for Juvenile Justice (2012). *Continuous Quality Improvement Guide for Juvenile Justice* Organizations. http://www.ncjj.org/pdf/Qii%20Improvement%20Guide%20for%20Juvenile%20Justice.pdf

Figure B3. Juvenile Court Services Continuous Quality Improvement Diagram



As an additional measure to ensure a comprehensive program evaluation occurs, JCS will utilize the Standardized Program Evaluation Protocol (SPEP) to evaluate program performance for all eligible services. The SPEP process is a data-driven tool derived from meta-analytic research designed to compare existing juvenile justice services to the characteristics of the most effective services found in the research. It evaluates the effectiveness of four characteristics of juvenile programs: service type, amount of service, quality of service and risk level of youth served.

SPEP identified 14 therapeutic services as effective in reducing delinquent behavior and recidivism. These fourteen service types divide into five separate services groups and assigned a point value based on the size of the effect that research has indicated that particular service group is likely to have upon recidivism. A trained evaluator will match the Family First identified services to the SPEP service groups and assign a corresponding rating.

Quality of service is the second element of the SPEP evaluation, with rating of low, medium or high. The basis for these ratings are individual assessments in four areas: 1) the presence of a comprehensive written protocol/manual 2) the level of staff training on the service and its protocols 3) staff supervision and monitoring of service delivery and 4) organizational procedures for responding to drift from protocol.

The third element of the SPEP evaluation is dosage or amount of service. This assesses the duration (number of weeks) and frequency (contact hours) the youth received services against the research identified target amount, which differs for each of the fourteen service types. The basis for the SPEP dosage score is the percentage of youth who receive at least the minimum, targeted amount of service.

The final element of the SPEP evaluation examines the risk level of youth served. This score comprises a formula that measures the proportion of moderate to high-risk youth, as identified by the Iowa Delinquency Assessment (IDA), who participated in the service. Simplified, the more moderate and high-risk youth served, the more likely a service is able to reduce recidivism.

A sum of the scores of these four elements produce two overall SPEP evaluation scores, the Basic Score and a Program Optimization Percentage (POP). The Basic Score compares the service to other intervention services found in the research, regardless of type. It is a reference for the expected overall recidivism reduction when compared to other service types. The POP is a percentage score that indicates where the service compares to its potential effectiveness if optimized to match the characteristics of similar services found in research. All of the scores described above, plus the accompanying recommendations provided in the report form, are the core of this diagnostic evaluation and establish a baseline intended for use in individual service improvement.

The Director of Juvenile Court Services will oversee this evaluation process in conjunction with each district's CJCOs, JCO Supervisors, Contract Administrator Accountants and Contract Administrator Auditors.

JCS requests a waiver for the following services:

- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)

JCW will follow each program's established protocols to monitor, evaluate, and report fidelity and outcomes data as part of its continuing effort to assess the efficacy of the selected prevention interventions.

The Title IV-E Prevention Services Clearinghouse rated both programs as "well-supported".

Compelling Evidence for Effectiveness of FFT and MST (how is the effectiveness of FFT and MST compelling?)

Functional Family Therapy (FFT): JCS is requesting a waiver of the evaluation required for FFT based on compelling evidence that FFT 1) improves family interactions; 2) decreases recidivism; and 3) decreases out-of-home placements. Below is a summary of the research conducted on FFT, which provides evidentiary support for this request.

Functional Family Therapy (FFT) has been utilized successfully in a variety of settings to treat high-risk youth and families. It is a treatment approach that combines "established clinical theory, empirically supported principles, and extensive clinical experience"[64] into a discrete and comprehensive clinical model that is flexibly structured. Because FFT spans the continuum of juvenile justice involvement, it is effective as an intervention or a prevention program.

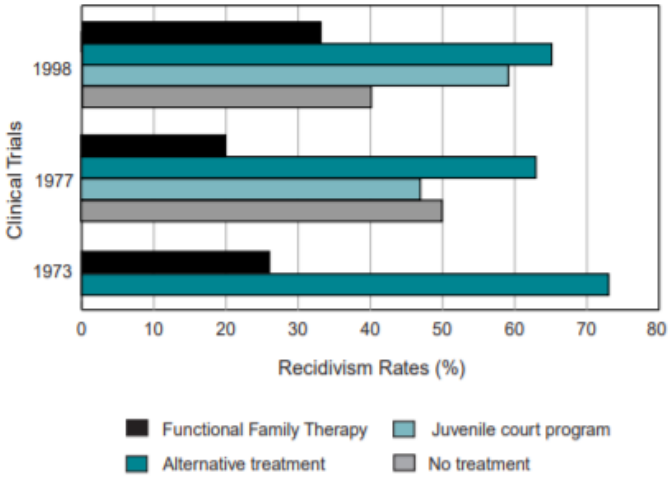
As a result of numerous peer-reviewed studies, FFT has been identified as a "blueprint program" (Alexander et al., 2000), an "exemplary model" program (Alexander, Robbins, and Sexton, 1999), and a "family based empirically supported treatment" (Alexander, Sexton, and Robbins, 2000).

The outcome findings of FFT studies conducted during the past 30 years is summarized in Figures 1 (randomized clinical trials) and 2 (comparison studies). The figures show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services, FFT reduces adolescent rearrests by 20–60 percent.[65]

[64] Alexander, J., Sexton, T.L. (2000). *Functional Family Therapy. "*OJJDP Bulletin" https://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf

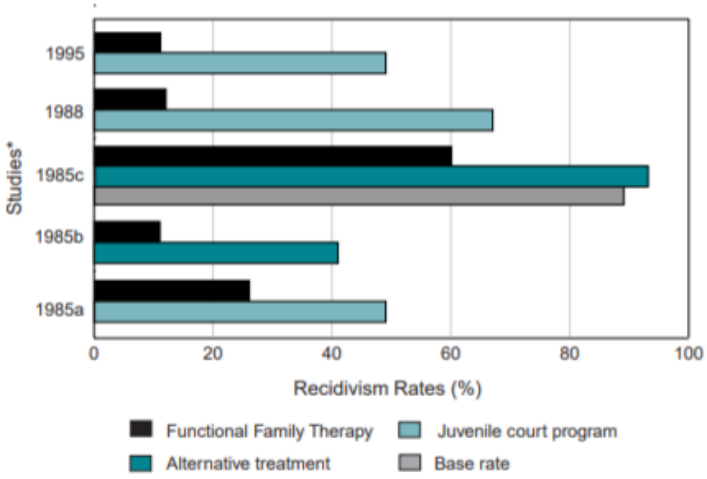
[65] Ibid.

Figure 1: Outcome Findings for Recidivism in Randomized Clinical Trials, 1973–1998



Source: Alexander and Parsons, 1973; Klein, Alexander, and Parsons, 1977; Hansson, 1998.

Figure 2: Outcome Findings for Recidivism in Comparison Studies, 1985–1995



* The three 1985 comparison studies (1985a, b, and c) appear in Barton et al., 1985.

Source: Barton et al., 1985; Gordon et al., 1988; Gordon, Graves, and Arbuthnot, 1995.

FFT has a proven body of research that validates its efficacy with a wide variety of negative youth behaviors, including violence, substance abuse, and delinquent acts. Most notable is the fact that FFT's positive outcomes are comparatively stable even after five-years.[66]

Below are several other studies that provide additional compelling evidence for the use of FFT in the treatment of juvenile delinquents and their families.

- Alexander J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. "Journal of Abnormal Psychology", 81(3), 219-225.

  This study examined the impact of FFT on the recidivism rates of delinquent teenagers and their families. Results of the study showed the FFT treatment group had a 26% recidivism rate. No-treatment control group had a 50% recidivism rate, the client-centered family group had a 47% recidivism rate, the psychodynamic family treatment group had a 73% recidivism rate.

- Klein, N., Alexander, J., & Parsons, B. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. "Journal of Consulting and Clinical Psychology, 45(3), 469-474."

- FFT produced significant reductions in recidivism and improvements in improvement in family relationships. In a 3 ½ year post-treatment, the siblings of youth receiving FFT had lower arrest rates than siblings who received an alternative treatment.

- Lantz, B. L. (1982). Preventing adolescent placement through Functional Family Therapy and tracking. Grant. CDP 1070 UT 83-0128020 87-6000-545-W). Kearns, UT: Utah Department of Social Services

- FFT had lower rates of recidivism and out-of-home placement than those receiving an alternative treatment.

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. "Journal of Consulting and Clinical Psychology," 69(5), 802-813.

[66] Gordon, D. A., Arbuthnot, J., Gustafson, K. E., & McGreen, P. (1988). Home-based behavioral-systems family therapy with disadvantaged juvenile delinquents. *American Journal of Family Therapy, 16*(3), 243–255. https://doi.org/10.1080/01926188808250729

- FFT showed significant reductions in heavy marijuana that persisted until the 7-month assessment.

- Stout, B. D., Holleran, D. (2013). The impact of evidence-based practices on requests for out-of-home placements in the context of system reform. "Journal of Child and Family Studies," 22, 311–321. doi:10.1007/s10826-012-9580-6.
- FFT had an estimated reduction of 31 out-of-home placements month – an annual reduction of 372 out-of-home placements – and an estimated cost savings of $1.33 million.

Multi-systemic Therapy (MST): Compelling evidence for MST shows MST 1) Reduces long-term recidivism rates for serious juvenile offenders by a median of 42%; 2) Reduces out-of-home placements by a median of 54%; and 3) Improved family functioning.[67] MST has had 79 published peer-review studies completed with more than 58,000 families included in those studies. MST targets risk factors at the individual, family, school, and community levels. Developed precisely for this reason, MST shown through multiple studies to be highly effective in treating serious clinical issues that increase a youth's risk of out-of-home placement, including juvenile offending, serious externalizing behaviors, substance abuse, and parental physical abuse and neglect. Researchers for MST have proven the importance of "high treatment fidelity and pioneered a quality assurance system that allows for replication of positive outcomes in community settings through ongoing supervision and support from MST experts."[68]

Additional studies providing evidentiary support for MST are below.

- Xuan Tan, J. and Lourdes Restrepo Fajardo, M.(2017). Efficacy of multisystemic therapy in youths aged 10–17 with severe antisocial behaviour and emotional disorders: systematic review. "London Journal of Primary Care (Abingdon)". Nov; 9(6): 95-103.

  MST is an effective intervention for reducing delinquency and incarceration for youth with severe antisocial behavior.

- McCart, M., Sheidow, A.J. (2016). Evidence-Based psychosocial treatments for adolescents with disruptive behavior. "Journal of Clinical Child and Adolescent Psychology", Sep-Oct; 45(5); 529-563.

  MST meets the criteria for a well-established for treatment youth presenting with serious anti-social behavior and substance abuse issues. It has also been adapted for other particular problems in adolescents and young adults, such as

[67] MST Services (2020). Multisystemic therapy research at a glance 2020 summary. https://www.mstservices.com/mst-whitepapers
[68] Zajac, K., Randall, J., Cupit Swenson, C. (2015). Multisystemic therapy for externalizing youth. Child and Adolescent Psychiatric Clinics of North America, July; 24(3): 601-616.

"juvenile sexual offenders; youth in psychiatric crisis; youth with physical abuse; youth with chronic health conditions; emerging adults with justice involvement and mental illness."

- Sawyer, A.M., Borduin, .C.M. (2011). Effects of multisystemic therapy through midlife: A 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders. "Journal of Consulting and Clinical Psychology" 79(5):643–652. doi: org/10.1037/a0024862.

  MST has demonstrated long-term outcomes, including sustained disruptive behavior outcomes for MST versus individual therapy at 14- and 22-years posttreatment.

- Painter K. (2009). Multisystemic therapy as community-based treatment for youth with severe emotional disturbance. "Research on Social Work Practice." 19(3):314-324. doi:10.1177/1049731508318772

  MST can prevent families from surrendering custody of their children to obtain successful treatment for them and avoid involvement in the juvenile justice system.

- Sheidow, A.J., Woodford, M.S. (2003). Multisystemic therapy: An empirically supported, home-based family therapy approach. "The Family Journal." 11(3):257-263. doi:10.1177/1066480703251889.

  MST has been validated as an effective treatment for serious clinical problems presented by adolescents and their families. Numerous randomized clinical trials have shown MST reduces out-of-home placements, delinquent behavior, substance use, and mental health symptoms.

Please see Attachment II: State Request for Waiver of Evaluation Requirements for a Well-Supported Practice for each service.

Monitoring Child Safety

The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.

The mission of Juvenile Court Services (JCS) is to serve the welfare of children and their families within a sound framework of public safety. To accomplish this, JCS is committed to providing the guidance, structure and services needed by every child under its supervision. Iowa's Juvenile Court System will utilize the following established tools and practices to assess and monitor child safety.[69]

Safety Assessment

At the initial intake with a youth and family, the JCO will utilize the Iowa Delinquency Assessment (IDA) to assess a youth's risk and protective factors in eleven domains. Included in these eleven domains are a youth's exposure to physical, emotional and sexual abuse and neglect. In addition to assessing a youth's risk factors, the IDA also assesses a family's risk factors in substance abuse, mental health, criminal conduct and child maltreatment. The IDA is a developmentally appropriate, structured decision-making tool based on the Risk-Need-Responsivity (RNR) principle. The JCO administers the IDA every six-months and anytime thereafter when there is a change in the youth's circumstances.

For any youth that scores as a moderate or high risk to reoffend, and who is determined to be a "candidate for foster care" or a pregnant or parenting youth in foster care, the JCO will complete a Treatment Outcome Package (TOP) assessment. The TOP is an evidence-based tool that captures multiple perspectives of a child's well-being and functioning in twelve behavioral health categories. These categories include suicide, violence, psychosis, depression, substance abuse, ADHD, mania, social conflict, sleep, conduct, work/school functioning and sexually worrisome behavior.[70]

The TOP, which documents statistically significant change in 96% of patients, enables the parent, child and other individuals involved in the child's care to have a voice in the assessment process. Results from the TOP are in real time; the JCO receives immediately notifications of worsening of symptoms or a degeneration in youth functioning. In addition, the JCO receives critical alerts anytime there is an identification of an immediate concern of suicide or violence. These alerts provide a detail of the items that precipitated the alert and required same day contact with the youth and parent. The JCO will administer the TOP every six months and anytime a significant change in circumstance occurs.[71]

The JCO also will assess and monitor a youth's safety through periodic reviews of the child's Prevention Case Plan. The JCO will review the child's Prevention Case Plan quarterly and at least once during a 12-month period by a supervisor.

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[69] Tuell, J. and Harp, K. (2016). *Letting Go of What Doesn't Work for Juvenile Probation, Embracing What Does.* Juvenile Justice Exchange.
[70] Outcome Referrals. (2020). *Treatment Outcome Package*. http://www.outcomereferrals.com/main/sub-page/category/top-assessment/top-assessment
[71] IBID

Safety Monitoring: JCO assessment and monitoring of child safety is not limited to the IDA and TOP. JCS will also assess and monitor child safety through standardized policies and procedures, family engagement, supervision, collaboration and training.

Each district has a policy and procedure work group that periodically reviews JCS policy and procedure. This includes policies and procedures related to assessing and monitoring child safety. Currently, JCOs are required to provide a verbal report of any suspected child abuse to HHS within 24 hours, with a written report of the suspected abuse submitted to HHS within 48 hours. Districts also have written policies detailing the process for developing a safety plan when a JCO has determined a child's safety is at risk. Policy is aligned with the practice of 1) Respond 2) Report 3) Record and 4) Refer.[72]

JCS provides for flexible and authentic opportunities for family engagement, which allows the JCO to assess and monitor youth safety through observations of family dialogue and interactions. These opportunities include interactions with the family in the home, community and office settings.

For moderate and high-risk youth, JCOs provide intensive monitoring and supervision integrated with effective services and programs to ensure child safety. Monitoring and supervision include weekly in-person contacts with youth and their families in settings that include the office, school, home and the community. During these visits, JCOs utilize evidence-based approaches, such as Effective Practices in Community Supervision (EPICS) and Motivational Interviewing (MI), to conduct semi-structured open-ended interviews with youth and family members that assess potential and immediate potential threats to a child's safety.[73]

Individual districts also worked to establish partnerships that promote the sharing of information and resources. These relationships exist on multiple levels to promote child safety, and includes collaboration with:

- Community mental health providers to establish reliable and timely access to mental health and substance abuse treatment services. These relationships have created an advanced level of support for safety assessment of youth and have allowed some districts to provide on-site mental health services.
- Agencies who provide services, such as Functional Family Therapy (FFT), Multi-dimensional Family Therapy (MDFT), Multisystemic Therapy (MST) and Behavioral Health Intervention Services (BHIS).

[72] ACF. *Safety Plan*. https://training.cfsrportal.acf.hhs.gov/section-2-understanding-child-welfare-system/3016

[73] Pecora, P., Chahine, Z. Graham, J.C. (2013). *Safety and Risk Assessment Frameworks: Overview and Implications for Child Maltreatment Fatalities*. Child Welfare 92(2), 143-160.

- School districts to provide liaison services, which increases consistent monitoring and supervision and enhances the sharing of contemporaneous information relevant to assessing child safety.

JCS districts also employ a team approach to case-management, which allows JCOs to review cases with colleagues weekly and gather collateral information that allows for a more comprehensive safety assessment. District teams typically include a JCO supervisor, JCOs, a mental health provider and school liaisons.

To ensure that all JCOs have the knowledge necessary to identify certain types of safety threats to children, JCS requires all JCOs to participate in Mandatory Reporter

Training. This training provides JCOs with the information necessary to recognize the categories and signs of child abuse and the knowledge needed to report suspected instances of child abuse. The Iowa Department of Health and Human Services (HHS) provides the training and requires it every three years.

Safety Planning: To establish what constitutes a viable threat to child safety, JCOs evaluate the information from the IDA, TOP, prevention plan and other sources of information based on the following criteria:

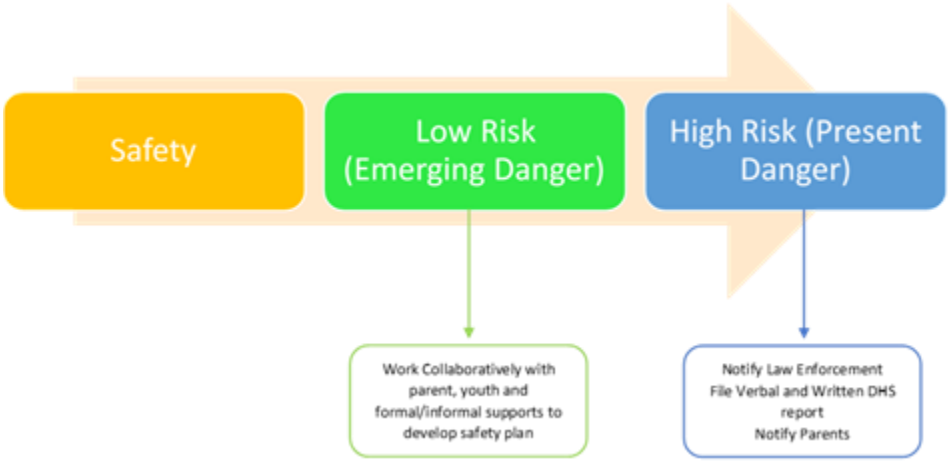
- Potential to cause child serious harm and/or pain and suffering.
- Condition is clearly identifiable – specific and observable
- Situation is out of control and family has no mean to assume control
- Child is vulnerable – susceptible to danger and unable to protect self
- Danger is imminent – could happen at any time

JCS views child safety on a continuum ranging from safety to danger. At any time a JCO identifies a threat to a child's safety, the JCO will work collaboratively with the parent, child, and involved parties to determine the level of threat, low or high, which will dictate the course of action taken by the JCO.

A low-level threat is one in which serious harm to a child is not immediately present but may occur in the near future. JCS procedure in this category requires JCOs to work cooperatively with the parent, youth and formal/informal supports to develop a written safety plan. This safety plan identifies the services, actions, activities and responsible parties necessary to immediately control and mitigate any threats to child safety. The safety plan remains in effect for the duration that a threat to a child's safety exists and the family is unable to ensure the child's safety.

A high-level safety threat is a threat that presents the capacity for immediate and serious harm to a child. These threats require an immediate response by the JCO. This response, which is dependent upon each child's situation, may include contacting law enforcement, filing a verbal and written report with HHS, and notifying the parents/caregivers.

Figure B4. Safety Planning



SECTION II: CONSULTATION AND COORDINATION

The state must describe: 1) how it will consult with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services (including community-based organizations), in order to foster a continuum of care for children, parents and caregivers receiving prevention services; and 2) how the prevention services provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state title IV-B plan.

Consultation with State, Public and Private Agencies: Iowa's JCS employs the Systems of Care model to guide cross-system consultation and collaboration. The Systems of Care model is an approach to service delivery that creates collaborative relationships to develop a comprehensive process for addressing a family's complex needs. Research has shown that agency adoption of and adherence to its principles, which include cross agency cooperation; strength-based, and individualized care; family engagement; community-based services; and responsibility result in improved outcomes for children, youth, and families.[74] JCS engages in consultation with state, public and private agencies to achieve safety and permanency for children and improve agency efficiency, resources and opportunities.

JCS believes that an open and mutual exchange of information is integral to effective collaboration. Relationships must be mutually beneficial and built around common goals that motivate stakeholders to improve the assessment and delivery of individualized

[74] Child Welfare Information Gateway (n.d.). *Systems of Care*. US Department of Health and Human Services.

services for youth and families. This requires the development of trust and an effort to understand and consider the effects of any action taken on all involved parties.

To initiate the consultation process, JCS uses the strategic approach below:

- Define area of need
- Identify purpose of consultation
    - Outreach – provide information, exchange data, opinions and options
    - Information exchange
    - Recommendation – non-binding options that provide influential/expert advice
    - Agreement – reach a practical and feasible arrangement
    - Stakeholder action – empower stakeholders to act
- Based on purpose of consultation identify appropriate consultation model
    - Expert – evaluation of problem and technical assistance in identifying solution
    - Process –how to solve problem and system's role in problem
    - Medical – interactive decision making focusing on primary intervention
    - Emergent – evolving process for discovery and shaping
- Identify and contact possible state, public and private agencies available and interested in consultation
- Utilize consultation to
    - Identify and clarify problem/issue
    - Recognize factors that influence change process
    - Review technical and structural factors connected to change
    - Collect data
    - Formulate, organize and present data
    - Identify interventions
    - Implement, monitor, assess and modify policies, procedures and/or services

The described consultation approach is inclusive of assessment, program formulation and development of recommendations. It ensures that a process of dialogue and measurement occurs that leads to decisions about comprehensive system improvement for JCS.

JCS has utilized all four models of consultation. JCS collaborated with national experts in the juvenile justice field:

- Dr. Edward Latessa, director and professor at the University of Cincinnati School of Criminal Justice;
- Dr. Robert Macy, founder and president of the International Trauma Center in Boston;
- Dr. Mark Lipsey, Research Professor at Vanderbilt Peabody College; and

- Diana Wavra, Orbis, consultant and trainer for evidence-based services in juvenile justice to identify evidence-based services and programs best suited to the identified needs of Iowa's youth and families.

JCS also established consultative relationships with national and local higher learning institutes, e.g. the University of Cincinnati, Georgetown University, the University of Iowa and Iowa State University for the purpose of program evaluation and implementation of evidence-based practices. JCS sought consultation with nationally recognized agencies for system improvement guidance, which includes state and federal agencies, such as:

- the Iowa Department of Health and Human Services (HHS),
- the National Center for State Courts (NCSC),
- the Council for State Governments (CSG),
- the Office of Juvenile Justice and Delinquency Prevention (OJJPD),
- the Center for Juvenile Justice Reform,
- the Iowa Criminal and Juvenile Justice Planning (CJJP),
- the Iowa Department of Education (DoE),
- the Iowa Department of Labor and
- the Iowa Vocational Rehabilitation Services.

Individual districts also consult locally. These local collaborative partnerships include advisory groups, oversight committees, work groups and service provider meetings. The purpose of this local consultation is to assess goals, objectives, data and progress by establishing working relationships with individuals and agencies in the private sector. This learning collaborative approach allows JCS to adopt and adapt best practices across diverse settings and create changes in the agency that promote effective interventions and services. Organizations can learn from each other and experts in specific areas and collaborate on where and how to improve practice. Members of these consultation teams, which include attorneys, judges, faith-based organizations, school representatives, Native American tribe members, service providers and law enforcement, often assist JCS in closing the gap between what it knows and what it does.

Service Coordination: Under Title IV-B, subpart I and II, states may claim certain allowable expenses for youth identified as an eligible candidate for foster care. The purpose of Title IV-B, the Stephanie Tubbs Jones Child Welfare Service Program, is to promote state flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based organizations. Allowable expenses under Title IV-B, subpart I, are JCO case management services and contracted services, such as crisis intervention. The goal of Title IV-B, subpart II, is to promote safe and stable families through developing, expanding, and operating coordinated programs of community-based services for family preservation. Eligible expenses for Title IV-B, subpart II, include specific expenses related to family

preservation, family reunification, community-based family support and administrative costs (maximum of 10% of total costs).

JCS will work collaboratively with HHS to develop a Memorandum of Understanding (MOU) detailing the responsibilities of JCS and HHS. This memorandum will outline the purpose of the MOU, each agency's role and responsibilities, financial and data sharing arrangements, reporting requirements, and time period.

SECTION III: CHILD WELFARE WORKFORCE

Support

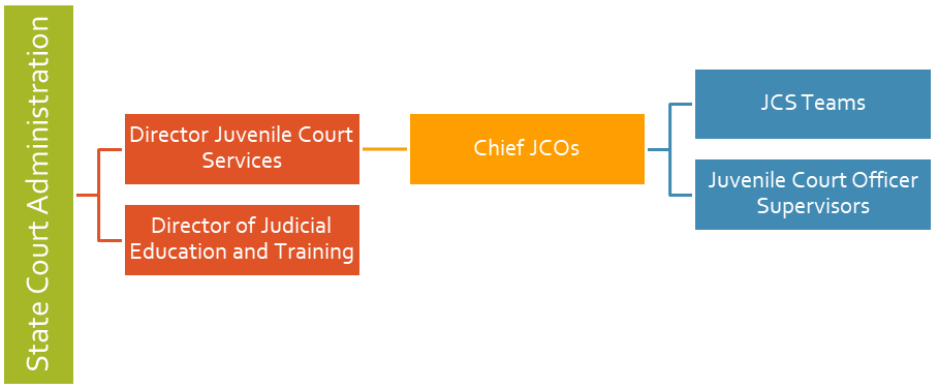
The state must describe the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including:

- *ensuring that staff is qualified to provide services that are consistent with the promising, supported, or well-supported practice models selected; and*
- *developing appropriate prevention plans and conducting risk assessments for children receiving prevention services.*

A. Assurance of Staff Qualifications:

Juvenile Court Services (JCS) Staff: Iowa's JCS structure provides assurance of staff qualifications, as well as support for JCS employees.

Figure B5. Juvenile Court Services (Structure)



JCOs play a critical role in the justice process and have a unique opportunity to intervene in a youth's life. Because of this, it is imperative that JCOs are properly trained and qualified.[75]

[75] Harvell, S. et al (2018). *Building Research and Practice in Juvenile Probation: Rethinking Strategies to Promote Long-term Change.* Urban Institute.

To increase assurance of staff qualifications, JCS has an intensive training process that requires completion of training requirements set by the Iowa Supreme Court. This includes 100 hours of mandated orientation the first year of employment and fifteen hours of mandated yearly continuing education units.[76]

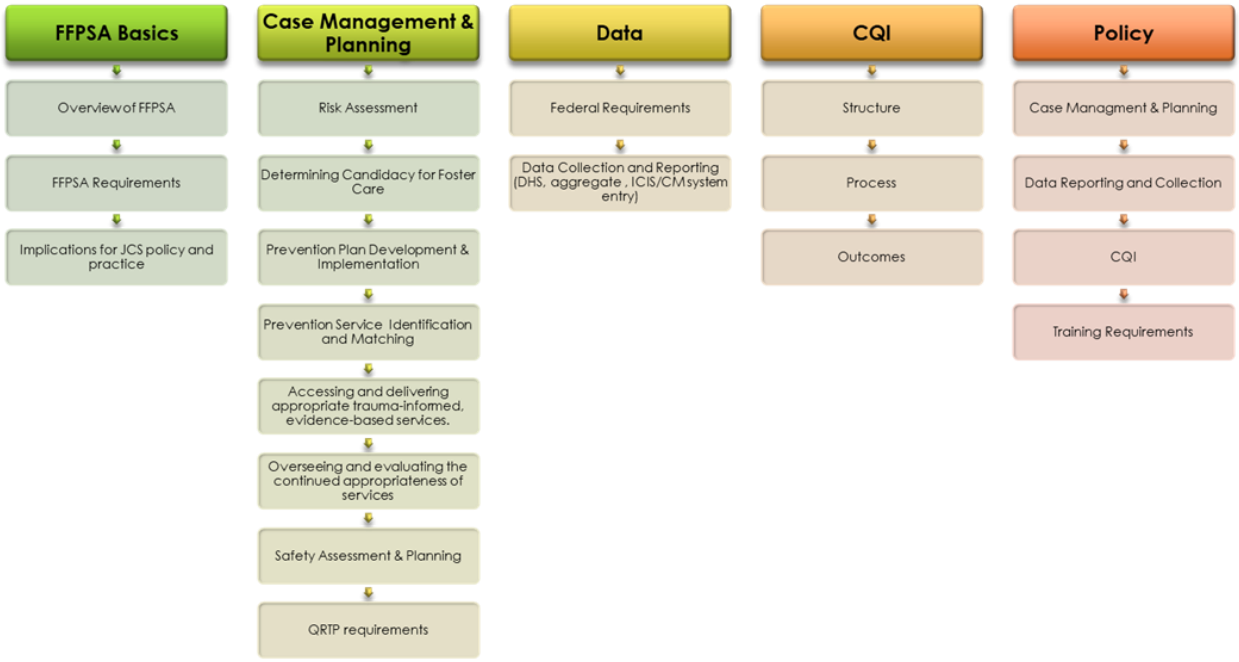
Because JCS recognizes the importance of highly qualified staff, it also provides additional training opportunities through seminars, professional conferences and in-house trainings. Recent training topics have included youth development, communication skills (Motivational Interviewing), assessment, safety planning, case management and supervision, ethics, resources and time management, substance abuse, human trafficking, trauma, community supervision (EPICS), services and programming and family engagement. In addition, JCS collaborates with a variety of local agencies to provide training on specific topics, such as trauma, opioid addiction, and vaping. Individual training opportunities are also available through the Iowa Judicial Branch online learning management system "i-learn."

JCS also employs annual performance reviews, based on competency, self-assessment, feedback and specifically identified criteria to ensure a highly qualified JCS staff.

JCS recognizes that there is a need to provide additional staff training to prepare JCS staff to implement Family First. In anticipation of this, JCS developed a training plan for staff to ensure they are qualified to implement properly all elements of Family First. Figure B5 provides an outline of the training plan elements (for detailed information, see Attachments B3 and B4).

[76] Reddington, F. and Kreisel, B. (2000). *Training Juvenile Probation Officers: National Trends and Patterns.* Federal Probation 64(2).

Figure B6: Family First Training Plan for JCS



Service Provider Staff: Because JCS is committed to quality programming to youth and families, JCS monitors all service provider contracts for quality assurance and compliance. To ensure further that service provider staff are qualified to provide services/programs that are consistent with the promising, supported, or well-supported practice models selected, JCS will implement the following procedures:

- Service contracts will have a framework for accountability included in the contract language. This framework will include identification of service delivery outcomes (performance domains, indicators, and measures), defined responsibilities in the areas of monitoring and reporting outcomes, data collection, program evaluation and fidelity, and provider qualification and training.
- Service providers will submit quarterly compliance reports to ensure they are meeting the accountability standards outlined in the contract. These reports will include written verification regarding staff, who deliver the services, professional training and licensing, as required by the specific service.
- Contracts reviews at the district level will occur annually for compliance of these requirements.
- A district level Contract Administrator (CA) will conduct independent contract audits. The CA will be responsible for ensuring providers meet contract expectations and submit monthly outcome reports.

Quality assurance is not a method for assuring that something was done but rather a process of assuring that something was done well. To that end, JCS will use the

Continue Quality Improvement (CQI) process for service planning, implementing, assessing, and adjusting. As part of this process, JCS will elicit youth and family feedback, engage in quarterly meetings with providers, assist with providing booster trainings (when financially feasible), peer to peer consultation and individual coaching.[77]

B. Prevention Plan Development: JCS utilized information from research, ACF technical bulletins, other state agencies and the Iowa Department of Health and Human Services (HHS) to identify the key components and requirements of the prevention plan. An established workgroup met to develop the policies and procedures related to prevention plan development and implementation.

Because of the workgroup's efforts, JCS developed a child's Title IV-E Prevention Plan (Attachment B5). The JCO completes this prevention plan, a separate document from a child's case plan, following the JCO's completion of the Candidate for Foster Care Screening Tool. The prevention plan identifies the specific family and child strengths and needs and the child's criminogenic risk factors. The prevention plan requires JCOs to enter a prevention strategy, treatment objectives and appropriate service(s). It also instructs JCOs to enter the recipient(s) of the service(s) and dates of service(s), which includes initial start date and completion dates.

JCS requires a JCO to develop the prevention plan with input from the family and child. The JCO's supervisor will review and approve the prevention plan prior to implementation. The JCO will review prevention plans at six- and twelve-month intervals, or when a substantial change in family circumstance occurs.

Training and support for JCS staff, as it relates to the development of the Child Prevention Case Plan: Training for JCS staff, as it relates to the Child Prevention Case Plan (CPCP), was a multi-step process that involved the creation of specific FFPSA workgroups and the development of several new policies and a training plan (see Attachment B3). JCOs are also required to complete training on the Iowa Delinquency Assessment (IDA), which is the JCS risk assessment tool, prior to participating in any of the FFPSA trainings.

All FFPSA related trainings went through a review and feedback process by HHS, the FFPSA training workgroup, Director of Juvenile Court Services (DCJS), Chief Juvenile Court Officers (CJCO), and the JCO IV supervisors prior to publication.

The training process began with introducing JCS staff to FFPSA through a web-based iSpring training that provided an overview of FFPSA. This 60-minute training provided JCS staff with a context for future learning related to FFPSA. JCS staff

[77]Pennsylvania Juvenile Justice System (2019). *Continuous Quality Improvement (CQI) Sustainability Planning Guide.* Juvenile Justice System Enhancement Strategy.

were required to pass successfully a short exam prior to advancing to the next FFPSA training.

Following the FFPSA introductory training, JCS staff were required to complete the Title IV-E Candidate for Foster Care Determination training. This web-based training introduced JCS staff to the structured process for determining if a youth is a Title IV-E eligible candidate. Using the iSpring interactive platform, the training provided JCS staff with instruction in the definition of candidacy and the methods of determining and documenting candidacy, in particular, the use of the JCS Candidate for Foster Care Screening Tool (CFST)(see Attachment B2).

Upon successful completion of the Title IV-E Candidate for Foster Care Determination Training, JCS staff received training on the process for developing the Child Prevention Case Plan (CPCP). In preparation for the CPCP training, JCS used FFPSA guidance to develop a CPCP policy and a FFPSA specific CPCP form. Using this policy and form, JCS created a web-based training for JCS staff.

The learning objectives for the CPCP training are on the JCS FFPSA training plan (see Attachment B3). The training, which is an interactive iSpring training, consists of two modules. Module one introduces JCS staff to the CPCP and summarizes its purpose, requirements, and key components. Module two utilizes an interactive case scenario to guide JCS staff through actually completing each section of the CPCP sections (see Attachment B5) from start to finish in real-time. JCS staff are required to pass a short exam at the conclusion of the training to verify successful completion of the training.

Prior to the CPCP training, JCS staff received training support materials to complement CPCP instruction. These materials included the CPCP policy document (see Attachment B6), a hard copy of the CPCP form (see Attachment B5), a PDF training handout with accompanying notes, and a CPCP desk reference. In addition to these resources, JCS assigned a Point of Contact (POC) to each district's office. This POC is responsible for providing coaching and aggregating and fielding questions related to the CPCP training. Questions from all districts were compiled and put into a Q & A document that will be updated regularly and stored on the Judicial Branch's (JB) SharePoint file; so JCS staff has access when needed. In addition, the CPCP training is accessible on the JB SharePoint.

All future JCS staff will be required to complete the CPCP training, as part of their orientation. In addition, JCS will offer a refresher training for those who require it or at any time changes need to be made to the process. JCS staff will also be required to complete a safety training upon completion of the CPCP training. This safety training introduces JCS staff to the components of formal safety assessment and planning and provides instruction and guidance for JCS staff in the practical skills and knowledge required to complete safety assessments and plans for youth and their families.

Training

The state must describe how it will provide training and support for caseworkers in assessing what children and their families need; connecting to the families served; knowing how to access and deliver the needed trauma-informed and evidence-based services; and overseeing and evaluating the continuing appropriateness of the services.

To ensure families receive quality treatment and supervision, JCS is committed to providing the training needed to retain a highly skilled and competent workforce. JCS recognizes the passage of the Family First Prevention Services Act (Family First) will create changes in the Juvenile Justice System. These changes necessitate the development and implementation of a workforce-training plan to ensure all JCS staff have the knowledge and skills required to incorporate successfully Family First policies into daily practices.

To assist in the training process, the Director of Juvenile Court services and Chief Juvenile Court Officers (CJCOs) created Family First implementation teams. These teams were tasked with assisting with the development and implementation of training related to Family First in six areas, Family First basics, case planning and management, data, CQI, youth and family needs, and policy. JCS will implement training in these areas with a phased approach (see Attachment B4). Phase one of the training will focus on providing JCS staff a context for learning through an overview of Family First and its requirements. This phase of training will cover case planning and management related to Family First requirements, inclusive of risk/needs assessment, candidacy determination screening tool, prevention plan development and implementation, identification, matching, monitoring and evaluation of services and family needs/safety assessment planning.

Phase two of training will introduce JCS staff to the data required for Family First. This will include data collection, reporting, entry and RMS. Phase three of training will focus on youth and family needs and address topics, such as trauma informed care, child development, and family engagement. Phase four of training will center on training specific JCS staff in the Continuous Quality Improvement (CQI) process. The final phase of training, phase five, will train staff on policy changes related to Family First. This phase will serve to bring all the components related to Family First together in a comprehensive manner.

JCS will utilize a blended learning approach throughout the trainings. This approach will include direct and on-line instruction, discussion, demonstration, and collaborative learning.

JCS will also continue to provide ongoing training opportunities for staff in family engagement, accessing and delivering trauma informed services and evidence-based practices. The Director of Juvenile Court Services and CJCOS will work collaboratively with the Judicial Branch Director of Education and Training in identifying future statewide and individual district training needs. JCS will elicit additional input on training

needs on the local level through feedback from JCS staff, youths and families and service providers.

Training and Support for JCS staff, as it relates to overseeing and evaluating the continuing appropriateness of services: Training and support for JCS in the area of overseeing and evaluating the continuing appropriateness of services developed in the same manner as the CPCP training described above.

JCS developed a policy outlining the procedures for identifying, accessing, monitoring, and assessing prevention services (see Attachment B6). JCS utilized this policy, along with guidance from relevant research, to develop a web-based iSpring training that introduced JCS staff to what an FFPSA prevention service is and provided JCS staff with instruction and guidance on the process and tools for overseeing and evaluating these services. Instruction included program monitoring and evaluation using the use of the Iowa Delinquency Risk Assessment (IDA); screening tools; parent, child, and service provider input; collateral contact information; and quality, frequency, intensity, and availability of service. In addition, the training, which contained an interactive case-scenario, provided JCS staff with timeframes for evaluation and courses of action for services deemed ineffective.

Support for JCS staff included training support materials to complement instruction. These materials include the policy document (see Attachment B6) and a PDF training handout with accompanying notes. In addition to these resources, JCS assigned a Point of Contact (POC) to each district's office. This POC is responsible for providing coaching and aggregating and fielding questions related to the training. Questions from all districts were compiled and put into a Q & A document that will be updated regularly and stored on the Judicial Branch's (JB) SharePoint file for JCS staff to access as needed. In addition, the training was also accessible on the JB SharePoint.

To complement this training, JCS staff will also be required to complete a training on Continuous Quality Improvement (CQI). This training will introduce them to program evaluation and familiarize them with the process and outcome measures associated with specific prevention services.

All future JCS staff will be required to complete these trainings as part of their orientation. In addition, a refresher training will be offered for those who require it or at any time changes occur to the process.

Prevention Caseloads

The state must describe how the caseload size and type for prevention caseworkers will be determined, managed, and overseen.

Currently JCS does not have an established client to JCO ratio. Because JCOs handle a variety of case types that fall on a continuum of court involvement, supervision and service needs, typical staffing formulas based solely on case counts are not able to

differentiate the amount of time needed to manage cases. Due to JCOs' need to provide varying amounts of supervision to be effective and efficient, their practice lacks the consistency needed to establish workload standards for JCOs. In addition, caseloads vary significantly between urban and rural areas, with rural areas often having larger coverage areas and higher travel time requirements.[78]

Iowa currently has 193 JCO positions. These positions are responsible for a continuum of cases that range from intake to formal probation and adult waivers. When considering the youth on informal probation, formal probation, consent decrees and adult waivers, JCOs managed 5,156 cases in 2017. This produced a caseload ratio of 26.7 youth to 1 JCO.[79] This is lower than the President's Commission on Law Enforcement and Administration of Justice recommended caseload of 35 clients per JCO[80] and the national average caseload of 40 to 1.[81]

JCS will utilize the Iowa Court Information System to monitor and evaluate time spent on Title IV-E activities to determine if prevention caseloads will need adjusting in the future.

ATTACHMENTS

- Attachment B1: Iowa Delinquency Assessment (IDA)
- Attachment B2: IV-E Candidacy for Foster Care Screening Tool (CFST)
- Attachment B3: JCS Training Plan
- Attachment B4: JCS Training Summary
- Attachment B5: Child Prevention Case Plan (CPCP)
- Attachment B6: CPCP Policy Document

[78] Moran, B. (2013). *Juvenile Court Officers Perceptions of Innovation Adoption.* University of Nebraska
[79] CJJP, 2017. *State of Iowa Juvenile Delinquency Annual Statistical Report*. https://humanrights.iowa.gov/sites/default/files/media/2017%20State%20Annual%20Report%20for%20JCS.pdf
[80] Bilchik, S. (1999). *Workload Measurement for Juvenile Justice System Personnel: Practices and Needs*. US Department of Justice
[81] Torbet McFall, P. (1996). *Juvenile Probation: The Workhorse of the Juvenile Justice System*. US Department of Justice.

PART C: PLAN ASSURANCES AND ATTACHMENTS

ASSURANCE ON PREVENTION PROGRAM REPORTING

The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).

The Director of Juvenile Court Services and the Chief Juvenile Court Officers (CJCOs) will work collaboratively with HHS to identify all required reporting elements and timeframes for the submission of data to HHS. JCS will then utilize the Iowa Court Information System (ICIS) as the mechanism for collecting data. JCS already began the work to identify data collection points in the system and to build the Candidate for Foster Care Screening Tool and Prevention Plan into the case management system. JCS will work with Criminal and Juvenile Justice Planning (CJJP) to aggregate and analyze data and develop a mechanism for reporting data in timely fashion to HHS.

ASSURANCE OF TRAUMA-INFORMED SERVICE-DELIVERY

An assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program)

Attachment III

ATTACHMENTS

- Attachment B: Plan Submission Certification
- Attachment I: State title IV-E prevention program reporting assurance
- Attachment II:
  - (a) State request for waiver of evaluation requirement for a well-supported practice - Functional Family Therapy (FFT)
  - (b) State request for waiver of evaluation requirement for a well-supported practice - Multisystemic Therapy (MST)
  - (c) State request for waiver of evaluation requirement for a well-supported practice – Motivational Interviewing (MI)
- Attachment III: State assurance of trauma-informed service delivery
- Attachment IV: State annual maintenance of effort (MOE) report

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Iowa Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Healthy Families America (HFA) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

Janee Harvey Digitally signed by Janee Harvey Date: 2026.02.25 11:44:31 -06'00'

(Date) (Signature and Title)

RYAN P. HANLON -S Digitally signed by RYAN P. HANLON -S Date: 2026.08.27 09:24:40 -04'00'

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Iowa Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parents As Teachers (PAT) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

Janee Harvey Digitally signed by Janee Harvey Date: 2026.02.25 11:43:40 -06'00'

(Date) (Signature and Title)

RYAN P. HANLON -S Digitally signed by RYAN P. HANLON -S Date: 2026.08.27 09:23:17 -04'00'

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The Iowa Department of Health and Human Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

Janee Harvey Digitally signed by Janee Harvey
Date: 2026.02.25 11:45:21 -06'00'

(Date) (Signature and Title)

RYAN P. HANLON -S Digitally signed by RYAN P. HANLON -S
Date: 2026.08.27 09:22:23 -04'00'

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)