



## DEPARTMENT OF HEALTH & HUMAN SERVICES

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**ADMINISTRATION FOR CHILDREN AND FAMILIES**  
**Administration on Children, Youth and Families**  
330 C Street, S.W.  
Washington, D.C. 20201

September 24, 2019

Gerd Clabaugh  
Interim Director  
Iowa Department of Human Services  
1305 East Walnut Street  
Des Moines, Iowa 50319

Dear Director Clabaugh:

Thank you for submitting Iowa's Child and Family Services Plan (CFSP) Final Report for fiscal years (FYs) 2015-2019, the CFSP for FYs 2020-2024, and the CFS-101s to address the following programs:

- Title IV-B, subpart 1 (Stephanie Tubbs Jones Child Welfare Services) of the Social Security Act (the Act);
- Title IV-B, subpart 2 (Promoting Safe and Stable Families Program and Monthly Caseworker Visit Grant) of the Act;
- Child Abuse Prevention and Treatment Act (CAPTA) State Grant;
- Chafee Foster Care Program for Successful Transition to Adulthood (Chafee Program); and
- Education and Training Vouchers (ETV) Program.

These programs provide important funding to help child welfare agencies enact the state's vision of safety, permanency, and well-being for children, youth and their families. The CFSP planning process facilitates development, continued assessment, and implementation of a comprehensive continuum of services for children and families. It provides an opportunity to integrate more fully each state's strategic planning around the use of federal funds with its work relating to the primary prevention of maltreatment, the Child and Family Services Reviews Program Improvement Plan and continuous program improvement activities.

### **Approval**

The Children's Bureau (CB) has reviewed your CFSP Final Report for FYs 2015- 2019 (including the annual report on the use of CAPTA funds) and the CFSP for FYs 2020- 2024 and finds them to be in compliance with applicable federal statutory and regulatory requirements. Therefore, we approve FY 2020 funding under the title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; Chafee and ETV programs. For the Chafee program, your state has elected to serve eligible youth up to age 23.

A counter-signed copy of the CFS-101 forms is enclosed for your records. The Children's Bureau may ask for a revised CFS-101, Part I, should the final allotment for any of the approved programs be more than that requested in the Annual Budget Request.

The Administration for Children and Families' Office of Grants Management (OGM) will issue a grant notification award letter with pertinent grant information. Please note that OGM requires grantees to submit additional financial reports, using the form SF-425, at the close of the expenditure period according to the terms and conditions of the award.

**Training Plan**

The Training Plan for title IV-B and IV-E programs is also approved. Approval of the Training Plan does not release the state from ensuring that training costs included in the Training Plan and charged to title IV-E of the Act comply with the requirements at 45 CFR 1356.60(b) and (c) and 45 CFR 235.63 through 235.66(a), including properly allocating costs to all benefiting programs in accordance with the state's approved cost allocation plan.

**Additional Information Required**

Pursuant to Section 424(f) of the Act, states are required to collect and report on caseworker visits with children in foster care. The FY 2019 caseworker visit data must be submitted to the Regional Office by December 16, 2019. States that wish to use a sampling methodology to obtain the required data must obtain prior approval from the Regional Office.

The CB looks forward to working with you and your staff. Should you have any questions or concerns, please contact Deborah Smith, Child Welfare Regional Program Manager in Region 7, at (816) 426-2262 or by e-mail at [deborah.smith@acf.hhs.gov](mailto:deborah.smith@acf.hhs.gov). You also may contact Amy Hance, Children and Families Program Specialist, at (816) 426-2230 or by e-mail at [amy.hance@acf.hhs.gov](mailto:amy.hance@acf.hhs.gov).

Sincerely,



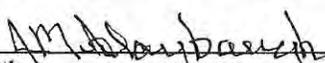
Jerry Milner  
Associate Commissioner  
Children's Bureau

Enclosure(s)

cc: Gail Collins, Director; CB, Division of Program Implementation; Washington, DC  
Deborah Smith, Child Welfare Regional Program Manager; CB, Region 7; Kansas City, MO  
Amy Hance, Children and Families Program Specialist; CB, Region 7; Kansas City, MO  
Jana Rhoads, Division Administrator of Adult, Children, and Family Services; IA DHS;  
Des Moines, IA

**CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CHAFEE, and ETV and Reallotment for Current Federal Fiscal Year Funding**

For Federal Fiscal Year 2020: October 1, 2019 through September 30, 2020

<b>1. Name of State or Indian Tribal Organization and Department/Division:</b>		<b>3. EIN:</b>	42-6004571	
Iowa		<b>4. DUNS:</b>	137348624	
<b>2. Address:</b> (insert mailing address for grant award notices in the two rows below)		<b>5. Submission Type:</b> (select one)		
Hoover State Office Building - 1305 Walnut		<input checked="" type="checkbox"/> NEW		
Des Moines, Iowa 50319-0114		<input type="checkbox"/> REALLOTMENT		
a) <b>Email address</b> for grant award notices: <u>jhavig@dhs.state.ia.us</u>		<input type="checkbox"/> REVISION		
<b>REQUEST FOR FUNDING for FY 2020:</b>				
Hardcode all numbers; no formulas or linked cells.				
<b>6. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:</b>			\$3,050,021	
a) Total administrative costs (not to exceed 10% of the CWS request)		ok	\$150,000	
<b>7. Requested title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds and estimated expenditures:</b>		<b>% of Total</b>	<b></b>	
a) Family Preservation Services		1%	\$37,271	
b) Family Support Services		21%	\$548,250	
c) Family Reunification Services		21%	\$545,271	
d) Adoption Promotion and Support Services		21%	\$545,271	
e) Other Service Related Activities (e.g. planning)		28%	\$731,758	
f) Administrative costs ( <i>APPLICABLE TO STATES ONLY: not to exceed 10% of the PSSF request</i> )		9.3%	\$247,456	
g) Total itemized request for title IV-B Subpart 2 funds: <i>NO ENTRY: Displays the sum of lines 7a-f.</i>		100%	\$2,655,277	
<b>8. Requested Monthly Caseworker Visit (MCV) funds: (For STATES ONLY)</b>			\$165,401	
a) Total administrative costs ( <i>FOR STATES ONLY: not to exceed 10% of MCV request</i> )		ok	\$0	
<b>9. Requested Child Abuse Prevention and Treatment Act (CAPTA) State Grant: (STATES ONLY)</b>			\$881,274	
<b>10. Requested John H. Chafee Foster Care Program for Successful Transition to Adulthood:</b>			\$1,938,522	
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of CFCIP request).		ok	\$0	
<b>11. Requested Education and Training Voucher (ETV) funds:</b>			\$642,953	
<b>REALLOTMENT REQUEST(S) for FY 2019:</b>				
<i>Complete this section for adjustments to current year awarded funding levels.</i>				
<b>12. Identification of Surplus for Reallotment:</b>				
a) Indicate the amount of the State's/Tribe's FY 19 allotment that will not be utilized for the following programs:				
<b>CWS</b>	<b>PSSF</b>	<b>MCV (States only)</b>	<b>Chafee Program</b>	<b>ETV Program</b>
\$0	\$0	\$0	\$0	\$0
<b>13. Request for additional funds in the current fiscal year, should they become available for re-allotment:</b>				
<b>CWS</b>	<b>PSSF</b>	<b>MCV (States only)</b>	<b>Chafee Program</b>	<b>ETV Program</b>
\$0	\$0	\$0	\$0	\$0
<b>14. Certification by State Agency and/or Indian Tribal Organization:</b>				
The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.				
<b>Signature of State/Tribal Agency Official</b>		<b>Signature of Federal Children's Bureau Official</b>		
				
Title CFO		Title		
Date 6/28/19		Date 9/24/2019		

**CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services**

Name of State or Indian Tribal Organization: Iowa

For FY 2020: OCTOBER 1, 2019 TO SEPTEMBER 30, 2020

SERVICES/ACTIVITIES	(A) IV-B Subpart I- CWS	(B) IV-B Subpart II- PSSF	(C) IV-B Subpart II- MCV	(D) CAPTA	(E) CHAFEE	(F) ETV	(G) TITLE IV-E	(H) STATE, LOCAL & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served	(L) Geog. Area To Be Served
1.) PROTECTIVE SERVICES	\$ -			\$ 881,274				\$ 28,071,400	NA	1265/month	reports of abuse/neglect	statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	\$ 746,130	\$ 37,271		\$ -				\$ 10,233,942	NA	1443/month	families children	statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	\$ -	\$ 548,250		\$ -				\$ 62,755,811	NA	27530/month	families children	statewide
4.) FAMILY REUNIFICATION SERVICES	\$ 1,209,308	\$ 545,271		\$ -				\$ 17,199,920	NA	3227/month	families children	statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	\$ -	\$ 545,271						\$ 1,424,487	NA	NA	adoptive families	statewide
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	\$ -	\$ 731,758						\$ 1,275,510	NA	NA	NA	statewide
7.) FOSTER CARE MAINTENANCE:												
(a) FOSTER FAMILY & RELATIVE FOSTER CARE	\$ 724,000						\$ 6,926,674	\$ 26,694,058	1901/month	NA	all eligible children	statewide
(b) GROUP/INST CARE	\$ 220,583						\$ 2,230,590	\$ 102,672,057	2004/month	NA	all eligible children	statewide
8.) ADOPTION SUBSIDY PYMTS.	\$ -						\$ 36,980,132	\$ 38,825,105	9843/month	NA	all eligible children	statewide
9.) GUARDIANSHIP ASSISTANCE PAYMENTS	\$ -						\$ -	\$ -	NA	NA	NA	NA
10.) INDEPENDENT LIVING SERVICES	\$ -				\$ 1,938,522		\$ -	\$ 6,837,720	481/month	NA	eligible youth	statewide
11.) EDUCATION AND TRAINING VOUCHERS	\$ -				\$ -	\$ 642,953	\$ -	\$ 160,738	150/year	NA	eligible youth	statewide
12.) ADMINISTRATIVE COSTS	\$ 150,000	\$ 247,456	\$ -				\$ 3,365,364	\$ 7,189,360				
13.) FOSTER PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ 958,665	\$ 1,366,020				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	\$ -	\$ -		\$ -			\$ 883,100	\$ 1,291,177				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	\$ -						\$ 1,701,374	\$ 4,211,174	NA	1969/month	eligible families	statewide
16.) STAFF & EXTERNAL PARTNERS TRAINING	\$ -	\$ -		\$ -	\$ -	\$ -	\$ 1,587,736	\$ 872,433				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	\$ -	\$ -	\$ 165,401				\$ -	\$ 55,134				
18.) TOTAL	\$ 3,050,021	\$ 2,655,277	\$ 165,401	\$ 881,274	\$ 1,938,522	\$ 642,953	\$ 54,633,635	\$ 311,136,046				

19.) TOTALS FROM PART I

\$3,050,021 \$2,655,277 \$165,401 \$881,274 \$1,938,522 \$642,953

20.) Difference (Part I - Part II)

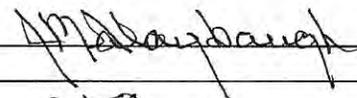
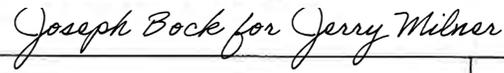
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00

(If there is an amount other than \$0.00 in Row 20, adjust amounts on either Part I or Part II. A red value means Part II exceeds request)

21.) Population data required in columns I - L can be found:

On this form  
 In the APSR/CFSP narrative

**CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence and Education And Training Voucher Reporting on Expenditure Period For Federal Fiscal Year 2017 Grants: October 1, 2016 through September 30, 2018**

<b>1. Name of State or Indian Tribal Organization:</b> Iowa		<b>2. Address:</b> Hoover State Office Building - 1305 Walnut Des Moines, Iowa 50319-0114				<b>3. EIN: 42-6004571</b>
<b>5. Submission Type: (select one)</b> <input checked="" type="checkbox"/> NEW <input type="checkbox"/> REVISION						<b>4. DUNS: 137348624</b>
Description of Funds	(A) Original Planned Spending for FY 17 Grants	(B) Actual Expenditures for FY 17 Grants	(C) Number Individuals served	(D) Number Families served	(E) Population served	(F) Geographic area served
<b>6. Total title IV-B, subpart 1 (CWS) funds:</b>	\$ 2,672,957	\$ 2,664,465	8,082	7,830	eligible children & families	statewide
a) Administrative Costs <i>(not to exceed 10% of CWS allotment)</i>	\$ 150,000	\$ 150,000				
<b>7. Total title IV-B, subpart 2 (PSSF) funds:</b>						
Tribes enter amounts for Estimated and Actuals, or complete 7a-f.	\$ 2,524,443	\$ 2,523,008	53,305	8,454	eligible children & families	statewide
a) Family Preservation Services	\$ 10,000	\$ 12,908				
b) Family Support Services	\$ 731,000	\$ 538,498				
c) Time-Limited Family Reunification Services	\$ 544,306	\$ 611,388				
d) Adoption Promotion and Support Services	\$ 519,129	\$ 530,347				
e) Other Service Related Activities (e.g. planning)	\$ 588,758	\$ 582,411				
f) Administrative Costs <i>(FOR STATES: not to exceed 10% of PSSF allotment)</i>	\$ 131,250	\$ 247,456				
<b>g) Total title IV-B, subpart 2 funds:</b>						
NO ENTRY: This line displays the sum of lines a-f.	\$ 2,524,443	\$ 2,523,008				
<b>8. Total Monthly Caseworker Visit funds: (STATES ONLY)</b>	\$ 158,985	\$ 158,985				
a) Administrative Costs <i>(not to exceed 10% of MCV allotment)</i>	\$ -	\$ -				
<b>9. Total Chafee Foster Care Independence Program (CFCIP) funds: (optional)</b>	\$ 1,798,332	\$ 1,798,332	4,028	-	eligible youth	statewide
a) Indicate the amount of allotment spent on room and board for eligible youth <i>(not to exceed 30% of CFCIP allotment)</i>	\$ 77,000	\$ 36,262	86	-	eligible youth	statewide
<b>10. Total Education and Training Voucher (ETV) funds: (Optional)</b>	\$ 589,271	\$ 603,521	158	-	eligible youth	statewide
<b>11. Certification by State Agency or Indian Tribal Organization:</b> The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan, which was jointly developed with, and approved by, the Children's Bureau.						
<i>Signature of State/Tribal Agency Official</i>			<i>Signature of Federal Children's Bureau Official</i>			
						
<i>Title</i>	<i>Date</i>	<i>Title</i>			<i>Date</i>	
CFO	6/28/19				9/24/2019	



Department of  
**HUMAN SERVICES**

***FFY 2020-2024  
CHILD AND FAMILY SERVICES PLAN***

**June 2019**

# FFY 2020-2024 Child and Family Services Plan

State of Iowa  
Iowa Department of Human Services  
Division of Adult, Children and Family Services

Contact Person:

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Program Manager  
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Division of Adult, Children and Family Services  
Hoover State Office Building – 5<sup>th</sup> Floor  
1305 E. Walnut Street  
Des Moines, IA 50319  
**Phone:** (515) 281-8977  
**FAX:** (515) 281-6248  
**E-Mail:** [kregula@dhs.state.ia.us](mailto:kregula@dhs.state.ia.us)

Once approved by the federal Children’s Bureau, the Iowa Department of Human Services will post the approved FFY 2020-2024 Child and Family Services Plan, with attachments to the Iowa Department of Human Services’ website, <http://dhs.iowa.gov/reports/child-and-family-services-review>.

## Table of Contents

Section I: Collaboration and Vision .....	3
Section II: Performance Assessment in Improving Outcomes.....	9
Child and Family Outcomes.....	10
Systemic Factors .....	15
Section III: Plan for Enacting Iowa’s Vision .....	59
Section IV: Services .....	91
Child and Family Services Continuum .....	91
Prevention .....	92
Intervention .....	104
Treatment and Foster Care Services .....	112
Service Coordination .....	141
Service Description.....	156
Stephanie Tubbs Jones Child Welfare Services Program .....	156
Promoting Safe and Stable Families (PSSF)(title IV-B, subpart 2) .....	161
Monthly Caseworker Visit Formula Grant and Standards for Caseworker Visits .....	163
Additional Services Information .....	164
Section V: Consultation and Coordination between States and Tribes .....	165
Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) .....	172
Education and Training Vouchers (ETV) Program.....	197
Consultation with Tribes .....	199
Section VII: Targeted Plans.....	201
Section VIII: Financial Information.....	201
Payment Limitations: Title IV-B, Subpart 1 .....	201
Payment Limitations: Title IV-B, Subpart 2 .....	202

## Section I: Collaboration and Vision

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

The Iowa Department of Human Services (DHS) is the state agency that administers the Child Abuse Protection and Treatment Act (CAPTA), the Children's Justice Act (CJA), the Community-Based Child Abuse Protection program (CBCAP), titles IV-A, IV-B, IV-D, IV-E, and XX of the Social Security Act, the John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) and the Education and Training Vouchers (ETV) program.

The Governor of Iowa appoints the DHS' Director to lead the agency. The Deputy Director oversees the day-to-day operations of the DHS. The DHS comprises six divisions and a discreet bureau with half of the administrators reporting directly to the Director and the other half reporting directly to the Deputy Director.

- Reports to the Director:
  - The Division of Adult, Children and Family Services is responsible for policy and state/federal compliance for Food Assistance (FA), Family Investment Program (FIP)(Iowa's Temporary Assistance for Needy Families), PROMISE JOBS, Child Care Assistance (CCA), Child Welfare, and Community Family Services (CFS) programs, and monitors and oversees related contracts. The division's Bureau of Child Welfare and Community Services is the organizational unit responsible for the Child and Family Services Plan.
  - The Division of Field Operations comprises:
    - Five service areas with 42 full-time county offices that provide the following services:
      - Child and dependent adult abuse protective services
      - Child welfare case management services
      - Eligibility services for Iowa's income maintenance (IM) programs, such as Medicaid, Hawk-I, FA, FIP, PROMISE JOBS, CCA, and CFS
      - Refugee services
    - Centralized service area comprises nine specialized units: child and dependent adult abuse hotline, the child abuse registry, child care assistance, child care licensure unit, facility eligibility unit, IM customer service center, IV-E claims unit, IM related claims recovery, and interstate compact.
    - Child Support Recovery Unit (CSRU) that provides services to Iowans and employers in the establishment and collection of child support payments.
    - Central office that provides help desk and technical support for the five service areas.
  - The Division of Fiscal Management budgets, monitors, and accounts for the DHS' budget, processes checks, provides service contract support, coordinates

all state and federal financial and program audits, manages the DHS' federal cost allocation plan, submits required federal reports, and provides agency human resources and COOP/COG oversight.

- Reports to the Deputy Director:
  - The Division of Mental Health and Disability Services (MHDS) is responsible for Iowa's MHDS Regional Services implementation, oversight of the 6 DHS facilities, accreditation of more than 220 community providers annually, administrative oversight of DHS Targeted Case Management, and monitors and oversees related contracts.
  - The Division of Information Technology supports management information systems and computer networks statewide, provides technical assistance to help desk inquiries, and ensures DHS systems and data security complies with all state and federal law requirements.
  - Iowa Medicaid Enterprise (IME) administers Iowa's Medicaid, Iowa Health and Wellness Plan, and Children's Health Insurance Plan (CHIP) - Health and Wellness Kids in Iowa (Hawk-I), and monitors and oversees related contracts.
  - The Bureau of Policy Coordination manages the appeals and exceptions to policy process in collaboration with the Attorney General's office and the Department of Inspections and Appeals. The Bureau also manages the development and implementation of administrative rules for the Department, written translations, and provides public policy information as requested.

Please see Attachment 1A: Table of Organization and Attachment 1B: Field Operations Map for more information.

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

Iowa's child welfare vision statement: *"Family Connections are Always Strengthened and Preserved."*

### Principles and Commitments

1. *Family Voice and Choice.* Family and youth/child perspectives are intentionally elicited and prioritized during all phases of involvement. Nothing about the family without the family.
  - A. Case planning and services must be family-centered.
  - B. Children's concerns and identification of caring adults will be specifically solicited and included in case planning.
  - C. Children in foster care deserve normalcy and access to activities and experiences similar to their peers.

2. *Team Based.* The team consists of individuals agreed upon by the family and are committed to them. The team is family inclusive, but not family exclusive.
  - A. Conferences will be held at multiple key junctions: child safety (pre-removal), case planning, and risk of changes in placement.
  - B. Intentional in ensuring that the team members understand their role in advocating for the preservation and support of family connections.
3. *Natural Supports.* The team actively seeks full participation of team members drawn from family members' networks of natural support. This is particularly true when a child is being placed out of home. This must occur from the first contact with a family and ongoing.
  - A. Parents and natural support caregivers receive support equivalent to, or greater than, what foster parents receive.
  - B. Placement is with a known, caring adult.
4. *Collaboration.* Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating the family plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
  - A. In-person meetings are necessary to positive engagement, cohesive case planning, and building trust.
  - B. Relationship-based work enhances engagement, trust, services, and outcomes. Consistency of workers is critical to effective work. Fewer workers involved with a family are better.
5. *Community-Based.* The team implements service and support strategies that take place in an accessible and in the least restrictive settings as possible; and that safely promote child and family integration into home and community life.
  - A. Use opportunity of involvement with families to enhance well-being and prevent maltreatment, such as addressing safe sleep and connecting families to Early Access.
  - B. Services, such as domestic violence, public assistance, mental health and substance abuse, are strategically embedded where family engagement and planning takes place.
  - C. Connections to community of origin are important.
6. *Culturally Responsive.* The team demonstrates respect for, and builds on the values, preferences, beliefs, culture and identity of, the child/youth and family and their community.

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

*Describe how the state agency has engaged and will continue to engage in substantial, ongoing and meaningful consultation and collaboration with families, children, youth and other partners in the development and implementation of the 2020-2024 CFSP and, if applicable, any state CFSR PIP or title IV-E PIP.*

*Specify how families, children, youth; tribes, courts and other partners were involved in key aspects of the 2020-2024 CFSP development such as: 1) the review of current performance data, 2) assessment of agency strengths and areas needing improvement, and 3) the selection of goals and objectives for improvement in the 2020-2024 CFSP five year strategic plan.*

### **Vision Development and Discussions**

DHS staff engaged stakeholders in the development of the Family First, Blueprint for Iowa's Future Child Welfare System. After finalization of the Blueprint, DHS staff discussed the Blueprint with a multitude of stakeholders, including Achieving Maximum Potential (AMP)(Iowa's foster care youth councils), Parent Partners, contracted service providers, courts, tribes, and posted the Blueprint on the DHS website at [https://dhs.iowa.gov/sites/default/files/Comm534%20FF%20Blueprint%20for%20Iowa's%20Future%20Child%20Welfare%20System%20\(Abbreviated%20Version\).pdf?062120191912](https://dhs.iowa.gov/sites/default/files/Comm534%20FF%20Blueprint%20for%20Iowa's%20Future%20Child%20Welfare%20System%20(Abbreviated%20Version).pdf?062120191912).

### **Child and Family Services (CFSR) Review**

- Parents, children, and foster parents participate in the case review process through case related interviews when reviewers evaluate selected cases; reflected in the case review data provided in Section II: Performance Assessment for Improving Outcomes and Section III: Plan for Enacting Iowa's Vision. Some reviewer staff also engages service providers in these case related interviews.
- Stakeholders participated in Iowa's 2018 CFSR stakeholder interviews (for a total of 30 groups interviewed) held in June, July and August 2018 to provide information on their experiences with Iowa's child welfare system.
- Iowa Children's Justice (ICJ)(court improvement project (CIP)) staff, DHS staff, and judges participated in a CIP/DHS PIP Development meeting in December 2018.
- Stakeholders, approximately 100 of them, participated in the February 2019 Iowa 2018 CFSR Final Results and PIP Kickoff meeting as part of conducting root cause analysis of performance.
- Stakeholders, approximately 30 of them, participated in March 2019 PIP strategy development meeting.

*Section II: Performance Assessment in Improving Outcomes and Section III: Plan for Enacting Iowa's Vision reflects data and information gathered from Iowa's 2018 CFSR and PIP development processes.*

### **Iowa Children's Justice (ICJ)(CIP)**

- DHS staff also remains active in the Children's Justice State Council, as well as Children's Justice (CJ) Advisory Committee, and other taskforces and workgroups. The CJ State Council and CJ 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 year, 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, and developed a report, with recommendations, which will be provided to the Iowa Supreme Court. Additionally, Iowa Children's Justice staff serves on various DHS committees.

- CIP staff, DHS staff, and Judge Tabor participated in a CFSP development meeting in Washington, D.C. hosted by the federal Children's Bureau, which resulted in a quality legal representation strategy in this CFSP with a CIP Strategic Plan component.

**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 DHS 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 its three year strategic plan, the primary focus of the CWPC shifted to support DHS with implementation of the Family First Prevention Services Act (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.

Information on the CWPC is available at <https://dhs.iowa.gov/about/advisory-groups/childwelfare/partner-committee>

### **Family First Implementation**

The DHS developed five workgroups, comprising internal and external stakeholders, including services providers, to implement Family First. The five workgroups include:

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

For additional information on child welfare stakeholder engagement, please see *Section II: Performance Assessment in Improving Outcomes*, *Section III: Plan for Enacting Iowa's Vision*, *Service Coordination in Section IV: Services*, *Section V: Consultation and Coordination between States and Tribes*, and *Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)*.

*The description must also specify how families, children, and youth; tribes, courts and other partners; will be involved throughout the five year period in the implementation of the goals and objectives and in the monitoring and reporting of progress (45 CFR 1357.15(l)(4)).*

The DHS will utilize existing collaborative venues, mentioned above and throughout this CFSP, to engage stakeholders in the implementation, monitoring, and reporting of CFSP progress. Additionally, as part of Iowa's QA feedback loop process, Iowa will hold an annual Quality Improvement focus group where stakeholders from across the state will work together to identify strengths, opportunities for improvement, and make recommendations for course corrections when needed. The DHS also may utilize focus groups, electronic surveys, and other means to gather qualitative information for continued evaluation of CFSP progress.

## **Section II: Performance Assessment in Improving Outcomes**

In federal fiscal year (FFY) 2018, Iowa completed its state-led review for the Child and Family Services Review (CFSR) Round 3. As part of the review, Iowa completed its CFSR Statewide Assessment in February 2018. During the CFSR Onsite Review period, April 1, 2018 through September 30, 2018, state reviewers conducted 65 case reviews utilizing the federal CFSR Onsite Review Instrument with federal government participation in secondary oversight of the reviews. In June, July and August 2018, a joint federal-state review team conducted state level stakeholder interviews to help determine performance for items related to the seven CFSR systemic factors.

In FFY 2019 (February 2019), Iowa received its CFSR Round 3 results, which reflect the latest assessment of Iowa's child welfare system. Included under Child and Family

Outcomes and Systemic Factors are excerpts, as applicable, from 1) I. Summary of Performance, pages 3-5, Children’s Bureau Comments on Iowa Performance, and 2) Appendix A: Summary of Iowa 2018 Child and Family Services Review Performance, pages A-1 through A-8, of the report. The full report is available at [https://dhs.iowa.gov/sites/default/files/IA\\_CFSR\\_Final\\_RPT\\_2018.pdf](https://dhs.iowa.gov/sites/default/files/IA_CFSR_Final_RPT_2018.pdf).

## Child and Family Outcomes

### Appendix A: Summary of Iowa 2018 Child and Family Services Review Performance

#### I. Ratings for Safety, Permanency, and Well-Being Outcomes and Items

**Outcome Achievement:** Outcomes may be rated as in substantial conformity or not in substantial conformity. 95% of the applicable cases reviewed must be rated as having substantially achieved the outcome for the state to be in substantial conformity with the outcome.

**Item Achievement:** Items may be rated as a Strength or as an Area Needing Improvement. For an overall rating of Strength, 90% of the cases reviewed for the item (with the exception of Item 1 and Item 16) must be rated as a Strength. Because Item 1 is the only item for Safety Outcome 1 and Item 16 is the only item for Well-Being Outcome 2, the requirement of a 95% Strength rating applies.

#### **SAFETY OUTCOME 1: CHILDREN ARE, FIRST AND FOREMOST, PROTECTED FROM ABUSE AND NEGLECT.**

Data Element	Overall Determination	State Performance
<b>Safety Outcome 1</b> Children are, first and foremost, protected from abuse and neglect	Not in Substantial Conformity	71% Substantially Achieved
<b>Item 1</b> Timeliness of investigations	Area Needing Improvement	71% Strength

#### **SAFETY OUTCOME 2: CHILDREN ARE SAFELY MAINTAINED IN THEIR HOMES WHENEVER POSSIBLE AND APPROPRIATE.**

Data Element	Overall Determination	State Performance
<b>Safety Outcome 2</b> Children are safely maintained in their homes whenever possible and appropriate	Not in Substantial Conformity	51% Substantially Achieved
<b>Item 2</b> Services to protect child(ren) in home and prevent removal or re-entry into foster care	Area Needing Improvement	86% Strength
<b>Item 3</b> Risk and safety assessment and management	Area Needing Improvement	51% Strength

**PERMANENCY OUTCOME 1: CHILDREN HAVE PERMANENCY AND STABILITY IN THEIR LIVING SITUATIONS.**

<b>Data Element</b>	<b>Overall Determination</b>	<b>State Performance</b>
<b>Permanency Outcome 1</b> Children have permanency and stability in their living situations	Not in Substantial Conformity	45% Substantially Achieved
<b>Item 4</b> Stability of foster care placement	Area Needing Improvement	80% Strength
<b>Item 5</b> Permanency goal for child	Area Needing Improvement	85% Strength
<b>Item 6</b> Achieving reunification, guardianship, adoption, or other planned permanent living arrangement	Area Needing Improvement	60% Strength

**PERMANENCY OUTCOME 2: THE CONTINUITY OF FAMILY RELATIONSHIPS AND CONNECTIONS IS PRESERVED FOR CHILDREN.**

<b>Data Element</b>	<b>Overall Determination</b>	<b>State Performance</b>
<b>Permanency Outcome 2</b> The continuity of family relationships and connections is preserved for children	Not in Substantial Conformity	68% Substantially Achieved
<b>Item 7</b> Placement with siblings	Area Needing Improvement	88% Strength
<b>Item 8</b> Visiting with parents and siblings in foster care	Area Needing Improvement	74% Strength
<b>Item 9</b> Preserving connections	Area Needing Improvement	63% Strength
<b>Item 10</b> Relative placement	Area Needing Improvement	78% Strength
<b>Item 11</b> Relationship of child in care with parents	Area Needing Improvement	66% Strength

**WELL-BEING OUTCOME 1: FAMILIES HAVE ENHANCED CAPACITY TO PROVIDE FOR THEIR CHILDREN'S NEEDS.**

<b>Data Element</b>	<b>Overall Determination</b>	<b>State Performance</b>
<b>Well-Being Outcome 1</b> Families have enhanced capacity to provide for their children's needs	Not in Substantial Conformity	38% Substantially Achieved
<b>Item 12</b> Needs and services of child, parents, and foster parents	Area Needing Improvement	45% Strength
<b>Sub-Item 12A</b> Needs assessment and services to children	Area Needing Improvement	66% Strength

Data Element	Overall Determination	State Performance
<b>Sub-Item 12B</b> Needs assessment and services to parents	Area Needing Improvement	44% Strength
<b>Sub-Item 12C</b> Needs assessment and services to foster parents	Area Needing Improvement	85% Strength
<b>Item 13</b> Child and family involvement in case planning	Area Needing Improvement	49% Strength
<b>Item 14</b> Caseworker visits with child	Area Needing Improvement	51% Strength
<b>Item 15</b> Caseworker visits with parents	Area Needing Improvement	25% Strength

**WELL-BEING OUTCOME 2: CHILDREN RECEIVE APPROPRIATE SERVICES TO MEET THEIR EDUCATIONAL NEEDS.**

Data Element	Overall Determination	State Performance
<b>Well-Being Outcome 2</b> Children receive appropriate services to meet their educational needs	Not in Substantial Conformity	84% Substantially Achieved
<b>Item 16</b> Educational needs of the child	Area Needing Improvement	84% Strength

**WELL-BEING OUTCOME 3: CHILDREN RECEIVE ADEQUATE SERVICES TO MEET THEIR PHYSICAL AND MENTAL HEALTH NEEDS.**

Data Element	Overall Determination	State Performance
<b>Well-Being Outcome 3</b> Children receive adequate services to meet their physical and mental health needs	Not in Substantial Conformity	48% Substantially Achieved
<b>Item 17</b> Physical health of the child	Area Needing Improvement	59% Strength
<b>Item 18</b> Mental/behavioral health of the child	Area Needing Improvement	56% Strength

**III. Performance on Statewide Data Indicators<sup>8</sup>**

The state's performance is considered against the national performance for each statewide data indicator and provides contextual information for considering the findings. This information is not used in conformity decisions. State performance may be statistically above, below, or no different than the national performance. If a state did not provide the required data or did not meet the applicable item data quality limits, the Children's Bureau did not calculate the state's performance for the statewide data indicator.

Statewide Data Indicator	National Performance	Direction of Desired Performance	RSP*	95% Confidence Interval**	Data Period(s) Used for State
Recurrence of maltreatment	9.5%	Lower	14.1%	13.3%–15.0%	FY15–16
Maltreatment in foster care (victimizations per 100,000 days in care)	9.67	Lower	19.77	17.68–22.11	15A–15B, FY15–16

<sup>8</sup> In October 2016, the Children’s Bureau issued Technical Bulletin #9 (<http://www.acf.hhs.gov/cb/resource/cfsr-technical-bulletin-9>), which alerted states to the fact that there were technical errors in the syntax used to calculate the national and state performance for the statewide data indicators. Performance shown in this table reflects performance based on May 2017 revised syntax that is pending final verification.

Statewide Data Indicator	National Performance	Direction of Desired Performance	RSP*	95% Confidence Interval**	Data Period(s) Used for State
Permanency in 12 months for children entering foster care	42.7%	Higher	42.5%	40.9%–44.0%	14B–17A
Permanency in 12 months for children in foster care 12–23 months	45.9%	Higher	69.2%	66.7%–71.7%	16B–17A
Permanency in 12 months for children in foster care 24 months or more	31.8%	Higher	46.8%	43.7%–50.0%	16B–17A
Re-entry to foster care in 12 months	8.1%	Lower	9.5%	8.2%–11.1%	14B–17A
Placement stability (moves per 1,000 days in care)	4.44	Lower	3.15	3.02–3.29	16B–17A

\* Risk-Standardized Performance (RSP) is derived from a multi-level statistical model and reflects the state’s performance relative to states with similar children and takes into account the number of children the state served, the age distribution of these children and, for some indicators, the state’s entry rate. It uses risk-adjustment to minimize differences in outcomes due to factors over which the state has little control and provides a more fair comparison of state performance against national performance.

\*\* 95% Confidence Interval is the 95% confidence interval estimate for the state’s RSP. The values shown are the lower RSP and upper RSP of the interval estimate. The interval accounts for the amount of uncertainty associated with the RSP. For example, the CB is 95% confident that the true value of the RSP is between the lower and upper limit of the interval.

\*\*\* Data Period(s) Used for State Performance: Refers to the initial 12-month period and the period(s) of data needed to follow the children to observe their outcomes. The FY or federal fiscal year refers to NCANDS data, which spans the 12-month period October 1–September 30. All other periods refer to AFCARS data. "A" refers to the 6-month period October 1–March 31. "B" refers to the 6-month period April 1–September 30. The 2-digit year refers to the calendar year in which the period ends.

### *Children's Bureau Comments on Iowa Performance<sup>1</sup>*

CFSR case review results showed that the state's highest performing outcome was Well-Being 2: Children receive appropriate services to meet their educational needs, followed by Safety 1: Children are, first and foremost, protected from abuse and neglect, and Permanency 2: The continuity of family relationships and connections is preserved for children. In many of the cases reviewed, DHS made efforts to respond in a timely manner to reports of maltreatment and to place children in foster care with their siblings and relatives.

The identification and involvement of relatives was another positive factor in many of the outcomes. Case review results showed that Iowa uses relative placements to maintain stability, help achieve permanency goals such as adoption and guardianship, and maintain significant connections for children removed from their homes. Iowa also routinely identifies and locates paternal and maternal relatives when a child enters care and evaluates possible relatives for placement and support. Case review results indicated that DHS is effective in placing siblings together when possible and appropriate, and in ensuring that siblings placed in different foster homes have frequent and quality contact to keep the siblings connected.

The lowest performing outcomes for Iowa were Well-Being 1: Families have enhanced capacity to provide for their children's needs; Permanency 1: Children have permanency and stability in their living situations; and Safety 2: Children are safely maintained in their homes whenever possible and appropriate. Positive areas to highlight in Iowa's practice include establishing timely and appropriate permanency goals for children in foster care and keeping children stable in their placements. However, the agency and courts often do not make concerted efforts to achieve the goals in a timely manner, and a lack of concurrent planning was identified as a barrier to achieving timely permanency. This was more evident in cases where reunification was no longer an appropriate goal; often children with permanency goals of guardianship or adoption were found to languish in care for long periods of time. In stakeholder interviews, the practice of delaying permanency hearings to combine them with Termination of Parental Rights (TPR) hearings was identified as a concern that potentially may cause delays in achieving permanency for children in care.

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<sup>1</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 3-5.

Areas of challenge for both in-home and foster care cases included accurate assessment and management of risk and safety; comprehensive assessment of the needs of children and parents; provision of appropriate and individualized services; and a lack of frequent and quality caseworker visits with children and parents. In-home cases were rated significantly lower than foster care cases in these areas, often due to a lack of agency efforts to effectively assess or meet with all family members, especially children. Case review results also showed noteworthy differences between Iowa's engagement and assessment of parents, with fathers typically less involved and engaged by the agency than mothers.

Current or Planned Activities to Improve Performance on Child and Family Outcomes  
– Iowa addresses all of the child and family outcomes in *Section III: Plan for Enacting Iowa's Vision*.

## **Systemic Factors**

*Information System (45 CFR 1355.34(c)(1))*

Item 19: Statewide Information System: Iowa's statewide child welfare information system (CWIS), referred to as Joining Applications and Reports from Various Information Systems (JARVIS), comprises two main components, Family and Child Services (FACS) and Statewide Tracking of Assessment Reports (STAR). FACS is the child welfare case management and payment system for the DHS. It applies to children remaining in the home and in foster care and collects demographic data, caseworker information, household composition, services provided, current status, status history, placement information, and permanency goals, among other information. It tracks the services provided to approximately 12,000 children at any specific point in time and automates issuance of over \$220 million annually to foster and adoptive parents and other child welfare providers. STAR collects information related to child protective assessments, child abuse assessments and family assessments.

441 Iowa Administrative Code (IAC) 130.6(4) and (5) requires DHS staff to enter case information, which includes information such as the status, demographics, location, and permanency goals for children in foster care, into the reporting system and to monitor the case to ensure the information in the reporting system is correct but no time frames for data entry are mentioned in the rules. However, DHS has time frames for data entry for various work products, but there currently are no time frames for all data entry, including for the elements in this item.

Iowa's statewide information system also includes components to increase data quality, such as interfacing with income maintenance programs (e.g. food assistance, Temporary Assistance to Needy Families (TANF), Medicaid, etc.) and child support program to collect and confirm the accuracy of case participant demographic information. Additionally, the Child Care Assistance system (KinderTrack (KT)) and JARVIS interface to facilitate system check pulls to see if a perpetrator is conducting a day care business. The income maintenance programs, the child support program, and the child care assistance program are all part of the DHS. For example, an interface

with the statewide income maintenance system application allows child welfare staff to inquire about participants receiving services such as Temporary Assistance to Needy Families (TANF). This interface allows verification of household member names, dates of birth, family's address, and other information that is obtained and verified during eligibility determination processes by DHS income maintenance personnel.

Iowa implemented a case review process for assuring data accuracy, which continues on an annual basis. Iowa Bureau of Quality Improvement staff examined data accuracy for 100 cases randomly selected from all children served in out of home care. This comprised comparison of FACS/AFCARS data with case narrative and file documentation from sources other than FACS/AFCARS (i.e. court orders and narratives, social history, case plan narratives, etc.). Areas explored: basic demographics (race, sex, and ethnicity); foster care placement data (latest removal, manner of removal, current setting, discharge date, discharge reason); case plan goal and diagnoses. For data changes, when DHS staff make changes within the original entry, the modify date is updated but we are unable to tell specifically what was changed. For the FACS/AFCARS review, data was counted as "accurate" when it was consistent with case file documentation; data was counted as "inaccurate" when there was clearly an inconsistency between FACS/AFCARS and case file documentation. Individual data was counted as "unable to verify" when data comparison could not be made because there was no independent paper file source for comparison (items scored as such were not invalid and were counted towards accurate valid data). Another data accuracy process involved analysis of administrative data and relationship between data elements (for example age and grade in school) to help identify possible out of range or out of date data, and then collaboration occurred with the Bureau of Service Support and Training to address training and data cleanup issues.

**Table 2(a): Adoption and Foster Care Analysis and Reporting System (AFCARS)**

Element	AFCARS Data Validation Review - Item Description	CY 2017	CY 2018
<b>FC-06</b>	Does the child's DOB in FACS accurately reflect what's listed in paper file documentation?	99%	100%
<b>FC-07</b>	Does the child's Gender in FACS accurately reflect what's listed in paper file documentation?	100%	100%
<b>FC-08</b>	Does the child's Race in FACS accurately reflect what's listed in paper file documentation?	99%	97%
<b>FC-09</b>	Does the child's Hispanic or Latino Ethnicity in FACS accurately reflect what's listed in paper file documentation?	99%	92%
<b>FC-21</b>	Does the child's Date of Latest Removal in FACS accurately reflect what's listed in paper file documentation?	96%	96%
<b>FC-25</b>	Does the child's Manner of Removal in FACS accurately reflect what's listed in paper file documentation?	99%	95%

**Table 2(a): Adoption and Foster Care Analysis and Reporting System (AFCARS)**

Element	AFCARS Data Validation Review - Item Description	CY 2017	CY 2018
<b>FC-41</b>	Does the child's Current Setting in FACS accurately reflect what's listed in paper file documentation?	98%	94%
<b>FC-43</b>	Does the child's Case Plan Goal in FACS accurately reflect what's listed in paper file documentation?	90%	93%
<b>FC-56</b>	Does the child's Discharge Date in FACS accurately reflect what's listed in paper file documentation?	97%	95%

Source: DHS AFCARS Case Reviews

Iowa’s last AFCARS review was in 2004. Shortly afterwards, Iowa began implementation of a PIP for AFCARS. Out of the 9 data elements in the table above, two are not included in the PIP (#6 and #7); five (#8, #9, #21, #25 and #56) meet all of the AFCARS requirements and the DHS sustains a high level of quality data; and two (#41 and #43) have not fully met technical requirements for AFCARS. Iowa anticipates meeting AFCARS requirements with implementation of its new comprehensive child welfare information system (CCWIS).

Substantial Conformity Rating

**STATEWIDE INFORMATION SYSTEM**

Data Element	Source of Data and Information	State Performance
<b>Statewide Information System</b>	Statewide Assessment and Stakeholder Interviews	Not in Substantial Conformity
<b>Item 19</b> Statewide Information System	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

Children’s Bureau Comments on Performance<sup>2</sup>

“Data and information from the statewide assessment and stakeholder interviews indicated Iowa’s statewide information system is not able to accurately and readily identify the location of children in foster care. Stakeholder interviews also highlighted

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<sup>2</sup> Child and Family Services Review, Iowa Final Report, 2018, p. 15.

the lack of policy expectations surrounding the timely documentation of placement changes for children in care.”

### Current or Planned Activities to Improve Performance

- In FFY 2020, Iowa will implement a policy to enter required data elements for this systemic factor within 3 business days of a child’s placement and/or placement change. Policy staff will work with applicable field staff to implement the requirement. Monitoring will occur through the child welfare information system (CWIS), which will require creation of a specific report. Policy staff will work with our field and IT staff to implement the monitoring component.
- Iowa received state funding from the legislature to move toward a CCWIS, which will:
  - be modular,
  - have well defined business processes to support case management, including support of mobile technology,
  - support registration and monitoring of evidence based interventions,
  - enable stakeholders working with the child and family to have role-based permission to information, and
  - integrate with other systems to make coordination more effective.
- During FFY 2020-2024, Iowa will continue collaboration with the federal Children’s Bureau in implementing its CCWIS.
  - FFY 2020 – DHS will continue the following planning activities on an ongoing basis:
    - Continue development of the DHS Project Management Plan
      - Summarizes approach to managing project activities, deliverables, products, project organization, State and contractor resource needs, and anticipated system life
      - Describes how and when the project activities will be conducted
      - Outlines the associated project documentation and contractor deliverables
    - Continue CCWIS calls with the federal Children’s Bureau
  - FFY 2020-2022: Design, develop, and implement CCWIS by user role.
    - FFY 2020-2021: Social Worker 2s/3s
    - FFY 2021: Supervisors, Service Area Leaders, Support Staff, and Specialized Staff (DoIT, Fiscal, ICPC)
    - FFY 2022: IV-E Staff, Management Analyst/Quality Assurance Staff, Program Managers, Providers, External Partners, and Citizens (reports)
  - FFY 2023-2024: Ongoing monitoring and upgrading, as necessary

### *Case Review Information System (45 CFR 1355.34(c)(2))*

#### Item 20: Written Case Plan

Iowa’s policy requires a written case plan be developed jointly with the child’s parents and the child, if appropriate. The initial case plan is due within 60 days of the child entering foster care. The *Family Case Plan*, form 470-3453, is the official record of the DHS’ involvement with the family. It serves to:

- Document the child and family’s strengths and needs, including how the family became involved with the child welfare system.

- Document the most appropriate services and supports needed to assure and promote child safety, permanency, and well-being. The family’s plan includes a description of:
  - A plan to keep children safe.
  - Individual family strengths, supports, and needs.
  - How the strengths and family supports can be used to assist the family in self-directed change.
  - How the DHS and others will assist the family in overcoming the needs through appropriate services.
  - The child’s placement and its appropriateness.
  - The child’s health and educational records.
  - The child’s transition plan.
  - Efforts to achieve the permanency goal.
  - Efforts to ensure the child’s educational stability.

The Family Case Plan comprises three main parts:

- Part A. Family Case Plan Face Sheet includes identification, statistical, historical, service summary, placement, and court hearing information for the family.
- Part B. Family Case Plan documents the strengths, needs, goals and concrete steps with time frames to meet child and family needs for five functional domains (child well-being, parental capabilities, family safety, family interactions, and home environment) with another domain of “other” to capture strengths and needs that impact safety, permanency or well-being not captured in the previous domains.
  - *Child Well-Being*: Child’s mental health/behavior, relationship with peers, school performance, motivation and cooperation, relationship with caregivers, and relationship with siblings
  - *Parental Capabilities*: Parental supervision of children, mental health, disciplinary practices, physical health, use of drugs or alcohol, and developmental and enrichment activities
  - *Family Safety*: Domestic violence or physical abuse, sexual abuse, emotional abuse, or neglect of a child
  - *Family Interactions*: Bonding with child, expectations of child, relationship between parents or caregivers, mutual support within the family
  - *Home Environment*: Housing stability, financial management, income and employment, safety in community, personal hygiene, habitability, transportation, food and nutrition, learning environment
  - *Other*: Additional issues or concerns about the child or family
 Part B also includes a narrative review section to capture case plan review information and a signature page to reflect individuals’ participation in development of the case plan and case plan review.
- Part C. Child Placement Plan, in combination with Parts A and B, documents federal requirements related to the child’s placement outside the home, which includes but is not limited to:
  - Initial and subsequent placements;
  - Permanency goals and any applicable concurrent permanency goals;
  - Indian Child Welfare Act applicability;

- Placement status information, including assessment of the appropriateness of the placement;
- DHS staff efforts to support the placement and prevent disruption;
- Placement history;
- Child's length of stay related to the Adoption and Safe Families Act (ASFA) including information on termination of parent rights (TPR) petition filing or reasons a petition was not filed;
- Visitation plan with parents and siblings;
- Health records, such as:
  - Description of treatment or evaluations conducted by a health, mental health, and/or substance abuse care provider with the provider's address and date of service provided and date of when the information was given to the child's placement caregiver or provider. This information may reflect the status of the child's immunizations, medical problems, or medications prescribed.
- Educational records, such as:
  - Early ACCESS or AEA referrals
  - School name and address
  - Attendance
  - Whether the child is working on grade level
  - Reference to Individual Education Plan, if applicable
- Transition plan, inclusive of documentation of results of Youth Life Skills Assessment, strengths and needs of the youth to transition to adulthood, and a description of the services provided to the youth to address identified needs

Updates to the Family Case Plan are due at a minimum every 6 months as part of the 6 month periodic case review or more frequently as required by juvenile court.

Iowa's 2018 CFSR showed performance of 49% for Item 13: Child and Family Involvement in Case Planning.

Item 21: Periodic Reviews: Iowa's policy is that, at least every six months, the child's case plan must be reviewed and the case presented to a review body following local protocols. The review must meet the federal requirement that a review be "conducted by a panel of appropriate people, at least one of whom is not responsible for the case management of or the delivery of services to either the child or the parents." A minimum of at least three people take part in the review.

Iowa utilizes one of three options for meeting the periodic review requirement:

- Court hearing: This is the option used by most jurisdictions in Iowa.
- Iowa Citizen Foster Care Review Board (FCRB): Local foster care review boards (LFCRB) composed of volunteers representing various disciplines conduct administrative reviews in various counties across the state from all judicial districts except the Fourth Judicial District.
- DHS administrative review: The DHS review can be used to ensure compliance with federal law when a review conducted by the court or a Citizens FCRB:
  - Will fall outside the six month time frame, or

- Fails to cover the required elements.

In these hearings or reviews, there is a comprehensive review of the case, including the child’s safety, the continuing necessity for and appropriateness of the placement, the extent of compliance with the case plan, and the extent of progress toward mitigating the need for out-of-home care.

Item 22: Permanency Hearings: Iowa’s policy is to conduct permanency hearings within 12 months of the child’s removal from the home and at least every twelve months thereafter.

Table 2(b) represents data collected by Iowa Children’s Justice (ICJ). There are no known limitations for the permanency hearing data.

During implementation of the statewide Electronic Document Management System, court order templates were developed that were generic in nature. Some judges and clerks were unaware that those templates supported individualized modification of the hearing titles, leaving the generic "Order" which did not identify the type of hearing. When a clerk was faced with this type of order, they were frequently unable to determine the nature of the hearing without reading the entire order, leading to mistakes in data entry. ICJ staff implemented two strategies to address this issue:

- provided training at the Clerk’s Conference in September 2016, and
- formed a judicial committee to set up juvenile template orders that reflect the hearings of CINA cases.

<b>Table 2(b): Timeliness of Initial and Subsequent Permanency Hearings</b>					
<b>Court Function Indicator</b> <i>[Specific, observable, and measurable indicators to track change towards the desirable outcomes]</i>	<b>Previous Year Baseline Rate (FY2017)</b>	<b>Initial Baseline Rate or Level (FY2018)</b>	<b>Total Cases During Current FY</b>	<b>Target Improvement (if applicable)</b> <i>[Projected levels of improvement in performance measure by end of granting period]</i>	<b>Difference From Baseline</b> <i>[Difference in the annual level from the baseline. if appropriate, note significant changes.]</i>
<b>Time to First Permanency Hearing*</b>	74%	79%	1,011	100%	5%
<b>Time to Subsequent Permanency Hearing**</b>	96%	98%	1,545	100%	2%

Source: Iowa Children’s Justice; October 2017-September 2018

\*From DHS Placement Date to Issuance of the Permanency Hearing Order in 365 days.

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

Item 23: Termination of Parental Rights

When a child has been in foster care under the responsibility of the DHS for 15 of the most recent 22 months, the DHS staff initiates the process to file a petition to terminate parental rights. Typically one petition is filed for each parent. Petitions are typically filed by the County Attorney acting on behalf of the DHS staff or by order of the court. The petitions must be filed by the end of the child’s fifteenth month in foster care. However, Iowa policy stresses that it is important that permanency planning occur early in all foster care cases and that nothing prevents earlier petitions to terminate parental rights when appropriate.

Table 2(c) represents data collected by Iowa Children’s Justice (ICJ). The data represents TPR petitions filed from across the state. There are no known limitations for the TPR petitions data.

<b>Table 2(c): Timeliness of Termination of Parental Rights (TPR) Petitions</b>					
<b>Court Function Indicator</b> <i>[Specific, observable, and measurable indicators to track change towards the desirable outcomes]</i>	<b>Previous Year Baseline Rate (FY2017)</b>	<b>Initial Baseline Rate or Level (FY2018)</b>	<b>Total Cases During Current FY</b>	<b>Target Improvement (if applicable)</b> <i>[Projected levels of improvement in performance measure by end of granting period]</i>	<b>Difference From Baseline</b> <i>[Difference in the annual level from the baseline. if appropriate, note significant changes.]</i>
<b>Time to TPR Petition</b>	65%	86%	1,107	100%	21%

Source: Iowa Children’s Justice

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

DHS staffs follow local protocols for initiating a petition to terminate parental rights unless:

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

If there are exceptions or compelling reasons to the timely filing of TPR, the exceptions or compelling reasons must be documented in the child’s case file.

Table 2(d) below shows case review data from Iowa’s 2018 CFSR Onsite regarding the filing of TPR petitions and whether exceptions applied to the timely filing.

Table 2(d): Case Reviews – Item 5 – Sub-Items F & G	
	2018 CFSR Onsite Case Reviews
<b>5F: Did the agency (DHS) file or join a termination of parental rights petition before the period under review or in a timely manner during the period under review?</b>	68% (n=13/19)
<b>5G: Did an exception to the requirement to file or join a termination of parental rights petition exist? (More than one option can apply)</b>	50% (n=3/6)
<ul style="list-style-type: none"> <li>• <b>No exceptions apply</b></li> <li>• <b>At the option of the state, the child is being cared for by a relative at the 15/22-month time frame.</b></li> <li>• <b>The agency documented in the case plan a compelling reason for determining that termination of parental rights would not be in the best interests of the child.</b></li> <li>• <b>The state has not provided to the family the services that the state deemed necessary for the safe return of the child to the child’s home.</b></li> </ul>	<ul style="list-style-type: none"> <li>• 3 cases</li> <li>• 3 cases</li> <li>• 2 cases</li> <li>• 0 cases</li> </ul>

Source: DHS Case Reviews

Item 24: Notice of Hearings and Reviews to Caregivers: The Iowa process by which foster parents, pre-adoptive parents, and relative caregivers of children in foster care receive notification of a court hearing held with respect to the child occurs through the clerk of court or the caseworker. Through the clerk of court, the court uses its’ automated system to send notices of upcoming hearings to foster parents and other caretakers. A data match between DHS foster parent or other caretaker contact information, i.e. name and address, and the court data is the source of information by which the automated system sends the hearing notices. A limitation of this data may be timely DHS staff data entry to ensure the foster parent name and address is current. The court monitors the automatic notification process to assure it runs timely. Attachment 2A is an example court notice, which shows information on the hearing date, time and location as well as the foster parent or caretaker’s right to provide information during the hearing.

As previously mentioned under periodic reviews for this systemic factor, Iowa also utilizes foster care review board (FCRB) reviews. FCRBs comprise citizens of Iowa who volunteer their time to review cases of children in foster care and to provide recommendations to DHS and the juvenile court for that particular case. The local FCRB invites parents, youth, caseworkers, guardian ad litem, attorneys, foster parents, and service providers to attend the meeting and provide information to the board. Attachment 2B is an example FCRB notice, which shows information on the review date, time, and location as well as the foster or pre-adoptive parent or relative caregiver’s right to provide information in the meeting.

## Substantial Conformity Rating

### **CASE REVIEW SYSTEM**

<b>Data Element</b>	<b>Source of Data and Information</b>	<b>State Performance</b>
<b>Case Review System</b>	Statewide Assessment and Stakeholder Interviews	Not in Substantial Conformity
<b>Item 20</b> Written Case Plan	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 21</b> Periodic Reviews	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 22</b> Permanency Hearings	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 23</b> Termination of Parental Rights	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 24</b> Notice of Hearings and Reviews to Caregivers	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

### Children's Bureau Comments on Iowa Performance<sup>3</sup>

- “In stakeholder interviews, the practice of delaying permanency hearings to combine them with Termination of Parental Rights (TPR) hearings was identified as a concern that potentially may cause delays in achieving permanency for children in care. All five items assessed in the Case Review System systemic factor were rated as areas needing improvement. The Children's Bureau recommends that Iowa further analyze agency and court-related challenges and barriers that affect timely permanency for children and families.” (p. 4)
- Item 20: “Data and information from the statewide assessment indicated that case plans for children in foster care are not consistently developed jointly with parents, and that practice is disparate between mothers and fathers. Stakeholders reported mixed experiences with the case planning process, noting that case plans are not developed or not updated timely. When case plans are developed, they are often created without parental knowledge or input.” (p. 16)

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<sup>3</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 5 and 16.

- Item 21: “Data provided in the statewide assessment indicated that timely periodic reviews most often occur via court hearings. Stakeholders interviewed noted that the two remaining periodic review processes, the Foster Care Review Board and the Administrative Reviews, do not occur consistently across the state and do not always include key participants. The state does not have data or a reliable tracking system to ensure that children in foster care receive periodic reviews as required.” (p. 16)
- Item 22: “Stakeholders reported that initial permanency hearings are not occurring for many children in foster care in a timely manner, as they may be combined with other hearings, including contested TPR hearings, or be delayed beyond the 12-month initial requirement due to a variety of circumstances. Data and information in the statewide assessment indicated that subsequent permanency hearings appear to be occurring timely. Stakeholders, however, reported inconsistencies in how the different hearings are coded, which affects the quality of the data.” (pp 16-17)
- Item 23: “Caseworkers initiate the process to file TPR petitions and the county attorneys typically file the petitions. Data and information provided in the statewide assessment showed that TPR petitions are not routinely filed across the state in a timely manner. The statewide assessment and stakeholder interviews identified some barriers to timely TPR filing, including high caseworker caseloads as well as limited resources in the county attorney offices.” (p. 17)
- Item 24: “Data and information in the statewide assessment indicated that foster parents, pre-adoptive parents, and relative caregivers of children in foster care do not consistently receive notices for the various types of hearings held, including court hearings and Foster Care Board reviews. Stakeholders reported variation in notices, with relative caregivers being informed of the opportunity to be heard and asked to provide input at court hearings but foster and adoptive caregiver notices indicating only an opportunity to provide written information to the court and caregivers having no opportunity to provide input when attending a hearing.” (p. 17)

#### Current or Planned Activities to Improve Performance

- Item 20: Written Case Plan – Please see *Section III: Plan for Enacting Iowa’s Vision*, Goal 3, for planned activities to improve joint case planning with parents.
- Item 21: Periodic Reviews:
  - While FCRB and Administrative reviews will continue, Iowa will discontinue their usage as a means to meet the periodic reviews requirement. Court hearings will be the means by which Iowa will meet this requirement.
  - Implementation of our CCWIS, described earlier in this section under *Information System*, will assist DHS staff in tracking timeliness of the six month periodic reviews requirement. DHS anticipates tracking mechanism will be implemented no later than FFY 2022.
- For Item 22: Permanency Hearings and Item 23: Termination of Parental Rights (TPR), Iowa Children’s Justice (ICJ) and the DHS believe quality legal representation may prevent:
  - unnecessary removals,
  - placements with strangers,

- long lengths of stay in foster care, and
- re-entries into foster care, which will positively impact timeliness of permanency hearings and TPR petition filings.

Therefore, Iowa plans to conduct the following activities in FFY 2020-2021 with continuation of implementation and quality assurance activities during the rest of the CFSP period.

- FFY 2020 – 2021:
  - Examine current quality legal projects, e.g. Waterloo project, to determine components needed in a quality legal representation framework.
  - Collaborate with applicable entities to create a Quality Legal Representation framework replicable across the state.
  - Determine requirements needed to draw down title IV-E funding and develop required processes/documents, e.g. cost allocation plan, Title IV-E State Plan Amendment, DHS MOU with SPD, etc.
  - Develop and implement a training plan for DHS, families, attorneys, courts, etc.
  - Develop and implement a staged implementation plan.
  - Implement ICJ’s strategic plan related to CQI for Quality Legal Representation (see Attachment 3B)
- FFY 2022-2024:
  - Continue execution of staged implementation plan
  - Continue continuous quality improvement (CQI) activities for quality legal representation
- For Item 24: Notice of Hearings and Reviews to Caregivers, in FFY 2020, CIP, DHS, and the legal community will work together to identify the root causes of performance and develop strategies to address root causes for these items. In FFY 2021 and thereafter, CIP, DHS, and the legal community will implement and monitor strategies to improve performance, with strategy revisions implemented when necessary.

*Quality Assurance System (45 CFR 1355.34(c)(3))*

Below is Iowa’s updated assessment of its Quality Assurance System.

*Foundational administrative structure: (1) operating in the jurisdictions where the services included in the CFSP are provided*

The foundational administrative structure of the Quality Improvement process remains consistent since the last CFSP. The Service Business Team (SBT) continues to be the primary oversight force for continuous improvement in child welfare services.

The Bureau of Quality Improvement itself consists of QI Coordinators located in each of the six (6) service areas in addition to QI Coordinators (2) and Management Analysts (4) centrally located in Des Moines. Through this strategic disbursement of staff, Iowa addresses statewide priorities with a consistent approach as well as service area specific priorities that may be unique to the geographic region or in which a service area

may be under-performing. Bureau staff is fluid in assignment and routinely work with both statewide and local service area initiatives. Bureau staff located in the service areas work with the Quality Improvement Bureau Chief as well as the Service Area Manager (SAM) and leadership team to prioritize projects and balance their time. Centralized supervision allows for coordination as well as the sharing of resources across the state and sharing of information regarding current projects, effectiveness of efforts, etc.

The Bureau of Quality Improvement also continues to collaborate with Iowa's Department of Management, Office of Lean Enterprise in the development of standard Continuous Improvement training regarding Lean philosophy and specific methodologies. Quality Improvement staff participates in the classroom training aspect as well as the experiential learning and mentoring which is in place to enhance the learning process. As QI staff becomes more knowledgeable in the use of Lean, the QI staff demonstrates the concepts through hands-on projects with staff and the implementation of continuous improvement into daily work.

*Quality Data Collection:* DHS works to assure data accuracy focusing on four main points:

- Entry quality: Did the information initially enter the system correctly (timely, accurately)?
  - Entry quality is probably the easiest problem to identify but is often the most difficult to correct. Entry issues occur when a person enters data into a system. The problem may be a typo or lack of clear guidance, or a willful decision, such as providing a dummy phone number or address when factual data are unknown. Identifying these outliers or missing data is usually easily accomplished with SBT engaging analysts to use profiling tools and simple queries, and through quick quality spot checks.
- Process quality: Was the integrity of the information maintained during processing in the system?
  - Process quality issues usually occur systematically as data moves through the organization. They may result from a system crash, lost file, or any other technical occurrence that results from integrated systems. These issues are often difficult to identify, especially if the data had a number of transformations on the way to its destination. Process quality can usually be remedied easily once the source of the problem is identified. The DHS uses process mapping with IT staff, user staff and policy staff to help ensure problem identification.
- Integration quality: Is all the known information about a case integrated to the point of providing an accurate representation of the case or groups of cases?
  - Integration quality, or quality of completeness, can present big challenges. Integration quality problems occur because information is isolated by system or departmental boundaries. It might be important for a child welfare manager to know the status of the child involvement with special educational programs, but if the child welfare and educational systems are not integrated, that information will not be readily available. SBT charges small groups with IT staff, user staff and policy staff to address focus issues with other agencies to address issues.

- Usage quality: Is the information available and interpreted and used correctly at the point of access?
  - Usage quality often presents itself when developers lack access to legacy source documentation or subject matter experts. Without adequate guidance, they guess the meaning and use of certain data elements. SBT provides data governance to identify and document corporate systems and data definitions, and plan for analysis, dissemination, training, and usage of the information.

*(2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety),* Iowa utilizes the federal Child and Family Services Review (CFSR) as standards to evaluate the quality of its services. This is accomplished through CFSR case reviews and performance measures aligned with the CFSR outcomes in Iowa's performance based service contracts.

*Case Record Review Data and Process:* Following successful completion of the CFSR Round 2 PIP in 2014, DHS staff developed a new case review model for CFSR Round 3. This model includes paired review teams comprising one field Supervisor from each service area and the Quality Improvement Coordinator from that service area. The goal of these pairs is to generate rich discussion and observation based on diverse experience. This process is in the hands of people with expertise doing the work in the field in order to increase quality, promote education, and assure consistent application of CFSR standards and practice standards.

Iowa received approval in 2018 to conduct the on-site review rather than utilize the traditional review. From April – September 2018, Iowa coordinated with Children's Bureau to assure all requirements within the case reviews were completed. The DHS outlines Iowa's case review process in detail in the Child and Family Services Review, Iowa Case Review Information document (Attachment 2C), which Iowa utilized during the on-site, and will use for Iowa's CQI case reviews and CFSR program improvement plan (PIP) monitoring.

Iowa reviews the minimum number of cases, to help ensure the state has the capacity to complete the selected number of reviews through the entirety of the PIP period. Iowa has a point in time population of around 10,500 which at 65 cases would bring in confidence level of about 58%; although this is not ideal, to achieve a 95% confidence rate, Iowa would need to review about 370 cases, which is not practical for the state to complete. As part of the case review process, reviewers complete case level interviews with key participants on each case reviewed. Additionally, both initial QA and 2<sup>nd</sup> level QA occurs. The review of 65 cases annually is sustainable for Iowa for the on-site, PIP periods, and ongoing monitoring of practice.

Iowa continues to expand the number of supervisors fully trained to complete the CFSR case reviews for PIP monitoring. Currently we are in the training phase of new reviewers and are able to capitalize on the experience of our existing reviewers. Each of the five service areas has identified an additional supervisor to conduct reviews and

have started reviewing mock/practice cases utilizing the existing experienced review team for training and continuity of application of criteria.

DHS staff identify ongoing training for reviewers through QA trends, self-identified areas needing clarification, routine meetings (conference call and/or in person) for discussion and clarification of issues. In addition, at least two times per year all reviewers complete an inter-rater reliability case review. This consists of all review teams and QA teams reading and scoring the same case using the OSRI, then coming together to discuss discrepancies, questions that could be asked in interviews to seek clarification, and other issues associated with assuring reliability of data across the teams. These reviews provide the opportunity for all reviewers, regardless of experience, to promote learning and consistency through specific case discussion. All reviews are entered into the OMS Training site for Iowa. Prior to the meeting, a report showing scoring on each team's review is run and provides the foundation to start the discussion. Through this process, the review teams have been able to identify which items are most prone to different interpretation and through dialogue have worked to understand the thought process of different teams when evaluating the same information. At times they have been able to further define factors within an item that influence the rating in order to increase consistency; other times they may have identified interview questions that, if the information were available would have provided decisive information on the "right" answer.

Iowa remains dedicated to establishing a sustainable process for the long-term so evaluating the time commitment needed for the case review process, including interviews, continues. Options for utilizing staff resources most efficiently, increasing statewide involvement in CFSR concepts related to practice, and furthering the culture of and involvement in continuous quality improvement throughout the DHS continue to be considered and evaluated. Regardless of the process specifics, well-trained, experienced, and knowledgeable reviewers will always be the foundation of Iowa's reviews.

#### Performance Measures in Services Contracts

Iowa's contracted services include performance contract measures that align with the safety, permanency, and well-being outcomes of the CFSR. Please see Iowa's FFY 2015-2019 Final Report and *Section IV: Services* in this report for examples of these measures and performance information.

*Analysis and dissemination of quality data: (3) identifies strengths and needs of the service delivery system* - Iowa utilizes the aforementioned CFSR case reviews, services' contract performance measurements, regular performance monitoring, and provider performance and feedback mentioned under *(4) provides relevant reports* to identify strengths and needs of the service delivery system. The most current example of this is Iowa's 2018 CFSR (described in this section) and PIP development reflected in *Section III: Plan for Enacting Iowa's Vision*.

(4) *provides relevant reports*: Iowa has multiple systems capable of reporting on collected data including CFSR factors; state-identified key performance measures; other foster care and child protective systems; related reports through ROM; case review data and reporting; ad hoc reports as needed; and survey data. Iowa has some goals regarding data that affect analysis and dissemination of data (please refer to Quality Data Collection above).

Iowa has both an internal and public facing ROM, which examines the placement population, CFSR Round 3 Measures, and Iowa’s in-home services population. Because Iowa depends on ROM, much of our monitoring and analysis is information made available via ROM. This allows staff to find most of the information they use to support and manage work in ROM, and also data used as part of the evaluation of both the child welfare system and staff performance. The “freshness” of data in ROM helps staff to get prompt feedback on practice and performance issues, and also supports the ability to easily “ask the data the next question” based on the initial standard analysis of the data.

The top ten ROM reports used most frequently by state staff are:

1. Monthly Visits Made With Involved Children
2. State Involved Child Counts
3. Initial Face-to-Face Contact Timely
4. Report Conclusions/Findings
5. (Federal) Placement Stability
6. (Federal) Recurrence of Maltreatment
7. Foster Care Counts
8. Safe from Maltreatment Recurrence for 6 months
9. Assessments Completed Within Required Time
10. (Federal) Maltreatment in Foster Care

Below is a table listing all the reports available to DHS staff in ROM.

Table 2(e): Internal ROM Reports Available to DHS Staff	
(Federal) Re-Entry to Foster Care	DU.1 User Report Activity
(Federal) Recurrence of Maltreatment	Federal Administrative Settings
CFSR Round 3 - Federal Report Outcomes Compared to the Supplemental Reports	Federal Indicators
Case Management (CM) Reports:	Counts Reports - Transferred onto and Transferred off caseloads:
<ul style="list-style-type: none"> <li>• CM 1.1 Children in Foster Care 17+ Months</li> <li>• CM.1 Foster Care Counts</li> <li>• CM.10 Siblings Placed Together</li> <li>• CM.12 Average Daily Foster Care Population per 1000</li> <li>• CM.13 No Re-Involvement in 12 Months After Exit</li> <li>• CM.14 Average Daily Population by</li> </ul>	<ul style="list-style-type: none"> <li>• CPS.1 Report Conclusions/Findings</li> <li>• CPS.2 Investigations Completed Within Required Time</li> <li>• CPS.3 Initial Face-to-Face Contact Timely</li> <li>• CPS.4 Pending CPS Reports</li> <li>• CPS.5 Maltreatment Allegations</li> <li>• CPS.6 Child Protection Reports</li> <li>• CPS.7 Victim Rate per 1000</li> <li>• CPS.8 CPS Report Recurrence</li> </ul>

**Table 2(e): Internal ROM Reports Available to DHS Staff**

<ul style="list-style-type: none"> <li>Involvement</li> <li>• CM.15 Median Length of Stay at Exit</li> <li>• CM.2 Placement Type</li> <li>• CM.4 Countdown to Permanency</li> <li>• CM.4.1 Countdown to Adoption/Other Permanency</li> <li>• CM.4.2 Countdown to TPR</li> <li>• CM.5.1 Discharge Reason - Federal</li> <li>• CM.5.2 Discharge Reason - Site</li> <li>• CM.7 Removal rate per 1000</li> <li>• CM.8 Initial Placements with Relatives (of those entering care)</li> <li>• CM.9 Placement in Same or Adjoining County</li> </ul>	<ul style="list-style-type: none"> <li>• CPS: Counts</li> <li>• CPS: Key Practice Indicators</li> <li>• CPS: Outcomes</li> </ul>
<p>Caseworker Visits:</p> <ul style="list-style-type: none"> <li>• CV.1 Months Worker-Child Visit Made</li> <li>• CV.2 Months with Visit In-Home</li> <li>• CV.3 Worker-Child Visitation Pending/Completed</li> </ul>	<p>Foster Care:</p> <ul style="list-style-type: none"> <li>• Foster Care: Caseworker Visits</li> <li>• Foster Care: Countdown to Outcomes</li> <li>• Foster Care: Counts</li> <li>• Foster Care: Discharge Counts</li> <li>• Foster Care: Key Practice Indicators</li> <li>• Foster Care: Outcomes</li> </ul>
<p>General Definitions</p>	
<ul style="list-style-type: none"> <li>• IA.1 Involved Child Visitation Pending/Completed</li> <li>• IA.2 Visitation Summary</li> </ul>	<ul style="list-style-type: none"> <li>• IC.1 In-Home Intact Counts</li> <li>• IC.10 Monthly Visits Made With Involved Children</li> <li>• IC.11 Monthly Contact With Adults of Involved Children</li> <li>• IC.2 State Involved Counts</li> <li>• IC.3 Permanency Maintained for Children Exiting In-Home</li> <li>• IC.4 No Re-Involvement in 6 Months After Exit</li> <li>• IC.5 Safe from Maltreatment 6 Mos. After involvement</li> <li>• IC.6 Children Safe Each Month of In-Home Services</li> <li>• IC.7 Length of Time State Involved</li> <li>• IC.8.1 Median Length of Time State Involved</li> <li>• IC.8.2 Median Length of Time in Foster Care</li> <li>• IC.8.3 Median Length of Time Receiving In-Home</li> <li>• IC.9 Current Child Status by Involvement Entry Cohort</li> </ul>
<ul style="list-style-type: none"> <li>• In-Home: Counts</li> <li>• In-Home: Key Practice Indicators</li> </ul>	<ul style="list-style-type: none"> <li>• PA.10 Permanency During Year for Children in Care 24+ Mos.</li> </ul>

**Table 2(e): Internal ROM Reports Available to DHS Staff**

<ul style="list-style-type: none"> <li>• In-Home: Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• PA.11 Permanency During Year for Children in Care 12 - 23 Mos.</li> <li>• PA.12 Adopted in less than 12 months of TPR</li> <li>• PA.6 Placement Moves Rate per 1,000 Days of Care</li> <li>• PA.7 Permanency in 12 Months of Entry</li> <li>• PA.8 Permanency in 24 Months of Entry</li> <li>• PA.9 Permanency Maintained 12 Months Following Exit</li> </ul>
<ul style="list-style-type: none"> <li>• Racial Disparity: Decision Points</li> <li>• Racial Disproportionality: Decision Points</li> <li>• Racial Disproportionality: Overview</li> <li>• RD 2 through 7: Disproportionality Index (DI)</li> <li>• RD 8 through 13: Disparity Ratio (DR)</li> <li>• RD.1 Decision Point Analysis</li> <li>• RD.14 Outcomes Summary by Race</li> </ul>	<ul style="list-style-type: none"> <li>• SA.3 Maltreatment Reports During Foster Care</li> <li>• SA.4 Safe from Maltreatment Recurrence for 6 months</li> <li>• SA.5 Maltreatment Rate per 100,000 days In-Home Services</li> <li>• SA.6 Maltreatment Reports During In-Home</li> </ul>
<ul style="list-style-type: none"> <li>• State Involved Counts</li> <li>• State Involved: Caseworker Visits</li> <li>• State Involved: Length of Services</li> <li>• State Involved: Outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• SU.5 Involved Episode Summary</li> <li>• SU.6 Outcomes Summary by Administrative Unit</li> <li>• SU.7 (Federal) Outcome Indicators Summary</li> </ul>

Source: Internal DHS ROM

The DHS QI unit also produces statewide monthly reporting supporting both workflow and performance on Worker and Parent Visitation, and on Initial Case Planning. The unit also produces other monthly reports which are service area (SA) specific to support needs specific to local focus areas. The unit also produces a variety of ad-hoc type reports and performs analysis on a wide range of topics.

One ad-hoc report/analysis project identified and quantified a set of factors in common across Recurrence of Maltreatment, Maltreatment in Care, and Re-entry into Foster Care. While it is probably common practice knowledge that the three factors contribute significantly to each of the measures, examining the three together helped Iowa to identify that we had no protocol (standard or best practice) when young children, who first experience the child welfare system while under 6, are abused or neglected and removed due to parental drug use. Not only does this represent about half of Recurrence, it is also nearly half of abuse in care. The abuse in care is not happening at the hands of substitute caregivers, but during weekend visits with the family during placement and over the six months while on trial home visits (THVs). Additionally, the frequency of the incidents of children returned home continues beyond the six months of THV and then begins to contribute to nearly half of the Re-entry into Foster Care for the young child's second episode. Iowa is now working to identify, train, and implement a protocol to improve child safety and performance on all three metrics.

Table 2(f): Recurrence of Maltreatment in SFY 2017 by Age

Recurrence SFY17	0 - 2	3 - 5	6 - 8	9 - 11	12 - 14	15+	Grand Total
Met	2334	1398	1264	997	817	532	7342
Not Met	358	224	185	147	77	41	1032
Grand Total	2691	1622	1449	1144	894	573	8374

Below are Tables 2(g): Abuse in Care (aka Maltreatment in Foster Care), 2(h): DHS Abuse in Care by Removal, Parental Drugs, 2(i): DHS Abuse in Care by Number Prior FC Episodes, 2(j): Re-Entry into Foster Care in SFY 2017 by Age, and 2(k): Interconnection of Maltreatment in Foster Care and Re-Entry into Foster Care.

ABUSE IN CARE (AKA - MALTREATMENT IN FOSTER CARE)							
DHS Abuse in Care by Age Group	0 - 2	3 - 5	6 - 8	9 - 11	12 - 14	15+	Grand Total
CEDAR RAPIDS	9	17	5	8	9	7	55
DES MOINES	15	14	14	14	10	8	75
EASTERN	17	15	11	5	5	6	59
NORTHERN	11	3	7	9	5	11	46
WESTERN	13	20	9	17	11	7	77
<b>Grand Total</b>	<b>65</b>	<b>69</b>	<b>46</b>	<b>53</b>	<b>40</b>	<b>39</b>	<b>312</b>
Cumulative #	65	134	180	233	273	312	
Cumulative %	21%	43%	58%	75%	88%	100%	

Of the 312 children with Abuse during episode of FC, 134 or 43% were under age 6.

\* 36% of all children in care are under age 6.

DHS Abuse in Care by Removal - Parent Drugs	Applies	Does Not Apply	Grand Total
CEDAR RAPIDS	12	14	26
DES MOINES	17	12	29
EASTERN	21	11	32
NORTHERN	12	2	14
WESTERN	19	14	33
<b>Grand Total</b>	<b>81</b>	<b>53</b>	<b>134</b>
Cumulative #	81	134	
Cumulative %	60%	100%	

Of the 134 children under 6 with Abuse during episode of FC, 81 or 60% were removed due to parents drug use.

\* 45% of all children in care were removed dur to parents drug use.

DHS Abuse in Care by Number Prior FC Episodes	0	1	Grand Total
CEDAR RAPIDS	10	2	12
DES MOINES	16	1	17
EASTERN	20	1	21
NORTHERN	12		12
WESTERN	16	3	19
<b>Grand Total</b>	<b>74</b>	<b>7</b>	<b>81</b>
Cumulative #	74	81	
Cumulative %	91%	100%	

Of the 81 children removed due to parents drug, under 6, with Abuse during episode of FC, 74 or 91% were experiancing their 1st episode in care.

ReEntry	Age						Grand Total
	0 - 2	3 - 5	6 - 8	9 - 11	12 - 14	15+	
<b>Met</b>	254	225	169	152	112	403	1315
Removal parent drug Applies	126	126	91	78	44	53	518
Removal parent drug Does Not Apply	128	99	78	74	68	350	797
<b>Re-entry</b>	42	26	15	15	19	17	134
Removal parent drug Applies	25	15	12	12	8	7	79
Removal parent drug Does Not Apply	17	11	3	3	11	10	55
<b>Grand Total</b>	<b>296</b>	<b>251</b>	<b>184</b>	<b>167</b>	<b>131</b>	<b>420</b>	<b>1449</b>

Time →			
RPT1	Plcmnt1	Rpt2	Abuse in Care
RPT1	Plcmnt1	THV1	Rpt2 Abuse in Care
RPT1	Plcmnt1	THV1	Home Rpt2 ReEntry to Care

Iowa also uses the OMS to extract data from the CFSR case reviews conducted. Staff generates annual reports based on the data from the OMS. However, the data must be manipulated following extraction in order to put the data in a format that is easily understood, allows for comparison across geographic areas of the state, and provides longitudinal information to assess performance trends both by service area and statewide.

*Feedback to stakeholders and decision makers and adjustment of programs and processes:* Iowa shares data and analysis with stakeholders through existing collaborations as noted throughout this report and Iowa's FFY 2015-2019 Final Report, which will be available on the DHS website at <https://dhs.iowa.gov/reports/child-and-family-services-review>. Data via ROM is available on demand from the DHS website. Stakeholders may submit questions or suggestions regarding ROM to the DHS Program Manager noted on the website. Data related to Differential Response (DR) implementation is also on the DHS website with contact information if stakeholders have questions and/or comments. Stakeholders requested we engage them in their expertise areas. The most efficient way to do this is to utilize existing collaborations. We continue to explore how the feedback loop can be strengthened.

Examples of specific stakeholder processes include:

- Service Area All Contractor Meeting – Held in each Service Area, these meetings are attended by agency leadership; i.e. Director level of agencies that hold contracts with DHS. This group comes together in quarterly to share agency updates, performance data, as well as the current focus of the state as a result of upcoming policy and/or contract changes. This allows everyone to have a voice and provide feedback regarding upcoming changes. Often times this is a time for stakeholders to communicate regarding any barriers that they are experiencing and begin problem-solving issues. Attendees include Leadership from providers of group care, shelters, FSRP agencies, PMIC, Parent Partner program, Foster care

recruitment contract holder, as well as Decategorization (Decat) project coordinators, and JCS Chiefs.

- Foster/Adopt Parents – Service Area Adoption/Licensing Supervisors periodically attend regularly scheduled foster parent support groups within the service area to gather any feedback from them, to ensure that their needs are being met and brought back to DHS.
- Joint Supervisor Meetings – These occur quarterly between DHS, FSRP, and Foster Care supervisors. This is time to partner and problem solve regarding service-related issues that staff are experiencing. Any Contractor Meeting is also shared with supervisors here. Supervisors often jointly develop topics for cluster PALS meeting that are warranted as a need for field staff.
- Preparation for Adult Living (PAL) Meetings – These occur quarterly between front line staff from DHS, FSRP, and some foster care Case Managers. Various topics that are directly related to services and upcoming policy/practice changes are discussed. Local speakers will share information related to the resource available to DHS staff and clients.
- Joint QA Meetings – Occurs in some Service Areas quarterly between DHS QA staff and QA staff from the contracted agencies 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 agencies for continuous improvement.
- Community Outreach – Social Work Supervisors have each developed a plan that outlines what community members they are committed to contacting and how frequently to ensure that the lines of communication are open. For example, local schools, substance abuse providers, judges, JCOs, Decat boards, mental health providers, clinical case consultation teams, etc.

*(5) evaluates implemented program improvement measures*

The DHS will incorporate the CFSR data into our existing process for CQI, specifically being referred to the Service Business Team (SBT) and the Child Welfare CFSR Oversight Group to help guide decision-making regarding focus areas and action steps.

- Service Business Team (SBT): The DHS leadership identifies key performance areas for the state. These areas represent a subset of all CFSR measures that are prioritized for state focus and are determined by review and analysis of performance reports. The DHS is moving toward an organized system of prioritizing items in sequence so, as quality improvement efforts are completed, the next focus area is initiated. By identifying statewide priority areas, Iowa creates focus, alignment, and consistency in efforts to change/improve practice. Staff reviews monthly, at the service area level, and statewide at all levels throughout the DHS, data on the priority items. Staff analyzes the data identifying trends, which helps to determine where strategies are effective and where strategies need enhanced. The process also identifies those service areas that are achieving the established target, which leads to sharing of information on effective strategies that may be implemented across service areas.
- Child Welfare CFSR Oversight Group: The Child Welfare CFSR Oversight Group is the core/oversight working group responsible for leading the PIP change effort. The

team is also responsible for the communication plan to facilitate the engagement and involvement of all other partners and stakeholders in the development of the PIP and communication thereafter. Group members use existing channels of communication with other partners, courts, providers and other to share information and to seek feedback. Through the work of this group, the CFSR data can provide a lens to begin to funnel information and target strategic focus areas.

When developing the program improvement plan (PIP) following the 2018 on-site CFSR, each strategy for improvement includes a monitoring phase early during the implementation period in order to provide real-time data as to the implementation success or the need to adjust strategies if progress is not being made. (Please see Attachment 2C: State of Iowa Performance Monitoring and Improvement Business Process)

Please see *Section III: Plan for Enacting Iowa’s Vision* which reflects CFSR PIP feedback loops utilized to develop Iowa’s CFSR PIP that comprises Section III.

Substantial Conformity Rating

**QUALITY ASSURANCE SYSTEM**

<b>Data Element</b>	<b>Source of Data and Information</b>	<b>State Performance</b>
<b>Quality Assurance System</b>	Statewide Assessment and Stakeholder Interviews	Not in Substantial Conformity
<b>Item 25</b> Quality Assurance System	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

Children’s Bureau Comments on Iowa Performance<sup>4</sup>

- “The Children’s Bureau notes that although Iowa has a functioning Continuous Quality Improvement (CQI) system in place in all regions of the state, the quality assurance system varies in operation across regions. The CQI system also lacks a healthy feedback loop to ensure that frontline staff and providers can readily identify strengths and areas needing improvement statewide.” (p. 5)
- Item 25: “Information in the statewide assessment showed that elements of a quality assurance system exist in each jurisdiction of the state but that not all elements are functioning as required in all geographic areas. There is not a functional feedback loop to ensure that frontline staff and providers can identify

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<sup>4</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 5 and 18.

strengths and needs, and it is unclear how program improvement measures are being evaluated across the state. Stakeholders reported that some frontline staff do not have access to relevant data reports. Others stated that while they do have access, the reports are underutilized statewide.” (p. 18)

#### Current or Planned Activities to Improve Performance

- FFY 2020: Improve feedback loops through:
  - Develop standard talking points, by SBT or their delegate, to prompt data analysis and feedback
  - Utilize existing structures (local and statewide meetings with SAMs, SWAs, field staff and providers; quarterly provider meetings; Child Welfare Partners Committee; PIP oversight group, etc.) to add a standard agenda item to present data, promote discussion, and receive feedback; this will include feedback on actions taken based on previous stakeholder feedback.
  - Conduct annual QA meeting with internal and external stakeholders to review data, discuss strengths and opportunities for improvement, and discuss any changes needed in improvement plan strategies
  - Develop a centralized repository to compile stakeholder feedback for routine review and action as warranted
  - Family First implementation activities - Feedback loops for implementation of Family First, e.g. for Title IV-E Prevention Services, will be another feedback loop with internal and external stakeholders that can only strengthen Iowa’s QA system overall.
- FFY 2021-2024: Continue feedback loop processes discussed above

#### *Staff Training (45 CFR 1355.34(c)(4))*

Item 26: Initial Staff Training and Item 27: Ongoing Staff Training - Please see Iowa’s FFY 2020-2024 Training Plan, Attachment 7D(1) and (2), with attachments, referenced in *Section VII: Targeted Plans* of this report.

#### Item 28: Foster and Adoptive Parent Training

**Foster and Adoptive Parents:** Each RRTS contractor completes pre-service and in-service training in their Service Areas. Pre-service training consists of Trauma Informed Partnering For Safety and Permanence - Model Approach To Partnerships In Parenting (TIPS-MAPP), Caring for Our Own, and Deciding Together. Contractors must have training available for families within 60 days of the family completing an orientation session. The aligned curricula provide families with much of the same information but allows for more flexible and accessible training across the state, especially for families in rural areas. For example, Deciding Together allows training in smaller group settings or individually if needed. Iowa requires prospective foster families to complete CPR, First Aid, Mandatory Reporter of Child Abuse, Universal Precautions, and Reasonable and Prudent Parenting Standards trainings prior to licensure. This allows new families to receive more specialized training related to the children in their care during the first year of licensure.

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

There is no data available at this time for ongoing training of foster and adoptive parents under the new RRTS contracts. However, in FFY 2020, the new DHS family foster care program manager will be working with the contractors and contract specialist to implement a tracking mechanism.

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

In addition, licensure standards require training for staff (with a designated staff person responsible for staff development). Internal training includes, but is not limited to, agency policies and procedures, mandatory reporter training and safe use of restraints. New contracts that began on July 1, 2017, require DHS approved training plans that are comprehensive and targeted to the services for which staff are responsible and delivered in a manner that teaches staff to promote the safety, permanency, and well-being for each child in care. They include, but are not limited to, the following:

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

### Child Welfare Provider Training Academy (Training Academy)

The Child Welfare Provider Training Academy (Training Academy) is a partnership with the DHS 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 service organizations and DHS in their efforts to train and retain child welfare workers and positively impact 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 DHS Training Committee. The Training Academy Coordinator leads the Training Academy Workgroup and is an active member of the DHS Training Committee.

During the reporting period, April 2018 – March 2019, the Training Academy delivered a total of **50** in-person trainings in three regions throughout the state and via live webinar. The Training Academy reached a total of **813** participants in the following topic areas:

- Trauma Informed Program: Understanding Trauma – Level 1 (Foundation)
- Trauma Informed Program: Understanding Trauma – Level 2 (Self Care)
- Trauma Informed Program: Understanding Trauma – Level 3 KINNECT: (Safety)
- Trauma Informed Program: Understanding Trauma – Level 4 KINNECT: (Emotion)
- Trauma Informed Program: Understanding Trauma – Level 5 KINNECT: (Loss)
- Webinar: Impact of Neglect
- Webinar: Fundamental Behavioral Conditioning
- Webinar: Supervision Dynamics in Human Services
- Blended Learning: Reactive Attachment Disorder
- Blended Learning: Dangerous Playgrounds 3.0
- Family Team Decision-Making (FTDM) Meetings
- Youth Transition Decision-Making (YTDM) Meetings
- Family Team-Decision-Making (FTDM) Meetings with Domestic Violence
- Coaching for Family Team Decision-Making (FTDM) Meeting Facilitators and Youth Transition Decision-Making (YTDM) Meeting Facilitators

In comparison to the previous reporting period, the Training Academy delivered one (1) additional in-person training and reached an additional seventy-four (74) participants.

**In-Person Trainings:** The in-person trainings occur throughout the state and consist of either a six (6) hour training course, a three (3) hour training course, or via live webinar, designed around identified training topics/needs of child welfare workers. The courses reflect different levels of child welfare practice, such as basic/new worker, intermediate/more experienced worker, and advanced/supervisory level worker.

During the reporting period, April 2018 – March 2019, of the completed evaluations received from the in-person trainings, **92.03%** of participants reported the information provided at the training was relevant to their jobs, while **94.15%** reported they will be able to apply the knowledge they learned.

**Blended Learning Training:** This is a package of training established to provide a tiered learning process.

1. Pre-Learning: The attendee completes the identified pre-learning component of the training prior to attending the in-person training. Pre-learning could consist of watching a power point presentation or other online video component or completing self-guided reading. The intent is to introduce the training topic to the participant prior to the in-person event.
2. In-Person: This training process builds upon the foundation created in the on-line course. The in-person training occurs in at least three (3) regions throughout the state.
3. Webinar: The webinar occurs, on average, two weeks after the last in-person training. The webinar provides an opportunity for discussion, including any challenges the participants have implementing what they learned.

During the reporting period, April 2018 – March 2019, the Training Academy hosted two blended learning courses covering the topics of reactive attachment disorder and substance abuse.

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

Contractors utilize Relias to train new hires and ongoing professional development to retain current workers and supervisors. During the reporting period, April 2018 – March 2019, **14** of the **15** active child welfare service contractors completed **3,757** courses (**236** unique courses) for a total of **4,839.10** credits earned by **982** users. In comparison to the previous year's reporting, the number of course and credit hours earned increased, while overall unique users decreased.

The Training Academy began utilizing Relias as a mechanism by which to create and share enhanced professional development opportunities relatable to the needs of Iowa child welfare service contractors. There continues to be ongoing sharing of course content with Relias users and supervisors through a course of the month. This highlights the various training opportunities available through the online learning library.

**Understanding Trauma Training:** The Training Academy contracted with Frank Grijalva, President of Midwest Trauma Services Network (MTSN), for delivery and training of the Understanding Trauma trainings. Under Grijalva's mentorship, Billy

Claywell received a contract to assist in the development of facilitators for the Level 1 (Foundation of Trauma) and Level 2 (Self-Care) trainings. Grijalva maintained the delivery, oversight, and mentorship for the KINNECT series, Levels 3-5, dealing with Safety, Emotion, and Loss. Utilization of the KINNECT series occurs with youth placed in residential settings. KINNECT Level 6 (Future) is the last module in the Understanding Trauma Training and offerings are in May or June 2019. The KINNECT curriculum builds a progressive set of skills that lead to future orientation. The final week of KINNECT allows the participants to look forward to future activities based on previous experience and begin to plan with positive thoughts and energy to engage in pro-social processes.

The goals of the MTSN and Training Academy partnership are to design, support, maintain, and sustain as experts in Trauma Informed Care and through the Training Academy's implementation of quality assured training and a train the trainer program to build capacity to meet the needs of the various child welfare service contracts.

The Training Academy continued to develop facilitators in order to deliver the Understanding Trauma training within organizations and communities across Iowa. Facilitators completing the process gain the knowledge, skills, and experience to deliver the Understanding Trauma training at the appropriate level; receive mentorship and coaching from Frank Grijalva or Billy Claywell; and receive technical assistance support through the Training Academy. In order to complete the process, facilitators need to participate in Roundtable training, offered by either Frank Grijalva or Billy Claywell; complete two (2) co-facilitations with a colleague in the cohort under the supervision of either Grijalva or Claywell; and complete two (2) individual facilitations under the supervision of either Grijalva or Claywell.

During the reporting period, April 2018 – June 2019, the following cohorts were completed, or in process of completion:

- Level 1 (Foundation): Seven (7) participants completed the training. A selection of another cohort occurred with six (6) new participants.
- Level 2 (Self-Care): Five (5) participants.
- KINNECT Level 3 (Safety): Two (2) participants.
- KINNECT Level 5 (Loss): Four (4) participants.
- KINNECT Level 6 (Future): A cohort of the approved Level 5 will move forward to Level 6 during the next fiscal year.

As of March 31, 2019, there are twenty-two (22) approved facilitators to deliver the Understanding Trauma training curriculum. All twenty-two (22) are approved to deliver the Level 1 (Foundation) training; eleven (11) are approved to deliver the Level 2 (Self-Care) training; six (6) are approved to deliver the Level 3: KINNECT (Safety) training; and four (4) are approved to deliver the Level 4: KINNECT (Emotion) training. By June 30, 2019 the four (4) completing the Level 5: KINNECT (Loss) will be approved and eventually move on to Level 6: KINNECT (Future) in FY 2020.

One purpose of the training model is to have the information readily available within organizations and communities across the state. Once a facilitator successfully completes the process, they may provide the training as requested and needed. During this reporting period, collection of the following information occurred to determine the reach of the training across the state. The numbers reflected below are beyond the trainings completed during the facilitator training process.

- Level 1 Foundation: Total **59** trainings; **643** individuals trained
- Level 2 (Self-Care): Total **26** trainings; **310** individuals trained
- KINNECT Level 3 (Safety): Total **14** trainings; **82** individuals trained
- KINNECT Level 4 (Emotion): Total **10** trainings; **50** individuals trained

**Family Team Decision-Making (FTDM) Meeting and Youth Transition Decision – Making (YTDM) Meeting Training:** The Training Academy partnered with the DHS to manage the delivery of the FTDM and YTDM meeting training series. Additional courses include FTDM Meeting with Domestic Violence and FTDM/YTDM Coaching training.

During the reporting period, the Training Academy provided the three-day FTDM meeting facilitator course on four (4) occasions, with **63** individuals in attendance. This course is required for participants to become eligible for approval to facilitate FTDM meetings within their organizations and communities. This remains an ongoing need within child welfare service contractor and other service provider organizations as worker turnover has been a challenge to maintain FTDM meeting facilitators. The YTDM meeting facilitator course occurred on two (2) occasions and included **23** participants.

**Website Maintenance:** The Training Academy continues to maintain a website, <https://www.iatrainingsource.org/>, to host training information, which includes easy access to online registration. This is also a valuable training tracking tool for the Training Academy to determine the availability of courses in the community. The website is also a hosting mechanism for the required FTDM and YTDM meeting documents, forms, and additional supportive information as well as family interaction.

**Ongoing Training Plan Maintenance:** The following courses are scheduled during April, May, and June 2019:

- Family Team Decision-Making (FTDM) Meeting Facilitation
- Youth Transition Decision-Making (YTDM) Meeting Facilitation
- Family Team Decision-Making (FTDM) Meeting with Domestic Violence
- Family Team Decision-Making (FTDM) and Youth Transition Decision-Making (YTDM) Fundamentals
  - The purpose of this course is to provide an understanding on the philosophy, roles, and outcomes of FTDM and YTDM meetings as a child welfare service contractor attending meetings, not facilitating. This course was recently developed and a pilot offering will occur in June 2019. Once feedback is collected and any necessary modifications made to the course, it will be finalized and offered in the next fiscal year.
- Coaching for Family Team Decision-Making (FTDM) Meeting Facilitators and Youth Transition Decision-Making (YTDM) Meeting Facilitators

- Understanding Trauma: Level 1 (Foundation)
- Understanding Trauma: Level 2 (Self Care)
- Understanding Trauma: KINNECT Level 3 (Safety)
- Understanding Trauma: KINNECT Level 5 (Loss)
- Understanding Trauma: KINNECT Level 6 (Future)
- Blended Learning: Over the Line? Ethics & Boundary Issues in Social Media and the Real World
- Blended Learning: Compassion Fatigue
- Stay in Your Lane: How to Navigate Testifying in Court
- Supervision Training

**Training Academy Workgroup:** The Training Academy workgroup includes representation from the various child welfare services contracts and geographical regions across the state. The mission is to inform and guide the direction of the Training Academy to ensure courses meet the needs of the child welfare service direct line workers and supervisors.

During this reporting period, the workgroup met on four (4) occasions, two in-person and two by phone. The meetings provided updates to the workgroup on activities of the Training Academy as well as elicit information about ongoing needs in the profession. During the in-person meeting in April, the workgroup members provided greater understanding for needs for SFY 2020. The workgroup will meet in July 2019 to review and provide feedback for development of the SFY 2020 training plan.

A meeting occurred on April 30, 2019 with the DHS Contract Manager and the Training Academy Coordinator to discuss the scope of work for this contract moving forward in SFY 2020.

Substantial Conformity Rating

**STAFF AND PROVIDER TRAINING**

<b>Data Element</b>	<b>Source of Data and Information</b>	<b>State Performance</b>
<b>Staff and Provider Training</b>	Statewide Assessment and Stakeholder Interviews	Not in Substantial Conformity
<b>Item 26</b> Initial Staff Training	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 27</b> Ongoing Staff Training	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 28</b> Foster and Adoptive Parent Training	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

### Children's Bureau Comments on Iowa Performance<sup>5</sup>

- “All three items under Staff and Provider Training were rated as areas needing improvement, with a noted lack of available supervisor training to enhance supervisor leadership and management skills” (p. 5).
- Item 26: “Information in the statewide assessment and collected during stakeholder interviews showed that very few new staff complete the initial training curriculum within the required timeframes. Stakeholders said there can be significant waiting times for training that is offered on a set cyclical schedule. Stakeholders provided varied information regarding the effectiveness of initial training, with some indicating that the effectiveness is directly linked to the timeliness of training. For instance, the training is more effective if offered during the first few months of hire rather than waiting several months. Stakeholders said that formal classroom training meets the needs of new workers, but that support and education in non-classroom settings is also essential to learning the case manager responsibilities.” (p. 19)
- Item 27: “Information in the statewide assessment and collected during interviews with stakeholders showed that many of the staff across the state do not complete the required ongoing training hours within the state’s established timeframes. Stakeholders also reported a lack of supervisor training to promote development of child welfare supervisory and management skills.” (p. 19)
- Item 28: “In the statewide assessment, no data were provided to determine the extent to which foster parents and staff of state-licensed facilities have completed the required training within the specified timeframes. Stakeholders reported that the training for state-licensed facilities and for foster and adoptive parents does not adequately prepare them for the increasingly high-need population of children entering foster care.” (p. 19)

### Current or Planned Activities to Improve Performance

- Initial and ongoing staff training – Please see Iowa’s FFY 2020-2024 Training Plan, Attachment 7D(1) and (2), referenced in *Section VII: Targeted Plans* of this report.
- Foster and adoptive parent training, which includes staff of state licensed facilities (CISR contractors):
  - DHS will work with RRTS and CISR contractors to conduct the following improvement activities:
    - Training Data:
      - In FFY 2020, develop and implement a tracking mechanism for foster parents and staff of state-licensed facilities to ensure completion of required training within specific timeframes.

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<sup>5</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 5 and 19.

- In FFY 2021-2024, monitor, and revise as necessary, tracking of training completion within required timeframes.
- Training Content:
  - In FFY 2020, in coordination with considering models of therapeutic family foster care and collaboration with staff of state licensed facilities,:
    - review existing initial and ongoing training requirements
    - consider additional training needs as expressed through CFSR stakeholder interviews, surveys, forums, etc.
    - revise initial and ongoing training requirements, if needed, based on identified needs
    - develop additional training to meet identified needs
  - In FFY 2021, implement revised training and training requirements, if applicable
  - In FFY 2022-2024, monitor progress so that foster care providers, which includes staff of state licensed facilities, have the knowledge base and skills needed to carry out their duties with regard to foster and adopted children.

*Service Array (45 CFR 1355.34(c)(5))*

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

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

Please see *Section IV: Services* and *Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)* of this report for information regarding Iowa’s child welfare service array.

Substantial Conformity Rating

**SERVICE ARRAY AND RESOURCE DEVELOPMENT**

Data Element	Source of Data and Information	State Performance
Service Array and Resource Development	Statewide Assessment and Stakeholder Interviews	Not in Substantial Conformity

Data Element	Source of Data and Information	State Performance
<b>Item 29</b> Array of Services	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement
<b>Item 30</b> Individualizing Services	Statewide Assessment and Stakeholder Interviews	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

Children’s Bureau Comments on Iowa Performance<sup>6</sup>

- “The Service Array systemic factor was not in substantial conformity. A lack of resources across Iowa is a cross-cutting concern identified by stakeholders during the review. Information gathered from the statewide assessment and stakeholder interviews indicates significant challenges in accessing and individualizing needed services in the more rural areas of Iowa, primarily areas farther from Des Moines and Cedar Rapids. The top concerns across the state include a lack of access to mental health services, housing, substance abuse treatment services including in-patient care, developmental disability services, and transportation services. A lack of drug testing locations and services to get parents to those locations was also a statewide concern, as were limited drug testing hours that can be a barrier for parents employed during traditional work hours. Stakeholders indicated the possible overuse of drug testing in Iowa, such as even when behavioral indicators of substance abuse are not present. Another service concern expressed was whether placement resources are routinely individualized for youth in foster care, with some stakeholders reporting that placement resources are not individualized to address youth with high needs, and as a result, youth are placed in homes or facilities based on bed availability or location rather than on services that match the youth’s needs.” (p. 4)
- Item 29: “Statewide assessment information indicated, and stakeholders confirmed, that while many services exist within the service array, there are significant issues of accessibility to available services, especially in the more rural areas of the state. Stakeholders also identified barriers to services including a lack of transportation, distance, and waitlists for needed services such as mental health, substance abuse treatment, disability services, and housing.” (p. 20)
- Item 30: “Data and information from the statewide assessment indicated variation in individualizing and tailoring services to the unique needs of children and families, including the provision of culturally competent services. Stakeholders reported that services may be more individualized in urban areas of the state than in rural areas, and that a lack of foster homes across all jurisdictions of the state affects the state’s

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<sup>6</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 4 and 20.

capacity to match available placements to the needs of the child. Stakeholders also noted that more children are entering care after adoption and spoke of a need for individualized post-adoption services across the state.” (p. 20)

### Additional Assessments

- **Annie E. Casey Foundation, Child Welfare Strategy Group (CWSG)** – In the fall of 2018, Iowa 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. Specifically, the CWSG:
  - Assessed the needs of children and families served by Iowa’s child welfare system and Iowa’s service array to see if services provided met identified needs.
  - Recommended service models for foster care prevention services.
  - Assisted the DHS in planning to support Family First Prevention Services Act 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 use disorder (SUD) issues. CWSG noted that child welfare system issues that undergird these challenges are lack of individualization of services, lack of experienced workforce capacity, and lack of efficacious accountability. In response, CWSG recommended the following:

- Develop a clear case management model
- Use targeted evidence-based interventions
- Institute stronger accountability for DHS and FSRP providers

Iowa will continue working with CWSG to guide implementation efforts.

- **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, crafting effective implementation strategies, and strengthening the quality of front-line practice through training and coaching.
  - In 2019, the CWG continued its work by eliciting 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). DHS central office staff managed the venues, invitations, and scheduling, there were no DHS employees present at any of the Forums. Recommendations include, but are not limited to, the following:
    - “Create a new provider manual to enhance role clarity and communication between DHS staff and provider care coordinators (CC), with CC involved in the development of the manual.

- Determine and clearly define in both policy and the provider manual the role of the DHS staff in relation to the FSRP CC.
  - Consider whether the current system provides the greatest efficiency and is most effective in engaging families and meeting their needs.
- Gather information from DHS staff regarding their experiences in working with CC regarding issues of communication, FTDM's, transportation, court, and drug testing.
- After analysis of DHS staff information, host, with neutral facilitation, joint DHS/provider in-person opportunities, within counties or Service Areas, to "launch" the manual and re-emphasize the need for strong relationships. The manual is a logical first step toward addressing issues identified by both service providers and DHS. Additionally, use the day for team-building, review of Iowa child welfare data, etc.
- DHS staff should define "negotiations" related to the next contracting process, decide whether they can occur or not, and share decision with providers as soon as possible.
- Transportation – Explore ways to minimize the need for formal transportation services:
  - Is there an opportunity to keep more children in their communities through increased kinship placements?
  - Are foster parents involved as full members of the child and family team and thus understanding of their role in accompanying children to visits, court hearings, therapy sessions, and medical appointments?
  - Are foster parents prepared to interact with children's bio parents including hosting visits in the foster home when this is appropriate?
  - How can informal resources be involved or parents helped to develop their own transportation resources?
    - Identify which county/service area has the greatest number of informal supports providing transportation; find out how they have made this a successful priority; and work to replicate.
  - Are there locales where bus tokens would enable parents to use public transit?
- Consider why there is a provider service plan and a DHS case permanency plan.
  - Do families understand the purpose of these?
  - Are families involved in the development of each one and invested in their fulfillment?
- Determine the education and skill level truly needed by direct service personnel both in DHS and in provider agencies. It is important that DHS act now to define its actual labor force needs and costs and work to engage

universities and clinical professional groups as partners in defining and developing an effective workforce.”<sup>7</sup>

### Current or Planned Activities to Improve Performance

Iowa will improve prevention and front-end intervention services through improved case management services (e.g. Solution-Based Casework), evidence-based interventions (e.g. SafeCare®), and robust teaming and collaboration, along with changes in how federal funds support the child welfare system.

- In FFY 2020, DHS staff will be trained in Solution Based Casework® (SBC), which will be the department’s “clear case management model”.
- Beginning in the last quarter of FFY 2020, DHS will enter into 10 performance-based contracts, two in each of the five Service Areas, for delivery of family centered services (FCS) in all areas across the state. Contracts will meet the following objectives:
  - FCS will be available to intact families (in-home), families with children placed with kin/fictive kin caregivers, and families with children placed in foster care.
  - FCS will require an evidence-based intervention designed to improve parent skill training and/or address youth-driven behavior.
  - FCS provision will be less than 12 months.
  - FCS will include family preservation services designed to meet the intensity of family need most likely to result in foster care placement.
  - Integrated teams may be used to meet families’ needs. Integrated teams may comprise Intervention Specialists certified/trained in evidence-based interventions and Family Support Specialists.
  - FCS provision will not be available for children placed in shelter or group care placement longer than 30 days.

FSC comprise the following:

- Solution Based Caseworker® (SBC) and Child Safety Conference Facilitation
- Family Team Decision-Making (FTDM) and Youth Transition Decision-Making (YTDM) Meeting Facilitation
- SafeCare®
- Family Preservation Services, Child Safety Conference Facilitation, and Motivational Interviewing

Contracts will have an initial two year contract term with the ability to extend the contract for four additional one-year terms. Bidder requirements include the following:

- Accreditation:

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<sup>7</sup> The Child Welfare Policy & Practice Group, Iowa Department of Human Services, Provider Forums Report, June 2019.

- Must be accredited by Council on Accreditation (COA) for one or more services related to child welfare, Joint Commission for Behavioral Health Care Services, or Council on Accreditation for Rehabilitation Services (CARF) for child and youth services
  - Maintain accreditation during contract period
  - If not accredited, apply for accreditation within 3 months of contract execution, receive accreditation within 21 months of contract execution date, and main accreditation during contract period.
- SafeCare:
  - Accredited by the National SafeCare Training and Research Center
  - If not accredited, apply for accreditation within 3 months of contract execution, receive accreditation within two years of contract execution date, and main accreditation during contract period.

Additional contract requirements include:

- DHS and providers jointly develop practice standards to be utilized under the contracts
- Providers have case management for non-DHS cases
- Transportation:
  - Providers coordinate transportation planning for parent/child or sibling interaction with the child’s kin/fictive kin caregivers, foster parents, DHS staff, providers, or other applicable persons.
  - Providers can directly provide transportation assistance, provide funding for transportation supports, or arrange transportation through a community resource or the family’s support network.
- Complete service plan that aligns with the department’s family case plan and give the service plan to the parents, unless parental rights have been terminated. Accreditation criteria require providers have service plans.
- Staff qualifications and caseload sizes by staff role
- Quality assurance and improvement reporting requirements
- Expedited Kin License: In FFY 2020, DHS will explore an expedited kin license process as a mechanism to provide financial support to unlicensed relatives/kin and keep more children with relatives. Implementation will depend upon the availability of resources.
- Robust teaming/collaboration with the following systems to address significant challenges in accessing and individualizing needed services in the more rural areas of Iowa, including addressing barriers to services such as a lack of transportation, distance, and waitlists
  - Mental health services – DHS’ MHDS Division, Community Mental Health Centers, Rural Health Centers, potential use of “telehealth” services, etc.
  - Housing – Iowa Finance Authority
  - Substance use disorder treatment services, including in-patient care – Iowa Department of Public Health and private providers
  - Developmental disability services - DHS’ MHDS Division, Iowa Department of Human Rights, Office of Persons with Disabilities, etc.
  - Transportation services – local transportation authorities

- Drug testing – Please see *Section IV: Services, Intervention, Drug Testing* for planned services’ improvements
- Foster care placement resources – Please see *Attachment 7A – FFY 2020-2024 Diligent Recruitment Plan* and *Attachment 7A(1) – Five Year Diligent Recruitment Plan* for activities to improve foster care placement resources

*Agency Responsiveness to the Community (45 CFR 1355(c)(6))*

Please see Collaboration in *Section I: Collaboration and Vision*, Service Coordination in *Section IV: Services*, and *Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)* for information regarding this systemic factor.

Substantial Conformity Rating

**AGENCY RESPONSIVENESS TO THE COMMUNITY**

<b>Data Element</b>	<b>Source of Data and Information</b>	<b>State Performance</b>
<b>Agency Responsiveness to the Community</b>	Statewide Assessment and Stakeholder	Substantial Conformity
<b>Item 31</b> State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR	Statewide Assessment and Stakeholder Interviews	Strength
<b>Item 32</b> Coordination of CFSP Services With Other Federal Programs	Statewide Assessment and Stakeholder Interviews	Strength

Source: Child and Family Services Review, Iowa Final Report, 2018

Children’s Bureau Comments on Iowa Performance<sup>8</sup>

- Item 31: “Information from the statewide assessment and collected during interviews with stakeholders showed that the state actively seeks input from stakeholders in leadership and upper management positions within the agency in the development of CFSP goals and annual updates. Stakeholder interviews also confirmed that the state has various processes in place to solicit and gather feedback from the legal and Tribal communities to develop CFSP goals and annual updates.”
- Item 32: “Information in the statewide assessment and gathered from stakeholder interviews included numerous examples to illustrate how the state coordinates services and benefits with other federal programs serving the same population. As examples, the state noted coordination and partnership activities with the child

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<sup>8</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 21.

support and child care programs, Temporary Assistance to Needy Families, Medicaid, and the Iowa Department of Workforce Development.”

Current or Planned Activities to Improve Performance – Continue and enhance collaboration with the substance use disorder, mental health, disability services, housing, and workforce systems to increase system capacity to serve child welfare involved families

*Foster and Adoptive Parent Licensing, Recruitment, and Retention (45 CFR 1355.34(c)(7))*

Item 33: Standards Applied Equally

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

DHS has a process to waive non-safety standards for relatives who apply to become licensed foster parents for a child in their care. Relatives who are caring for a child in the home and who apply to become licensed or approved may have the 30 hours of pre-service training waived, as well as any non-safety standards such as bedroom space, or sibling sharing a room. Licensed relative foster parents are required to complete the same in-service training hours and other licensing requirements as any other licensed foster family.

Non-relative applicants complete the 30 hours of pre-service training, background checks on all adult household members, and the home study. Non-relative foster family applicants may be given a variance to a non-safety standard when an alternative is presented that meets the requirement. An example would be an applicant who cannot secure their divorce decree provides a written statement from a family member that the divorce occurred.

Requests to waive a non-safety standard or allow a variance to meeting a standard are presented in writing to local area leadership. The request is reviewed and a written decision made to allow or deny the waiver or variance request. Child specific requests are voided when the child leaves the foster home.

In SFYs 2016 through 2018, Iowa licensing data for foster homes indicate that 0% of foster homes were approved without meeting full licensing standards. All licensed foster family homes meet licensing standards as Iowa does not issue provisional licenses. If after licensure a licensed foster family is found to be out of compliance or no longer meets a licensing standard that has not been waived or given an approved

variance, a corrective action plan is put in place to correct the deficiencies. Failure to complete the corrective action plan may result in removal of the license. Iowa does not have data available at this time regarding corrective action plans.

**Shelter and Group Care Facilities:** DHS signed a Memorandum of Understanding with the Department of Inspections and Appeals (DIA) for the initial licensure survey, annual and other periodically scheduled onsite visits, unannounced visits, complaint investigations, and re-licensure surveys of emergency juvenile shelter and group care facilities. The DHS is the licensing agent for these programs and uses the DIA's written reports and recommendations to make all final licensing decisions before it issues licenses, certificates of approval, and Notices of Decision. Exceptions to licensure policies may be granted for shelter and group care facilities by the DHS when circumstances justify them, but they are rarely requested or needed. Provisional licenses are not common, but they might be used temporarily in lieu of full licensure in order to give a facility time to correct licensing deficiencies. Not all identified deficiencies result in the need for provisional licensing or a formal corrective action plan. However, all licensing deficiencies are to be corrected by the licensee. Services continue under a provisional license when determined that the safety of the youth in care is not jeopardized. Provisional licenses require corrective action plans that generally last for about 30 days, which is usually sufficient to correct the deficiencies and for the DIA to re-inspect the program.

Licensing data indicate that the DHS issued one provisional license in calendar year (CY) 2016, one in CY 2017, and seven in CY 2018. Each provisional license was due to discovered licensing deficiencies serious enough to require corrective actions but did not place youth in care in unsafe conditions. All of the provisional licensees returned to full licensure status within the time periods comparable to the description above.

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

**Foster and Adoptive Parent Licensing:** The foster and adoptive parent licensing contractors, under the previous Recruitment and Retention (R&R) contract and the current Recruitment, Retention, Training, and Support (RRTS) contract, prepare and submit licensing packets to service area field staff. Licensing packets include the following:

- Universal Precaution self-study training
- PS-MAPP family profile
- Physician's report for foster and adoptive parents
- HIV general agreement
- Foster Care Private Water supply survey (well water)
- Provision for alternate water supply (if applicable)
- Floor Plan of the home/living space
- Three reference names and addresses (The home study licensing worker selects and contacts three additional references.)
- Criminal background checks
- Applicable consents to release of information

- The Foster Family Survey Report, which documents the foster family's compliance with all licensing requirements
- The home study summary and recommendation
- All forms obtained through record checks and assessment of the family.

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

The RRTS contractors have a DHS approved checklist of all required documents that need to be in a packet. DHS licensing staff review 100% of all packets and advise the RRTS contractor if a document is missing. Missing documents and dates requested are recorded on a tracking tool by DHS. DHS central office staff reviewed the tracking tool and no licenses were issued to any family who did not have complete record checks in SFY 2016 through 2018. A packet would be returned or the contractor notified if any document, especially a record check, was missing.

Shelter and Group Care Facilities: The DHS has a Memorandum of Understanding (MOU) with the Iowa Department of Inspections and Appeals (DIA) for DIA staff to conduct initial and renewal licensing inspections, which includes review of the facility's child abuse and criminal history checks for new facility employees. DHS staff sends completed application materials for initial and renewal licenses to DIA for conducting the licensing inspections. DIA staff provides written reports to DHS staff containing documentation of findings and licensure recommendations within twenty (20) business days following the inspection. When a facility is required to provide a plan of correction, DIA staff provides its recommendation to DHS staff regarding the plan. DHS staff then makes licensing decisions, including decisions of approval for the corrective action plans, based on the DIA report and other available information. DHS then issues the licenses to applicants as applicable. Shelter licenses are for one year; foster group care facilities licenses vary from one to three years; and supervised apartment living cluster site licenses are three years.

DHS central office staff took a spreadsheet with the list of the child welfare facility contracts for SFYs 2016 and 2017, assigned the contracts a number, and then randomly chose 70 contracts out of 75 to review the contractors' DIA licensing review and unannounced visit reports. The random sample is statistically significant with a 95% confidence level within +/- 3%. The data indicated that in 98% of all licensing reviews and unannounced visits' reports, criminal background checks were completed in accordance with the federal requirement. Any licensing deficiency discovered is cited in the final report of the visit and licensees receive instruction to correct the deficiency. There is no known limitation of the data.

Item 35: Diligent Recruitment of Foster and Adoptive Homes

At the start of the new contract, July 1, 2017, the Recruitment, Retention, Training and Support of Resource Families (RRTS) providers received child welfare information data on children in foster care in Iowa, including race and ethnicity data, as well as race and ethnicity data on licensed foster parents. The DHS requires that RRTS contractors collaborate with DHS staff in their service area to develop a recruitment and retention plan to address the needs of that area, including non-white foster families, families for sibling groups, families for teens and families who can care for children with specialized needs. DHS and RRTS contractors review these plans throughout the year and adjust the plans as needed based on changes in the data. The RRTS contractors are also able to track the race and ethnicity of foster families in their area, and use that data to track numbers of families and the areas where families live. The new contract has a paid performance measure for the RRTS contractor to increase the number of non-white foster families based on a target provided by DHS. It is an annual target but progress towards the target is tracked and reported quarterly to the service areas.

Below are related RRTS contract performance measures:

- **Measure 2 – Recruitment and Retention (Overall Net Increase in Families):** The contractor shall increase the net number of licensed foster families available for matching on an annual basis. The contractor’s net increase in number of licensed foster families will be based on the number of licensed foster families available for matching on July 1<sup>st</sup> at the beginning of that contract year and the number of licensed foster families available for matching on June 30<sup>th</sup> at the end of that same contract year.
  - Available for matching means a family that is not providing respite only, or is licensed for a specific child, or has accepted a child within the previous 12 months. Baseline numbers were provided for each service area in September 2017. The contract payment for performance is based on the following increases in net number of families during each year per Service Area:

Table 2(I): RRTS Performance Measure 2				
Service Area	Baseline	Standard	SFY 2018 Target Net Increase	SFY 2018 Achieved
1 (Western)	251	Gold	280	388 Met Gold
		Silver	271	
2 (Northern)	205	Gold	232	272 Met Gold
		Silver	224	
3 (Eastern)	154	Gold	169	175 Met Gold
		Silver	165	
4 (Cedar Rapids)	207	Gold	239	293 Met Gold
		Silver	230	
5 (Des Moines)	222	Gold	258	335 Met Gold
		Silver	247	

Data Source: DHS CCWIS and CareMatch

Achievement of the performance measure for SSY19 will be determined in August 2019.

Each area significantly increased the number of families available for matching. A contract amendment for SFY2019 defined available for matching to exclude families licensed for a specific child; families who only provide respite; families who have not had a child placed in their home for 12 months; and families who have asked not to have children placed in the home for six months or more. The baseline for SFY2018 did not exclude families who did not have a child placed in the home in the 12 previous months. The families are excluded in the SFY2019 baseline which significantly lowered the baseline numbers.

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

Table 2(m): RRTS Performance Measure 3				
Service Area	Baseline	Standard	SFY 2018 Target Net Increase	SFY 2018 Achieved
1 (Western)	16	Gold	26	26
		Silver	23	
2 (Northern)	8	Gold	19	15
		Silver	16	
3 (Eastern)	23	Gold	31	19
		Silver	29	
4 (Cedar Rapids)	29	Gold	37	32
		Silver	35	
5 (Des Moines)	35	Gold	53	44
		Silver	49	

Data Source:  
DHS CCWIS  
and CareMatch

Contractors saw increases in the number of non-white families although the incentive targets were not met in all but one area. The same changes were made to the definition for Performance Measure 3 as were made for Performance Measure 2. The baselines were changed for 2019.

Contractors have done a variety of activities to increase awareness in communities on the need for foster families. For example, LSI continues to partner with tribes in Woodbury County to specifically target the Native American community through culturally appropriate orientation and Native American TIPS-MAPP pre-service training.

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

The Interstate Compact on the Placement of Children (ICPC) is a statutory agreement between all states which provides safety and protection to children in out of state placements. The rules and regulations of ICPC are adopted and enacted by each state and governed by policies and procedures that must be followed when placing children out of state. The agreement also includes directives to a state's financial responsibility for the welfare of each child's placement.

Services under ICPC include a home study of the proposed resource prior to placement in the receiving state. Each home study assesses the safety of the home and ensures the placement resource can meet the individual needs of the child. Once the home is approved and the child placed, the receiving state provides post placement supervision and reports until permanency is established or until the child returns to the sending state. If a child placed experiences a disruption in the placement, the receiving state will notify and assist in returning the child to the sending state's jurisdiction.

The DHS employs the ICPC unit in Iowa DHS at the central office in Des Moines, IA. Iowa's foster care recruitment and retention contractor(s) receives and completes the majority of the home studies requested through ICPC. There is a 60 day timeframe to process and complete parent and relative home studies.

Provisions exist under ICPC Regulation 7 for expedited cases in which a home study must be completed within 20 business days. An internal computer program is used to record the date a home study packet is received at the Iowa ICPC office, the date the request is forwarded to the field, and the date the completed home study is sent to the sending state.

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

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

## Substantial Conformity Rating

### **FOSTER AND ADOPTIVE PARENT LICENSING, RECRUITMENT, AND RETENTION**

<b>Data Element</b>	<b>Source of Data and Information</b>	<b>State Performance</b>
<b>Foster and Adoptive Parent Licensing, Recruitment, and Retention</b>	Statewide Assessment and Stakeholder Interviews	Substantial Conformity
<b>Item 33</b> Standards Applied Equally	Statewide Assessment and Stakeholder Interviews	Strength
<b>Item 34</b> Requirements for Criminal Background Checks	Statewide Assessment and Stakeholder Interviews	Strength
<b>Item 35</b> Diligent Recruitment of Foster and Adoptive Homes	Statewide Assessment and Stakeholder Interviews	Strength
<b>Item 36</b> State Use of Cross-Jurisdictional Resources for Permanent Placements	Statewide Assessment	Area Needing Improvement

Source: Child and Family Services Review, Iowa Final Report, 2018

#### Children's Bureau Comments on Iowa Performance<sup>9</sup>

- Item 33: "Information from the statewide assessment and confirmed in stakeholder interviews included examples to illustrate that the state applies the same licensing standards to individuals who apply to foster or adopt children, and that an agreement exists with the Iowa Department of Inspections and Appeals to monitor the equal application of licensing standards in shelter and group care facilities." (p. 22)
- Item 34: "Information from the statewide assessment and stakeholder interviews showed that criminal background checks occur according to federal policy before the licensure of a foster or adoptive home. Information from the statewide assessment and stakeholder interviews also showed that criminal background checks are conducted on shelter and group care facility staff members." (p. 22)
- Item 35: "Information in the statewide assessment indicated, and stakeholder interviews confirmed, that there is a process in place to ensure diligent recruitment of foster and adoptive parents who reflect the ethnic and racial diversity of children in all jurisdictions of the state." (p. 23)
- Item 36: "Information from the statewide assessment showed that Iowa does not complete out-of-state home study requests within the required timeframes. Barriers to timely completion include difficulty connecting the home study worker with the

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<sup>9</sup> Child and Family Services Review, Iowa Final Report, 2018, pp 22-23.

placement resource to schedule the required visit, and failure of the placement resource to complete the necessary documentation. There is a process in place to ensure effective use of cross-jurisdictional resources, such as AdoptUSKids, to place children in permanent placements.” (p. 23)

### Current or Planned Activities to Improve Performance

- Item 36:
  - Develop a mechanism to track the 60 day requirement and a way to determine if Iowa meets the requirement
  - Educate home study workers on required timeframes

## **Section III: Plan for Enacting Iowa’s Vision**

Given that Iowa is currently revising its Child and Family Services Review (CFSR) program improvement plan (PIP), it is likely that this section will undergo revisions after CFSP approval. Therefore, changes made as a result of Iowa’s CFSR PIP approval process will be reflected in next year’s Annual Progress and Services Report (APSR).

### **Background**

From the beginning, whether from a systemic view or a specific case review, individuals directly involved in Iowa’s child welfare system received the opportunity to provide their perspectives on their experience with the child welfare system, what works well and what does not. The DHS documented this information over a 5-year period of time, starting with the FFY 2015-2019 Child and Family Services Plan (CFSP) in 2014, its annual progress and services reports (APSRs), including the Final Report, and through conclusion of the 2018 CFSR on-site review. In state fiscal year (SFY) 2014, the DHS contracted with the State Public Policy Group (SPPG) to facilitate a workgroup comprising a variety of internal and external stakeholders to review performance data, identify strengths and opportunities for improvement, and provide recommendations for continuous improvement of Iowa’s child welfare system. The DHS utilized the workgroup’s final report to develop Iowa’s FFY 2015-2019 CFSP. Thereafter, the DHS engaged internal and external stakeholders through meetings, surveys, independent contracted reviews, etc. to develop the yearly APSRs. These activities generated diverse opinions and perspectives, as well analysis of trends. The DHS aggregated the feedback and confirmed the three goal areas identified in the state’s FFY 2015-2019 CFSP, stated below, remain appropriate for the FFY 2020-2024 CFSP:

1. Children abused or neglected will be safe from re-abuse in their own homes or in their foster care placements.
2. Children experience permanence in their living situations.
3. Children experience optimal well-being through their family’s enhanced capacity to provide for their needs.

Prior to conducting the on-site review, the state of Iowa assessed current functioning of Iowa’s child welfare system through engagement of stakeholders and review of data regarding current agency performance. Following receipt of Iowa’s 2018 Statewide

Assessment, the federal Children's Bureau (CB) conducted 31 focus groups with stakeholders between July – September 2018 and the state conducted 65 case reviews between April – September 2018, which were finalized following federal secondary oversight.

Iowa's case review process used two person teams of paired reviewers to review each case. The teams consisted of one Social Work Supervisor and one Quality Improvement Coordinator for each of the state's five Service Areas. The two-person team provided an arm's length independence and perspective through the Quality Improvement Coordinators, while all under the coordination and supervision of the statewide Quality Improvement Unit, to help identify and share opportunities for local practice improvement through involvement of one of the local Service Area Supervisors serving as the second reviewer. The paired reviewers received training and participated in inter-rater reliability reviews prior to the state self-assessment year and throughout the state self-assessment. The periodic inter-rater reliability reviews help to consistency across all, as possible, in the application of scoring criteria and in the documentation of rationale for scores. Following the on-site period, staff from the Iowa Department of Human Services (DHS) along with a variety of stakeholders received the Child and Family Service Review (CFSR) round three Final Results on February 5, 2019.

Iowa's plan for improvement included utilization of existing goal-oriented documents that reflect stakeholder feedback, as well as the information gathered in preparation of the on-site review and the information gathered during the on-site review, in order to bring consistent focus to the state's performance improvement activities. This includes the following:

- Child and Family Services Plan (CFSP) (FFY 2014-2019).
- Annual Progress and Services Report (APSR) (Annual updates to the CFSP).
- CFSR Statewide Assessment (February 2018).
- Feedback from Federally led focus groups (July - September 2018).
- Case review results (for cases read April - September 2018).
- Child Welfare Provider and DHS PIP workgroup (December 2018).
- CIP and DHS PIP workgroup (December 2018).
- Final Report Out and Root Cause workgroup (February 2019).
- Strategy Workgroup (March 2019).
- Oversight group final strategy deselection (April 2019).

The groups that met in December through March received information prior to the meetings, which was based on the three goal areas identified in the CFSP and the results of the on-site review with their peers in order to gather a broad spectrum of feedback to bring to the meeting. Information gathered was consistent across the three goal areas amongst all groups, which if improved, could positively impact the services delivered, success of services, and the experience of those served.

Below is a brief overview of additional stakeholder group processes, which usually occurred at a local area but rolled-up to a state level.

- Service Area All Contractor Meeting – Held in each Service Area, these meetings are attended by agency leadership; i.e. Director level of agencies that hold contracts with DHS. This group comes together in quarterly to share agency updates, performance data, as well as the current focus of the state as a result of upcoming policy and/or contract changes. This allows everyone to have a voice and provide feedback regarding upcoming changes. Often times this is a time for stakeholders to communicate regarding any barriers that they are experiencing and begin problem-solving issues. Attendees include Leadership from providers of group care, shelters, FSRP agencies, PMIC, Parent Partner program, Foster care recruitment contract holder, as well as Decategorization (Decat) project coordinators, and JCS Chiefs.
- Foster/Adopt Parents – Service Area Adoption/Licensing Supervisors periodically attend regularly scheduled foster parent support groups within the service area to gather any feedback from them, to ensure that their needs are being met and brought back to DHS.
- Joint Supervisor Meetings – These occur quarterly between DHS, FSRP, and Foster Care supervisors. This is time to partner and problem solve regarding service-related issues that staff are experiencing. Any Contractor Meeting is also shared with supervisors here. Supervisors often jointly develop topics for cluster PALS meeting that are warranted as a need for field staff.
- Preparation for Adult Living (PAL) Meetings – These occur quarterly between front line staff from DHS, FSRP, and some foster care Case Managers. Various topics that are directly related to services and upcoming policy/practice changes are discussed. Local speakers will share information related to the resource available to DHS staff and clients.
- Joint QA Meetings – Occurs in some Service Areas quarterly between DHS QA staff and QA staff from the contracted agencies 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 agencies for continuous improvement.
- Community Outreach – Social Work Supervisors have each developed a plan that outlines what community members they are committed to contacting and how frequently to ensure that the lines of communication are open. For example, local schools, substance abuse providers, judges, JCOs, Decat boards, mental health providers, clinical case consultation teams, etc.

The culmination of all these activities and information is the foundation for this improvement plan. The DHS actively solicited involvement from stakeholders in determining the root causes of insufficient performance in order to strategize how to approach improvement in a strategic manner to achieve sustainability. Since stakeholders provided much of the information on deficits within the DHS' processes and services, it was critical for these stakeholders to be intricately involved in determining how to fix/improve the system.

The majority of this improvement plan is Iowa's PIP. As such, the CFSSR Oversight Team is the core/oversight working group responsible for the plan. This is the internal

team, which used data and stakeholder feedback to select implementation strategies. The team is also responsible for the communication plan to facilitate the engagement and involvement of all other partners and stakeholders in the development of the PIP and communication thereafter and incorporated into this CFSP and subsequent APSRs. Group members use existing channels of communication with other partners, courts, providers and other to share information and to seek feedback.

### Performance Assessment and Root Cause/Strategy Exploration

Please see *Section II: Performance Assessment in Improving Outcomes* for performance information. Additional problem and strategy exploration is below.

#### Root Cause Exploration

Approximately 100 individuals, comprising external and internal stakeholders, met on February 6, 2019 after Iowa’s CFSR Final Report Out. Stakeholders received both quantitative and qualitative data in order to identify key root causes underlying Iowa’s CFSR performance. The stakeholders identified the root causes/problems; listed below in their own words to maintain integrity of the stakeholder work. The stakeholders then grouped root causes into categories and associated each category to the three general outcome areas.

**Table 3(a): IA CFSR ROUND 3 – Root Cause Exploration**

Category	Safety	Permanency	Well-Being
<b>Workforce-related: lack of time, high turnover</b> <ul style="list-style-type: none"> <li>High caseloads, resulting in lack of time for quality visits, concurrent planning, training of staff</li> <li>High turn-over (DHS and Providers) relates to adequate service provision to family</li> <li>Resources/Training-FSRP</li> </ul>	X	X	<b>X</b>
<b>Lack of access or gaps to needed services</b> <ul style="list-style-type: none"> <li>Lack of services for mental health and substance abuse</li> <li>Lack of foster/adopt homes, older children/teen especially</li> <li>Lack of wrap-around services</li> </ul>	X	X	<b>X</b>
<b>Lack of collaboration across agencies, court, providers</b> <ul style="list-style-type: none"> <li>Working in silos, lack of communication with providers</li> <li>Lack of partnering between DSH and Court regarding family recommendations/decisions</li> <li>Inefficient use of resources-FTDMs, Parent Partners, Foster Parents, Social Histories</li> </ul>	X	X	<b>X</b>

**Table 3(a): IA CFSR ROUND 3 – Root Cause Exploration**

Category	Safety	Permanency	Well-Being
<p><b>Lack of understanding safety versus risk</b></p> <ul style="list-style-type: none"> <li>Lack of common understanding/definition across the system of the difference between safety and risk</li> <li>Inconsistent application of safety vs risk concerns related to removal of children and when to reunify</li> </ul>	X	X	X
<p><b>Lack of identifying and engaging relatives and informal supports</b></p> <ul style="list-style-type: none"> <li>Parents are overwhelmed with what they are told they need to do (visits, SA treatment, counseling, UA's, in-home services, etc.)</li> <li>Need to ID supports formal and informal</li> </ul>	X	X	
<p><b>Lack of comprehensive assessment and service provision for children and families</b></p> <ul style="list-style-type: none"> <li>During assessment, underlying causes of abuse are not addressed; focus only on surface symptoms</li> <li>Services are narrowly focused-addressing safety issues but not getting at underlying factors</li> <li>Child abuse-shifted policy, practice, break out allegations, focus on singular not all parts</li> </ul>	X		X
<p><b>Policy/procedure</b></p> <ul style="list-style-type: none"> <li>New founded reports based on past or substance use when child may be there (dangerous)</li> <li>THV-length of 6 months affects data and definition</li> </ul>	X		X
<p><b>Lack of concurrent planning</b></p> <ul style="list-style-type: none"> <li>Lack of concurrent planning</li> <li>Lack of diligent concurrent planning; not starting until too late</li> </ul>		X	
<p><b>Court-related delays/inconsistencies/procedures</b></p> <ul style="list-style-type: none"> <li>Court delays, late reports, attorney schedule, not enough time scheduled</li> <li>Judicial oversight/expectations of appropriate relatives</li> <li>Inconsistency among state courts</li> </ul>		X	

**Table 3(a): IA CFSR ROUND 3 – Root Cause Exploration**

Category	Safety	Permanency	Well-Being
<b>Lack of quality safety plans and effective use of safety plan services</b> <ul style="list-style-type: none"> <li>Unclear criteria for a “good” safety plan</li> <li>Not fully utilizing safety services (i.e. THV, open services, first 30 days)</li> </ul>	X		

*Strategy Development*

In March 2019, a smaller group of approximately 30 stakeholders met to identify strategies, based on the root cause exploration above. The goal was to identify cross-cutting strategies to provide the most improvement for resources expended. Similar to the root cause exploration, stakeholders identified the strategies; listed below in their own words to maintain integrity of the stakeholder work. The stakeholders divided into two groups, with the top strategies from both groups shown below.

**Table 3(b): Group One - Strategy Recommendations**

Votes Received	Strategy
6	Holistic family and community engagement to create and preserve supports
5	Utilize an Evidence Based tool to assess safety that creates a common understanding of the difference between safety and risk
4	Identify and implement evidence-based practices in a cost effective and family-focused manner
3	Develop clear, timely family driven case plans through a team approach (FTMs?)
3	Develop an EBP service array that matches the underlying and individualized challenges of families, children and youth (includes MH, SA, DV, etc.)
2	Identify and provide support and services to relatives and other important people in families’ lives to care for children and youth to support parent/child connection.
2	Adopt a consistent family (loosely defined to include kin and fictive kin and other important to family) identification and engagement policy that is ongoing and frequent through the life of the case
2	Improve employee knowledge, skills and abilities by providing mentoring, coaching and skill-building opportunities
1	Expand data and information sharing with all stakeholders

<b>Table 3(b): Group One - Strategy Recommendations</b>	
<b>Votes Received</b>	<b>Strategy</b>
1	Improve communication among all child welfare stakeholders to better align our work

<b>Table 3(c): Group Two - Strategy Recommendations</b>	
<b>Votes Received</b>	<b>Strategy</b>
6	Create and fund a search and engagement process or services to identify, engage relatives, kin, fictive kin before kids enter the system or early in the case. Approaches to include ecomap and human to human to human dialogue
5	Develop a standardized tool that effectively defines and assists in assessing for danger opposite of safety to help with collective understanding of danger vs. risk.
5	Bring court, partners, foster parent, and DHS into alignment regarding key child welfare principles, including sibling connections, relative/kinship care, safety vs. risk, concurrent planning and other family first concepts. Approaches may include pilot of a family court and similar to tribal training, (shared and also specialized focused).
2	Legal representation trained in child welfare contracted to represent DHS and parents
2	Break out CFSR measurements. i.e. Can't meet unless all are met
1	Coordination of care/roles
1	Preventing foster parents from intervening in cases because they want to keep a child-causes permanency delays.
1	Prioritize financial supports to relative/kin (same as those available to regulated placements).
1	Standardized a system of change management where DHS central office and legal community leadership provide guidelines for state changes to regional multi-disciplinary teams (court, legal, provider, DHS and need stakeholders) to operationalized implementation/changes. e.g. FFPSA
1	Identify and implement a range of evidence-based community-based substance abuse and mental health services that include in-home options, transportation and levels of care.
1	Provide service to families to achieve outcomes through reducing duplication of services, implementing and adequate funding evidence-based practices, allow service flexibility and intensity based on family need.
1	Develop shared principles with DHS and the legal system aligning with Family First.

## Iowa Approach for Change



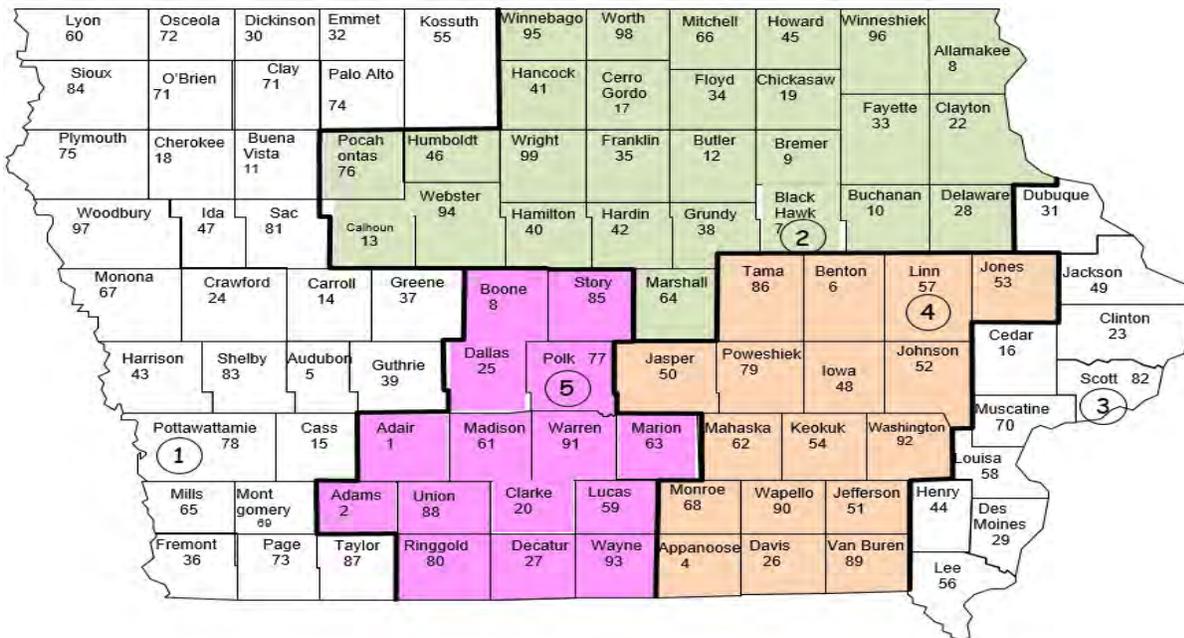
One of many ways this approach for change occurs is through the processes Iowa will use to create and implement the changes driving our improvement. A benchmark for each of the identified objectives includes a workgroup comprising people involved in the topic; this will include direct staff, supervisors, and stakeholders as appropriate, with additional team members added based on the focus. These will be small groups of approximately 8-15 people and team members will vary by strategy; the common thread through all workgroups will be significant grass roots representation of those who do the work. The work of those groups is part of the State of Iowa Performance Monitoring and Improvement Business Process (Attachment 2C).

The workgroup is important because it uses those who do the work to find practical solutions that work in real life. The workgroup does not make recommendations; they develop a successful solution per timeframes of the charter, which is implemented. The workgroup process goes something like this:

1. SBT develops a charter for the group indicating the specific goal(s) to be reached
2. The charter includes diverse membership representing various stakeholder roles
3. The majority of membership are front line staff, the remainder are supervisors, one Social Work Administrator (SWA), and other stakeholders

4. The group usually spends about 3 days to analyze the problem (root causes), identify barriers the SBT can help to remove, identify necessary supports, and develop solutions, which include implementation, communication, and monitoring plans.
5. The group hands the plans off to the SWA's who manage social work operations in each Service Area for implementation usually in 30 to 60 days, and on-going monitoring.

The DHS leadership identifies key performance areas for the state. These areas represent a subset of all CF SR measures prioritized for state focus and determined by review and analysis of performance reports. The DHS is moving towards an organized system of prioritizing items in sequence so, as quality improvement efforts are completed, initiation of the next focus area occurs. By identifying statewide priority areas, Iowa creates focus, alignment, and consistency in efforts to change/improve practice. Staff reviews monthly, at the service area level, and statewide at all levels throughout the DHS, data on the priority items. Staff analyzes the data identifying trends, which helps to determine where strategies are effective and where strategies need enhanced. The process also identifies those service areas achieving the established target, which leads to sharing of information on effective strategies for possible implementation across service areas. For example, the Eastern Iowa Service Area (EISA) implemented child safety conferences, which resulted in improved family engagement and reduced child placements in non-relative foster care. Information shared by EISA with the other Service Areas has led to these other Service Areas considering child safety conferences in their areas. (Iowa DHS has geographic 5 SA – see below, and another which performs statewide activity including child welfare intake)



Based upon the performance assessment, the additional problem and strategy exploration, and the improvement process outlined above, the following is Iowa's plan to

improve the child welfare system and to achieve Iowa’s vision of “Family connections are always strengthened and preserved.”.

**Goal 1: Children abused or neglected are safe from re-abuse in their own homes or foster care placements.**

**Objective 1.1: DHS workers see identified alleged child victim(s) within assigned timeframes or follow procedures for appropriate delay of timeframe to assure child safety.**

Iowa’s child protection intake prioritizes investigations based on the type of abuse, access of the abuser, and child vulnerability. Based on assessment of these factors, intake assign a timeframe of 1 hour, 24 hours, 72, or 96 hours within which face-to-face contact between the DHS child protective worker (CPW) and alleged child victim(s) must occur.

In Iowa’s on-site review, 71% of cases reviewed (25/35) met the criteria for item 1: Timeliness of Initiating Investigations of Reports of Child Maltreatment. Primary reasons for the ten cases not meeting the assigned timeframe include:

- The assessor/investigator delayed the timeframe, but without supervisory approval, or
- The waiver of timeframes did not document the reason for the delay and assure safety or identify a new timeframe to see the child.

<b>Table 3(d) - Objective 1.1: DHS workers see identified alleged child victim(s) within assigned timeframes or follow procedures for appropriate delay of timeframe to assure child safety.</b>			
<b>Benchmarks</b>	<b>Who</b>	<b>Activity Start</b>	<b>Implementation</b>
1.1.1: Review and update as needed, current procedural expectations regarding timeframes and documentation requirements for supervisory approval of delayed face-to-face contact with identified child victim(s).	Child Protection Workgroup	June 2019	October 2019
1.1.2: Develop guidelines for acceptable reasons to delay assigned timeframes (what are outside the control of the agency, what constitutes concerted efforts, criteria to assess a child as safe without seeing within timeframe, etc.)	Child Protection Workgroup	June 2019	October 2019
1.1.3: Develop implementation plan including supervisory consultation, problem solving and decision making regarding assessing and assuring safety.	Child Protection Workgroup	June 2019	October 2019
1.1.4: Monitor implementation and impact of benchmarks, meeting practice expectations.	Service Business Team (SBT)	October 2019	

**Table 3(d) - Objective 1.1: DHS workers see identified alleged child victim(s) within assigned timeframes or follow procedures for appropriate delay of timeframe to assure child safety.**

Benchmarks	Who	Activity Start	Implementation
1.1.5: SBT will review the prior quarter's performance on benchmarks and outcome data quarterly and will post the reporting to the DHS website. The website will also have a link for stakeholder feedback, which will be monitored by the Quality Improvement Bureau to be shared with SBT for review and/or action as needed.	Service Business Team	January 2020	
1.1.6: Strategy impacts CFSR outcomes beginning December 2020			

Objective 1.1 impacts the following CFSR items:

- Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect (Item 1)
- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate (Items 2 & 3)

**Objective 1.2: Assure child safety at each visit**

Case review data from Iowa's 2018 CFSR on-site review indicated that Risk and Safety Assessment and Management received a strength rating 51% of the time (33/65 cases). Analysis of the data and corresponding narrative explanations found the lowest areas of performance were connected to ongoing assessment (9% N=32), and safety planning (36% N=11). Ongoing assessments are by far the primary issue, with 29 of the 32 (91%) applicable cases for item 3B indicating that a thorough, in-depth assessment did not occur. In addition to a lack of quality assessment, case reviews also identified that all children in the home were not clearly assessed for individual safety/risk issues. Similar to assessment of needs and services in item 12A, safety and risk assessments tended to focus only on the child/ren with the greatest presenting needs based on the reason for agency involvement.

Looking at the narrative of the case reviews to identify the most frequent root causes contributing to the absence of an in-depth assessment, the following reasons reflect the areas needing improvement (ANI):

- *3B. Ongoing assessment and management*
  - No/inadequate assessment – lack of probing questions (N=8)
  - Did not assess all children (N=8)
  - Lack of visits to primary home (N=8)
  - Lack of consistent visits (N=8)

Regarding cases where there was a lack of visits to the child's primary home, to better understand why, the reviewers noted that 4 of the 8 cases concerned children of divorced parents and blended families where there was more than one primary

household. In these cases, the definition of “household” members was not clear, due to complicated household configurations, such as 50-50 parenting, which led the agency to focus service provision on one home to the exclusion of another resulting in:

- lack of safety assessment of the environment
- lack of assessment of adults living in the home
- lack of assessment of non-relative children within the home of abuse
- lack of provision of services to non-relative children within the home of abuse

Other cases noted that case management tended to focus on the home to which the child would be reunified or, conversely, the placement home. They did not take into consideration the direction of the case or comprehensively assess environments in which the children spent time.

Similarly, household definition became confused in cases in which the child resided with one parent during part of the period under review (PUR), then moved to the other parent’s home for the remainder of the PUR. In some cases, the household of focus was on the home in which the children planned to live permanently rather than the current setting (e.g. focus on primary parent rather than non-custodial parent (NCP) with whom the children live until primary parent addresses issues).

A Court Improvement Project (CIP) stakeholder group, including court personnel, DHS personnel, and federal Region VII Children’s Bureau personnel, met in December 2018, facilitated by the Capacity Building Center for Courts, to discuss strategies for DHS and the courts to positively affect timely permanence, in particular, reunification. However, one of the two workgroups identified safety as an issue affecting reunification achievement. The “Safe for Home” project’s goal is to increase timely successful reunification, which also will have a ripple effect in reducing foster care re-entry. Specifically, Iowa’s hypothesis is that:

- Iowa child welfare professionals will collaborate to learn about each other’s perspectives and standards around when a child is “Safe for Home”© so that
- All the professionals can reach some consensus around when a child is “Safe for Home” so that
- Professionals are more confident in their recommendations, even when they do not align, so that
- Judges can make more informed and timely decisions so that
- The right permanency goal is achieved at the right time so that
- Children do not stay in foster care longer than absolutely necessary.

Please see Attachment 3A for the root cause analysis conducted.

In addition, the Root Cause Work Group, which met on February 6th, identified the same issue/barrier based upon their practice experience. One of the crosscutting themes identified by the diverse group of 100 stakeholders was “lack of understanding safety [danger] vs risk”. Further, the smaller group of stakeholders, who met in March 2019 to continue the work by identifying strategies, prioritized a strategy of “Develop a standardized tool that effectively defines and assists in assessing for danger opposite of safety to help with collective understanding of danger vs. risk.”

### *Safety Plans and Safety Plan Services*

During the secondary oversight portion of the on-site review, Children's Bureau (CB) and Iowa representatives had discussions regarding the philosophy and purpose of safety plans as well as elements that must be addressed in order to develop a quality safety plan. Based on the discussions, it seems Iowa does not have a consistent definition of required content of safety plans nor a consistent understanding of danger versus risk.

In case reviews, 7 of the 11 applicable cases for item 3C (develop an appropriate safety plan with the family and continually monitor and update the safety plan as needed) received a rating of needing improvement. CB noted that many of the "safety plans" described in case review narratives:

- Did not clearly identify the safety issue
- Did not identify and address behavioral issues
- Did not include an actionable plan to mitigate identified issues -- passive, promissory
- Did not involve external interventions to support the safety of the child
- Did not include how they would be monitored, measured, and/or revised as needed
- Did not clearly identify the focus of safety services in relation to mitigation of issues

The above trends reflect three distinct issues regarding the use of safety plans:

- Safety plans used as "promissory notes", with parents agreeing to abstain from identified behavior (i.e. substance use)
  - Discussions between Iowa reviewers determined that "safety" plans did not consistently address safety issues, but rather clarified expectations of behavior or demonstrated actions of a caretaker. Feedback from reviewers, based on interviews conducted, indicated that Iowa's Safety Plan form is the one document the workers have with them on home visits that provides the ability for a worker to leave a copy with the family and have a copy for the file. This could be one reason safety plans appear to address non-safety issues and lack meaningful intervention.
  - There also appears to be different interpretations of danger (aka safety) versus risk and when/how to use safety plans to keep a child in their home rather than utilizing foster care.
- Safety services
  - Utilization of "Safety Services" often occurred to monitor the safety plan through daily drop-in visits; it was difficult to describe any specific intervention aimed at mitigation of safety issues but consisted primarily as a "checkup" on the family to assure compliance. Another issue was monitoring and revision of safety plans, which primarily resulted from the promissory nature of the plans as there was no progress to monitor, but documented compliance.
  - Lack of a common understanding of what qualifies as "safety services" between DHS and contractors for these services may contribute to this issue. The DHS may need to revise the contract for these services to more clearly articulate the actions of both DHS and contractors.
- Safety plans misnamed

- At times, there appeared to be a safety plan in place, but upon review of the content, it was not a plan for maintaining ongoing safety for the child but rather a crisis plan for handling a hypothetical future situation to mitigate risk (e.g. violation of a no contact order (NCO)).
- This also relates to item 1 above regarding an attempt to document clear expectations of the family using the Safety Plan form as it most closely and conveniently meets the logistical need of the worker when interacting with the family.

When looking at these issues, it is clear that one issue easily leads to another. The safety plan must be specific, actionable and thorough in order to measure, monitor, and revise when needed.

To this end, Iowa will conduct the following activities to make sure all parties involved in the child welfare system have the same common understanding and terminology to make decisions more consistently to prevent removals and timely achieve permanency if the child is removed.

<b>Table 3(e) - Objective 1.2: Assure child safety at each visit</b>			
<b>Benchmarks</b>	<b>Who</b>	<b>Activity Start</b>	<b>Implementation</b>
1.2.1: Update safety assessment tool and safety plan utilizing standardized and evidence-based resources	Safety Assessment and Safety Plan Re-Design Workgroup	November 2018	July 2020
1.2.2: Update practice expectations for safety assessment and safety plans, and for consistent use of definitions of “danger” versus “risk” in practice, communication, and decision-making.	Safety Workgroup	June 2019	August 2019
1.2.3: Train DHS staff on the new practice skills for evidence-based tools and how they inform decision-making, including initial and on-going safety assessment, removal, and writing actionable safety plans consistent with safety expectations.	Safety Workgroup/Service Support & Training Bureau	September 2019	October 2019
1.2.4: Assure all child welfare stakeholders (court, providers, etc.) are trained on, and able to apply, definitions of “danger” versus “risk” as they pertain to decision- making (including removal and reunification) when work with families, youth, and children.	Service Business Team / Training Academy	October 2019	December 2019

<b>Table 3(e) - Objective 1.2: Assure child safety at each visit</b>			
<b>Benchmarks</b>	<b>Who</b>	<b>Activity Start</b>	<b>Implementation</b>
1.2.5: Monitor implementation and impact of benchmarks	Service Business Team	December 2019	
1.2.6: SBT will review the prior quarter's performance on benchmarks and outcome data quarterly and will post the reporting to the DHS website. The website will also have a link for stakeholder feedback, which will be monitored by the Quality Improvement Bureau to be shared with SBT for review and/or action as needed.	Service Business Team	April 2020	
1.2.7: Strategy impacts CFSR outcomes beginning December 2020			

Objective 1.2 impacts the following CFSR items:

- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate (Items 2 & 3)
- Permanency 1: Children have permanency and stability in their living situations (Items 4 & 6)
- Permanency 2: The continuity of family relationships and connections is preserved for children. (Item 8)
- Well-Being 1: Families have enhanced capacity to provide for their children's needs (Items 12, 14, & 15)

**Objective 1.3: Identify and implement evidence-based practices for working with substance abusing caregivers, regardless of case type.**

According to data in the Adoption and Foster Care Analysis and Reporting System (AFCARS), parental substance abuse is frequently reported as a reason for removal, particularly in combination with neglect (Correia, 2013). For almost 31% of all children placed in foster care in 2012, parental alcohol or drug use was the documented reason for removal and in several states that percentage surpassed 60% (National Data Archive on Child Abuse and Neglect, 2012, Child Welfare Information Gateway). It is clear that substance abuse by a caregiver is a prodigious issue for the child welfare system nationwide.

Iowa statistics align with the national statistics regarding substance abuse in the child welfare system. Of all children with substantiated or indicated reports in SFY2018, 51% were due to parental substance abuse. Iowa's victimization in foster care rate for SFY 2018 is 25.26 for children substantiated or indicated reports per 100,000 days of care provided to children in foster care. The goal is 8.5 or less. In examining the performance of abuse in care with administrative data, most of the abuse occurred while children visited with parents versus at the hands of foster parents, and substance abuse was the primary factor.

- 12% due to parent alcohol use
- 49% due to parent drug use

In addition, case review data from Iowa's 2018 CFSR onsite case review mirrors national trends with parental substance abuse as the major contributing factor.

- *Reason for Agency Involvement*
  - Substance abuse by parent(s) (N=34)
  - Neglect (not including medical) (N=13)
  - Presence of illegal drugs in a child's body (PIDS) (N=8)
  - Domestic violence in child's home (N=8)
  - Dangerous Substances (N=5)
  - Physical abuse (N=2)
  - Mental/physical health of parent (N=1)
  - Mental/physical health of child (N=1)
  - Child's behavior (N=1)

Substance abuse by a caregiver affects the family in many ways, including the caregiver's capacity to respond to a child's needs. The parent may become unable to control their impulses thereby giving way to anger and violence. Substance abuse also affects decision-making abilities for the child's care. Caregivers may spend all or most of the family funds on their substance of choice. Children may be left to their own devices to find food, shelter, or take care of hygiene needs. There are many, many reasons people abuse substances, e.g. stress, trauma (past or present), anxiety, inadequate coping mechanisms, feeling of pleasure, etc.

When examining parental recovery from substances, recovery is anything but a straight line. The process often involves relapse as a person finds ways to address the underlying issues contributing to their addiction. Up to 60% of patients who receive substance abuse treatment will relapse within one year and the relapse rate is even higher for some drugs, like heroin (Journal of the American Medical Association). The Root Cause Work Group, which met on February 6th, identified the same issue/barrier based upon their practice experience. One of the crosscutting themes identified by the diverse group of 100 stakeholders present was "Lack of access or gaps to needed services". Further, a smaller group of stakeholders, who met in March to continue the work by identifying strategies, prioritized a strategy of "Developing an EBP service array that matches the underlying challenges of families including SA". Implementation of Family First over the course of the CFSP will help to address service

array issues. For more information about plans to improve Iowa’s child welfare service array, please see *Section II: Performance Assessment in Improving Outcomes*.

One of the largest safety concerns for a child is the presence of a substance abusing caregiver. Since there is prevalence of this issue in child welfare cases, Iowa chose to make this a priority. Due to the expected, yet unpredictable, difficulties during treatment, it is difficult for DHS staff, providers, and court representatives to consistently agree on the level of acceptable risk when discussing preventing a child’s removal or reunifying a child with his/her parent if removed. Clarification of danger versus risk will help everyone to get on the same page.

Iowa’s current practice for substance-involved cases is not consistent from region to region, worker to worker, or courtroom to courtroom. Some stakeholders note that Iowa does not have consistency when determining reasonable efforts to not remove a child. It is routinely based on caseworker experience. In order to effectively work with this growing population, to address the inconsistencies surrounding decision-making regarding permanency, and promote teamwork between families and the many child welfare roles, stakeholders prioritized locating resources to broaden the understanding of addiction and recovery. It will be important to utilize these resources to educate all involved child welfare parties, i.e. caseworkers, service providers, courts, etc., on addiction as a disease and the recovery process. Additionally, more in-depth programming and utilization of evidence-based practices for serving caregivers with substance use disorders (SUDs) will help to remedy the inconsistency.

**Table 3(f) - Objective 1.3: Identify and implement evidence-based practices for working caregivers with substance use disorders (SUDs).**

<b>Benchmarks</b>	<b>Who</b>	<b>Activity Start</b>	<b>Implementation</b>
1.3.1: Request technical assistance regarding evidence-based practice from the National Center of Substance Abuse and Child Welfare	Policy	April 2019	July 2019
1.3.2: Integrate evidence-based practice into state procedure	Policy	July 2019	October 2019
1.3.3: Assure all DHS staff are trained on, and able to apply, the practices as they pertain to decision-making with families, youth, and children	Bureau of Service Support and Training	October 2019	November 2019
1.3.4: Assure all child welfare partners (court, providers, etc.) are trained on, and able to apply, the practices as they pertain to decision-making with families, youth, and children	Service Business Team / Training Academy	December 2019	January 2020

**Table 3(f) - Objective 1.3: Identify and implement evidence-based practices for working caregivers with substance use disorders (SUDs).**

Benchmarks	Who	Activity Start	Implementation
1.3.5: Partner with IDPH to develop map of SUD treatment facilities and providers by county available to general public	Policy	June 2019	January 2020
1.3.6: Partner with IDPH to explore ways to increase SUD treatment capacity, including potential implementation of foster care maintenance payments for children residing in a residential treatment facility with their parent	Policy	June 2019	
1.3.7: Monitor implementation and impact of benchmarks, including identifying gaps in needed services, and developing a plan to address the gaps for inclusion in Iowa's CFSP via APSR submission.	Service Business Team	January 2020	
1.3.8: SBT will review the prior quarter's performance on benchmarks and outcome data quarterly and will post the reporting to the DHS website. The website will also have a link for stakeholder feedback, which will be monitored by the Quality Improvement Bureau to be shared with SBT for review and/or action as needed.	Service Business Team	April 2020	
1.3.9: Strategy impacts CFSP outcomes beginning January 2021			

Objective 1.3 impacts the following outcomes and systemic factors:

- Safety Outcome 2: Children are safety maintained in their homes whenever possible and appropriate (Items 2 & 3)
- Permanency Outcome 1: Children have permanency and stability in their living situations (Item 5 & 6)
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children (Items 8 & 11)
- Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs (Items 12, 13 & 15)
- Systemic Factor: Service Array and Resource Development

- Systemic Factor: Staff and Provider Training

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

**Objective 2.1: Increase timely successful permanency through quality legal representation.**

For several years, ICJ worked on improving the quality legal representation of children and parents. ICJ and the DHS believe quality legal representation may prevent:

- unnecessary removals,
- placements with strangers,
- long lengths of stay in foster care, and
- re-entries into foster care.

Additionally, the recent Children’s Bureau clarification that states can use title IV-E funds to pay for quality legal representation provides an opportunity for Iowa to invest more in this needed service.

In spring 2019, ICJ Executive Director, Kathy Thompson, Iowa Supreme Court Justice Christensen, State Public Defender’s office, Jeff Wright, and the DHS’ Director, Jerry Foxhoven, met to discuss the opportunity to utilize title IV-E funding to ensure quality legal representation of children and parents as early in their cases as possible. Results of the discussion identified a need for the DHS and the SPD’s office to enter into a memorandum of understanding (MOU) and to work to identify next steps.

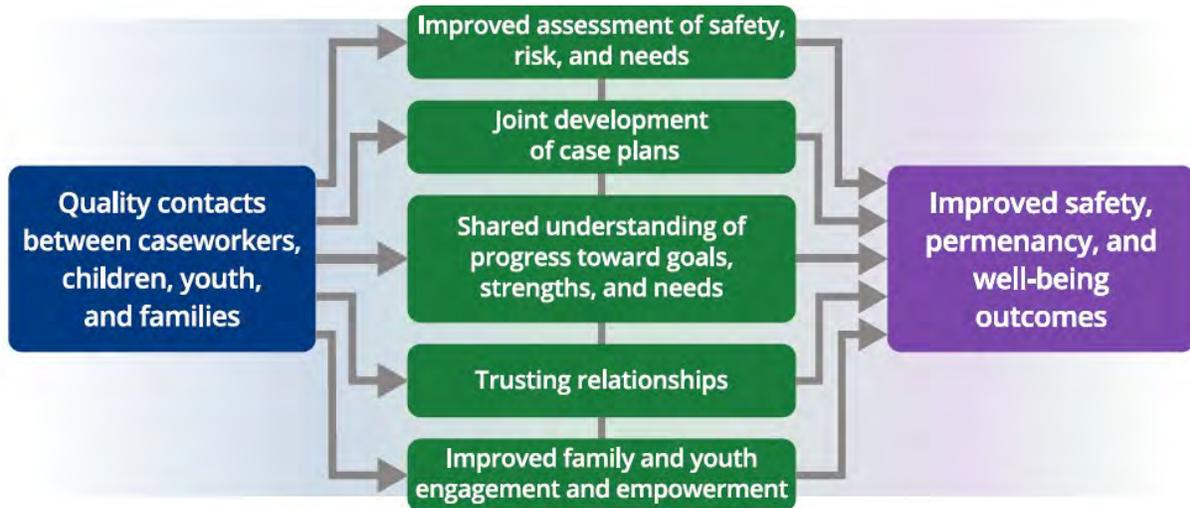
<b>Table 3(g) - Objective 2.1: Increase timely successful permanency through quality legal representation.</b>			
<b>Benchmarks</b>	<b>Who*</b>	<b>Activity Start</b>	<b>Implementation</b>
2.1.2(a): Examine current quality legal projects, e.g. Waterloo project, to determine components needed in a legal representation framework.	CIP, DHS, and Judges	Fall 2019	Fall 2019
2.1.2(b): Collaborate with applicable entities to create a Quality Legal Representation framework replicable across the state.	CIP, DHS, Judges, Legal Aid, etc.	Winter 2019	Winter 2019
2.1.2(c): Determine requirements needed to draw down title IV-E funding and develop required processes/documents, e.g. cost allocation plan, Title IV-E State Plan Amendment, DHS MOU with SPD, etc.	CIP, DHS, and SPD	Winter 2019/2020	Spring 2020
2.1.2(d): Develop and implement a training plan for DHS, families, attorneys, courts, etc.	CIP, DHS, etc.	Spring 2020	Summer 2020 and ongoing
2.1.2(e): Develop and implement a staged implementation plan.	CIP and DHS	Spring 2020	Fall 2024

**Table 3(g) - Objective 2.1: Increase timely successful permanency through quality legal representation.**

Benchmarks	Who*	Activity Start	Implementation
2.1.2(f): Implement ICJ's strategic plan related to CQI for Quality Legal Representation (see Attachment 3B)	CIP and DHS	Ongoing	Ongoing

\*CIP staff, DHS staff, judges, SPD staff, etc.

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



Iowa believes that focusing on engaging families and exploring evidence-based methodologies for assessment and engagement will impact all items in Well-Being Outcome 1 as well as the other CFSR outcomes.

This is not a new concept for Iowa's performance improvement plans as visits between the worker/parents and worker/children was an element in each of the previous CFSR PIPs. While recognizing the importance of frequent and quality visits as a core strategy for family success, increased clarification of requirements and traditional training created only minimal, and generally short-term, results. Iowa assessed reasons for this limited success and found that previous plans failed to fully engage DHS staff who did the work in identifying existing barriers and developing adaptive and technical strategies to overcome these challenges. Just as families and their natural support systems are the experts on their strengths, needs, and challenges, field staff are the experts on the best approach to improving practice.

To that end, Iowa is changing the approach to developing detailed action plans to address the strategy. A benchmark for each of the identified strategies includes a workgroup comprising people involved in the topic; this will include direct staff, supervisors, and stakeholders as appropriate, with additional team members added

based on the focus. These will be small groups of approximately 8-15 people and team members will vary by strategy; the common thread through all workgroups will be significant grass roots representation of those who do the work.

Through case reviews conducted in SFY 2016, SFY 2017, July 2017 – March 2018, and the on-site CFSR review conducted between April and September 2018, data clearly indicates that Iowa has the opportunity to improve in the area of family well-being.

Iowa's view is that the items in the CFSR on-site review instrument (OSRI) Items 12 - 15 are wholly interconnected and active engagement is the cornerstone of effective practice. Approaches that build on families' strengths and enable them to identify solutions to problems are more likely to result in enhanced co-creation and motivation to make needed changes related to safety, permanency, and well-being. A comprehensive family assessment is vital to the system's understanding of the nature of the family's strengths, needs, and circumstances; Iowa recognizes that assessment is an ongoing process that continues to build over time through interaction between the workers and the family. Comprehensive assessment is central to identifying root causes, identifying and delivering appropriate services, and effective case planning.

*Logic for Strategy Focusing on Visits with Children and Parents:*

“Engaging families in the casework process promotes the safety, permanency, and well-being of children and families in the child welfare system and is central to successful practice. Effective family engagement occurs when child welfare practitioners actively collaborate and partner with family members throughout their involvement with the child welfare system, recognizing them as the experts on their respective situations and empowering them in the process.” (Child Welfare Information Gateway, 2016 Bulletin for Professionals, “Family Engagement: Partnering with Families to Improve Child Welfare Outcomes”)

Iowa uses Family Team Decision-Making (FTDM) meetings (FTDM) as one method to engage case participants in case planning, including identifying strengths and needs. While this is a strategy used at key points in the life of the case to engage participants, consistent monthly visits are the primary opportunity to build trust and rapport with families; this relationship building promotes:

- ongoing meaningful discussions regarding progress on goals,
- opportunity to problem-solve together,
- thorough ongoing assessment of safety, and
- identification of how to best support families in achieving their goals.

In order to thoroughly assess and engage with children and parents, the worker must have ongoing contact with them and understand the importance of, and process to, thoroughly assess at each interaction; critical to the assessment process is child and parental engagement and collaboration with the worker in order to “drive” their case. “It is understood that approaches that build on families' strengths and enable them to identify solutions to problems are more likely to enhance families' ownership and

motivation to make needed changes to achieve case plan goals”. (U.S. Department of Health & Human Services, November 2010 “Family Involvement in the Improving Child Welfare Outcomes through Systems of Care Initiative”)

[https://www.childwelfare.gov/pubpdfs/familyinvolvement\\_report.pdf](https://www.childwelfare.gov/pubpdfs/familyinvolvement_report.pdf)

Per the CFSR Round 3 Findings for 2015-2016: “For both mothers and fathers, sub-item 12B was more likely to be rated as a Strength when parents were involved in case planning and had visits with the caseworker that were of sufficient frequency and good quality.” In addition, CFSR Round 2 Findings concluded: “The reviews showed that, when state child welfare agencies do well on the caseworker visits, they are better positioned to assess children’s risk of harm and need for alternative permanency options, to identify and provide needed services, and to engage children and parents in planning for their future.”

Quality contacts are purposeful interactions between caseworkers and children, youth, parents, and resource parents that reflect engagement and contribute to assessment and case planning processes. These face to face interactions are often referred to as “home visits” or “caseworker visits”. (Capacity Building Center for States funded by Children’s Bureau, ACF; “Quality Matters: Defining Quality Contacts”)

**Objective 3.1: Enhance parents’ capacity to ensure child well-being through effective, consistent use of worker/parent visits focusing on:**

- **Assessment of family needs**
- **Identification of services to meet the needs,**
- **Evaluation of goal progress, barriers to meeting goals, and problem-solving solutions to promote progress.**

*Analysis of factors affecting thorough assessment of needs and the provision of services (Item 12) - Parents:*

Data regarding assessment of needs and service provision for parents also indicate the primary issue surrounds ongoing assessments through the life of the case. Analysis of case review narratives indicate the top two issues for assessment of mothers and fathers is lack of:

- regular contact between the worker and parents in order to conduct ongoing assessment, and
- sufficient exploratory questions/conversation to identify underlying issues

The lack of thorough assessment directly impacted performance in the provision of services, i.e. needs were not identified so not addressed through services; in some cases, a service need was identified but the service not provided and not known to the DHS worker; and in other cases, some services were provided but not at the intensity or frequency needed.

**Table 3(h): Item 15 Overall Rating**

Item 15, Overall Rating		
Strength	15	25.4%
Area Needing Improvement	44	74.6%
Total Applicable	59	100.0%
6 cases = NA		

**Table 3(i) – Item 15 by Service Type**

Service Type	Mother		Father	
	FC	IH	FC	IH
Frequency	51.5%	41.7%	50.0%	52.4%
Quality	67.8%	56.6%	56.5%	55.6%

Based on case reviews and interviews, **common quality issues across all case types with visits** centered around:

- lack of meaningful conversation regarding progress and case planning;
- location of visits was not conducive to open discussion (at court, in public, in conjunction with parent/child visit);
- visits at times were very brief, not allowing time to thoroughly engage with parents and address progress or barriers;
- parents reported that they did not feel the worker seriously considered their opinion nor was responsive regarding concerns being discussed.

Primary issues for visits with parents receiving **in-home** services include:

- Lack of efforts to engage a non-custodial parent, regardless of that parent expressing the desire to be involved. Of the total twenty-one in-home cases rated ANI for item 15, 38% (8/21) of those were due to not making concerted efforts to engage the non-custodial father. In-home cases tended to focus on the primary household both in who was visited and which location was evaluated for risk and safety issues.
- Frequency and quality tended to be correlated within cases, i.e. The fewer visits the less quality engagement.

Primary issues for visits with parents of children in foster care include:

- Lack of efforts with incarcerated parent(s)
- Lack of efforts to locate homeless parents or those who frequently moved

- Lack of efforts to engage the non-custodial parent/parent with whom we were not working toward reunification.

**Objective 3.2: Strengthen child engagement to ensure the child’s/youth’s voice is heard throughout the life of the case through effective, consistent use of worker/child or youth visits that focus on:**

- active engagement,
- understanding the case plan, and
- the child’s/youth’s vision of their and their family’s well-being.

*Analysis of factors affecting thorough assessment of needs and the provision of services (Item 12) - Child:*

Data regarding assessment of the child’s needs and services indicates that the primary issue was ongoing assessments rather than initial assessments at the beginning of a case. The majority of cases resulting in an ANI in this area had some assessment completed but the assessment was not in-depth or thorough in identifying all underlying contributing factors and appropriate services to address them. Specific factors contributing to the ANI ratings were a lack of:

- sufficient exploratory questions/conversation,
- regular contact with the child in order to conduct ongoing assessment,
- follow up on service effectiveness and the impact on service needs, and,
- assessment of all children in the home (in-home services cases).

Item 12 correlates with the results in item 14 regarding frequency and quality of visits between the worker and the child/ren; this item was rated as a Strength in only 57% of the cases (37/65).

Rating	Count	Percentage
Strength	37	57%
ANI	28	43%
Total	65	100%

<b>A. Frequency</b>	
No	16
FC	6
IH	10
<b>B. Quality</b>	
No	27
FC	14
IH	13

Below is an analysis of visit quality issues identified during the case reviews and interviews with children, parents, foster parents, and workers. These issues mirror those from item 12 and provide additional details on how the visits fall short:

<b>Table 3(I): Visit Quality Issues Identified</b>			
<b>Quality Issues Identified</b>	<b>Foster Care</b>	<b>In-Home</b>	<b>Total</b>
Not seen alone	4	5	9
Lack of effort to engage in meaningful conversation	4	5	9
Needed to try alternative approach to engaging the child (due to verbal delay, lack of rapport, short attention span, English as a 2nd language)	4	3	7
Brief duration	4	3	7
Lack of visits in current placement/home	5	NA	5
Did not meet with all children in family	NA	3	3
Occurred during parent/child visits	1	NA	1

*Common Issues for 3.1 and 3.2*

Analysis of the common issues across items 12, 13, 14, and 15 indicates the shared issues behind not seeing parents and children on a regular monthly basis and, when seen, not engaging children and parents in well planned, focused conversation on the issues that brought the family to DHS’ attention, assessment of safety and risk, progress on goals, needed services, and barriers encountered.

Item 13:

Case review data from Iowa’s on-site review indicates that performance on item 13 falls short when applying the “active involvement” definition for both children and parents.

- According to the CFSR OSRI, active involvement for the child means that the agency consulted with the child as developmentally appropriate regarding
  - the child’s goals and services,
  - the plan including explaining terms used in the plan in language the child can understand, and
  - periodic case planning meetings and changes to the plan.
- According to the CFSR OSRI, active involvement for the parents means that the agency involved the mother or father in
  - Identifying strengths and needs,
  - Identifying services and service providers,
  - Establishing goals in case plans,
  - Evaluating progress towards goals, and
  - Discussing the case plan.

The Root Cause Workgroup which met on February 6th, identified the same issue/barrier based upon their practice experience. One of the cross-cutting themes identified by the diverse group of 100 stakeholders was a “Workforce Related - lack of time & turnover” which stakeholders described as a barrier to effective engagement with families and establishing a trusting relationship with families. Caseload size and

workload issues make it difficult for staff to have the time and the stress of the work leads to turnover.

The information clearly shows a theme between assessment and engagement and centers around workers spending time with parents and children, focusing on all the same important issues that impact safety, permanency, and well-being raised both by the Root Cause workgroup and the Strategy workgroups.

**Table 3(m) - Objective 3.1: Enhance parents’ capacity to ensure child well-being through effective, consistent use of worker/parent visits focusing on: assessment of family needs, identification of services to meet the needs, evaluation of goal progress, barriers to meeting goals, and problem-solving solutions to promote progress.**

<b>Benchmarks</b>	<b>Who</b>	<b>Activity Start</b>	<b>Implementation</b>
3.1.1: Review current visit expectations, best models for parent engagement, assessment and service response	Visit Case Management Expectations Group	July 2019	December 2019
3.1.2: Review and update narrative template to align with best practice expectations	Visit Case Management Expectations Group	July 2019	December 2019
3.1.3: Update procedural expectations for visits and documentation	Visit Case Management Expectations Group	July 2019	December 2019
3.1.4: Train DHS staff on the new practice skills assure demonstrated understanding of what it means to “actively engage” parents and children in case planning during routine visits.	Bureau of Service Support and Training	January 2020	February 2020
3.1.5: Assure all child welfare partners (court, providers, etc.) are trained on, and able to assure a common understanding of what it means to “actively engage” parents and children in case planning during routine visits.	Service Business Team / Training Academy	February 2020	March 2020

**Table 3(m) - Objective 3.1: Enhance parents' capacity to ensure child well-being through effective, consistent use of worker/parent visits focusing on: assessment of family needs, identification of services to meet the needs, evaluation of goal progress, barriers to meeting goals, and problem-solving solutions to promote progress.**

Benchmarks	Who	Activity Start	Implementation
3.1.6: SBT will review the prior quarter's performance on benchmarks and outcome data quarterly and will post the reporting to the DHS website. The website will also have a link for stakeholder feedback, which will be monitored by the Quality Improvement Bureau to be shared with SBT for review and/or action as needed.	Service Business Team	July 2020	
3.1.7: Strategy impacts CFSSR outcomes beginning July 2021			

Strategy 3.1 impacts the following CFSSR items:

- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate (Items 2 & 3)
- Permanency Outcome 1: Children have permanency and stability in their living situations (Items 5 & 6)
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children (Items 8 & 11)
- Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs (Items 12, 13 & 15)

**Table 3(n) - Objective 3.2: Strengthen child engagement to ensure the child's/youth's voice is heard throughout the life of the case through effective, consistent use of worker/child or youth visits that focus on active engagement, understanding the case plan, and the child's/youth's vision of their and their family's well-being.**

Benchmarks	Who	Activity Start	Implementation
3.2.1: Review current visit expectations, best models for child/youth engagement, assessment and service response	Visit Case Management Expectations Group	July 2019	December 2019
3.1.2: Review and update narrative template to align with best practice expectations	Visit Case Management Expectations Group	July 2019	December 2019
3.1.3: Update procedural expectations for visits and documentation	Visit Case Management Expectations Group	July 2019	December 2019

**Table 3(n) - Objective 3.2: Strengthen child engagement to ensure the child’s/youth’s voice is heard throughout the life of the case through effective, consistent use of worker/child or youth visits that focus on active engagement, understanding the case plan, and the child’s/youth’s vision of their and their family’s well-being.**

Benchmarks	Who	Activity Start	Implementation
3.1.4: Train DHS staff on the new practice skills and assure demonstrated understanding of what it means to “actively engage children/youth in case planning during routine visits.	Bureau of Service Support and Training	January 2020	February 2020
3.1.5: Assure all child welfare partners (court, providers, etc.) are trained on, and able to assure a common understanding of what it means to “actively engage” children/youth in case planning during routine visits.	Service Business Team / Training Academy	February 2020	March 2020
3.1.6: SBT will review the prior quarter’s performance on benchmarks and outcome data quarterly and will post the reporting to the DHS website. The website will also have a link for stakeholder feedback, which will be monitored by the Quality Improvement Bureau to be shared with SBT for review and/or action as needed.	Service Business Team	July 2020	
3.1.7: Strategy impacts CFSR outcomes beginning July 2021			

Strategy 3.2 impacts the following CFSR items:

- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate (Items 2 & 3)
- Permanency Outcome 1: Children have permanency and stability in their living situations (Items 5 & 6)
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children (Items 8 & 11)
- Well-Being Outcome 1: Families have enhanced capacity to provide for their children’s needs (Items 12, 13, and 14)
- Well-Being Outcome 2: Children receive appropriate services to meet their educational needs (Item 16)
- Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs (Items 17 & 18)

## Conclusion

Iowa's child welfare system is dedicated to practice improvements outlined in this plan, including those outlined for systemic factors in *Section II: Performance Assessment in Improving Outcomes*, which will positively impact the children and families served by the system in Iowa. Upon final approval, the plan will be posted on the DHS website for public viewing. The objectives and benchmarks contained within will be shared broadly with staff and stakeholders. Progress throughout the CFSP period including the group work, implementation and monitoring processes will also be shared.

Based on the stakeholder feedback, and success of the statewide groups convened for the PIP process, the state will hold an annual Quality Improvement focus group where stakeholders from across the state will work together to identify strengths, and opportunities to improve. This work will be in addition to the on-going SA based work, which continues throughout the year to address the more local interests.

### *Staff Training, Technical Assistance and Evaluation (45 CFR 1357.15(t))*

- *As detailed in section D7 (Training Plan), the 2020-2024 CFSP must include a staff development and training plan in support of the goals and objectives of the CFSP. Explain how the training activities identified in the training plan are designed to support the goals and objectives in the plan.*

As outlined in Attachment 7D1, FFY 2020-2024 Training Plan, and its attachments, Iowa will conduct the following training activities in support of the goals and objectives in the plan:

- Conduct trainings that focus on child and family safety – understanding danger versus risk, assessing safety, and planning for safety
- Conduct training that focuses on caseworker engagement for active involvement of the child, parents, and family in their case.
- Conduct a training on the Child and Family Service Review (CFSR) expectations of best practice and their intersection with Iowa practice.

For more training information, please see Attachment 7D1 and its attachments.

- *Describe the state's technical assistance activities that will be provided to counties and other local or regional entities that operate state programs and its impact on the achievement of the goals and objectives of the plan.*

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

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

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

- *Describe the technical assistance and capacity building needs that the state anticipates in FY 2020 - 2024 in support of the CFSP PIP and CFSP goals and objectives. Describe how capacity building services from all partnering organizations or consultants will assist in achieving the identified goals and objectives. (See 45 CFR 1357.16(a)(5).)*

Below is information regarding technical assistance/capacity building needs and services identified to address Iowa's TA needs:

- Dr. Amelia Frank Meyer, LISW, APSW: In September and October 2019, Dr. Frank Meyer will be presenting six trainings on the "Human Need for Belonging" throughout the state (one training in each service area) for DHS staff. External stakeholders are also encouraged to attend. The trainings explore the life-long impact of out-of-home placement on children and the importance of safely connecting children to their family. These trainings will prepare the DHS workforce, and stakeholders, for Family First implementation and necessary shifts in practice mentioned earlier in this section.
- Annie E. Casey Foundation (AECF): In FFY 2020, AECF will continue to assist the DHS in implementation of its family centered services (FCS) package, which is part of Iowa's Family First implementation activities. FCS will be the evidence-based interventions provided to the family to support the safety, permanence, and well-being of the children and family.
- National Center for Substance Abuse and Child Welfare (NCSACW): As referenced earlier in this section (Goal 1, Objective 1.3), Iowa plans to access technical assistance from (NCSACW) to explore evidence-based interventions and responses in working with families with substance use disorder (SUD).
- National Child Welfare Workforce Institute (NCWWI): To support staff in utilizing best practices, Iowa may access technical assistance from NCWWI. This may include, but not be limited to, online microlearnings, online leadership academy

for supervisors, leadership academy for middle managers, one pagers, infographs, toolkits, etc.

- Casey Family Programs: DHS began receiving technical assistance from Casey Family Programs (CFP) in October 2009. The initial focus was to decrease foster care entries and lengths of stay, particularly for minority children, which continued and evolved over the last ten (10) years. Today, technical assistance (TA) from CFP focus on the following areas:
  - Increase exits to entries ratio (foster care)
  - Decrease maltreatment recurrence
  - Decrease re-entry into foster care
  - Increase permanency for children within 12 months for children who have been in care 24+ months
  - Decrease child abuse and neglect fatalities

DHS anticipates continued TA from CFP on the above areas, with continued focus on the following efforts:

- Development and launch of a Safe Sleep Campaign,
- Piloting Child Safety Conferences,
- Expanding our existing Communities of Hope pilot project,
- Piloting approaches to improve family finding efforts,
- Conducting an independent, systematic review of evidence-based interventions that Iowa wants to implement as part of our Family First Prevention Services, e.g. SafeCare®, and
- Educating community partners and stakeholders of the impacts of the federal Family First Prevention Services Act.

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

- Casey Family Programs: CFP contracted staff will conduct an independent, systematic review of evidence-based interventions that Iowa plans to implement, e.g. SafeCare®, Solution-Based Casework, Parent Partner, etc.
- Parent Partner:
  - Researchers from the University of Nebraska-Lincoln's Center on Children, Families and the Law (UN-L) provide quarterly and annual reports on participants involved with the Parent Partner Program. These reports present data retrieved from the Online Parent Partner Database. The Online Parent Partner Database stores data from seven forms: intake, contact log, client registration form, family self-assessment (entry), family self-assessment (exit), family feedback, and fidelity checklist. The quarterly and annual reports provide analyses of the number of participants completing the entrance and exit Parent Partners participant self-assessments and fidelity to the Parent Partner model.
  - Through on-going research, UN-L found a positive statistically significant difference for parents who receive Parent Partner supports. Parent Partner

- families have a higher rate of reunification and less reentry than families without a Parent Partner. DHS partnered with UN-L to write a research article regarding these findings (see Attachment 3C), which will be published in a social science journal. Once published, UN-L will submit required documentation to the California Evidence-Based Clearinghouse for Child Welfare classification.
- SafeCare®: In December 2018, the National SafeCare® Training and Research Center (NSTRC) with Georgia State University (GSU) reached out to DHS to share information on a grant opportunity that one of the NSTRC Directors was applying for with the National Institute on Health. The grant will focus on integrating a very brief smoke-free home intervention into SafeCare® to examine whether positive parent-child outcomes can improve and reduce the risk for second hand smoke exposure for young at-risk children. The NSTRC with GSU asked the DHS to partner in this work, and if interested, to submit a letter of support, with a conference call scheduled to further discuss the opportunity.

On January 8, 2019, a conference call occurred with Dr. Shannon Self-Brown, the NSTRC Director applying for the grant, and others with GSU to gather additional information regarding the grant opportunity. SafeCare® data indicated that between 65% and 73% of caretakers use tobacco. Second hand smoke is a major but preventable threat to infant and child health causing ear infections, respiratory problems, exacerbating asthma, and increasing risk of Sudden Infant Death Syndrome (SIDS). NSTRC with GSU selected the DHS to partner in this work for two reasons. One, Iowa has a strong ongoing SafeCare® implementation with certified providers and SafeCare® data suggesting high rates of smoking among caretakers in Iowa. In Iowa, queried data reflects that 67% of Iowa caretakers smoke daily.

On March 6, 2019, DHS submitted a letter of support to Dr. Self-Brown for the grant opportunity. On this same date, the SafeCare® providers received notification of DHS's support to participate in the study but acknowledged that for this to occur, it required commitment from them as current providers of SafeCare®. If NSTRC with GSU receives the grant, it will be for five years, with more information forthcoming. If selected, the earliest funding would be available in spring 2020. In addition to Iowa, Oklahoma agreed to partner on this grant.

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

- Training and coaching (as outlined in Attachment 7D1, FFY 2020-2024 Training Plan and referenced in *Section II: Performance Assessment in Improving Outcomes, Systemic Factor, Staff and Provider Training*):
  - In FFY 2020-2024, develop, implement, and monitor a mentoring program for new workers.
  - In FFY 2020-2024, develop, implement, and monitor a Master of Social Work (MSW) stipend program for staff.
  - In FFY 2020-2024, develop, implement, and monitor for effectiveness supervisory specific training.
  - Continue to encourage staff usage of DHS HelpDesks, when needed
  - Continue Iowa State University's training orientation call with new workers
- Financing:
  - Beginning with FFY 2020, fourth quarter, Family First implementation will provide an opportunity for Iowa to receive additional federal funding to implement title IV-E prevention services, kinship navigator program, etc. Please see *Section II: Performance Assessment in Improving Outcomes, Systemic Factor, Service Array* for more information on our new family centered services package recently released request for proposal (RFP).
  - In FFY 2020-2021, DHS staff will work with Iowa Children's Justice staff to establish a memorandum of understanding with the State Public Defender's Office to draw title IV-E administrative funding for quality legal representation of children and parents in child in need of assistance (CINA) proceedings, which reflects Goal 2: Quality Legal Representation in this section.
- Data Systems: Please see *Section II: Performance Assessment in Improving Outcomes, Systemic Factor, Information System* for description of our implementation of a comprehensive, child welfare information system (CCWIS) by persona (role) with initial role out for frontline staff (SW2s, SW3s, and supervisors) no later than FFY 2021.
- Memoranda of Understanding with Tribes: Please see *Section V: Consultation and Coordination Between States and Tribes* for information on planned activities to review and revise Iowa's intergovernmental agreement and protocol with the Sac and Fox Tribe of the Mississippi in Iowa and in establishing intergovernmental agreements with Tribes domiciled in Nebraska. These intergovernmental agreements will support achievement of safety, permanency, and well-being for Native American children served by Iowa's child welfare system.

Additional supports may be identified in the key activities outlined in this section's plan for enacting Iowa's child welfare vision.

## **Section IV: Services**

### **Child and Family Services Continuum**

*Describe the publicly funded child and family services continuum, including child abuse and neglect prevention, intervention, and treatment services and foster care; family preservation services; family support services; and services to support reunification,*

*adoption, kinship care, independent living, and services for other permanent living arrangements.*

## Prevention

### *Iowa Child Abuse Prevention Program (ICAPP) and Community-Based Child Abuse Prevention (CBCAP) Program*

The Iowa Child Abuse Prevention Program (ICAPP) is the Department of Human Services' (DHS) foremost approach to the prevention of child maltreatment. ICAPP's premise is that each community is unique, with its own distinct strengths and challenges in assuring the safety and well-being of children, depending upon the resources available. Therefore, the structure of ICAPP allows for local Community-Based Volunteer Coalitions or "Councils" to apply for program funds to implement child abuse prevention projects based on the specific needs of their respective communities. Although this program receives state and federal funding from a variety of sources, title IV-B, subpart II, Promoting Safe and Stable Families (PSSF) remains the largest single source of funding for this program overall. Iowa utilizes approximately 31% of PSSF, Family Support category, for the ICAPP program. In addition to the local projects, DHS contracts with an external administrator to provide technical assistance, contract monitoring, and program evaluation services.

### ICAPP Core Family Support Service Descriptions

The core of funding goes to programs typically thought of as "Family Support". These programs include parent development/leadership (education, support, etc.), home visitation (using an evidence-based model), and crisis child care. Full descriptions are below.

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

- *The Nurturing Program:* a curriculum that teaches nurturing skills to parents and children while reinforcing positive family values through multiple home or group-based instruction.
- *The Love and Logic* program: a group-based program that typically occurs in six weeks of sessions.
- *Active Parenting:* a group-based, six-session program that teaches basic skills to parents.

- *Systematic Training for Effective Parenting (STEP)*: group-based skills training for parents dealing with frequent challenges in behavior, often resulting from autocratic parenting styles.

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

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

**Crisis Childcare:** Crisis Childcare is a service which provides for a temporary, safe environment for children aged birth through 12 years whose parents are unable to meet their needs due to overwhelming circumstances or an emergency in their lives. Services are available to families under stress 24 hours per day, seven days per week and families may utilize the services for up to 72 hours at a time. Program staff conducts intake interviews, arrange temporary care for the children with licensed/registered providers, and offer advice and support to parents. Some programs also provide transportation to care when requested. These programs also will travel to pick up children if necessary.

#### *Community-Based Child Abuse Prevention (CBCAP) Program*

The DHS, Bureau of Child Welfare and Community Services, also oversees the Community Based Child Abuse Prevention program (CBCAP) in Iowa. This program runs very similarly to ICAPP in that the DHS contracts with an administrator and then issues a competitive statewide request for proposals (RFP) to local Community Partnerships for Protecting Children (CPPC) sites. CPPC sites comprise local volunteer community members, professionals, and families who work together to develop and implement local programs, services, supports, and policies that positively impact families and protect children from abuse.

The DHS requires that CPPC sites applying for CBCAP funds assess their community's needs and propose programs to effectively address them. For SFY 2016-2018, CPPC sites submitted a proposal for funding for up to two prevention projects in one of four CBCAP categories: Parent Development, Fatherhood, Crisis Care, and Community-Based Family Team Meetings. An independent grant review committee evaluated site proposals and recommended how to distribute the funds with the DHS' approval prior to distribution of the funds.

### CBCAP Core Services Descriptions

CBCAP core services are very similar to those funded under ICAPP (see descriptions from previous section). The key differences include Fatherhood as a separate category of funding and the inclusion of Community-Based Family Team Meetings (CBFTM). Since federal fiscal year (FFY) 2014, Iowa utilized CBCAP funding to launch the Responsible Fatherhood Initiative, establishing the evidence supported 24/7 Dad™ program through seven Fatherhood programs across Iowa. Unfortunately, the only CBFTM project funded under CBCAP in SFY 2016-2017 did not receive funding in SFY 2018 due to an inability to meet projected deliverables. In addition, CBCAP funds are not used for any community development, respite care, or child sexual abuse prevention projects.

### Future Direction of the Program/Goals for 2020-2024

ICAPP and CBCAP underwent significant structural changes in the programs. In SFY 2018, a new administrative contract began with PCA Iowa. New deliverables in this contract included:

- Inclusion of CBCAP funding into the broader statewide ICAPP program;
- A requirement of the program administrator to conduct a statewide needs assessment and develop a strategic plan; and
- Additional emphasis on racial/cultural equity, parent involvement, fidelity monitoring, and continuous quality improvement.

With both programs combined, DHS and the ICAPP Administrator released a new competitive procurement for grantees for SFY 2019-2020. This was the first procurement that combined both funding streams into a single application process. Some of the highlighted differences from the previous procurement include:

- Funding limitations were based on county risk analysis,
- Elimination of respite care as a funded project,
- Requirement for crisis child care to use registered or licensed child care or foster care providers only,
- Elimination of a separate stand-alone category of funding for Fatherhood initiatives (these can still be funded under home visitation or parent development projects), and
- Better alignment by funding intent.
  - For example, Sexual Abuse Prevention projects were limited to the state appropriated fund specifically for those services.

The full RFP and all documents is available at:

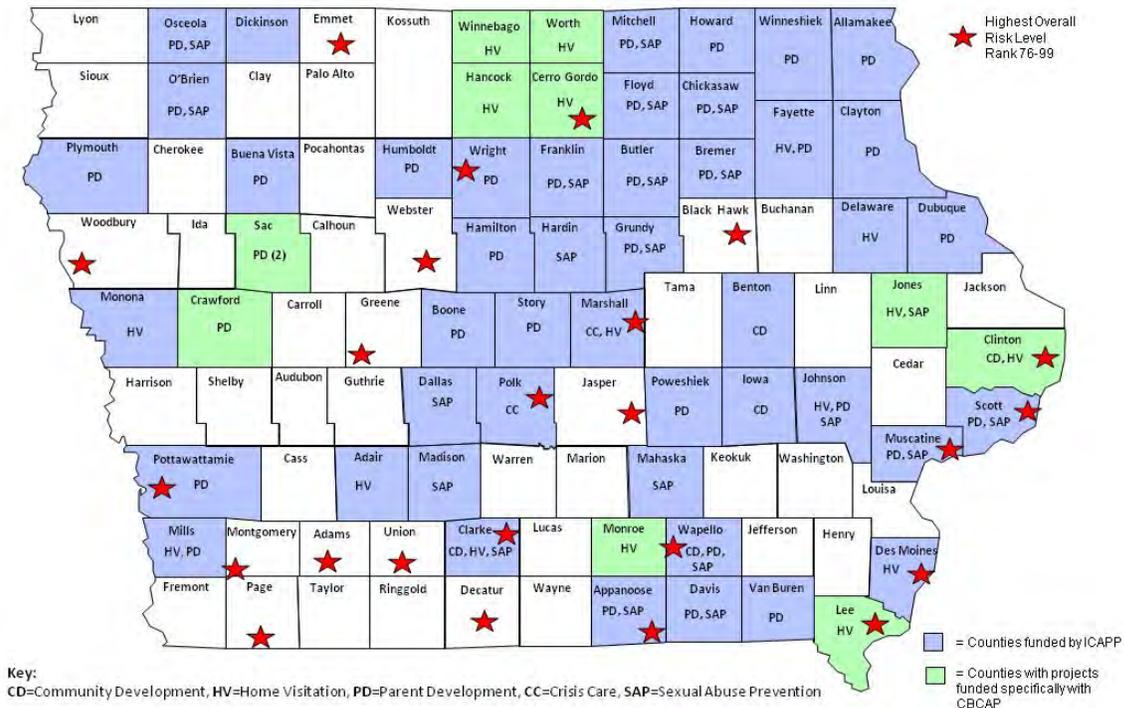
The changes in the RFP process had some significant impacts on the location and number of projects across the state. The DHS anticipated this and felt it was necessary to enhance program efficacy. Of Iowa's 99 counties, 56 counties now have child abuse prevention services. The breakdown of funding, illustrated in Figure 4.1, includes the following:

- 43 counties currently do not have services funded through ICAPP/CBCAP.
  - Several clusters of counties, including a high-risk area in southwest Iowa, received disqualifications due to late proposal submissions or other missed mandatory requirements.
- 10 counties received exclusive funding through CBCAP (separated out during the contracting process for reporting purposes).
  - These projects all utilize the Healthy Families America home visitation model.
- 46 counties have projects using the various funding streams that previously comprised ICAPP.

Although this was a decrease in the number of counties with funding for prevention projects (from 93 counties in SFY 2016-2018), the average award went from approximately \$11,000 per SFY to an average of \$28,000. As a result, some projects received award amounts that were significant enough to fund full or partial salaries. In the past, with grants being so small, they typically were just an add-on to local programs funded by a variety of different sources and likely did little to increase program capacity. DHS intends to continue moving in this direction of funding fewer projects at a more significant level. Doing so increases service capacity, improves evaluation outcomes, and makes project management and continuous quality improvement (CQI) more effective.

The program administrator, with the support of a consultant (Public Consulting Group), evaluates the results of the Protective Factors Survey. Analysis and discussion of the evaluation results for SFY 2019 will be in next year's Annual Progress and Services Report (APSR). The outcomes measured will guide the program in future years to assure we are reaching those most in need of services and to enhance practice by assuring reliance on program models proven effective in the prevention of child maltreatment.

**Figure 4.1: FY 2019-2020 ICAPP and CBCAP Funded Projects**



Source: DHS Program Manager

### *Community Adolescent Pregnancy Prevention (CAPP)* Overview

In 1987, the DHS, as a result of a taskforce recommendation, created the Adolescent Pregnancy Prevention and Services to Pregnant and Parenting Adolescents Program, now known as Community Adolescent Pregnancy Prevention (CAPP). The program, currently funded entirely through federal Temporary Assistance for Needy Families (TANF) block grant dollars, resides within the DHS' Bureau of Child Welfare and Community Services, given the correlation between young parenting and risk of maltreatment.

The DHS administers the program, with the support of an external administrator. Iowa Administrative Code (IAC) Chapter 441—173 identifies program rules, which directs funds go to local/regional coalitions for projects providing:

1. Broad-based representation from community or regional representatives including, but not limited to, schools, churches, human service-related organizations, and businesses.
2. Comprehensive programming focusing on the prevention of initial pregnancies during the adolescent years.
3. Services to pregnant and parenting adolescents, with not more than 25% of the community grant used for these services.

## Services

Services provided by local contractors and subcontractors use various evidence-based curricula. Contractors offer services primarily through area schools, but also in alternative settings such as foster group care homes. The CAPP program administrator collects service data and the program evaluator gathers and analyses pre/post surveys measuring changes in knowledge, attitudes, and beliefs. Grantees submit required quarterly service reports indicating the numbers of youth served through various program requirements, including:

- Full sexual health curriculum implementations (with fidelity)
- Partial sexual health curriculum implementations (for example, some schools will not allow parts of curricula to be presented, such as condom demonstrations)
- Topical presentations on a range of issues, such as:
  - Sexually transmitted infections
  - Healthy relationships
  - Social media safety
  - Human trafficking
- Young parent support services

## Fidelity Monitoring

The University of Northern Iowa (UNI), contracted to evaluate CAPP services, developed a process for monitoring the fidelity of teaching the various CAPP approved curricula. SFY 2015 was the first year that the process began for all grantees.

The CAPP fidelity process considers and scores five aspects of fidelity:

- *Adherence* (the extent to which program components are delivered as prescribed)
- *Exposure* (dosage, or the amount of the program delivered compared to the amount prescribed by the program model)
- *Participant responsiveness* (manner in which participants react to or engage in the program)
- *Quality of delivery* (manner of delivery)
- *Program differentiation* (the degree to which critical components are distinguishable from each other).

With feedback from grantees and the CAPP administrator, UNI developed hard copy and online versions of fidelity logs for each of the CAPP approved curricula. Each log contains a section for the curriculum's modules and activities, as well as questions about the classroom, school, and teacher.

## Future Direction of the Program/Goals for 2020-2024

The DHS initiated a new procurement for CAPP grantees for SFY 2020-2022, as the current contracts are set to end on June 30, 2019. The DHS engaged in a similar planning process as was completed in the procurement of child maltreatment prevention services, conducting surveys and focus groups with current grantees, partners, and stakeholders to determine the specific gaps and needs across the state.



The DHS just announced awards on May 31, 2019, with contract negotiations occurring at the time of this report. If all grantees enter into a contract, the program will include 20 grantees, covering 58 counties, providing comprehensive pregnancy prevention services. This includes 13 grantees providing teen parent support services and 6 grantees working in child welfare out-of-home placement facilities. The full RFP and all related documents are available at:

<https://bidopportunities.iowa.gov/Home/BidInfo?bidId=dd135811-7bf6-4364-9f02-991257c72cf2>

In SFY 2020, the CAPP Administrator, PCA Iowa, will finalize the CAPP Needs Assessment and Strategic Plan, with key findings in next year's APSR. Depending on the recommendations that come out of these two documents, and in consideration of ongoing evaluation results, DHS and the CAPP administrator will begin considerations for the next round of services for SFY 2023 and beyond.

#### *Community Partnerships for Protecting Children (CPPC)*

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

The CPPC philosophy is:

- Parents and youth need to be full partners in shaping supports and services for themselves and their communities
- Children should be with their own families whenever possible
- Families are stronger when all members, including caregivers are safe from abuse
- There is no substitute for strong families to ensure that children and youth grow up to be capable adults
- Families need supportive communities to help them be strong and offer a sense of belonging
- Children can be best kept safe when families, friends, residents, and organizations work together as partners
- Services and supports need to be closely linked to communities in which families live
- Government alone, through the Department of Human Services, cannot keep children safe from abuse and neglect
- Efforts to reduce abuse and neglect must be closely linked to broader community initiatives and priorities

The long-term focus of CPPC is to protect children by changing the culture to improve child welfare processes, practices and policies. The approach involves four key strategies implemented together to achieve desired results, which are Shared Decision Making, Community Neighborhood Networking, Individualized Course of Action, and Policy and Practice Change. It is through this philosophy, and many years of dedication to the development of the four strategies and their levels, that initiatives flourished with CPPC's support and through CPPC Shared Decision Making teams who partnered locally to tailor the CPPC approach to meet their community's needs. Additionally, many of the DHS's statewide initiatives started with CPPC sites piloting new ideas focused on child welfare policy and practice changes. These initiatives include but are not limited to Family Team Decision-Making, Parent Partners and the Safe and Together model.

CPPC sites collect performance outcome data on the implementation of all four strategies: Shared Decision Making, Community Neighborhood Networking, Individualized Course of Action, and Policy and Practice Change. The Iowa DHS program manager receives proposed plans and progress reports. The program manager compiles the data from the reports and verifies the correctness of the level identified for each strategy. During site visits and regional meetings, the program manager has an opportunity to compare reported and actual progress on each of the strategies.

#### Community Partnerships for Protecting Children Level Summary

CPPC sites report a specific level (1-4) for each strategy obtained during the year. Sites received training on requirements to meet each specific level and written materials to assess the level for each strategy. In order to achieve desired results, simultaneous implementation of each of the four strategies (Shared Decision Making, Policy and Practice Change, Community Neighborhood Networking and Individualized Course of Action) must occur.

Moving through the levels of each strategy involves the CPPC sites first identifying or developing plans for activities to identify community needs and plan strategies within the lower levels, and then move toward implementation of their plans as the sites advance through the levels. CPPC sites must also continue to build their Shared Decision Making Team representation as they move through the levels, including involving representatives from domestic violence, substance use and mental health partners. CPPC sites are to include members who represent the demographics and diversity of their communities, in addition to youth and parents with lived experience who have currently or previously been involved in the child welfare system. Parent Partners are routinely included on Shared Decision Making Teams to provide input, educate other members and the community on the Parent Partner program, and in leading or participating in collaborative programs in the community. Plans and strategies to increase linkages for informal and professional supports for families in need and increasing collaborations across child welfare and community partners are further reflected through Neighborhood Networking activities as the site moves through each of the levels.

Additional information regarding the information collected for the levels and their associated strategy is in the Community Partnership Reporting and Evaluation Form (Attachment 4A) submitted annually by each of the individual CPPC sites.

### CPPC Education and Training

CPPC Immersion 101 gives those involved with CPPC (or those interested in being involved) a better understanding of the four strategies of community partnerships. Participants observe a presentation on each of the CPPC's strategies (Shared Decision Making, Neighborhood/Community Networking, Policy and Practice Change, and Individualized Course of Action) and learn the flexibility of implementation of these strategies to meet local community needs. The training concludes with participants interacting in small groups to prepare a presentation around one of the four strategies to develop creative ways to share CPPC information locally. The goal of CPPC Immersion 101 is to engage participants in recognizing the components of CPPC and the value in the implementation of the four strategies.

The primary audience members for CPPC 101 Immersion are:

- New CPPC Coordinators
- New Decat Coordinators
- Those involved in their local CPPC: Shared Decision-Making Team members
- Targeted CPPC recruits: DHS staff, community members, practice partners, foster parents, agency providers, etc.
- Local city and county government representatives

CPPC statewide meetings occur on a bi-annual basis. CPPC coordinators, child welfare system and practice partners, community members involved in local Shared Decision Making teams, and CPPC community networks attend the statewide meetings for learning opportunities, networking, idea and strategy sharing, and to celebrate successes. Workshop and presentation offerings reflect trends in child welfare, local and statewide resources and programs, strategies for engaging communities, ideas and action planning for application of information for CPPC sites to increase their capacity, leveraging resources, and assessing for gaps and developing plans to meet needs of children and families in their communities.

### *AmeriCorps Partnering to Protect Children (APPC)*

The DHS partners with Iowa State University (ISU) to implement an AmeriCorps program which provides an AmeriCorps member to CPPC sites to promote the communities' ability to strengthen the four strategies of CPPC. A statewide AmeriCorps program coordinator provides oversight to members serving within each of the host sites. The coordinator also distributes a regular newsletter that features members and offers information on local site initiatives. Members report monthly on their capacity building activities and corresponding CPPC strategy. Local site supervisors complete an annual assessment of member impact toward achieving their CPPC goals. AmeriCorps expands sites' capacity to engage the community and promote child well-being.

### *Parent Cafés*

Parent Cafés is a recent initiative piloted and promoted through CPPC. CPPC sponsored the rollout of Parent Café facilitator training through working with the BeStrong Families organization in Illinois. The Parent Café model allows participants “individual deep self-reflection and peer-to-peer learning, opportunity for participants to explore their strengths, learn about the Protective Factors, and create strategies from their own wisdom and experiences to help strengthen their families.” (<https://www.bestrongfamilies.org/>). Parent Cafés are opportunities for persons in a parenting role to come together and share their experiences, their joys, and their concerns with others in an informal and participant led setting. Table conversation topics center on the five Protective Factors: Resilience/Parent Resilience; Relationships: Positive Social Connections; Support: Concrete Support in Times of Need; Knowledge of Parenting and Child Development; and Communication: Social and Emotional Competence.

In the initial rollout and in partnership with BeStrong Families, 40 new Parent Café facilitators and table hosts received training as teams from areas across the state. In developing in-state trainers, the BeStrong Families staff mentored 6 new trainers in Iowa. CPPC supported training for a total of 113 individuals completing Parent Café facilitator training. Parent Cafés occur in a variety of locations across the state and include parents in family preservation court, Parents as Teachers participants, parents with school age children and parents recruited through facilitators such as teen parents, fathers, and refugees.

Through a local contract with a CPPC site with established experience in implementing Parent Cafés in their area, the contractor began efforts to synthesize information for Iowa CPPC communities through development of a guidebook and implementation tools for sites to utilize in addition to offering facilitator training on the Parent Café curriculum. These efforts will support CPPC local sites to strategize action steps to implement Parent Cafés locally, such as determining cost analysis for necessary funding and resources, identifying populations or groups in their communities they wish to serve, and generating ideas for sustainability. Outcome collection tools and tracking are in development to capture from participants whether protective factors strengthened around parenting skills and knowledge, increased informal supports and connections to the community, and decreased feelings of stress and improvement in overall well-being.

### Direction for 2020-2024 CPPC plan

Looking ahead, the vision for CPPC includes bolstering the local sites efforts to align with both trends in policy and practice in child welfare, including implementation of Family First, as well as to continue to support local CPPC sites in meeting the needs of children and families in their communities through the CPPC Approach.

State efforts will promote and provide technical assistance to the CPPC sites to enhance movement through the levels among each of the four strategies. Increased movement within the levels promotes family and youth engagement, and improved linkages among community members, organizations, and available services. Increased

cross collaboration occurs to strengthen strategic partnerships and to ensure diverse representation of the local population on Shared Decision Making Teams (SDM). Meaningful involvement of youth, families, and community partners through representation and participation around activities within all four strategies is essential. Local SDM teams will continue to assess gaps in services through gathering input from children and families in their communities, and through gathering and utilizing data and community insights to identify and assess needs for potential policy and practice changes with the goal to prevent families from entering the child welfare system and to prevent re-entry into the system.

Efforts are underway and will continue to bolster implementation opportunities for local sites around Parent Cafés. Identifying and building on informal supports and establishing community connections for both families and youth in communities through resources such as Parent Cafés are critical to increasing protective factors around resilience and bolstering overall well-being. Parent Cafés further provide opportunity to build knowledge of parenting and child development, and can increase social and emotional competence of children in families who participate in Parent Cafés. Through providing technical assistance to local CPPC sites, such as through regularly scheduled Parent Café Facilitator calls to solicit input and feedback on local efforts, on-going needs for sustainability and the need for additional Facilitator training opportunities will be identified and addressed to increase opportunities for Parent Café offerings across the state.

Community-based FTDM and YTDM are effective processes for engaging youth and parents in identifying and utilizing their support systems and creating plans to meet their needs that can help prevent formal child welfare involvement. Local CPPC sites will explore strategies for building capacity to offer CBFTDM and CBYTDM, such as the marketing and referral process, training and support of facilitators, and a process for tracking and quality assurance.

CPPC will continue to explore creative ways to educate their communities and offer these family support services to respond to community needs and build protective factors. For example, opportunities to implement community activities and education to support families in recovery can increase connections to the community, enhance well-being for families, and decrease stigma around the recovery process and substance use disorders. Activities may include family oriented events to normalize recovery and provide linkages and collaboration with the recovery community such as through holding community picnics, parades, and fairs, as well as educational forums on substance use and recovery. Parent Partners are collaborating with foster parents, parents, judges, and community partners to host reunification picnics.

Local CPPC sites will seek opportunities to support and align with Family First evidenced-based programs (EBPs). As EBPs can have a singular focus, CPPC sites can look for opportunities to assess policy and practice around adapting community supports and services that meet complex needs of families in addition to the EBP in which they participate.

CPPC sites will receive support and encouragement on innovative ways for communities to move within the levels to implement evaluative strategies to measure efforts around learning exchanges, community activities, engagement strategies, services and supports, policy and practice changes and other efforts. Opportunities will occur to share outcome measures for tracking trends, feedback, and programmatic outcomes.

CPPC goals include increasing parent engagement within each of the four strategies through expanding opportunities for input, identifying and engaging informal supports, providing additional linkages between children, youth, and parents and community resources, and further developing collaborations between community partners to further strengthen safety nets, close gaps in services and available resources, and meet the individualized needs of communities.

## Intervention

### *Child Protective Assessments*

When the DHS receives a report of suspected child abuse and the allegation meets the three criteria for abuse or neglect in Iowa (victim is under the age of 18 years; allegation involves a caretaker for most abuse types; and the allegation meets the Code of Iowa definition for child abuse), the DHS accepts the report of suspected abuse for a child protective assessment. On January 1, 2014, Iowa implemented a Differential Response (DR) System. Under the DR System, when the DHS intake staff accepts a report of suspected abuse, the staff assigns the report to one of two pathways for assessment, a Family Assessment or a Child Abuse Assessment

The DHS staff assigns accepted reports of suspected abuse as a Family Assessment when only Denial of Critical Care is alleged with no imminent danger, death, or injury to a child and other criteria as outlined in 441 Iowa Administrative Code (IAC) 175.24(2)(b) is also met. Cases eligible for a FA are less serious allegations of abuse or neglect. During the course of a Family Assessment, the DHS child protection worker (CPW):

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

CPWs must complete Family Assessment reports by the end of 10 business days, with no finding of abuse or neglect, no consideration for placement on the Central Abuse Registry, and no recommendation for court intervention made. Successful closure of a Family Assessment indicates the children are safe without further need for intervention to keep the child safe. CPWs make recommendations for services available in the

community for families with low risk; they offer families at moderate and high risk voluntary, state-purchased Community Care services.

If at any time during the Family Assessment the CPW receives information that makes the family ineligible for a Family Assessment, inclusive of a child being “unsafe”, the DHS staff reassigns the case to the Child Abuse Assessment pathway. The same CPW continues to work the case.

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

- make a finding of whether abuse occurred,
- consider whether a perpetrator’s name meets criteria to be placed on the Central Abuse Registry, and
- determine whether court intervention will be requested.

Findings 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.

If a report of suspected child abuse does not meet the criteria to be accepted for assessment, DHS intake staff rejects the report. DHS intake staff must screen a rejected report 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). DHS uses CINA Assessments to determine if juvenile court intervention should be recommended for a child and also examines the family’s strengths and needs in order to support the families’ efforts to provide a safe and stable home environment for their children.

#### *Child Advocacy Centers*

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

CAC/CPCs employ staff that specializes in the emotional and physical needs of children who have experienced sexual abuse, severe physical abuse and/or substance use related maltreatment or neglect. Services include forensic interviews, medical exams, treatment, and follow-up services for alleged child victims and their families. These specialized services strive to limit the amount of trauma experienced by child victims and non-offending family members. In addition to providing case consultation services to DHS, the CAC/CPCs coordinate with law enforcement and county attorneys in the prosecution of criminal cases involving child endangerment, child fatalities, and sexual abuse. Other services provided by CAC/CPCs include multidisciplinary trainings for professionals involved in child welfare services.

Currently, there are five CAC/CPCs and one satellite CAC/CPC in Iowa. The names and locations of the CAC/CPCs are as follows: Mississippi Valley CAC/CPC which is located in Muscatine, Iowa; St Luke's CAC/CPC in Hiawatha, Iowa; Blank Regional Children's Hospital in Des Moines, Iowa; Mercy CAC/CPC in Sioux City, Iowa; and Allen CAC/CPC in Cedar Falls, Iowa. Allen CAC/CPC also hosts a satellite facility in Mason City, Iowa. In addition to Iowa's CAC/CPCs, there is also Project Harmony, a CAC/CPC that is located in Omaha, NE. Project Harmony serves children and families in the southwestern area of Iowa.

The Iowa CAC/CPCs have a monetary contract with the Iowa Department of Public Health (IDPH). On May 31, 2001, a Child Protection Center Grant Program was established within IDPH to provide grants to eligible applicants for the purpose of establishing new Child Protection Centers and to support the existing ones (Iowa Code Section 135.118). Grants are available to eligible organizations that meet, or are in the process of implementing Child Protection Center standards as established by the National Children's Alliance. These standards relate to the provision of services to child abuse victims and their families referred by DHS or law enforcement agencies. The Iowa CAC/CPCs currently receive funding under this grant program. Project Harmony receives a separate state appropriation as it is located in Nebraska.

The five Iowa CAC/CPCs operate under a nonmonetary agreement with DHS. The agreement is in the form of a collaborative Memorandum of Understanding (MOU) between the Department and each of the CAC/CPC. The MOU establishes the guidelines and identifies the services that the CAC/CPAs will provide to DHS clients. As Project Harmony is located out of state, a formal contract is in place for their services.

### *Safety Plan Services*

During the assessment process, child protection workers may determine that the family needs Safety Plan Services (SPS) in order to ensure the safety of the child (ren). SPS provide oversight of children assessed by the DHS worker to be conditionally safe and in need of services, activities, and interventions to move them from conditionally safe status to safe status during a time limited DHS child abuse assessment (CAA) or Child In Need of Assistance (CINA) assessment. SPS include culturally sensitive assessment and interventions. SPS assure that the child (ren) will be safe and that without such services the removal of the child(ren) from the home or current placement will occur.

These services are provided in the family's home and/or other designated locations as determined by the DHS Safety Plan; remediate the circumstances that brought the child to the attention of DHS; and keep the child(ren) safe from neglect and abuse while maintaining or improving a child's safety status.

There are currently eight (8) different contractors under sixteen (16) contracts in the local service areas.

As a part of the current contract, there are two contract performance measures that evaluate effectiveness of the services:

- Performance Measure 1 (PM1): Children are safe in their homes and communities. Children will not be removed from their homes during Safety Plan Services.
- Performance Measure 2 (PM2): Children are safe in their homes and communities. Children do not suffer maltreatment during Safety Plan Services.

Quarterly onsite reviews occur with the assigned DHS service contract specialist and representatives from the respective contracts. Onsite reviews ensure that contractors meet the contract requirements and are in compliance.

#### *Drug Testing Services*

In child welfare, usage of drug testing is to better protect children. As such, drug testing results are one component of the accumulated information to be considered in determining issues of safety and risk for a child.

In terms of practice, DHS drug testing protocols promote a strengths-based approach to testing. The appropriate use of drug testing under a strengths-based approach includes such things as using a drug test to identify and/or eliminate substance abuse as a possible contributing factor or risk in a child abuse case or to, either confirm or contradict what DHS has learned through direct observation. Under this approach, the role of the DHS child welfare worker is to support the client's recovery and to reduce barriers to treatment services.

The Department of Human Services (DHS) currently contracts for drug testing collections and laboratory services through two separate statewide contracts, one for collections and one for laboratory services. The use of statewide contracts for drug testing began in 2013. Prior to this, DHS Service Areas contracted individually for services in their local areas. The move to statewide contracts was due to the need for cost containment in this area and for statewide consistency in collection services and laboratory analysis.

The benefits gained from statewide Collection and Laboratory contracts include the following:

- Certification Requirements. Certification requirements include the College of American Pathologists, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Clinical Laboratory Improvement Amendments Program.

- Standardized cutoff levels. All drug testing analysis under these contracts require the industry standard cut off levels established through SAMHSA to ensure that all testing of all DHS clients are in the same manner.
- Uniformity in confirming tests. All laboratory testing incorporates immunoassay technology, with positive results verified by Gas Chromatography/Mass Spectrometry (GC/MS), Liquid Chromatography/Mass Spectrometry (LC/MS) or Liquid Chromatography – Mass Spectrometry/Mass Spectrometry (LC-MS/MS).
- Statewide Drug Testing Protocol. The Laboratory and Collections contract reflect the drug testing protocol alignment with SAMHSA requirements.

DHS drug testing collection and laboratory services are currently available to children, parents/caretakers, and families involved in a child abuse assessment and/or during an ongoing child welfare services case. DHS staff does not utilize drug testing during a family assessment; however, if during the course of a family assessment a child protective worker (CPW) determines there are behavioral indicators of substance use/abuse and the child's safety is in question, DHS staff reassign the case as a child abuse assessment and then drug testing is available.

### Drug Testing Contracts

In 2018, a drug testing workgroup convened to write the request for proposal (RFP) for two new Drug Testing Collections and Laboratory Services Contracts. The current Drug Testing Collections and the Laboratory Services Contracts expire on June 30, 2019. Membership on the workgroup consisted of: a service area manager, a social work administrator, two Service Area drug testing contacts, the drug testing policy program manager and program specialist and representatives from the field.

The group began its work by examining drug testing areas needing improvement. The group also researched how other states handled drug testing and reviewed past and current data, including the number, type, frequency and duration of testing and the use of fixed sites, in-home and emergency testing services. The group met over a number of months and in late 2018 the DHS posted the RFPs. In the spring of 2019, the DHS announced that the current contractors for the Drug Testing Collections and Laboratory Contracts will continue to provide drug testing services to DHS. The contractors are for the Drug Testing Collections Services contract, Central Iowa Juvenile Detention Center (CIJDC), and for the Laboratory Services contract, CSS Inc. (Comprehensive Screening Solutions).

The new contracts will begin July 1, 2019. New and improved elements under the contracts include the addition in the number of fixed sites and hours of operation; increased randomization in the drug testing process; system upgrades; and improvements in tracking and collection of data. To better meet the needs of the DHS, the contracts also adjusted the drug testing panels based upon a conducted review.

### 2019 – 2020 DHS Drug Testing Activities

In addition to new Drug Testing Collections and Laboratory Services contracts, effective on July 1, 2019, DHS also will review the practice regarding frequency of drug testing

needed, type of test to order, and for how long. The DHS plans to assemble a Drug Testing Technology Team for this purpose. The team will review system changes to the Drug Testing Authorization System to assist DHS staff when authorizing drug tests. The improvements to the Drug Testing Authorization System will be to identify behavioral indicators regarding the parent/caretaker's substance abuse.

Whenever possible, drug testing should be limited to those situations in which the parent/caretaker has exhibited behavioral indicators of substance abuse that could potentially impact a child's safety. The system changes will require the worker to enter the behavioral indicators and will then guide the worker in determining the appropriate type, frequency and duration of testing. The system will allow for supervisory overrides and for court ordered testing when needed.

Additional duties of the team will include a review of current DHS drug testing training for staff, including training needs and enhancements to create a proposal for the DHS Service Business Team.

### *Community Care*

At the conclusion of a DHS child abuse assessment (CAA), DHS child protection workers (CPW) may refer the family for an ongoing DHS service case or may refer the family to Community Care. At conclusion of a DHS family assessment (FA), DHS CPWs may refer a family to community resources (Information and Referral) or may refer to Community Care. Community Care is voluntary with the purpose of strengthening families and reducing child abuse and neglect in Iowa by building on the family's resources and developing supports for the family in their community. These are child and family-focused services and supports provided to families referred from DHS to keep children in the family safe from abuse and neglect.

Community Care works directly with families referred by DHS after completion of a CAA or a FA. The outcome of the CAA or FA and identified level of risk determines service eligibility. The completed standardized DHS family risk assessment identifies the level of risk. The family risk assessment examines factors known to be associated with the likelihood of abuse or neglect occurring at some point in the future. Identification of risks also assists in identifying the need for individualized services. Services strive to keep the child(ren) safe, keep the family intact, and prevent the need for further or future intervention by DHS, including removal of the child(ren) from the home.

Community Care eligibility criteria includes:

- Community Care identified as needed and the family agreed to participate voluntarily in services related to a CAA that is not confirmed but the child is at moderate to high risk of future abuse or neglect; or
- Community Care identified as needed and the family agreed to participate voluntarily in services related to a CAA that is confirmed, not placed and the child is at moderate risk of future abuse or neglect; or
- Community Care identified as needed and the family agreed to participate voluntarily in services related to a FA and the child is at moderate to high risk.

Goals of Community Care include the following:

- Reduce concerns for families that create stress and negatively impact relationships between family members;
- Partner with families to improve relationships within the family and build connections to their community;
- Provide contacts and services that meet the family's needs;
- Meet the cultural needs of families through better matching of service providers; and
- Develop support systems for families to increase the resources they have available in order to reduce stressors the family may be experiencing.

If a family declines to participate in Community Care after completion of either the CAA or the FA, they have the right to do so. However, if at the end of a FA the CPW believes a service is necessary to maintain safety for the child(ren), then the FA must be reassigned as a CAA.

Presented below are Community Care service intervention activities and supports. This is not an exhaustive list but describes the range of core activities that may be necessary to achieve desired outcomes in the types of cases referred for Community Care:

- Safety and Risk Management Planning
- Family Skill Development
- Family Focused Service Planning
- Empowerment and Advocacy Service
- Parenting Skills and Education
- Substance Abuse Education
- Domestic Violence Education
- Consumer Education
- Mental Health Education
- Flex Fund Assistance
- Budgeting
- Household Management Assistance and Instruction
- Family Team Decision-Making (FTDM) Meetings
- Communication Skills Parent/Child Relationship building
- Information and Referral (I & R) to a wide range of community resources and services

Community Care is provided through a single statewide performance-based contract covering all 99 counties in Iowa, with services to be flexible, individualized to the child and family's specific needs, and culturally responsive, including providing interpreter services when needed. The DHS recently renewed the contract for July 1, 2019 through June 30, 2020.

There are four contract performance measures to evaluate effectiveness of the services. Below are the four contract performance measures:

- **Performance Measure 1 (PM 1)** - The percent of families referred to the Community Care contractor who has a child adjudicated CINA and DHS ordered to provide supervision or placement within six months of the date of referral to Community Care will be five percent (5%) or less.
- **Performance Measure 2 (PM 2)** - The percent of families referred to the Community Care contractor who has a confirmed or confirmed and placed (founded) report of child abuse or neglect within twelve months where the actual incident occurred fourteen (14) days after the date of referral to Community Care will be nine percent (9%) or less.
- **Performance Measure 3 (PM 3)** - The Community Care contractor will make in-person or telephone contact with all families referred to Community Care within fourteen (14) calendar days of the date of referral from DHS and at least seventy percent (70%) of all high risk families will achieve successful completion of services when the Community Care service ends.
- **Performance Measure 4 (PM 4)** - The Community Care contractor will make in-person or telephone contact with all families referred to Community Care within fourteen (14) calendar days of the date of referral from DHS and at least sixty five percent (65%) of all moderate risk families will achieve successful completion of services when the Community Care service ends.

Regarding the above stated performance measures, the Community Care contractor is responsible for the population of all families referred to Community Care at completion of the CAA or FA, regardless if the family follows through with accepting and engaging in services.

In some cases, when the CPW speaks to the families regarding the eligibility and opportunity for Community Care, the families may agree to the referral at the time the completion of the assessment. However, oftentimes when Community Care reaches out to the family to engage them in services, they may decline without any provision of support and/or service. In some cases, they may decline accepting direct service but may ask for information to be provided to them without scheduling an in-person meeting. Regardless if the family accepts or declines Community Care, since the referral occurred, these families fall into the population for determining performance measure outcomes.

The contractor determines successful completion of services when the family progresses in addressing the needs and issues identified within the CAA and FA Summary reports. At conclusion of either assessment, if the family is eligible for Community Care, the CPW completes the assessment disposition screen to document service recommendations discussed with the family and a service plan is appropriate to address the identified issues. The CPW documents those identified issues within the assessment disposition screen, which provides direction to Community Care to determine which strategies, interventions, services, and/or supports move toward successful completion of services.

The DHS program manager, DHS service contract specialist, and representatives from the Community Care contract conduct quarterly onsite data validation reviews. Data validation reviews is the means by which DHS reviews the contractor's records chosen by a random sample for the purpose of validating the contractor's website entries and to ensure the contractor completed the service documentation and reporting deliverables for each family file reviewed. Quality assurance reviews also take place. The contract defines quality assurance as the procedures established and activities undertaken by the Community Care contractor to ensure that delivery of service is in accordance with requirements established by DHS and to improve the quality of services to achieve safety, permanency, and well-being. Quality assurance reviews periodically occur throughout the contract period to validate that the contractor implemented a quality assurance system as described in their contract.

On regular basis, the Community Care contractor provides "Success Across Iowa: Community Care Program: Stories from Case Managers", which are shared with all DHS child protection workers, supervisors, social work administrators, service area managers, and other program staff. These stories are actual cases that represent services and/or activities provided to families through this program that resulted in successful case closure. The feedback to date is that DHS workers find value in these stories knowing that someone follows up with the families who could not receive services from DHS. These stories reinforce feelings about the benefits of Community Care. As CPWs better understand what services Community Care can provide to a family, they can do a better job of sharing this information with the family as they engage the family to determine service readiness during the assessment.

### Treatment and Foster Care Services

#### *Family Safety, Risk and Permanency (FSRP) Services*

Families receive Family Safety, Risk, and Permanency (FSRP) Services. FSRP Services target children and families with an open DHS child welfare service case, following a child abuse assessment (CAA), a Child in Need of Assistance (CINA) assessment, or Juvenile Court action. FSRP Services contractors provide interventions and supports for children and families who meet DHS criteria for child welfare services because of their:

- Adjudication as a Child in Need of Assistance (CINA) by Juvenile Court; or
- Placement in out-of-home care under the care and responsibility of the Agency (DHS); or
- Need for DHS funded child welfare interventions, based on one of these factors:
  - Any child in the family is a founded victim of child abuse or neglect, regardless of whether the child's DHS assessed risk level is low, moderate, or high; or
  - Any child in the family is a confirmed victim of child abuse or neglect, and the child's DHS assessed risk level is high.

FSRP Services deliver a flexible array of culturally sensitive interventions and supports to achieve safety, permanency, and child and family well-being in the family's home and/or other designated locations as determined by the family case plan. Contracts

focus on the outcomes desired, require use of evidence based/informed practice, and allow greater flexibility for contractors to deliver services based on child and family needs in exchange for greater contractor accountability for positive outcomes. The child and family receive individualized services according to their unique needs.

The scope of work for SP/FSRP Services incorporates facilitation of Family Team Decision-Making (FTDM) meetings and Youth Transition Decision-Making (YTDM) meetings on open DHS child welfare service cases. By contract, SP/FSRP Services contractors provide trained FTDM and YTDM meetings facilitators with active approval numbers to facilitate these meetings. The DHS social workers complete a required referral form initiates, which initiates all FTDM and YTDM meetings. On cases where this is a removal or anticipated removal, DHS requests a FTDM meeting through electronic communication and later follows up with the official referral form. Facilitation of FTDM meetings before or after a removal occurs as soon as possible, sooner than 30 days.

Responsibility for providing the FTDM and YTDM meeting facilitation courses shifted to the Child Welfare Provider Training Academy (CWPTA). All of the current statewide standardized documents for FTDM and YTDM meetings as well as family interaction are accessible on the CWPTA website at <http://www.iatrainingsource.org/ftdm-ytdm-documents>. There is also an ongoing FTDM/YTDM meeting Q&A document updated upon receipt of questions. The intent of the FTDM/YTDM meeting Q&A document is to provide consistency in responses and provide clarification as necessary. The responses within this document complement those that are in the FTDM/YTDM meeting category of the ongoing Q&A document specific to SP Services and FSRP Services.

DHS currently has an internal Share Point tracking system for FTDM and YTDM meeting facilitators which tracks initial approval date, re-approval dates, active and non-active status, etc. The local service area point person for FTDM and YTDM meeting facilitator and coach approvals enters this information manually.

The DHS recently renewed contracts for July 1, 2019 through June 30, 2020. There are currently eight (8) different contractors providing this service under sixteen (16) contracts in the local service areas, with the majority of contractors having no subcontracts.

As a part of the current contract, there are four contract performance measures implemented to evaluate effectiveness of the services which align with the CFSR Round 3 outcomes. Below are the four contract performance measures:

- **Performance Measure 1 (PM1):** Child(ren) are safe from abuse during the episode of services and for twelve (12) consecutive months following the conclusion of their episode of services.
- **Performance Measure 2 (PM2):** Children are safely maintained in their own homes during episodes of services and for six (6) consecutive months following the conclusion of their episode of services.

- **Performance Measure 3 (PM3):** Child(ren) are reunified within twelve (12) months and remain at home without experiencing reentry into care within twelve (12) consecutive months of their reunification date.
- **Performance Measure 4 (PM4):** Child(ren) achieve permanency through guardianship placement within eighteen (18) months of removal or through adoption within twenty-four (24) months of removal.

**Performance Measure 1 - Definition of the Measure:** Children in cases receiving Family Safety, Risk, and Permanency Services will be safe from abuse\* for the entire episode\*\* of services and for at least twelve (12) consecutive months following the service end date of their Family Safety, Risk, and Permanency Services, regardless of contractor\*\*\*.

\*For purposes of calculating this measure, abuse in which the person responsible is employed by or a caretaker in the child's placement setting or a childcare setting will not be counted against the contractor. However, if abuse occurs in a relative placement and the relative is responsible, it will be counted against the contractor.

\*\*Episode of service means the period from the start date of services through the service end date in which a case receives services under the same contract.

\*\*\*For purposes of this measure, cases must be closed from receiving Family Safety, Risk, and Permanency Services for at least twelve (12) consecutive months, without any confirmed, not placed or founded abuse reports to be eligible for incentive payments. It is possible that more than one contractor would be eligible for an incentive payment on the same case in situations where the case was transferred to another contractor, without a break in services, and no abuse occurred while either contractor delivered services and within twelve (12) consecutive months of final service closure.

**Performance Measure 2 - Definition of the Measure:** All children receiving Family Safety, Risk, and Permanency Services who are residing in the case household at the time the contractor initiates services are not removed from the home throughout the episode of service and are placement-free for six (6) consecutive months after the conclusion of their episode of service\*.

\*Episode of service means the period from the start date of services through the service end date in which a case receives services under the same assigned case ID and period of service.

**Performance Measure 3 - Definition of the Measure:** Children who are in placement in the beginning of, or enter placement during, their case's episode of Family Safety, Risk, and Permanency Services will be reunited within twelve (12) months and remain at home without experiencing reentry into care within twelve (12) consecutive months of their reunification date.

**Performance Measure 4 - Definition of the Measure:** Children who are in placement in the beginning of, or enter placement during, their case's episode of Family Safety, Risk, and Permanency Services will achieve finalized guardianship placement within eighteen (18) months or a finalized adoptive placement within twenty-four (24) months.

Quarterly onsite reviews occur between the assigned DHS service contract specialist and representatives from the respective contracts. Onsite reviews occur to ensure that contractors meet the contract requirements and are in compliance. These reviews are the means by which DHS reviews the contractor's records, including the records of subcontractors as necessary, chosen by a random sample for the purpose of validating the monthly service reporting and their compliance with the service requirements.

Quality assurance reviews also occur. The contract defines quality assurance as the procedures established and activities undertaken by the SP/FSRP Services contractor to ensure that service delivery is in accordance with requirements established by DHS and to improve the quality of services to achieve safety, permanency, and well-being. Quality assurance reviews periodically occur throughout the contract period to validate that the contractor implemented a quality assurance system as described in their contract.

There is a solid process in place for responding to questions and sharing collaboratively across the state. All questions related to Safety Plan (SP) Services and FSRP Services are answered and received by those asking and then incorporated into an ongoing document posted to the SP/FSRP Services website for statewide access, [https://dhs.iowa.gov/Consumers/Child\\_Welfare/BR4K/FamilySafety](https://dhs.iowa.gov/Consumers/Child_Welfare/BR4K/FamilySafety). The website also contains additional information specific to SP/FSRP Services, which includes: Contract 101, contractor by contract area map, family interaction observation checklist, and all applicable reporting documents.

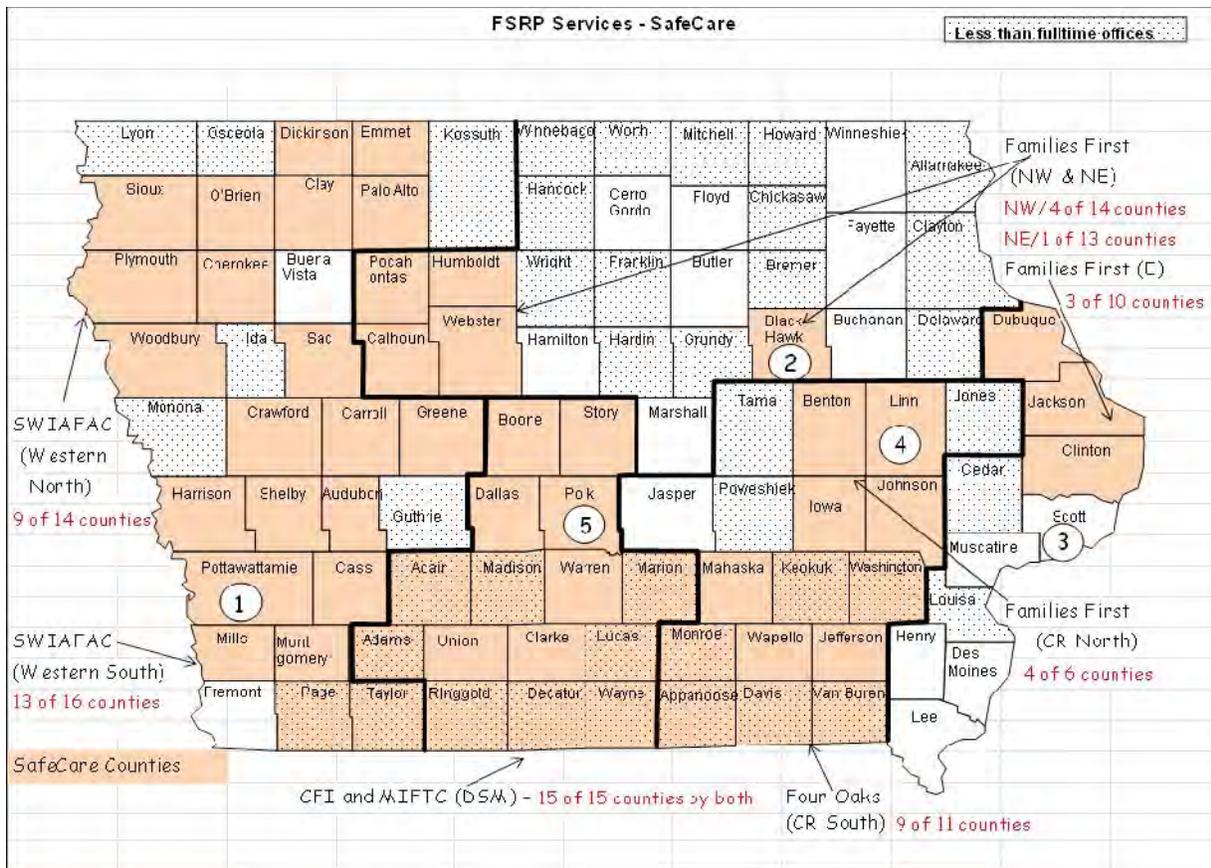
#### *SafeCare®*

SafeCare® is an evidence-based behavioral parenting model shown to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 in at-risk families. It is a home visitation-based parent training program conducted over 18 sessions. Parents who are at-risk for neglect receive instruction on how to have positive parent-child and parent-infant interactions, keep their homes safe, and improve their child's health. For more information on SafeCare®, please visit the following website: [www.safecare.org](http://www.safecare.org).

The following child welfare service contractors currently provide SafeCare® in the state of Iowa: Mid Iowa Family Therapy Clinic (MIFTC) for both Safety Plan Services (SPS)/Family Safety, Risk, and Permanency (FSRP) Services and Community Care; Children and Families of Iowa (CFI), Four Oaks, Southwest Family Access Center (SWIAFAC), and Families First Counseling for SPS/FSRP Services.

In January 2019, the SafeCare® maps were updated to reflect the counties covered within the contract areas by both Community Care and FSRP Services as follows:





Currently, there are ten (10) approved SafeCare® trainers and over 70 approved SafeCare® home visitors within the five (5) organizations across the state. All continue to build capacity through internal training to approve additional home visitors and coaches.

State level DHS staff and Georgia State University staff continue to collaborate with all five FSRP Services contracting organizations to provide them the necessary support, guidance, and technical assistance as they continue through implementation of SafeCare®.

### *Crisis Intervention, Stabilization, and Reunification (CISR)*

For the child and family services plan (CFSP) period of 2020-2024, the DHS will continue the evolution of the child welfare system of care. The role of the Crisis Intervention, Stabilization, and Reunification contracts will continue in this system.

Focal points of CISR overall include the following.

- Each child served near the child’s home and/or community.
- Service delivery occurs at a local level, based upon the DHS defined Service Areas and any counties that are within two (2) contiguous Iowa counties of the contractor’s facility. Children should be in their communities of origin to preserve connections to their families, home communities, schools, and positive support systems.

- All CISR services use the “One Caseworker Model” to coordinate the delivery of the child’s service plan and to be the point of contact for the child, the child’s family or other persons in the child’s positive support system, and the referring worker. The one caseworker model ensures that a child and the child’s family have consistent access to contractor staff and better coordinated services for each child.
- Each child and youth in care receives an “education specialist” to coordinate all education related matters.
- Child welfare services continue to be integrated through collaboration across DHS child welfare contracts and community partners. In the future, the DHS will continue pursuit of a more cohesive and comprehensive array of services.
- Contractors will participate with DHS to further develop strategies for and to implement:
  - Evidence-based practices;
  - Continuity of care for children receiving child welfare services;
  - Innovative community-based services that stabilize children and the children’s families so that children can return home; and,
  - Strategies to engage family members in treatment.

CISR comprises three of Iowa’s child welfare services. They are Child Welfare Emergency Services (CWES), Foster Group Care Services (FGCS), and Supervised Apartment Living (SAL). Through competitive procurement under a combined Request for Proposal (RFP), the contracts for each of these services began on July 1, 2017, for CWES and FGCS and on October 1, 2017, for SAL. The intent of combining these three services into a single RFP was to encourage Iowa’s child welfare service provider community to begin thinking systematically about better coordination of services and combining efforts to better meet the needs of Iowa children and families. The services were in place for the final two years of the FFY 2014-2019 CFSP.

The DHS may annually renew these contracts for up to a six-year period before required to conduct new competitive bidding. The six-year period takes these contracts through June 30, 2023, unless the DHS decides to pursue a new procurement. The DHS anticipates that each of these services will be available during at least the initial years of the FFY 2020-2024 CFSP.

The CISR general scopes of work will continue to focus services to be consistent with the DHS Family-Centered and Child Welfare Models of Practice, the Juvenile Court Service’s (JCS) Model of Practice, and the Guiding Principles for Iowa’s future child Welfare System of Care available at [https://dhs.iowa.gov/sites/default/files/Guiding\\_Principles\\_for\\_CWS.pdf?053020192010](https://dhs.iowa.gov/sites/default/files/Guiding_Principles_for_CWS.pdf?053020192010)). Efforts will concentrate on families and building on their strengths. The parameters of each contracted service (including performance measures) address needs related to maintaining or achieving permanence, keeping children safe, and assuring well-being. Performance incentives allow contractors to earn additional funding if meeting outcome targets. The performance measures and practice of placing children in their communities of origin (or at least as close to home as possible) by contracting with providers of the services in each of DHS’s five Service Areas and preserving children’s

connections to their families, home communities, schools, and positive support systems while placed outside their home, and assurances that children who age-out of foster care have the skills and connections needed to successfully transition to young adulthood directly address attention to safety, permanence, and well-being.

The Iowa legislature (HF766) directed the Department of Human Rights Division of Criminal and Juvenile Justice Planning (CJJP) to explore transitioning of juvenile justice services out of DHS, either to State Court Administration or another appropriate entity. Those involved include foster care alumni, the courts, DHS, Office of the Attorney General, etc. The goal is to explore moving community based services and Foster Group Care for delinquent youth out of DHS. CJJP formed a workgroup and subcommittees, including one specific to group care, which have started meeting. It remains to be seen whether the group will recommend administration be moved out of DHS and if it does, recommend separation of youth in residential facilities, but how we can do high quality, specialized, and separate services is "on the table". Josh Weber, Program Director, from the Collaboration of State Governments is a key voice, quite involved, and quite vocal about his "SMART" grant recommendations, which among other things, separates services for juvenile justice youth from child in need of assistance (CINA) youth. A report is due to the legislature in December 2019.

#### Child Welfare Emergency Services (CWES)

Child Welfare Emergency Services comprise an array of short term and temporary interventions provided to children under the age of 18 years who are eligible due to the fact they are on their way to an emergency juvenile shelter bed placement. The intention of CWES interventions is to divert children from these placements by offering alternatives to a bed. When avoiding out of home placement is not possible, CWES also offers the most restrictive emergency service of juvenile shelter care (to the extent placements permitted by Iowa law). The DHS, Juvenile Court Services (JCS), and law enforcement refer eligible children.

- Scope of the service: Diversion from placement into a shelter bed shall be accomplished by successful screening, child welfare related "triage," and interventions that may be provided at locations such as in the child's home, school, police stations, or at a shelter, in order to keep children in their homes. CWES contractors must also have the capacity to provide the contracted number of shelter beds in order to meet the needs of this part of Iowa's child welfare system, although beds shall be reserved for the most difficult cases when lesser restrictive options are not feasible and when placement in shelter is specifically required, such as by court order.
- Desired outcome: Whenever possible to prevent children from being placed out of home while keeping them safe or to provide a safe and temporary environment when children need a place to stay as they await final disposition of their case by the court.
- CWES delivery shall:
  - Ensure services are provided in a manner consistent with the expectations of the guiding principles, JCS's Model of Practice, Family-Centered Model of Practice,

- child Welfare Model of Practice, the Federal child and Family Services Review, and when appropriate, the Family-Team Decision Making model;
- Safeguard children from abuse;
  - Collaborate with partners at the local and state levels to achieve the most desirable case-specific and system outcomes;
  - Make decisions with families using approaches that include informal supports and the child's positive support system;
  - Ensure a supportive environment for each child;
  - Accept all referrals and provide contracted services on a no reject, no eject basis (with the understanding that individual cases may be reviewed with the DHS);
  - Use measurable outcomes to evaluate the quality of CWES;
  - Use approaches to services for outcomes that best address the needs of the child welfare and juvenile justice systems;
  - Implement culturally and linguistically competent approaches and practices that address any special language needs, reinforce positive cultural practices, and acknowledge and build upon ethnic, socio-cultural, and linguistic strengths;
  - Ensure no child is ever refused services or discharged from service except in approved cases per the Admission and Discharge Protocol related to emergency juvenile shelter care placement;
  - Collaborate with the DHS to develop and implement written plans for the contractor's response to disasters and other emergency situations that are consistent with state, federal, and local guidelines;
  - Implement and use a "one caseworker" model;
  - Assign an "education specialist" to all children placed in care;
  - Develop individualized crisis intervention plans patterned on specific child needs and behaviors; and,
  - Develop service plans for each child in care that addresses screening for service and identified needs, family and community connections, crisis and stabilization, reintegration planning, education, physical and mental health needs and supports, medication management, and discharge.
- CWES methodologies for diversion activities will:
    - Actively work to safely keep children in their home;
    - Respond to referrals within one hour and initiate services as soon as possible;
    - Serve children up to 47-hours outside their home when that approach will divert from shelter placement;
    - Provide mobile outreach for child welfare emergency intervention in all counties covered by the CWES contract, taking the service to the child, rather than have the child come to the service;
    - Provide in-home onsite mediation services and follow-up diversionary activities;
    - Develop a service plan for shelter alternatives and diversion for a child receiving shelter alternatives and diversion services using the format and instructions provided by DHS;
    - Maintain supporting documentation for shelter alternatives and diversion; and,
    - Initiate follow up contact after a child leaves CWES shelter alternatives and diversion services unless the child has been placed in another foster care setting, psychiatric medical institution for children (PMIC), detention, or other institution.

- CWES methodologies for diversion activities may also:
  - Provide child welfare crisis telephone lines or other manners of access available around the clock;
  - Offer intensive supervision or services provided daily in a child's home;
  - Establish information and referral networks;
  - Offer individual or family counseling provided by appropriate, approved entities;
  - Explore options other than shelter care when a child's situation needs stabilization;
  - Collaborate with the RRTS contractor to develop the capacity of family foster care homes with training and supports to deal with emergency placements; and,
  - Develop community partnerships to provide any of the above or other service approaches determined to be locally relevant.
- CWES methodologies for emergency juvenile shelter care shall:
  - Accept all referrals for children into its contracted number of beds from all counties in the contractor's contracted Service Area and from within two (2) contiguous Iowa counties of the shelter facility's physical location;
  - Discharge children from shelter to a permanent placement at the earliest possible time and work closely with the referral worker to develop a service approach to accomplish this within 30 days from the date of admission;
  - Follow the reasonable and prudent parent standards with all children placed in shelter;
  - Structure emergency juvenile shelter care placement to align with principles of the least restrictive care and most family-like setting and maintain family connections as appropriate; and,
  - Utilize the DHS-adopted Treatment Outcome Package (TOP) tool to assess the well-being of each child.
- Performance measures:
  - Divert children from shelter beds - Greater than or equal to 85% of the children receiving diversion services will remain out of shelter care for at least 30 days from the date of disengagement from diversion services; and,
  - Discharge from shelter care to family or other family-like setting - Greater than or equal to 75% of children discharged from shelter will be discharged to their family or a family-like setting.
- Anticipated for the CFSP period 2020-2024
  - Define CWES's role in the implementation of Iowa activities in response to the Family First Act by July 2020.
  - Re-evaluate the performance measures with contractors and other interested parties to: determine if the activities being measured align with the intent of the service; identify unintended consequences of measure statements; and, determine what factors should be considered for each measure and what factors should not be considered.

### Foster Group Care Services (FGCS)

FGCS is part of the child welfare array of services that offers a safe, protective, and structured living environment for eligible foster care children considered unable to live in a family situation due to social or emotional needs, but are able to interact in a

community environment with varying degrees of supervision. Eligible children are those adjudicated by the court as either a child in need of assistance (CINA) or for having committed a delinquent act (delinquent). The service provision occurs in licensed congregate facilities offering room, board, and age appropriate and child welfare services 24 hours a day and seven days per week. The contracted service aligns with:

- A safe, structured, and stable living environment for foster care children unable to live in a family situation;
- Compliance with all required licensures, certifications, or approvals;
- Acceptance of all referrals and provide contracted services on a no reject, no eject basis (with the understanding that individual cases may be reviewed with the DHS);
- Facilitating child development and the acquisition of age-appropriate life skills;
- Helping each child develop and maintain relationships with the child's family and community and ensure each child stays connected to their kin, culture, and community; and
- Support of a child's education and ensuring the child continues to attend the child's school of origin whenever that is in the child's best interest.
- Scope of the service: FGCS provide children with a safe and protective setting where they can thrive and not commit delinquent acts. Qualified and competent staff provide 24/7 parenting-type support and programs shall be designed to suit children's individual needs. The safety, permanency, and well-being of children is addressed by:
  - Providing a stable living environment;
  - Engaging families to help eliminate conditions that may have led to a child's removal from the home;
  - Maintaining connections to home and community in collaboration with the referral entities and the child's positive support system; and,
  - Providing for children's and rehabilitation needs.
- Desired outcome: Stabilize the situations of the children in care and reunite them with their family or other lesser restrictive family-like setting at the earliest possible time.
- FGCS delivery shall:
  - Help children with high needs to thrive and develop the skills necessary to return home;
  - Utilize a service delivery approach that conforms to the Guiding Principles, the Agency's Family-Centered Model of Practice, Child Welfare Model of Practice, Juvenile Court Services' Model of Practice (as applicable), the Federal Child and Family Services Review, and the Family Team Decision Making and Youth Transition Decision Making Meeting models;
  - Provide the following minimum service elements for each child in FGCS:
    - Implementation of the service plan;
    - Monitoring and recording each child's behavior daily;
    - Supervising the daily living activities of each child and providing oversight and maintenance of their general health and well-being;
    - Scheduling in-person conferences as needed;
    - Ensuring a supportive atmosphere and providing leadership and guidance to each child;

- Coordinating and participating in internal and external activities of each child; and,
    - Maintaining ongoing communication with the referring worker.
  - Provide an array of services and supports to meet the needs, objectives, services, and outcomes described in the DHS Case Permanency Plan or Juvenile Court Services Plan;
  - Provide supervision, planning for daily activities, discipline, guidance, development of peer relationships, and delivery of recreational programs (community resources in both the location of where the child is placed and the location of a child's family may be used for education, recreation, medical, social, and/or rehabilitation services);
  - Assure that services are appropriate to the age, gender, sexual orientation, cultural heritage, and the developmental and functional level of the child;
  - Follow the reasonable and prudent parent standards;
  - Implement the Culturally and Linguistically Appropriate Service Standards as adopted by the DHS;
  - Provide programs that ensure children reside with persons within their own age group and with common treatment needs, taking into consideration the behavioral, psychological, emotional, and developmental levels of children to determine appropriate groupings;
  - Facilitate the participation of the child in other necessary programs and services to ensure their overall needs are met - such programs or services include, but are not limited to, the following:
    - Various medical services;
    - Outpatient mental health or substance abuse treatment;
    - Behavioral Health Intervention Services;
    - Educational or vocational services; and,
    - Other community-based services.
  - Provide appropriate individualized care that is responsive to the needs of specific and outlier populations, such as sex offenders, children adjudicated for delinquent acts, children with special needs, etc.;
  - Utilize the DHS-adopted Treatment Outcome Package (TOP) to assess the well-being of each Child; and,
  - Design programs with varying levels of structure that can be applied as a child's need for supervision decreases.
- FGCS methodologies will:
  - Use the “One Caseworker Model” and assign an “education specialist” to each child;
  - Concentrate on individual child development and life skills; and,
  - Implement service plans for each child in care that address identified needs, family and community connections, crisis and stabilization, reintegration planning, education, physical and mental and behavioral health needs and supports, medication management, and discharge.
- Performance measures:
  - Length of stay - Greater than or equal to 60% of the children entering FGCS will be discharged within 180 days;

- Return to group care for CINA youth - Greater than or equal to 93% of CINA children discharged from FGCS will not return to FGCS within one year of discharge;
- Recidivism of delinquent youth - Greater than or equal to 75% of children adjudicated for having committed a delinquent act who are discharged from FGCS will not be charged with a simple misdemeanor or higher charge within one year of discharge; and,
- Discharge to family-like setting - Greater than or equal to 75% of children discharged from FGCS will be discharged to family or a family-like setting.
- Anticipated for the CFSP period 2020-2024
  - In SFY 2020 the DHS will participate on a legislatively established work group led by the state court administrator to review and develop a plan to transfer the administration of graduated sanctions and court-ordered services programs for delinquents and funding and the oversight of group foster care placements for delinquent eligible children. Among other mandated tasks, the work group will:
    - Develop an action plan to transfer the administration of juvenile court graduated sanction services, court-ordered services, and associated funding from the DHS to the office of the state court administrator or other appropriate state entity;
    - Develop an action plan to transfer the oversight of group foster care services for delinquent eligible children from the DHS to the office of the state court administrator or other appropriate state entity with the necessary expertise to provide such services;
    - Recommend statutory and administrative policies and court rules to promote collaborative case planning and quality assurance between the DHS and juvenile court services for youth who may be involved in both the child welfare and juvenile justice systems or who may utilize the same providers or services; and,
    - Determine the impact and role of the federal Family First Prevention Services Act relative to the various funding streams and services under the purview of the work group, and recommend statutory and administrative policies and rules to coordinate the duties of the work group with implementation and administration of the federal Act.
  - By July 2020, the DHS will implement its plans for FFPSA and clarify the role of foster group care in the implementation of that law.
  - Continue to evaluate the need for congregate out of home placements in light of declining group care populations.

### Supervised Apartment Living (SAL)

SAL is the least restrictive type of foster care placement in Iowa; eligibility begins at age 16½ years old. These living arrangements provide youth an environment in which they experience living in the community with less supervision than that provided by a foster family or foster group care setting. The goal of the supports and services is to prepare the youth for self-sufficiency.

Supplemented by life skills training and staff guidance and supports, youth in the SAL program attend school, prepare their own budgets, pay their own bills, shop for their own food, prepare their own meals, do their own laundry and cleaning, and engage with the community.

- Scope of the service: SAL contractors provide two types of SAL setting; they are cluster sites and scattered sites. Cluster sites allow a maximum of six children to be located in the same building (such as apartments located in one building or private housing or their own rooms in a shared unit). Contractor staff must be on-site and available at any time more than one youth is present. Scattered sites (e.g., an individual youth's apartment unit in a community) also provide access to SAL staff 24 hours a day, seven days a week and they must be available as needed. Staff supervision and guidance is flexible to meet the needs and behaviors of each individual in the program.
- Desired outcome: Youth self-sufficiency and the development of interdependence with their community and the systems that support daily living on one's own.
- SAL services and methodologies: Throughout the delivery of SAL services, contractors support each youth's development of necessary skills, tools, and abilities to attain self-sufficiency while ensuring their safety and well-being and working toward permanency. Contractors:
  - Collaborate with the referral worker to explore and select safe settings, where a youth is able to experience relative independence, learn life skills, and move on a successful path to adulthood;
  - Visit each youth's SAL potential setting prior to moving in and on a weekly basis to confirm there is no reasonable cause for believing the mode of living or living situation presents unacceptable risks to the youth's health or safety and that the living arrangement has been approved by the referring worker;
  - Provide ongoing supervision of the youth including, but not limited to:
    - Guidance, oversight, and behavior monitoring to ensure that the youth's living arrangement is maintained in a safe condition;
    - Ensuring the following:
      - The youth has immediate access to their living arrangement 24/7;
      - The youth has access to a functioning telephone;
      - There is an operating smoke alarm on each level of occupancy;
      - The youth receives necessary health care;
      - The youth receives appropriate and sufficient services and supports that meet individual needs; and,
      - The youth is complying with their service plan.
  - Implement the culturally and linguistically appropriate service standards as adopted by the DHS;
  - Provide for the youth's participation in other necessary programs and services to ensure the youth's overall needs are met - such programs or services include, but are not limited to, the following:
    - Various medical services;
    - Outpatient mental health or substance abuse treatment;
    - Behavioral Health Intervention Services (BHIS);
    - Educational or vocational services;

- Other community-based services; and
  - Food assistance, if applicable.
- Utilize the Treatment Outcome Package (TOP) tool to assess the well-being of each youth;
- Design SAL programs that are flexible with varying levels of structure that can be applied as a youth's need for supervision changes and that focus on the youth acquiring and building life skills that allow them to better access the community;
- Follow the “One Caseworker Model”;
- Provide services to assist youth development and life skills learning;
- Assist each youth in developing and maintaining relationships with their family and community, actively ensuring that each youth stays connected to kin, culture, and community;
- Develop individualized crisis intervention plans patterned on specific child needs and behaviors;
- Assign to all youth an “education specialist” who is responsible for coordinating educational needs with the youth’s caseworker to support education activities;
- Use individualized service plans that address identified needs and goals, individual youth development and life skills, family and community connections, crisis and stabilization, transition planning, education and career planning, physical and mental and behavioral health needs and supports, medication management, and discharge; and,
- Assist each youth to develop a budget by:
  - Assisting the youth to open a savings account in their name that is accessible with a signature from both the youth and the contractor's staff designee;
  - Assigning a staff member to hold the duties and obligations of a fiduciary to the youth, including ensuring the contractor and staff member receive no financial benefit from the youth’s finances;
  - Receiving, if needed, the monthly SAL stipend on the youth's behalf;
  - Using the budget format and instructions provided by the DHS;
  - Assuring each youth has access to their SAL stipend and SAL start-up allowance for the youth’s personal use;
  - Providing assistance to the youth to help make monthly deposits into their savings account;
  - Reconciling and update the budget monthly with each youth;
  - Maintaining a detailed record of all financial transactions including all deposits and withdrawals; and,
  - Assisting the youth to gain full access to their savings account when they exit SAL.
- Performance measures:
  - Stability (remaining in SAL as long as possible to achieve maximum benefits) - Greater than or equal to 60% of youth transition out of SAL at age 18, or older as permitted by law and regulations, or discharging to their family, a family-like setting, or other positive support system setting;
  - Aftercare (to maintain communication with SAL youth after transition to encourage participation in Aftercare programs) - Greater than or equal to 85% of Aftercare-eligible youth will have engaged in at least two contacts during the

calendar month of discharge or any of the six full calendar months immediately following the youth's date of discharge from SAL, as reported by the Aftercare services provider. A "contact" occurs in person for a minimum of 30 minutes; and,

- Life Skills Attainment - Greater than or equal to 80% of youth discharged will have shown improvement in their Casey Life Skills Assessment from pre-placement to discharge from SAL.
- Anticipated for the CFSP period 2020-2024
  - Promote collaboration between foster group care providers, SAL contractors, and interested others to develop strategies to better prepare children in group care for independent living if they continue to be in foster care, yet are approaching adulthood and transitioning out.
  - Release a Request for Information to help the DHS identify parties interested in providing SAL so that access to this service is available at least in every one of the five DHS Service Areas. Lack of total state coverage will occur on July 1, 2019, and the DHS would like this program expanded.

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

The DHS completed the first full year of the Recruitment, Retention, Training and Support of Resource Families (RRTS) contract, and is near the end of the second year. Much of the first year built capacity and fully implemented the significant changes in the contract from the previous contract. Lutheran Services in Iowa serves the Western Service Area. Four Oaks received the contract for the Northern Service Area, the Eastern Service Area, the Cedar Rapids Service Area, and the Des Moines Service Area.

Iowa designed the contracts to strengthen and enhance:

- Matching children – The child's foster family match is the best match.
- Well-trained foster parents capable of meeting the needs of children in care.
- Face-to-face support with foster parents to enhance stability.
- Alignment and streamlining roles and responsibilities to meet the fundamental needs of foster parents and children placed.
- Increased capacity for siblings, older youth, and cultural matching.
- Increased capacity for youth with higher levels of needs who could be successful in family-like settings with additional supports and services.
- Integration and communication between foster families, residential providers and other stakeholders.
- Outreach to non-licensed relative caregivers to encourage relatives to become licensed foster parents.

The contract requires the selected agencies to:

- Develop recruitment and retention plans based on service area needs and data.
- Complete all activities related to licensing foster families and approving adoptive families.
- Provide pre-service and in-service training.
- Perform matching activities.

- Provide required face-to face contacts and support services to foster families through a one caseworker model.
- Identify, train and support enhanced foster families to care for children coming out of congregate care, psychiatric medical institute for children (PMIC) or long-term shelter stays.
- Have at least one face-to-face meeting with referred relative caregivers to explain the foster home licensing process and the benefits and supports of licensure.
- Provide post-adoption services to families eligible for adoption assistance.

Recruitment and retention of foster families focus on increasing the net gain of foster families available for general matching. Recruitment and retention plans reflect service area data including the demographics of children coming into care, the geographic location of children coming into care, and enhancing capacity in the areas needing foster families.

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

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

RRTS contractors remain responsible for carrying out the activities related to the licensing of foster families and the approval of adoptive families. The RRTS caseworkers complete the required home visits and paperwork related to initial licensure/approval and for renewals. The RRTS contractors continue to conduct record checks at initial licensure/approval and at renewal. Interstate Compact for the Placement of Children (ICPC) and relative home studies also continue under the new contract.

Each RRTS contractor completes pre-service and in-service training in their Service Areas. Pre-service training consists of Trauma Informed Partnering For Safety and Permanence - Model Approach To Partnerships In Parenting (TIPS-MAPP), Caring for Our Own, and Deciding Together. Contractors must have training available for families within 60 days of the family completing an orientation session. The aligned curricula provide families with much of the same information but allows for more flexible and accessible training across the state, especially for families in rural areas. For example, Deciding Together allows training in smaller group settings or individually if needed. Iowa requires prospective foster families to complete CPR, First Aid, Mandatory

Reporter of Child Abuse, Universal Precautions, and Reasonable and Prudent Parenting Standards trainings prior to licensure. This allows new families to receive more specialized training related to the children in their care during the first year of licensure.

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

Under the RRTS contract, localized matching occurs. As stated above, RRTS caseworkers are directly involved in recommending families that can best meet the needs of the child based on the direct knowledge caseworkers have of their families. Post-adoption support services also continue under the RRTS contract. RRTS caseworkers can assist with the transition from foster care to adoption, develop post-adoption support plans with families, and provide a seamless transition to post-adoption services staff. RRTS contractors are also responsible for providing training and support groups open to all adoptive families, not just families who adopted through DHS. Respite for adoptive families remains in the contract, as well as support for finding homes for waiting children through the AdoptUSKids exchange.

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

Incentivized performance measures are as follows:

**Measure 1 – Stability:** Children placed into a licensed foster family home from their removal home or shelter within the quarterly reporting period will experience stability in placement. A child's first placement should be the child's only placement. The contract payment for performance will be based on the percent of a cohort of children who remain in the same licensed foster home 180 days after placement or:

- will have exited the licensed foster home to a trial home visit working towards
- reunification; or
- will have exited to a relative home; or
- will have exited to a pre-adoptive placement working toward permanency; or
- will have attained permanency through adoption or guardianship.

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

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

Several factors affect stability: the amount of time the RRTS contractor has to find a home; sufficient referral information from the DHS to allow foster families to make an informed decision about their ability to care for a child; the age of the child; sufficient capacity to keep siblings together; and supports available to the foster family and child to support stability. DHS and RRTS contractors are looking at strategies to positively impact stability in foster family care. Strategies may include:

- Looking at data on time frames for referral – does increased time to match result in greater stability.
- Increased use of and strengthening stability staffings – bringing together a child's team when the child and foster family are at risk of disrupting.
- Identifying gaps in services needed to prevent disruption, and to assist foster families to care for children with challenging needs.

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

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

Available for matching excludes families licensed for a specific child; families who only provide respite; families who have not had a child placed in their home for 12 months; and families who have asked not to have children placed in the home for six months or more.

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

Contractors conduct a variety of activities to increase awareness in communities on the need for foster families. For example, LSI continues to partner with tribes in Woodbury County to specifically target the Native American community through culturally appropriate orientation and Native American TIPS-MAPP pre-service training.

**Performance Measure 4 – Enhanced Foster Family Homes**

- Performance Measure 4a. *Contract Year One Only*: The contractor shall increase the number of enhanced foster family homes available for matching during the first contract year. The contract payment for performance is based on the following number of enhanced foster family homes in the Service Area during the first contract year (note: the Gold and Silver Standards are mutually exclusive by year and both cannot be earned for the same year):
  - Gold Standard (payment of 2.5% of annual eligible contract value) – Greater than or equal to six (6) unique approved enhanced foster family homes in the contractor’s Service Area at the end of the first contract year
  - Silver Standard (payment of 1.5% of annual eligible contract value) – Greater than or equal to three (3) unique approved enhanced foster family homes in the contractor’s Service Area at the end of the first contract year
- Performance Measure 4b. *Starting Contract Year Two*: During the second contract year, the contractor shall be measured on stable placement of children in enhanced foster family homes on an annual basis. The contract payment for performance is based on the following number of stable placements (placements with children who remain in the same enhanced foster family home for three (3) months in the Service Area during the second contract year (note: the Gold and Silver Standards are mutually exclusive by year and both cannot be earned for the same year):
  - Gold Standard (payment of 2.5% of annual eligible contract value) – Greater than or equal to twelve (12) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year
  - Silver Standard (payment of 1.5% of annual eligible contract value) – Greater than or equal to six (6) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year

RRTS contractors identify and train selected families who have experience, skills, and willingness to care for children who are coming from residential care, PMIC level care, or who have been in shelter for an extended period of time to become Enhanced Foster Families. RRTS and DHS staff collaborates on selecting and interviewing families with Service Area Managers having final approval. Families selected care only for children at the enhanced level. A child must be stable in the home for three months before the family can receive the placement of another child at the enhanced level in the home. Families receive an increased rate, and receive more intensive support and training.

Implementation of enhanced foster homes did not occur as quickly as anticipated. Identified barriers include families not wanting to be limited to only two children; inability to have children not at the enhanced level placed in the home; insufficient wrap around

services especially for child care/supervision for older youth; and difficulty finding respite. The DHS will explore enhanced care models in 2019-2020 in light of the Family First Preservation Services Act.

See the FFY 2020-2024 Diligent Recruitment Plan for additional information.

CareMatch is a data system to manage foster and adoptive family licensing/approval activities. CareMatch records all demographic information on families, as well as history of children placed in the home. RRTS staff uploads all documents related to licensing and approval into the system and is available to DHS staff. RRTS and DHS staff are able to pull a variety of reports regarding foster families, children placed in the home, matching rates, and families' progress through the recruitment/licensing flow from inquiry to final decision.

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

### **Promoting Safe and Stable Families (PSSF) (title IV-B, subpart 2)**

#### *Program Goals:*

- (1) To prevent child maltreatment among families at risk through the provision of supportive family services.
- (2) To assure children's safety within the home and preserve intact families in which children have been maltreated, when the family's problems can be addressed effectively.
- (3) To address the problems of families whose children have been placed in foster care so that reunification may occur in a safe and stable manner in accordance with the Adoption and Safe Families Act of 1997.
- (4) To support adoptive families by providing support services as necessary so that they can make a lifetime commitment to their children.<sup>10</sup>

The services described below under the four main categories of PSSF support achievement of the PSSF goals through the provision of services to children and families to ensure child safety, family safety and stability, timely reunification, and adoptive families lifelong commitment to their children, which also help to achieve Iowa's vision that family connections are always strengthened and preserved.

#### *Family Preservation*

DHS allocates less than 20% of Promoting Safe and Stable Families (PSSF) funding for family preservation services. Iowa's family preservation services are part of Iowa's

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<sup>10</sup> 42 U.S.C. 629

family centered services, specifically Family Safety, Risk and Permanency (FSRP) services, available statewide. A combination of state and federal SSBG, TANF, and Medicaid funds provide funding for Iowa's family centered services.

### Caring Dads™

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

Caring Dads™ is a weekly two hour session for 17 weeks. The primary referrals come from DHS staff and participants must sign in each week. DHS staff receives weekly attendance reports on a quarterly basis. Each 17 week cycle has a maximum capacity of 12-15 participants. Over the last two years, two sessions per year occurred with approximately 25 men completing the 17 week session. Currently, there are three participating facilitators for the Caring Dads™ group, including a licensed mental health clinician, and several more facilitators trained.

There are many highlights and challenges to each group. The biggest challenge appears to be the initial attitude of the father during the first group session. Typically participants have a resistance to the group process and the referral in general. This is quickly curbed with ongoing discussion of personal choices and behaviors. Once the fathers begin to take accountability for their choices, share with the peer group, family members and their social workers, they begin to see positive things happen with their lives and respective cases.

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

The plan is to continue Caring Dads™ in the Des Moines Service Area and possibly expand the number of offerings per year to three or four. Due to limited capacity, expansion of the Caring Dads™ beyond the Des Moines Service Area is not possible at this time but may be possible at some point within the five year CFSP period.

### Parent Partners

The Iowa Parent Partner Approach seeks to provide better outcomes around re-abuse and reunification. Parent Partners are individuals who previously had their children removed from their care and were successfully reunited with their children for a year or more. Parent Partners provide support to parents that are involved with DHS and are

working towards reunification. Parent Partners mentor one-on-one, celebrate families' successes and strengths, exemplify advocacy, facilitate trainings and presentations, and collaborate with DHS and child welfare professionals.

Parent Partners share experiences and offer recommendations through: foster/adoptive parent training; new child welfare worker orientation; local and statewide planning/steering committees and conferences; and Community Partnerships for Protecting Children (CPPC) participation. Parent Partners work with social workers, legal professionals, community based organizations, and others to provide resources for the parents they mentor. Parent Partners frequent Family Treatment Court as supports and coaches for participants. The goal of the Parent Partner Approach is to help birth parents be successful in completing their case plan goals by providing families with Parent Partners who are healthy, stable, and model success.

Parent Partners are available in all 99 counties. A statewide structure includes 12 lead Parent Partners, 18 coordinators, five Service Area Coordinators, one statewide coordinator and administration assistance. There is a Parent Partner Practice Manual, Handbook, forms, training curricula, etc. Parent Partners have access to flex-funds for their mentees, a collection of local resources guides, and receive an increase in reimbursement rates. Through partnering with community colleges, county extension and Iowa Workforce Development, Parent Partners receive education on resources available to assist in their Professional Development goals.

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

### **Parent Partners and Diversity**

Through the Parent Partner Statewide Steering Committee meeting, each service area assessed the diversity of the Parent Partners in relation to the population and developed and shared a plan for recruiting Parent Partners in order to be more proportionally representative and serve populations more effectively. This plan included recruiting more males and diverse race and ethnicity populations to become Parent Partners.

The local Service Areas implemented their recruitment plans, with a result of increased participation by men and more diversity. There are now 20 men, 10 African Americans, 6 Latinos, 2 Native American, and 1 bi-racial Parent Partners. The effort to incorporate diversity included management positions. Across the state, there are currently two African American and three men Parent Partner Coordinators. A local Parent Partner Coordinator successfully engaged members of the Meskwaki tribe. Currently, four Native American parents from the Meskwaki Settlement receive Parent Partners and Parent Partners are participating in Meskwaki's resource day and buffalo tours.

### **Parent Partner Pilots: In-Home and Continuing Supports**

In October 2018, the DHS asked the Parent Partner contract provider to develop a work plan and implement two pilots. One pilot focused on parents involved in the child protective system whose children remain in the home (In-Home Pilot). The purpose of this pilot was to determine if this shift in target populations had an impact on the fidelity of the Parent Partner model. The contractor provided mentoring supports to approximately 16 parents involved in the In-Home Pilot. Although the sample size was small, there did not seem to be any significant impact on the current program fidelity.

The second pilot was to provide mentoring supports to parents who have substance abuse issues, for up to six months after the child protective and court case closes. The purpose of this pilot was to determine if additional mentoring supports would have an impact on relapse and re-entry outcomes. The contractor provided mentoring supports to 10 parents after their case closed. At this time, due to the sample size and length of time needed to evaluate re-entry, the impact on outcomes remains unknown.

Iowa will continue these pilots over the next year utilizing PSSF funding.

### **Direction for 2020-2024 Parent Partner Plan**

The current Parent Partner statewide contractor, Children and Families of Iowa (CFI), just received the contract for the next six years. As a result, there are no significant changes in Parent Partners, staff and protocol/procedures. Two items added to the contract start July 2019:

- CFI shall ensure clients receive face-to-face visits by developing and implementing a protocol to conduct random phone audits. Based on lessons learned, the aim of this new procedure is to improve the quality of mentoring.
- CFI shall develop a team, Parent Partners' Policy and Practice Recommendation Team, protocol, and structure for incorporating statewide Parent Partners collective feedback on recommendations for child welfare policy and practice changes. This structure shall integrate feedback from the local program, Parent Partner Service Area Steering Committees and Advisory Committee. The contractor shall develop and implement a team of Parent Partners with representation from each Service Areas. The team shall meet quarterly to discuss and compile recommendations; meeting minutes shall serve as documentation and submitted quarterly to the Contract Manager. Annually, the Contract Manager will receive the formal recommendations for child welfare policy and practice changes.

Parent Partners will continue to monitor program data and utilize feedback to continually implement course corrections to strengthen model fidelity and outcomes. DHS partnered with UN-L to write a research article regarding program findings, which will be published in a social science journal. Program findings indicate families who have a Parent Partner have a higher rate of reunification and less reentry than families without a Parent Partner. After publication of the Parent Partner journal article, the University of Nebraska will submit application to the California Evidence-Based Clearinghouse for Child Welfare to receive classification. We anticipate this classification will provide the

necessary access to Family First funding in July 2020. If Parent Partners is appropriate for this funding, the Parent Partners mentoring supports could expand to more parents involved in child protective services and for those parents whose children remain at home.

### Wrap-Around Emergency Services

The five DHS service areas receive PSSF funds to provide flexible funding for services to low income families who would have their infants or children returned to their care but for the lack of such items as diapers, utility hook-up fees, beds or cribs, or house cleaning or rent deposits on apartments, etc. Additionally, these funds may be used to provide services to allow children to remain in the home, such as mental health and/or substance abuse treatment for children or parents, etc. Usage of these funds supports program goals of assuring safety of children within the home and addressing barriers to reunification.

### *Family Support*

Please see Iowa Child Abuse Prevention Program (ICAPP) earlier in this section.

### *Family Reunification*

Iowa allocates a minimum of 20% of the PSSF dollars to Family Reunification Services. DHS central office staff removes some of the funding, usually allocated to the five services areas, to include in the Family Safety, Risk and Permanency (FSRP) services contracts since these contracts include facilitation of family team decision-making (FTDM) meetings, which was previously included in the menu of services. For the balance of the funding, central office staff allocates to the service areas funding based on the number of children in out-of-home placements for the service area out of all children in out-of-home placements for the entire state. All services to children and their families remain traceable to the eligible child. Service areas determine how their funds will be used and sub-contract with service providers. In some of the service areas, the service area's Decategorization (Decat) committee has responsibility for projects funded under Family Reunification Services.

Services, from the following menu, are available to children and families, including relative caregivers, during the child's foster care stay and up to 15 months after the child reunifies with the parents or relatives. These services promote the program goal of safe and timely reunification of the child with the family and prevention of foster care re-entry.

Iowa's Family Reunification Services "Menu":

- **Functional Family Therapy** –FFT is an outcome-driven prevention/intervention program for youth who demonstrate the entire range of maladaptive, acting out behaviors and related syndromes. Clinical trials demonstrate that FFT is effective.
- **Child Welfare Mediation Services** – a dispute resolution process seeking to enhance safety, permanency and well-being for children. When two or more parties are "stuck" on a position, DHS staff uses mediation to help get them "unstuck". The goal of mediation is a fair, balanced and peaceful solution that allows the parties to move forward. Child Welfare Mediation cases often involve children in the middle or

children whose parents need help with establishing parenting plans, often with the custodial and/or non-custodial parent. Mediation typically involves about six hours of billable time and sixty days of service.

- **Substance Abuse Services (non-Title XIX)** – Testing, evaluations, and treatment services
- **Mental Health Services (non-Title XIX)** – Evaluations, including psychosocial, psychological, and psychiatric, and treatment, including therapy and medications
- **Substance Abuse and Mental Health Counseling Services (non-Title XIX).** Group and home substance abuse services combined with mental health services.
- **Domestic Violence Services.**
- **Respite Care.** Includes crisis nurseries
- **Fatherhood Programs, including Incarcerated Fathers** – more extensive, intensive and targeted services to assure that fathers, including incarcerated fathers, maintain an on-going presence in their child's life
- **Motherhood Programs, including Moms Off Meth groups and Incarcerated Mothers** – support groups specifically for mothers with children, including those mothers with past drug usage problems (Moms Off Meth)
- **Child and Family Advocates** –Advocates supervise visits between the child and their siblings and/or parents and may provide other needed services.
- **Transportation Services** – Services may include but not be limited to gas cards, bus tokens, payment for services received through the Iowa Department of Transportation, transportation provided by Child and Family Advocates, etc.

#### *Adoption Promotion and Supportive Services*

The goal of adoption promotion and supportive services is to help strengthen families, prevent disruption and achieve permanency. Iowa uses a minimum of 20% of PSSF dollars for adoption promotion and supportive services.

The RRTS contracts provide post-adoption services. Designated RRTS staff in each service area provides post-adoption support to families with adopted children who receive or are eligible to receive adoption subsidy. Support services include, but are not limited to:

- Home visits to assess a family and child's needs
- Develop service goals to stabilize a child's placement and meet the family's needs
- Provide behavior management plans and assistance
- Respond to crisis situations and crisis planning
- Assist and support the family's relationship with a birth family or kin
- Advocate with the schools, DHS and service providers for a child's treatment or needs
- Coordination with licensing staff or providers
- Referral assistance to community based providers
- Support and information on grief and loss and how to effectively parent
- Adoption support groups
- Cultural issues within adoption and reinforcing culturally competent parenting
- Transition issues related to adoption

DHS or other provider staff refers families, who also can self-refer, for post-adoption services through the RRTS contract. DHS staff and post-adoption support staff strive to meet with families prior to finalization in order to provide information about services that are available.

Any family who adopted one or more special needs children eligible for Adoption Subsidy may receive post-adoption support services. These voluntary services are available statewide. Each RRTS contractor tracks the number of referrals received in a month. Contracts require RRTS contractors to contact the family within 7 days of referral receipt, and report this data to DHS to determine contract compliance with the timeframe. This allows families to receive supportive services without DHS involvement or feel reported to DHS if they request post-adoption services.

Families receive contacts ranging from one phone call to multiple phone calls and face to face visits. Services include referral information to community providers, behavior management strategies, advocacy, and support groups.

The Iowa Foster and Adoptive Parents Association (IFAPA) continues to provide resources and information on its website, which is easily accessible to adoptive families. IFAPA offers four trainings a month that are open to any adoptive family.

*Kinship Navigator Program (title IV-B, subpart 2)*

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

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

The Family First Prevention Services Act (Family First) within Division E, Title VII of the Bipartisan Act of 2018, amended Title IV-E of the Social Security Act to allow Title IV-E agencies the option to receive title IV-E funding for Kinship Navigator Programs that meet certain criteria, including operating in accordance with promising, supported, or well-supported practices. To assist states in developing their ability to apply for these Title IV-E funds, the federal government awarded states, upon application, Title IV-B,

subpart 2, funds to develop, enhance, or evaluate Kinship Navigator Programs. States could apply for these funds in July 2018, with awards made in September 2018. Iowa DHS applied and received allocated funds to develop a Kinship Navigator Program.

In July 2018, DHS released a Request for Proposals (RFP) to solicit proposals from qualified eligible bidders to develop and implement a Kinship Navigator Program to assist kinship caregivers in learning about, finding, and using programs and services designed to meet the unique needs of kinship caregivers; meet the unique needs of child (ren) placed with a kinship caregiver; and promote effective partnership among public and private organizations to ensure kinship caregiver families are served. The RFP also specified that bidders would be responsible to manage and deliver family finding and engagement efforts and provide services related to supporting relative caregivers, both kin and fictive kin, of child (ren) involved with DHS.

Service supports may include, but shall not be limited to:

- Assessment of kinship caregiver needs;
- Development of a Kinship Care Plan for each relative caregiver family;
- Provision of resources and/or training, as needed, including provision of parenting skill building classes for kinship caregivers and other persons as directed by DHS. Parenting skill building must be evidence-based, a promising practice, or supported or well-supported;
- Monthly face-to-face meetings with the kinship caregivers and kinship specialist; and
- Interface with DHS in order to ensure collaboration and continuity of services.

DHS entered into a contract with Families First Counseling Services, LLC effective October 15, 2018 through September 30, 2019. Services outlined in the RFP are provided under contract for a child (ren) whose county of origin is Linn County or Johnson County and are placed with kin, fictive kin, or relatives in Benton, Iowa, Johnson, Jones, Linn, or Tama counties. Although the contract went into effect October 15, 2018, DHS did not refer any cases to the contractor until November 1, 2018.

DHS utilized the funds allocated to this contract to develop a Kinship Navigator Program to provide the necessary services of kinship caregivers. Under this initial contract, the majority of the costs associated with this contract pay for the following positions:

- One (1) full-time Kinship Navigator Supervisor
- Three (3) full-time Kinship Navigator Specialists

In addition to payment of salaries of the supervisor and specialists, funds are also utilized to purchase concrete goods, tangible items, and gift cards for the kinship caregivers. The contractor is required to document the purpose and amount of funds provided to the kinship caregiver and obtain a signature for receipt and tracking of funds. The concrete supports provided may include items such as:

- Clothing allowance
- Beds, cribs, furniture, other items
- Gas cards to assist with transportation
- Gift cards for grocery/food items or other needed supplies

Any other costs associated with development of the necessary support network and provision of services to kinship caregivers referred by DHS is also included within the contract.

Performance measures and targets included as a part of the contract assess performance of the contractor. The performance measures and targets included are the minimum performance expectations.

**Performance Measure 1:** 90% of kinship caregivers referred under the Kinship Navigator Program engage in services with the kinship specialist.

**Performance Measure 2:** 100% of kinship caregivers who agree to services referred under the Kinship Navigator Program will have an Eco Map completed within thirty (30) calendar days from the date of the DHS referral.

**Performance Measure 3:** 85% of child (ren) who remain in foster care are maintained in a kinship care level of placement for three (3) months after the kinship specialist closes their case.

**Performance Measure 4:** 90% of kinship caregivers who engage in services, receive a minimum of two (2) hours of meaningful face-to-face contact on a monthly basis with the kinship specialist.

Currently, DHS and the contractor continue to work toward identifying the best method to gather data on the above performance measures as well as other desired outcomes to be determined at a later date. Performance Measures 1, 2, and 4 are elements reported by the contractor with validation on a small sample during the scheduled quarterly onsite reviews. (See below for more information regarding onsite reviews). At this time, there is no formalized method determined to track on additional outcomes. The goal is to identify the best method and report on data elements in next year's report.

The contractor reported that the relationship with the local service area is positive and interactive. The contractor presents on the Kinship Navigator Program during meetings with the local service area and is available to answer questions. The contractor is in the early stages of developing a policy and procedure manual describing their approach and methodology to providing Kinship Navigator Program services. Families First Counseling Services developed a flyer that provides information regarding services under the Kinship Navigator Program. The flyer is distributed to DHS, kinship caregivers, etc. There is also a dedicated webpage on Kinship Navigator Resources: <https://www.families-first.net/kinship-resources>. As the contractor becomes aware of barriers to providing services, the contractor will identify strategies to reduce or alleviate the barriers.

The DHS program manager maintains regular electronic correspondence with the contractor and also conducts two quarterly onsite reviews. Onsite reviews occur to ensure that contractors are in compliance with the contract requirements.

Families First Counseling Services developed a pre and post survey to assist with determining effectiveness of services under this contract. Both surveys are currently in the process of finalization. Kinship caregivers will receive the pre survey immediately after referral, during that first month of service. They will receive the post survey once the kinship navigator case closes. The contractor is exploring purchasing an application to assist with the surveys and data collection. In addition to development of the surveys, the contractor continues to work on developing the policy/procedures manual. The contractor reports the current draft manual aligns with their accreditation standards but is not finalized at this time.

In addition to collaboration with DHS at both the local and statewide level, the contractor continues to establish new relationships within the community as well as build upon already established relationships as evidenced by the number of items donated to their program as well as local community referrals made for kinship caregivers. The contractor is responsible for scheduling kinship support groups which occur the second Tuesday of each month in Cedar Rapids, Iowa. The support group provides an opportunity to network with others providing care to a relative.

#### *Adoption Subsidy Program*

When a child adopted from the child welfare system has a special need, DHS provides on-going support and services through the adoption subsidy program. Approximately 95% of all children adopted through DHS receive an adoption subsidy payment, and an additional 4% are eligible for an at risk agreement, which means the child is at risk of developing a qualifying condition or disability in the future based on the child and family history.

### **Service Coordination**

- *Considering the prevention vision articulated by CB, explain how the services will be linked to, coordinated with, or integrated into other services in the child and family services continuum and how services under the plan will be coordinated over the five-year period with services or benefits under other federal or federally assisted programs serving the same populations to achieve the goals and objectives in the plan.*
- *Describe who participates in the coordination process and provide examples of how the process led or will lead to additional coordination of services.*
- *Discuss the approach to include, and the involvement of, other federally funded programs (e.g. Temporary Assistance for Needy Families, Medicaid, Child Care, Head Start, Supplemental Nutrition Assistance Program, etc.); and state, local, tribal and community-based public and private providers for programs such as substance abuse, domestic violence, behavioral health, schools, developmental disability, private child welfare services, etc.*
- *Discuss the approach to engage and meaningfully involve representatives of the following Children's Bureau grant programs in service coordination and support of mutual goals and strategies to prevent child abuse, protect children and improve the*

*safety, permanency and well-being of children and families involved in the child welfare system. Include information on:*

- *Community-Based Child Abuse Prevention (CBCAP);*
- *Children's Justice Act (CJA); and*
- *Court Improvement Project (CIP).*

### **Coordination of services or benefits within the DHS**

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

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

Children in foster care may be placed with caregivers who need daycare assistance because the caregiver works. Daycare must be provided by a licensed or registered provider when:

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

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

When a child enters foster care, child welfare staff may enter information into the CWIS to complete an electronic referral to the Foster Care Recovery Unit (FCRU). The amount of parental liability for the child's foster care stay is set by a court order or by an administrative order filed by the FCRU, which is located in the Bureau of Child Support Recovery, and the parental liability is paid to the Collections Services Center. Referrals

to the FCRU are required for all children in family foster care, group care, shelter care, or supervised apartment living. However, referrals are not required for children in PMIC placements, other Medicaid placements (i.e., Iowa Plan), non-licensed relative placements, or subsidized adoption. Child welfare and child support staff work together to ensure parents are referred appropriately and that child support staff have all the documentation they need.

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

The DHS has a Memorandum of Understanding with the federal Office of Child Support Enforcement (OCSE) to utilize the federal parent locator service (FPLS). Child welfare staff utilize Iowa's state child support portal to search for parents and relatives via FPLS when children enter foster care. Child support policy staff and the child welfare FPLS program manager consult when needed to ensure there are no issues related to child welfare staff's use of the FPLS or to trouble shoot issues when they arise.

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

- *Community Adolescent Pregnancy Prevention Program:* TANF funds are used for teen pregnancy prevention programs designed to prevent adolescent pregnancy and to promote self-sufficiency and physical and emotional well-being for pregnant and parenting adolescents. Eligible adolescents must be less than 18 years of age and attending school to pursue a high school diploma or equivalent. Services to an adolescent under 18 may continue beyond the adolescent's eighteenth birthday under certain circumstances.
- *Child Abuse Prevention Program:* TANF funds are used for community-based child abuse prevention services that provide family support, home visitation, and respite care. Programs are expected to provide targeted services to families with specific risk factors for maltreatment. Local child abuse prevention councils compete for funds to develop and operate programs in one or more of five major areas: (1) community development (i.e. public awareness, engagement); (2) home visitation (requires use of a federally recognized evidence-based model); (3) parent development (group family support or education); (4) respite care; and (5) sexual abuse prevention. Crisis and/or respite care provided using TANF funds are limited to non-recurrent, short-term services. Child abuse prevention programs are open to all members of the community without regard to family structure, education, income or resources; however, non-TANF funds are used for individuals and families not eligible to receive benefits funded by TANF; e.g., ineligible aliens programs are expected to provide targeted services to families with specific risk factors for maltreatment.
- *Child Protective Assessments:* TANF funds are used to assess reported incidents of child abuse and neglect when the family is determined to be ineligible for funding under Title IV-E of the Social Security Act.

- *Community Care Services:* Community Care is a voluntary service that provides child and family focused services and supports to families referred by the DHS, to reduce safety and risk concerns. These services and supports are geared to: keeping the children in the family safe from abuse and neglect; keeping the family intact; preventing the need for further and future intervention by the DHS (including removal of the child from the home); and building ongoing linkages to community-based resources that improve the safety, health, stability, and well-being of those served.
- *Child Welfare Services:* Iowa uses TANF funds for a number of child welfare services. These services include: social casework; protective day care; family centered/family preservation which includes safety plan services; family safety, risk, and permanency services with family team decision-making meeting facilitation; and drug testing.

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

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

#### *Adolescent Health Advisory Committee*

With a number of changes that occurred with the Community Adolescent Pregnancy Prevention (CAPP) program, DHS initiated an interagency Advisory Committee of relevant stakeholders at the statewide level. This committee currently includes representatives from the following agencies or disciplines:

- Iowa Department of Human Services, including the DHS program manager;
- Iowa Department of Public Health, including the Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) program managers;
- Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning (CJJP); and
- Iowa Department of Education.

The committee heavily participated in some of the decision making processes around the most current CAPP grantee RFP. In addition, it was critical for DHS and IDPH to be in communication as both agencies released RFPs for similar services over the past 6 months, which helped to reduce the potential for duplication or gaps in services. The committee also will play a role in the review of the statewide needs assessment and strategic plan underway to look at the issue of adolescent pregnancy in Iowa.

#### *Annual All Contractors Meetings*

Each year there is a statewide meeting that includes representation from current child welfare service contractors, DHS field and central office staff, and other external partners. The purpose of the statewide meeting is to bring DHS 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 volunteer to participate in a planning committee to prepare and plan for the statewide meeting.

The annual statewide child welfare service meeting occurred on June 6, 2018 which included representation from child welfare service contractors, DHS field and central office staff, JCS staff, and other external partners. The topics covered during this meeting included key performance measures/CFSR (what is the data telling us, what we are doing well, what we need to improve, and how do we get there), a presentation on Family First, and a keynote speaker who focused on inspiration, transformation, and strategic planning.

The SFY 2019 annual statewide occurred June 18, 2019. The topics included a presentation by Kerri Smith with the Annie E. Casey Foundation (AECF) regarding their assessment findings and recommendations on steps DHS needs to take to improve services in Iowa. Additional topics include a data presentation on outcomes similar to last year's presentation, as well as pre-implementation activities associated with Family First.

#### *Child Abuse Prevention Program Advisory Committee (CAPPAC)*

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

- Advise the director of human services and the administrator of the division of the department of human services responsible for child and family programs regarding expenditures of funds received for the child abuse prevention program.
- Review the implementation and effectiveness of legislation and administrative rules concerning the child abuse prevention program.
- Recommend changes in legislation and administrative rules to the general assembly and the appropriate administrative officials.
- Require reports from state agencies and other entities as necessary to perform its duties.
- Receive and review complaints from the public concerning the operation and management of the child abuse prevention program.
- Approve grant proposals.

The CAPPAC played an important role in decision making around the ICAPP, including changes in the scope of services and the manner by which DHS set funding limits. The CAPPAC reviewed all proposal scores for grantees who submitted bids for the SFY 2019-2020 contracts, along with comments provided by an independent team of evaluators, before making the final award recommendations to the DHS' Adult, Children and Family Services (ACFS) Division Administrator. More information on the CAPPAC is available at: <https://dhs.iowa.gov/capac>

### *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 DHS 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 the three year strategic plan, the primary focus of the CWPC shifted to support DHS with implementation of the Family First Prevention Services Act (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.

Information on the CWPC is available at <https://dhs.iowa.gov/about/advisory-groups/childwelfare/partner-committee>

### *Child Welfare Provider Training Academy (Training Academy)*

The Child Welfare Provider Training Academy (Training Academy) is a partnership with the DHS 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 service organizations and DHS in their efforts to train and retain child welfare workers and positively impact 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 DHS Training Committee. The Training Academy Coordinator leads the Training Academy Workgroup and is an active member of the DHS Training Committee.

#### *Children's Justice Act*

The Child Protection Council, Citizen Review Panel (CPC/CRP) is Iowa's Children's Justice Act state taskforce, which meets on a bi-monthly basis in Des Moines, Iowa. Council members also attend conferences and trainings throughout the year related to the work of the panel. The CPC seeks to encourage public outreach and input in assessing the impact of current Iowa law, policy, and practice on families and the communities in which they live. All meetings are open to the public and a public notice is posted regarding the date, time, location, and agenda of the council meetings. In addition, the CPC Annual Report is posted on the DHS website. Members of the public who are unable to attend meetings can direct any comments and/or questions to the Department of Human Services (DHS) or to the State Coordinator through the DHS website.

The current membership on the CPC comprises professionals with knowledge and experience in the diverse areas of child protective services. These areas include: law enforcement, civil and criminal court proceedings, child advocacy, youth housing/shelter programs, pediatric medicine, mental health, substance abuse and childhood disabilities. In addition to this group of professionals, the Council membership includes individuals with first-hand knowledge and experience in the child welfare system as former victims of abuse, parents, and representatives from parent advocacy groups. In Attachment 4B, there is a full listing of the CPC's membership with names, titles, and a brief description of the relevant personal/professional experience of each member along with the designated category they represent on the Council. Each of the required areas of discipline, specified in Section 107(c)(1) of the Child Abuse Prevention and Treatment Act, is currently represented on the CPC (Iowa's state taskforce). In addition to these members, there is also a representative from Children's Justice (Iowa's Court Improvement Program (CIP)) and a representative from the Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation).

The Council's duties are in accordance with Section 107(a) of the Child Abuse Prevention and Treatment Act as amended by the "CAPTA Reauthorization Act of 2010". The Council is governed by a set of by-laws that stipulates the federal mandates

of the state taskforce. All members are appointed to 3-year staggered terms with no member appointed to more than two consecutive terms. Any member appointed to fill a vacancy for a partial term has the option to continue membership through the equivalent of two full terms (6 years).

It is the duty of the Council to review Iowa's child protection system and to make recommendations to the DHS on the development, establishment and operation of programs & activities designed to improve the system and which fall within Section 107(e) (1) (A) (B) and (C) of the Child Abuse Prevention and Treatment Act.

#### *Collaboration with Courts*

DHS transition policy staff and practice leaders frequently receive invitations to speak with our court partners. This is especially true when new federal law passes, such as the recent Family First Act.

One example of collaboration is when DHS researched child welfare information systems in late 2018 to discover some youth have another planned permanent living arrangement (APPLA) as their permanency goal, despite federal changes to discourage the practice for youth under age 16<sup>11</sup>. State policy staff presented at an all judges conference in February 2019. Judges pointed out that they are not necessarily limited to the age 16 and older, but appreciate the importance of permanency for children. DHS staff provided guidance including the following:

#### DHS Approach:

- APPLA for children under age 16 will no longer be an option.
- For youth age 16 or above, with a permanency goal of APPLA, case plans and reviews must include documentation of intensive, ongoing, and unsuccessful efforts to find permanency.
- Continue conversations with judges and other partners.

#### Observations:

- Myth that APPLA helps kids get transition supports or services is not true. The permanency goal is not used to determine eligibility for programs (Aftercare, ETV).
- Caregivers of children with severe disabilities hesitate, but relational permanency is achieved. Consider perm goal of Guardianship.
- Foster parents may not take guardianship if they are going to lose the foster care payment. Similarly, the goal might be guardianship or adoption, even if they have not committed to permanency yet.

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<sup>11</sup> Family First Prevention Services Act

- Subsidized Guardianship would remove the financial barrier for some relatives (expect SG later this year).

Discussion/Notes:

- See also ACYF-CB-IM-14-03

Additionally, system level considerations are underway which may affect transition planning. For example, the DHS appropriation (HF766) included expectations that the division of criminal and juvenile justice planning (CJJP) of the department of human rights (DHR) convene and provide administrative support to a workgroup to review and develop a plan to transfer the administration of graduated sanctions delinquency services and court-ordered services for youth adjudicated delinquent, as well as funding and the oversight of group foster care placements for eligible children, from the DHS to the office of the state court administrator. Currently, DHS administers both programs. The plan is to ensure that the office of the state court administrator has the capacity, resources, and expertise to manage the funding and services effectively. DHS will join JCS and other judicial representatives this fall with hopes decisions will be made in time to inform Family First processes. One key consideration for the workgroup, for example, asked by TPS and others, “Will youth adjudicated delinquent placed in foster group care be eligible for transition services, such as aftercare, if the judicial or some other agency takes over the administration of foster group care?”

DHS continues our collaboration with the DHR’s CJJP by participating on the Juvenile Reentry Task Force (JRTF) in the development and implementation of the juvenile justice reentry system. Multiple state agency partners assist with institutionalization and/or development of policy, procedure, and structural elements of its Juvenile Reentry System (JReS). The goal of JReS is the reduction of recidivism rates and to improve other youth outcomes through implementation of comprehensive system-wide reforms to juvenile reentry policies and processes which include: enhanced cross-system coordination, utilization of quality and effective programing, and prioritization of resources. This effort most directly affects group care services and foster care transition supports for youth leaving residential care in Iowa.

*Collaboration with educators and transportation services*

Fostering Connections to Success and Increasing Adoptions Act (2008) included provisions around child welfare ensuring education stability by partnering with schools to keep youth in foster care in their home school, unless not in their best interest. Children in foster care face education challenges before, during, and after their experiences with child welfare. DHS identified lead staff in policy and field operations at central office, as well as Points of Contact in each of DHS’ five service areas who work closely with similarly positioned staff in education. Efforts are to accomplish the following:

- Children in foster care remain in the school of origin, unless it is determined that it is not in his or her best interest to do so;
- If determined the child needs to change schools, the child shall be immediately
- enrolled;

- DHS maintains designated service area points of contact (POC) for all school districts; and
- Districts and local DHS have a Memorandum of Agreement that identifies key aspects of the law, transportation guidelines, and dispute resolution processes.

DHS maintains a contract with the Iowa Department of Education to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. ACFS wrote the contract with a maximum of \$300,000 per year, but it was hard to gauge how much money would be needed.

Previous reports mentioned our intent to share data between departments, in order to promote education stability and hold teams in both systems accountable. Programmers received assigned tasks to complete a data sharing portal or process, but this is still in the development stages. We expect data sharing will occur near the end of the current school year, with a functional bi-weekly data sharing process in place sometime in the 2020-2021 school year.

#### *Early Childhood Iowa*

Early Childhood Iowa (ECI) was founded on the premise that communities and state government can work together to improve the well-being of our youngest children. The initiative is an alliance of stakeholders in early care, health, and education systems that affect a child prenatal to 5 years of age in the state of Iowa, who are at greatest risk of maltreatment. ECI's efforts unite agencies, organizations and community partners to speak with a shared voice to support, strengthen and meet the needs of all young children and families. Information on ECI is available at:

<https://earlychildhood.iowa.gov/>

#### *ECI – Results Accountability*

The DHS prevention program manager (who oversees child abuse prevention and adolescent pregnancy prevention programs) continues to be an active member of the ECI Results Accountability (RA) workgroup and was elected in February 2018 as the “public co-chair” of this group. The workgroup’s purpose and responsibilities stem from the ECI Strategic Plan, which identifies RA as a key work group in meeting the following objectives:

- Create a data culture as we develop an integrated data system, for improving access to quality of programs and services and to inform decision making. Policies to promote prevention services for young children and their families.
- Develop and distribute resources and tools on evaluating, adopting and implementing promising practices and evidence-based services, programs and system building strategies.
- Use data to ensure we have high-quality programs serving at-risk children and families. (Governance Lead, RA secondary)
- Review and document current funding/spending trends by state departments. (Funding and Resources, RA secondary)

The group also continues work on an integrated data system (IDS). Iowa became a “pilot” site in the University of Pennsylvania’s, Actionable Intelligence for Social Policy (AISP) national IDS network (<http://www.aisp.upenn.edu/>) in 2017-2018 and more recently Iowa received a Preschool Development Grant (PDG) to continue this work. Currently the state is in a demonstration project (matching birth records with kindergarten enrollment records) and points of interest for analysis include items such as:

- Demographics
- Enrollment patterns
- Kindergarten readiness gaps
- Child/family characteristics that may predict readiness gaps

Other data, when added, could address other experiences and how they correlate (i.e. poverty, maltreatment, unemployment, lead exposure, etc.). This would also allow policy/program staff to look at touch points over the 0-5 span and service utilization patterns and how those may impact outcomes.

#### *ECI – Family Engagement*

Another committee under ECI, which sits under the Governance component group, is the Family Engagement Advisory Committee. This committee was stagnant for a while until last year when the DHS prevention program manager was asked to lead the group. Since last July, the group met six times and achieved a number of milestones including the adoption of the following mission statement and values statements.

**MISSION STATEMENT:** The mission of the ECI Family Engagement Advisory Committee is to ensure that all early childhood systems and services:

- 1) Understand the importance of family engagement,
- 2) Make family engagement a core element to their work, and
- 3) Promote the use of strength-based, goal-oriented partnerships with families to enhance the well-being of young children.

#### **VALUES STATEMENTS:**

- We value intentional and authentic engagement of families.
- We value active leadership by family members, ensuring their contributions inform decision-making and planning on a level equal to service providers.
- We value the development of vital, goal-oriented partnerships with families that are based on a family’s strengths.
- We value equity within family engagement activities and outcomes.

In addition, the Family Engagement group drafted a PDSA (Plan, Do, Study, Act) to pilot an effort to strengthen family engagement throughout family support programs in Iowa. A summary of the PDSA and draft plan is below.

**Pre-work: Planning** – Review Iowa Family Support Standards (IFSS), Family Support Worker and Supervisor competencies, Head Start Relationship based

competencies, National Parent Family Child Engagement, National Family Support Network, Children's Trust, Ascend (Aspen Institute), National Resource Center for Family Centered Practice (University of Iowa)—Family Development Certification, Family Peer Support Specialist competencies (National Federation of Families with Children with Mental Illness), and various model standards/competencies.

**Step 1: Survey/Inventory** – Survey IFSS credentialed program providers and/or caregiver participants about current engagement activities in Family Support, measuring items from across the spectrum from minimal engagement (i.e., satisfaction surveys) to very significant parent/family partnership (i.e., parent led decision making).

- Measure attitudes/beliefs, knowledge, and behaviors
- Gather baseline engagement data and examples of what is occurring (i.e. specific strategies, curricula/models, etc.)
  - Specific practices at varying levels (organization, supervisor, support worker)

**Step 2: Intervention** – Develop a comprehensive approach to enhancing beliefs, knowledge, and skills around family engagement. Activities may include:

- Presenting on Family Engagement/Leadership during a Family Support Lunch-n-Learn and/or at ECI Area Director meetings (i.e., Family Engagement 101)
- Review IFSS for ways to encourage/enhance family engagement policies/practices through the standards
- Intermediate Training – Develop (with support, if available) a more advanced learning opportunity around engaging families with complex needs, intergenerational work, and promoting family partnership/leadership (i.e. parent advisory committees)
  - Highlight Iowa programs who ranked high in survey results as best practice
- Other activities TBD

**Step 3: Evaluation** – Resurvey the network after approximately one year to see how things have changed, get feedback for additional needs, etc.

**Step 4: CQI Process** – Feedback loop, implement lessons learned, present outcomes and (if successful) revamp and roll out in other areas/programs throughout the early childhood system

#### *Family First Prevention Services Act (Family First) Implementation*

The DHS developed five workgroups, comprising internal and external stakeholders, including services providers, to implement Family First. The five workgroups include:

- Communication and Marketing
- Training
- Information and Technology/Systems

- Practice and Forms
- Data

*Infant and Early Childhood Mental Health Consultation*

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 do 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 the state can address this is through the promotion and development of Early Childhood Mental Health Consultation (ECMHC) services as part of a continuum of services related to children's mental health.

Over the past year the DHS continued to participate in the ECMHC workgroup formed under the direction of the IDPH to assess the needs of the state in this area and to develop a plan to increase capacity. The DHS prevention program manager is a member of this state level group of leaders currently working with a TA Specialist from the [Center of Excellence for Infant and Early Childhood Mental Health Consultation \(IECMHC\)](#) to improve access to ECMHC in Iowa for professionals in the early childhood fields (i.e., childcare, early learning, family support, home visitation, etc.).

The group had monthly conference calls/webinars and had a second onsite TA visit in August of 2018. The group also conducted a survey of professionals in the field for the purposes of an environmental scan. As our work grows, the group is currently looking into the possibility of breaking into smaller subgroups, including:

- Messaging/Financing - focused on crafting messages to identified target groups, developing a communications plan, and searching for funding opportunities;
- Workforce Development - focused on identifying workforce needs and supporting development of consultant competencies;
- Model Development - focused on identifying the core components of ECMHC that we want embedded in Iowa's model; and
- Evaluation - focused on identifying and gathering data needs and assessing outcomes.

*Iowa Children's Justice (Iowa's Court Improvement Project (CIP))*: The DHS works collaboratively with Iowa's Children's Justice regarding family treatment courts (FTCs). Iowa's FTCs ensure that services provided through the FTCs are coordinated with DHS' family centered services, i.e. Family Safety, Risk and Permanency (FSRP) services. The Iowa Family Treatment Court Standards and Practice Recommendations, Adopted by the Iowa Supreme Court on July 17, 2014 (Attachment 4C), provides information regarding collaboration and the coordination of services. Additionally, with some of the FTCs implementing the Strengthening Families™ program, DHS staff and Children's Justice staff met to discuss ensuring that FSRP providers, in the Strengthening

Families™ implementation areas, are aware that these services are provided to the families they serve in an effort to avoid duplication of services. Service coordination discussions continue as needed.

For information regarding collaboration with Iowa Children's Justice (Iowa's court improvement program (CIP)), please see *Section III: Plan for Enacting Iowa's Vision, Case Review System*.

#### *Iowa Collaboration for Youth Development (ICYD)*

The Iowa Collaboration for Youth Development council members are leaders of 12 state agencies with the vision that "All Iowa youth will be safe, healthy, successful, and prepared for adulthood." Iowa DHS representative staff participates in the ICYD. The ICYD Council oversees the activities of the State of Iowa Youth Advisory Council (SIYAC) and seeks input from these youth leaders in the development of more effective policies, practices, programs. DHS representatives are members of ICYD's State Council and the Results teams.

#### *Iowa College Aid Partnership*

Since 2004, DHS contracted with the Iowa College Student Aid Commission (College Aid) to implement and administer the Chafee ETV program, which is an invaluable partnership. The only Chafee ETV expense for College Aid to administer the ETV program is the cost of one FTE and any costs to the National Clearinghouse regarding student data.

DHS provides access via a data sharing contract for College Aid to view the Family and Children Services (FACS) screen to verify eligibility. College Aid staff work closely with field and policy staff to ensure information gets out about FAFSA and ETV. College Aid coordinates communication between child welfare, youth and the schools they attend.

The ETV coordinator attends all regional youth "Futurefest" or similar events for teens in foster care and alumni. The coordinator will set up a table with college aid materials, answer questions for youth, and participate in activities where youth are educated about college and career opportunities. The coordinator attends other trainings and meetings as requested by DHS and other partners.

#### *Iowa Department of Public Health*

The Iowa Department of Public Health and the DHS collaborate on the State Youth Treatment Implementation Grant (STY-I). The purpose of this partnership is to expand and enhance evidence-based treatment and recovery support services for substance use disorders and/or co-occurring disorders among adolescents and transitional aged youth and their families. Specifically, the DHS routinely participates in the Adolescent Steering Committee meeting, which takes place on a quarterly basis. In addition, the DHS agreed to participate in the Youth and Family Subcommittee, which focuses on developing strategies to increase adolescents and family involvement in treatment services.

### *Iowa Family Support*

The State of Iowa has worked towards state infrastructure building in the area of family support for many years. However, as a recipient of federal MIECHV (Maternal Infant Early Childhood Home Visitation) funding, the state had an opportunity to significantly advance this work. The Iowa Family Support Program is in the Iowa Department of Public Health (IDPH), Bureau of Family Health and serves as a hub for numerous programs, services, and initiatives including:

- [Institute for the Advancement of Family Support Professionals](#) – an online learning environment built upon core competencies necessary for success in the field of family support
- [The Iowa Family Support Network](#) website – an information and resource referral source for various support programs in the state
- [Parentivity](#) – a web-based community for parents
- [The Iowa Family Support Credentialing Program](#) – an accreditation program for family support programs in Iowa
- Family Support Leadership Group (ECI) – a multidisciplinary group of stakeholders from various public/private agencies who lead various state family support and/or home visitation programs
- Family Support Programming:
  - HOPES/HFI – Healthy Opportunities for Parents to Experience Success - Healthy Families Iowa (HOPES-HFI) follows the national Healthy Families America evidence-based program model.
  - MIECHV – Maternal Infant Early Childhood Home Visitation, federal funding for various evidence based home visitation models being used in a number of “high risk” communities in Iowa

The DHS, Bureau of Child Welfare, staff participates on the Family Support Leadership Group and serves on the MIECHV State Advisory Committee. In addition, child abuse prevention programs now utilize Iowa’s Family Support Statewide Database (FSSD) and on June 6, 2019 participated with other state teams from across Regions V and VII to provide input on data exchange standards under MIECHV.

### *Iowa Finance Authority Partnership for Housing*

DHS contracted with the Iowa Finance Authority (IFA), a state agency, for the past ten years to implement and administer the Aftercare Rent Subsidy Program for youth in Iowa’s aftercare program. For 2020, DHS entered into another up to six year contract. Rent subsidies (100% Chafee funded) can go as high as \$450 per month.

Aftercare self-sufficiency advocates assist youth in completing the IFA aftercare rent subsidy application, based on a budget created with the youth. IFA funds and monitors the activities of aftercare, who work directly with the youth. DHS holds the contract with both IFA and Aftercare, using Chafee funds to pay for basic aftercare services and all of the rent payments. This has been an innovative partnership since IFA also partners with local housing authorities and Section 8 housing. Since IFA is basically the “state’s

mortgager”, this partnership also raised awareness for low rent housing; IFA is the state entity that awards tax credits to low-income housing projects on a statewide basis.

Youth who exit foster care prior to age 18 are not eligible for room and board. Because of the relationship with IFA, aftercare youth and families may benefit from a host of other programs offered by IFA, in addition to the rent subsidy program. Aftercare providers and participating youth describe a lack of affordable housing. Iowa’s five year Chafee plan, starting in October of 2019, will include a goal with specific activities to address this need.

#### *Iowa Head Start*

The Bureau of Child Welfare also recently took a more active role in partnering with the Iowa Department of Education (DOE) around Head Start. In June 2019, DHS staff participated with a team with representatives from other state agencies to travel to Kansas City to develop a state action plan around opioid use and the impacts for early childhood. The team plans to continue their work moving forward to assure various disciplines (education, child welfare, law enforcement, medical, etc.) are cross-training and collaborating around the issue of opioid and other substance use.

### **Service Description**

Please see *Section II: Performance Assessment in Improving Outcomes* for an assessment of Iowa’s service array.

### **Stephanie Tubbs Jones Child Welfare Services Program**

*Services for Children Adopted from Other Countries (section 422(b)(11) of the Act)*  
*Describe the activities that the state plans to take over the next five years to support children adopted from other countries, including the provision of adoption and post-adoption supports.*

Families who adopt children from other countries have the ability to access training through the Iowa Foster and Adoptive Parent Association (IFAPA) and Iowa’s Recruitment, Retention, Training, and Supports (RRTS) contractors Lutheran Services in Iowa and Four Oaks. Support groups across the state are also open to any adoptive family, including families who adopt from other countries. Families may receive services through the child welfare system through a CINA assessment or through allegations of abuse or neglect, or through Medicaid based on Medicaid eligibility criteria.

DHS recognizes the need for strong post-adoption supports and services in order to prevent disruptions and dissolutions of all adoptions, including children adopted from other countries. Limited resources and very diverse racial and cultural needs are significant barriers to expanding post-adoption services for families who adopt from other countries. Resources are not limited to available funds, but staff time to develop

an array of post-adoption services that can be available to any family. However, DHS has, and will continue to do the following over the five year period:

- Work collaboratively with private adoption agencies to identify gaps in services by engaging the Iowa Association of Adoption Agencies in gathering information from families who adopt from other countries and identifying gaps in services.
- Work collaboratively with private adoption agencies to creatively explore how services and supports can assist families who adopt from other countries within current funding and service provision constraints.
- Should additional funds become available, DHS will work collaboratively with private adoption agencies to prioritize, develop and implement services and supports to assist families who adopt from other countries.

*Services for Children under the Age of Five (section 422(b)(18) of the Act)*

*Describe the activities the state plans to undertake over the next five years to reduce the length of time young children under the age of five are in foster care without a permanent family, and to address the developmental needs of all vulnerable children under five years of age.*

Iowa utilizes its child welfare service array to meet the unique needs of children and families served, which includes children under the age of five remaining in the home or in foster care. These services include but are not limited to Community Care, Family Safety, Risk and Permanency (FSRP) services, child care, referrals to Early ACCESS (described below), referral of parents to mental health, substance abuse, domestic violence, employment, disability services, etc. Additionally, children and families also may receive SafeCare®, provided by Community Care or FSRP providers, as mentioned earlier in this section. Another public service available to families is Head Start and Early Head Start. Social work case managers may discuss Head Start and Early Head Start services with families, with the families accessing services through direct application to the programs.

The DHS' child protective workers (CPWs), as part of their assessment of child abuse allegations, inclusive of safety and risk assessments, assess the strengths and needs of the children and the family. The DHS' social work case managers build upon the initial assessment by working with the family to continually assess the strengths and needs of the children and family, connect the children and family to the appropriate services, and monitor the effectiveness of those services to meet their needs with the goal of achieving safety and permanency for these children in accordance with the Adoption and Safe Families Act (ASFA, P.L. 105-89) guidelines, and child and family well-being. Through clinical case consultation with social work case managers, supervisors provide oversight of the social work case managers' assessment of and provision of age-appropriate services to children. Please see discussions of these services earlier in this section.

## **Early ACCESS (IDEA Part C)**

### *Background*

Early Intervention Services or Early ACCESS (EA), as the program is referred to in Iowa, is a collaborative partnership between three State agencies (Iowa Department of Human Services (DHS), Iowa Department of Public Health (IDPH), Iowa Department of Education (IDOE)), and the Child Health Specialty Clinics (CHSC). These agencies and clinics promote, support, and administer EA services. The IDOE is the lead agency responsible for administering the program.

EA services are available to any child in Iowa from birth to three who demonstrates a 25% developmental delay or who has a known medical, emotional, or physical condition in which there is a high probability of future developmental delays. DHS, in response to the Child Abuse Prevention and Treatment Act (CAPTA) under the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), refers children under the age of three who: a) are the subject of a substantiated case of child abuse or neglect, b) are identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or c) have been identified as developmentally delayed.

Infants that fall under the 2016 Comprehensive Addiction and Recovery Act (CARA) are also eligible for a referral to EA. This population includes infants born and identified as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder. This includes infants born with and identified as affected by all substance abuse, not just illegal substance abuse.

### *Referral Process*

DHS social workers are responsible for making referrals after discussing EA with the family of the child who may be eligible. The social worker makes a referral through a phone call to the Iowa Family Support Network (IFSN) or through the online referral website. IFSN then sends the referral to the appropriate Area Education Agency (AEA) that would serve the child, based on the location of the child in Iowa.

EA for DHS social workers (child protective workers (CPW) and social work case managers (SWCM)) training focuses on potential developmental delays in children and provides instructions on how to encourage families to participate in eligible services and how to make meaningful referrals to the EA program. EA training is part of the basic training that all new workers receive. Ongoing training occurs in a mental health, substance abuse, and domestic violence screening training that is mandatory for all DHS supervisors, CPWs, and SWCMs. EA information is provided during this training to assist workers in referring families to EA services, even if there is not a substantiated case of abuse following the assessment (i.e., in the case of "Family Assessments).

In response to the Comprehensive Addiction and Recovery Act (CARA) of 2016, DHS, in conjunction with IDOE, implemented a new referral process for specific populations. On October 1, 2018, DHS began referring children that meet the criteria under CAPTA and CARA to EA via an automatic email process. Once a case involving a child meets

the criteria, the DHS automatically sends an email with referral information to IFSN. Every child under the age of three that meets the criteria under the CAPTA and CARA provisions receives a referral to EA. A Service Coordinator contacts the family within two business days to determine if the family is interested in having their child evaluated. Training AEA staff on how to engage with child welfare families occurred and we are beginning to see progress with families accepting the service.

#### *Efforts to Track and Prevent Child Maltreatment Deaths*

- *A description of the steps the state is taking to compile complete and accurate information on child maltreatment deaths to be reported to NCANDS, including gathering relevant information on the deaths from the relevant organizations in the state including entities such as state vital statistics department, child death review teams, law enforcement agencies, or offices of medical examiners, or coroners; and*
- *A description of the steps the state is taking to develop and implement a comprehensive, statewide plan to prevent child maltreatment fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts. Provide a copy or link to any comprehensive plan that has been developed.*

In 1995, Iowa Code §135.43 and 641 Iowa Administrative Code (IAC) § 90 established Iowa's statewide Child Death Review Team. The purpose of this team is to "aid in the reduction of preventable deaths of children under the age of eighteen years through the identification of unsafe consumer products; identification of unsafe environments; identification of factors that play a role in accidents, homicides and suicides which may be eliminated or counteracted; and promotion of communication, discussion, cooperation, and exchange of ideas and information among agencies investigating child deaths".

The DHS designates a staff liaison to assist the team in fulfilling its responsibilities. The liaison reviews data available in the DHS information systems for each child death and prepares case summaries and statistics regarding each child. The liaison also attends all review team meetings and sub-committee meetings as needed.

Additionally, the Iowa Child Death Review Team developed protocols for Child Fatality Review Committees 641 IAC § 92, which the state medical examiner appoints on an ad hoc basis, to immediately review the child abuse assessments which involve the fatality of a child under age eighteen. The purpose of the Child Fatality Review Committee is for system improvement that may aide in reducing the likelihood of child death.

The majority of Iowa children die by natural means, which includes prematurity, congenital anomalies, infections, cancers, and other illnesses. The Iowa Child Death Review Team considers other manners of death, such as accidents, suicides, homicides, and undetermined deaths as preventable. Iowa Code §232.70 requires mandatory reporters to report such suspected child abuse to the DHS. When the DHS receives and accepts a report of a child fatality for assessment, staff assigns a one hour response time for the child protective worker (CPW) to assure the safety of siblings or

any other children involved. Throughout the course of the assessment, the CPW makes a determination of whether abuse occurred and makes the appropriate recommendations and/or referrals to address the family's needs.

Because a child death review does not occur until completion of all assessments, investigations, and data collection, the Iowa Child Death Review Team typically reviews cases from the previous year and the Iowa Office of the State Medical Examiner thereafter releases the Annual Reports. Distribution of the Annual Reports to the Governor's Office, the Legislature, and various stakeholders occurred in June 2017 for the 2013 and 2014 Annual Reports and June 2018 for the Annual Report for 2015. The Iowa Child Death Review Team completed the calendar year 2016 reviews in 2017, with the annual report not yet formally published. Completion of the calendar year 2017 reviews occurred in 2018 and that report is currently in draft. Review of cases for the 2018 report is in progress in calendar year 2019. All Annual Reports released are available at: <https://iosme.iowa.gov/about-us>.

As the Iowa Child Death Review Team convened in February 2019 to begin reviews for 2018 cases, they also spent time (as they do each year) discussing goals for the team and strategies for how the information that this team works so diligently at gathering and analyzing can be presented and disseminated in as effective manner as possible. While the team made tremendous improvements in the way crafting of recommendations occurred, there is still little to no action taken on those recommendations. As a result, the team determined that, in addition to continued evaluation and improvement of the annual report generated, they would also identify one specific initiative to bring more awareness to each year.

For 2019, the team identified that initiative would be to focus on safe sleep. Babies in general are the most vulnerable age group among all children as they are completely dependent on their caretakers for every need. In Iowa, deaths in infants through age one are most often attributed to unsafe sleep environments. A focus on a safe sleep initiative will not only highlight recommendations by the American Academy of Pediatrics to reduce deaths in children related to unsafe sleep environments, but it will also compliment the work underway by the DHS to track and prevent child maltreatment deaths.

To compile complete and accurate information on child maltreatment deaths reported to National Child Abuse and Neglect Data System (NCANDS), the DHS accepts reports of suspected abuse regarding the death of a child in accordance with state laws. During the course of a Child Abuse Assessment regarding the death of a child, the CPW collaborates with law enforcement, local coroners or the office of state medical examiners, and the county attorney's office to gather relevant information on the child's death.

Upon completion of any Child Abuse Assessment, Iowa's child welfare information system requires the CPW to select a "Fatality Type" for all child victims listed on the report. The fatality types include "Not Fatal", "Fatal – Result of Abuse", or "Fatal –

Abuse a Contributing Factor”. If the CPW chooses one of the two “fatal” types, the “Date of Death” is a required entry. This documentation within the system allows the DHS to easily identify children who died as a result of abuse or with abuse as a contributing factor to report to NCANDS for each federal fiscal year. Prior to an NCANDS submission, the DHS manually reviews each incident identified to confirm the accuracy of the NCANDS submission. Any inaccurate or incomplete information identified during the course of review by the Iowa Child Death Review Team or any other quality assurance efforts would also assist in the DHS process to compile complete and accurate information on child maltreatment deaths reported to NCANDS.

To develop and implement a comprehensive, statewide plan to prevent child maltreatment fatalities in Iowa, a DHS leadership group referred to as G-5 created a Safe Sleep Workgroup Charter (Attachment 4D) to develop a research-based strategic plan for supporting safe sleep with DHS-involved families as a means of reducing sleep related maltreatment deaths. G-5 defined tasks of the workgroup and will submit a preliminary draft of the plan for implementation consideration by June 30, 2019.

The Safe Sleep Workgroup includes DHS policy and field operations staff who have researched existing data and initiatives both locally and on a national level and are collaborating with DHS direct field staff, supervisors, and administrators as well as engaging relevant public and private agency partners to develop a strategic plan to prevent child maltreatment fatalities in Iowa. Current efforts have included consideration for DHS policy, practice, system, and training changes for the intake, assessment, and case management departments; improved service coordination with Early Access (IDEA, Part C) and visiting nurse service programs; intersection with Zero to Three Safe Babies Court Teams; and communication with the Iowa Child Death Review Team (and the multitude of disciplines/agencies which comprise the team) with how to best join efforts to bring increased awareness to Safe Sleep within our state.

## **Promoting Safe and Stable Families (PSSF)(title IV-B, subpart 2)**

Please see *Service Description* for a description of services provided under PSSF.

*Service Decision-Making process for Family Support Services*  
*In the 2020- 2024 CFSP, explain how agencies and organizations were selected for funding to provide family support services and how these agencies meet the requirement that family support services be community-based.*

Please see *Prevention*, Iowa Child Abuse Prevention Program (ICAPP) and Community-Based Child Abuse Prevention (CBCAP) Program, earlier in this section.

*Populations at Greatest Risk of Maltreatment (section 432(a)(10) of the Act)*  
*Identify and describe which populations are at the greatest risk of maltreatment, how the state identifies these populations and how services will be targeted to those populations over the next five years.*

In 2017, the DHS asked Prevent Child Abuse (PCA) Iowa, ICAPP administration contractor, to complete a statewide Needs Assessment (Attachment 4E) and a Strategic Plan (Attachment 4F) to move prevention efforts forward in the state of Iowa. The information that follows is from that Needs Assessment.

PCA Iowa contracted with Hornby Zeller Associates, Inc. (HZA) to develop data collection tools, provide analysis and synthesize the results. PCA Iowa conducted the focus groups and administered the surveys. In completing the assessment, the following occurred:

- Inventory of existing child abuse prevention programs sponsored by DHS and other federal, state, local, and private sources of funding;
- Analysis of how programs intersect and of gaps in services, including an examination of evidence-based prevention practices used in Iowa by ICAPP and CBCAP grantees;
- Analysis of the need for maltreatment prevention services using a social indicator approach to identify the prevalence and impact of abuse and neglect risk factors; and
- Collection of stakeholder feedback on data and initial findings through focus groups and surveys of prevention professionals, parents and youth.

In identifying which populations are at the greatest risk for maltreatment, the assessment identified the following statistically correlated risk factors:

- poverty,
- teen births,
- low birthweight,
- high Adverse Childhood Experience (ACE) scores,
- children 0-5,
- high rent,
- domestic violence, and
- mental illness.

Therefore, those at greatest risk for maltreatment are children who live in households where these risk factors are present.

Based on the recommendations of the Needs Assessment and the vision and guiding principles in the Strategic Plan, development of the following seven primary goals occurred:

- Reduce maltreatment by targeting services to families exhibiting risk factors that most closely correlate with child abuse and neglect
- Coordinate maltreatment prevention funding sources across multiple service sectors (e.g. public health, early childhood, human services) to use each source strategically in combatting child abuse and neglect
- Balance funding between primary and secondary prevention with a greater emphasis on reaching more vulnerable families
- Embed culturally competent practices in prevention services
- Increase the use of informal and non-stigmatizing supports for families and youth

- Increase the use of evidence-based practices (EBPs) in child maltreatment prevention while introducing and evaluating innovative approaches
- Engage in a statewide evaluation of prevention services' effectiveness, monitoring protective and risk factors at the organization and community level

Over the next five years, Iowa will utilize its prevention services to target services to children and families at greatest risk of abuse or neglect. For example, the combined Iowa Child Abuse Prevention Program (ICAPP) and Community-Based Child Abuse Prevention (CBCAP) Program utilizes local child abuse prevention councils to provide services that include home visiting programs, parent development programs, crisis child care, programs targeted at sexual abuse, and programs to develop community prevention responses. Additionally, Iowa will utilize its continuum of services to provide services to at risk families and families involved with the child welfare system to ameliorate family conditions that contribute towards child maltreatment. For more information regarding these services, please see *Prevention* and *Intervention* earlier in this section.

### **Monthly Caseworker Visit Formula Grant and Standards for Caseworker Visits**

*Describe the state's standards for the content and frequency of caseworker visits for children who are in foster care under the responsibility of the state, which, at a minimum, ensure that the children are visited on a monthly basis and that caseworker visits are well-planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency and well-being of the children (section 422(b)(17) of the Act).*

The Department shall conduct face-to-face visits with each child receiving services in out-of-home placements. The frequency of the visitation shall be based upon the needs of the child but, at minimum, shall occur once every calendar month.

The visit shall take place in the child's place of residence the majority of the time. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

For children placed out of state, a caseworker from the jurisdiction in which the child is placed or a case worker from the jurisdiction from which the child was placed must visit the child in the placement on a schedule that is consistent with the child's needs and no less frequently than once per year.

*Describe how the state plans to use the Monthly Caseworker Visit Grant over the next five years to improve the quality of caseworker visits, to continue to meet state and federal standards for caseworker visits, and to improve caseworker decision-making on the safety, permanency, and well-being of foster children, and to improve caseworker*

*recruitment, retention and training. Note that Monthly Caseworker Visit Grant funds may not be used to supplant funding provided to the state under the title IV-E program (section 436(b)(4)(B)(ii) of the Act).*

Iowa anticipates that usage of the funds over the five year plan will include:

- Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs, and the JCS-DHS systems data matching to more accurately capture visits for juvenile justice children in foster care.
- Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. The CareMatch system:
  - Tracks beds in group care, shelter and supervised apartment living and
  - Tracks and matches licensed foster parents and children in foster care. The license agreement contract includes system enhancements, data conversion, training, and an annual licensing fee. The tracking system assists caseworkers in determining the closest and most appropriate placement for the child. Research suggests that children placed closer to home receive more frequent, quality caseworker visits, which in turn impacts caseworkers' assessment of safety, efforts to achieve timely reunification or other permanency goals, and efforts to achieve child and family well-being.
- Purchased access to CultureVision™ for staff and service providers to utilize to engage children and families in a culturally responsive manner. CultureVision™ is a user-friendly database with information on a variety of racial, ethnic, and religious cultures. CultureVision™ assists caseworkers in providing culturally responsive services and supports.

Iowa is in the process of determining how best to use the funds in light of Family First implementation and results from Iowa's Child and Family Services Review, including how to better support the achievement of frequent, quality caseworker visits. Results from this process decision-making process will be in next year's Annual Progress and Services Report (APSR).

## **Additional Services Information**

### **Adoption and Legal Guardianship Incentive Payments**

- *The services the state expects to provide to children and families using the Adoption and Legal Guardianship Incentive funds.*
- *The plan for timely expenditure of the funds within the 36 month expenditure period.*

### **Adoption Savings**

- *Describe the services the state expects to provide to children and families using the Adoption Savings over the next five years.*
- *Provide an estimated timetable for spending unused savings calculated for previous years.*
- *Discuss any challenges in accessing and spending the funds.*

- *If needed, complete the Adoption Savings Methodology form at Attachment E and return it with the 2020- 2024 CFSP. (Not Needed)*

Iowa is in the process of determining how best to use the funds in light of Family First Prevention Services Act implementation and results from Iowa's Child and Family Services Review. It is Iowa's plan to spend funds within the allocated time period to enhance Iowa's service array with the goal of timely achievement of permanency for children. Additional information will be in next year's Annual Progress and Services Report (APSR).

## **Section V: Consultation and Coordination between States and Tribes**

*Describe the process used to gather input from tribes for the development of the 2020-2024 CFSP, including the steps taken by the state to reach out to all federally recognized tribes in the state. Provide specific information on the name of tribes and tribal representatives with whom the state has consulted. Please provide information on the outcomes or results of these consultations. States may meet with tribes as a group or individually. (See 45 CFR 1357.15(l) and 45 CFR 1357.16(a)).*

Iowa utilized the following processes, outlined below, to gather input from the federally recognized tribe in Iowa, The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) and tribes who have a presence in Iowa.

### **Child and Family Services Review (CFSR) Stakeholder Interviews**

- On July 6, 2018, Meskwaki Family Services (MFS) staff, Mylene Wanatee, Brian Walker, and Samantha Benson, met with the federal-state staff conducting the CFSR stakeholder interview regarding Service Array and Resource Development and Agency Responsiveness to the Community.
  - Strengths:
    - communication with DHS, at the local and state levels
    - relationships at the local and state levels
  - Opportunities for improvement:
    - lack of accessibility and individualization of services in rural areas of Iowa, e.g. concrete support for kinship caregivers, drug testing, housing, transportation, etc.
    - issues with Family Safety, Risk and Permanency (FSRP) Services and Parent Partner program
    - state policy that MFS must have tribal court order to access service array
    - lack of DHS staff holding themselves accountable for activities in the State/Tribe Agreement
- On August 30, 2018, federal-state staff conducting the CFSR stakeholder interview regarding Service Array and Resource Development and Agency Responsiveness to the Community spoke with the following tribal representatives:
  - Liz Brown – Omaha Tribe (Director of Child Welfare Operations)
  - Mosiah Harland – Omaha Tribe (ICWA Director)
  - Stephanie Pospisil – Ponca Tribe (Social Services Director)

- Chiara Conoyer – Winnebago Tribe (Human Services Director)
- Clarissa LaPlante – Santee Sioux

The discussion identified the following strengths and opportunities for improvement:

- Strengths:
  - communication with DHS at the local level, e.g. quarterly meetings
  - services mostly accessible and individualized
  - some culturally relevant services, e.g. Fatherhood and Motherhood Is Sacred
- Opportunities for improvement:
  - lack of agreements between the State of Iowa and the tribes to address foster care, day care, sharing of home studies, etc.
  - lack of services, e.g. concrete supports for relative caregivers, transportation
  - some issues with ICWA cases and transfers to tribes
  - cultural relevant services as part of service array
  - qualified expert witness process not defined in Iowa, including compensation

### **Discussions with Meskwaki Nation**

Meskwaki Nation is the only federally recognized tribe located in Iowa. MFS provides services and supports to tribal families located on and off the settlement. DHS and MFS developed a strong working relationship for Meskwaki families involved in state court proceedings and tribal court proceedings. Mylene Wanatee, director of MFS, Brian Walker and Samantha Benson, Social Workers/ICWA Coordinators, DHS local frontline staff, leadership for Linn and Tama Counties, and central office staff discuss ongoing case specific and systemic issues, as needed.

- November 30, 2018 – DHS central office staff participated in a meeting with DHS local office and service area staff and MFS staff at the MFS office to discuss the following:
  - General discussion of how things are going/communication
  - Protocol execution
  - Review of the Family Safety, Risk and Permanency/Safety Plan Services (FSRP/SPS) contract by the program manager with questions answered afterwards.
  - MFS staff discussed issues they had with one of the local FSRP/SPS providers.
    - Discussed process for provider and MFS staff to meet monthly to address issues.
    - Discussed MFS conducting a training for Cedar Rapids Service Area (CRSA), the local Breakthrough Series Collaborative (BSC) team, and the service provider staff
  - DHS staff invited MFS staff to the all contractors' meeting, scheduled for June 18, 2019, and to participate in the local BSC team.
- April 12, 2019 – DHS central office staff attended two specific meetings on this date with MFS staff.
  - DHS central office staff, including the Parent Partner program manager, MFS staff, and contract staff for Parent Partners met to discuss Meskwaki's experience with Parent Partners, including trouble shooting some issues. As a

result of the meeting, strengthening in some processes in the Parent Partner program, such as quality assurance and feedback to MFS staff, occurred. Additionally, Parent Partner staff will participate in Meskwaki community activities to build rapport and recognition in the community. MFS staff will provide some training to the Parent Partner program regarding Meskwaki Nation culture.

- DHS central office staff and MFS staff met and discussed several items:
  - MFS staff shared continuing concerns regarding their local SPS/FSRP providers, such as workers not arriving for scheduled appointments, not contacting the family about missing appointments, cultural inappropriateness, etc. MFS staff indicated they thought travel times affected active efforts. MFS offered office space in their office for both contractors but neither provider chose to do so.
  - DHS central office staff will explore with MFS staff implementation of Positive Indian Parenting for Native families in Iowa. MFS staff requested implementation of Native specific parenting programs in Iowa to meet the needs of their families.

## **Discussions with Nebraska Tribes**

DHS local, service area, and central office staff actively participates in monthly meetings in Sioux City involving tribes domiciled in other states but who have a significant presence in the area. The Community Initiative for Native Children and Families (CINCF) includes representation from the tribes in the area – Ho-Chunk, Omaha, Ponca, Santee Sioux, Rosebud, and Winnebago. CINCF also includes representatives from area service providers, the judiciary, housing, law enforcement, the Recruitment, Retention, Training, and Supports (RRTS) contractor Lutheran Services in Iowa (LSI), health, and education. The group collaboratively works to find resources and support for Native families.

The service area manager (SAM) for the Western Iowa Service Area (WISA), the supervisor of the Native unit, a social work administrator (SWA) for WISA, and Native unit staff regularly attend the meeting and update representatives on new DHS initiatives, data regarding Native children, and concerns related to practice or ICWA compliance. The DHS ICWA program manager receives information regarding ICWA compliance concerns and makes policy or practice changes, in concert with field staff, as needed.

The DHS Native unit in Woodbury County includes four caseworkers and two Native Liaisons. The liaisons role is to exchange cultural and case information between tribes, DHS and the Native families.

The DHS SAM, SWA, and Native Unit supervisor meets with the four Nebraska Tribes semi-annually or quarterly, depending upon the tribe. The purpose of these meetings is to establish communication, build relationships, and provide a forum to discuss practice and policies that may or may not be going well. These meetings may include Tribal Social Service Director's, ICWA specialists, Tribal Caseworker's and Supervisors.

Topics discussed include, but are not limited to, terminations of parental rights, customary adoptions, relative placements, transfer proceedings, and improving communication.

- Two times per year:
  - Winnebago Tribe of Nebraska:
    - These meetings include the Tribe's Attorney - Roz Koob, Social Service Director - Chiara Cournoyer, Tribal Social Service Supervisor - Kitty Washburn, and ICWA Specialist - Elexa Mollett.
    - During the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the state ICWA/Tribal Relations program manager to address statewide policy concerns.
    - Outcomes attained include strengthening relationships, improved communication, and improved understanding of how each other's programs operate to increase efficiency of services for children and families.
  - Omaha Tribe of Nebraska:
    - These meetings include the Tribe's Attorney - Roz Koob, Social Service Director - Mosiah Harlan, and ICWA Specialist - Kash Echtenkamp. Often times, due to both the Winnebago and Omaha Tribes sharing the same attorney, both tribes and DHS meet together as one group.
    - Similar to the Winnebago Tribe, during the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the state ICWA/Tribal Relations program manager to address statewide policy concerns.
    - The outcomes established by these meetings is similar to that of the Winnebago Tribe, i.e. improved communication and a better understanding of how each other's program's operate to increase efficiency of services for children and families.
- Semi-annual meetings:
  - Ponca Tribe of Nebraska:
    - The DHS recently met with the Ponca Tribe of Nebraska. The first meeting occurred on January 11, 2019 with the Social Services Director of the Ponca Tribe, Stephanie Pospisil. The purpose of the meeting was to build the relationship and communication with the Ponca Tribe. During the meeting, participants discussed policy, services provided by the Ponca Tribe, and the Tribe's position on termination of parental rights hearings.
  - Santee Sioux Tribe of Nebraska:
    - The purpose of meeting with the Santee Sioux Tribe is similar to that of all Tribes, i.e. to establish communication and build relationships. In attendance from the last meeting were representatives of the Santee Sioux Tribe, i.e.

Social Services Director, Danielle LaPointe, Supervisor Clarissa LaPlante and ICWA Specialist Karen Red Owl . The Tribe was in a transition period at the time and was still waiting to appoint a new Director of the Social Services program. The last meeting occurred at the Santee Sioux Reservation when the WISA SAM and SWA attended representing the DHS. There was a tour of the reservation and discussions included communication and needed resources, similar to the other mentioned Tribes.

## Next Steps

In cooperation and consultation with the Tribe(s):

- In the summer or fall 2019, Meskwaki Nation, DHS representatives, and federal Children's Bureau staff will reconvene to discuss the State of Iowa and Meskwaki Nation Intergovernmental Agreement and the Protocol.
- The DHS ICWA/Tribal Relations program manager will schedule quarterly meetings with MFS, which will include federal Children's Bureau Region VII staff. The DHS ICWA/Tribal Relations program manager will discuss inclusion of the other tribes or establishing a similar separate call with them.
- Explore the following:
  - Services:
    - lack of accessibility and individualization of services in rural areas of Iowa, e.g. concrete support for kinship caregivers, drug testing, housing, transportation, etc.
      - Kinship Navigator Program
      - Expedited licenses for kinship families
    - issues with Family Safety, Risk and Permanency (FSRP) Services
    - cultural relevant services as part of service array
      - Fatherhood and Motherhood Is Sacred programs
      - Positive Indian Parenting
  - Policies:
    - state policy that MFS must have tribal court order to access service array
      - research the state policy issue and resolve, particularly in light of Family First implementation
    - lack of DHS staff holding themselves accountable for activities in the State/Tribe Agreement
      - improve DHS accountability through enhanced communication
    - lack of agreements between the State of Iowa and the tribes not federally recognized in Iowa but who have a presence in Iowa to address foster care, daycare, sharing of home studies, etc.
      - work with the tribes to implement agreements
  - ICWA practice:
    - some issues with ICWA cases and transfers to tribes
      - work with ICWA Training and Technical Assistance contractor to develop trainings, tip sheets, improved processes, etc. to improve ICWA practice
    - qualified expert witness (QEW) process not defined in Iowa, including compensation
      - develop a QEW process, including possible compensation

- Have discussions with judges, county attorneys, and Iowa Children’s Justice regarding ICWA related matters, such as “active efforts”
- Share technical assistance and possibly start a continuous quality improvement project at the local level

*Provide a description of the state’s plan for ongoing coordination and collaboration with tribes in the implementation and assessment of the 2020- 2024 CFSP. Describe any barriers to this coordination and the state’s plans to address these barriers.*

The DHS will include representatives from all of the tribes in the annual Quality Improvement focus group where stakeholders from across the state will work together to identify strengths and opportunities to improve Iowa’s child welfare system, which will be in the Annual Progress and Services Reports (APSRs). Additionally, DHS will include tribal representatives in the ongoing Service Area meetings, which continue throughout the year to address local interests.

- Meskwaki Nation – quarterly meetings
- Winnebago and Omaha Tribes of Nebraska – twice per year meetings
- Ponca and Santee Sioux Tribes of Nebraska – semi-annual meetings
- Monthly CINCF meetings attended by the various tribes

*Provide a description on the arrangements made with tribes as to who is responsible for providing the child welfare services and protections for tribal children delineated in section 422(b)(8) of the Act, whether the children are under state or tribal jurisdiction. These services and protections include operation of a case review system (as defined in section 475(5) of the Act) for children in foster care; a preplacement preventive services program for children at risk of entering foster care to remain safely with their families; and a service program for children in foster care to facilitate reunification with their families, when safe and appropriate, or to place a child in an adoptive home, legal guardianship or other planned, permanent living arrangement subject to additional requirements outlined in section 475(5)(c) and 475A(a) of the Act. (See 45 CFR 1357.15(q).)*

Meskwaki Nation is the only federally recognized tribe domiciled in Iowa and established their tribal court in 2005. DHS and Meskwaki Nation finalized a State/Tribal Agreement initially in 2006, which outlined Tribal and DHS responsibilities for service provision, payment for services, federal reporting and assessing child abuse. DHS and MFS finalized a protocol in June 2011. The protocol further defines the roles and responsibilities of DHS staff and MFS staff in child protective assessments for Meskwaki families who reside on and off the settlement and case management of cases in state court. The DHS and Meskwaki Nation updated the State/Tribal Agreement and Protocol in 2018.

The Tribal/State Agreement states DHS will be responsible for payment for foster care or other child welfare services accessed by Meskwaki Nation children under tribal court jurisdiction. MFS has all case management responsibilities. Children under tribal court

jurisdiction may access any service available to a child under state court jurisdiction as long as the child is eligible for DHS services.

The agreement also states the cases of children under tribal court jurisdiction, but for whom DHS pays for services, may be subject to federal review through an IV-E Eligibility Review or through a Child and Family Services Review. MFS provides all required IV-E documentation including court orders and family household composition, income and resources, and ongoing documentation to DHS in order to determine initial and continued eligibility for IV-E claiming.

MFS has responsibility for the management of cases under tribal court jurisdiction and meeting the law of their nation regarding case requirements and a case review system. Tribal law explains case planning requirements including required federal language in case plans. Tribal law also includes periodic review and reporting requirements by MFS. Tribal law addresses case requirements to prevent children's removal from their home, to achieve reunification, and to achieve permanency.

DHS will continue to engage Meskwaki Nation tribal representatives in the CFSR process on-going as well as provide training and technical assistance to assist Meskwaki Nation in their case review process.

DHS performs all case review requirements for Meskwaki Nation children under state court jurisdiction, which includes providing credit reports to children age 14 or older in foster care.

There are several tribes domiciled in Nebraska and South Dakota who have a presence in the northwest part of Iowa. At this time, the DHS does not have agreements to pay for services for children under the jurisdiction of the tribal courts of these tribes. However, during the five year period, the DHS plans to establish agreements with as many of these tribes as possible. Children under state court jurisdiction are eligible for all child welfare services. DHS pays for these services and manages these cases in collaboration with the child's tribe. Children under the jurisdiction of a tribal court in another state would receive services by that tribe or state.

*Provide a description, developed after consultation with tribes, of the specific measures taken by the state to comply with ICWA. (See section 422(b)(9) of the Act.)*

At this time, the DHS does not have an automated mechanism to collect data about ICWA compliance. However, as part of developing the comprehensive child welfare information system (CCWIS), Iowa plans to include several adoption and foster care analysis and reporting system (AFCARS) data elements and possibly additional elements related to ICWA compliance. Currently, Iowa determines compliance through periodic case readings, case consultation with tribal representatives, and annual trainings.

The ICWA Training and Technical Assistance contract held by Meskwaki Family Services (MFS) uses case reading to determine ICWA compliance and to develop training based on the case reading results. DHS staff pulls data for all children identified as American Indian/Alaska Native from the DHS' child welfare information system (CWIS). DHS excludes cases under tribal court jurisdiction, delinquent (non-status offenses), and in-home cases from the sample. DHS and MFS agreed that MFS would read a random sample of cases from Woodbury County and case read 100% of all other cases across the state. The timeline for completion of the case reading and a report of findings is June 30<sup>th</sup> each year.

DHS and MFS staff are in the process of exploring development of more in-depth training regarding tribal culture, "active efforts", and other issues identified in case readings, which will occur sometime in the near future.

*Provide information regarding discussions with Indian tribes in the state specifically as it relates to the Chafee program. States may provide this information either in this section or in the Chafee section of the 2020- 2024 CFSP, but are requested to indicate clearly where the information is provided.*

Please see *Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)*, Consultation with Tribes (section 477(b)(3)(G)), of this report.

*State agencies and tribes must also exchange copies of their 2020-2024 CFSP and their APSRs (45 CFR 1357.15(v)). Describe in detail how the state will meet this requirement for the 2020-2024 CFSP and the plan for exchanging future APSRs.*

The DHS will provide the 2020-2024 CFSP and subsequent APSRs directly to the director of MFS and to the director of Four Directions in Sioux City. Additionally, the DHS will explore other avenues of exchanging the 2020-2024 CFSP and subsequent APSRs directly with the tribes in the northwest area of the state.

## **Section VI: John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program)**

### **Agency Administering Chafee (section 477(b)(2) of the Act)**

*Identify the state agency or agencies that will administer, supervise, or oversee the Chafee program. Describe how the agency that administers the program provides oversight to the programs or agencies that directly provide Chafee services and supports.*

The Iowa Department of Human Services (DHS) is the state agency that administers, supervises, or oversees the Chafee program. The DHS maintains a full time Independent Living (IL) Coordinator. This state funded position will continue unchanged for the next five year period. The IL Coordinator, within the Division of Adult, Children and Family Services (ACFS), is responsible for multiple programs and activities

centered on the DHS services and supports for youth transitioning from foster care to adulthood. Responsibilities include:

- Ensuring projects, policies, and practices serve transitioning youth efficiently and effectively, resulting in positive outcomes for youth formerly in foster care.
- Coordination duties for the Chafee funded Transition Planning Specialists (TPSs) as well as the regional Point of Contact (POC) for education and child welfare partnerships to implement Fostering Connections and Every Student Succeeds Act foster care stability provisions, monitored as follows:
  - Regional supervisors
  - Regional administrator oversight
  - “Lead” administrators
  - Central office activity monitoring
  - Performance tracking and monitoring
- Managing contracts for the following programs:
  - Iowa Aftercare Services Program, which utilizes combined state and federal funding to serve transitioning youth through a network of child welfare agencies, monitored as follows:
    - Annual reports reviewed by DHS
    - Annual audits conducted by DHS
    - Monthly claims approved by DHS
    - Satisfaction surveys
    - Referring worker feedback (informal)
  - Iowa Foster Care Youth Council, for children in foster care, monitored as follows:
    - Annual reports reviewed by DHS
    - Annual audits conducted by DHS
    - Satisfaction surveys
    - Monthly claims approved by DHS
    - Referring worker feedback (informal)
  - Education and Training Voucher (ETV) program, which utilizes combined state and federal funding to support education attainment of current and former foster care recipients, monitored as follows:
    - Quarterly reports reviewed by DHS
    - Annual reviews by DHS
    - Performance outcomes (retention)
    - Monthly claims approved by DHS
    - Referring worker feedback (informal)
  - Foster Care Transportation for Education Stability Contract with the Iowa Department of Education (DE), monitored as follows:
    - Quarterly team meetings
    - MOU annual reviews
    - Monthly claims approved by DHS
  - The Iowa Finance Authority to administer the rent subsidy program is monitored as follows:
    - Periodic reviews by DHS
    - Monthly claims approved by DHS
    - Aftercare feedback (informal)

## **Description of Program Design and Delivery**

*Describe how the state designed and intends to deliver and strengthen programs to achieve the purposes of the Chafee program over the next five years (section 477(b)(2)A(A) of the Act). Indicate how these activities and any identified goals align with the state's vision and support those developed as part of the CFSP/CFSR PIP.*

The design of the Chafee transition program and how DHS intends to achieve the purposes of Chafee over the next five years is below. Included are descriptions of state and local level oversight, as well as basic program information.

The purpose of the transition planning program is to provide services, supports, activities and referrals to programs that assist children currently or formerly in foster care in acquiring skills and abilities necessary for transition to successful adulthood. The transition planning program offers a life skills assessment, transition plan development, and transition-related services, supports, activities and referrals to programs.

The Chafee goals include, but are not limited to, helping support youth in relationships, educational attainment and career aspirations; ensuring adequate health care and health care coverage options; and obtaining safe, affordable housing, which perfectly align with the state's goal to help youth transition successfully to adulthood. Iowa believes, if we engage youth, assess for life skills needs, and help youth build a social support system, achievement of these goals will occur and young people will have the opportunity to enter adulthood and experience positive outcomes.

Iowa organizes the Chafee program around a desire to provide good leadership infrastructure driven by customer input and data, quality life skills assessments for youth, and genuine youth centered planning practice.

Descriptions of activities are below:

### Youth Centered Planning:

Due to completing provider trainings and implementation of ongoing training in FFY 2017, the youth centered planning process is considerably improved. For example, the current training process, now taught to all DHS foster care case management and foster care provider teams, includes requirements around the five primary components of transition planning: 1) housing; 2) positive support system; 3) education; 4) employment; and 5) health care and access to health care. TPS share information on all state and federal laws regarding transition planning and required activities including:

- youth-centered planning;
- planning inclusive of the five primary components mentioned above;
- ensuring smooth access for youth who need services and supports from the adult disability system;
- a written transition plan for each youth in foster care age 14 or older; and
- an update completed at each six month case review (or more often if needed), within 90 days of a youth turning 18 years of age, and within 90 days of departure for a

youth who elects to stay in voluntary foster care past 18 years of age to complete a high school diploma or obtain their high school equivalency.

Additionally, materials developed comprised:

- samples of transition plans/guidelines that caseworkers may use to supplement the DHS transition plan within the case permanency plan;
- specifics for caseworkers on how to electronically (hard copy for those without the internet) send a Casey Life Skills Assessment (CLSA) for children in family like foster care settings;
- monthly transition topic conversations to have with youth;
- information about what a Power of Attorney for Health Care is and why it is important for youth aging out of foster care to understand this process;
- resources available to youth aging out of care;
- transition eligibility scenarios;
- ways in which the TPS may assist the caseworker with difficult cases regarding transition; and
- a thorough checklist by ages 16, 17, 17 ½, and 18 and what specific required transition processes occur during each of these ages. The checklist is in each youth's case file as a measure to track progress during one-on-one meetings between the caseworker and their supervisor.

In addition to face to face, statewide DHS and provider trainings, TPS created and delivered a webinar that addresses changes to transition and reinforces existing practices, such as the new start date for formal transition planning and enhancements to the youth centered transition process. The webinar (<http://training.hs.iastate.edu/course/view.php?id=577#section-3>) is available for viewing by DHS/JCS, all providers, and the public and will continue to be available. This webinar covers:

- Specifics of the Strengthening Families Act, that lowered the age of transition planning requirements for youth in out-of-home placement from age 16 to age 14 and older;
- Casework practice activities and obligations; and
- Tools and resources to assist caseworkers in meeting requirements for transition planning.

To reach foster and relative care families, training is available using various approaches. In addition to the available webinar described above, the recruitment and retention contractor (RRTS) staff provide training, including during foster family support group meetings. TPS continue outreach to providers (foster group, shelter, supervised apartment living (SAL), RRTS) to make our training services available and we will continue to have the transition webinar available to staff and providers.

All new case managers in Iowa travel to Des Moines for comprehensive training. Each training includes a presentation on all aspects of foster care transition planning and connects the new workers to the tools and the TPS who will be their resources for transition in the service areas.

### Life Skills Assessments:

TPS are responsible to record such things as the date when youth over the age of 14 complete the Casey Life Skills Assessment; the date of the Local Transition Committee's approval of the youth's transition plan; and the date the case manager meets with the youth 90 days prior to the youth's 18th birthday. TPS send email reminders to case managers when any required item is due. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14. The intent of these emails is to ensure all youth have a viable plan whether leaving at age 18 or whenever they leave foster care. The tracking system is an invaluable monitoring tool. The CFSP goals will address ways to better use the tool, including new elements and thinking about ways to inform supervisors and engage them in the accountability of staff.

### Iowa Aftercare Services:

The DHS funds the Iowa Aftercare Services Program with approximately half of the state's total Chafee funds. Over the years, the DHS used the success of the Aftercare program to leverage over four million state dollars, which complements the Chafee funds to provide a monthly stipend to children aging out of licensed foster care and also to provide the states' only juvenile justice system transition supports for youth who aged out of Iowa detention centers and the Iowa Boy's State Training School in Eldora.

The Iowa Aftercare Services Program provides services and support in all of Iowa's 99 counties. Aftercare focuses on helping youth reach their personal goals for education, employment, housing, health, life skills and relationships. Youth Shelter Services (YSS) of Ames holds the aftercare contract and serves as the lead agency since initiation in 2002.

YSS subcontracts with the Youth Policy Institute of Iowa (YPII) for quality assurance (QA), which includes QA activities, such as annual site visits, file reviews, and extensive training opportunities. YPII also handles all of the data collection, analysis and reporting of status of participants and outcomes. YPII is an excellent partner in data, as evidenced by high quality semi-annual progress reports and annual outcomes reports, all of which are available on the [aftercare website](#).

In 2019, rule changes are in process to extend Iowa Aftercare Services to the participant's age 23. Iowa DHS appropriations changes has allowed flexibility in the four million dollar Preparation for Adult Living funding, enabling Iowa to implement the extension of aftercare, which we are calling "post services" as early as FFY 2020. The newly eligible aftercare population (pending Chapter 187 Administrative Rule approval) is youth age 21 or 22 who previously participated in the Iowa Aftercare Services Program (at age 18-21).

Key changes in progress are below and in no special order:

- Extend program to participant's age 23
- Merged Aftercare rules and PAL rules into one division

- Revised goal to “path to” self sufficiency
- Require youth meet “regularly” each month
- PAL max may change with age of participant
- Services provided in a safe location
- Youth are to contribute to vendor purchases, if they are financially able
- Revised reasons for termination, including a focus on personal accountability and safety
- Youth discharged may not return to the program immediately
- Increased standards for proof of purchase
- Expanded the start-up funds to aftercare participants
- Remove approved living arrangement from termination of stipend
- Identify one or more sites for a pilot program to evaluate stipend based on income and eligibility only

According to aftercare services data, young people entering Aftercare in SFY 2018 accessed services in 60 of Iowa’s 99 counties. Nearly half (123) of these youth began services in one of five counties—Polk (44); Linn (23); Black Hawk (22); Woodbury (22); and Story (12). There were 28 counties where just one young person accessed services for the first time in SFY 2018.

Young people are able to initiate and discontinue services, then return one or more times as they need the service, as long as they are between the ages of 18 and 21 (up to 23 in 2020) and meet other eligibility requirements. The average duration of participation for all youth exiting services in SFY 2018 was 635 days (or 1.74 years), although this may include some disruptions in participation.

A total of 251 young people accessed Aftercare services for the first time between July 1, 2017 and June 30, 2018. The number of new participants declined over the last two years, after peaking in SFY 2016. New participants in SFY 2018 included 44 youth discharged from the State Training School or detention.

A total of 798 young adults participated in aftercare services in state fiscal Year 2018, a 5.5% decrease from the prior year. For reference, aftercare reported 760 participating in 2015. Of those served in 2018, 68.7% (548) met requirements and received a PAL stipend for at least a portion of the time they participated; the remaining 250 youth did not receive PAL during the year. On average, 493 young people participated in Aftercare each month during SFY 2018.

More than half of all youth accessing aftercare each year come to the program with a history of mental health assessment, diagnosis and treatment. In SFY 2018, 54% of the 798 youth served had one or more Serious Emotional Disorders (SED) prior to leaving foster care.

Overall, about 58% of youth accessing Aftercare in SFY 2018 were in care for more than two years. Young people accessing services also reported multiple placements with 26.3% of intakes reporting six or more placements prior to exiting care. Similar to

the previous year, over half (59%) of new intakes had a DHS social worker while in court-ordered placement, 36% had a JCO worker, and 5% had involvement of both a DHS social worker and a JCO. Females were much more likely to have a DHS worker (81.2%) as opposed to a JCO (13.9%), while 52% of males had a JCO versus 43.8% of males who had a DHS worker while in placement.

Education and Training Voucher Program: The DHS partners with the Iowa College Student Aid Commission (Iowa College Aid) to administer the Education and Training Voucher (ETV) program. An intergovernmental contract, administered by DHS, ensures there is one full time Coordinator, employed by Iowa College Aid. Iowa College Aid draws ETV funds through DHS to pay for tuition and housing for eligible foster care alumni attending accredited schools. More information about ETV is later in this report and in the FFY 2015-2019 Final Report.

State Independent Living Coordinator: Please see Agency Adminstrating Chafee earlier in this section.

Transition Planning Specialist (TPS): TPS are social workers who do not carry a caseload. Their primary goal is to help case managers engage youth and provide transition planning for young people in foster care as they transition to adulthood. TPS will continue in their current roles in coming years. There is one TPS in each service area.

Each TPS tracks completion of transition plans for every youth, flagging them for review at the child's age 17 and 4 months' so that the reviews occur by the time the youth is 17 and 6 months. DHS/JCS workers join Transition Committee meetings at their scheduled time (in person or via phone) and present the Transition Plan portion of the case permanency plan for the youth and discuss the case with the Transition Committee. The Transition Committee asks and answers any questions, and provides feedback, resources, and recommendations to the worker about their case and documents this on the Transition Committee Review form during the review. Some workers who do not "pass" the first time are required to return with an improved plan.

Over the next five years, the DHS anticipates significant and impactful changes occurring for Iowa's child welfare system, and foster care in particular. Descriptions of many of these changes are throughout the FFY 2015-2019 Final Report and this CFSP. The Family First Act provides states the opportunity to prevent children from entering foster care by providing high quality, evidence based programs. The law implies it is not enough to address the "front end" of the system. Older youth remain in care and may not have had the benefit of high quality diversion activities. It is for this reason the Chafee program has maintained goals and objectives with focus on youth driven case planning and practice, use of data, and exploration of smart and developmentally appropriate housing options. We did not include mentoring and permanency specific goals, but commit to using our transition work to bolster permanency goals in other sections of this CFSP. Naturally, permanency is also a big part of case practices addressed in the Chafee plan, such as within youth centered planning activities.

- Promote and help coordinate infrastructure at the service area level for youth centered planning meetings.
- Facilitate information sharing about transition services with tribes and other partners.
- Coordinate with Iowa Workforce, colleges and universities, and trade programs to highlight training opportunities available to meet the needs of youth.
- Increase connection to workforce centers and be active on the State Plan
- Align with Workforce Innovations and Opportunities Act, so children in foster care and alumni receive the supports needed to help them achieve education and career goals.
- Assist management in assuring compliance with foster care transition indicators

TPS continue to visit DHS county offices throughout their Service Area on a periodic basis, some monthly and some less frequently, but always as needed to support the area. They provide formal trainings, attend team meetings, and just “take work and camp out” in order to get some work done while available for questions as needed. TPS train staff at on-going in-service staff trainings and work with caseworkers throughout their area on an individual basis on difficult cases regarding transition needs.

For three years, DHS central office made limited funds available to DHS Service Areas for transition projects. “Project Transition” was a successful intervention that capitalizes on local passion and creative spirit. TPS take the lead to ensure transition training and resource fairs are annual and in every Service Area.

#### Foster Care Transition Tracking System:

DHS maintains an electronic tracking system for transition planning activities to ensure youth get the support they need and that DHS remains in compliance with all requirements for case planning of transition aged youth. Iowa Code § 232.2(4)(f) lays out the requirements.

TPS are responsible to record such things as the date when youth over the age of 14 complete the Casey Life Skills Assessment; the date of the Local Transition Committee’s approval of the youth’s transition plan; and the date the case manager meets with the youth 90 days prior to the youth’s 18th birthday. TPS send email reminders to case managers when any required item is due. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14. The intent of these emails is to ensure all youth have a viable plan whether leaving at age 18 or whenever they leave foster care. The tracking system is an invaluable monitoring tool. Iowa’s FFY 2020-2024 Child and Family Services Plan (CFSP) will address ways to better use the tool, including new elements and thinking about ways to inform supervisors and engage them in the accountability of staff.

System level considerations are underway which may affect transition planning. For example, the DHS appropriation (HF766) included expectations that the division of criminal and juvenile justice planning (CJJP) of the department of human rights (DHR) convene and provide administrative support to a workgroup to review and develop a plan to transfer the administration of graduated sanctions delinquency services and

court-ordered services for youth adjudicated delinquent, as well as funding and the oversight of foster group care placements for eligible delinquent youth, from the DHS to the office of the state court administrator. Currently, DHS administers both programs. The plan is to ensure that the office of the state court administrator has the capacity, resources, and expertise to manage the funding and services effectively. DHS will join JCS and other judicial representatives this fall with hopes that decisions will occur in time to inform Family First processes. One key consideration for the workgroup, for example, asked by TPS and others, "Will youth adjudicated delinquent placed in foster group care be eligible for transition services, such as aftercare, if the judicial or some other agency takes over the administration of foster group care?"

*Describe how the state has involved youth/young adults in the development of the Chafee plan. Provide the name(s) of the youth organization(s), advisory boards, leadership councils, how they were consulted, and information on any support (financial or other) the state provides to the group or organization.*

DHS involves young people in planning in multiple ways. Below are but a few examples:

- On November 7, 2018, DHS' Director Foxhoven hosted a discussion with youth in his office. AMP youth and youth from the Casey InSight group attended. Child and Family Policy Center staff also came to articulate what they heard from youth and what they believe. One example, which stands out, was the InSight group's desire for another look at supervised apartment living (SAL). Their concern was with access to SAL in certain areas of the state as well as the quality of assessment/life skills training for older youth. Our five year plan will address this concern. Other key points articulated in Attachment 6A and excerpted below:
  - *More foster homes for teens are needed—ones experienced working with teens.*
  - *Youth deserve to grow up in a family.*
  - *Families First Prevention Services Act (FFPSA) will restructure child welfare to decrease congregate care.*
  - *Family foster homes are not prepared for the high level of care needed. Resource families need specialized training (basic, therapeutic, enhanced) to match youth's needs.*
  - *AMP youth request safe and affordable housing for young adults aging out of the foster care system.*
    - *Tax incentives/tax breaks may be an options for landlords who rent to transitioning youth*
- The NYTD contractor initiated the popular "Wall" project, where young people in residential facilities, shelters, and other foster care settings use sticky notes on the wall to express their dreams, improvements in their own case or in the system. Some examples of youth voice which influenced our plans include:
  - *"I wish they had more placements available"*
  - *"More contact with workers"*
  - *"Have youth help train new foster parents alongside adult trainers"*

- On April 8, 2019, an annual event, AMP “Day on the Hill”, occurred, where young people educated lawmakers and the public about the personal experiences and service needs of children in foster care. Attachment 6A was the legislative agenda.

*Describe how the state is incorporating principles of Positive Youth Development (PYD) in its Chafee program.*

The DHS leverages Chafee funds (approximately \$100K Chafee and \$300K state funds) to contract with YSS to deliver the foster care youth council, known as Achieving Maximum Potential (AMP). AMP is a youth engagement program for current and former foster and adoptive youth summarized by the motto “Nothing about us, without us.” The primary purpose of AMP is to empower young people to become advocates for themselves and give them a voice in system-level improvements in child welfare policies and practices. When supported through productive partnerships with adults, youth can be authoritative advocates for making the foster care system more responsive and effective.

AMP offers leadership opportunities, service learning projects, speaking opportunities, and educational/vocational assistance to youth ages 13 and older who were in foster care, adoption, or other out-of-home placements. AMP also offers participating youth opportunities to learn life skills and shares resources available to them as they transition from foster care to adulthood.

AMP works to accomplish two primary goals:

- Provide youth an opportunity to support each other through relationship based, trauma informed activities created with youth, for youth and facilitated by trained facilitators. AMP mirrors elements of Positive Youth Development Practices including:
  - *meeting social needs through “fun” activities and structured social activities*
  - *Instruction to help youth build competencies needed to become successful adults*
  - *Community service to “give back” and become more connected to others.*
  - *Mentoring programs to build relationships and allow teens to share what they have learned with others*
- Provide a venue for youth to learn to advocate with the goal of collectively improving the child welfare system. A few examples are below:

Eight private, non-profit youth-serving agencies, led by YSS, comprise a statewide collaboration known as the Partnership of Iowa Foster Care Youth Councils. Through the contract with DHS, these eight agencies supported 15 AMP Youth Councils during the report period of July 1, 2018 through February 28, 2019. This compared to 13 in 2014 and 10 in 2011.

## Participation

According to the AMP report, from July 2018-February 2019, 154 meetings occurred across the state. According to council attendance logs, 572 young people attended AMP meetings for 2,053 points of contact over the report period.

**Chart 6(a): AMP Monthly Attendance, SFY 2019 vs. SFY 2018**

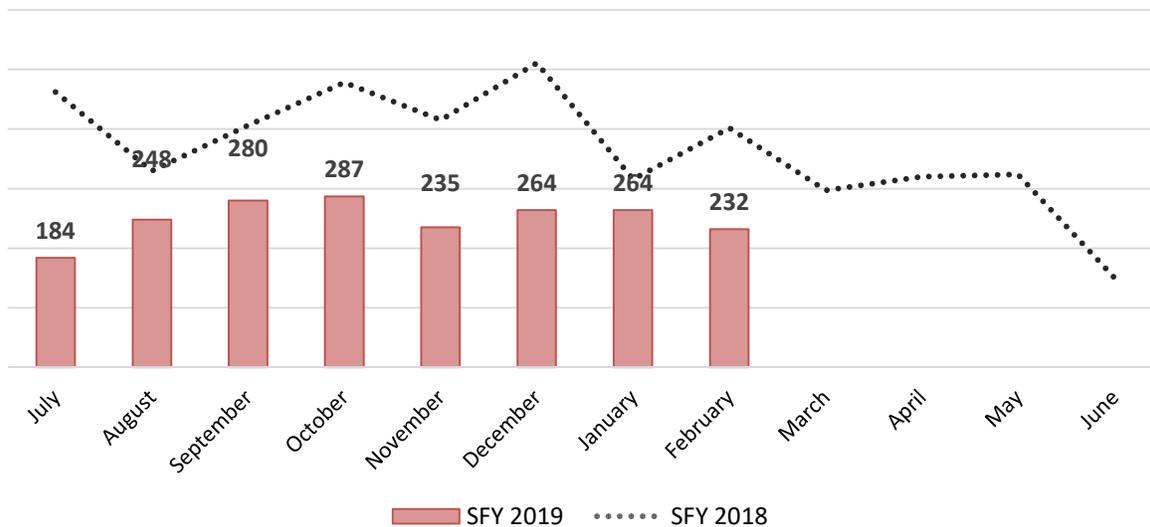


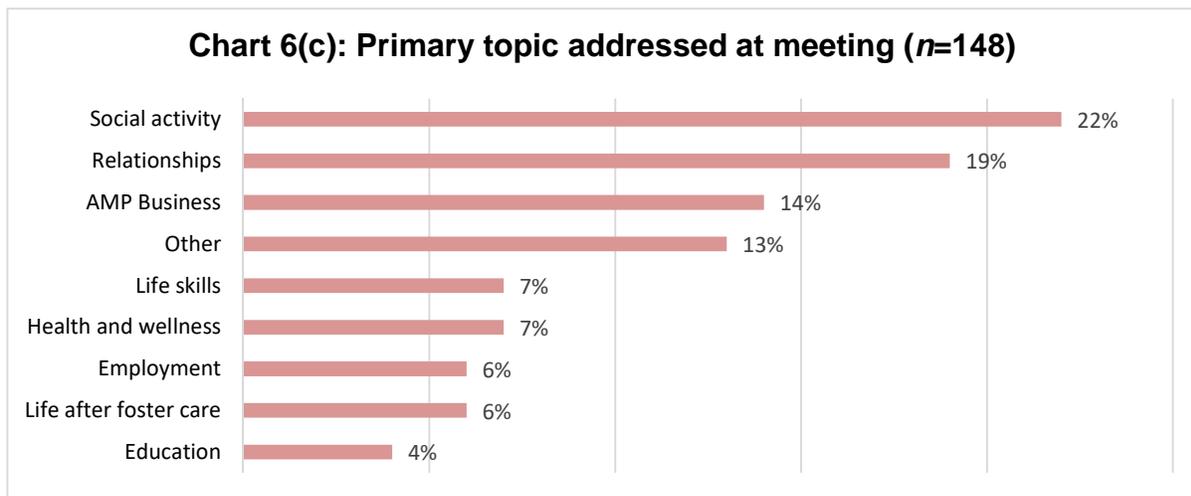
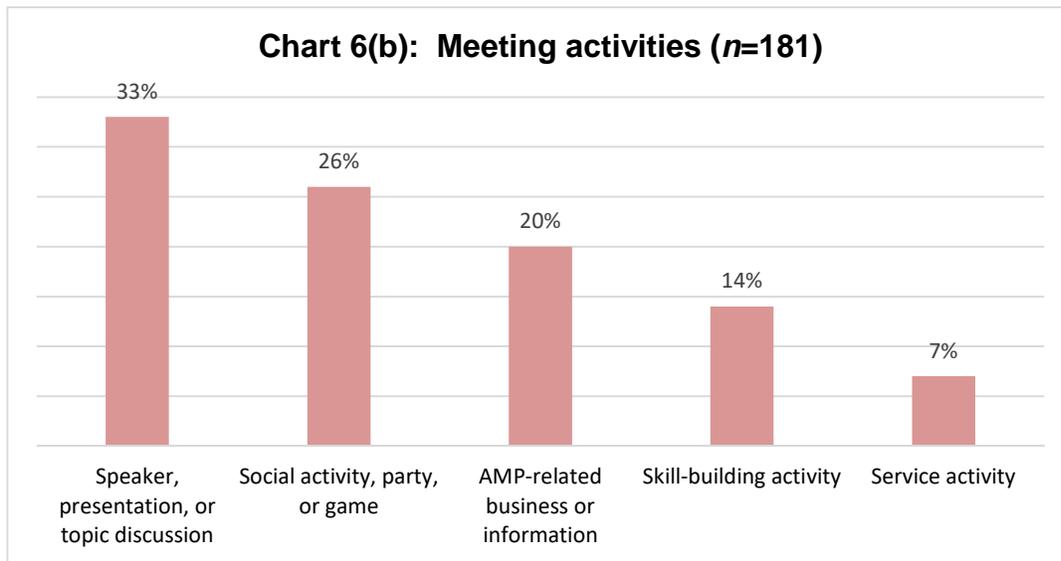
Chart is from the AMP Annual Report, created by YPII.

## Topics

The following charts and tables provide information on the types of activities, topics, and partners involved in the numerous meetings across the state. All councils have at least one meeting entry. Most councils submitted at least twelve meeting summaries. Three councils submitted fewer than ten meeting summaries over the report period (Dubuque: 4 meetings, Sioux City: 8 meetings, and Marshalltown: 9 meetings).

Presentations, activities and discussions on various topics during regular AMP meetings partially met the information-sharing and skill-building functions of AMP. Facilitators selected the primary topic, and had the option to comment on additional topics addressed or indicate something other than a category given. Within the “Other” category, the majority of the topics written in were service projects and volunteerism.

The following charts are from the AMP Annual Report.<sup>12</sup>



The 4th Annual AMP Conference took place on April 6, 2019 at Des Moines Area Community College (DMACC) in Ankeny and Des Moines, Iowa. AMP facilitators

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<sup>12</sup> AMP Annual Report, created by YPII

collaborated with the college to provide a venue for youth to learn about the college experience. Sixty (60) youth from seven different councils participated in this event. From five years ago, annual conferences have changed from being one central conference for children in foster care and related populations, to a more specific focus on only children in care and alumni. Also, conferences are smaller, college campus based, and more frequent.

An example is the Ankeny event described below:

*The morning session took place at the Ankeny campus and featured hands-on experiences with a wide range of academic programs. The Vice President of Enrollment Services opened the day with a wonderful presentation regarding the youth's future. Following her inspiring words, the enrollment team discussed DMACC and the steps to enroll in any college. The team went through the different types of programs available at the different DMACC locations.*

*A student panel representing several different cultures took questions from the youth and did a fantastic job of answering them. Following the panel, the youth had the opportunity to attend the DMACC faculty and staff program fair. They had the opportunity to interact and ask questions to members of DMACC staff about the different programs they offer. After the program fair, all the youth got a campus tour.*

AMP maintains a website, [www.ampiowa.org](http://www.ampiowa.org), which serves to share information about AMP councils, statewide activities, and original work of its members. The website includes personal journeys written by AMP teens and nearly 100 poems submitted by youth. Updates to the website include new stories and poetry throughout the year. An AMP youth who started her own photography business took many of the photos. This youth takes senior pictures for foster teens, to give back to a program that helped promote her talent.

The website has a new resource section that contains six transition videos from collaboration with Iowa Department of Public Health and Juvenile Justice. Using the first word "Got" at the beginning of each topic, the videos cover: Got Money? Got Meds? Got School? Got Housing? Got People? Got Help?. These videos featured AMP youth sharing their experiences transitioning to adulthood; and supported by a new website, youth can access several regularly updated resources. The videos are a great way for youth to access information at their own time and location, especially for teens who live in a rural setting and cannot attend an AMP council meeting.

Since SFY 2018, the youth council contract includes Chafee Foster Funds. The DHS scholarship provides funding for system-involved families to cover social or developmental needs (i.e., social and cultural activities, graduation, prom, instruments). To date in SFY 2019, the scholarship provided for over 60 youth activities/needs.

AMP appears to have had a slightly greater impact on youth personal development and immediate relationships with peers than with the larger community or the foster care system; although overall the feedback is positive. Nearly 80% of youth agree or somewhat agree that because of AMP, they have positive relationships with peers (77.9%) and have developed skills for later in life (77.8%). Fewer youth agree or somewhat agree that because of their participation in AMP, they have been able to engage with their community (69.9%) and make positive change in foster care policy (69%).

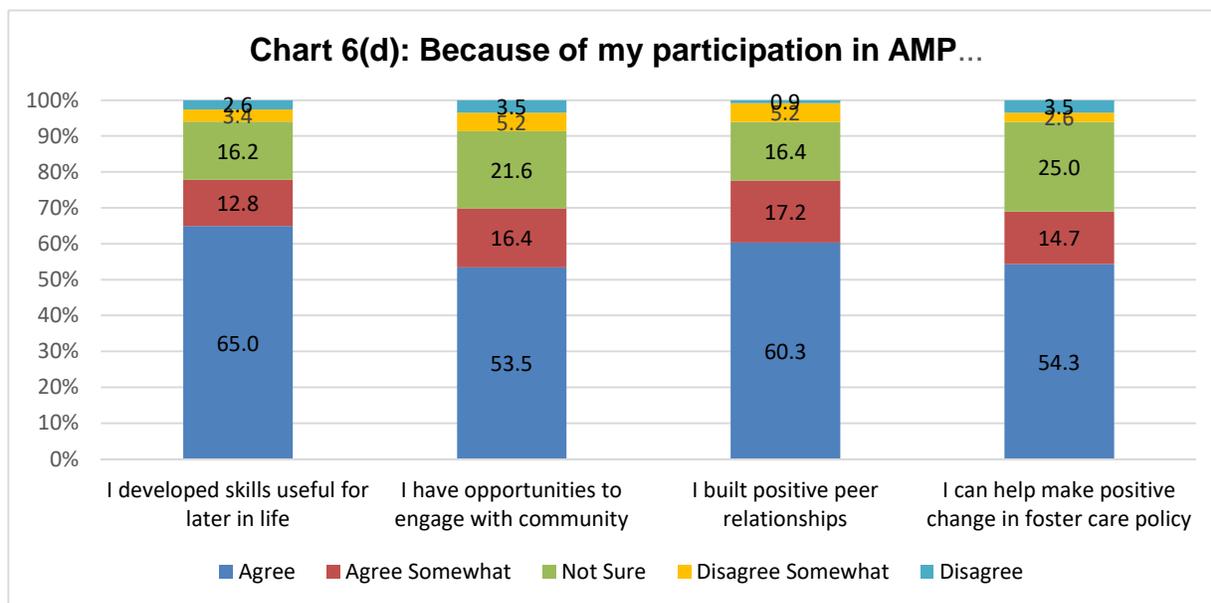


Table is from the AMP Annual Report, created by YPII.

*Describe the state's process for sharing the results of NYTD data collection with families, children, and youth; tribes, courts and other partners; Independent Living coordinators; service providers and the public. Describe how the state, in consultation with youth and other stakeholders, is using these data and any other available data to improve service delivery.*

To more effectively collect data in Iowa, DHS contracted with the Department of Human Rights (DHR) in 2016 to survey youth, track data, and create reports for the NYTD federal requirements. DHS chose the DHR as a partner based on their effective researched-based practices. Through grant projects and oversight of state level coalitions, like the statutorily recognized Iowa Collaboration for Youth Development (ICYD), DHR makes an impact on child welfare and juvenile justice. Thus, DHS believes this intergovernmental contract helps to increase NYTD participation rate and access to data. DHS intends to capitalize on the skills of DHR staff to help DHS and providers use data to improve services. Social media is a powerful tool to engage youth. Iowa NYTD utilizes the social media platforms of Facebook, Twitter, YouTube, and Google to promote the NYTD survey and youth activities. Iowa NYTD's online presence grew since its inception on October 1, 2016.

Since 2017, the contract includes an annual report requirement (to align with the CFSP), so we can use the data for community discussions. The DHS intends the community discussions primarily for youth and Chafee funded providers, but may include others, such as workforce, public health, housing, etc. The intent, of course, is to look at the data together, discuss it, and determine how to use that information to improve programs and services. DHS' goal is to:

- inform stakeholders, including youth who provided the data, that we now have and are using data;
- inform Chafee funded providers that we believe they need to work together to improve transition outcomes; and take what they learned back to their teams.

DHS policy staff hosted the workgroup meetings, comprising transition planning specialists and key providers, such as Iowa College Aid and Iowa Finance Authority, and monitored the workgroup for performance and documentation. The intent of the workgroup was to utilize existing data to improve programming as well as to identify where we have gaps in data. The workgroup examined services that youth receive in care and compared that information to the outcomes of youth at age 17, 19 and 21. DHS staff will broaden the conversation by engaging public health and workforce and more intentionally discussing with AMP youth.

The workgroup successfully identified areas of need, including but not limited to concerning data around homelessness and early pregnancy of aging out youth. Activities such as a pregnancy prevention group hosted by Youth Policy Institute of Iowa, where DHS foster care and ICAPP staff participate, and increased family planning instruction for AMP and Aftercare youth have been a result. Another example, our rent subsidy contractor Iowa Finance Authority is looking into innovative funding and programs. The coordinator stays connected with DHS and Aftercare so that in the next five years we may have more housing options. The FFY 2020-2024 CFSP will address housing with a goal entitled: Increase appropriate housing opportunities for Transitioning Youth.

DHS transition staff and providers used data in 2018 (and will continue to use data) in the following ways:

- Training utilized NYTD data to demonstrate the needs of youth, especially the statistics on homelessness and employment, as a basis for why transition planning is so important for youth.
- TPS used the Maximus transition list to check the status of youth for whom the state applied for SSI, i.e. where the application is in the process and if a decision occurred. This is very important for youth who will need adult services due to ongoing mental or physical health needs.
- TPS regularly use the tracking tool and FACS as a vital part of being able to do their job. It is used to track which youth are placed out of home to ensure timely completion of transition objectives and to ensure the caseworker is aware of what transition supports are available to the individual.

One key example how DHS uses transparent and comprehensive youth data to achieve program goals and inform the community is the Annual Transition Report. The DHS released the report<sup>13</sup> on January 16, 2019 in a webinar, on a Google site<sup>14</sup>, and via email. The DHS and NYTD contractor delivered the information to partners in the DHS and provider community. Youth discussed the report at their AMP meetings. DHS will release another report this year in November. We will host a public discussion with providers, youth and others. DHS also anticipates that part of the discussion will include how to track outcomes and included this as a goal in the new CFSP.

*Provide information on the state's plan to strengthen the collection of high-quality data through NYTD over the next five years.*

DHS will maintain the contract with the DHR to survey youth, track data, and create reports for the NYTD federal requirements. DHS believes this intergovernmental contract will help increase NYTD participation rate, access to data, and intends to capitalize on the skills of DHR staff to help DHS and providers use data to improve services.

The conversations which occurred around the Annual Foster Care to Adulthood in Iowa Report, in person and via email, left DHS feeling our efforts in the previous five years to better use data were worth it. Furthermore, the DHS added another data goal for the new CFSP. Primarily, the new goals will address specific, hard to measure items, such as how many youth get a driver's license.

The NYTD contractor will also continue an innovative project, called the "Talking Wall", mentioned earlier in this section, where young people in residential facilities, shelters, and other foster care settings use "sticky notes" on the wall to express the dreams improvements in their own case or in the system. Please see Attachment 6C – Talking Wall Preliminary Results for more information about this project.

DHS will continue to provide contractors and citizens who request data basic information from NYTD and Results Oriented Management (ROM). ROM is a collation of data for state and federal reporting requirements. ROM has extensive historical records about assessments and children in placement. Data include child welfare outcomes and tend to be more up-to-date than federal sources which can run two years behind.

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<sup>13</sup> Please see Attachment 6B: Foster Care to Adulthood in Iowa, FFY 2018 Report

<sup>14</sup> <https://sites.google.com/a/iowa.gov/national-transition-youth-database-nytd/annual-report/21-year-old-annual-report>

Iowa Aftercare and AMP will continue to be required to submit annual reports, which contribute to federal reports and drive data informed discussions about needed youth services. AMP and Aftercare contracts will continue to include performance measures and associated payments, including but not limited to youth's perceived financial stability, housing stability and connection to trusted adults.

### **Serving Youth Across the State of Iowa**

*Describe how the state has ensured and will continue to ensure that all political subdivisions in the state are served by the Chafee program, though not necessarily in a uniform manner (section 477(b)(2)(B) of the Act).*

Under Iowa's Transition Planning Program, services are available to all youth in foster care who are 14 years of age and older and youth adopted from foster care at age 16 or older. If they exited foster care at age 17 ½ or older, they may be eligible for Iowa Aftercare Services to age 21 or Iowa's postsecondary education and training voucher (ETV) to age 26.

Specifically, the population to be served in SFY 2020-24 includes all of the following:

- (1) Is currently in foster care and is 14 years of age or older.
- (2) Is under the age of 21 and adopted from foster care at 16 years of age or older.
- (3) Is under the age of 21 and in a subsidized guardianship arrangement from foster care at 16 years of age or older.
- (4) Was formerly in foster care and eligible for and participating in Iowa's aftercare services program as described at 441 Iowa Administrative Code (IAC) § 187.
- (5) Was formerly in foster care and eligible for and participating in Iowa's postsecondary ETV program as described at 42 U.S.C. § 677(a)(6-7).

Services are available on a statewide basis.

Iowa ensures, and will continue to ensure, that all political subdivisions implement the Chafee program in a youth driven, but statewide consistent manner, by relying on the network of providers and infrastructure described above to maintain a firm dedication to statewide consistency and flexibility at the case level. This means the state has statewide contracts for services like aftercare, AMP, and ETV so young people in different areas of the state have equitable opportunities, but at the child level, each individual receives youth centered planning, voluntary services, and varied support, depending on their desire and the youth's assessment of life skills.

*Provide relevant data from NYTD or other sources that addresses how services vary by region or county.*

DHS ensures that the Chafee program serves all political subdivisions in the state by having a transition planning specialist (TPS) in each DHS Service Area, designated coverage in the Iowa Aftercare program by county, and AMP councils in every DHS service area. The result is that we glean information from the data specific to each area and are able to provide a familiar level, quality, and quantity of services across the state while maintaining flexibility in response to poor outcomes or other needed changes. We

are also able to see “high points” and hold those better practices up for other service areas to see and emulate.

Iowa selected the CLSA as its life skills assessment. We believe this quality, evidence-informed tool is a good way to view individual strengths and needs of a youth regarding life skills. Moreover, it can open conversations between the caseworker, the youth and their support system, and the care provider.

After the assessment is complete, the case manager works with the youth and their team to develop the transition plan, which lays out goals and action steps for the youth and those who will assist and may occur around the first youth centered planning meeting. Some are formal and others less formal, depending on the family and the needs of the child. The case manager, the youth, and their team review and update the plan with the overall case plan at a minimum of every 6 months. TPS are available to assist in specific transition planning for youth who will most likely have a difficult transition (this could include youth who will need adult disability services, youth who experienced a number of placement disruptions, youth who have substance abuse issues, etc.).

One key example of how DHS uses transparent and comprehensive youth data to achieve program goals and inform the community is the Annual Transition Report. The DHS released it on January 16, 2019 on a webinar, Google site, and via email. The DHS and our NYTD contractor delivered the information to partners in the DHS and provider community.

DHS service areas are responsible to maintain transition committees in accordance with Iowa Code §235.7. Each area maintains two or more local transition committees to address the transition needs of those children receiving child welfare services who are age fourteen or older and have a case permanency plan as defined in Iowa Code §232.2. The DHS adopted rules (441 IAC §202.18) establishing criteria for transition committee membership, operating policies, and basic functions. The rules provide flexibility for a committee to adopt protocols and other procedures appropriate for the geographic area addressed by the committee. Committees review cases no later than the child’s age 17 and 6 months.

The Foster Care to Adulthood in Iowa Annual Report (referenced above) includes NYTD data and other trend data. A TPS may use this data to help guide local transition committee discussions and build local coalitions to improve outcomes. A recent example is pregnancy data in the annual report, which suggests 18% of youth at 17 had an unintended pregnancy and over 25% are parenting upon leaving aftercare. TPS across the state are finding their own way to raise conversations about how we are supporting young people to bring these numbers down, as least comparable to their same aged peers.

On a related note, a small grant from the Annie E. Casey Foundation to the Youth Policy Institute of Iowa (YPII) in June 2017 supported a collaborative effort to increase

our understanding of the reproductive health education, pregnancy, and parenting experiences of young people transitioning from Iowa's foster care system to adulthood. In addition to YPII and DHS, other stakeholders involved in the project include representatives from the Iowa Department of Public Health, Child Welfare Research and Training Academy at Iowa State University, private organizations, and others. Survey data collected from more than 80 young people who aged out of foster care and currently expecting or parenting and two focus groups from that population occurred. The information generated will inform policy, program and practice recommendations to address the high rate of unintended pregnancies and early child-bearing among this population. The project will share research results and recommendations in an upcoming report and will create a resource directory of state programs to leverage in order to improve reproductive health and parenting supports for youth transitioning from foster care to adulthood.

In addition, the DHS prioritized serving current and former foster youth for pregnancy prevention services in a new contract for the administration of the state's Community Adolescent Pregnancy Prevention grants.

### **Serving Youth of Various Ages and Stages of Achieving Independence (section 477(b)(2)(C) of the Act)**

*Describe how youth of various ages and at various stages of achieving independence are to be served. For states that have elected or plan to extend Chafee services to age 23, provide a description of the services offered or to be offered to youth ages 21 – 22 (up through 23rd birthday) and how the expansion of the program will be implemented, including how youth, service providers, and community partners were or will be informed of the change.*

Iowa has not taken the option to extend foster care to 21.

However, in accordance with ACYF-CB-PI-18-06, the Iowa Department of Human Services (DHS) submitted certification of a "comparable" program in our Annual Progress and Services Report, dated June 2018, along with Attachment A, Chafee Assurance, which the federal Children's Bureau approved. DHS also submitted the Chafee Assurance again, as required, as part of this year's submission. DHS contracts for a "comparable" state funded program for former foster care youth up to age 21. Iowa Aftercare Services Program is the primary service we intend to provide for youth age 21 and 22. We are in the process of determining if we have the funds available to start services right away, but we intend to do so in January 2020, if funding allows. DHS has already extended Chafee ETV to age 26, for the 2019-2020 school year. A description of this program extension is in the ETV section of this report.

*Identify any assessments or other tools the state uses to determine the individualized needs of youth and to evaluate young peoples' stage of development and how these assessments inform the provision of services. If the state is in the process of developing or creating new assessments, please provide additional information on this process.*

The DHS believes young people develop at different ages and in different stages. It is for this reason, for teens in foster care of any type, Iowa utilizes the Casey Life Skills Assessment (CLSA), described in this section, and youth centered planning meetings, such as the Youth Transition Decision-Making (YTDM) meetings. A youth driven model ensures young people express their dreams, receive help to engage trusted adults and formal and informal connections, and help to realize their dreams. Social work case managers (SWCMs)/juvenile court officers (JCO)s and TPSs constantly monitor the process. Iowa convenes and conducts reviews of final transition plans, in what we call Local Transition Committees.

As mentioned previously in this section, the DHS has approval to serve youth, who aged out of foster care, up to age 23. DHS contracts for a “comparable” state funded program for former foster care youth up to age 21. Iowa Aftercare Services Program is the primary service we intend to provide for youth age 21 and 22. The DHS is in the process of determining if we have the funds available to start services right away, but we intend to do so in January 2020, if funding allows.

Iowa will limit the newly eligible aftercare population to youth age 21 or 22 who previously participated in the Iowa Aftercare Services Program (at age 18-21). Aftercare rule amendments are in process and the IL coordinator expects approval around the delivery of this report, with an expected publish date of July 10, 2019.

Regarding the preparation for older youth to attend college, it is apparent many youth who we support to attend college are not successful. They attend and seem relatively stable in housing and relationships, but many times are not getting the grades and they are not staying connected to school. It is for this reason, DHS, in partnership with Iowa College Aid, is reframing our efforts. It is not enough to send young people to college. We need to do a better job of providing options for young people that fit their interests and ability. The new CFSP goals will reflect this shift. The ETV section of the FFY 2015-2019 Final Report includes application, entry and participation data.

**Collaboration with Other Private and Public Agencies (section 477(b)(2)(D) of the Act)** *Discuss how the state involves the public and private sectors in helping youth in foster care achieve independence.*

DHS is confident outcomes for transition aged youth will continue to improve. We have found that partnerships with other private and public agencies are necessary for improvement. Below are several examples of partnerships that contributed to achievements.

Education Stability: On December 10, 2015, President Obama signed into law the Every Student Succeeds Act (ESSA). ESSA reauthorizes the Elementary and Secondary Education Act (ESEA), a 1965 federal law governing education last reauthorized as the No Child Left Behind Act in 2002. Among its provisions, the law requires states to ensure protections for vulnerable youth in foster care. These include provisions around child welfare ensuring education stability by partnering with schools

to keep youth in foster care in their school of origin, unless not in the child's best interest.

- Completed 2014-2018:
  - Initiate regional point of contact (POC) calls (2016)
  - Implemented a transportation claiming process (2017)
  - Manual and forms (2017 and ongoing)
  - State and federal reporting (2019)
  - Consider batch data sharing/possible web based tool (pending)
- Planned for the next five years:
  - Ongoing POC calls
  - Refine manual
  - Continue contract for transportation claiming
  - Data sharing periodically between DHS and Iowa Department of Education (DE), in order to ensure proper enrollment and educational supports
  - More outreach to local levels as there is time and interest

Since July 2017, DHS maintains a contract with the DE to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. The Division of Adult, Children, and Family Services (ACFS) wrote the contract with a maximum of \$300,000 per year. It is very expensive to transport children when they are out of their school bussing zone.

Iowa Foster Care Youth Council Contract (AMP): DHS contracts with Youth and Shelter Services, Inc. (YSS) for the Iowa Foster Care Youth Council, known as "Achieving Maximum Potential (AMP)". DHS funds the program with just over \$90,000 federal Chafee dollars and nearly \$320,000 state dollars. Some of the state funds support youth adjudicated delinquent in the state training school for boys. SFY 2018 is the first year of a six-year contract (conditional on annual extensions).

Eight non-profit youth-serving agencies comprise a statewide collaboration known as the Partnership of Iowa Foster Care Youth Councils. For the 2017-2018 contract period, there are fifteen AMP Youth Councils (including a Mobile Council and a Council at the State Training School). The eight partner agencies and the locations of the Councils they support are:

- YSS (Ames, Davenport, Des Moines, Eldora/State Training School (STS), Marshalltown, and Mobile)
- American Home Finding Association (Ottumwa)
- Children's Square USA (Council Bluffs and Sioux City)
- Foundation 2 (Cedar Rapids)
- Four Oaks (Waterloo Council and Iowa City)
- Hillcrest Family Services (Dubuque)
- Youth Shelter Care of North Central Iowa (Fort Dodge)
- Young House (Burlington/Mt. Pleasant)

The Iowa Collaboration for Youth Development (ICYD): Council members are leaders of 12 state entities with the vision that “All Iowa youth will be safe, healthy, successful, and prepared for adulthood.” The ICYD Council oversees the activities of the State of Iowa Youth Advisory Council (SIYAC) and sought input from these youth leaders in the development of more effective policies, practices, programs, and this report. SIYAC consists of youth between 14 to 21 years of age who reside in Iowa, with the purpose to fostering communication with the governor, general assembly, and state and local policymakers regarding programs, policies, and practices affecting youth and families and to advocate on important issues affecting youth.

**Determining Eligibility for Benefits and Services (section 477(b)(2)(E) of the Act)**

*Address how the state uses objective criteria to determine eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.*

DHS maintains one full time employee for each of the five service areas, who are responsible for understanding the programs, policies, and processes for foster care transition. TPS are the go-to people for DHS social work case managers and juvenile court officers who work to ensure youth under their responsibility have all of the supports they need to be successful. Because of the variety of eligibility criterion in the different programs, their working knowledge of the system is invaluable to DHS staff, as well as youth and public and private partners.

Iowa has an electronic tracking system for transition planning activities, to ensure youth age 14 and older in foster care as well as young adult foster care alumni get the support they need and that DHS remains in compliance with all requirements for case planning of transition aged youth. TPS are responsible to record such things as the date when youth over the age of 14 complete the Casey Life Skills Assessment; the date of the Local Transition Committee's approval of the youth's transition plan; and the date the case manager meets with the youth 90 days prior to the youth's 18th birthday. TPS send email reminders to case managers when any required item is due. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14. The intention of these emails is to ensure all youth have a viable plan whether leaving at age 18 or whenever they leave foster care.

The TPS utilize the child welfare information system (FACS) to check eligibility for ETV, Iowa Aftercare, and other services relying upon foster care experience for eligibility. TPS complete application forms, as needed, or direct the case manager of a child in foster care on how to do so.

**Cooperation in National Evaluations (section 477(b)(2)(F) of the Act)**

*Provide a statement that indicates that the state agency will cooperate in any national evaluations of the effects of the programs in achieving the purposes of Chafee.*

The DHS will cooperate in any national evaluations of the effects of the programs in achieving the purposes of Chafee.

DHS reports NYTD data semi-annual and proud to report full no-penalty compliance since implementation.

### **Chafee Training**

*States must provide information on specific training planned for FYs 2020 - 2024 in support of the goals and objectives of the Chafee plan. Chafee training may be incorporated into the training information discussed in the Training Plan for the 2020-2024 CFSP, but should be identified as pertaining to Chafee.*

The distinctively positioned TPS address training needs of staff and foster care providers. Their oversight of Local Transition Committees (LTCs) places them in a unique position to see the training needs of the caseworkers.

The IL coordinator conducts the current training for new workers and includes requirements around the five primary components of transition planning: 1) housing; 2) positive support system; 3) education; 4) employment; and 5) health care and access to health care. TPS share information on all state and federal laws regarding transition planning and requirements including:

- Role of TPS as support to ongoing workers;
- Youth-centered planning;
- Planning inclusive of the five primary components mentioned above;
- Ensuring smooth access for youth who need services and supports from the adult disability system;
- A written transition plan for each youth in foster care age 14 or older;
- Required documents; and
- Services available, including AMP and Iowa Aftercare Services Program.

During the FFY 2015-2019 Child and Family Services Plan (CFSP), the DHS completed a transition webinar, (<http://training.hs.iastate.edu/course/view.php?id=577#section-3>), which remains available for viewing by DHS/JCS, all providers, and to the public. To reach foster and relative care families, training is available using various approaches. In addition to the available webinar described above, the recruitment and retention contractor (RRTS) staff provides training, with some training occurring during foster family support group meetings. TPS continue outreach to providers (foster group care, shelter, supervised apartment living (SAL), and RRTS) to make our training services available.

TPS visit DHS county offices throughout their service area on a periodic basis, some monthly and some less frequently, but always as needed to support the area. They provide formal trainings, attend team meetings, and just “take work and camp out” in order to get some work done while available for questions as needed.

TPS train staff at on-going in-service staff trainings and work with caseworkers throughout their area on an individual basis on difficult cases regarding transition needs. All new social work case managers in Iowa travel to Des Moines for comprehensive training. Each training includes a presentation on all aspects of foster care transition

planning and connects the new workers to the tools and the TPS who will be their resources for transition in the service areas.

The training information discussed in the FFY 2020-2024 CFSP Training Plan incorporates foster care transition training planned for FFYs 2020 – 2024. In addition, several of the Chafee goals for FFY 2020-2024 include specific training and training tool development, all to address Chafee foster care transition requirements and the needs of youth, as indicated by youth voice and our review of NYTD and related data.

**FFY 2020-2024 CFSP Goals, Objectives, and Benchmarks are as follows:**

**Goal 1:** Meet the transition needs of youth in foster care, age 14 and older, for successful transition into adulthood.

**Objective 1.1:** Identify a reliable method to track, monitor, and follow up to ensure that youth age 14 and older in foster care have an individualized transition plan.

**Benchmarks:**

1. Implement and monitor revised transition plan (case permanency plan Part C) in year one, and tweak as needed in year two, resulting in better quality and complete transition plans.
  - a. TPS will train DHS staff at regional meetings by October 1, 2019.
2. Identify methods to track completion of quality transition plans in year one.
3. Identify method to track frequency and type of transition committee meetings in year two.
4. Systematically monitor all transition plans developed and reviewed by the DHS local transition committees no later than year 5.

**Objective 1.2:** Ensure youth aging out of foster care have a driver's license if they want one.

**Benchmarks:**

1. Research how many youth get their driver's license in year one.
2. In year one, use focus groups with youth in foster care to explore desire and need for a driver's license, automobile, public transportation, and related.
3. No later than year two, use focus groups with youth and others to identify barriers to youth driving and driving their own car.
4. Address barriers in years four and five.

**Objective 1.3:** Assist youth in acquiring state identification, birth certificate and social security card.

**Benchmarks:**

1. Identify baseline data elements regarding acquisition of documents (minimally required documents in Iowa Code §232.2) in year one.
2. Provide guidance to case managers on how to help youth acquire documents in year one.
3. No later than year four, institute a strategy to collect data (on each youth age 14 and older and aggregate) regarding acquisition of necessary documents.
4. Monitor accomplishments and resolve deficits in years four and ongoing.

**Objective 1.4:** Create a path to social and developmental opportunities for transition aged youth.

**Benchmarks:**

1. Engage youth to discuss their needs for social and developmental opportunities in year one.
2. Provide case managers serving children age 14 and older with a flier in year two, for use in discussions with youth, which suggests opportunities for positive youth development, including peer to peer opportunities.
3. Provide transition service tools to providers who work with teens in foster care in year two (Family Centered, SAL, RRTS, Foster Parents, etc.). Tools may include training materials and tools they may use in direct service (i.e., ecomap, permanency pact).

**Goal 2:** Increase appropriate housing opportunities for Transitioning Youth.

**Objective 2.1:** Ensure SAL is effectively meeting the needs of transition youth.

**Benchmarks:**

1. Create a workgroup charter in year two, to establish a workgroup to study SAL.
2. Convene the SAL workgroup no later than year three.
3. Stakeholders shall include but not be limited to:
  - a. Youth who have experienced transition programs
  - b. SAL and RRTS service providers
  - c. Homeless program service providers
  - d. State level foster care policy staff
  - e. Adult services
  - f. Iowa Aftercare Services
4. The workgroup will explore items including but not limited to:
  - a. Performance measures.
  - b. Capacity
  - c. Assessment and services
  - d. Appropriateness of referrals
  - e. Alternatives to SAL
5. Approve and implement practicable ideas from the workgroup no later than year five.

**Goal 3:** Utilize NYTD and other existing data to improve service delivery.

**Objective 3.1:** Use data to inform case managers and providers, thereby creating data-driven practice.

**Benchmarks:**

1. Continue annual transition report in years 1-5 as planned and delivered for the CFSP 2015-2019. Representatives from state agencies in the key domain areas will be invited and included in the discussion. DHS will work to align activities across systems (education/DE and College Aid; employment/Iowa Workforce and Job Corps; health/IDPH; housing/IFA, and relationships/RRTS, for example).
2. Formalize and highlight data sharing between DHS, CJJP, and the Iowa Aftercare Services Program in year two.
3. Create and disseminate at least two infographics or educational tidbits in years three and five, which use data to inform and direct services.

**Goal 4:** Improve understanding of and align efforts to address human trafficking.

**Objective 4.1:** Ensure staff and contractors can identify signs of trafficking and refer for appropriate services.

**Benchmarks:**

1. Continue to educate and train staff ongoing about human trafficking and the increase risk to children in foster care and alumni, urging those working with older youth to attend relevant training.
2. TPS will send out training opportunities starting in year one and ongoing.
3. TPS will develop training as needed to complement existing anti-trafficking training, as indicated.

**Goal 5:** Increase career opportunities for transitioning youth.

**Objective 2.1:** Research varied options for employment, education, and career choices which may appeal to youth.

**Benchmarks:**

1. Research the following in year one and two:
  - a. Job Corps
  - b. Military
  - c. Apprenticeships, including but not limited to trade unions
  - d. Direct employment opportunities
  - e. Other educational or employment opportunities
2. In years two through five, distribute written information and create multiple presentations regarding promising opportunities for children in foster care and alumni participating in foster care.

**Education and Training Vouchers (ETV) Program (section 477(i) of the Act)**

*Describe the methods the state uses to operate the ETV program efficiently.*

The DHS partners with the Iowa College Student Aid Commission (Iowa College Aid) to administer the Education and Training Voucher (ETV) program. An intergovernmental contract, administered by DHS, ensures there is one full time Coordinator, employed by Iowa College Aid.

As mentioned above, the ETV program, which utilizes combined state and federal funding to support education attainment of current and former foster care recipients, is monitored as follows:

- Quarterly reports reviewed by DHS
- Annual reviews by DHS
- Performance outcomes (retention)
- Monthly claims approved by DHS
- Referring worker feedback (informal)

Each year Iowa's ETV application is available online beginning in October, to coincide with the early Free Application for Federal Student Aid (FAFSA) release. Students must

submit both a FAFSA and the Iowa Financial Aid Application annually with awards made until depletion of funds. Students renewing their awards prior to March 1st receive priority consideration.

The ETV Coordinator maintains a database to track the number of ETV applicants, to determine and document eligibility, and to track the number of awards, including the award amount. The ETV Coordinator also reviews and updates ETV promotional materials, website, brochures and pamphlets and distributes materials statewide to numerous audiences. Students in Iowa receive information about ETV's existence in a variety of ways and learn to apply early in the application cycle. If the student is an Iowa resident, but attends school out of state, the ETV program will support them financially as any child attending in Iowa.

*Describe the methods the state will use to: (1) ensure that the total amount of educational assistance to a youth under this and any other federal assistance program does not exceed the total cost of attendance (as defined in section 472 of the Higher Education Act of 1965); and (2) to avoid duplication of benefits under this and any other federal or federally assisted benefit program. (sections 477(b)(3)(J) and (i)(5) of the Act)*

Colleges sign a certification form indicating that they will not exceed the cost of attendance for any of the programs administered by Iowa College Aid and receive annual guidance when told who is eligible for the ETV. Along with this, Iowa College Aid periodically audits colleges to ensure they are not awarding students above cost of attendance and are following all other eligibility rules including but not limited to Satisfactory Academic Performance (known as SAPP. Iowa College Aid also ensures awarding of funds in conjunction with all other institutional, state, and federal financial aid and provides guidance to colleges throughout the year.

In order to ensure proper eligibility vetting of applications, Iowa College Aid utilizes a financial aid system called the Iowa College Aid Processing System (ICAPS®). Iowa College Aid staff use this system to collect applications, determine eligibility, monitor continual eligibility, send notifications to applicants and colleges, monitor commitment levels of spending, and make payments to colleges. Upon receipt of applications, the program administrator uses the child welfare information system to determine if an applicant was in an eligible status. These statuses, flagged in ICAPS®, help to determine the number of eligible applications. After eligibility determination, eligible applicants and their colleges receive a system generated notification. Once colleges determine a student is in attendance, they will notify Iowa College Aid, who generates a payment.

*Describe how the program is coordinated with other appropriate education and training programs, including any state tuition waiver program, state scholarship programs, or College Success Programs<sup>15</sup> available in the state at colleges, universities, community colleges, or other post-secondary institutions, if applicable (section 477(i)(6) of the Act).*

Foster care alumni may also qualify for the All Iowa Opportunity Scholarship (AIOS). The State of Iowa funds this scholarship and it is available to students who have financial need and are attending an eligible Iowa college or university within two years of graduating high school. Students who self-identify as a current or formerly in foster care receive first priority for the AIOS. This scholarship is renewable for four years as long as the student maintains continuous enrollment in school.

The Iowa Financial Aid Application is an online electronic tool, which provides all Iowans with an opportunity to apply for scholarships, grants and loan repayment programs offered through the State of Iowa, private funds, and in some cases, the federal government. Our young people and their advocates appreciate that it is a single application that not only determines if a youth might be eligible for ETV or AIOS, but may introduce the young person to funding sources they had not considered. Applicants can transfer information directly from the FAFSA to the Iowa Financial Aid Application making a seamless transition to ease the barrier of multiple applications.

In recent years, the AMP council conferences and Futurefest, a DHS sponsored event centered around transition services, occurred on community college campuses. The ETV Coordinator is available to staff the “ETV table” at the events to educate youth on services and opportunities available. This is an intentional effort to get young people in foster care on campus and familiar with the staff and facilities. Young people have been receptive to this, causing hope that youth who have an experience on a college campus before exiting foster care will be more likely to attend and succeed after exiting foster care.

**Consultation with Tribes (section 477(b)(3)(G))**

*Describe the results of the state’s consultation with Indian tribes as it relates to determining eligibility for Chafee/ETV benefits and services and ensuring fair and equitable treatment for Indian youth in care. Specifically:*

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<sup>15</sup> In general a “College Success Program” is at a post-secondary institution and is specific to youth in foster care or formerly in foster care. These programs offer services such as: additional orientation activities; assistance with financial aid and enrollment services; more intensive technical advising; deliberate faculty-student interaction; more intensive housing assistance; mentoring; summer bridge services; supplemental instruction; social events; and learning communities. The goal of these programs are to facilitate and support young people attending, persisting, and graduating from the institution. (ACYF-CB-PI-19-02, dated February 26, 2019, page 45)

*Describe how each Indian tribe in the state has been consulted about the programs to be carried out under the Chafee.*

The only federally recognized tribe in Iowa, the Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) has a settlement in Tama County, Iowa (northeast part of Iowa). Additionally, there is a concentration of Indian families in northwest Iowa (primarily Woodbury County). All child welfare agencies, including tribal ones, are continuously in the loop concerning the CFCIP purposes and programs funded under CFCIP (including the ETV program). The DHS TPS are the point of contact for CFCIP services and transition process questions.

The Meskwaki Nation has Meskwaki Family Services (MFS) located within the settlement in Tama County. The TPS for the DHS service area in which Tama County is located meets with the MFS staff to train on the new transition planning protocol and provide all transition materials developed as outlined in CFSP Goal 1. The MFS staff is continuously in the loop concerning Iowa's transition planning protocol, practices, and resources for youth still in care and aftercare resources, including the ETV program, for youth who age out of care.

DHS makes efforts to ensure tribal youth receive the same transition program supports as described for all teens in foster care. Tribal children in Iowa foster care typically have a state caseworker (either through DHS or JCS) due to no tribe requesting to develop an agreement to administer, supervise, or oversee the CFCIP, or ETV, program with respect to Indian children.

The TPS in the Cedar Rapids Service area visits with the MFS case manager periodically at the settlement to assist with resource ideas and to help develop transition plans for Meskwaki youth. Case plans for Native youth are also in the transition review meetings.

*Describe the efforts to coordinate the programs with such tribes.*

Native Youth Standing Strong (NYSS) - Native youth in Woodbury County receive encouragement to participate in cultural and recreational activities. NYSS is a collaborative between the Native communities, Sioux City School District, Four Directions Community Center, Juvenile Court Services, DHS, Goodwill Industries, Big Brothers Big Sisters and counseling and support services.

Native youth eligible for CFCIP benefits and supports have their transition plan reviewed beyond court and agency review by a local transition committee prior to turning 17 ½ years of age (or if entering foster care after the age of 17 ½, within 30 days of completion of the transition plan).

*Discuss how the state ensures that benefits and services under the programs are made available to Indian children in the state on the same basis as to other children in the state.*

The Tribal/State Agreement with Meskwaki states DHS is responsible for contracting and payment for foster care and Chafee transition services accessed by Meskwaki children. MFS has all case management responsibilities, which includes activities such as life skills assessments and youth centered meetings. Aftercare services and AMP are available through DHS contracted services.

*Report the Chafee benefits and services currently available and provided for Indian children and youth.*

DHS works with tribal partners to ensure tribal youth have similar opportunities for engagement in transition planning (including assessments and planning activities) and the same array of services provided for non-native teens in foster care/alumni. Tribal children in Iowa foster care typically have a state caseworker (either through DHS or JCS) due to no tribe requesting to develop an agreement to administer, supervise, or oversee the CFCIP program with respect to Indian children.

*Report on whether any tribe requested to develop an agreement to administer, supervise, or oversee the Chafee or an ETV program with respect to eligible Indian children and to receive an appropriate portion of the state's allotment for such administration or supervision. Describe the outcome of that negotiation and provide an explanation if the state and tribe were unable to come to an agreement.*

No tribe requested to develop an agreement to administer, supervise, or oversee the Chafee or an ETV program with respect to eligible Indian children and to receive an appropriate portion of the state's allotment for such administration or supervision.

For more information regarding Iowa's child welfare system collaboration and coordination with tribes, please see *Section V: Consultation and Coordination between States and Tribes* of this report.

## **Section VII: Targeted Plans**

Please see the following attachments for the targeted plans:

- Attachment 7A: Foster and Adoptive Parent Diligent Recruitment Plan
- Attachment 7A(1): Five Year Diligent Recruitment Plan
- Attachment 7B: Health Care Oversight and Coordination Plan, with attachments
- Attachment 7C: Disaster Plan
- Attachments 7D1 and 7D2: Training Plan, with their attachments

## **Section VIII: Financial Information**

Payment Limitations: Title IV-B, Subpart 1

In FFY 2005, Iowa expended \$724,000 under title IV-B, subpart 1, for foster care maintenance. Iowa will allocate the same amount for foster care maintenance in FFY

2020. Iowa did not and does not use title IV-B, subpart 1, funds for child care or adoption assistance payments.

In FFY 2005, Iowa utilized \$241,334 state expenditures, non-federal funds, for foster care maintenance payments as state match for title IV-B, subpart 1. Iowa will apply the same amount of non-federal funds expended for foster care maintenance payments as state match in FFY 2020.

### Payment Limitations: Title IV-B, Subpart 2

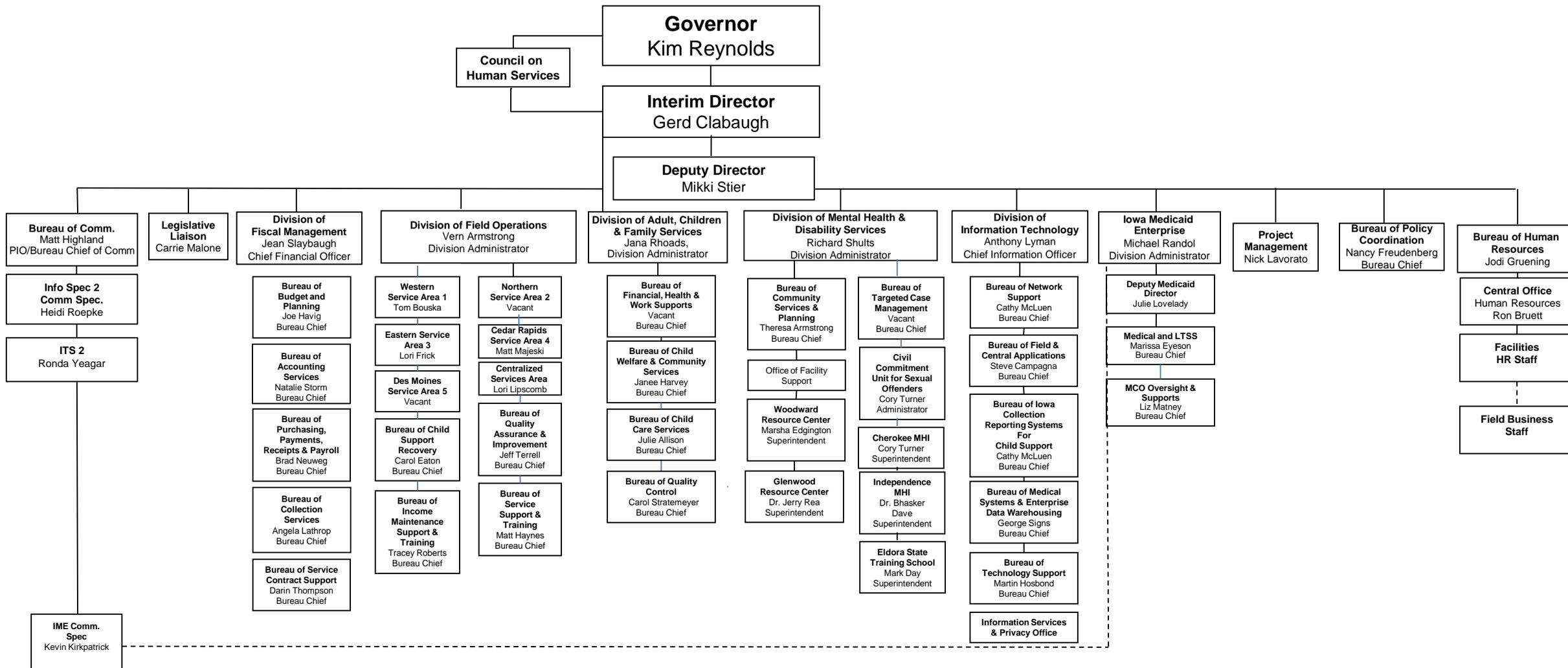
Iowa does not utilize 20% of the PSSF funds for family preservation. Iowa utilizes federal Temporary Assistance for Needy Families (TANF) and Social Services Block Grant (SSBG) as well as state appropriations to fund Iowa’s main family preservation service, Family Safety, Risk and Permanency (FSRP) Services. Iowa secured authorization from the Children’s Bureau Region VII office in 2007 to utilize less than 20% of PSSF funds for family preservation. Iowa utilizes approximately 21% of PSSF funds for the family support category to provide services to prevent child abuse or neglect.

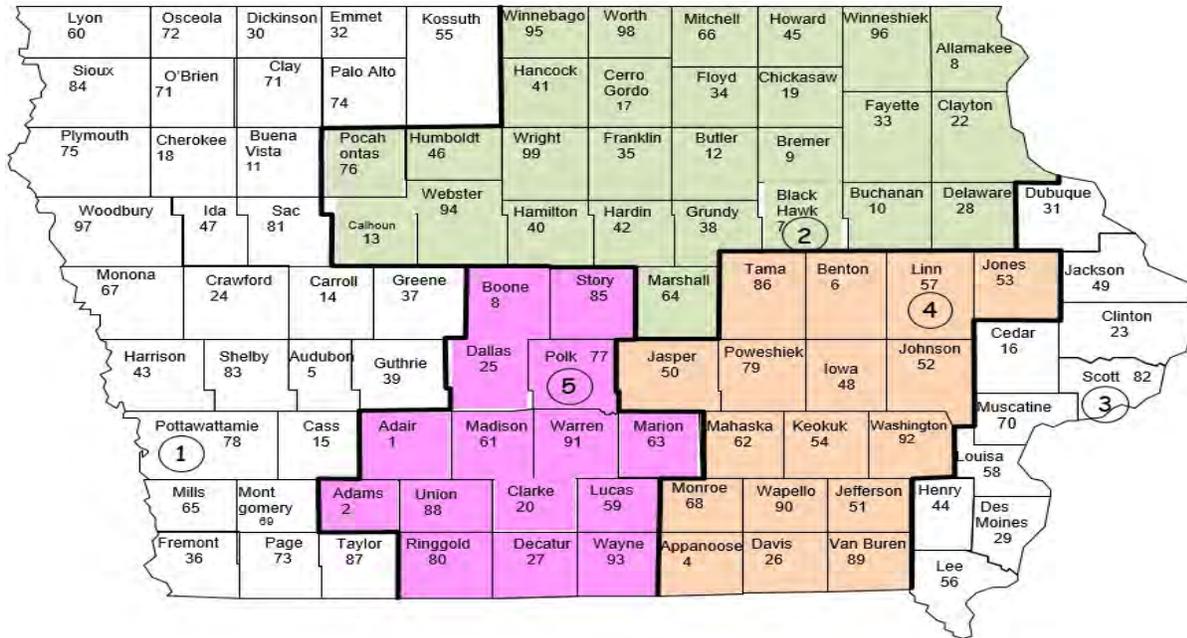
Table 8 below shows financial information comparing FY 2017 state and local share spending for subpart 2 programs against the 1992 base year amount as required to meet the non-supplantation requirements in section 432(a)(7)(A) of the Act.

<b>Table 8: Comparison of FY 2017 State/Local Spending and 1992 Base Year Spending</b>		
<b>Category</b>	<b>FY 2017</b>	<b>FY 1992</b>
<b>Family Preservation</b>	12,908	-
<b>Family Support</b>	538,498	581,841
<b>Family Reunification</b>	611,388	-
<b>Adoption Promotion</b>	530,347	-
<b>Other Service Related Activities</b>	582,411	-
<b>Total Administration</b>	247,456	-
<b>Total</b>	<b>2,523,008</b>	<b>581,841</b>
<b>Source: DHS</b>		

In FY 2007, Iowa began targeting the adoption promotion portion of PSSF funds to provide adoption support services to adoptive families via the statewide Resource and Recruitment contract, which became the Resource, Recruitment, Training and Support of Resource Families (RRTS) contract effective July 1, 2017. Iowa updated the FY 1992 baseline to reflect that change in the use of these funds.

# Iowa Department of Human Services Table of Organization





# FAMILY FIRST

## BLUEPRINT FOR IOWA'S FUTURE CHILD WELFARE SYSTEM

“Family Connections are Always Strengthened and Preserved”

### Principles and Commitments

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



**5. Community-Based.** The team implements service and support strategies that take place in accessible and least restrictive settings possible; and that safely promote child and family integration into home and community life.

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

**6. Culturally Responsive.** The team demonstrates respect for, and builds on the values, preferences, beliefs, culture and identity of, the child/youth and family and their community.

- A. Intentional strategies towards recruiting, hiring, and supporting staff who reflect the culture and life experience of the population served.
- B. Family history, culture, life experiences, and ethnic identities are relevant and important to establishing a trusting and productive relationship.

**7. Strengths Based.** The case plan must identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family by utilizing their community and other team members.

- A. All families and communities have inherent strengths and value.
- B. Leadership will identify opportunities to match worker's strengths and skills with specific family needs.

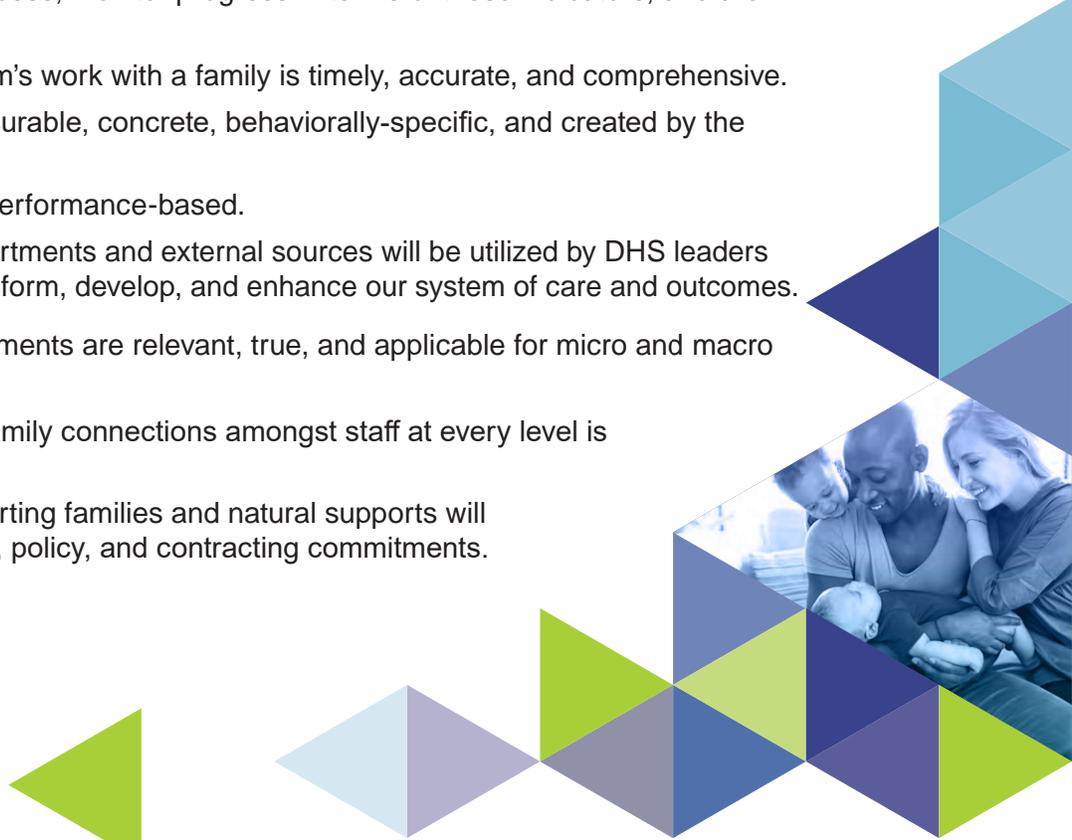
**8. Persistence and Creativity.** Despite challenges, the team persists in strengthening and preserving family connections by considering possibilities outside the status quo.

- A. Treating every family as though they were our own drives practice.
- B. Have the courage to recognize when something isn't working and commit to pursuing alternative solutions.

**9. Outcome Based.** Goals and strategies of the system and case planning are observable, have measurable indicators of success, monitor progress in terms of these indicators, and are revised accordingly.

- A. Documentation of the team's work with a family is timely, accurate, and comprehensive.
- B. Case plan goals are measurable, concrete, behaviorally-specific, and created by the team.
- C. Contracted services are performance-based.
- D. Integrated data from Departments and external sources will be utilized by DHS leaders and service providers to inform, develop, and enhance our system of care and outcomes.

**10. Universal.** Practice commitments are relevant, true, and applicable for micro and macro interactions.

- A. Insisting on the value of family connections amongst staff at every level is critical to success.
  - B. Gaps in the system supporting families and natural supports will be resolved through fiscal, policy, and contracting commitments.
- 

CLERK OF DISTRICT COURT  
2018 JAN 29 AM 11:05  
LINN COUNTY, IOWA

**IN THE JUVENILE COURT OF LINN COUNTY, STATE OF IOWA**

In the interest of:  
A Child(ren) Under 18 Years of Age

**NOTICE OF RIGHT TO BE HEARD**

You are hereby notified that a hearing will be held in the interest of the above named child(ren) on:  
JAN-31-2018 10:00 at the Juvenile Court.

As the provider of the child(ren's) current placement, you are entitled to notice of this hearing and to a right to be heard in this matter, per Iowa Code 232.91(3). You may appear at the hearing at the date and time above stated to provide oral information or you may submit written information which will be distributed to all parties.

**PLEASE NOTE: YOU ARE NOT REQUIRED TO APPEAR UNLESS YOU RECEIVE A SEPARATE SUBPOENA.**

You are not considered a legal party to these proceedings, so you may not be permitted to remain in the courtroom throughout the entire proceeding. You are not entitled to have a lawyer represent you to the Court. Since you are not a party to the case, you cannot cross examine or call witnesses or object. Your role is to provide current information regarding the child in your home. If you present written or oral information, you may be required to testify and be subject to cross-examination. If you choose to attend this hearing, please be sure that the Court, the Guardian Ad Litem or DHS caseworker knows you are present and desire to be heard or present information.

Thank you for taking care of a child or children under the supervision of this Court.

If you require the assistance of auxiliary aids or services to participate in court because of a disability, immediately call your district ADA coordinator at (319) 398-3920 . (If you are hearing impaired, call Relay Iowa TTY at 1-800-735-2942.)

DATED: 01/17/2018

February 15, 2018

## NOTIFICATION OF CASE TO BE REVIEWED

**To:** Name of Foster Parents

**CHILD:** Youth Name

**DATE OF REVIEW:** Wednesday, April 11, 2018

**TIME:** 11:00 - 11:40 AM

**BOARD:** Name of Board

**LOCATION OF REVIEW:**

Name of Location

Address

City, State Zip

The Iowa Citizen Foster Care Review Board will be meeting to review the Case Permanency Plan and to measure progress being made to reach identified goals. You are encouraged to attend and provide information for the Board's consideration. The Board will report its findings and recommendations on this case to the Juvenile Court. Persons notified of Board reviews have the right to representation by counsel at the review.

If you cannot attend in person, please telephone our office (319)362-8057 **at least 3 DAYS BEFORE THE REVIEW DATE** and make a tape recorded statement. The recording will be played at the review on your behalf. If you have any questions please call (712) 213-1021.

Please complete and return the bottom portion of this form to:

Child Advocacy Board  
Mailing Address  
City, State Zip



**CASE TO BE REVIEWED:** Child's Name

**NAME:** Names of Foster Parents or Relative

**RELATIONSHIP:** Placement - Foster Family

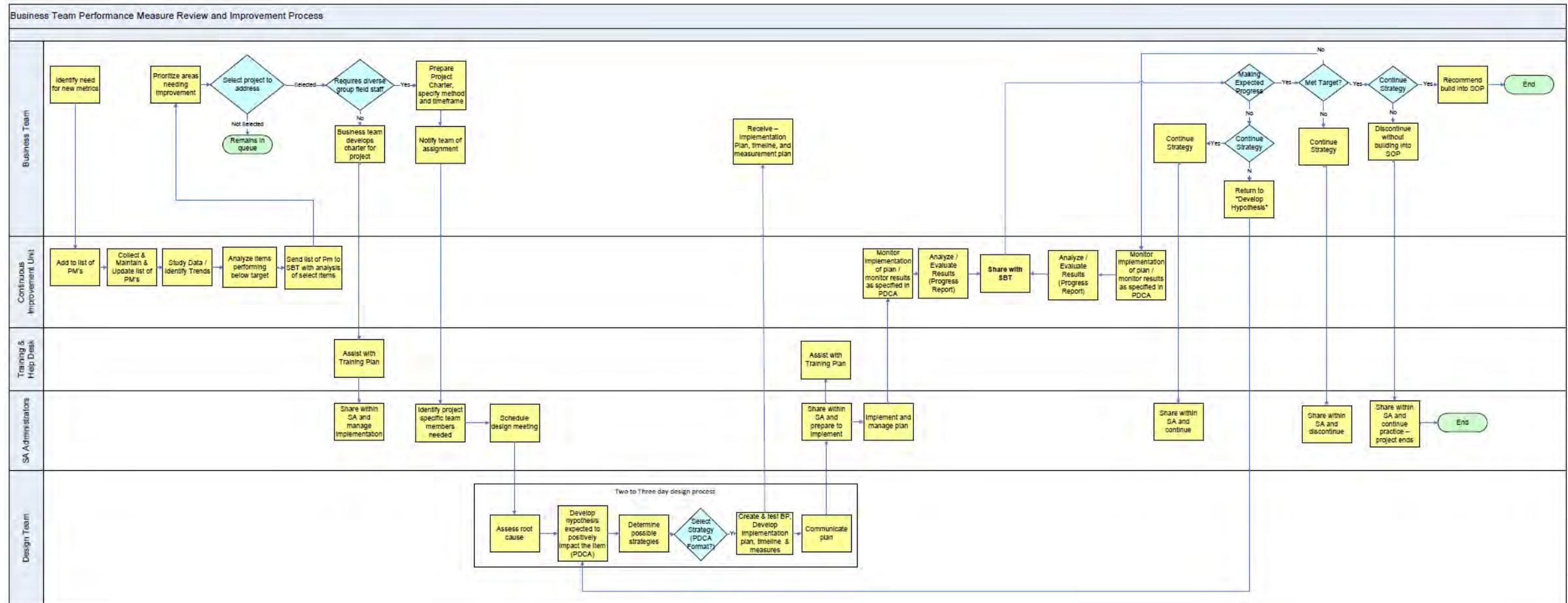
\_\_\_\_\_ I plan to attend the Foster Care Review on Wednesday, April 11, 2018.

\_\_\_\_\_ I do not plan to attend the Foster Care Review on Wednesday, April 11, 2018. I will phone in to record a statement for the Board at (319)362-8057.

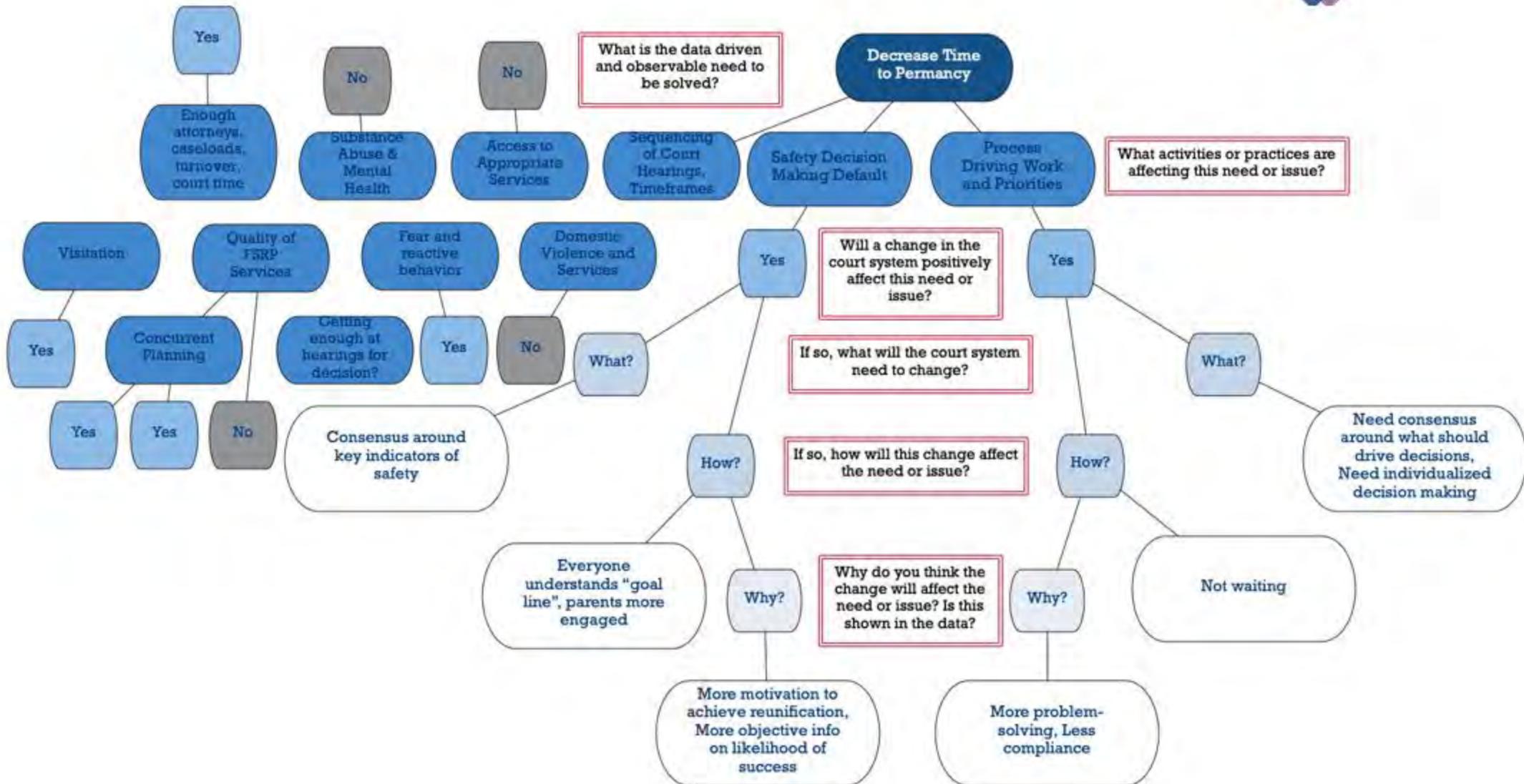
Board Name

**Signature** \_\_\_\_\_

# State of Iowa Performance Monitoring and Improvement Business Process



# Root Cause Analysis: Permanency



**State Name: Iowa**

**Date Strategic Plan Submitted: July 30, 2018**

**Timeframe Covered by Strategic Plan: 2017-2021**

**Overall Goal/Mission of CIP:** To improve the quality and timeliness of juvenile court disposition of abuse, neglect, foster care, and adoption cases and other child welfare matters. This was the original goal established by the Supreme Court of Iowa and remains as the primary goal today

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**Priority Area #1: Quality Legal Representation**

**Project #1:** Develop a Continuous Quality Improvement Process for Quality Representation

**Need Driving Activities & Data Source:** Quality of hearings has been a cornerstone of the work of Iowa Children's Justice. Training for staff on court hearing assessments, team court observations using a common assessment tool and a common format for reporting have been used for several years. Since the initiation of the data dashboard, developed through the funding of the CIP data grant, desk reviews on timeliness, continuances and reasonable efforts are also a routine assessment. A matrix of our assessment plan is attached. The reports developed from these various review processes are provided to the judge(s), Chief Judge and District Court Administrator of the county being reviewed. In addition, judge led District child welfare teams are provided with the reports. ICJ staff provide the results and facilitate a discussion about strengths and areas for improvement. They assist in development of a plan for improvement as appropriate or requested. The assigned staff will continue to work with the county or district if requested, with the goal of ownership of their process.

Inconsistent quality of representation was identified in the first study of the court process at the initiation of the Court Improvement Project grant. Since then, through our court assessments, quality of representation has been raised as a consistent concern for the Iowa Children's Justice Advisory Committee. According to recent Children's Justice Assessment reports, court observations, and feedback, inconsistency in representation remains an issue that leaves some families without adequate advocacy and representation. Some attorneys have met with their clients in between court hearings, represents their interest during the hearing and explain the court results to the parents at its conclusion. Others have not met with their client prior to the hearing, can't reflect accurately what their clients requests are, request continuances that delay permanency and rush off at the end of the hearing without discussion with the client. The luck of the draw in assigning attorneys should not be the determining factor in whether parents and children have quality representation.

Several steps were taken to improve the quality of representation. With involvement in ICJ activities and support from ICJ over the last several years, Iowa law schools have increased classes and clinic opportunities that focus on juvenile and child welfare issues. An ICJ task force co-chaired by the State Public Defender and a judge serving on the juvenile bench developed Standards of Parent Representation that were adopted by the Supreme Court, effective January 2015. These standards included a 3 hour CLE requirement in juvenile training. The taskforce intended that the 3 hour requirement would accomplish the first step to improved quality representation: 1) assure that quality training was available and obtained by

Iowa Children's Justice, Application and Strategic Plan 2017-2021

attorneys who serve in child welfare cases; 2) raise the level of awareness and respect for the practice of child welfare law; 3) and assure compliance with the CAPTA requirements.

While Iowa had taken some steps to improve the consistency of quality representation, the Advisory Committee determined a task force should be established to support continuous improvement toward a quality system of representation for parents and children. Drake University Law School, a member of the Advisory Committee, agreed to lead the task force on Quality of Representation. A co-chair has been identified from the State Public Defender's Office. We continue our task force on multi-year continuous quality improvement of representation, with the focus currently on improving parental representation.

This standing Attorney Committee was established by Iowa Children's Justice: 1) to develop an annual training plan that incorporates training identified by assessments and those identified by practicing attorneys and assuring that all attorneys who want to serve in juvenile court can obtain the requisite hours of juvenile topics; 2) to develop a plan of continuous quality assurance for attorney representation. Over 200 CLE hours of juvenile training was available in 2017 and 65 hours of juvenile training have been provided so far in 2018. Federal CIP funds have been used to offer summer fellowship experiences to support 2L students. The summer fellowship experiences provide students with a stipend. We are offering these fellowships again this summer. With the restoration of the CIP Training Grant, the court will be able to continue to offer training and student fellowships.

The task force is made up of Advisory Committee members and other representatives from the various fields serving in child welfare. Co-chaired by the Director of the Middleton Children's Rights Clinic of Drake University and the Supervisor for the State Public Defender's Council Bluffs office, the group continues to meet regularly. To develop their CQI plan, the task force chose to do an in-depth study that included a review of what other states have done to assure quality, gathered information from developed or adapted surveys for many constituents, including judges, attorneys, state agency, foster parents, parents and contract providers. The task force also requested a contract with the American Bar Association, Center on Children and the Law for assistance in developing a doable CQI process that could be institutionalized.

A new project on improving the quality of representation for incarcerated parents has been started. The Middleton Children's Rights Center at Drake University will serve as the lead for this project. An attorney in private practice will work with the correctional facilities across Iowa to identify technological options to increase opportunities for incarcerated parents to participate in court hearings. Efforts will also be made to identify various ways to increase communication between incarcerated parents and their children. Opportunities will be available for law students to work on this project which will raise the awareness of the specific legal representation needs of this population.

**Measurable Objective:**

- A. Complete and implement a continuous quality improvement plan for quality of representation.
- B. Develop an annual training plan that includes a variety of presentation modalities, including in-person, online on-demand, and webinars.

**Theory of Change:** The theory of change is by elevating the visibility and importance of the quality of representation, being more inclusive of the attorneys serving in juvenile court, encouraging judges to have clear expectations of quality representation in the courtroom, and engaging the State Public Defender in supporting the improvement of representation, we will increase the consistency of quality of representation, thus increase the quality of hearings. Developing a manageable CQI plan has been difficult. Attorneys serving in juvenile court are generally employed by the State Public Defender or through contracts with the private practice attorneys. Although the Iowa State Bar Association has a Juvenile Committee of the Family and Juvenile Section, membership is small. There has not been a centralized organization to support attorneys who serve in juvenile court. While ICJ tried to engage attorneys in the development of the standards, in the development of relevant training, and in development of continuous quality improvement, only a small number of the 600 attorneys were part of any discussion, although they all had an opportunity to complete a survey. The development of the next steps in the 2017-2021 strategic plan will include engagement of judges and attorneys, training, and supports for attorneys who serve in juvenile court to assist in improving the consistency of the quality of representation. Through demonstrating the importance of quality representation to the outcomes of cases, engaging judges in expecting quality representation, and recognizing those attorneys that exemplify quality representation, the committee expects a willingness to develop a manageable CQI process that both acknowledges and highlights quality practice, and looks at improving outcomes for children and families.

2017-2021 Strategic Plan – Quality of Representation

<b>Activity or Project Description</b> <i>Specific actions or project that will be completed to produce specific outputs and demonstrate progress toward the outcome.</i>	<b>Collaborative Partners</b> <i>Responsible parties and partners involved in implementation of the activity.</i>	<b>Anticipated Outputs of Activity</b> <i>What the CIP intends to produce, provide or accomplish through the activity.</i>	<b>Goals of Activity (short and/or Long-term)</b> <i>Where relevant and practical, provide specific, projected change in data the CIP intends to achieve. Goals should be measurable.</i> <b>Progress toward Outcome</b>	<b>Timeframe</b> <i>Proposed completion date or, if appropriate, “ongoing”.</i>	<b>Resources Needed</b> <i>Where relevant identify the resources needed to complete the activity.</i>	<b>Plans for Evaluating Activity</b> <i>Where relevant, how will you measure or monitor change?</i>	<b>Status of Project/ Activity</b>  <i>Completed, Ongoing, Abandoned</i>
<p><b>Project 1 – Develop a Continuous Quality Improvement Process for Quality Representation</b></p>							
<p>1. Continue a multi-disciplinary task force to meet the 2 objectives. Through the use of sub-committees, this task force will develop a CQI Plan, and data elements to inform on the quality of representation.</p>	<p>State Public Defender, Iowa State Bar, DHS, judges, Parent Partners, foster parents, ICJ staff, ICJ Advisory Committee, Youth representative</p>	<p>A Continuous Quality Improvement Plan for representation, with identified data elements, timeframes for review.</p>	<p>Proximal; Engage the judges, State Public Defender, Juvenile Committee of the Bar increase attorneys involvement in CQI                       Develop preliminary CQI plan.                       Medial: Develop a set of data measures and case related</p>	<p>Proximal: February 2019                       February 2019                       Medial:</p>	<p>Funding from the data grant will be used to assess the quality of representation                       Increased attorneys to participate</p>	<p>Data will be gathered on the newly identified data elements.                       Data that is already available will be used to track child outcomes.</p>	<p>Ongoing</p>

Iowa Children’s Justice, Application and Strategic Plan 2017-2021

			<p>outcomes that rely on attorney representation for ongoing CQI.</p> <p>Collect first assessment information.</p> <p>Distal: Institutionalize a CQI process on representation through adoption by the Court.</p>	<p>February 2019</p> <p>Medial: April 2019</p> <p>Distal: Sept. 2021</p>	<p>Participation of Juvenile Committee of Iowa Bar</p> <p>Data on child outcomes from DHS</p> <p>State Public Defender participation</p> <p>Court data</p>	<p>Court assessment data</p> <p>Surveys of parents, children as appropriate, attorneys, judges and other partners.</p>	
<p><b>Activity or Project Description</b></p> <p><i>Specific actions or project that will be completed to produce specific outputs and demonstrate progress toward the outcome.</i></p>	<p><b>Collaborative Partners</b></p> <p><i>Responsible parties and partners involved in implementation of the activity.</i></p>	<p><b>Anticipated Outputs of Activity</b></p> <p><i>What the CIP intends to produce, provide or accomplish through the activity.</i></p>	<p><b>Goals of Activity (short and/or Long-term)</b></p> <p><i>Where relevant and practical, provide specific, projected change in data the CIP intends to achieve. Goals should be measureable.</i></p> <p><b>Progress toward Outcome</b></p>	<p><b>Timeframe</b></p> <p><i>Proposed completion date or, if appropriate, “ongoing”.</i></p>	<p><b>Resources Needed</b></p> <p><i>Where relevant identify the resources needed to complete the activity.</i></p>	<p><b>Plans for Evaluating Activity</b></p> <p><i>Where relevant, how will you measure or monitor change?</i></p>	<p><b>Status of Project/ Activity</b></p> <p><i>Completed, Ongoing, Abandoned</i></p>
<p>2. Develop an annual attorney training plan of juvenile approved CLE that assures adequate opportunities, diversity of formats, entry level to advanced topics that meet CAPTA and the 3 hour training requirement to serve in juvenile court. Training will also be provided on the new federal FFPSA legislation.</p> <p>Committee will continue to meet to monitor quality and adjust for needed topics.</p>	<p>State Public Defender, Iowa State Bar, DHS, judges, Parent Partners, foster parents, ICJ staff, ICJ Advisory Committee, Youth representative</p>	<p>An annual training plan with adequate options to meet the 3 hour requirement.</p> <p>With the restoration of the training grant we will be able to offer 2 regional trainings each year.</p>	<p>Proximal: Develop annual training plan</p> <p>Medial: Establish a training council that develops an annual training .</p> <p>Distal: Annual training plan to assure adequate juvenile related training, including standards of representation, CAPTA</p>	<p>Proximal: November 2018</p> <p>Medial: November 2018</p> <p>Distal: Ongoing</p>	<p>Funding from the CIP training grant will be used to sponsor training</p> <p>Funding from the CIP data grant will be used to monitor case outcomes</p>	<p># of attorneys attending training, baseline and annually</p> <p>Increased attendance in court hearings of parents, children, baseline and annually</p> <p>Increased attendance in court hearings by attorneys</p>	<p>Ongoing</p>

Iowa Children’s Justice, Application and Strategic Plan 2017-2021

						Reduction in continuances	
						Improved permanency timelines.	

<b>Activity or Project Description</b> <i>Specific actions or project that will be completed to produce specific outputs and demonstrate progress toward the outcome.</i>	<b>Collaborative Partners</b> <i>Responsible parties and partners involved in implementation of the activity.</i>	<b>Anticipated Outputs of Activity</b> <i>What the CIP intends to produce, provide or accomplish through the activity.</i>	<b>Goals of Activity (short and/or Long-term)</b> <i>Where relevant and practical, provide specific, projected change in data the CIP intends to achieve. Goals should be measureable.</i> <b>Progress toward Outcome</b>	<b>Timeframe</b> <i>Proposed completion date or, if appropriate, “ongoing”.</i>	<b>Resources Needed</b> <i>Where relevant identify the resources needed to complete the activity.</i>	<b>Plans for Evaluating Activity</b> <i>Where relevant, how will you measure or monitor change?</i>	<b>Status of Project/ Activity</b>  <i>Completed, Ongoing, Abandoned</i>
3. Develop a pilot project with Middleton Children’s Rights Center at the Drake Law School for incarcerated parents	State Public Defender, Private Attorney-Mentor, DHS, judges, Parent Partners, ICJ staff, ICJ Advisory Committee,	Identify key elements of quality legal representation for parents who are incarcerated	Proximal: Provide legal representation for parents who are incarcerated  Medial: Establish a model of practice that better meets the needs of this population  Distal: Provide training on this model of legal representation for incarcerated parents that can be replicated throughout the state	Proximal: September 2017  Medial: February 2019  Distal: Ongoing	We will utilize funding from the CIP data grant to evaluate this pilot.  We will also utilize funding from the CIP training grant to offer training on best practices in representing this population and lessons learned.  Case outcome data	# of attorneys attending training  Increased attendance in court hearings of incarcerated parents either in person or through the use of technology,  Increased communication or visits between incarcerated parents and their children  Improved permanency timelines.	Ongoing



## 1. Introduction

Current data suggest that children are being removed from their homes and placed into foster care at increasing rates. For example, the most recent Adoption and Foster Care Analysis and Reporting System (AFCARS) Report (#24) stated that the number of children in foster care increased by 10,100 between 2015 and 2016, and these youth stayed in foster care for an average of almost two years (Children's Bureau, 2017). Family reunification is a primary goal of the child welfare system (Promoting Safe and Stable Families Act of 1997, 42 U.S.C. § 629 [2003]; U.S. DHHS, 2000; Wulczyn, 2004), though juvenile courts require evidence of parental engagement in the services that are intended to treat the parents' behaviors that lead to the child(ren)'s removal (Berrick, Cohen, & Anthony, 2011), provide a safer home environment for the child(ren), and minimize the risk of the child(ren)'s reentry into the system (D'Andrade, 2015; Wells & Correia, 2012). Though the steps towards reunification are clear, facilitating a change in parents' behaviors can be challenging as evidenced by the fact that successful reunifications only occur in 50% of cases where youth are removed and that this number has not changed in recent decades (Children's Bureau, 2017; Wulczyn, 2004).

For families with removed youth, the process of reunification and behavior change is typically coordinated by a case worker who refers parents to appropriate service providers and, ideally, continues to partner with the families throughout the process. Active partnering between the case worker and the parents has been documented to result in better alignment between the families' needs and formal case planning, which increases family commitment and compliance to the case plan (Nilsen, Affronti, & Coombes, 2009). However, the reality is that child welfare workers are not always able to be a fully engaged partner with their families because of high caseloads (GAO, 2003; Marcenko, Brown, DeVoy, & Conway, 2010), burdensome paperwork (Falk, 2015; Marcenko, et al., 2010), and increased levels of stress and burnout (Anderson, 2000; Mor Barak, Nissly, & Levin, 2001). Many birth parents also find it difficult to trust and relate to their case workers. Indeed, Berrick and colleagues (2011) note a distinct "social distance" between child welfare workers and birth parents that can make interactions feel adversarial. These tensions can result in parents feeling like there is no one who truly understands them or is really "on their side," which can compromise their level of engagement in services and, thus, their likelihood of successful reunification with their child(ren). Additionally, the lack of equality in social and structural power further creates interpersonal separation between workers and the parents they intend to serve (Reich, 2005; Thoits, 2006). Between the increasing number of youth in foster care, low reunification rates, and barriers that case workers face in striving to facilitate families' reunification process, it is evident that unique solutions are needed to assist parents in implementing behavioral changes, providing safe and stable rearing environments, and having previously removed children successfully returned home.

### 1.2. Parent Partner Programs

In an effort to help bridge the gap in trust and equality between workers and parents, improve reunification outcomes for families, and empower the families that workers serve, child welfare agencies across the country have begun implementing parent partner programs (Bohannon, Gonzales, & Summers, 2016; Capacity Building Center for States, 2016; Leake, Longworth-Reed, Williams, & Potter, 2012; Summers, Wood, Russell, & Macgill, 2012). These programs identify parents who were previously involved in the child welfare system due to child protection issues and who overcame interpersonal

obstacles through their own recovery process to achieve reunification with their children. Individuals who meet these criteria are recruited and formally trained to mentor parents that are currently navigating the child welfare system while their children are in foster or kinship care (Cohen & Canan, 2006; Leake et al., 2012; Oates, Lint, Persons, & Reinburn, 2016; Williamson & Gray, 2001). Parent partners work to validate parents' experiences and perspectives while helping to hold parents accountable to making the behavioral changes necessary for reunification (Layzer, Goodson, Bernstein, & Price, 2001). Parent partners serve as role models, demonstrate effective communication, promote self-advocacy, provide individualized support to the parents they are assigned, and often collaborate with or train agency staff on how to more successfully interface with parents (Cohen & Canan, 2006; Frame, Conley, & Berrick, 2006; Leake et al., 2012; Lothridge, McCroskey, Pecora, Chambers, & Fatemi, 2012; Oates et al., 2016; Polinsky, Levine, Pion-Berlin, Torres, & Garibay, 2013). Additionally, parent partners network within communities and collaborate with case workers and providers to meet the needs of families, facilitate trainings and learning opportunities, assist in policy and program development, and change community perceptions about the system of child welfare (Cohen & Canan, 2006). While the specific roles and responsibilities of parent partners can vary across programs (Frame et al., 2010), the overarching goal of effective parent partner programs is to use a peer-mentoring model to actively engage and connect parents with the formal service systems that parents must utilize to achieve successful reunification (Chaffin, Bonner, & Hill, 2001; Cohen & Canan, 2006; Layzer et al., 2001).

While parent partner programs have shown some promise for improving distal outcomes such as increased placement stability, few studies have rigorously examined their effectiveness or have attempted to directly link intervention activities to child welfare-related outcomes (Leake et al., 2012). For example, previous research has demonstrated the positive effects of peer support interventions on increased parent engagement and knowledge (Center for Social Services Research, 2004; Layzer et al., 2001; Summers, Wood, Russell, & Macgill, 2012), expanded social networks (Budde & Schene, 2004), improved family functioning and parenting skills (Layzer et al., 2001), and improved youth functioning (Suter & Bruns, 2009). In a cross-sectional study, Bohannon, Gonzales, and Summers (2016) demonstrated increased engagement and reunification rates for families who participated in a peer-mentoring program compared to families who did not participate. Additionally and via a quasi-experimental study, Berrick and colleagues (2011) found that parents who engaged in a parent partner program evinced higher reunification rates compared to matched controls. Though these emerging findings begin to demonstrate the utility of parent partner programs, further rigorous evaluations of parent partner programs are needed to satisfy the increased emphasis on promoting evidence-based practices to strengthen family functioning (Family First Prevention Services Act, 2018).

The current study aims to extend the body of research evidence on the effectiveness of parent partners who are working with child welfare-involved parents. Data for this study were taken from a large, state-level sample of parents who participated in a parent partner program based on the Iowa Parent Partner Approach. The current study aims to: (a) examine how the program influenced youths' lengths of stay in out-of-home care compared to the children of non-participant parents; (b) test whether children of parents involved in the program were more likely to be discharged from their foster care placement to reunification than the children of non-participant parents; and (c) investigate whether the children of Parent Partner program participants were less likely to be subsequently removed from the home within 12 and 24 months of reunification than the children of non-participant parents.

## 2. Iowa Parent Partner Approach

### 2.1 Program Overview

The Iowa Parent Partner Approach is a model of parent partner programming that seeks to reduce re-abuse rates and increase reunification rates by pairing parents whose children have been removed from the home and are presently receiving child protection services with parents who were formerly involved with the child welfare system due to child protection issues but achieved successful reunification. Parent partners are selected based on their interpersonal skills, success within the child welfare system, and proven abilities to overcome obstacles. Additionally, the program values the participation from individuals with a variety of backgrounds. Iowa parent partners provide support, guidance, motivation, and hope to their parent mentees and work with social workers, legal professionals, community-based organizations, and other professionals to provide resources for the parents they are mentoring. In Iowa, parent partners also share their experiences and offer recommendations through foster/adoptive parent training, new child welfare worker orientation, local and statewide planning/steering committees and conferences, and Community Partnership participation. Lastly, parent partners build trust and bridge connections between the child welfare worker and other professionals with the family (Iowa Department of Human Services, 2018).

How agencies define and implement their parent partner programs can vary greatly in formality and structure as well as what roles and responsibilities they endow upon the parent partners (Frame et al., 2010). The responsibilities of Iowa parent partners include completing required and supplemental training curricula, working intensively to engage parents in case plan activities to increase the likelihood of reunification, providing parental advocacy and support, and collaborating with agency personnel and community partners (Iowa Department of Human Services, 2018). More information about the responsibilities of Iowa Parent Partners and the history of the program can be found at <https://dhs.iowa.gov/parent-partners>.

### 2.2 Program Design

Iowa Parent Partner services are available to any family that has had their child removed from the home with the exception of removals due to sexual abuse perpetrated by the parent or another party in the home. Parents who can only reside with their children under special conditions directed by the courts (i.e. substance abuse treatment or relative care) are able to participate. There is also flexible funding associated with parent partners that can be utilized specially for individualized family needs. The Parent Partner Approach is voluntary and those who decline receive traditional child welfare services.

Families may be referred to the Parent Partner program during the initial assessment, an early Family Team Decision-Making meeting, or at the beginning of case management. Generally speaking, Iowa families with child welfare involvement are informed of the Parent Partner mentoring program and associated services during the removal of their children by their assessment and/or case worker. The case worker then makes a referral to the local parent partner coordinator for that parent. Iowa parent partners are grouped by regional areas, some of which are single counties while others cover multiple counties.

When a family is referred to the program, the local regional parent partner coordinator reviews the basic information provided with the referral and identifies a parent partner that would be a good fit with the family's situation. Parent partner coordinators try to match participants with parent partners who

have had similar experiences and history such as challenges with substance abuse, mental health problems, and domestic violence. The identified parent partner then reaches out to the parent to introduce themselves and offer parent partner services.

Specific criteria to become an Iowa parent partner are established to ensure that future parent partners clearly overcame the issues that initially involved them with DHS Meeting (Iowa Department of Human Services, 2018). These criteria did not automatically designate someone as a parent partner but instead provided a framework for recruiting potential parent partners. Complete information about the criteria to become an Iowa parent partner can be found at <https://dhs.iowa.gov/parent-partners>.

### 3. Present Study

The focus of the current study is to evaluate the extent to which the Iowa Parent Partner program achieved its intended child and family outcomes. Following previous research, the primary outcomes examined in this study are the length of stay in out-of-home care (Cohen & Canan, 2006; Shaw, 2006), family reunification rates (Cohen & Canan, 2006; D'Andrade, 2015), and subsequent removals by 12 and 24 months post-reunification (Needell et al., 2009; Shaw, 2006; Victor, Ryan, Moore, Mowbray, Evangelist, & Perron, 2016; Wells & Correia, 2012). The identified participants for this analysis were the Iowa families that had a child protective services investigation start date between 2011 and 2014 and experienced the removal of a child from the home. The current study aimed to answer the following research questions that are displayed below along with their corresponding hypotheses:

- Research Question 1: Do the children of Parent Partner program participants have reduced lengths of stay in out-of-home care compared to the children of non-participant parents?
  - Hypothesis 1: The children of Parent Partner program participants will have reduced lengths of stay in out-of-home care compared to the children of non-participant parents.
- Research Question 2: Are the children of Parent Partner program participants more likely to be discharged from their foster care placement to reunification (“return home”) than the children of non-participant parents?
  - Hypothesis 2: The children of Parent Partner program participants will be more likely to be discharged from their foster care placement to reunification (“return home”) than the children of non-participant parents.
- Research Question 3a: Are the children of Parent Partner program participants less likely to be subsequently removed from the home within 12 months of reunification than the children of non-participant parents?
  - Hypothesis 3a: The children of Parent Partner program participants will be less likely to be subsequently removed from the home within 12 months of reunification than the children of non-participant parents.
- Research Question 3b: Are the children of Parent Partner program participants less likely to be subsequently removed from the home within 24 months of reunification than the children of non-participant parents?

- Hypothesis 3b: The children of Parent Partner program participants will be less likely to be subsequently removed from the home within 24 months of reunification than the children of non-participant parents.

## **4. Methods and Materials**

### **4.1 Design and Procedure**

The study utilized a quasi-experimental design, defined by Shadish, Cook, and Campbell (2002) as one “in which units are not assigned to conditions randomly” (p. 12) and participants may be assigned to treatment conditions through the process of self-selection (p. 14). Families who participated in the Parent Partner program were matched with non-participant families via propensity score matching in an attempt to closely replicate the effects of randomization (see Stuart & Rubin, 2007). Matching participant and non-participant groups on multiple relevant, observable characteristics has widely been shown to increase confidence in treatment impact in non-experimental settings by significantly reducing selection biases that could confound treatment results (Brand and Halaby, 2006; Dehejia & Wahba, 1999; Dehejia & Wahba, 2002; Heckman, Ichimura, Smith, & Todd, 1996; Heckman, Ichimura, Smith, & Todd, 1998; Heckman, Ichimura, & Todd, 1997; Heckman, Ichimura, & Todd, 1998; LaLonde, 1986; Reynolds and DesJardins, 2007; Rosenbaum & Rubin, 1985; Rubin, 1979; Titus, 2007). This is accomplished by balancing group covariates, sub-classifying the groups, and performing regression adjustments (Caliendo & Kopeinig, 2008; D’Agostino, 1998; Frolich, 2004). The utilization of matching has a rich history in a wide variety of research domains such as economics, job training, higher education, and medicine. Additionally, matching has also been used in child welfare research to address selection bias in studies comparing permanency outcomes among children in kinship and non-kinship foster care (Koh & Testa, 2008), the effects of parent substance abuse services on recurrences of child maltreatment, (Guo, Barth, & Gibbons, 2006), the influence of corporal punishment on children’s behavior (Morris & Gibson, 2011), and the effects of a family group decision making intervention (Weigensberg, Barth, & Guo, 2009). More information on the matching conducted for the current study can be found in section 4.4 below.

### **4.2 Data**

Data for this study were drawn from two sources: The Iowa Department of Human Services Statewide Automated Child Welfare Information System (DHS SACWIS) and the Iowa Parent Partner program database. Data from both sources were included for calendar years 2011, 2012, 2013, and 2014. The Iowa DHS investigation start date determined the date used to identify the date of the case. This study included only those participants enrolled in the program through 2014 as an analysis of the subsequent removal outcome required at least two years of post-intervention data.

### **4.3 Participants**

All families with children involved in the child protective services system and living in service areas where the program was offered had the right to request a referral to the Iowa Parent Partner program and could accept those services on a voluntary basis. The potential pool of subjects included all families with children removed from their home by the Iowa Department of Human Services, Child Protection Services from 2011 through 2014. The families in this study included both single and co-parenting family

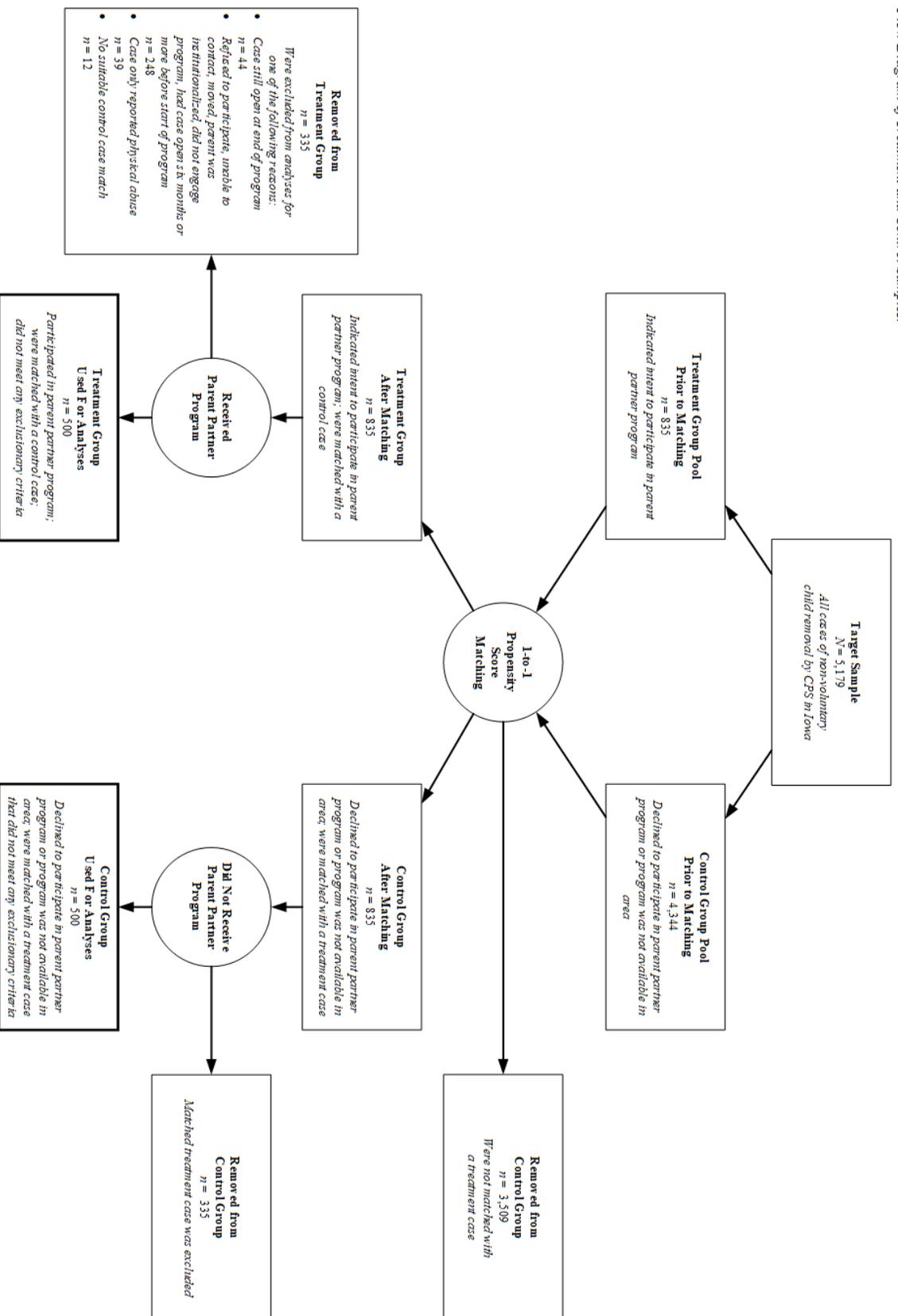
units. Co-parents could be assigned the same parent partner or request to be assigned to different ones. Within any given family in which a removal had occurred, the youngest child was designated the child of interest and was the focus of outcome data collection. The decision to designate the youngest child as the child of interest is supported by demographic data of child victims, which indicate that younger children are often the most vulnerable to maltreatment (Children's Bureau, 2016).

Families who completed a parent partner program intake assessment and began active engagement with the program (defined as participation in at least two Parent Partner service activities) within 60 days of intake were included in this study. A total of 835 parent partner records were identified; 500 parent partner cases were included in analyses and 335 cases with parent partner intakes were excluded from analyses due to evincing one or more of the following exclusionary criteria:

- The DHS foster care placement was still open ( $n = 44$ ).
- The parent refused parent partner services after initial acceptance and entry; the parent was not able to be contacted by the parent partner, moved out of state, or was placed in an institutional situation; the parent participant did not engage with the assigned parent partner; and/or the time between the child's removal from the home and the referral to the Parent Partner program exceeded six months ( $n = 248$ ).
- The reason for removal from the home was only for physical abuse (this was used as an exclusion criteria due to the very low number of cases that included physical abuse as the only allegation) ( $n = 39$ ).
- A suitable matched non-participating family could not be identified ( $n = 12$ ).

The potential non-parent partner pool was composed of 4,344 families who had children involved in the Iowa child protection system during the same time period. The control group consisted of both parents who chose not to participate in the Iowa Parent Partner program and also parents who lived in areas where the program is not offered. From these data, one-to-one matches with the parent partner participating families were drawn for analysis of differences between the matched pairs on the identified outcomes. See Figure 1 for a diagram of the selection choices for treatment and control samples.

**Figure 1.**  
Flow Diagram of Treatment and Control Samples.



Note. Final samples used for analyses are indicated in bolded boxes.

#### 4.4 Matching

The matching technique used to create a comparison group was propensity score matching (PSM). PSM creates a probability that expresses how likely a participant is to be assigned to or to select the treatment condition given certain observed characteristics (Caliendo & Kopeinig, 2008; D’Agostino, 1998; Frolich, 2004; Rosenbaum & Rubin, 1983; Thoemmes & Kim, 2011). Padgett, Salisbury, An, and Pascarella (2010) suggest that PSM methodology is most effective when used “to make a within-study comparison between nonrandomized design estimates adjusted with propensity score methods and results from a randomized experiment” (p. 32). Since a family’s participation in the Parent Partner program was voluntary and random assignment to the program was not an option due to ethical concerns from agency leadership, PSM was used in this evaluation to simulate a random assignment to treatment versus non-treatment conditions. The propensity scoring module within IBM SPSS Statistics Version 23.0 was used to create matched pairs.

Propensity scores were calculated for parent partner families and non-parent partner families based upon the following factors in the Iowa DHS SACWIS dataset: *Child’s Age, Child’s Gender, Child’s Race, Child’s Ethnicity, Prior Removals from the Home, Reason for Removal is Neglect, Reason for Removal is Parental Drug Abuse, Reason for Removal is Parental Alcohol Abuse, Finding of Neglect, Number of Iowa DHS Findings, and Polk County (MSA) vs Balance of State (non Polk)*. These factors were chosen based on: 1) existing research evaluating factors relevant to reunification and permanency rates as potential predictors and confounds, and 2) discussions with the Parent Partner program stakeholders regarding variables of interest and the population served. These factor selections aligned with research emphasizing the importance of selecting a rich set of matching factors based on theory, knowledge of previous research, and information about the organizational setting (Caliendo & Kopeinig, 2008; D’Agostino, 1998; Dehejia, 2005; Luellen et al., 2005; Padgett et al., 2010; Thoemmes & Kim, 2011).

PSM scores were computed for each cohort year in order to ensure that parent partner families with investigation start dates in any given year were matched only with non-parent partner families with investigation start dates in that same year. The data for each cohort year were then combined into a single matched-pair file across years.

Matching algorithms were used to pair parent partner participant cases to non-participant cases. The match algorithm consisted of a match tolerance set to .02 (i.e., the standard deviation of propensity scores was .1476 and 1/4 of the standard deviation of propensity scores for this sample was .0369, following leading recommendations), without replacement (i.e., once a case is used it is no longer available for a subsequent match), with maximum match priority to exact matches, and random selection from multiple eligible matches (Guo & Fraser, 2010; Rosenbaum & Rubin, 1985). The results of the matching process are discussed in section 5.1 below.

#### 4.5 Variables and Analysis

A single data file with matched pairs of participating and non-participating cases combined into a single line of data was created with the four following outcomes of interest:

- *Time in out-of-home Placement* was derived from the Iowa SACWIS data set by calculating the number of days from the “Foster Care Removal Start Date” to the “Foster Care Removal End Date.”

- *Reunification* was based on the Iowa SACWIS data element “Foster Care Discharge Reason.” A binary variable was created from “Foster Care Discharge Reason” indicating whether the case was ended by “Return to Home” or another discharge reason. A successful result for the Parent Partner program was defined in this analysis as a return to the parent from which the removal occurred.
- *Subsequent Removal from Home within 12 and 24 Months* were two binary variables based upon whether another “Foster Care Removal Start Date” occurred after the relevant “Foster Care Removal End Date” and, if so, whether the removal occurred at less than 12 months or less than 24 months. Analysis of subsequent removals includes only those cases in which “Return Home” was the prior foster care discharge location so as to specifically examine how program participation was linked with parents’ ability to avoid subsequent child removals. Future removal of a child from a placement other than their biological parents was not a research question of interest in the current study.

Analyses of the outcomes of interest were conducted using IBM SPSS Statistics Version 23.0. Analysis of *Time in out-of-home Placement* of the matched pairs was done using a paired-sample t-test to evaluate differences in population means. Analyses of *Reunification* and *Subsequent Removals within 12 and 24 Months* were done using the McNemar  $\chi^2$  test. McNemar’s is a statistical test used on paired nominal data and is applied when there is a dichotomous condition (e.g., returned home vs. not returned home, subsequent removal vs. no subsequent removal, etc.) with matched pairs of subjects. The alpha level used for all statistical tests in this study is  $p < .05$ .

## 5. Results

### 5.1 Matching

Results of the matched-pair process using PSM are presented in Table 1, including each of the matching factors used, the descriptive statistic on each factor for the parent partner cases, the matched non-parent partner cases, and the comparison to the overall pool of non-parent partner cases from which the non-parent partner matched pairs were identified.

*Table 1*  
*Comparison of Parent Partner Cases to non-Participant Cases*  
*Quality of the Match on the Identified Matching Factors*

Matching Factor	Parent Partner Cases <i>n</i> = 500	Non-Participant Matched Cases <i>n</i> = 500	Non-Participant Pool <i>n</i> = 3,663
Child Age (mean)	2.1 years <sup>c</sup>	1.8 years <sup>c</sup>	3.8 years <sup>c</sup>
Child Gender (% male)	49.7 %	48.5%	49.6%
Child's Race (% minority)	20.2% <sup>a</sup>	25.7% <sup>a</sup>	19.7%
Child's Race (% white)	79.8% <sup>a</sup>	74.3% <sup>a</sup>	80.3%
Child's Ethnicity (% Hispanic)	9.5%	8.2% <sup>b</sup>	11.7% <sup>b</sup>
Prior Removals (% with at least one)	13.0%	16.0% <sup>b</sup>	12.3% <sup>b</sup>
Reason for Removal includes: Neglect	47.3%	51.5%	50.3%
Reason for Removal includes: Parental Drug Abuse	64.9% <sup>c</sup>	63.2% <sup>c</sup>	55.6% <sup>c</sup>
Reason for Removal includes: Parental Alcohol Abuse	14.6%	16.0%	15.3%
Neglect Findings (% of cases)	90.6%	90.2%	91.0%
Number of DHS Findings (mean)	1.2	1.1	1.2
Polk County Residence <sup>1</sup>	35.9% <sup>c</sup>	35.2% <sup>c</sup>	17.3% <sup>c</sup>

*Note.* a = Significant difference between Parent Partner cases and Non-Participant Matched cases.  
b = Significant difference between Non-Participant Match cases and Non-Participant Pool.  
c = Significant difference between Matched cases (Parent Partner and Non-Participant) with Non-Participant Pool.

The resulting paired matches of participating and non-participating families were not statistically dissimilar across the matched factors with the exception of child minority status. For several factors the matched participating and non-participating cases were more similar to each other than the overall pool from which non-participant cases are drawn, including *Child's Age*, *Reason for Removal includes Parental Drug Abuse*, and *Polk County Residence*. These factors likely reflect meaningful differences in the families and cases that are served by the Parent Partner program in contrast to the universe of Iowa DHS cases during this time period in which a removal occurred.

The distribution of participating parent partner families used in this outcome analysis by cohort year (Iowa DHS Investigation Start Year) is presented in Table 2.

<sup>1</sup> Polk County Iowa is the county with the City of Des Moines and the largest metropolitan area in the state. The highest number of out-of-home placements overall are from Polk County. Matching parent partner cases within Polk County with non-participant cases from Polk County was required to most accurately identify a matching non-participant due to racial/ethnic differences as well as the presence of available parent partners. Use of metropolitan area v. rural area as a matching factor was not as effective in generating as close of matched pairs as was utilizing Polk County v. non Polk County as a matching factor.

*Table 2*  
*Parent Partner Families by Year of Investigation Start*

	Frequency	Percent
2011	69	13.8%
2012	154	30.8%
2013	166	33.2%
2014	111	22.2%
Total	500	100.0%

## 5.2 Findings

### **Research Question 1: Time in out-of-home Placement**

As shown in Table 3, children with a parent who participated in the Parent Partner program experienced an average of 466 days in out-of-home placement; children of matched non-participants experienced an average of 459 days in out-of-home placement. There was no statistically significant difference in the number of days in out-of-home placement when comparing the children of parent partners with the children of non-participants;  $t(499) = .549, p = .58$ . Thus, our first hypothesis was not supported by the data.

*Table 3*  
*Comparison of Parent Partner Cases to non-Participant Cases on Number of Days in out-of-home Placement*

	Mean	<i>n</i>	Standard Deviation
Parent Partner Children	466.3 days	500	206.4 days
Non-Parent Partner Children	458.7 days	500	239.2 days

### **Research Question 2: Reunification with the Parent**

Children with a parent who participated in the Parent Partner program were discharged from foster care to “return home” 62.4% of the time. Matched children with a parent who did not participate in the Parent Partner program were discharged from foster care to “return home” 55.8% of the time. Table 4 summarizes these results.

*Table 4*  
*Comparison of Parent Partner Cases to non-Participant Cases on*  
*Number and Percentage of Discharged Children Who Returned Home*

	Returned Home		Other Discharge Type	
	Number	Percentage	Number	Percentage
Parent Partner Children	312	62.4%	188	37.6%
Non-Parent Partner Children	279	55.8%	221	44.2%

*Note.*  $n = 500$  for Each Group

The percentage of children reunified with their parent differed by parent partner program participation, McNemar  $\chi^2 (1, N = 500) = 4.39, p = .036$ . The children of parent partner program participants were significantly more likely to return home at discharge from their foster care placement than the children of matched non-participants. Thus, our second hypothesis was supported by the data.

### **Research Question 3a: Subsequent Removal from Home within 12 Months**

The analysis of subsequent removal from the home includes only those children who met the following criteria: both the parent partner case and the matched non-parent partner case were closed by DHS and reflect a discharge from foster care to "return home." Only 179 of 500 matched pairs met these criteria; this number is reduced from the 500 cases as only those matched pair cases were used in which both the parent partner case and the non-participating matched pair case were returned home.

Children with a parent who participated in the Parent Partner program were subsequently removed within 12 months of returning home 13.4% of the time. Matched children of non-participants were subsequently removed within 12 months of returning home 21.8% of the time.

*Table 5*  
*Comparison of Parent Partner Cases to non-Participant Cases on*  
*Number and Percentage of Reunified Children Who Were Subsequently Removed within 12 Months*

	NOT Subsequently Removed within 12 Months		Subsequently Removed within 12 Months	
	Number	Percentage	Number	Percentage
Parent Partner Children	155	86.6%	24	13.4%
Non-Parent Partner Children	140	78.2%	39	21.8%

$n=179$  matched pairs for each group

The percentage of children subsequently removed within 12 months of reunification differed by parent partner program participation, McNemar  $\chi^2 (1, N = 179) = 4.00, p = .046$ . Parent partner program participants were significantly less likely to have a subsequent child removal within 12 months of the child returning home than matched non-participants. Thus, our third hypothesis (regarding the 12 month milestone) was supported by the data.

### **Research Question 3b: Subsequent Removal from Home within 24 Months**

Children of a parent who participated in the Parent Partner program were subsequently removed within 24 months of returning home 17.3% of the time. Children of a parent who did not participate in the Parent Partner program were subsequently removed within 24 months of returning home 24.6% of the time. Table 6 presents this comparison. It should be noted that the subsequent removals within 24 months include those cases in which a subsequent removal occurred within the 12 month time period, (e.g. 75% of subsequent removals from the Parent Partner participating families occurred within 12 months of return home).

*Table 6*

*Comparison of Parent Partner Cases to non-Participant Cases on Number and Percentage of Reunified Children Who Were Subsequently Removed within 24 Months*

	<b>NOT Subsequently Removed within 24 Months</b>		<b>Subsequently Removed within 24 Months</b>	
	Number	Percentage	Number	Percentage
Parent Partner Children	148	82.7%	31	17.3%
Non-Parent Partner Children	135	75.4%	44	24.6%

*n* = 179 for Each Group

The percentage of children subsequently removed within 24 months of returning home did not differ by parent partner program participation, McNemar  $\chi^2$  (1, *N* = 179) = 2.71, *p* = .099. Parent partner program participants were not significantly less likely to have a subsequent child removal within 24 months of the child returning home than matched non-participants, though this difference approached the level of statistical significance. Thus, our third hypothesis (regarding the 24-month milestone) was not supported by the data.

## **6. Discussion**

The current study aimed to address gaps in research on the efficacy of parent partner programs in achieving child welfare-related outcomes. The results of this study indicated positive and significant results on two of the four hypothesized outcomes; Parent Partner participants experienced a higher percentage of discharges to return home and a lower percentage of subsequent removals within 12 months of foster care discharge. While there was no statistically significant difference in the subsequent removals within 24 months between participants and non-participants, the 7.3% lower rate of removal among the children of Parent Partner participants is similar to the 8.4% lower rate of removal that we found for the 12 months outcome. These findings demonstrated that families who participated in the Iowa Parent Partner program had higher rates of family reunification and lower rates of subsequent child removals than their matched families who did not participate in the program. Our findings align with past studies that have documented the effectiveness of peer-based supports in the substance abuse and mental health fields (Chinman et. al., 2014; Davidson, 2013; Davidson et. al., 2018; Pfeiffer et. al., 2011) and add to the growing body of literature on the effects of parent partner programs among

children and families with child welfare involvement (Berrick et. al., 2011; Bohannon et. al., 2016; Budde & Schene, 2004; Layzer et al., 2001; Summers et. al., 2012; Suter & Bruns, 2009).

### **6.1 Research Question 1: Parent Partner Programs and Time in out-of-home Placement**

The results of the current study did not find an impact of the parent partner program on the length of stay in out-of-home placement. One explanation for this finding is that, although parent partners can provide input to the court indirectly through the assigned child welfare worker on these matters, they have minimal influence over judges who are bound by federal regulations and, ultimately, have discretion and decision-making authority in determining when a child returns home (Noonan, Sabel, & Simon, 2009). It should also be noted that substance abuse recovery is often a key variable in the court's determination of a child's length of stay in out-of-home care (Semidei, Radel, & Nolan, 2001). Previous research indicates that parents involved in peer mentoring programs are more engaged in their case plan than similar parents who are not involved in such programs (Bohannon et. al., 2016; Summers, et. al., 2012). Thus, it is possible that judges who are privy to parent partner program involvement and believe that the parent is making positive changes may choose to leave a child in placement for a longer period of time to ensure safety and demonstrate consistency with decisions involving similar non-parent partner cases. Additionally, the lack of an effect on length of stay in out-of-home care should be considered in the broader context of the system of care as other results of this study demonstrate a significant increase in reunification rates and decreased rates of short-term reentry into the system when a parent partner provides support to the family. Future research should examine how specific case details (such as substance abuse as the reason for removal) and court dynamics impact the effects of parent partner involvement on case outcomes.

### **6.2 Research Question 2: Parent Partner Programs and Reunification Rates**

The results of the current study demonstrate that children of Iowa Parent Partner Program participants were significantly more likely to return home at discharge from their foster care placement than were children of matched non-participants. These results align with previous findings that parent partner program participants achieve higher reunification rates than do participants who do not participate (Berrick, et al., 2011; Bohannon, et al., 2016). Past research suggests that parents may experience a greater sense of motivation when exposed to others who have successfully navigated the system, and this motivation may contribute to a faster reunification (Young & Gardner, 2002). A key component to the success of these types of support models is the shared experiences between parent partners and program participants. Berrick and colleagues (2011) note a distinct "social distance" between child welfare workers and birth parents that can make interactions feel adversarial. These tensions can result in parents feeling like there is no one who truly understands them or who is really on their side, which can compromise their level of engagement in services and, thus, their likelihood of successful reunification. Having these shared experiences allows parent partners to provide a different perspective from the professional approach, which is often directive and focused on intervention compliance, and can serve to engage parents more effectively in their recovery process. The majority of parents who have had their children removed by the child protection system face a variety of challenges, including substance abuse, mental health problems, and domestic violence (Semidei, Radel, & Nolan, 2001), which many parent partners have personally overcome. Cohen and Canan (2006) suggest that "the individual's perception that the helper has had similar experiences allows the helper's suggestions and behavior to

become more acceptable to the individual than those of others - such as child welfare professionals - who may be perceived as different in experiences, situation, social status, or authority role” (p. 875). Other scholars echo the benefits of parent partners being able to engage with families in a more informal manner (Anthony, Berrick, Cohen, and Wilder, 2009) and with a mutual understanding about shared experiences in the child welfare system (Ireys, Devet, & Sawka, 2002; Leake et al., 2012). The focus of this peer support is to build resilience, overcome barriers to reunification, and promote a healthy and nurturing environment for children and families. Many of these families have a multitude of complex issues to address and, due to federal regulations, substantial behavioral changes need to be made in a relatively short period of time. Future research is needed to examine how working with families on a longer term basis to create valuable and trusting relationships (such as through extending the program to allow for peer mentoring services beyond case closure) may contribute to an overall increase in successful reunifications.

### **6.3 Research Questions 3a & 3b: Parent Partner Programs and Subsequent Removals**

The results of the current study indicate that participants in the Iowa Parent Partner program were significantly less likely to have a subsequent child removal within 12 months of the child returning home compared to matched non-participants, but this same effect was not found within 24 months of the child returning home. This suggests that the program may have short term impacts on the reentry into the system but that these impacts are not fully sustained in the long term. Substance use recovery timelines may provide one possible explanation for these findings as recent data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) indicates that 36% of the children who were removed from their home in the 2017 fiscal year - approximately 96,700 children - were removed because at least one parent had a substance abuse issue (Children’s Bureau, 2017). Moreover, parents who struggle with substance abuse and dependence are at an increased risk of having their children re-enter the child welfare system (Ryan, Victor, Moore, Mowbray, & Perron, 2016). It is often the case that once the initial success of reunification is achieved and the case is closed, the services that had yielded these outcomes (e.g. drug treatment, parenting classes, peer support programs, etc.) are discontinued. This may put children at increased risk for future out-of-home placement because the road to long-term recovery is not linear; in fact, the recovery process is arduous and often involves relapse (Bosk, Van Alst, & Van Skoyoc, 2017). Additionally, mental health issues often co-occur with substance abuse (National Institute on Drug Abuse, 2018), which could result in similar setbacks around maintaining stability and addressing risk and safety concerns, increasing the need for an out-of-home placement. Future research should explore how case complexities such as parental substance abuse and mental health issues impact recidivism and the resulting reentry of children into the system. Future research should also evaluate peer mentoring programs that allow parent partners to remain with the family after the case is closed. It is possible that by increasing the length of parent partner support provision, families dealing with substance use and/or mental health issues could strengthen their recovery and reduce rates of reentry for longer periods of time.

### **6.4 Limitations**

The findings of this study provide supportive evidence of the impact of the Iowa Parent Partner program, though there are some limitations to the current study including non-random assignment and lack of statewide implementation in some years of data collection. First, random assignment of Parent

Partner participants was not feasible, necessitating a quasi-experimental design. According to Luellen, Shadish, and Clark (2005), the major disadvantage to using quasi-experimental designs is that key differences between the participant and participant groups that existed during the selection process can be misinterpreted as treatment effects (p. 531). To mitigate the risk of detecting selection effects and incorrectly interpreting them as treatment effects, propensity score matching was used in this study to closely simulate a true experimental model in which participation in the intervention is determined by random assignment. The success of this method is highly dependent upon the accurate selection of factors that potentially influence both the outcomes themselves and the individual's decision to participate in a voluntary program (Smith & Todd, 2003). To the extent that the factors that influenced a parent's choice to participate in the Parent Partner program are reflected in the matching factors, there is a higher level of confidence in the results. Other threats to validity of the current findings include that the differences found between treatment and control groups are related to the choice to participate and engage in the Parent Partner program and/or that the differences found are related to unobserved factors that influence the outcomes (see Dehejia & Wahba, 1999). Although PSM produces equivalent comparison groups on the observed factors, an experimental design with random selection would produce equivalent groups on both observed and unobserved factors. While the current findings are grounded in a unique sample and are consistent with emerging evidence on the effectiveness of parent partner programs, some caution is advised when interpreting the results until future studies that utilize randomized designs are conducted.

It should also be noted that during the course of the study period different parts of the state were in various stages of implementing the Parent Partner Program; thus, some areas had several years of program implementation experience while other areas of the state had begun implementation more recently. Our analyses included data from 2011 when the program was not yet fully statewide in coverage through the transition of the Parent Partner program to a statewide contracted implementation in 2013 and beyond. This variability in implementation also has implications for our decision to exclude cases that were still open ( $n = 44$ ; 5.27% of eligible treatment group after matching); these exclusions were made to ensure our data matched the federal guidelines for reunification milestones (i.e., 12 and 24 months). It is important to note that due to the various stages of Parent Partner Program implementation throughout the state while evaluation work was being conducted, the current analyses inevitably included parents who were substantively similar to those who did not finish the program by the end of the evaluation period and were excluded from analyses ( $n = 44$ ). Potential variations in implementation fidelity in different parts of the state and over time may also have contributed to variations in the effectiveness of the Parent Partner program. Case-level data on differences in service provision, program fidelity, and parental engagement in all facets of programming were not included in this study. While the fidelity measures used by the agency did indicate high levels of fidelity, these measures were preliminary. Future studies should examine these child outcomes in relation to program fidelity as fidelity is a key element in being able to identify a program as evidence-informed and evidenced-based (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Polinsky et al., 2013). Additionally, studies should carefully examine how differences in service provision and parental engagement influence treatment outcomes. Finally, due to the nature of the evaluation design that was driven by 1) the funding agency's needs and 2) the programmatic and practical limitations of a state level evaluation effort, we were unable to examine the effects of other potentially influential variables on program outcomes. We encourage future researchers to examine the effects that family structure,

parental willingness to participate in peer mentoring programs, and other important factors have on parent partner program outcomes.

In light of the limitations of the current study, several unique study strengths bear mentioning. First, the current study utilized a large sample of state-level data. Few studies are able to secure a sample of child welfare-involved families of this size. Second, the treatment group was compared to a control sample that was created via propensity score matching. Despite this method being less rigorous than a randomized controlled trial (which was not possible for this study due to agency ethical concerns), treatment findings based on matched samples are much more reliable than lesser methods of detecting treatment effects (e.g., simply comparing treatment recipients to treatment non-recipients; Guo & Fraser, 2010; Rosenbaum & Rubin, 1985). Lastly, the current results add to a rather limited area of research. Much more research is needed to understand the effects of parent partner programs and the mechanisms through which effects are achieved, and these results serve as a starting point for future studies and prompt additional research questions that need answering.

## **6.5 Conclusion**

This study of the Iowa Parent Partner program provides preliminary evidence that these types of peer-mentoring programs can increase the chance of family reunification and decrease the likelihood of foster care re-entry. The findings suggest that – when parent partners support program participants in making authentic and positive life changes – successful reunification becomes more easily achieved. If treatment impacts can be sustained, instances of recidivism that result in a child’s reentry into the system should respectively decrease. When subsequent reports do occur, we anticipate that the improved condition of the family environment could shorten the child’s length of stay in their out-of-home placement. We also anticipate that parents who encounter challenges following their experience with a peer-based model of support will be more likely to utilize healthy avenues of both formal and informal supports to overcome challenges. We recommend that future studies rigorously evaluate parent partner programs, ideally using an experimental design in which families are randomly assigned to receive these services, and examine potential treatment mechanisms. Additionally, an emphasis on fidelity monitoring and sustained practice effects will be essential in continuing to establish parent partner programs as an evidence-based practice in child welfare (“Overview of the CEBC scientific rating scale,” 2016). Finally, future research should examine the impacts of case complexities, such as parental substance use and mental health issues, on parent partner program outcomes. In addition to the growing evidentiary support for parent partner programs, agencies considering the implementation of a parent partner program should make use of available resources on funding models, recruitment strategies, policy guidelines, and common challenges with implementation (Capacity Building Center for States, 2016; Cohen & Canan, 2006; Leake et al., 2012; Marcenko, et al., 2010).

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## Community Partnership Reporting / Evaluation Form

Name of CPPC Site:

County(ies):

Reporting Period:

Coordinator(s):

Contact Information:

Check the Following: Proposed Plan  Year-End

Community Partnership Reporting is based not only on the 4 strategies of Community Partnerships (Shared Decision Making, Neighborhood and Community Networking, Individualized Course of Action, and Policy and Practice Change) but also on the levels within each strategy. If you find yourself questioning how to complete this report, the CPPC Practice Guide should answer many of your questions both in planning and in capturing successes at year end.

CPPC funding runs on the state fiscal calendar July 1 - June 30. There will be two times reporting is due:

- 1) In the **SPRING** (May 15) where the **yellow** section will be completed to capture your proposed planning and projected goals for the upcoming fiscal year starting July 1. (Report with projected/future activities) The yellow section will be completed on a new report identifying your future goals.
- 2) In the **SUMMER** (August 15) where the **green** section will be completed to capture the goals achieved for the fiscal year that ended June 30. (Summary report with completed activities) The green section will be completed on a report that already has the yellow filled out and was submitted May 15 the prior year.

Starting on page 5, the blank columns entitled Ongoing, Proposed, Met need only be marked with an 'x', and the narrative should reflect any steps you are taking or have achieved. This is an active document utilized with your Shared Decision Making Team to give them investment/ownership in planning, allow them to share in the monitoring of progress, and recognize and celebrate successes. Whereas this report may appear long and prescriptive, it provides only a framework for growth and activity. This framework and reporting mechanism was developed with the input of many different coordinators from the start of CPPC in 2007. How you choose to grow and what activities you choose to promote growth have much flexibility.

The data from this report is captured in the Community Partnerships Brochures so communities may see how CPPC impacts the state in many ways. This data is also shared with the federal government and highlights the progressive nature of community initiatives in the state of Iowa. Thank you for your time and careful attention to this document.

## Community Partnership Involvement Instructions & Definitions

Page 3 is to identify during planning and at year-end the composition and roles of individuals who are involved. Below are some helpful hints to assist you. Page 3 should be completed in **planning** and updated at **year end**.

- In the gray columns put the number of professional and the number of community members who are associated with the respective category.
- In the FTDM (ICA), Shared Decision-Making, Neighborhood Networking and Policy and Practice Change columns put a check mark if there are professionals and/or community members participating in these activities.
- Please do not duplicate numbers. Select one primary category for each person. The comment section may be useful to explain when more than one category applies to one person. If a person represents two or more categories, include the person in the number count of the primary role and check mark the gray column for the other categories and explain in the comment section.
- # of Community members involved – This number count is for those who are involved as volunteer community members and are associated with one of the categories listed. Examples: faith-based members can be volunteers if they are not being paid to attend, professional who volunteers but is not serving/participating as a representative in their official/professional capacity, substance abuse sponsor who is not being paid, volunteer advocate for domestic violence.
- # of Neighborhood/Community Members – these are individuals who are neighborhood/community residents or parents and are not associated with any of the other categories.
- FTDM (ICA) - those who are facilitators conducting FTDM defined by Iowa's Standards.
- Shared Decision Making - those who are involved on the CPPC leadership committee(s).
- Practice Partners - includes social service agencies that do not fall under another category (i.e. in-home workers, early childhood programs, when applicable).
- Economic Supports - includes social service agencies that provide financial and basic-need supports (FaDSS's workers, Income Maintenance, Community Action Agency when applicable).
- Former Clients of DHS-anyone who has been involved in child protection services and is not a Parent Partner.
- Provide a total count and % for both the professional and community members involved.

## Community Partnership Involvement

Partner (Categories)	# of professionals involved*	FTDM (ICA)*	Shared Decision Making *	Neighborhood Networking *	Policy and * Practice	# of Comm. members involved*	FTDM (ICA) *	Shared Decision-Making *	Neighborhood Networking *	Policy and * Practice Change	Comments/Member Names
DHS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Decat		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ECI		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neighborhood/Comm. Members*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Domestic Violence		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Faith-based groups		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Education		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Business		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legal System (Court)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Law Enforcement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Government (i.e. City, Co.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Practice Partners*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Economic Supports*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prevention Councils		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Youth		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Former Clients of DHS*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parent Partners		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total											

<b>Total % of Professionals involved in the initiative</b>	<b>Total % of Community members Involved in the initiative</b>
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Describe your community partnership shared decision-making leadership group and oversight role. Who coordinates? How is it structured? How is it linked to Decat? Are there task teams or subcommittees?

How often does this group meet?

The remainder of the report includes the 3 blank columns:

- **No color-labeled 'Ongoing'** - for things you have accomplished in the past and continue to do
- **Yellow color-labeled 'Proposed (NEW)'** - for new goals you are working towards
- **Green color-labeled 'Met'** - the year-end information on success and/or barriers faced

The 4<sup>th</sup> column allows for narrative on the columns described.

Note: The **Ongoing category** is to be briefly detailed in narrative in the 4<sup>th</sup> column to explain routine and/or steps taken to meet this goal ongoing. The coordinator must be able to explain Ongoing steps to the SDM team and state/federal entities if audited, and may use the narrative in this report to track current processes, plans, accomplished goals and implementation.

## Shared Decision Making-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
1-a	New CPPC Coordinator attends first available CPPC Immersion 101 and 201 within the 1st year				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-b	Membership of Shared Decision Making Team must include Department of Human Services (DHS) Representative and Decategorization (Decat) Representative				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-c	Membership of Shared Decision Making Team must include local community and professional members				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-d	Establish linkages and develop protocol for decision-making with Decat Boards				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-e	Implement the use of the Shared Decision-Making Survey				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Shared Decision Making-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
1-f	Develop plan for Ongoing comprehensive understanding of the four strategies for individuals involved in Shared Decision Making process				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-g	Establish and develop plan to meet membership recruitment goals for SDM, including diversity				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-h	Provide oversight for the planning and implementation of the four CPPC strategies				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-i	Develop orientation plan for new members				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Shared Decision Making-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
2-a	<b>Must meet all of the Level 1 items and also</b> add additional members and 1 of those members needs to be one of the following: domestic violence, substance abuse, or mental health partner				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
2-b	Implement plan for Ongoing comprehensive understanding of all four strategies				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
2-c	Implement orientation plan for all new members				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
2-d	Conduct Parent Partner orientation for all Shared Decision Making Team members				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
2-e	Share information and progress of the local Parent Partner program regularly				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
2-f	A Parent Partner is added to the membership of the SDM Team				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>

## Shared Decision Making-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
2-g	Membership recruitment plans that address diversity according to the demographics of your community				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
2-h	Review and report on diversity and disparity in the community and within the local Child Welfare system				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
2-i	Host a CPPC Immersion 101 event in CPPC area at least once every three years				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
2-j	Identify and meet goal for adding additional community members (this number can be reviewed and re-established each year)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

### Shared Decision Making-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
3-a	<p><b>Must meet all Level 1 and 2 items</b> and also have two of the following members: domestic violence, substance abuse and mental health partners</p>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
3-b	<p>Have a broad representative of at least five (5) of the following members: Faith-Based Groups, Health Care, Education, Business, Legal System (courts), Law Enforcement, Government (County or City), Economic Supports, Practice Partners and Prevention Councils (See CPPC reporting and evaluation form for definition)</p>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
3-c	<p>SDM develop avenue for youth voice (youth in foster care or foster care alumni)</p>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
3-d	<p>Develop linkages and partnerships with other groups into SDM team</p>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>

### Shared Decision Making-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
3-e	SDM membership diversity is representative of the local population				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
3-f	Role of the SDM group expands to include identifying, and developing a plan to meet unmet needs within the community				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
3-g	Develop and implement a plan to host a Race: Power of an Illusion in CPPC area (and/or related training opportunity, such as Understanding Implicit Racial Bias training or utilization of the Courageous Conversations Toolkit)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
3-h	Shared decision making survey scores used as a tool to guide quality improvement of strategy implementation				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
3-i	SDM goals for community members are met (see CPPC Community Involvement and Instructions for definition, page 2)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Shared Decision Making-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-a	Must meet all Level 1, 2 and 3 items and also have all three of the following members: domestic violence, substance abuse and mental health partners				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-b	Have ongoing implementation of new member orientation				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-c	SDM recruitment goal for Community Members must have been exceeded by 10%				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-d	Have 100% of the representation identified in the list in Level 3				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-e	Community representatives take a leadership SDM role as defined by the site				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Shared Decision Making-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-f	Role of SDM group expands to include advocacy for CPPC's goals with funders and policy-makers (legislators, governor, boards of supervisors, city council members, mayor, etc.)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-g	SDM group implements plan and successfully addresses unmet needs within the community				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-h	Coordinator and/or member of SDM contributes to state and/or regional events/activities. (I.e. serve on planning committees, assisting with logistics, presenting, etc.)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

**At the writing of this proposed report, select the level\* for Shared Decision Making that best fits your site:**

**Based on your completed activities, select the level\* for Shared Decision Making that best fits your site:**

**\*For more detailed information on the levels, please see the CPPC Practice Guide**

Please have each committee member on the leadership/steering committee fill out the Shared Decision Making form, compile the average response for each question, and report the average response below.

**\*Instructions:**

Baseline= 1<sup>st</sup> year at the beginning of year on proposed plan

(Yellow). Previous Year= Previous year on progress report

(Green). Current Year:= Current year on progress report (Green)

**Shared Decision Making Survey 1=disagree, 2=mildly disagree, 3=neutral, 4=mildly agree, 5= agree**

Category	Description	Baseline Year* 2008	Previous Year* 2017	Current Year* 2018
1. Common Vision:	Members have a shared common vision.			
2. Understanding and Agreement Goals:	Members understand and agree on goals and proposed outcomes/objectives.			
3. Clear Roles & Responsibilities:	Roles & responsibilities of members are clear.			
4. Shared Decision Making:	All members have a voice and are engaged in the decision making process.			
5. Conflict Management:	We are able to successfully manage conflict.			
6. Shared Leadership:	Leadership is effective and shared when appropriate.			
7. Well Developed Work Plans:	Work Plans are well developed and followed.			
8. Relationships/Trust:	Members trust each other.			
9. Internal Communication:	Members communicate well with each other.			
10. External Communication:	Our external communication is open and timely within the broader community and partners.			
11. Evaluation:	We have built evaluation performance into our activities.			
12. Understanding of CPPC:	Members have a clear understanding of the Community Partnerships Four Strategies.			
<b>Average Response Score:</b>	This is an average score for all of the responses, the number should be between 1-5			

## Community/Neighborhood Networking-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
1-a	Develop Neighborhood/Community Networking plan that includes goals for engagement strategies and planned activities that identifies potential network members to whom strategies will be directed				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-b	Engage the community and build awareness about Community Partnerships for the Protection of Children’s four strategies through community forums, events and activities				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-c	Develop (select and educate) a cadre of spokespersons who are able to deliver CPPC information, such as the “CPPC 101” information				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-d	Establish performance and outcome measures and evaluate these to ensure the goals (from the planning stage) are obtained				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Community/Neighborhood Networking-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
2-a	Continue to promote community awareness/engagement listed in level 1				Ongoing:  Proposed Plan:  Progress:
2-b	Develop Neighborhood/Community Networking Plan that includes goals for linkages, collaborations, strategies and planned activities				Ongoing:  Proposed Plan:  Progress:
2-c	Develop/promote a plan to increase linkages between informal and professional supports and resources				Ongoing:  Proposed Plan:  Progress:
2-d	Develop a plan to increase collaboration among economic supports, domestic violence, mental health, substance abuse and other child welfare professional partners				Ongoing:  Proposed Plan:  Progress:
2-e	Involve Parent Partners in collaborative programs in the community				Ongoing:  Proposed Plan:  Progress:

2-f	Involve Foster Parents in collaborative programs in the community				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
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### Community/Neighborhood Networking-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
3-a	Continue with Neighborhood/Community Networking levels 1 and 2				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
3-b	At least one of the following is established (mark the X and detail narrative next to the appropriate category listed below)				
	<ul style="list-style-type: none"> <li><b>Organize</b> groups/networks of community members and/or parents with prior CPS involvement and/or foster care youth - these groups focus on leadership and providing informal supports</li> </ul>				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

### Community/Neighborhood Networking-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
	<ul style="list-style-type: none"> <li>• <b>Implement</b> plan to increase collaboration among economic supports, domestic violence, mental health, substance abuse and other child welfare professional partners</li> </ul>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
	<ul style="list-style-type: none"> <li>• The development of <b>hubbing</b> resources and activities that enhance the accessibility of services and supports</li> </ul>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
	<ul style="list-style-type: none"> <li>• Increase awareness and develop plans to address <b>diversity</b> and disparity locally</li> </ul>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>

### Community/Neighborhood Networking-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-a	<b>Must meet all Levels 1, 2 and 3 items and also</b> the implementation of at least 2 or more level 3 type programs				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-b	The use of informal supports is standard practice for families involved with DHS (including involvement with family team meetings)				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-c	Implementation of all programs and activities consistently address Diversity and Disparity issues				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>



**At the writing of this proposed report, select the level\* for Community/Neighborhood Networking that best fits your site:**

**Based on your completed activities, select the level\* for Community/Neighborhood Networking that best fits your site:**

**\*For more detailed information on the levels, please see the CPPC Practice Guide**

## Individualized Course of Action CBFTDM/CBYTDM-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
1-a	Educate SDM and community about strength-based engagement/assessment skills and the Family Team Decision Making (FTDM) and Youth Transition Decision Making (YTDM) processes within the child welfare system				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-b	Promoting the understanding, the use, and the importance of informal supports in the FTDM and YTDM processes				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-c	Promoting FTDM and YTDM trainings, and coaching and mentoring if needed				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-d	Understand how FTDMs and YTDMs are available and accessed for families involved in the child welfare system				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
1-e	Explore and understand FTDM and YTDM Iowa standards and how they are implemented				<p>Ongoing:</p> <p>Proposed Plan:</p>

### Individualized Course of Action CBFTDM/CBYTDM-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
					Progress:
1-f	Promote collaboration between FTDM and YTDM facilitators from different organizations and agencies				Ongoing:  Proposed Plan:  Progress:

### Individualized Course of Action CBFTDM/CBYTDM-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
2-a	Must meet all Level 1 items				Ongoing:  Proposed Plan:  Progress:
2-b	Develop plan to implement Community Based Family Team Meetings (CBFTDM) and Community Based Youth Transition Decision Making (CBYTDM) Plans need to include: <ul style="list-style-type: none"> <li>• <b>Assessing</b> the need for state-approved facilitators</li> <li>• <b>Recruitment</b> of state-approved facilitators</li> <li>• <b>Maintain</b> or have access</li> </ul>				Ongoing:  Proposed Plan:  Progress:

### Individualized Course of Action CBFTDM/CBYTDM-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
	to a list of state approved facilitators <ul style="list-style-type: none"> <li>• <b>Educating</b> Community about CBFTDM and CBYTDM</li> <li>• <b>Marketing</b> Strategies</li> <li>• <b>Building</b> relationships with potential referral resources</li> <li>• <b>Funding</b> resources and sustainability</li> <li>• <b>Tracking</b>, evaluation and Quality Assurance</li> </ul>				

### Individualized Course of Action CBFTDM/CBYTDM-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
3-a	Must meet all Level 1 and 2 items				Ongoing:  Proposed Plan:  Progress:
3-b	Implement plan for CBFTDM-Community-Based Family Team Decision Making				Ongoing:  Proposed Plan:

### Individualized Course of Action CBFTDM/CBYTDM-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
					Progress:
	Number of CBFTDM held				Ongoing:  Proposed Plan:  Progress:

### Individualized Course of Action CBFTDM/CBYTDM-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-a	Must meet all Level 1, 2, and 3 items				Ongoing:  Proposed Plan:  Progress:
4-b	Implement plan for CBYTDM-Community-Based Youth Transition Decision Making				Ongoing:  Proposed Plan:  Progress:

### Individualized Course of Action CBFTDM/CBYTDM-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
	Number of CBYTDM held				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>

**At the writing of this proposed report, select the level\* for Individualized Course of Action that best fits your site:**

**Based on your completed activities, select the level\* for Individualized Course of Action that best fits your site:**

\*For more detailed information on the levels, please see the CPPC Practice Guide

### Policy and Practice Change-Level 1

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
1-a	Identify need(s) for policy and practice change: discussion about policy and practices with various agencies				Ongoing:  Proposed Plan:  Progress:
1-b	Identify youth and/or parents who have been involved in the child welfare system and ask for their input about what works and what does not, from their perspective				Ongoing:  Proposed Plan:  Progress:

### Policy and Practice Change-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
2-a	Must meet all Level 1 items				Ongoing:  Proposed Plan:  Progress:
2-b	Develop a plan to address identified needs: <ul style="list-style-type: none"> <li>• Gather data about policy and practice changes-needs/gaps in services</li> <li>• Document information gathered (using sources</li> </ul>				Ongoing:  Proposed Plan:  Progress:

## Policy and Practice Change-Level 2

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
	<p>such as APSR, surveys, focus groups) to prioritize practices and/or procedures needing to be changed or improved</p> <ul style="list-style-type: none"> <li>• <b>Ensure</b> that frontline staff from child protection system and partner agencies are included in development and implementation of practice change planning</li> <li>• Within the planning process <b>identify</b> cultural disproportionality and disparity issues related it policy and practice change</li> </ul>				

### Policy and Practice Change-Level 3

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
3-a	<p><b>Must meet all Level 1 and 2 items</b></p>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>
3-b	<p><b>Implement plan</b> for changes and re-evaluate using Plan Do Study Act (PDSA) or similar process</p> <ul style="list-style-type: none"> <li>• Develop communication strategies for implementing the change</li> <li>• Develop and implement monitoring to ensure change is successful</li> <li>• Develop specific methods for ensuring quality changes are maintained</li> </ul>				<p>Ongoing:</p> <p><b>Proposed Plan:</b></p> <p><b>Progress:</b></p>

## Policy and Practice Change-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-a	Must meet all Level 1, 2, and 3 items and add the implementation of 2 or more policy and practice changes				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-b	Community agencies routinely involve SDM in developing and reviewing policies and practices				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-c	Agencies involved in CPPC routinely survey consumers and partners about their programs and make changes in response to feedback including diversity and disparity issues				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-d	SDM group solicits ongoing feedback from families and community members and makes changes in response to feedback				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-e	Ensure that all neighborhood network members and DHS-contracted agencies require specific “best practice” standards for delivering human services				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

## Policy and Practice Change-Level 4

No.	Description	Ongoing	Proposed (NEW)	Met	Describe current goal in your proposed plan and progress.
4-f	Ensure that the SDM group, agency administrators and service recipients evaluate service delivery on a regular basis				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>
4-g	Implement recommendations of various state and federal reviews				<p>Ongoing:</p> <p>Proposed Plan:</p> <p>Progress:</p>

**At the writing of this proposed report, select the level\* for Policy and Practice Change that best fits your site:**

**Based on your completed activities, select the level\* for Policy and Practice Change that best fits your site:**

\*For more detailed information on the levels, please see the CPPC Practice Guide

<i>Name:</i>	<i>Title:</i>
<i>Site:</i>	<i>Address:</i> <span style="float: right;"><i>Phone:</i></span>

**Please return this completed form to both Sandy Lint *and* Julie Clark-Albrecht:**

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 1305 E Walnut  
 Des Moines, Iowa 50319-0114

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**2019 CHILD PROTECTION COUNCIL (CPC)**  
**Required CJA Areas of Discipline/Members/Term Limits/Organizations Represented**

Required CJA Area of Discipline	CPC Members	Years on CPC	2 <sup>nd</sup> Term Ends (Yearly Terms start July 1st to June 30th)	Organization
Law Enforcement	Jason Hugi	2 yrs. (2017)	2023	Mason City Police Dept., Mason City, Iowa
Criminal Court Judge	Sylvia Lewis	6 yrs.	2019	Senior Judge, Sixth Judicial District, Johnson Co
Civil Court Judge	Mary Timko	6 yrs.	2019	Associate Judge, Third Judicial District, Buena Vista Co
Prosecuting Attorney	Andrea Vitzthum	6 yrs.	2019	Polk County Attorney's Office, Des Moines, Iowa
Defense Attorney	Penny Reimer	2 yrs. (2017)	2023	Cooper, Goedicke, Reimer & Reese, P.C.
Defense Attorney	Lesley Rynell	2 yrs. (2017)	2023	Juvenile Law Center
Child advocate (Attorney for Children)	Andrea McGinn	1 yr. (2018)	2024	The Law Shop by Skogerson McGinn, Van Meter, Iowa
Child Advocate; Attorney for Children	Josephine Gittler	6 yrs.	2019	College of Law, University of Iowa, Iowa City
Court Appointed Special Advocate (CASA)	James Hennessey (Chair 2019)	5 yrs.	2020	Iowa Department of Inspections and Appeals
Health Professional	Katie Strub	1yr. (2018)	2024	Allen Child Protection Council, Waterloo, Iowa
Health Professional	Jennifer Boeding	1 yr. (2018)	2024	Blank Children's STAR Center & Development Center, Des Moines, Iowa
Mental Health Professional	Alison Boughn	2 yrs. (2017)	2023	Mercy Child Protection Center, Sioux City, Iowa
Individual with Experience Working with Children with Disabilities	Liz Cox	3 yrs. (2016)	2022	Polk County Mental Health and Disability Services, Des Moines, Iowa

Parent (Representative of Parent Groups)	Kayla Stevenson	6 yrs.	2019	Parent Partners
Parent	Leslie Marquez	6 yrs.	2019	Child Advocate
Adult Former Victim of Child Abuse or Neglect	Gabby Farrell	2019	2025	Achieving Maximum Potential (AMP)
Adult Former Victim of Child Abuse or Neglect	Kayla Eckerman	2019	2025	Youth Policy Institute
Individual Experienced in Working with Homeless Youth	Stephen Quirk	6 yrs.	2019	Youth Emergency Services & Shelter, Des Moines
Child Protective Services Agency Representative	Tricia Barto		N/A (Ex-Officio)	CJA/CAPTA Program Manager, Iowa Department of Human Services
<b>Additional Members</b>				
Child Advocate	Kathy Thompson	1 yr. (2018)	2024	Children's Justice, Des Moines, Iowa
Child Advocate	Mylene Wanatee	1 yr. (2018)	2024	Sac & Fox Tribe of the Mississippi in Iowa, Tama, Iowa
<b>Iowa Department of Human Services</b>				
	Roxanne Riesberg	—	—	Child Protection Program Manager
	Janee Harvey	—	—	ACFS Bureau Chief

**Children's Justice Act Grant (Sec. 107 of CAPTA)**

The Child Abuse Prevention and Treatment Act (CAPTA) (Sec.107(C)) requires that the state taskforce, which is the Child Protection Council in Iowa, is to have a representative from each of the following discipline areas:

- Law Enforcement Community
- Criminal Court Judge
- Civil Court Judge
- Prosecuting Attorney

- Defense Attorney
- Child advocate (Attorney for children)
- Court Appointed Special Advocate Representative
- Health Professional
- Mental Health Professional
- Individuals Experienced in Working with Children with Disabilities
- Parents & Representative of Parent Groups
- Adult former Victim of child abuse/neglect
- Individuals Experienced in Working with Homeless Children and Youths
- Child Protective Service Agency Representative

## Iowa Family Treatment Court Standards and Practice Recommendations

Adopted by the Iowa Supreme Court on July 17, 2014

### Guiding Permanency Vision and Principles

In 2011, Iowa adopted a Blueprint for Forever Families, which outlined and defined a cohesive set of strategies to address the complex issue of permanency. This Blueprint is built on Iowa's permanency vision – *Every child deserves a forever family*—and the following foundational principles:

- **Urgency:** Permanence is treated with a sense of urgency as if the child were our own or a child of a family member.
- **Diversity:** The culture, race, ethnicity, language, religion and sexual orientation of children, youth and families are respected.
- **Family and Youth Empowerment:** Families and young people are full partners in all decision-making and planning for their futures.
- **Accountability:** Services and supports are strength-based, fair, responsive, accessible, and accountable to children, youth and their families.
- **Shared Responsibility:** Multiple systems (including child welfare, juvenile courts, education, substance abuse, mental health, domestic violence and others) and the community at large work together to identify and support permanent relationships for the child.

The goal of Family Treatment Courts is to promote permanency by assisting parents and children with the difficult issues of substance abuse and child abuse and neglect so that they can become safe, sober and permanent “forever” families. With that goal in mind, the Family Drug Treatment standards described below were developed to promote and support Iowa's permanency vision and principles and the Blueprint for Forever Families.

### Purpose

The purpose of the Family Treatment Court Standards is to provide a general framework of guiding principles and the basic elements that each Family Treatment Court must include. The Iowa Standards for Family Treatment Courts is based on the National Association of Drug Court Professionals', “Defining Drug Courts: The Key Components” (2004) and on the National Drug Court Institute's Drug Court Practitioner's Fact Sheet, Family Dependency Treatment Court: Applying the Drug Court Model in Child Maltreatment Cases (June 2006). These standards create a single orientation for all stakeholders to address parental substance abuse and its impact on a parent's capacity to provide a safe, permanent environment for their child. Some of the standards also include “Recommended Practices for the Family Treatment Court Team”

which would assist teams in moving towards best practice concepts. These standards are stated broadly to meet local needs while also ensuring uniformity across the state.

### **Standard 1**

#### ***Family Treatment Courts must utilize a comprehensive and collaborative planning process.***

- The Family Treatment Courts have participated in a planning process to ensure a coordinated, systemic family-focused approach to protect children from abuse and neglect through timely decisions, coordinated services, judicial oversight and the provision of timely substance abuse treatment for parents.
- Completion of the Memorandum of Understanding setting the terms of the collaboration among the lead Family Treatment Court judge, the county attorney, parent’s attorneys, guardians ad litem, the Department of Human Services, the substance abuse treatment agencies, private providers and other key stakeholders.
- Establishment of written policies and procedures which reflect shared goals and objectives for the Family Treatment Court program.

#### **Recommended Practices for the Family Treatment Court Team:**

- Family Treatment Court Teams should expect a minimum of 6 months to plan and prepare for implementation. This amount of time would allow the team to have started to collaborate and to reach consensus on a variety of issues related to the implementation of services.
- Other possible members of the team may include, but would not be limited to: mental health professionals, school representatives, housing representative, domestic violence specialists and other community members.
- A written community outreach and education plan should be developed and reviewed regularly.

### **Standard 2**

#### ***Family Treatment Courts intervene early in child abuse and neglect cases to involve parents and families in substance abuse treatment.***

- Once accepted for admission, parents are immediately enrolled in substance abuse treatment, if they have not already done this, and monitored for compliance by the Family Treatment Court team.
- The Family Treatment Court team, including social workers, treatment providers and court representatives and other service providers maintain ongoing internal communication. This communication would include the frequent exchange of timely and accurate information about the parent’s progress.

- The judge plays an active role in the team process, frequently reviewing the status of the family and the parent’s compliance with treatment and services.

**Recommended Practices for the Family Treatment Court Team:**

- DHS Assessment Workers and Case Managers should assess parents or caretakers for potential substance abuse issues by using screening tools such as “CAGE” or “Uncope.” If the screening detects a potential issue, the parent or caretaker should be referred to a substance abuse agency.
- A parent or caretaker should sign a multiparty Release of Information form which is used to facilitate communication across systems and with any other involved parties.
- At the time of the referral the caseworker should complete a Substance Abuse Disorder Evaluation Referral form providing the substance abuse treatment worker with information regarding the purpose of the referral.
- During a substance abuse treatment evaluation, treatment staff identifies any involvement the client may have with DHS and/or court services. If DHS is involved, clients are asked to provide the caseworker contact information so the treatment staff can contact the caseworker to initiate care coordination.

**Standard 3**

***Family Treatment Courts must have written eligibility and dismissal criteria that have been collaboratively developed, reviewed and agreed upon by the members of the Family Treatment Court Team and approved by the local Advisory Committee.***

- Eligibility screening process based on established written criteria, which cannot be changed without the full agreement of the Family Treatment Court Team and approval by the local advisory committee.
- Participation in the Family Treatment Court is voluntary.
- At a minimum, admission criteria includes a CINA Petition filing with at least one of the following: 1) an allegation of a parental substance use disorder; 2) at least one allegation of behavior or circumstances indicating there is or could be a substance use disorder; and/or 3) a parent who is willing to engage in substance abuse treatment and supportive services.
- While the parent is the primary focus of the Family Treatment Court, the program seeks permanency for all children involved in cases of child abuse and neglect. The needs of children will be identified and children may be referred for services as appropriate and may be included in family therapy if clinically indicated.

### **Recommended Practices for the Family Treatment Court Team:**

- Parents should be referred to Family Treatment Court as early as possible.
- Family Treatment Courts should consider referring parents to the program prior to the filing of a CINA Petition or right after a CINA Petition has been filed.

### **Standard 4**

***Family Treatment Courts will incorporate a non-adversarial approach in which the judge, the parties, their attorneys, guardians ad litem, the county attorneys, the Department of Human Services, substance abuse providers and private providers promote safety, permanency and child well-being while protecting the rights of parents and children.***

- Guardians ad litem, parent’s attorney, county attorney, the lead judge and other members of the local advisory committee participate in the design of the family treatment court, including criteria for screening, eligibility, and policies and procedures, to safeguard due process and promote safety, permanency and child and family well being.
- Family Treatment Courts will have a Memorandum of Understanding (MOU) setting forth the terms of collaboration between partners, i.e. Juvenile Court, Department of Human Services and substance abuse treatment providers and other agencies as appropriate. Individualized treatment and service plans are developed based on needs identified during the initial assessment.
- Interagency collaboration is important throughout the case planning process in order to ensure that the family’s needs, as identified by all agencies involved, are represented and monitored. This will also minimize any duplication of efforts.

### **Recommended Practice for the Family Treatment Court Team:**

- For consistency and stability in Family Treatment Court operations, the Family Treatment Court team members should be assigned to the Family Treatment Court for a minimum of one year.
- Family-centered orientation materials to the Family Treatment Court should be developed and reviewed annually.

### **Standard 5**

***Family Treatment Courts provide access to a comprehensive continuum of substance abuse treatment and rehabilitation services and schedule regular staffings and judicial court reviews.***

- Participants are initially screened and assessed and continue to be reassessed by both treatment personnel and the court to ensure that the most appropriate treatment services are being provided to parents.

- All substance abuse and mental health treatment services are provided by programs or individuals who are appropriately trained and licensed to deliver such services according to the standards of their profession.
- Regularly scheduled Family Treatment Court hearings before the judge are used to monitor progress and compliance with program expectations.
- Family Treatment Court team members and service providers conduct regularly scheduled meetings or staffings to ensure ongoing and open communication regarding parents and their children.
- Family support and outreach services are included in the continuum of services available to parents. These services would continue after the DHS and court cases have been closed. This continued support will assist parents in referral to services, support during times of stress and possible early detection of the risk of relapse.

**Recommended Practice for the Family Treatment Court Team:**

- Family Support and outreach services should begin when a parent has been identified as a potential participant in the Family Treatment Court. These services can assist in getting parents into substance abuse treatment and engaged in other identified services.
- Alumni groups have been an added informal support for both current and former Family Treatment Court participants. The alumni group participants provide guidance on guest speakers, topics for discussion and identify healthy sober activities for the group sessions.

**Standard 6**

***A coordinated strategy based on joint case planning will govern responses from the family treatment court to each parent’s performance and progress.***

- Regularly held treatment team meetings for pre-court staffings and court reviews will be used to monitor each participant’s progress.
- Communication among the court, the Department of Human Services, the substance abuse treatment providers, attorneys and private agency providers should be ongoing, including frequent exchanges of timely and accurate information about the individual participant’s overall performance. This includes the standardization of information that is to be communicated through the use of common forms.
- The Family Treatment Court team will develop with the parents a comprehensive, unified case plan that addresses the needs of the entire family. The unified case plan should be revisited quarterly, at a minimum, since the needs of the family may change.

**Recommended Practice for the Family Treatment Court Team:**

- Clients should be included in the review process along with all of the service providers involved in the family.

- Clients should be provided a simple, one-page summary of their goals and objectives.
- The Family Treatment Court Team should work with the clients to prioritize their goals.
- The Family Treatment Court Team should assist parents in developing longer term, self-sufficiency plans.

## **Standard 7**

### ***Family Treatment Courts ensure legal rights, advocacy and confidentiality for parents and children.***

- Eligibility screening is based on written criteria established by the local advisory committee. Department of Human Services staff and substance abuse treatment providers are designated to screen cases and identify potential Family Treatment Court participants. This does not preclude other key stakeholders from referring participants to the Family Treatment Court.
- All substance abuse and mental health treatment services are provided by programs or individuals who are appropriately trained and licensed to deliver such services according to the standards of their profession.
- All members of the local advisory committee, the county attorney, parent’s attorneys, and guardians ad litem actively participate in the design and ongoing review of Family Treatment Courts in order to safeguard the legal rights of the parents and to promote and protect the best interest of the children.
- Once accepted for admission, parents are immediately enrolled in substance abuse treatment, if they have not already done this, and monitored for compliance by the Family Treatment Court team.
- Each member of the Family Treatment Court team ensures advocacy, confidentiality and legal rights, including due process, are maintained by advising the parents and their attorneys of the guidelines for participating in the Family Treatment Court.
- The Family Treatment Court sets the terms of the collaboration through a Memorandum of Understanding which is signed by the court and all participating agencies.
- The Consent to Release Confidential Information form used by the Family Treatment Court permits communication regarding participation and progress in treatment, complies with 42 CFR, Part 2, HIPAA regulations and applicable state statutes, and requires the signed consent of the participating parent.
- While the decisions of the Family Treatment Court focuses on the interests of the parents and their recovery, the court maintains a parallel focus on the best interests of the children. The procedures, decisions and hearings of the Family Treatment Court, therefore, reflect the dual focus of integrating the needs of both children and parents.

## **Standard 8**

***A Family Treatment Court must incorporate ongoing judicial interaction with each participant as an essential component of the program.***

- Whenever possible, the same judge shall preside over the Family Treatment Court and CINA case, from filing through permanency.
- At a minimum, Family Treatment Court participants must appear before the Family Treatment Court judge at least twice a month during the initial phase of the program. Frequent review hearings during the initial phases of the program both establish and reinforce the Family Treatment Court's policies and ensure effective monitoring and support of each participant.

### **Recommended Practices for the Family Treatment Court Team:**

- Participants should appear before the judge weekly, whenever possible, during the initial phase of the program.
- Hearings should be before the same judge for the duration of the participant's time in the Family Treatment Court.

## **Standard 9**

***Family Treatment Courts monitor abstinence by random, frequent and observed alcohol and other drug testing and will implement consistent, graduated responses for compliance or noncompliance.***

- Family Treatment Courts will develop and document written policies and procedures for drug screening, sample collection, sample analysis, reporting results and the guidelines for the use of incentives and sanctions. The written policies and procedures will be based on the *Drug Testing Guideline* developed by Children's Justice.
- The drug testing policies and procedures will include a coordinated strategy for responding to noncompliance, including prompt responses to positive tests, missed tests and tampered tests.
- Drug testing should be random and observed.
- Drug testing should be sufficient to include each participant's primary substance of choice as well as a range of other common substances, including alcohol.
- Family Treatment Court will advise parents of the drug testing protocol and the incentive/sanction system and provide them with written guidelines during their orientation.
- During case staffings, the treatment team will recommend incentives to reward compliance or milestones achieved or will recommend sanctions for noncompliance.

- The Family Treatment Court judge will take recommendations regarding incentives and sanctions from the treatment team under advisement and after hearing from the parent will make a final decision regarding the incentive or sanction ordered.

**Recommended Practice for the Family Treatment Court Team:**

- A written policy regarding the use of prescription drugs should be shared with parents during orientation. Parents will need to identify all of the prescription drugs they are currently taking and which physicians prescribed them. Parents will need to sign a release of information for those physicians.

**Standard 10**

***The Family Treatment Court must have a plan to provide services that are individualized to meet the needs of each participant and their child/ren and incorporate evidence-based strategies for the participant population. Such plans must take into consideration services that are gender-responsive and culturally appropriate and that effectively address co-occurring disorders. Services should be trauma-informed<sup>1</sup> when appropriate and clinically necessary.***

- Family Treatment Court participants should be referred to family-centered treatment services whenever possible. Providing specialized services for children from families with substance abuse issues should be offered.
- Additional services that should also be considered are: education, housing, transportation, domestic violence, and employment.

**Recommended Practice for the Family Treatment Court Team:**

- Family Treatment Courts should become familiar with the stages of recovery in the Developmental Model of Recovery and implement stage-appropriate interventions to interrupt addictive patterns.
- Family Treatment Court team members should review research on gender differences in substance abuse treatment so they can tailor the services to better meet the needs of the participants.

**Standard 11**

***Family Treatment Courts must have policies and procedures that emphasize the central relationship of the parent’s and the children’s right to contact. These policies should also***

---

<sup>1</sup> Trauma-informed services are designed to provide appropriate interactions tailored to the special needs of trauma survivors. The focus is on screening for trauma and designing the drug court program to reduce or eliminate triggers of trauma for the survivor. This is particularly important because research shows that occurrence of trauma is a significant factor in most substance abuse populations, especially women.

***include the parent’s right to be heard in regard to the decisions made by the court impacting the child’s ultimate placement.***

- Withholding family interaction time or visits must not be used as a response to a parent’s noncompliance.
- Decisions to reduce family interaction time should only be due to concerns for the immediate safety of the child.
- When a child cannot be reunified with a parent, the parent should be included in developing the child’s permanent plan.

## **Standard 12**

***Immediate, graduated, and individualized responses must govern the responses of the Family Treatment Court to each participant’s compliance or non-compliance.***

- Regular Family Treatment Court team meetings for pre-court staffings and court reviews to monitor each participant’s performance.
    - Ongoing communication among the court, child protection, guardian ad litem, and treatment providers, which will include frequent exchanges of timely and accurate information about the individual participant's overall performance. This includes the standardization of information that is to be communicated through the use of common forms.
    - Progression by participants through the Family Treatment Court program will be based upon the individual’s progress with the treatment plan, compliance with program requirements, Family Treatment Court phases and an individual’s progress through those phases are not to be based solely upon pre-set program timelines.
    - Responses to a participant’s compliance and noncompliance (including criteria for dismissal) should be explained both verbally and provided in writing (i.e. in a Participant Handbook) to Family Treatment Court participants during their orientation.
    - While assuming the lead in the Family Treatment Court effort, the judge focuses on the parent’s sobriety, lawful behavior, parental accountability and effective and consistent service delivery for the parent and child. There is also a focus on insuring permanency for the child within the timelines established by ASFA.
    - The Family Treatment Court will focus on the progress to achieve the goal of reunification of a child in foster care with their parent. An additional focus is also maintained on the progress of achieving the designated concurrent permanency goal in the event that permanency through reunification is no longer possible.
    - In order to meet the ASFA mandated timelines, Family Treatment Courts will ensure close judicial supervision of the coordination and accountability among service providers.
-

## **Standard 13**

### ***Family Treatment Courts must evaluate their effectiveness.***

- Family Treatment Court goals are concrete and measurable. Minimum goals are:
  - a. Increase the safety, permanency and well-being of children and families by addressing the substance abuse treatment programming and service gaps through a community collaborative planning approach;
  - b. To prevent out-of-home placement whenever possible through early intervention, giving priority to the safety and well-being of children;
  - c. To achieve permanency in the shortest time possible in order to minimize the impact of out-of-home placement for children while meeting reasonable efforts guidelines;
  - d. To eliminate abuse and neglect within Family Treatment Court families;
  - e. Creating a common vision through ongoing, regular multi-disciplinary training.
- Evaluation of the Family Treatment Court will adhere to written policies consistent with state and federal guidelines that protect against unauthorized disclosure of confidential information.
- The Family Treatment Court will use current data from the court, Department of Human Services and the Department of Public Health to measure outcomes and progress in meeting their goals and the effectiveness of treatment and services.

### **Recommended Practices for the Family Treatment Court Team:**

- Family Treatment Court should collect data for each participant. At a minimum, they should gather information on: the number of participants served, the number of graduations/commencements, length of time in the Family Treatment Court, length of time before they entered substance abuse treatment, length of stay in substance abuse treatment, did children remain in the parent's care or were they removed from the home, length of stay in out of home care, did children re-enter out of home care after they were returned to their parents, were there subsequent child abuse reports once they began Family Treatment Court and length of time to achieve permanency.
- Follow-up information should be gathered on the participants for 12 months after they have been discharged from the Family Treatment Court. This allows monitoring of longer term outcomes for families.
- Additional information can be gathered on how many babies that have been born substance free to participants of the Family Drug Court. This information can be used to demonstrate a longer term cost savings or avoidance.

- Participant feedback should be a part of the Family Treatment Court. This information can be provided through a client satisfaction survey or by focus groups conducted by a neutral party.

#### **Standard 14**

***Family Treatment Courts must assure continuing interdisciplinary education and joint training of their team members to promote the effective implementation and ongoing operations of their problem-solving court.***

- In order to develop a shared understanding of the values, goals and procedures of child welfare, substance abuse treatment and the court components, multidisciplinary education will be provided for members of the Family Treatment Court.

#### **Recommended Practices for the Family Treatment Court Team:**

- Family Treatment Court Team members should complete the specialized, on-line training available on the National Center on Substance Abuse and Child Welfare website. This training will allow team members to better understand the frame of reference and operating system for the other team members.
- At a minimum, Family Treatment Court team members should assess team functionality, review all policies and procedures and assess the overall functionality of the program.
- Each Family Treatment Court should plan for the transition of a team member and provide sufficient training for the new team members.
- Local policies and procedures should include requirements for continuing education for Family Treatment Court team members.

# Safe Sleep Workgroup Charter

**Name of Workgroup:** Safe Sleep Workgroup

**Goal of Workgroup:** Develop a research-based strategic plan for supporting safe sleep with DHS-involved families as a means of reducing sleep related maltreatment deaths.

**Defined Tasks of the Workgroup:**

1. Work with at least one partner from each of the following to allow response and feedback to the draft plan: public health, law enforcement, and the courts.
2. Explore existing data on sleep-related deaths from the previous 5 years.
3. Research initiatives and strategies that have effectively promoted safe sleep and reduced sleep-related fatalities.
4. Look into existing DHS and partner training efforts and explore whether enhancements are in order.
5. Make a recommendation on the age efforts should be targeted (under 12 months? 6 months?)
6. Workgroup members will develop a plan that could include educating DHS staff and child welfare providers on red flags of co-sleeping; best practices around safe sleep; positive cultural engagement on discussing safe sleep practices.
7. Work group members will develop a plan that could include: IT changes, safe sleeping tool kits, tangible goods to support safe sleep, visual reminders, and PSA-related material.
8. Recommended initiatives should cost around \$40,000.

**Expected Products of the Workgroup:**

1. Develop brief logic paper describing research-related activities, conclusions and data.
2. Make formal recommendations on strategies for positively and effectively promoting safe sleep practices with DHS-involved families.

**Expected Time Frame of the Workgroup:** A preliminary draft version of the plan should be available to G5 by 6/30/19.

**Workgroup Members:**

Group Members	Job Title	Location
Roxanne Riesberg	Program Manager	Central Office
Maureen Barton	Service HelpDeskTrainer	Field



# Iowa Child Maltreatment Prevention NEEDS ASSESSMENT

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**December 2017**



# Iowa Child Maltreatment Prevention NEEDS ASSESSMENT

THIS REPORT IS PREPARED FOR  
THE IOWA DEPARTMENT OF HUMAN SERVICES



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**December 2017**





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Iowa Department of Public Health  
Parents and children of Iowa  
Prevention professionals  
The Coalition for Family and Children's Services in Iowa  
Youth & Shelter Services, Inc.  
Henry Stoddard

# Table of Contents

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Executive Summary.....	i
Introduction .....	i
Strengths .....	ii
Challenges .....	ii
Families .....	ii
Prevention Providers.....	iii
Recommendations .....	iv
Introduction.....	1
About This Report .....	2
Background .....	2
Protective Factors.....	2
Public Health Approach to Prevention.....	3
Iowa’s Prevention Programs and Funding Sources .....	5
Maltreatment Prevention as a Primary Goal .....	5
Prevention Funding.....	10
ICAPP and CBCAP Grantee Funding Sources .....	11
Prevention Evidence-Based Practices (EBPs).....	13
Evidence-Based Programs Funded by ICAPP and CBCAP.....	16
Risk Factors of Maltreatment and Needs of Iowa Families .....	19
Incidence of Abuse and Neglect in Iowa .....	19
County-Level Abuse and Neglect Rates .....	21
Risk Factors of Abuse and Neglect .....	21
Poverty.....	22
Other Risk Factors.....	23
Barriers to Services .....	25
A Closer Look at Who is Reached by ICAPP and CBCAP Programs.....	28
Conclusions and Recommendations .....	31
Strengths .....	31
Challenges .....	32
Families .....	32
Prevention Providers.....	32
Recommendations .....	33

References .....	35
Appendix A: Methodology .....	39
Analysis of Prevention Programs and Funding Sources.....	39
Funding Analysis .....	39
Review of Prevention Evidence-Based Practices .....	40
Maltreatment Risk Factor Analysis .....	40
Stakeholder Focus Groups and Surveys .....	42
Other Data Sources .....	43
Appendix B: Inventory of Evidence-Based Practices.....	44
Appendix C: Maps of Child Maltreatment and Risk Factors .....	93



## Executive Summary

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### Introduction

Prevention of child maltreatment is a central component of the mission of the Iowa Department of Human Services (IDHS): to help Iowans achieve healthy, safe, stable, and self-sufficient lives (IDHS, n.d.). IDHS has announced that it will be combining its two grant programs supporting prevention, the Iowa Child Abuse Prevention Program (ICAPP) and the Community-Based Child Abuse Prevention (CBCAP), to coincide with the end of the current contracts, which expire June 30, 2018. In preparation, IDHS tasked Prevent Child Abuse Iowa (PCA Iowa) to conduct a needs assessment and develop a strategic plan to guide future prevention efforts in Iowa. IDHS holds service contracts with community groups doing prevention work and PCA Iowa is contracted to administer the program.

To conduct the needs assessment, PCA Iowa contracted with Hornby Zeller Associates, Inc. (HZA), a longtime collaborator and evaluator of maltreatment prevention programs, to develop data collection tools, provide analysis and synthesize the results. PCA Iowa managed community outreach activities such as focus groups and survey administration. This report describes the results and findings of the needs assessment process.

The following steps were taken to develop a comprehensive picture of Iowa's prevention landscape through the needs assessment:

- Inventory of existing child abuse prevention programs sponsored by IDHS and other federal, state, local, and private sources of funding;
- Analysis of how programs intersect and of gaps in services, including an examination of evidence-based prevention practices used in Iowa by ICAPP and CBCAP grantees;
- Analysis of the need for maltreatment prevention services using a social indicator approach to identify the prevalence and impact of abuse and neglect risk factors;
- Collection of stakeholder feedback on data and initial findings through focus groups and surveys of prevention professionals, parents and youth.

Synthesis of data from these sources has resulted in the identification of the following strengths and challenges of child maltreatment prevention efforts in Iowa:

## Strengths

- **There is a strong commitment to families and children in Iowa.** Multiple funding sources at the federal, state, and local level are funding maltreatment prevention strategies, particularly secondary prevention targeting families at risk. Efforts such as ECI (which aims to establish family-focused early childhood infrastructure) and Decat (an initiative designed to ensure access to family-focused, needs-based services), and commitment to child and family well-being through local control of maltreatment prevention and treatment funds.
- **ICAPP and CBCAP are funding projects that other funding sources are not and reaching families experiencing the risk factors identified in this assessment.** Sexual Abuse Prevention, Fatherhood, Respite Care and Crisis Care grantees all rely heavily on the grant programs for a large portion of their budgets. These types of programs address unique needs or populations that may not align with other funders' criteria.
- **There is a good match between the types of programs professionals say parents need (e.g., parenting classes) and what is already funded by ICAPP, CBCAP and other prevention programs.**
- **Most ICAPP and CBCAP grantees have adopted evidence-based practices (EBPs),** including five which have the highest overall rating of exemplary for strong research evidence demonstrating positive outcomes among diverse groups of consumers.
- **Prevention providers note that collaboration with other programs and community members is helping them expand their reach.** There is a need to expand those efforts.
- **Both youth and parents identified family and friends as their primary sources of support.** Youth also mentioned other positive supports from activities like music and playing sports as being important to being successful.

## Challenges

The challenges identified in the needs assessment are grouped into two categories: those faced by families and those that impact prevention providers and programs.

### **Families**

- **Poverty and other risk factors of child abuse and neglect are issues throughout the state.** There were statistical correlations between poverty, teen births, low birthweight and high Adverse Childhood Experience (ACE) scores and both abuse and neglect; and children ages 0-5, households with high rent, domestic violence, and mental illness with child neglect. The correlations of abuse and neglect with teen births and low birth weight suggest the need to ensure strong collaboration between community groups, public health professionals, other service providers and stakeholders.

- **In focus groups and surveys, providers across the board identified mental illness, substance abuse, and other ACEs as major risk factors affecting families.** They also said that access to mental health and substance abuse services was lacking in many areas of the state.
- **Parents and youth said they needed financial stability, good jobs and close, positive relationships with family and people they could trust.** Employment in particular was an area that both groups said could be a challenge.
- **Both professionals and parents addressed families' lack of access to concrete supports (e.g., transportation, clothing and child care).** Professionals said that these issues made it difficult for families to access services and provide appropriate care for their children.
- **Funding restrictions and time may be impacting some parents' ability to participate in resources they need.** In particular, some families earn too much to qualify for programs targeting at-risk families. Others find their work and family life impede time to participate.

### ***Prevention Providers***

- **Providers say lack of funding and a lack of flexibility in how funds can be used impact their ability to reach as many people as they could.**
- **Stigma and a lack of awareness of the issue of maltreatment** impact whether members of the community access services and support for prevention. Providers note sharing information about ACEs and communication strategies like Connections Matter are helping address these issues in some areas.
- **Although many providers use EBPs, ICAPP and CBCAP fund a high number of interventions which lack research support.** Although there is a wide variety of maltreatment prevention EBPs, providers said identifying appropriate interventions and paying for training can be challenging. Some types of programs funded through ICAPP and CBCAP, particularly Fatherhood, Community Development, Respite Care and Crisis Care programs have little, if any research support. In addition, among those using EBPs there is not currently data to measure adherence to model fidelity, an important component to evaluating program quality.

Measurable goals and strategies to build on existing strengths and address the challenges identified in the needs assessment will be developed during the strategic planning process, which concludes in December 2017. Additional feedback on the plan's goals will be gathered from a statewide committee of diverse stakeholders. The strategic plan will be used to guide future requests for proposals for prevention services and evaluation of prevention efforts.

## Recommendations

The incidence of child maltreatment in Iowa remains above the national rate, despite decreases in recent years. Iowa's ACE data indicates that 56 percent of adult Iowans report experiencing one of the eight ACEs measured in the study. The rate of neglect in the state is four times that of physical abuse and ranges widely from county to county. The needs assessment found relationships between neglect and numerous risk factors, including teen births, poverty, low birthweight births, domestic violence, high ACE scores and mental illness.

A coordinated public health approach is recommended to reduce the risk of children's exposure to toxic stress caused by abuse, whether physical or sexual, or neglect and improving protective factors through early access to concrete supports, evidence-based parenting education, and social supports for parents and children. Qualitative and quantitative data collected in this needs assessment indicate an urgency for change in prevention practices in Iowa. The following recommendations are respectfully suggested:

**Coordinate maltreatment prevention funding sources across multiple service sectors (e.g., public health, early childhood, human services) to use each source strategically in combatting abuse and neglect.** Work collaboratively across funding sources to identify common goals, services and quality standards using the needs assessment and strategic plan as a starting point.

**Reduce child maltreatment by targeting risk factors presented by families which are most closely correlated with abuse and neglect.** Make information available and accessible about services that address the conditions of poverty, teen births, low birthweight, domestic violence, adverse childhood experience, mental illness and substance abuse.

**Increase workforce development in cultural competence, EBPs and trauma-informed prevention and care.** Embed culturally responsive, evidence-supported and trauma-informed practices into all systems that help families.

## Introduction

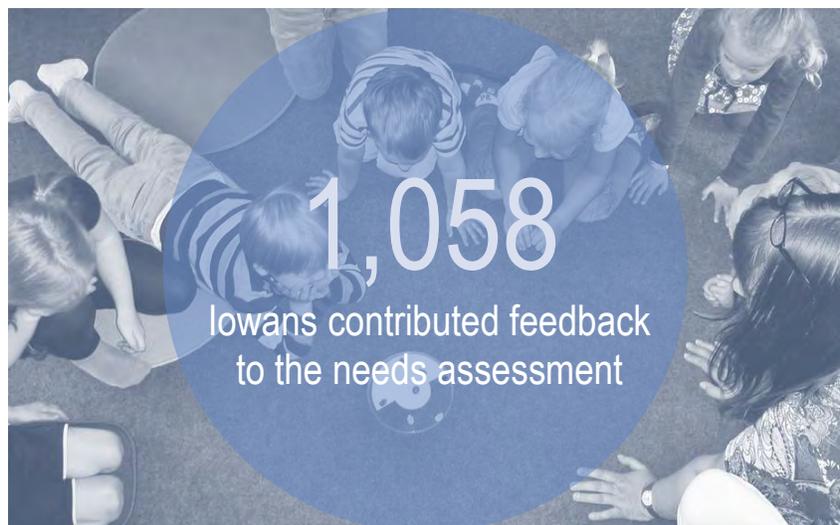
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Prevention of child maltreatment is a central component of Iowa Department of Human Services' (IDHS) mission to help Iowans achieve healthy, safe, stable, and self-sufficient lives (IDHS, n.d.). Two significant funding sources support prevention activities: the Iowa Child Abuse Prevention Program (ICAPP), established in Iowa Code in 1982 and funded through annual state legislative appropriation, federal sources, as well as birth certificate fees and donations made through a line item on state tax returns; and the Community-Based Child Abuse Prevention (CBCAP), funded through a provision of the federal Child Abuse Prevention and Treatment Act (CAPTA).

IDHS announced that it will be combining these grant programs to coincide with the end of the current service contracts, which expire June 30, 2018. In preparation, IDHS tasked Prevent Child Abuse Iowa (PCA Iowa) to conduct a needs assessment and develop a strategic plan to guide prevention efforts in Iowa. IDHS contracts with community groups for prevention services and PCA Iowa is contracted to provide administrative services for the program.

In 2016, IDHS reported that 8,892 children in the state were victimized (*e.g.*, had a confirmed or founded abuse or neglect report) (2017a). Research has shown that the effects of maltreatment are numerous and can last into adulthood (Flaherty et al., 2013; Molnar, Beatriz, & Beardslee, 2016). In Iowa, a 2016 study found that adults' risk of poor physical and mental health outcomes increases as the number of adverse childhood experiences (ACEs), including abuse and neglect, increase (Central Iowa ACEs Coalition, 2016).

The needs assessment and strategic planning process will guide future requests for proposals for ICAPP and CBCAP and provide a framework for IDHS' prevention strategies. To conduct the needs assessment, PCA Iowa contracted with Hornby Zeller Associates, Inc. (HZA), a longtime collaborator and evaluator of abuse prevention programs. HZA developed needs assessment data collection tools, provided analysis and synthesized the results. PCA Iowa managed community outreach activities such as focus groups and survey administration. This report describes the results and findings of the needs assessment process.



## About This Report

The goal of the needs assessment is to describe the needs and resources available to Iowa families and identify strengths and gaps in prevention services. The following steps were taken to develop a comprehensive picture of Iowa's prevention landscape:

- Inventory of existing child abuse prevention programs sponsored by IDHS and other federal, state, local, and private sources of funding;
- Analysis of how programs intersect, gaps in services, including an examination of evidence-based prevention practices used in Iowa by ICAPP and CBCAP grantees;
- Analysis of the need for maltreatment prevention services using a social indicator approach to identify the prevalence and impact of abuse and neglect risk factors;
- Collection of stakeholder feedback on data and initial findings through six focus groups with a total of 84 participants (including four youth) and surveys administered to prevention professionals, parents, and youth. A total of 978 surveys were collected: 912 from prevention professionals, 14 from youth, and 52 from parents.

A mixed method approach using both qualitative and quantitative data sources was used to provide a thorough understanding of Iowa's prevention services and barriers to meeting families' needs. Data sources used to compile the information can be found at the start of each section and a detailed description of the methodology appears in Appendix A.

## Background

Two constructs are used in Iowa to govern thinking about child maltreatment prevention, what approaches can be used, and how they should be targeted: protective factors and the public health approach. Protective factors were identified through research at the turn of the century, while applying the public health approach to child abuse prevention is more recent.

### *Protective Factors*

Protective factors mitigate risk factors of child maltreatment and reduce the impact of adverse experiences during childhood (Child Welfare Information Gateway, 2014). This emphasis on promoting protective factors grew up in the early 2000s when child abuse prevention efforts changed from a problem-focused approach to one that is more strengths- and resiliency-based (Child Welfare Information Gateway, 2017).

Table 1 describes the five protective factors identified in the FRIENDS National Center for Community-Based Child Abuse Prevention's framework utilized in Iowa ("Protective Factors," n.d.). Different prevention programs target specific protective factors based on the target audience and overall goal of the program. ICAPP and CBCAP fund six types of services which promote protective factors of children, parents, and families: Community Development, Crisis Care, Home Visiting, Parent Development and Fatherhood, Respite Care, and Sexual Abuse Prevention programs.

**Table 1. Definitions of Protective Factors by FRIENDS, NRC**

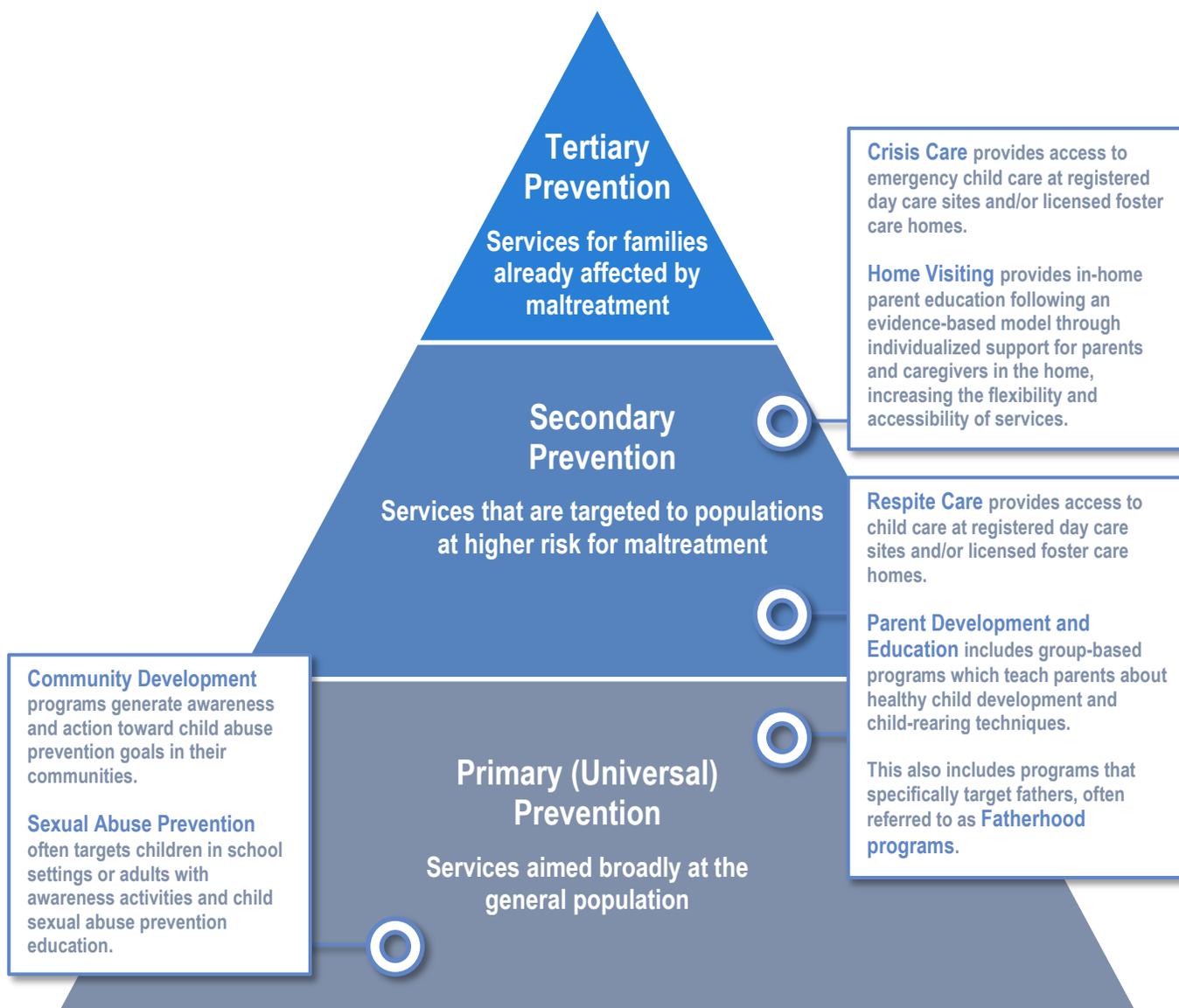
Protective Factors Domains	Definition
<b>Child Development and Knowledge of Parenting</b>	Understanding and utilizing effective child management techniques and having age-appropriate expectations for children’s abilities.
<b>Concrete Support</b>	Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.
<b>Family Functioning and Resilience</b>	Having adaptive skills and strategies to persevere in times of crisis. Family’s ability to openly share positive and negative experiences and mobilize to accept, solve and manage problems.
<b>Nurturing and Attachment</b>	The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.
<b>Social Emotional Support</b>	Perceived informal support (from family, friends and neighbors) that helps provide for emotional needs.

***Public Health Approach to Prevention***

Increasing calls have been made to adopt a public health approach to maltreatment prevention (Prinz, 2016). Public health classifies prevention into primary, secondary and tertiary levels. Primary prevention targets the general population, secondary efforts work with families identified as at a higher risk of maltreatment and tertiary services work with families and children where abuse or neglect has occurred (Child Welfare Information Gateway, 2017). The types of programs offered and the strategies used vary based on the level of prevention. For example, secondary prevention programs targeting families at greater risk may include more intensive interventions.

The scope of this needs assessment is primary and secondary prevention strategies. Figure 1 describes the types of prevention interventions funded through ICAPP and CBCAP and how they fit into the different levels of prevention. Throughout this report, these different types of programs and levels of prevention will be discussed.

Figure 1. Public Health Model Levels of Prevention and Iowa Maltreatment Prevention Services



Adapted from Child Welfare Information Gateway (n.d.) *Framework for prevention of child maltreatment*. Retrieved from <https://www.childwelfare.gov/topics/overview/framework/>

Results of this needs assessment will be used to guide the goals and objectives of the prevention strategic plan from 2017 through 2023. Activities to obtain feedback from stakeholders will continue throughout the strategic planning process. As goals and objectives are developed, a statewide committee will be convened to elicit feedback. In November 2017 PCA Iowa will deliver a full strategic plan to IDHS for comment and revisions.

## Iowa's Prevention Programs and Funding Sources

PCA Iowa looked beyond ICAPP and CBCAP to determine the current status of prevention programming in Iowa. Thirteen programs and funding sources providing some form of child maltreatment prevention<sup>1</sup> services and family support were identified. Descriptions of each program can be found on pages 10-11. Like ICAPP and CBCAP, most programs fund local organizations to carry out direct service work. For this reason, the terms “program” and “funding sources” are used interchangeably throughout this section.

### Data Sources

- Program websites & annual reports
- Children's Program Factbook
- Stakeholder focus groups and surveys
- ICAPP & CBCAP grantee reports

### Maltreatment Prevention as a Primary Goal

All thirteen programs identified seek to improve child and/or family wellbeing, but eight specifically identify child abuse and neglect prevention as central to program goals. Figure 2 displays the two groups of programs.

Figure 2. Sources of Maltreatment Prevention Funding

#### Programs with Maltreatment Prevention Focus

- Community-Based Child Abuse Prevention (CBCAP)
- Community Care
- Connections Matter
- Decategorization (Decat)
- Healthy Opportunities for Parents – Healthy Families Iowa (HOPES–HFI)
- Iowa Child Abuse Prevention Program (ICAPP)
- Iowa Coalition Against Sexual Assault (ICASA)/Rape and Prevention Education (RPE)
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

#### Other Programs

- 21st Century Community Learning Centers (CCLCs)
- Early Childhood Iowa – (ECI) Family Support
- Early Childhood Iowa – (ECI) Home Visiting
- Family Development Self Sufficiency (FaDSS)
- Title V – Maternal and Child Health Programs

<sup>1</sup> A public health approach to prevention considers child protective services (CPS) tertiary prevention. Some programs providing tertiary as well as primary or secondary services are in the needs assessment; however, they do not represent all Iowa CPS interventions.

## Descriptions of Iowa Prevention Programs

**21st Century Community Learning Centers (CCLCs)** – A federal title program funding after-school programs with learning opportunities to children and families (Iowa Department of Education, n.d.).

**Community-Based Child Abuse Prevention (CBCAP)** – Federally funded through the Child Abuse Prevention and Treatment Act (CAPTA), CBCAP funds Parent Development, Crisis Care and Home Visiting programs.

**Community Care** – A voluntary IDHS program which provides services and supports to families through a contracted agency that focus on reducing families' stress, and preventing maltreatment and additional contact with IDHS (IDHS, 2017c). Families are referred to the program by IDHS through the child abuse assessment or family assessment process and determined to need additional support (IDHS, 2017d).

**Connections Matter** – Connections Matter is a communication strategy focused on “building caring connections to improve well-being (PCA Iowa, 2017).” The initiative trains presenters to share the message of positive social supports to reduce the risk of child abuse or neglect and facilitating the development of resiliency within schools, businesses, faith communities, medical providers, and the community (PCA Iowa, 2017).

**Decategorization (Decat)** – Decat is an effort to change Iowa's child welfare system to a needs-based, family-focused, more intensive, less restrictive, and cost-effective system by “decategorizing” services from a state level to a local level (Community Partnerships for Protecting Children, 2012). State funding is provided to Local areas, which have the authority and funding flexibility to implement community-based services. Nineteen ICAPP and CBCAP grantees received Decat funds in FY 2017.

**Early Childhood Iowa (ECI) – Home Visiting & Parent Education** – ECI coordinates services across early care, health, and education systems of care to establish infrastructure to advance the early childhood system, ensure access to high quality services, and increase public will for supporting children and families (ECI, 2017). ECI funds family support programs that provide parenting and home visiting through its ECI and School Ready Grant Programs. Forty-six ICAPP and CBCAP grantees received ECI funding during the previous fiscal year.

**Family Development Self Sufficiency (FaDSS)** – Administered by the Department of Human Rights (DHR), FaDSS provides support services, including goal-setting, assessment and case management to families receiving cash benefits through Iowa's Family Investment Program (FIP) (Iowa Department of Human Rights, n.d.). Funded through a combination of state and federal dollars, FaDSS uses an evidence-informed, strengths-based approach to help families achieve self-sufficiency (Iowa Department of Human Rights, n.d.).

**Healthy Opportunities for Parents – Healthy Families Iowa (HOPES–HFI)** – An IDPH program providing services to families using the Healthy Families America (HFA) home visiting model (IDPH, 2017a). HOPES–HFI seeks to improve child health and development, family coping skills, positive parenting skills, and prevent maltreatment (IDPH, 2017a). HOPES–HFI grantees are supported by a state and private grant funds. About one-third of funds which support grantees are provided by the state. Thirteen programs operate in nine counties.

**Iowa Child Abuse Prevention Program** – ICAPP is funded through state and federal sources, birth certificate fees and line item tax return donations. ICAPP supports Community Development, Respite Care, Home Visiting, Parent Development, and Sexual Abuse Prevention programs.

**Iowa Coalition Against Sexual Assault (ICASA)/Rape and Prevention Education (RPE)** – ICASA provides support and leadership to a statewide network of services for survivors of sexual assault, and administers sexual violence program grants funded through IDPH. RPE is a federally funded Centers for Disease Control and Prevention (CDC) program supporting primary prevention of sexual violence (CDC, 2017a). ICASA provides training and support to advocates for survivors and funds primary prevention efforts targeting professionals and caregivers about how to talk about sexual violence with youth (ICASA, 2017). One ICAPP/CBCAP grantee receives funds through RPE.

**Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program** – Administered by IDPH, MIECHV funds four evidence-based home visiting models to improve maternal and child health, prevent childhood injury, improve school readiness and achievement, decrease crime and domestic violence and increase self-sufficiency and service coordination. Programs are funded in fourteen counties (IDPH, 2016). In Iowa, MIECHV is supported by a combination of state and federal dollars, with the state providing about 12 percent of the program’s funding. Five ICAPP and CBCAP grantees also receive MIECHV funding.

**Title V – Maternal and Child Health** – An IDPH Bureau of Family health program, Maternal and Child Health administers federal Title V funds to provide healthcare services to mothers and children from low income households (Bureau of Family Health, IDPH, 2017).

In addition to ICAPP and CBCAP, the programs that focus on maltreatment prevention are Community Care, Connections Matter, Decat, HOPES–HFI, ICASA/RPE, and MIECHV. Of those eight, three are administrated by IDHS, three by Iowa Department of Public Health (IDPH), and two by local or private organizations.

Among the eight programs with a goal of maltreatment prevention, five support or provide primary prevention strategies to universal audiences. Examples include community development strategies such as public awareness campaigns and training for broad audiences which are provided through Connections Matter, ICAPP and ICASA. ICAPP and CBCAP also fund other primary prevention strategies such as parenting programs open to all families. Yet one of the concerns raised by prevention providers in focus groups was the emphasis of funding sources on families at high risk of child abuse and neglect, which they said left out other families in need. Although the majority of programs targeting child abuse and neglect fund primary prevention strategies, they do not account for the bulk of the prevention funding, which may be driving prevention professional’s perceptions. This is discussed in more detail in the next section.

Other programs that did not identify prevention as their main intent seek to help children and families improve self-sufficiency (Family Development Self Sufficiency (FaDSS)); health (Title V – Maternal and Child Health); education (21st Century Community Learning Center (CCLC)); and overall well-being (ECI). Table 2 shows the number of people served, level of prevention, and types of interventions offered by all 13 programs. Although maltreatment prevention may not be a primary goal of the remaining five programs, these programs do provide critical support to families in Iowa (such as ECI’s support for home visiting and parent development programs), or provide families with prevention resources (for example, the Maternal and Child Health website includes resources for health providers on Period of Purple Crying, a maltreatment intervention).

**Table 2. Overview of Iowa Prevention Programs**

Program Name	Number Served (2017)	Prevention Level	Intervention Type	Total Funding	Funding Source
<b>21st CCLC</b>	14,670 school districts	Primary Secondary	ED	\$7,832,416	Federal
<b>CBCAP</b>	1,469 families	Primary Secondary	CC HV PD	\$410,535	Federal
<b>Community Care</b>	3,832 families	Secondary Tertiary	CM	\$3,433,850	Federal Local
<b>Connections Matter</b>	600+ trained professionals	Primary	CD	Not available	Private
<b>Decategorization</b>	Not available	Primary Secondary Tertiary	Unknown	\$1,717,753	State
<b>ECI – Home Visiting</b>	Not available	Secondary	HV	\$13,017,872	State Federal
<b>ECI – Parent Education</b>	Not available	Secondary	PD	\$1,108,331	State
<b>FaDSS</b>	1528 families	Secondary	CM	\$5,883,191	State Federal
<b>HOPES–HFI</b>	619 families	Secondary	HV	\$2,036,438	State Private
<b>ICAPP</b>	2,773 families	Primary Secondary	CD HV PD RC SAP	\$1,277,921	State Federal
<b>ICASA/RPE</b>	Not available	Primary Tertiary	CD SAP	Not available	Federal State
<b>MIECHV</b>	1,055 families	Secondary	HV	\$4,980,000	State Federal
<b>Title V – Maternal and Child Health Programs</b>	7,000 individuals	Secondary	HE	\$1,419,258	State Federal

**KEY:** CC=Crisis Care; CD=Community Development; HV=Home Visiting; PD=Parent Development; RC=Respite Care; SAP=Sexual Abuse Prevention; ED=Education, CM=Case Management; MI=Miscellaneous

*See pages 6–7 for program descriptions.*

## Prevention Funding

The goals of the funding analysis were to determine the following:

- The total amount of funding allocated in Iowa for child maltreatment prevention
- The amount of prevention funding per child in each county
- The percent of prevention funding provided by ICAPP and CBCAP statewide
- The percent of grantees' budgets funded by ICAPP and CBCAP

### DATA SOURCES:

- Program websites & annual reports
- Children's Program Factbook
- Stakeholder focus groups & surveys
- ICAPP & CBCAP grantee reports

Ultimately, funding information was available for 11 of the 13 programs. County-level funding amounts were available for five programs and were developed for the remaining programs that had total funding amounts available based on the child population per county.

Approximately \$41.3 million for prevention services annually is provided around the state of Iowa. **Prevention funds account for less than 0.003% of expenditures for children's**

**programs in Iowa.**<sup>2</sup> Per-county estimates of prevention dollars spent per child ranged from \$27 in Dallas County to \$181 in Decatur County.<sup>3</sup> The state average was \$58 per child. Figure 3 displays a map of prevention dollars spent per child per county. The 99 counties were divided into groups of 25 to represent the dollars spent per child by quartile. Counties with the darkest shade were in the top quartile of dollars per child, while the lightest shade indicates the counties in the lowest quartile.

**Among the 13 programs examined, the funding source contributing the most support was ECI funding for Home Visiting at \$13,017,872.** CBCAP provided the lowest amount, with \$410,535 awarded to organizations during the last fiscal year. ICAPP and CBCAP together (\$1,688,456) accounted for just over four percent of the all maltreatment prevention funding in the state.

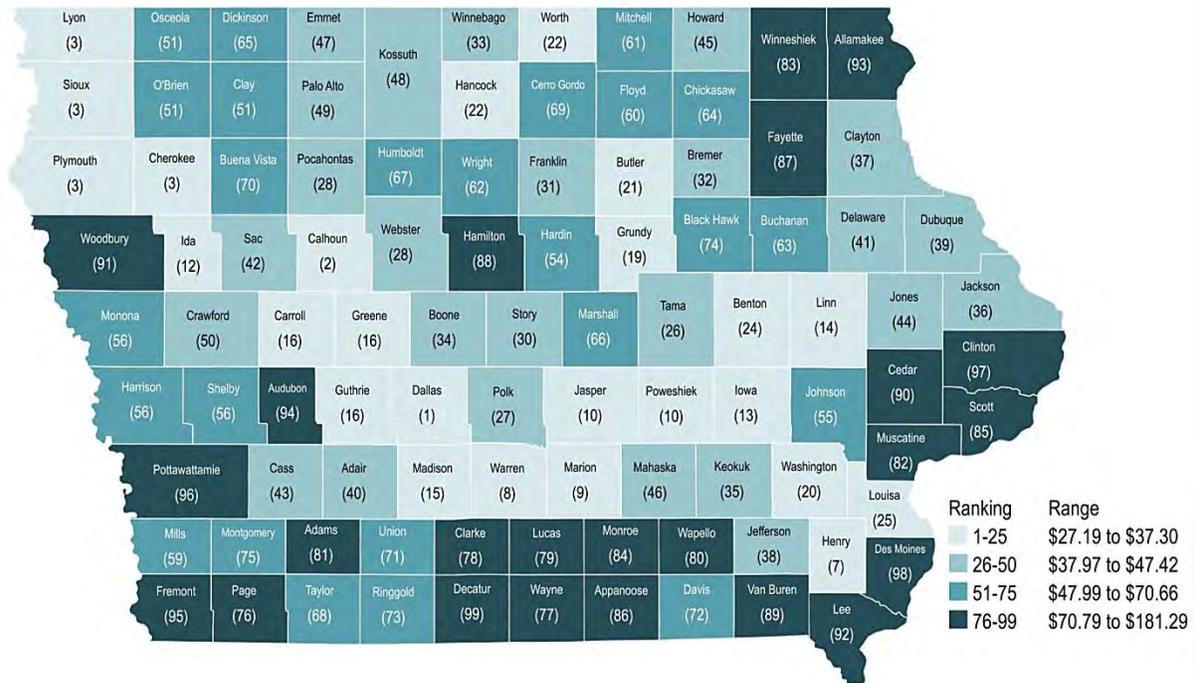
Among the eight programs which focus on maltreatment prevention, the largest amounts of funding were provided through IDPH's MIECHV (\$4.98 million) and IDHS' Community Care (\$3,433,850). Taken together, the budgets of the eight programs that focus on maltreatment totaled \$13.9 million or about 34 percent of all funding. In addition, programs funding primary prevention strategies made up only about a quarter of that \$13.9 million.

ICAPP and CBCAP provided  
4% of prevention  
funding in Iowa

<sup>2</sup> Funding for children's programs includes state, federal and local funding (Source: Children's Program Factbook).

<sup>3</sup> While a statewide total for Decatur funding was available in the Children's Program Factbook, funding information for each of the Decatur areas was not, so the source is excluded from county-level dollars per child estimates.

Figure 3. Prevention Dollars Spent per Child, County Ranking



### ICAPP and CBCAP Grantee Funding Sources

The needs assessment and strategic planning process will be used to guide the request for proposals and funding process for both ICAPP and CBCAP. For this reason, a detailed look at ICAPP and CBCAP grantees’ program budgets was undertaken. (NOTE: Many programs receive both ICAPP and CBCAP funds; the grant programs are being combined in fiscal year 2019, so for the purposes of this analysis, ICAPP and CBCAP funding amounts were combined.)

Table 3. Proportion of Program Budget Funded by ICAPP and CBCAP

Proportion of funding from ICAPP & CBCAP	Number of programs
0–33%	51
34–66%	23
67–100%	48

(n=125)

To provide prevention services, grantees seek funding from multiple sources. **About three out of four grantees (76%) reported funding from at least one source other than ICAPP or CBCAP**, indicating that most grantees have diversified their funding streams.

The largest amounts of other funding came from ECI and MIECHV. ECI funding was awarded primarily to Home Visiting and Parent Development programs, with one Respite Care and one Sexual Abuse Prevention grantee identifying the program as a funding source. MIECHV exclusively funds Home Visiting, and only five programs identified MIECHV as a source of support.

**Examining the individual programs and how they are funded, approximately 40 percent of programs receive one-third or less of their budget from ICAPP and CBCAP (Table 3).**

Almost the same number of programs (40%) receive between 67 percent and 100 percent of their program budgets from the grant programs.

The proportion of a program’s budget funded by ICAPP and CBCAP seems to be driven in part by the type of intervention. Home Visiting programs have lower proportions of ICAPP/CBCAP funding; 88 percent of Home Visiting Programs receive a third or less of their budget from ICAPP and CBCAP (Table 4). Sexual Abuse Prevention, Crisis Care, and Respite Care are all funded in large part through ICAPP and CBCAP. While about half of Parent Development programs (53%) receive a third or less of their funding through ICAPP and CBCAP, Fatherhood programs are much more reliant on these sources, with 75 percent receiving 67 to 100 percent of funding from them.

**Table 4. Proportion of Program Budgets Funded by ICAPP and CBCAP by Program Type**

Proportion of funding from ICAPP & CBCAP	Crisis Care	Fatherhood	Home Visiting	Parent Development	Respite Care	Sexual Abuse Prevention
<b>0%–33%</b>	10%	13%	88%	53%	13%	14%
<b>34%–66%</b>	40%	13%	8%	22%	13%	21%
<b>67%–100%</b>	50%	75%	4%	25%	75%	66%

Funding for maltreatment prevention appears to be focused on supporting secondary prevention strategies that target families with risk factors of abuse and neglect. Stakeholders saw funding—including the time and resources needed to identify and apply for new sources of support—as a barrier to providing services and support to families. The amount of funding ICAPP and CBCAP provide to organizations varies widely, with home visiting programs receiving the most support from other sources. In addition, ICAPP and CBCAP appear to fund programs that other funding sources do not, based on the high numbers of Crisis Care, Respite Care, Fatherhood and Sexual Abuse Prevention programs which rely heavily on ICAPP and CBCAP.

## Prevention Evidence-Based Practices (EBPs)

Looking more specifically at the quality of maltreatment prevention interventions funded, the degree to which evidence-based practices (EBPs) have been implemented by prevention programs was assessed. EBPs are interventions that have been found through research to produce their intended outcomes, minimize negative effects on participants, and whose results are reproducible among diverse populations (National Alliance of Children’s Trust and Prevention Funds, 2009). A review of all EBPs currently available in child maltreatment prevention was conducted as part of the needs assessment. Based on the results of that review, the levels of evidence of the specific EBPs funded by ICAPP and CBCAP were determined.

### DATA SOURCES:

- Stakeholder focus groups and surveys
- EBP Clearinghouses:
  - Blueprints for Healthy Youth Development
  - California Evidence-Based Clearinghouse (CEBC)
  - Home Visiting Evidence of Effectiveness (HomVEE)
  - National Registry of Evidence-based Programs and Practices (NREPP)
  - Office of Juvenile Justice, Detention and Prevention Model Programs Guide (OJJDP)

To determine whether curricula funded through ICAPP and CBCAP were evidence-based, the team reviewed five reputable evidence-based practices clearinghouses (see sidebar), as well as previous literature reviews performed for PCA Iowa. The product is an inventory of maltreatment prevention EBPs. Profiles for each intervention with program descriptions are found in Appendix B.

About half of Iowa’s prevention programs and funding sources were identified as supporting evidence-based interventions. Of the 16 programs supporting maltreatment prevention, eight provide or support evidence-based or evidence-informed interventions, according to program websites and annual reports. Some, such as CBCAP, MIECHV and HOPES–HFI fund EBPs exclusively, while others (*e.g.*, ECI) reserve a portion of their funding for innovative strategies.

Table 5 describes the interventions reviewed, each one’s overall level of evidence and the intervention type. Each clearinghouse utilizes different rating scales and criteria. For purposes of the needs assessment, the **National Alliance of Children’s Trust and Prevention Funds** levels of effectiveness were used to determine the overall level of evidence for each program. These criteria are based on the work of Buysse and Wesley (2006), the federal Centers for Disease Control and Prevention (CDC), and the Advisory Group to the Children’s Bureau Office of Child Abuse and Neglect (OCAN) (National Alliance of Children’s Trust and Prevention Funds, 2009).

The four levels of evidence, from low to high, are:

1. **Innovative Programs:** Professional experience and best available knowledge support the intervention that is undergoing evaluation to elicit family responses and to identify effectiveness under certain conditions with a selected group.
2. **Promising Programs:** Professional experience and family endorsement affirm the effectiveness of evidence-informed programs that have not yet accumulated evidence of effectiveness under rigorous evaluation.
3. **Supported Programs:** Scientific evidence of effectiveness is positive, professional experience is favorable, and family endorsement concurs but the programs have not been widely implemented. Evidence is favorable to implement a “supported program” under new conditions or a different population to generate more findings.
4. **Exemplary Programs:** Rigorous scientific evidence, accumulated professional experience, and family endorsement concur on the effectiveness of programs through positive outcomes that are evident with diverse groups in different settings.

In total, 37 EBPs with a goal of child maltreatment prevention were identified in at least one of the five clearinghouses (Table 5). All four of the categories above were reflected in one or more of the programs. The majority were group-based parenting classes and classified as Parenting Development (20 programs). Fourteen Home Visiting programs were reviewed, as were two Sexual Abuse Prevention Programs and one Community Development programs with public awareness components or community-level target audiences. Among the EBPs, just over two out of five (41%) received a rating of exemplary (7 programs) or supported (8 programs).

**Table 5. Maltreatment Prevention EBPs**

Type	Name	Evidence Level (4 is high)	Target Audience	ICAPP/CBCAP funded
CD	SEEK Safe Environment Every Kid	3	Primary care providers and families w/ children 0–5	
HV	Avance Parent-Child Education Program	3	Caregivers w/ children 0–3	
HV	Child FIRST	2	At-risk families w/ children 6–36 months	
HV	Circle of Security	2	At-risk families w/ children 0–6	Y
HV	Early Head Start	3	Families with low incomes and children 0–3	
HV	Exchange Parent Aide	2	Families w/ children 0–12	
HV	Families First	2	At-risk families w/ children 0–17	
HV	Healthy and Safe	2	Caregivers with cognitive difficulties w/ children 0–5	
HV	Healthy Families America	4	At-risk families w/ children 0–5	Y
HV	Home Builders	3	At-risk families w/ children 0–18	
HV	Home Instructions for Parents of Pre-School Youngsters (HIPPY)	3	Caregivers w/ children 3–5	
HV	Nurse Family Partnerships	4	High-risk, first-time mothers	

Type	Name	Evidence Level (4 is high)	Target Audience	ICAPP/ CBCAP funded
	(NFP)			
HV	Parents as Teachers	4	Families w/ children 0–5	Y
HV	SafeCare Augmented	2	Caregivers at risk	
HV	Step by Step Parenting Program	2	Caregivers with learning differences	
PD	1-2-3 Magic!	2	Caregivers w/ children 2–12	Y
PD	24/7 Dad	1	Fathers	Y
PD	Active Parenting Now	2	Caregivers w/ children 5–12	Y
PD	All Babies Cry	2	Caregivers with infants	
PD	Alternatives for Families – Cognitive Behavioral Therapy	2	Children 5–17 and caregivers	
PD	CARES	2	Caregivers w/ children 0–17 at risk of maltreatment	
PD	Effective Black Parenting Program	2	African-American caregivers w/ children 0–17	
PD	Families and Schools Together (FAST)	3	Families & children pre-K to grade 5	
PD	Family Connections	2	At-risk families; children 0–17	
PD	Incredible Years	4	Parents, teachers and children	Y
PD	Nurturing Parenting Program	2	Families reported to child welfare	Y
PD	Parent Management Training – Oregon Model	4	Caregivers w/ children 2–18	Y
PD	Parent-Child Interaction Therapy	4	Children ages 2–7 with behavior/relationship problems	
PD	Parents Anonymous	2	Caregivers of children with mental health, substance abuse, wellness issues	Y
PD	Period of Purple Crying	2	Caregivers of infants up to 5 months old; society	Y
PD	Safe Babies NY Program	2	Caregivers of infants	
PD	Strengthening Families	2	Parents and children age 0–17	Y
PD	Systematic Training for Effective Parenting (STEP)	2	Parents w/ children age 0–17	Y
PD	Triple P Level 4	4	Caregivers w/ children 0–12	Y
PD	Triple P System	3	Caregivers w/ children 0–16	
SAP	Stewards of Children	3	Adults	Y
SAP	Who Do You Tell?	2	Children Kindergarten–grade 6	

**KEY:** CC=Crisis Care; CD=Community Development; HV=Home Visiting; PD=Parent Development; RC=Respite Care; SAP=Sexual Abuse Prevention; Ch=child/children

## ***Evidence-Based Programs Funded by ICAPP and CBCAP***

ICAPP and CBCAP currently fund 125 grantees through over 140 contracts. Nearly two-thirds of ICAPP and CBCAP grantees (63%) use at least one EBP, and a total of 15 evidence-based curricula are funded. The majority of grantees administer two or more curricula and 20 percent use a combination of both EBPs and other, unrated interventions. This approach is particularly common among ongoing parent support groups that meet on a weekly basis throughout the year. These groups also invite guest speakers to talk to parents on a variety of topics including car seat checks, nutrition and maternal health.

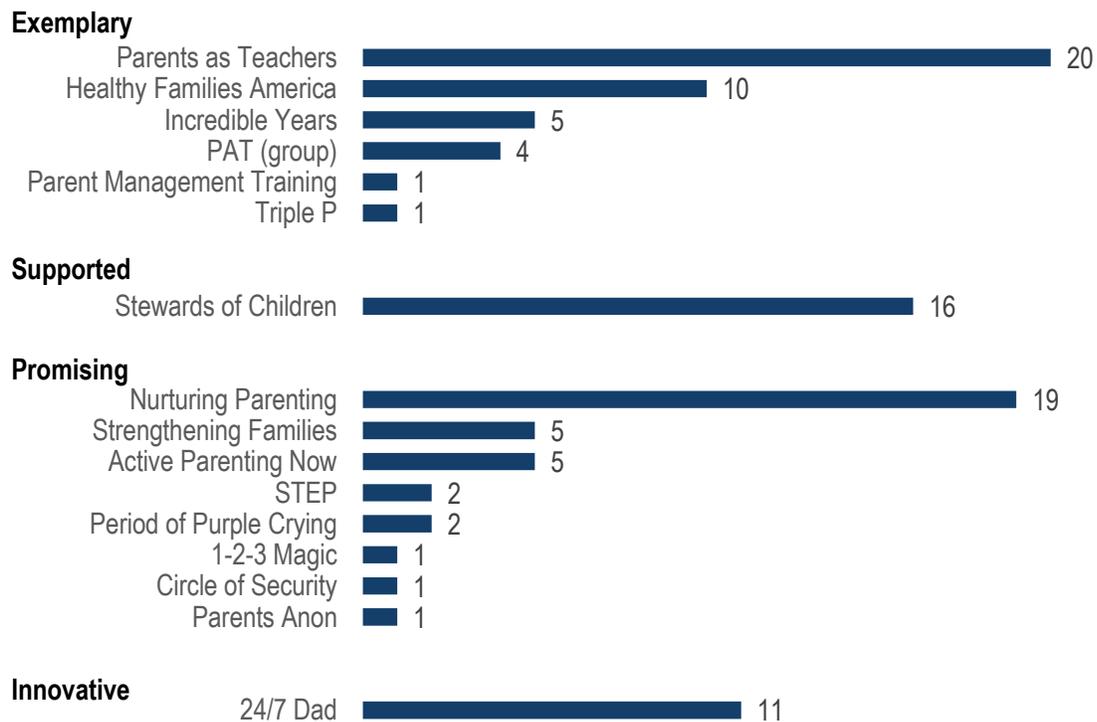
Reasons organizations choose not to administer EBPs can be complex, with focus group participants noting that high training costs can be prohibitive. Organizations may also develop their own approaches in keeping with their mission and vision, while others may utilize innovative programs that are awaiting further research and review. Programs also receive funding from multiple sources with a variety of objectives, including safety, health and school readiness, which also may lead them to adopt different curricula.



63%  
of ICAPP and CBCAP  
grantees use at least one  
evidence-based practice

The most common EBPs funded by ICAPP and CBCAP are Parents as Teachers (Home Visiting, 20 programs), Nurturing Parenting (Parent Development, 19 programs), Stewards of Children (Sexual Abuse Prevention, 16 programs), 24/7 Dads (Parent Development, 11 programs) and Healthy Families America (Home Visiting, 10 programs). Parents as Teachers and Healthy Families America are exemplary programs with the highest possible evidence rating, while Stewards of Children is rated as a supported program and Nurturing Parenting is rated as promising. In contrast, 24/7 Dad lacks strong evidence and was not reviewed by any of the clearinghouses. Figure 4 displays the 15 EBPs funded through the grant programs, grouped by evidence level.

**Figure 4. Number of ICAPP and CBCAP Programs Using EBP Curricula by Level of Evidence**



More than half of ICAPP and CBCAP programs use EBPs; however, an equal proportion also utilize curricula which lack formal support from research and evaluation (see Table 6 for a full list). Grantees offering unrated programs were almost exclusively Parent Development programs conducting recurring parent education groups. Some Sexual Abuse Prevention programs were unrated, and Respite Care and Crisis Care lack formal EBPs as well (Spach, Battis, & Nelson, 2014). A small number of programs funded by ICAPP and CBCAP identified as evidence-based practices by the grantees or other sources (*e.g.*, Positive Parenting, Positive Behavior Support, Positive Solutions for Families, Partners for a Healthy Baby and Talking About Touching) were not found in the clearinghouses.

IDHS has identified the need to monitor projects' fidelity to the EBPs they have adopted. Fidelity monitoring measures the degree to which programs are following guidelines and protocols of specific EBPs. This information is not collected from ICAPP and CBCAP grantees currently, and little is known about the degree to which organizations are following the models they have adopted. Fidelity monitoring is an important component to determining the quality of prevention services offered to families.

**Table 6. Unrated Programs Receiving ICAPP and/or CBCAP Funding**

Type	Name	Type	Name
PD	After Baby Comes	PD	Parent Café
PD	Boot camp for Dads	PD	Parenting Now!
PD	Born to Learn	PD	Partners for a Healthy Baby
PD	Beautiful Beginnings	PD	Positive Behavior Support
PD	Bright Beginnings	PD	Positive Parenting
PD	Circle of Parents	PD	Positive Solutions for Families
PD	Creative Curriculum	PD	Promoting First Relationships
CC	Crisis Care	SAP	Ready, Set, Know
PD	Infant massage	RC	Respite Care
PD	Kid Smart	PD	SOLVE program
PD	Let's Read Together	SAP	Take Charge of Your Body
PD	Love and Logic	SAP	Talking About Touching
PD	Loving Discipline for Children	PD	Teaching Strategies GOLD
SAP	Netsmartz	SAP	Think First Stay Safe
PD	New Babies	PD	Together We Can
PD	Nurtured Heart Approach	PD	Your Young Child: Managing Challenging Early Stages
SAP	Nurturing Health Sexual Development		

**KEY:** CC=Crisis Care; CD=Community Development; HV=Home Visiting; PD=Parent Development; RC=Respite Care; SAP=Sexual Abuse Prevention

In two of the focus groups conducted across the state with over 80 prevention professionals, participants emphasized the importance of funding EBPs and “what works” to prevent child maltreatment; however, more than half of respondents to the stakeholder survey said that identifying effective programs was somewhat or very much a barrier (56%). This is not surprising given the wide variety of evaluated programs and rating systems. The high cost of initial and continued training in evidence-based practices was another barrier mentioned. As one prevention professional put it, “Counties that don’t have evidence-based programming need more money to be able to get them there—capacity-building funds are needed.”

Through the stakeholder survey, prevention professionals shared their ideas about the types of maltreatment interventions they would like to see in their community. Most common were mental health and substance abuse treatment (16%), but responses were diverse, with 16 percent falling into the “other” category. Parenting classes, including gender-specific interventions for moms and dads were mentioned by one in ten respondents (11%), while specific curricula, including both EBPs and non-EBPs, was the next most common response (10%).

A wide number of evidence-based practices in prevention is available. Over half of ICAPP and CBCAP grantees utilize at least one EBP curricula, although many unrated curricula are also used. The cost and identification of EBPs were two barriers to wider adoption identified in focus groups and surveys.

## Risk Factors of Maltreatment and Needs of Iowa Families

To understand the current state of Iowa's child abuse and neglect prevention services, the needs assessment started by looking at current funding and programs implemented throughout the state. Next, the needs of communities were analyzed, including the incidence of abuse and neglect, risk factors that make children and families vulnerable to maltreatment and parents. In contrast to protective factors, risk factors impact families' ability to respond to children's needs and protect them from trauma and other negative influences in their lives.

To determine the needs and risk factors associated with child abuse and neglect in Iowa, an analysis of Iowa's population was undertaken. The analysis examined current child abuse and neglect incidence in Iowa, in conjunction with data on multiple known risk factors, such as child's age, mother's age, family poverty, and more. In addition, surveys and focus groups of local prevention professionals were conducted. The goals of the analysis were to determine the extent to which common risk factors of abuse and neglect were of concern in Iowa, and identify specific communities in the state (through a county-level analysis) that had an increased risk of abuse and neglect. More detail on the methodology used by HZA can be found in Appendix A.

To provide the most nuanced view of Iowa's needs in child abuse and neglect prevention, PCA Iowa and HZA created a county-by-county index of need. This index incorporates actual incidence of abuse and neglect, along with the incidence of known risk factors, as described above. Indexing Iowa's needs at the county level required using data that is robust at the county level. Some risk factors, such as parental substance abuse, have many challenges to collecting, confirming, and aggregating county-level data – all data used in the index are the most robust data available at the county level.

### Incidence of Abuse and Neglect in Iowa

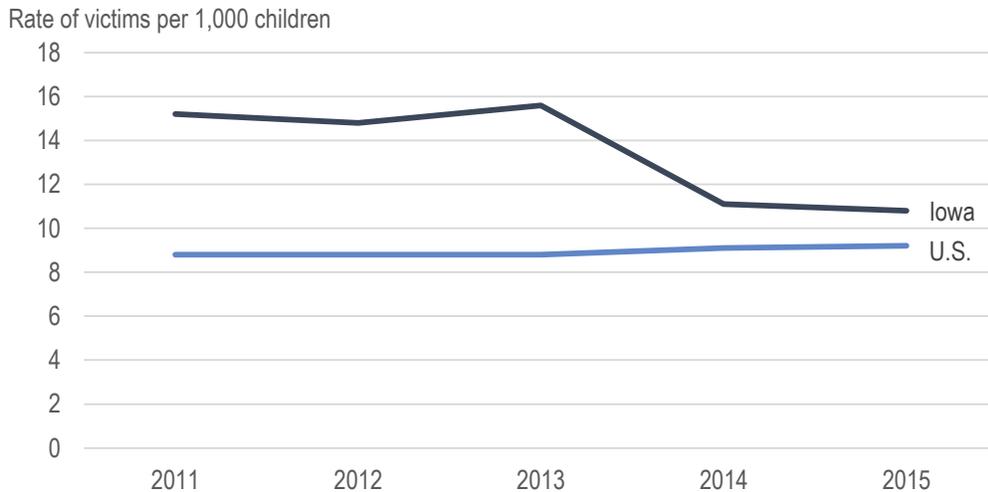
Child maltreatment is a serious issue in Iowa, impacting a broad cross-section of the population. In comparison to the United States overall, the rate of child maltreatment in Iowa is slightly higher, although it has decreased in recent years, while the U.S. rate has held steady (Figure 5). In 2015, the rate of abuse and neglect was 10.8 victims per 1,000 children in Iowa compared to 9.2 per 1,000 in the country. Iowa's rate of maltreatment may have declined in part because of the introduction of differential response in 2014. Under Iowa's differential response system, in circumstances in which a child is not in imminent danger and there has been a denial of critical

#### DATA SOURCES:

- Stakeholder focus groups and surveys
- County Health Needs Assessments
- Secondary datasets:
  - Behavior Risk Surveillance System (BRFSS) Survey
  - Community Health Needs Assessments (CHNAs)
  - Iowa Department of Public Safety Uniform Crime Reporting
  - Iowa Vital Statistics
  - IDHS Child Abuse Statistics
  - National Child Abuse and Neglect Data System (NCANDS)
  - Robert Wood Johnson Foundation County Health Rankings
  - U.S. Census, American Community Survey

care, families can undergo a family assessment followed by voluntary services and supports. Family assessments do not result in an abuse finding or placement on Iowa’s Central Abuse Registry (IDHS, 2013).

**Figure 5. Rate of Maltreatment in Iowa and the United States**



Source: (U.S. Department of Health & Human Services et al., 2017)

Neglect is a far more common phenomenon than abuse in the state. Overall, the statewide incidence of neglect is 8.0 victims per 1,000 children, compared to a rate of 1.8 victims of physical abuse per 1,000. Higher proportions of victims ages zero to five were reported (16.3 victims per 1,000 children) than of older children (8.1 victims per 1,000 children). Table 7 compares the rates of different types of maltreatment in Iowa to rates in the United States overall. Iowa’s rates of physical abuse and neglect are slightly higher than the national rates, although sexual abuse and emotional maltreatment are lower.

**Table 7. Comparison of Different Types of Abuse and Neglect**

Rate of Victims per 1,000 Children	Iowa Rate	U.S. Rate
<b>Overall</b>	<b>10.8</b>	<b>9.2</b>
<i>Children Ages 0–5</i>	<i>16.3</i>	<i>13.1</i>
<i>Children Ages 6–17</i>	<i>8.1</i>	<i>7.2</i>
<b>Rate of Victims per 1,000 Children by Type of Maltreatment</b>		
<b>Physical Abuse</b>	<b>1.8</b>	<b>1.6</b>
<b>Neglect (includes Medical Neglect)</b>	<b>8.0</b>	<b>7.1</b>
<b>Sexual Abuse</b>	<b>0.7</b>	<b>0.8</b>
<b>Psychological or Emotional Maltreatment</b>	<b>0.1</b>	<b>0.6</b>
<b>Other/Unknown</b>	<b>1.3</b>	<b>0.6</b>

Source: (U.S. Department of Health & Human Services et al., 2017)

Out of home placement is a significant consequence of abuse and neglect. In 2016, 9,787 children were living in foster care in Iowa (Division of Results Based Accountability, 2017). The most extreme cases of abuse and neglect can lead to death. While Iowa went for several years without a child death attributable to abuse, there were twelve reported in 2015 (U.S. Department of Health & Human Services, 2017).

### **County-Level Abuse and Neglect Rates**

To determine the degree to which abuse and neglect varies by county, the average rates of confirmed and founded reports of abuse and neglect over three years (2014-2016) were examined by county.<sup>4</sup> Average county rates of reports of abuse in Iowa vary from 0.9 reports per 1,000 children in Lyon County to 7.9 reports per 1,000 children in Decatur. Neglect rates range from 4.3 reports in Winneshiek to 35.3 per 1,000 children in Lee. Counties with high rates of abuse can be found throughout the state; however, there is a concentration of counties in the north-central part of Iowa. In contrast, the southwest corner (Pottawattamie, Cass, Montgomery, Adams, Page, and Decatur Counties) and the eastern border of Iowa (including Clinton, Muscatine, Des Moines, Henry and Lee) have concentrations of counties with high rates of neglect. (Detailed maps ranking counties on their rates of abuse and neglect can be found in Appendix C.)

Community Health Needs Assessments (CHNAs) show that communities across Iowa already have some awareness of the need to address maltreatment and ACEs in their counties. Twenty-four counties identified abuse and neglect as a public health issue that needed to be addressed (IDPH, 2017c). There was no discernable trend in the location of those counties, with counties identifying maltreatment as a need throughout the state and regardless of the rate of abuse or neglect in the community. Eight counties included reducing child maltreatment on their Health Improvement Plan (HIP), with the other counties most often stating that other priorities were rated higher or programs already existed to address the needs.

### **Risk Factors of Abuse and Neglect**

Twelve risk factors<sup>5</sup> of abuse and neglect were analyzed to determine the degree to which they impacted rates of abuse and neglect in Iowa, with eight ultimately showing a statistically significant relationship with abuse and/or neglect. The twelve factors, while perhaps not totally inclusive, had sufficient county-level data available to be analyzed and have been identified as potential risk factors within child maltreatment research (CDC, 2017b; Child Welfare Information Gateway, 2004; Sedlak et al., 2010). The purpose of this analysis, paired with the feedback from stakeholders, is to identify correlates of abuse and neglect in the data which can help inform programming decisions. It is important to note that the analysis may be impacted by underreporting, particularly with regard to sensitive topics that result in trauma and stigma, such as domestic violence and child abuse and neglect.

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<sup>4</sup> Types of confirmed or founded reports categorized as child abuse were Physical abuse, Sexual abuse, and Cohabitation with a registered sex offender. Types of confirmed or founded reports categorized as neglect were Neglect, Mental injury, Presence of illegal drugs in child's system, Exposure to methamphetamine manufacturing, and Access to child allowed by a registered sex offender.

<sup>5</sup> Risk factors analyzed were number of children ages zero to five, number of African-American children, number of Hispanic children, number of children living in poverty, teen births, low birthweight births, domestic violence, experience of four or more ACEs, children living in households with rent greater than 35% of income, mental illness, heavy drinking, and lack of insurance.

## Poverty

Table 8 shows the incidence of risk factors that had a statistically significant relationship between the incidence of abuse or neglect in Iowa counties and the incidence of each risk factor. Factors are ordered based on the strength of the relationship with abuse or neglect. The variable strongly correlated with both abuse and neglect was child poverty, although the relationship was more strongly associated with neglect than abuse. The rates of children living in poverty vary from four percent of the child population in Dallas County to twenty percent in Decatur.

**Table 8. Index of Child Abuse and Neglect Risk Factors**

	Iowa Percent	US Percent	Range Among All Counties	Average, Lowest 25 Counties	Average, Highest 25 Counties
<b>Factors Increasing Risk of Abuse</b>					
<b>Children Living in Poverty</b>	16%	21%	4%–20%	4%	20%
<b>Teen Births (rate per 1,000 teens)</b>	15.4	24.2	4.1–42.3	12.2	33.6
<b>Low Birthweight Births</b>	7%	8%	4%–10%	4%	10%
<b>Children Living with Parents with 4+ ACEs</b>	9%		2%–17%	2%	17%
<b>Factors Increasing Risk of Neglect</b>					
<b>Teen Births (rate per 1,000 teens)</b>	15.4	24.2	4.1–42.3	12.2	33.6
<b>Children Living in Poverty</b>	16%	21%	4%–20%	4%	20%
<b>Low Birthweight Births</b>	7%	8%	4%–10%	4%	10%
<b>Children Living with Domestic Violence</b>	1%	2%	0.0%–2%	0.0%	2%
<b>Children Living with Parents with 4+ ACEs</b>	9%		2%–17%	2%	17%
<b>Children Living in Households Where Rent is &gt;35% of Family Income</b>	16%	27%	3%–48%	3%	48%
<b>Children Between Ages Zero and Five</b>	27%	33%	21%–34%	24%	29%
<b>Children Living with Mental Illness in Family</b>	3%		0.0%–15%	0.1%	15%

**Sources:** (IDHS, 2017a; IDPH, 2017b; IDHP, 2017d; Iowa Department of Public Safety, 2017; University of Wisconsin Population Health Institute, n.d.; U.S. Department of Health & Human Services et al., 2017).

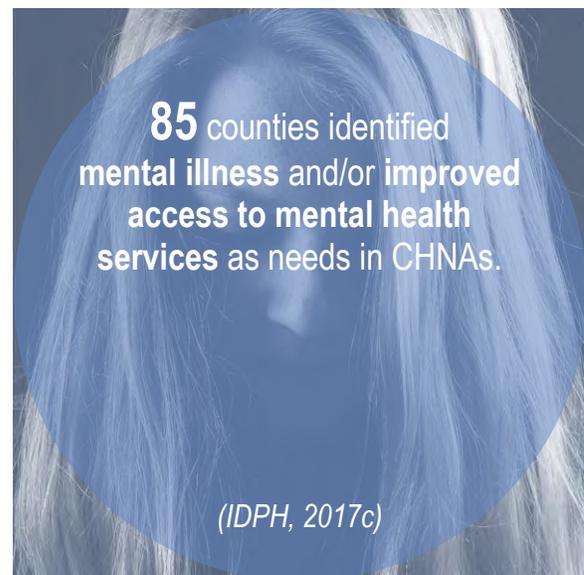
Poverty is a common presence in many problematic social trends such as poor health, obesity, substance abuse, and homelessness. It is beyond the scope of our analysis to claim causation of maltreatment, however. While poverty is correlated at a statistically significant level with both child abuse and neglect, this does not mean that poverty causes abuse and neglect, or that it only occurs when there is poverty. Rather, the correlation means that poverty is a risk factor; its prevalence in the community *can* be indicative of more abuse and neglect, but abuse and neglect can and does occur in the absence of poverty.

When these data were presented to prevention professionals through five focus groups conducted throughout the state, poverty and lack of employment opportunities offering a living wage were identified as important risk factors to address. In the separate survey of prevention professionals, 42 percent agreed that poverty is an important risk factor after substance abuse and mental illness. However, only one in three of those surveys said poverty should be targeted by prevention services and discussions regarding the relationship between poverty rates and abuse and neglect rates, which show some counties with high rates of maltreatment and low poverty rates and *vice versa*, highlighted the complicated relationship between these factors. One participant put it succinctly: “Just because you’re poor, doesn’t mean you’re abusing your kid.”

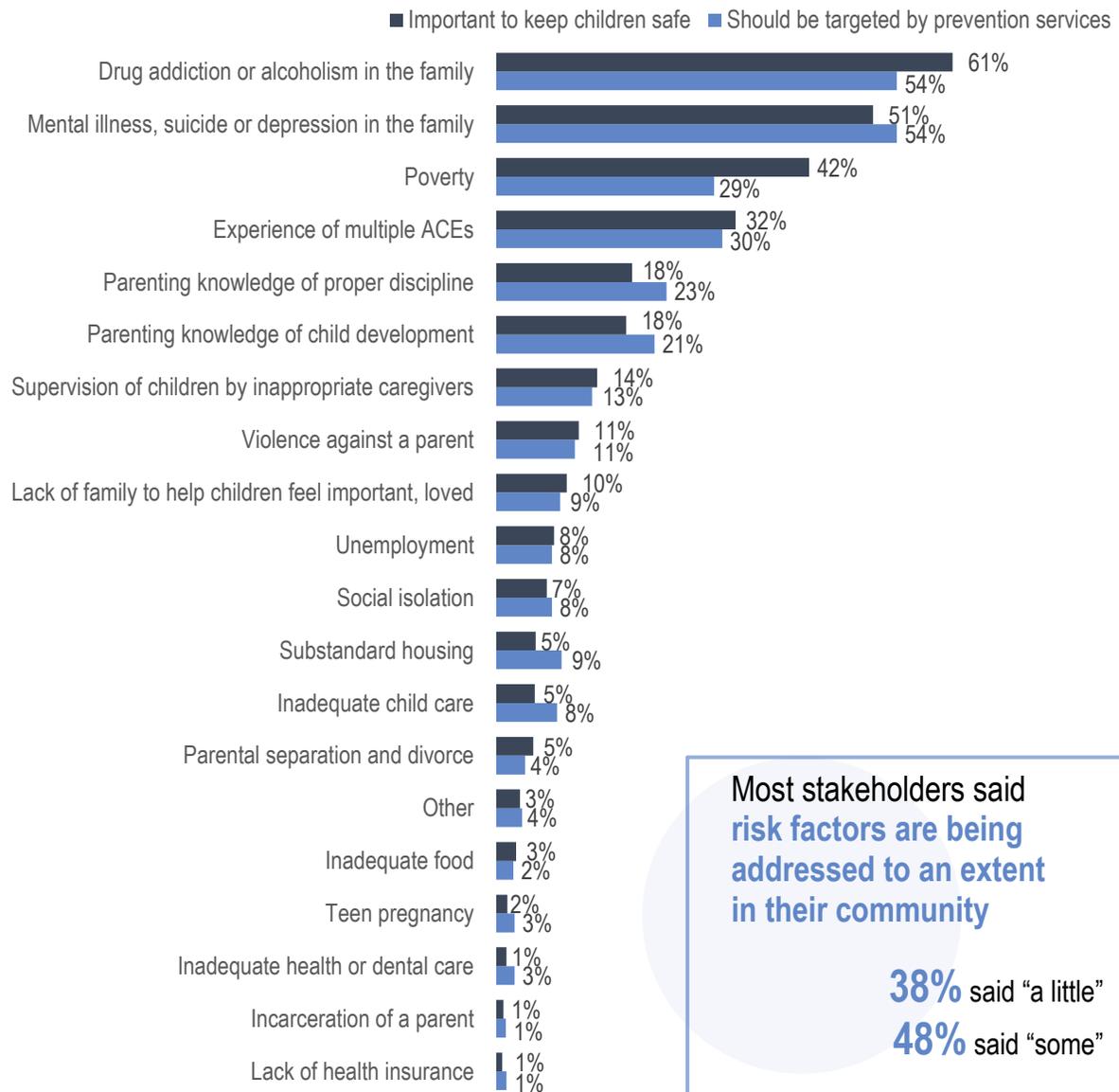
### **Other Risk Factors**

In addition to poverty, three other risk factors were correlated with both abuse and neglect: incidence of teen births, low birthweight births and high adverse childhood experience (ACE) scores. Others were correlated with neglect: domestic violence, high rent to income ratio, and mental illness. Looking broadly at county-level data, children who experience these risk factors are at increased risk of abuse or neglect.

Many other risk factors were identified by prevention professionals and other stakeholders in the focus groups and survey, demonstrating recognition of the complexity of child maltreatment. Figure 6 compares the factors prevention professionals identified as important to address to improve child safety and those that they said should be targeted by prevention interventions. Both addiction and mental illness were identified as important for child safety and critical to be targeted by half of those surveyed. In contrast, although 42 percent said poverty was important to keeping children safe, only about one third said it should be targeted by prevention services. More of those surveyed thought that adverse childhood experiences should be addressed through prevention.



**Figure 6. Comparison of Risk Factors Identified by Prevention Professionals**

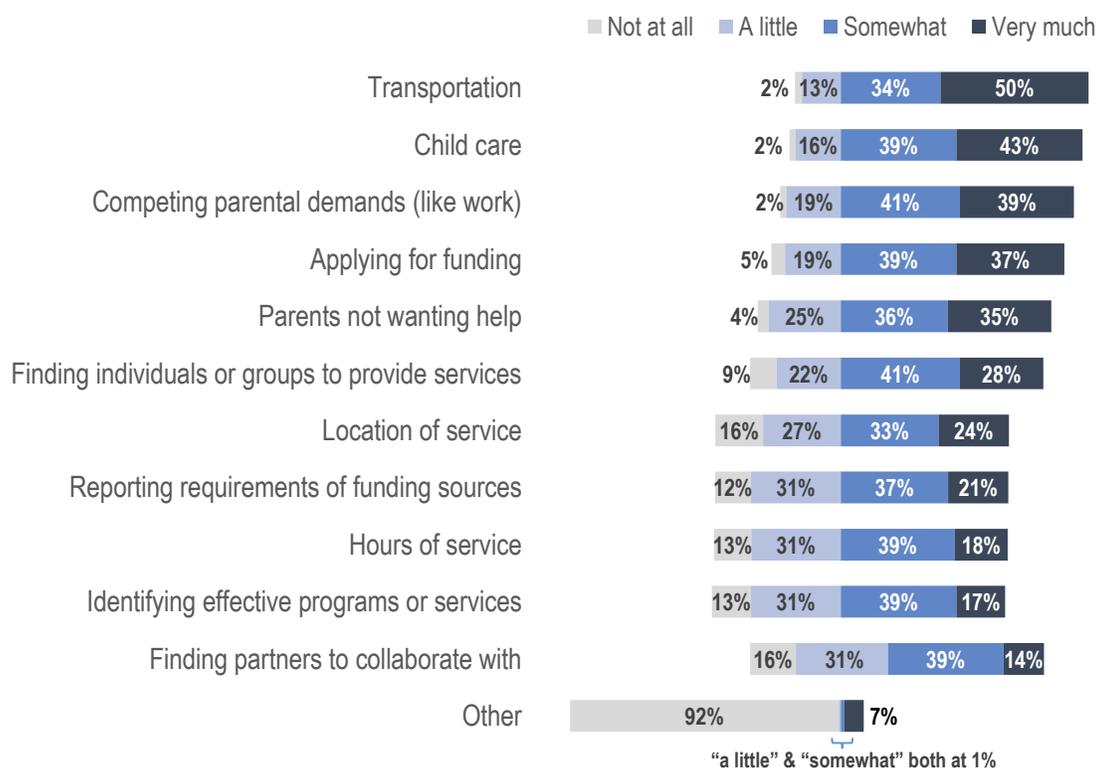


The risk factor analysis identified poverty, incidence of teen birth, low birthweight, domestic violence, four or more ACEs, high rent and mental illness as correlates with abuse and neglect. Alcoholism and drug addiction and mental illness were also underscored by professionals as important risk factors to address. This information will be used to inform the statewide strategic plan for prevention services.

## Barriers to Services

Numerous factors impacting families’ participation in services were identified by prevention professionals (Figure 7). For example, they identified some of the risk factors themselves as barriers, such as addiction and mental illness, and access to services was a common issue mentioned in the focus groups and surveys. In addition, lack of child care and transportation were identified as major concerns, with 50 percent of stakeholders surveyed saying transportation was very much a barrier and 43 percent saying the same regarding child care.

Figure 7. Barriers to Services



Four out of five survey respondents (80%) said that competing parental demands such as work impacted families’ ability to participate in services; this was a common theme in focus groups as well. Stigma, lack of service awareness and workforce development were among other concerns raised in focus groups. Although training costs of evidence-based practices have already been discussed, **providers also said challenges with staff turnover impacted their ability to build relationships and trust with families.** Finally, professionals emphasized the need for support for coordination of services and collaboration among providers. Ideas included creating “one-stop shops” for services and helping stakeholders build relationships with one another. One respondent saw the memorandum of understanding process under the upcoming combined ICAPP/CBCAP request for proposals as a step in that direction. Language barriers and the need for culturally competent services were issues discussed in some focus groups and surveys, although the prevention professional and youth surveys used in this needs assessment were not translated into other languages due to time constraints, and outreach to culturally specific groups was limited.

## Teens and Parents Said...

It was critically important to involve consumers of prevention services and messaging in the needs assessment process. Through collaboration with the Boys and Girls Clubs of Central Iowa, Parent Partners, and Youth & Shelter Services, Inc. surveys were collected from parents and teenagers; in addition, a focus group with youth in shelter was conducted. Overall, these efforts confirmed some of the same conclusions and risk factors mentioned by prevention professionals: the importance of good jobs and a living wage and the need for concrete supports like child care and transportation. However, an additional important finding was families' reliance on informal networks of families and friends and the importance that youth and parents put on strong positive relationships, emotional support, and stability.

### Informal Social Supports



**Family and Friends** Many more people said they relied on significant others, family and friends rather than professionals or people of authority. Nearly all parents said they trusted at least one family or friend, while only about one in three said they would seek help from formal sources of support, such as his or her child's teacher, a social worker or clergy. In the focus group youth said they felt more comfortable going to their peers or dealing with problems on their own. **Teens said that adults often minimize their needs or cannot understand what they need.**

### Positive Activities

Activities like sports and music were important to some of the youth surveyed and helped them get through difficult experiences. In contrast, not everyone had trusted resources they could go to for help. **About four out of 10 parents surveyed and six out of the 14 teens surveyed said they had an adult that they trusted to go to for help when they needed it.**



## What Families Need

### **Economic Opportunity**

The need for strong, steady incomes was a common theme for both parents and teens. **One in three of parents said their household has a living wage and two out of three had stable housing and reliable transportation.**



**Stability** When asked what they needed to succeed, teens said stability and support. Adults were not identified as common sources of support by youth, and one challenge mentioned in the focus group was the negative impact that being removed from family had on youth. **Among adults, emotional support and someone to talk to were also identified as needs.**



## A Closer Look at Who is Reached by ICAPP and CBCAP Programs

The results of the risk factor analysis indicate that families with certain characteristics are at greater risk of child abuse and neglect and stakeholders identified significant barriers to families' ability to access services. For this reason, the needs assessment looked at the recent ICAPP and CBCAP evaluation report to examine who existing programs are reaching and the extent ICAPP- and CBCAP-funded efforts are helping them.

**During fiscal year 2017 ICAPP and CBCAP grantees provided services to over 4,000 families and nearly 40,000 children.** Families primarily identified as white, although a higher proportion of Hispanic families participated than is represented in the overall population in the state (13% Hispanic or Latino served compared to 6% in the population). Based on reported income and household size, at least 40 percent of families were living below the federal poverty level, as well, compared to eight percent in the state.

Many caregivers also reported child maltreatment risk factors. The most common was mental illness, reported by 41 percent of caregivers, while 30 percent said they had been abused or neglected as a child, 21 percent said there had been violence in their home, and 19 percent said they abused drugs or alcohol. This information indicates that ICAPP and CBCAP grantees are successfully engaging many families impacted by the risk factors highlighted in the needs assessment.

Evaluation results also showed that ICAPP and CBCAP participants experienced an increase in protective factors during the course of program participation, based on the results of the Protective Factors Survey which participants complete at intake and regular follow-up periods. Overall, scores showed a significant increase, though small, in concrete support and family functioning and resiliency.

"It's more than providing parent education, you have to have a way to get people there, maybe a translator if [services are] not the appropriate language, child care, a meal, *et cetera*."

Prevention professional



Caregivers who reported certain risk factors of abuse and neglect had greater improvements in protective factors than other caregivers. Caregivers who were between the ages of 18 and 24 when their first child was born and those with a history of child abuse and neglect, drug and alcohol abuse, or a mental illness showed improvements in concrete support, while their counterparts without those risk factors did not. Caregivers with a history of child abuse also improved in social and emotional support. The conclusion of the evaluation was that programs may be successfully targeting those at a higher risk of child maltreatment and helping them improve their protective factors to a greater extent than other families.

**Poverty, mental health, addiction and childhood trauma stood out as the major risk factors of child abuse and neglect impacting families in Iowa. The index of social indicators also identified teen births, low birth weight, and domestic violence as statistically significant risk factors.** ICAPP and CBCAP programs do reach a diverse group of families across the state and evaluation results have shown that in the past families have experienced increases in concrete supports and family functioning protective factors as participants. Nonetheless, prevention professionals report families continue to face barriers to accessing services, particularly when they are working; other barriers are child care and transportation, the stigma associated with seeking help, and community attitudes which foster independence as opposed to interdependence.



## Conclusions and Recommendations

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PCA Iowa, in collaboration with HZA, conducted a comprehensive needs assessment of maltreatment prevention resources and risk factors. Programs and funding services were catalogued, including the EBPs utilized by ICAPP and CBCAP grantees. Programs provided through other state, federal and private entities were examined to determine if maltreatment prevention was their goal and to what extent they provided support to ICAPP and CBCAP grantees. In addition, a county-level analysis of risk factors of maltreatment was conducted. Finally, valuable input was gathered from teens, parents and prevention professionals through a series of regional focus groups and online surveys. Synthesis of these data sources have identified the following strengths and challenges of child maltreatment efforts in Iowa.

### Strengths

- **There is a strong commitment to families and children in Iowa.** Multiple sources at the federal, state, and local levels are funding maltreatment prevention strategies, particularly secondary prevention targeting families at risk.
- **ICAPP and CBCAP are funding projects that other sources are not and reaching families experiencing the risk factors identified in this assessment.** Sexual Abuse Prevention, Fatherhood, Respite Care and Crisis Care grantees all rely heavily on the grant programs for a large portion of their budgets. These types of programs address unique needs or populations that may not align with other funders' criteria.
- **There is a good match between the types of programs professionals say parents need (e.g., parenting classes) and what is already funded by ICAPP, CBCAP and other prevention programs.**
- **Most ICAPP and CBCAP grantees have adopted at least some EBPs,** including five which have the highest overall rating of exemplary for strong research evidence demonstrating positive outcomes among diverse groups of consumers.
- **Prevention providers note that collaboration with other programs and community members is helping them expand their reach.** There is a need to expand those efforts.
- **Both youth and parents identified family and friends as their primary sources of support.** Youth also mentioned other positive supports from activities like music and playing sports as being important to being successful.

## Challenges

The challenges identified in the needs assessment are grouped into two categories: those faced by families and those that impact prevention providers and programs.

### ***Families***

- **Poverty and other risk factors of child abuse and neglect are issues throughout the state.** There were statistical correlations between poverty, teen births, low birthweight and high ACE scores and both abuse and neglect; and children ages 0–5, households with high rent, domestic violence, and mental illness with child neglect. The correlations of abuse and neglect with teen births and low birth weight suggest the need to ensure strong collaboration between community groups, public health professionals, other service providers and stakeholders.
- **In focus groups and surveys, providers across the board identified mental illness, substance abuse, and other ACEs as major risk factors affecting families.** They also said that access to mental health and substance abuse services was lacking in many areas of the state.
- **Parents and youth said they needed financial stability, good jobs and close, positive relationships with family and people they could trust.** Employment in particular was an area that both groups cited as a challenge.
- **Both professionals and parents talked about families' lack of access to concrete supports (e.g., transportation, clothing and child care).** Professionals said that these issues made it difficult for families to access services and provide appropriate care for their children.
- **Funding restrictions and time may be impacting some parents' ability to participate in resources they need.** In particular, some families earn too much to qualify for programs targeting at-risk families.

### ***Prevention Providers***

- **Providers say lack of funding and a lack of flexibility in how funds can be used impact their ability to reach as many people as they could.**
- **Stigma and a lack of awareness of the issue of maltreatment** impacts whether people access services and support for prevention efforts among community members. Providers note sharing information about ACEs and communication strategies like Connections Matter are helping address these issues in some areas.
- **Although many providers use EBPs, ICAPP and CBCAP fund a high number of interventions which lack research support.** Although there is a wide variety of maltreatment prevention EBPs, providers said identifying appropriate interventions and paying for associated proprietary training can be challenging. Some types of programs funded through ICAPP and CBCAP, particularly Fatherhood, Community Development, Respite Care and Crisis Care programs have little, if any research support. In addition, among those using EBPs there is not currently data to measure adherence to model fidelity, an important component to evaluating program quality.

## Recommendations

Measurable goals and strategies that build on existing strengths and address the challenges identified in the needs assessment will be developed as part of the strategic planning process, which concludes in December 2017. Additional feedback on the plan's goals will be gathered from a statewide committee of diverse stakeholders. The strategic plan will be used to guide future requests for proposals for prevention services and evaluation of prevention efforts.

The incidence of child maltreatment in Iowa remains above the national rate, despite decreases in recent years. Iowa's Adverse Childhood Experiences (ACEs) data indicates that 56 percent of adult Iowans report experiencing one of the eight ACEs measured in the study. The rate of neglect in the state is four times that of physical abuse and ranges widely from county to county. While an average of 4.3 per 1,000 children experienced neglect in Winneshiek County between 2014 and 2016, 35.3 per 1,000 children in Lee County were neglected. The needs assessment found relationships between neglect and numerous risk factors, including teen births, poverty, low-birthweight births, domestic violence, high ACE scores and mental illness.

Research shows an increased risk for long-term physical, mental, and financial health outcomes for people exposed to household dysfunctions such as domestic violence, substance abuse, or mental illness or who have suffered child abuse or neglect without meaningful social supports. Risk factors for these social determinants of health are reduced when systems work together to implement trauma-informed practices that support the wellbeing of children and families. A coordinated public health approach is recommended to reduce the risk of children's exposure to toxic stress caused by abuse, whether physical or sexual, or neglect and improving protective factors through early access to concrete supports, evidence-based parenting education, and social supports for parents and children.

Qualitative and quantitative data collected in this needs assessment indicate an urgency for change in prevention practices in Iowa. The following recommendations are respectfully suggested:

**Coordinate maltreatment prevention funding sources across multiple service sectors (e.g., public health, early childhood, human services) to use each source strategically in combatting abuse and neglect.** This means working collaboratively across funding sources to identify common goals, services and quality standards using the needs assessment and strategic plan as a starting point. In the short term, ICAPP and CBCAP funding can be used to complement the programming already well-funded by other sources (e.g., early childhood and home visiting).

Long-term recommendations for coordinating funding include promoting CPPC and council membership so that families and stakeholders from all service sectors are represented and active throughout the state, and the unification of prevention programming and funding within a single state department (current funding for prevention programs in Iowa are divided among many departments). A single department managing prevention programming would minimize duplication of costly administrative oversight, improve collaboration, and direct more prevention dollars to the community.

**Reduce child maltreatment by targeting risk factors presented by families which are most closely correlated with abuse and neglect.** This means making information about services that address the conditions of poverty, teen births, low birthweight, domestic violence, adverse childhood experience, mental illness and substance abuse accessible and available. In the short term, all ICAPP and CBCAP grantees, no matter their function, should be able to identify community resources in each of these areas to consumers they currently serve.

In the long term, prevention providers can develop innovative strategies and partnerships to reach families and integrate prevention services into existing community supports such as schools and health care providers. Barriers to services such as lack of child care and transportation also need to be removed for all families. Existing prevention resources in the state can be improved. Information about prevention and early intervention programs and connection to local community resources is scattered across departments and non-governmental organizations and current online resources can be streamlined. Efforts could be made to provide universal access in multiple languages for families and community members seeking services through existing services such as United Way 2-1-1 and the Family Support Network.

**Increase workforce development in cultural competence, EBPs and trauma-informed prevention and care.** This means embedding culturally responsive, evidence-supported and trauma-informed practices into all systems that help families. In the short term, an assessment of prevention professionals' cultural competence and trauma-informed practices can be conducted. In addition, a single standard or rubric to identify evidence-based practices and innovative interventions can be adopted by ICAPP and CBCAP in order to minimize the confusion that professionals reported about EBPs. Developing a menu of EBPs for selection by ICAPP and CBCAP grantees, as well as standards for identifying and selecting innovative approaches, are other strategies that would improve the quality of services being provided.

Long-term strategies for improving the quality of prevention services include expanding the prevention workforce to be more culturally representative of the people served and funding EBP trainings to increase the adoption of supported practices. Professionals throughout the state said that organizations need help with the cost and infrastructure to adopt EBPs.

In addition, a prevention response to the ACEs study indicates a need for professionals working in all sectors (including Education, Human Services, Public Health, Corrections, Workforce Development, Human Rights, Judicial, and the Legislative branch, as well as all child-serving organizations) to share a common understanding of ACEs research, and to adopt trauma-informed practices that mitigate the costly impact of child abuse and neglect through earlier intervention and prevention. Other states such as Washington have seen significant declines in teen pregnancies, juvenile detention, school drop-out rates, and teen suicides within ten years of adopting trauma-informed practices and policies across sectors. Adopting these and other evidence-based and culturally competent practices improves outcomes for children and families.

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## Appendix A: Methodology

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A mixed method approach using both qualitative and quantitative data sources was used to gain a thorough understanding of prevention programming, funding, community needs and risks factors of child maltreatment among families in Iowa. The approach and descriptions of each data source for the assessment are provided below.

### Analysis of Prevention Programs and Funding Sources

To identify the prevention programs currently found in Iowa and their funding sources, HZA began by reviewing a list of 121 programs funded through state, federal and local expenditures provided by IDHS. Each program's website was visited to read an overview of the program. A challenge of the review was drawing a distinction between programs that benefit children and families and thus may have some impact on child abuse and neglect, and those programs that specifically work to prevent maltreatment. To be included in the analysis, programs had to identify child maltreatment prevention as a component of the program. From the original 121 programs, the list was narrowed to 16 which stated in their descriptions that they sought to prevent abuse and neglect. One additional program was identified, funded by private sources (PCA Iowa's Connection Matters).

For each of the 16 programs, a more thorough review of the programs' websites, annual and fiscal reports, and promotional materials was conducted to determine the following characteristics:

- Number of families or clients served
- Service area(s)
- Extent to which maltreatment prevention is a primary goal of the program
- Extent to which the program funds evidence-based practices (and which ones, if available)
- Types of prevention programs funded (*e.g.*, Crisis/Respite, Parent Development or Home Visiting)
- Total and county-level funding (for fiscal year 2017, unless unavailable)
- Type of funding (*e.g.*, state, federal, and/or local sources)

### Funding Analysis

The goals of the funding analysis were to determine the following:

- Total amount of funding in Iowa for child maltreatment prevention
- Amount of funding per child going to each county
- Percent of ICAPP and CBCAP grantees' budgets funded by ICAPP and CBCAP
- Percent of prevention funding provided by ICAPP and CBCAP statewide and by county

Ultimately, funding information was available for 13 of the 16 programs and county-level funding was available for five programs. In instances in which county-level information was not available, county-level estimates were developed based on counties' child population. For example, for statewide programs, a proportion of the overall budget was attributed to each county based on the proportion of the child population in each county. A similar approach was employed for programs in which funding information was available for smaller, multi-county service areas (e.g., ICAPP, CBCAP and ECI).

### ***Review of Prevention Evidence-Based Practices***

Another component of the needs assessment was a thorough review of prevention evidence-based practices (EBPs) utilized in Iowa. A list of EBPs currently funded by ICAPP and CBCAP was developed and additional prevention programs were identified. Five clearinghouses of EBPs were consulted to create an inventory of these EBPs and an overall rating was provided for each program based on the ratings of evidence given by each clearinghouse.

### **Maltreatment Risk Factor Analysis**

To determine the needs and risk factors associated with child abuse and neglect in Iowa, HZA analyzed data on multiple social indicators. The goals of the analysis were to determine the extent to which common risk factors of abuse and neglect were of concern in Iowa and identify specific communities in the state (through a county-level analysis) that had an increased risk of abuse and neglect.

To identify risk factors for the analysis, HZA conducted a review and analysis of secondary data sources. Based on the child maltreatment literature, risk factors of abuse and neglect were identified and researched to locate reliable, county-level data. To determine if there was a correlation between the risk factors identified and the incidence of child abuse and neglect, a correlation analysis was run using the Pearson correlation coefficient. Although it is not possible to determine causality based on this analysis, it does provide insight into what risk factors children who have been abused or neglected experience.

Only data sources with sufficient sample size and reputable sampling techniques (for survey data) were used in the analysis and are presented in this report. Data sources used include IDHS's child abuse and neglect data, the U.S. Census Bureau's American Community Survey, Behavioral Risk Factors Surveillance System (BRFSS) data, Iowa Department of Public Safety information on domestic violence, and Robert Wood Johnson County Health Rankings. For all sources, the most recent data available was used. Each data source is described in more detail below:

**IDHS Child Abuse Statistics:** IDHS compiles data on child abuse and neglect for all Iowa counties (IDHS, 2017). For the purposes of this report, 2016 counts of reports of types of maltreatment were used to determine the incidence of abuse and neglect per 1,000 children in each county. The following types of abuse were included in each category:

Types of Confirmed or Founded Reports Categorized as Child Abuse:

- Physical abuse
- Sexual abuse
- Cohabitation with a registered sex offender

Types of Confirmed or Founded Reports Categorized as Neglect:

- Neglect
- Mental injury
- Presence of illegal drugs in child's system
- Exposure to methamphetamine manufacturing
- Access to child allowed by a registered sex offender

**American Community Survey (ACS) (U.S. Census):** The ACS is an ongoing survey of the United States population which captures population and housing information (U.S. Census Bureau, 2013). Surveys are sent to a randomly selected sample of addresses in the United States each month. For the purposes of this report ACS estimates from 2011–2015 on race, ethnicity, poverty and housing costs were used.

**Behavioral Risk Factors Surveillance System (BRFSS):** BRFSS is a telephone survey of health-related behaviors and overall health (CDC, 2017). In Iowa, since 2008 the survey also contains questions regarding adverse childhood experiences (ACEs). County level estimates using data from 2011-2015 were used in the risk factor analysis. Data analyzed included prevalence of heavy drinking, adverse childhood experiences and mental illness.

**Iowa Department of Public Health Vital Statistics:** IDPH vital statistics data was used to determine the teen birth rate per county (IDPH, 2017d).

**Iowa Department of Public Safety (IDOPS):** IDOPS data was used to identify the number of victims of domestic violence per county, using Uniform Crime Reporting statistics from 2016 (Iowa Department of Public Safety, 2017).

**Robert Wood Johnson County Health Rankings:** The County Health Rankings provide a look at communities' health (University of Wisconsin Population Health Institute, n.d.). 2016 data on children born with low birth weights were used in the analysis of risk factors.

## Stakeholder Focus Groups and Surveys

To inform the discussion of the needs of Iowa families, a series of focus groups was conducted during PCA Iowa’s annual regional meetings. Participants were primarily representatives of grantee organizations funded through IDHS’ prevention programs. During the focus groups, participants reviewed and provided reactions to the preliminary risk factor and funding analyses. They shared their own experience as prevention providers, including the challenges and strengths of programs in their area. Focus groups were completed at the five regional meetings and one was held at the ECI leadership meeting.

In addition to the focus groups, online surveys were developed to gather feedback from a broader audience. A total of 52 parents responded to surveys in both English and Spanish through outreach to Parent Partners and the Girls and Boys Clubs of Central Iowa. To get feedback from teenagers, a focus group was held at a youth homeless shelter and fourteen teens completed an online survey. Table A-1 shows the demographic characteristics of both parents and children surveyed.

**Table A-1. Demographic Characteristics of Parents and Youth Surveyed**

Youth	Youth (n=14)	Parents (n=52)
<b>Gender</b>		
Male	42%	21%
Female	50%	77%
Other	8%	0%
<b>Race/Ethnicity*</b>		
White	64%	58%
Black/African American	36%	15%
American Indian/Alaska Native	8%	0%
Asian/Pacific Islander	0%	0%
Hispanic/Latino	14%	29%
Mixed or Multiple races	14%	2%
Other	8%	0%
<b>In school</b>	64%	10%
<b>Employed</b>	46%	81%
<b>Stable place to live</b>	36%	65%

\* Respondents could select more than one race or ethnicity.

Finally, a survey targeting prevention professionals circulated to Early Childhood Iowa and PCA Iowa’s listservs, with a total of 912 surveys collected. Table A-2 identifies the primary fields and affiliations of respondents. The most common field was Child Welfare, identified by about one in five respondents (19%). One-third of respondents were affiliated with a Community Partnership for Protecting Children Site (17%) or a Child Abuse Prevention Council (17%).

**Table A-2. Survey Respondents’ Primary Fields and Affiliations**

Primary Fields	Percent	Affiliation	Percent*
Child Welfare	19%	Community Partnership for Protecting Children Site	17%
Social Work	13%	Child Abuse Prevention Council	17%
Education	12%	Early Childhood Iowa	15%
Early Childhood	11%	Iowa State University Extension	5%
Family Support	7%	Other	15%
Public Health	6%	Unknown/Not Specified	52%
Advocacy/Community Development	6%		
Home Visiting	5%		
Psychology/Counseling	5%		
Youth Services	4%		
Domestic Violence/Victim Assistance	2%		
Developmental Disabilities	1%		
Public Assistance	1%		
Housing	0.3%		
Other (e.g., foster parent, health care, legal/law enforcement, substance abuse)	10%		

\*Respondents could identify more than one affiliation.

### Other Data Sources

Other data sources also were reviewed during the course of the needs assessment. Independent research on child maltreatment prevention strategies, Iowa’s county-level Community Health Needs Assessments and Health Improvement Plans, developed by local public health agencies every five years, and evaluation results from ICAPP and CBCAP programs are presented in this report to provide additional insight into successful prevention strategies, the needs of Iowa communities and the impact of current prevention efforts.

IDHS wishes to understand the goals of prevention programs currently funded in Iowa, the goals of other funding streams, the availability of evidence-based practices and the primary risk factors of child maltreatment in Iowa. A diverse set of qualitative and quantitative data sources were used to accomplish these goals of the needs assessment.

## Appendix B: Inventory of Evidence-Based Practices

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HZA reviewed five evidence-based practice EBP clearinghouses and previous literature reviews conducted on behalf of PCA Iowa to develop an inventory of maltreatment prevention EBPs. Clearinghouses utilize different criteria and rating scales. EBPs are also evaluated based on their effectiveness on multiple outcomes, which may result in more than one ranking. The clearinghouses consulted to develop the inventory and evidence levels were:

1. **California Evidence-Based Clearinghouse for Child Welfare (CEBC)** (CEBC, 2017)
2. **Blueprints for Healthy Youth Development** (Blueprints Programs, 2017)
3. **Home Visiting Evidence of Effectiveness (HomVEE)** (Home Visiting Evidence of Effectiveness, n.d.)
4. **National Registry of Evidence-based Programs and Practices (NREPP)** (Substance Abuse and Mental Health Services Administration, n.d.)
5. **Office of Juvenile Justice, Detention and Prevention (OJJDP) Model Programs Guide** (Office of Juvenile Justice, Detention and Prevention, n.d.)

A profile was developed for each EBP that includes a description of the program and its goals, the type of intervention, category of prevention, target audience and overall level of evidence. The National Alliance of Children's Trust and Prevention Funds' levels of effectiveness was used to determine the level of evidence for each program. Criteria are based on the work of Buysse and Wesley (2006), the federal Centers for Disease Control and Prevention (CDC), and the Advisory Group to the Children's Bureau Office of Child Abuse and Neglect (OCAN) (National Alliance of Children's Trust and Prevention Funds, 2009). The four levels of evidence are as follows:

1. **Innovative Programs:** Professional experience and best available knowledge support the intervention that is undergoing evaluation to elicit family responses and to identify effectiveness under certain conditions with a selected group.
2. **Promising Programs:** Professional experience and family endorsement affirm the effectiveness of evidence-informed programs that have not yet accumulated evidence of effectiveness under rigorous evaluation.
3. **Supported Programs:** Scientific evidence of effectiveness is positive, professional experience is favorable, and family endorsement concurs but the programs have not been widely implemented. Evidence is favorable to implement a "supported program" under new conditions or a different population to generate more findings.
4. **Exemplary Programs:** Rigorous scientific evidence, accumulated professional experience, and family endorsement concur on the effectiveness of programs through positive outcomes that are evident with diverse groups in different settings.

In addition, the ratings the intervention received from each clearinghouse are provided. Each source uses different criteria and ratings systems. SAMHSA’s NREPP recently changed its criteria and began reviewing previous ratings in 2015 (a process that will continue through 2019) (SAMHSA, 2016a). Those programs which were reviewed under the old criteria are marked as Legacy programs in the clearinghouse ranking tables. Because NREPP provides evidence ratings for each program outcome, those individual rankings are provided when available (see the “A closer look at NREPP” sections).

## 1-2-3 Magic

**Rated: Promising**

**Type of Program:** Parent Development



**Category:** Parenting Skills

**Target Audience(s):** Parents with children between the ages of two and 12

**Program Summary:** 1-2-3 Magic: Effective Discipline for Children 2–12 is a group-based discipline program for parents which breaks down parenting into three categories of tasks: controlling negative behavior, encouraging good behavior, and strengthening the parent-child relationship (California Evidence-Based Clearinghouse, 2017a). Groups are typically held once or twice a week for four to eight weeks. The overall goals of the program are to teach parents the following skills and knowledge: one tactic for managing negative behavior, six ways to encourage positive behavior and four strategies for building their relationships with their children.

### Clearinghouse Rankings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/1-2-3-magic-effective-discipline-for-children-2-12/>

## 24/7 Dad®

**Rated: Innovative**



**Type of Program:** Parent Education and Development

**Category:** Parenting Skills

**Target Audience(s):** Fathers with children aged 18 or younger

**Program Summary:** 24/7 Dad is composed of a two-part curriculum designed to teach fathers how to care for themselves, their children, and manage important relationships in their lives. The main goals are to increase awareness and knowledge among fathers about the elements to being good fathers and increase capacity or skills to carry out what fathers learn (California Evidence-Based Clearinghouse, 2017b). The programs cover pre-defined topics such as: defining manhood, communicating with children, providing guidance and discipline, handling anger, articulating the father's role, learning about how children grow and develop, and working with a co-parent (Spach, Battis, & Nelson, 2014). There are currently no peer reviewed studies on this program, though there are several technical reports available (Spach et al., 2014). There have been several studies, however, that have found that after completing the 24/7 Dad basic program, participants showed improvement in pre- and post-test scores in self-awareness, caring for self, parenting skills, relationship skills, and fathering skills (da Rosa & Melby, 2012; Olshansky, 2006).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	NR – Not able to be rated
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/24-7-dad/>

## Active Parenting Now

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Parenting Skills

**Target Audience(s):** Parents and caregivers of children ages five to 12

**Program Summary:** Active Parenting Now, also called Active Parenting 4th Edition is a parent development program targeting the parents of five to twelve-year-olds who want to improve their parenting skills. The program is based on the Adlerian parenting theory, which is to assure that all family members are heard and respected (Spach et al., 2014). A program for teens has also been developed, although it has not been reviewed by evidence-based clearinghouses. Through a video-based education program, parents are taught how to build their child’s self-esteem with strategies such as encouragement, active listening, honest communication, and problem solving. Active Parenting also teaches parents how to use natural consequences to reduce unacceptable behaviors. Active Parenting is made up of one two-hour class per week over the course of six weeks (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	NR – Not able to be rated
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.0 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP:

Outcome	Rating
Parental perceptions of child behavior	3.1 (0.0–4.0 scale)
Parental attitudes and beliefs	3.1
Parent-child relationship problems	3.3
Positive and negative child behaviors	2.2

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/active-parenting-now/detailed>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=110>

# All Babies Cry

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Caregivers with infants

**Program Summary:** All Babies Cry (ABC) is a prevention program for parents of infants, which aims to reduce incidences of child abuse during the first year of life. ABC aims to improve parents' ability to understand and cope with infant crying because it is the most common antecedent to child maltreatment in the first year of life. The program promotes protective factors that have been shown to increase positive outcomes for young children and their families and to reduce the likelihood of child abuse and neglect: 1) resilience, 2) social connections, 3) knowledge of parenting and child development, 4) concrete support, and 5) social and emotional competence of children (SAMHSA, 2016b).

ABC is intended for use at the time of hospital discharge through the infant's first months of life. The core program components are a short video program for hospital closed-circuit TV systems or classroom introduction; media, including videos, for families to access at home or on mobile platforms; and a booklet with checklists and activities. The components employ positive visual messaging and focus subtly on males (the perpetrators of a majority of pediatric abusive head trauma cases) (SAMHSA, 2016b).

## Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	Not listed
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Promising (three outcomes)
Office of Juvenile Justice and Delinquency Prevention	Not listed

## A closer look at NREPP:

Outcome	Rating
Knowledge, Attitudes, and Beliefs	Promising
Resilience	Promising
Self-Concept	Promising

## Resources:

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=118#hide1>

## Alternatives for Family – Cognitive Behavioral Therapy

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Mental health and behavioral treatment

**Target Audience(s):** Caregivers who are emotionally or physically aggressive or abusive with their children; Children ages five to 17 with aggression and/or trauma related symptoms

**Program Summary:** Alternatives for Families is an intervention for families who have experienced or are at risk for problems with anger, aggression or child maltreatment. Goals of the program include decreasing conflict, anger and hostility, threats of force and risk of maltreatment (SAMHSA, 2015). The program is administered via joint or individual sessions with caregivers and children, usually over a six- to nine-month period. Practitioners are master’s level clinicians in mental health or other fields (SAMHSA, 2015).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.1 out of 4.0
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP:

Outcome	Rating
Internalizing behaviors	3.1 (0.0–4.0 scale)
Externalizing behaviors	3.1
Family functioning	3.1
Disruptive behavior disorders	3.1

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=396>

# Avance Parent-Child Education Program

**Rated: Supported**



**Type of Program:** Home Visiting

**Category:** Parenting skills

**Target Audience(s):** Caregivers of children age zero to three; pregnant women and their partners

**Program Summary:** The Parent-Child Education Program is a nine-month parent education curriculum geared toward improving children’s physical, emotional, social and cognitive development. Home visits are conducted on a monthly basis, in addition to regular parenting classes. While parents participate enrichment activities are also available for children (CEBC, 2017a).

## Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	2 – Supported by research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

## Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/avance-parent-child-education-program/>

## C.A.R.E.S.

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention; Healthy child development; Juvenile justice prevention

**Target Audience(s):** Families at high risk for abuse or neglect with children ages zero to 17

**Program Summary:** C.A.R.E.S. (Coordination, Advocacy, Resources, Education and Support) is a community-based prevention and diversion program for families at high risk for abuse, neglect, or abandonment. C.A.R.E.S. uses Wraparound Family Team Conferencing to support both children and their parents. The program builds upon families' strengths using the Wraparound Principles of practice, convenes Family Team Meetings and designs an individualized plan of care to enhance family functioning and minimize the likelihood of child maltreatment and further family involvement with child protective services (California Evidence-Based Clearinghouse, 2017c).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/c-a-r-e-s-coordination-advocacy-resources-education-and-support/>

## Child FIRST

Rated: Promising



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** High-risk families with children ages six to 36 months

**Program Summary:** Child FIRST coordinates services and therapeutic support to decrease problematic outcomes for youth, including behavioral and emotional problems, developmental and learning difficulties, and abuse and neglect among high-risk families. The home visiting service is shaped by recent developments in neuroscience, which suggest that toxic environments (including poverty-ridden environments) can lead to negative outcomes. By combining mental health, early care and education, health care and social support programming, Child FIRST seeks to “improve parent-child relationships while creating an environment for healthy emotional and cognitive development” (Benedetti, 2012).

Child FIRST begins with a detailed family assessment including a family observation conducted by a clinician and care coordinator. With this information, the team (which is comprised of the family members, clinician, and care coordinator) develop a Child and Family Plan of Care. This plan includes determining goals, parent priorities, strengths, culture, and needs of the family. Weekly home visits teach parents about child development, behavior and age-appropriate expectations; help parents understand the long-term effects of trauma; review and practice problem solving strategies; and provide time for parent reflection on difficulties. An important component of this program is that it provides social support and connections to appropriate services (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Promising
California Evidence-Based Clearinghouse	Not listed
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Effective (four outcomes) Promising (four outcomes) Ineffective (one outcome)
Office of Juvenile Justice and Delinquency Prevention	No effects, one study

### A closer look at NREPP:

Outcome	Rating
Receipt of social services	Effective
Disruptive behavior disorders and externalizing/ antisocial behaviors	Effective
Depression/ depressive symptoms	Effective
Non-specific mental health disorders and symptoms	Effective
General functioning and well-being	Promising
Family cohesion	Promising
Self-regulation	Promising
Internalizing problems	Promising
Receipt of social services	Ineffective

### Resources:

**Blueprints profile:** <http://blueprintsprograms.com/evaluation-abstract/child-first>

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=138#hide1>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=447>

# Circle of Security-Home Visiting

**Rated: Promising**



**Type of Program:** Home Visiting

**Category:** Parenting skills

**Target Audience(s):** At-risk families with children ages zero to six years old

**Program Summary:** The Circle of Security-Home Visiting program combines the protocols of Circle of Security with mandatory home visits. The fundamental components of Circle of Security are teaching caregivers about attachment theory, exploring internal working models, and providing a simple structure for understanding how their own working models impact their reactions to their children’s behaviors (CEBC, 2017c).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/>

## Early Head Start

**Rated: Supported**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention; Child and maternal health

**Target Audience(s):** Women and families from low income households with children ages zero to three

**Program Summary:** Early Head Start provides a combination of home- and center-based services to families at or below the federal poverty level. Weekly home visits are conducted as well as two socialization activities per month involving caregivers and their children (U.S. Department of Health & Human Services, 2016). Targeted outcomes include improvements in child development, school readiness, child and maternal health, economic self-sufficiency, parenting practices and reductions in maltreatment.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Meets criteria for evidence-based home visiting model
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <https://cebc4cw.org/program/early-head-start/>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/Early-Head-Start-Home-Visiting--EHS-HV-/8/1>

# Effective Black Parenting Program

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** African-American caregivers of children ages zero to 17 at risk for maltreatment

**Program Summary:** Effective Black Parenting Program (EBPP) is a parenting program for parents of African-American children. The program has multiple goals including child abuse and child behavior disorder prevention and treatment, promotion of cultural pride, reduction of parents' stress and prevention of substance abuse (CEBC, 2017b). Originally designed as 15 small group sessions, a one-day seminar version for large numbers of parents has been created (CEBC, 2017b).

## Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

## Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/effective-black-parenting-program/detailed>

## Exchange Parent Aide

**Rated: Promising**

**Type of Program:** Home Visiting



**Category:** Child maltreatment prevention

**Target Audience(s):** Families with at least one child age birth through 12 years in the home and at-risk for maltreatment

**Program Summary:** Exchange Parent Aide is a home visiting program that is designed to help prevent child abuse and neglect through assuring child safety, improving parenting and problem-solving skills and improving social supports. Families that are at risk of child abuse or neglect, who voluntarily agree to engage in services, are matched with trained and qualified Parent Aides, who provide education and support to at-risk families.

The program focuses on strength-based, family-centered services. (Spach et al., 2014) Families are assigned a Parent Aide, who is either a volunteer or paid staff member of the program. Families are given an Initial Needs Assessment (INA), which identifies abuse histories, needs of the family, internal relationships, coping skills, and other basic information about the family. From this information, a treatment plan is created, which focuses on child safety, problem solving skills, parenting skills, and social support. The Parent Aide then begins visiting the home once or twice weekly for several months, providing the family with support and education, and helping them achieve goals on the treatment plan. Weekly phone calls, and parents have access to their Parent Aide 24 hours a day, seven days a week (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/exchange-parent-aide/detailed>

## Families and Schools Together

**Rated: Supported**



**Type of Program:** Parent Development

**Category:** Juvenile justice prevention

**Target Audience(s):** Children in pre-Kindergarten through fifth grade and their families

**Program Summary:** The purpose of FAST is to build relationships between and within families, schools and communities through group-based or social support activities. By utilizing social ecology, family systems and family stress theories, FAST works to enhance parent-child bonding and family functioning while reducing conflict, isolation and child neglect; enhance school success through more family engagement; prevent substance use by both adults and children by building protective factors and referring appropriately for treatment; and reduce the stress by empowering parents, building social capital, and increasing social inclusion (CEBC, 2017f; Spach et al., 2014). FAST is delivered through several phases, including eight weeks of multifamily meetings and parent group meetings for the following two years, which are parent-led sessions with support from the program (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.7 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Effective – More than one study

### A closer look at NREPP Ratings:

Outcome	Rating
School Mobility	3.7 (0.0–4.0 scale)

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/kids-families-and-schools-together-kids-fast/>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=375>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=185>

## Families First

**Rated: Promising**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** At-risk families and children ages zero to 17

**Program Summary:** Families First is a high-intensity home visiting model for families with at-risk youth. Home visitors meet at the home three to four times per week for ten to twelve weeks (CEBC, 2017d). The goals of the program include helping parents effectively intervene with their children, teaching parents and children prosocial skills, and improving family relationships. The model is not appropriate in homes in which a client is actively abusing drugs or alcohol, domestic violence is present in the home or there is a need for hospitalization due to suicide or other serious mental illness.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/families-first/>

# Family Connections

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Families at risk of child maltreatment; children age zero to 17

**Program Summary:** Family Connections is a community-based service program that works with families to help them meet the basic needs of their children and prevent child maltreatment. The principles that guide the interventions include ecological developmental framework, community outreach, individualized family assessment, helping alliance, empowerment, strengths-based practice, cultural competence and outcome-driven service plans (CEBC, 2017e). Practitioners meet with families at least once a week for one hour for at least three months, connect families to concrete supports, and use standardize assessment tools to help determine families' needs (CEBC, 2017e).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/family-connections/detailed>

## Healthy and Safe

**Rated: Promising**

**Type of Program:** Home Visiting



**Category:** Parenting skills; Healthy child development

**Target Audience(s):** Parents with learning difficulties who are caregivers to children ages zero to four

**Program Summary:** Through Healthy and Safe parent educators teach parents how to respond appropriate to their children’s health needs. Designed as a supportive program for parents with learning difficulties or unique learning needs, the curriculum using a combination of parent workbooks and in-home experiential education (CEBC, 2017h). The goals of the program are to improve parents’ understanding of child health and symptoms of illness, visiting the doctor, managing home dangers and prevention of injury.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/healthy-safe/>

# Healthy Families America

**Rated: Exemplary**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** High-risk families expecting a baby or who have children under five. Services must be initiated either prenatally or within three months after the birth of the baby.

**Program Summary:** Healthy Families America (HFA) is a home visiting program that targets high-risk families who are expecting a baby or who have children under five. HFA is affiliated with Prevent Child Abuse America (PCA) and as such is the primary home visitation model used by PCA in working to reduce child abuse and neglect and other adverse childhood experiences. The programs follow a series of best practice standards that provide a solid structure and flexibility to meet the unique needs of families and communities. The program asserts that different communities have different needs that can be addressed through their structured prevention service, when provided as part of a system of care (Spach et al., 2014). Identified families are served by paraprofessionals through regular home visits and to other services related to basic needs, mental health or substance abuse, school readiness, employment, and childcare.

## Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	1 – Well supported by research evidence <sup>6</sup>
Home Visiting Evidence of Effectiveness	Meets criteria for evidenced-based home visiting model
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Promising – One study

## Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-child-well-being/>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/Healthy-Families-America--HFA--sup--sup-/10/1>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=200>

<sup>6</sup> CEBC's rating of HFA for child well-being is 1 – Well Supported. CEBC's rating of HFA for prevention of child abuse and neglect is 4-Evidence fails to Demonstrate Effect (California Evidence-Based Clearinghouse for Child Welfare, 2017g).

## Homebuilders

**Rated: Promising**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** Families with children between the ages of zero and 18 at imminent risk of or with children returning from out of home placement

**Program Summary:** The goals of Homebuilders are to prevent out of home placement of children, and improve parenting skills, family relationships, children’s behavior and safety (National Institute of Justice, 2012). The program is intensive and time-limited, with one clinician serving two families for four to six weeks and available around the clock for crisis intervention. Therapists use evidence-based interventions such as motivational interviewing while working with families to help families build both informal and formal supports.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	2 – Supported by research evidence
Home Visiting Evidence of Effectiveness	Does not meet criteria for evidence-based model
National Registry of Evidence-based Programs and Practices	Promising (four outcomes) Ineffective (three outcomes)
Office of Juvenile Justice and Delinquency Prevention	Effective - More than one study

### A closer look at NREPP Ratings:

Outcome	Rating
Permanency	Promising
Self-concept	Promising
Family cohesion	Promising
Social connectedness	Promising
Internalizing problems	Ineffective
Disruptive behavior disorders and symptoms	Ineffective
Social competence	Ineffective

**Resources:**

**CEBC profile:** <http://www.cebc4cw.org/program/homebuilders/>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/HOMEBUILDERS--Birth-to-Age-5--sup---sup-/34/1>

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1250>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=210>

# HIPPY

**Rated: Supported**



**Type of Program:** Home Visiting

**Category:** School readiness

**Target Audience(s):** Parents with children ages three to five with limited formal education

**Program Summary:** Home Instruction for Parents of Preschool Youngsters (HIPPY) is a home visiting program which supports parents' role as their child's first teacher through weekly home visits and group meetings (U.S. Department of Health & Human Services, 2013). Home visitors help parents address their own reservations about school and negative experiences in education they have had. Program participation can last up to two years. Studies have found positive outcomes including improvements in child development, school readiness, and use of positive parenting practices.

## Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	2 – Supported by research evidence
Home Visiting Evidence of Effectiveness	Meets criteria for evidence-based home visiting model
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

## Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/home-instruction-for-parents-of-preschool-youngsters/>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/Home-Instruction-for-Parents-of-Preschool-Youngsters--HIPPY--sup---sup-/13/1>

## Incredible Years

**Rated: Exemplary**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Parents, teachers, and children

**Program Summary:** The Incredible Years (IY) program for parents seeks to reduce challenging behaviors, increase social skills, and encourage self-control abilities in children. Concurrent to these goals for children, goals for parents are intended to promote social support, positive discipline and encourage parent involvement in the child’s education experiences. This program is geared toward families with children who have been identified as having challenging behavior, either due to the child’s development or experiences or the parenting strategies or skills.

The IY programs are delivered to groups of parents, organized by the child’s age offered at various frequencies and intensities depending on the program series selected. Parents use the group times to collectively and individually develop new guidance strategies for their children (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Promising
California Evidence-Based Clearinghouse	1 – Well-supported by research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.5 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Effective – more than one study

### A closer look at NREPP Ratings:

Outcome	Rating
Parenting skills	3.7 (0.0–4.0 scale)
Child externalizing problems	3.8
Child emotional literacy, self-regulation, and social competence	3.5
Teacher classroom management skills	3.3
Parents’ involvement with school and teachers	3.2

**Resources:**

**Blueprints profile:** <http://blueprintsprograms.com/factsheet/incredible-years-teacher-classroom-management>

**CEBC profile:** <http://www.cebc4cw.org/program/the-incredible-years/detailed>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=311>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=194>

## Nurse-Family Partnership (NFP)

Rated: Exemplary



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** At-risk, first-time mothers

**Program Summary:** Nurse Family Partnerships (NFP) is an early childhood home visiting program that employs nurses as home visitors and targets high-risk, first-time mothers. The program has many interrelated objectives geared toward improving health outcomes for parents and children:

- Increasing positive connections between parents and children;
- Assuring women have access to good prenatal and postnatal care;
- Reducing the use of tobacco, alcohol and illegal substances;
- Encouraging positive, appropriate parenting practices;
- Reducing unintended pregnancy;
- Promoting family economic self-sufficiency;
- Promoting school readiness, improving child health and development; and
- Reducing child maltreatment.

Weekly or biweekly home visits are delivered typically for 90-minute sessions, beginning prenatally and continuing through the child’s second birthday (frequency and intensity depends on the child’s age) (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Model program
California Evidence-Based Clearinghouse	1 – Well-supported by research evidence
Home Visiting Evidence of Effectiveness	Meets criteria for evidenced-based home visiting model
National Registry of Evidence-based Programs and Practices	3.4 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Effective – More than one study

### A closer look at NREPP Ratings:

Outcome	Rating
Maternal prenatal health	3.5 (0.0–4.0 scale)
Childhood injuries and maltreatment	3.5
Number of subsequent pregnancies and birth intervals	3.3
Maternal self-sufficiency	3.2
School readiness	3.4

### Resources:

**Blueprints profile:** <http://blueprintsprograms.com/factsheet/nurse-family-partnership>

**CEBC profile:** <http://www.cebc4cw.org/program/nurse-family-partnership/detailed>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/Nurse-Family-Partnership--NFP--sup---sup-/14/1>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=88>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=187>

## Nurturing Parenting Programs (NPP)

**Rated: Promising**

**Type of Program:** Parent Development



**Category:** Child maltreatment prevention

**Target Audience(s):** Families reported to the child welfare system for child maltreatment

**Program Summary:** The Nurturing Parenting Programs (NPP), developed by Stephen Bavolek, have been widely used and incorporated into other programs implemented through child welfare agencies, substance abuse treatment programs, teen parent programs and home visitation (Spach et al., 2014). The programs aim to prevent child abuse and neglect while promoting positive, trauma-sensitive parenting practices. They allow for implementation in groups or one on one in family homes. Group sessions can include opportunities for parents to be with their children (called Family Nurturing Time) and interact with the facilitators separately. For home-based sessions, families meet with facilitators for 90 minutes, weekly for 15 weeks (Spach et al., 2014).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.1 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP Ratings:

Outcome	Rating
Parenting attitudes, knowledge, beliefs, and behaviors	3.1 (0.0–4.0 scale)
Recidivism of child abuse and neglect	2.9
Children’s behavior and attitudes toward parenting	3.0
Family interaction	3.2

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=171>

## Parent-Child Interaction Therapy (PCIT)

**Rated: Exemplary**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention; Mental health

**Target Audience(s):** Children ages two to seven with behavior and parent-child relationship problems and their caregivers

**Program Summary:** Parent- Child Interaction Therapy (PCIT) is categorized as a relationship-based therapy based primarily on attachment theory (Beckmann, Cooper, & Dicker, 2010). PCIT merges social work, adult education, early childhood intervention, and child abuse prevention. The program was originally designed for children with very difficult behaviors and families who have young children with diagnosed conduct disorders. PCIT has since been adapted to suit families with young children under twelve with history of physical abuse, child behavior issues, or for parents who wish to improve their parenting skills, targeting specific skills for improvement (Spach et al., 2014).

PCIT follows a very specific protocol and requires specialized training and supervision (Spach et al., 2014). Treatment is generally provided by a mental health professional, through one or two one-hour weekly sessions lasting twelve to twenty weeks. This program is described by the developers as “mastery-based,” meaning the dosage depends on the acquired skill and success over time. The interesting training methods used include an audio feedback system, where the parent is observed interacting with the child and given cues through a headset discreetly placed in the ear. The child is not aware that the parent has an audio feed, nor do they know that they are being observed.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Promising
California Evidence-Based Clearinghouse	1 – Well supported by research
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	3.4 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Effective – more than one study

### A closer look at NREPP Ratings:

Outcome	Rating
Parent-child interaction	3.2 (0.0–4.0 scale)
Child conduct disorders	3.3
Parent distress and locus of control	3.1
Recurrence of physical abuse	3.9

### Resources:

**Blueprints profile:** <http://blueprintsprograms.com/factsheet/parent-child-interaction-therapy>

**CEBC profile:** <http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=23>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=171>

## Parent Management Training

Rated: Exemplary

**Type of Program:** Parent Development



**Category:** Parenting Skills

**Target Audience(s):** Parents with children between the ages of two and 12

**Program Summary:** Parent Management Training–Oregon Model (PMTO) is a training program which seeks to improve parenting skills and reduce the use of negative parenting strategies (*e.g.*, coercion) (CEBC, 2017). The program can be delivered in individual family sessions or group settings over 14 to 40 weeks (SAMHSA, 2017).

The goals of the program are:

- Improving parenting practices
- Reducing family coercion
- Reducing and preventing internalizing and externalizing behaviors in youth
- Reducing and preventing substance use and abuse in youth
- Reducing and preventing delinquency and police arrests in youth
- Reducing and preventing out-of-home placements in youth
- Reducing and preventing deviant peer association in youth
- Increasing academic performance in youth
- Increasing social competency in youth
- Increasing peer relations in youth
- Promoting reunification of families with youth in care

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Model program
California Evidence-Based Clearinghouse	1 – Well-supported by research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Promising (4 outcomes) Ineffective (6 outcomes)
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP Ratings:

Outcome	Rating
Social competence	Promising
Disruptive disorders and behaviors	Promising
Internalizing problems	Promising
Parenting practices	Promising
General functioning and well-being	Ineffective
Employment and work readiness	Ineffective
Financial competence	Ineffective
Depression and depressive symptoms	Ineffective
Educational achievement	Ineffective
Family Cohesion	Ineffective

### Resources:

**Blueprints profile:** <http://www.blueprintsprograms.com/factsheet/parent-management-training>

**CEBC profile:** <http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/>

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=218>

## Parents Anonymous, Inc.

**Rated: Promising**

**Type of Program:** Parent Development



**Category:** Child maltreatment prevention

**Target Audience(s):** Caregivers and children of all ages with behavioral health, substance abuse, and wellness concerns

**Program Summary:** Parents Anonymous, Inc. is the nation's oldest and largest child abuse prevention, education and treatment program delivered as a peer support group model (Rafael & Pion-Berlin, 2000). The structured training follows the curriculum through weekly meetings with a certified instructor. Parent meetings are held separately but concurrently with optional children's groups. Parents learn to use appropriate methods of communication and work on building a network of positive peer relationships for themselves and their families (Spach et al., 2014).

The unique and effective aspects of the program include groups being co-facilitated by a parent leader and the professionally-trained facilitator; parents determining the agenda at the beginning of each meeting; basic parenting skills such as communication and discipline always reviewed at every meeting; and 24-hour support to parents when they experience stress or crises. The children's program activities help them develop skills in conflict resolution, appropriate peer interactions, identifying and communicating thoughts and emotions, and increasing self-esteem (Rafael & Pion-Berlin, 2000).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/parents-anonymous/detailed>

## Parents as Teachers (PAT)

**Rated: Exemplary**

**Type of Program:** Home Visiting



**Category:** Child maltreatment prevention; Healthy child development

**Target audience(s):** Families who are pregnant and/or parenting a child under five years old

**Program Summary:** Parents as Teachers (PAT) is a voluntary program designed to partner with new parents to address the health and developmental priorities of families with young children. While PAT does not dictate specific criteria for eligibility, PAT providers typically focus their efforts on families who are pregnant and/or parenting a newborn through children under five years old. The program goals focus on effective parenting strategies, knowledge of child development, and strong parent-child relationships through one-on-one home visits, child screenings, group activities, community events, and by providing resources and referrals to other agencies (Spach et al., 2014).

Home visitors who are trained and accredited by PAT provide parents support and information in a range of child development and health topics to improve outcomes for the family through regularly-scheduled home visits (frequency depends upon the family's needs). Visits include parent-friendly developmental screening for the enrolled children such as the Ages and Stages Questionnaire (ASQ), along with family-centered assessments of basic needs, parenting practices, and various health and safety topics. These tools help the parent educator and caregivers uncover the strengths, resources and needs for each family. PAT also offers opportunities for families to connect with each other through socialization events or groups.

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Meets criteria for an evidence-based model
National Registry of Evidence-based Programs and Practices	3.2 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	No effects – more than one study

### A closer look at NREPP Ratings:

Outcome	Rating
Cognitive development	3.4 (0.0–4.0 scale)
Mastery motivation	3.0
School readiness	3.1
Third-grade achievement	3.2

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/parents-as-teachers/detailed>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/Parents-as-Teachers--PAT--sup---sup-/16/1>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=221>

**OJJP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=282>

## Period of PURPLE Crying

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Caregivers of infants up to five months of age; society

**Program Summary:** The Period of PURPLE Crying program is dedicated to the prevention of shaken baby syndrome and educates parents and caregivers on normal infant crying, the most common trigger for shaking an infant. The program was designed to be used primarily in universal, primary prevention settings, but can be used in secondary prevention (CEBC, 2017i).

The goals of the Period of PURPLE Crying program are:

- Increase awareness of the infant crying phase and shaken baby syndrome/abusive head trauma
- Increase caregivers' understanding of early increased infant crying
- Reduce the shaken baby syndrome/abusive head trauma (CEBC, 2017i)

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/period-of-purple-crying/>

## Safe Babies New York

**Rated: Promising**

**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Caregivers of infants



**Program Summary:** Safe Babies New York is a hospital-based, post-natal intervention dedicated to educating parents of all newborn infants about shaken baby syndrome (SBS). Before leaving the hospital with their newborn baby, the mother and father (or father figure) receive written materials with information on SBS and are asked to view a video on the subject before taking their new baby home for the first time. The parents are then asked to voluntarily sign a commitment statement affirming their receipt of these materials; signed statements are returned monthly from nurse managers at each hospital and are tracked by the investigators. Since 2014 program materials have also included information on Safe Sleep which aims to prevent sleep-related infant fatalities by educating parents of newborn babies about safe sleep environments (CEBC, 2017j).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/the-upstate-new-york-shaken-baby-syndrome-education-program/>

# SafeCare Augmented

**Rated: Promising**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** Parents at risk for child maltreatment

**Program Summary:** SafeCare Augmented is based on Project 12-Ways and SafeCare, developed by Georgia State University. The program uses trained professionals to work with families who are at-risk of abuse or neglect in their homes to improve parents’ skills in several domains. The areas of focus include teaching how to respond appropriately to child behaviors, how to improve home safety, and child health and safety issues. SafeCare is generally provided in weekly home visits lasting between one and two hours. The program typically lasts 18–20 weeks for each family (Spach et al., 2014).

Following the guidelines of the curriculum using four preset modules: Health, Home Safety, Parent-Child/Parent-Infant Interactions, Problem Solving and Counseling, parents are taught so that skills gained are generalizable for various environments and experiences with their child. Each module is implemented through approximately one assessment session and five training sessions and is followed by a “social validation questionnaire” to assess parent satisfaction with training. Home visitors work with parents until they meet a set of skill-based criteria that are established for each module. All modules involve baseline assessment, intervention (training) and follow-up assessments to monitor change. SafeCare Augmented also includes motivational interviewing and additional training of home visitors in identification and response to family risk factors and child maltreatment, such as substance use and mental illness (Spach et al., 2014).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Meets criteria for evidenced-based home visiting model
National Registry of Evidence-based Programs and Practices	Promising (one outcome)
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP Ratings:

Outcome	Rating
Victimization and Maltreatment	Promising

#### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/safecare-home-visiting-for-child-well-being/detailed>

**HomVEE profile:** <https://homvee.acf.hhs.gov/Model/1/SafeCare-sup---sup-/18/1>

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=58#hide1>

# SEEK Safe Environment Every Kid

**Rated: Supported**



**Type of Program:** Community Development

**Category:** Child Maltreatment Prevention

**Target Audience:** Primary care providers and families with children aged 0–5 years old

**Program Summary:** SEEK works with pediatric primary care professionals to identify and assess and assist families with major risk factors for child maltreatment. The intervention provides training to professionals through online videos and supplemental materials on the SEEK website and Continuing Medical Education is offered to healthcare professionals. The model also includes a parent questionnaire which is used to screen for issues of parental depression, substance abuse, stress, domestic violence and other risk factors of child abuse and neglect (CEBC, 2017k).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	1- Well Supported by Research Evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/the-safe-environment-for-every-kid-seek-model/>

# Step by Step Parenting Program

**Rated: Promising**



**Type of Program:** Home Visiting

**Category:** Child maltreatment prevention

**Target Audience(s):** Parents with learning differences whose children are at risk; may be helpful for all caregivers

**Program Summary:** The Step by Step Parenting Program is designed to help parents with learning and intellectual disabilities learn to parent properly to reduce and prevent child abuse and neglect. The program divides guidance to parenting newborns through three-year-olds into small, manageable steps (Spach et al., 2014).

Step by Step Parenting is delivered through weekly home visits lasting 1.5 to two hours, though more frequent visits may be arranged, especially for families with newborns. The program includes pre-defined essential components intended to be used with families for up to two years. First, there is an assessment to determine risks, impediments and issues that exist for the family. The results of the assessment also provide information required to create a treatment plan, which may be in collaboration with child welfare agencies, other service providers, and family supports as needed. Next, the home visitor encourages using the Step by Step checklists for parenting help. The home visitor also directly helps with parenting and teaching parenting skills. As the parent becomes more comfortable with their skills, and as they use them repeatedly with their child, services are phased out (Spach et al., 2014).

## Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

## Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/step-by-step-parenting-program/>

## Stewards of Children

Rated: Supported



**Type of Program:** Sexual Abuse Prevention

**Category:** Child maltreatment prevention

**Target Audience(s):** Adults (regardless of whether they are parents or caregivers)

**Program Summary:** Stewards of Children is a targeted program that teaches adults how to prevent, recognize, and react responsibly to child sexual abuse, developed by Darkness to Light (Spach et al., 2014). Both an online and a facilitator-led version are available. The Darkness to Light: Stewards of Children program has been proven to increase knowledge, improve attitudes and change child-protective behaviors through numerous studies.

Topics covered during the two to three-hour Stewards of Children training include the types of situations where child sexual abuse may occur, an overall discussion of the problem of child sexual abuse, the importance of talking about the prevention of sexual abuse with children and adults, signs of sexual abuse, and how to interact and intervene. Qualitative and quantitative studies completed on Stewards of Children have found the training leads to increases in knowledge regarding child sexual abuse, likelihood of discussing issues of sexual abuse with children and adults, and recognition of signs of abuse (Spach et al., 2014).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Promising – One study

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/stewards-of-children/detailed>

**OJJDP profile:** [www.crimesolutions.gov/ProgramDetails.aspx?ID=327](http://www.crimesolutions.gov/ProgramDetails.aspx?ID=327)

# Strengthening Families

**Rated: Promising**



**Type of Program:** Parent Education

**Category:** Maltreatment Prevention

**Target audience(s):** Parents and their children ages zero to 17 who need skills to reduce family conflict and the risk of abuse or neglect

**Program Summary:** The Strengthening Families Program is an intervention for families with parents with a substance abuse issues, with components for both parents and children (Ashery, Robertson, & Kumpfer, 1998). The curriculum is delivered through 14 sessions, organized in three courses: Parent Skills Training, Children Skills Training, and Family Life Skills Training. Two group leaders typically work with parents and children separately at first, and then each group has the opportunity to practice their new skills. Participants are provided meals, incentives, child care, and ideas for follow-through (including homework assignments) after the sessions. Positive participation is rewarded, and “booster” sessions are arranged after the initial series is complete (Spach et al., 2014).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Promising
California Evidence-Based Clearinghouse	NR – Not able to be rated
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Model program (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Promising – more than one study

### A closer look at NREPP:

Clearinghouse	Level of evidence
Children’s internalizing and externalizing behaviors	3.1 (scale of 0.0–4.0)
Parenting practices/parenting efficacy	3.1
Family relationships	3.1

**Resources:**

**Blueprints profile:** <http://blueprintsprograms.com/factsheet/strengthening-families-10-14>

**CEBC profile:** <http://www.cebc4cw.org/program/strengthening-families-program-sfp/detailed>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=44>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=199>

## STEP

**Rated: Promising**



**Type of Program:** Parent Development

**Category:** Parenting skills

**Target Population:** Caregivers with children ages zero to 17

**Program Summary:** Systematic Training for Effective Parenting (STEP) is a parent development program and outreach service. The goals of this program are to identify circumstances that put children at risk for child abuse and neglect, reduce parenting stress, and improve the child's learning environment, including the emotional environment or connections with their caregivers (Huebner, 2002). STEP is targeted to work with families who have children under three who are at risk of maltreatment. This program is part of a system of care framework and consists of eight two- hour class sessions once a week for a total of sixteen hours of intensive interaction with an interdisciplinary team. The interdisciplinary team can be made up of professionals such as public health nurses, early childhood educators, social workers, and nutritionists, to name a few examples (Spach et al., 2014).

### Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 – Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Promising (two outcomes)
Office of Juvenile Justice and Delinquency Prevention	Not listed

### A closer look at NREPP:

Clearinghouse	Level of evidence
Family Cohesion	Promising
General Functioning and Well-Being	Promising

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/systematic-training-for-effective-parenting/>

**NREPP profile:** <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1263>

## Triple P Level 4

**Rated: Exemplary**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target Audience(s):** Parents and caregivers of children from birth to age 12

**Program Summary:** Triple P-Level 4 program is designed to reduce challenging behaviors; improve parenting knowledge, confidence and skills; and encourage healthy home environments. The program involves development of a parenting plan, practice of specific positive parenting strategies, and tracking of children's and parents' behavior (CEBC, 2017m). The program can be offered in group or individual formats, online or via a self-directed workbook.

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	1 – Well-supported by research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/triple-p-positive-parenting-program-level-4-level-4-triple-p/>

# Triple P System

**Rated: Supported**



**Type of Program:** Parent Development

**Category:** Child maltreatment prevention

**Target audience(s):** Parents and caregivers of children from birth to age 16

**Program Summary:** Triple P is designed to reduce challenging behaviors; improve parenting knowledge, confidence and skills; and encourage healthy home environments. This parent education and outreach program is family-focused and has multiple layers of intensity, each building on the previous step. Target populations for each level are defined, though with the multiple levels all families with children can participate. The goals of the program include improving parents' competence, preventing or changing negative parenting practices, and reducing family risk factors for maltreatment and emotional and behavioral problems (Spach et al., 2014).

## Clearinghouse ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Promising
California Evidence-Based Clearinghouse	2 – Supported by research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	2.9 out of 4.0 (Legacy)
Office of Juvenile Justice and Delinquency Prevention	Effective – One study

## A closer look at NREPP:

Clearinghouse	Level of evidence
Negative and disruptive child behaviors	2.9
Negative parenting practices as a risk factor for later child behavior problems	2.9
Positive parenting practices as a protective factor for later child behavior problems	3.0

## Resources:

**Blueprints profile:** <http://blueprintsprograms.com/factsheet/triple-p-system>

**CEBC profile:** <http://www.cebc4cw.org/program/triple-p-positive-parenting-program-system/detailed>

**NREPP profile:** <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=1>

**OJJDP profile:** <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=80>

## Who Do You Tell?™

**Rated: Promising**



**Type of Program:** Sexual Abuse Prevention

**Category:** Child maltreatment prevention

**Target Audience:** Children in Kindergarten through grade six

**Program Summary:** “Who Do You Tell?” is a child sexual abuse education program designed for children from kindergarten to grade six. The program is taught in a classroom setting, but can easily be adapted to other child-oriented settings (Spach et al., 2014). The program includes a one-hour session with teachers regarding the curriculum, how to recognize sexual abuse symptoms and respond to disclosures appropriately; there is also a parent-focused component to prepare caregivers for children’s participation in the program (CEBC, 2017n).

### Clearinghouse Ratings:

Clearinghouse	Level of evidence
Blueprints for Healthy Youth Development	Not listed
California Evidence-Based Clearinghouse	3 –Promising research evidence
Home Visiting Evidence of Effectiveness	Not listed
National Registry of Evidence-based Programs and Practices	Not listed
Office of Juvenile Justice and Delinquency Prevention	Not listed

### Resources:

**CEBC profile:** <http://www.cebc4cw.org/program/who-do-you-tell/>

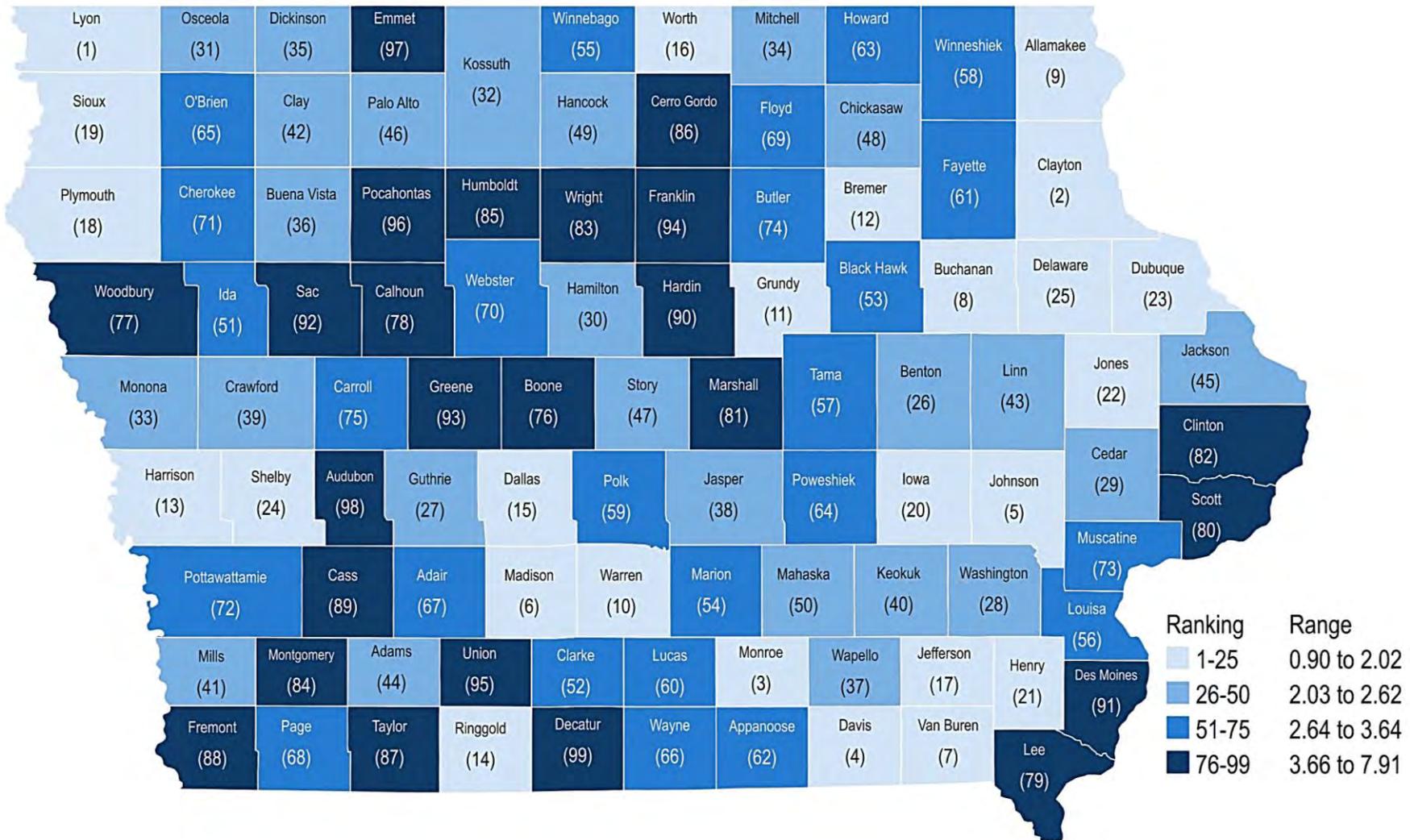


**Appendix C: Maps of Child Maltreatment and Risk Factors**

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## County Rank: Child Abuse

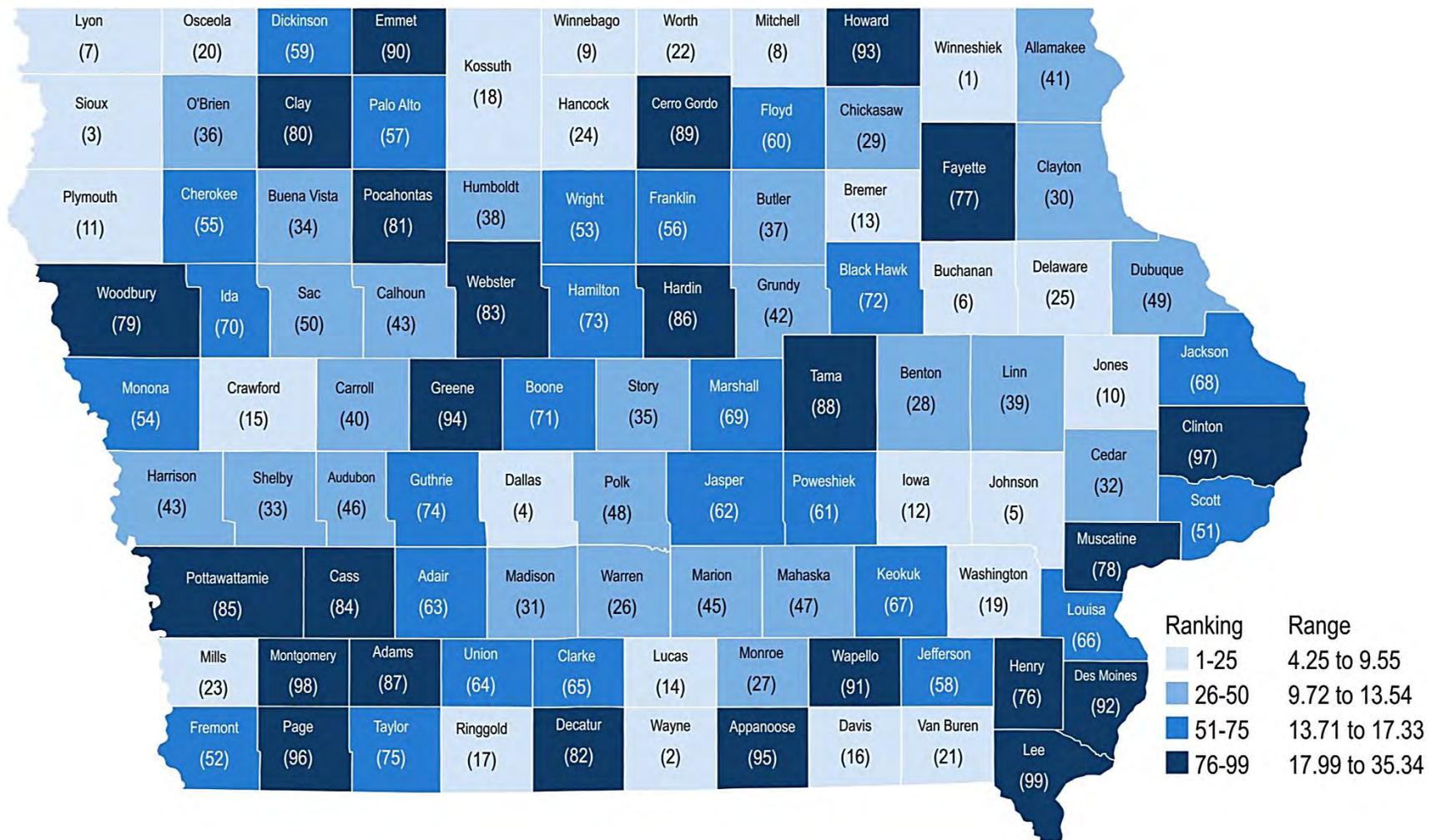


Counties with higher rankings (the darkest colors) have higher rates of abuse.

Child abuse rates per 1,000 by county range from a low of 0.90 to the highest rate of 7.91

The child abuse map ranks counties according to the average number of confirmed or founded reports of abuse over three years (2014–2016) per 1,000 children ages zero to 17. Confirmed or founded reports of physical abuse, sexual abuse and cohabitation with a registered sex offender were included (IDHS, 2016).

## County Rank: Child Neglect

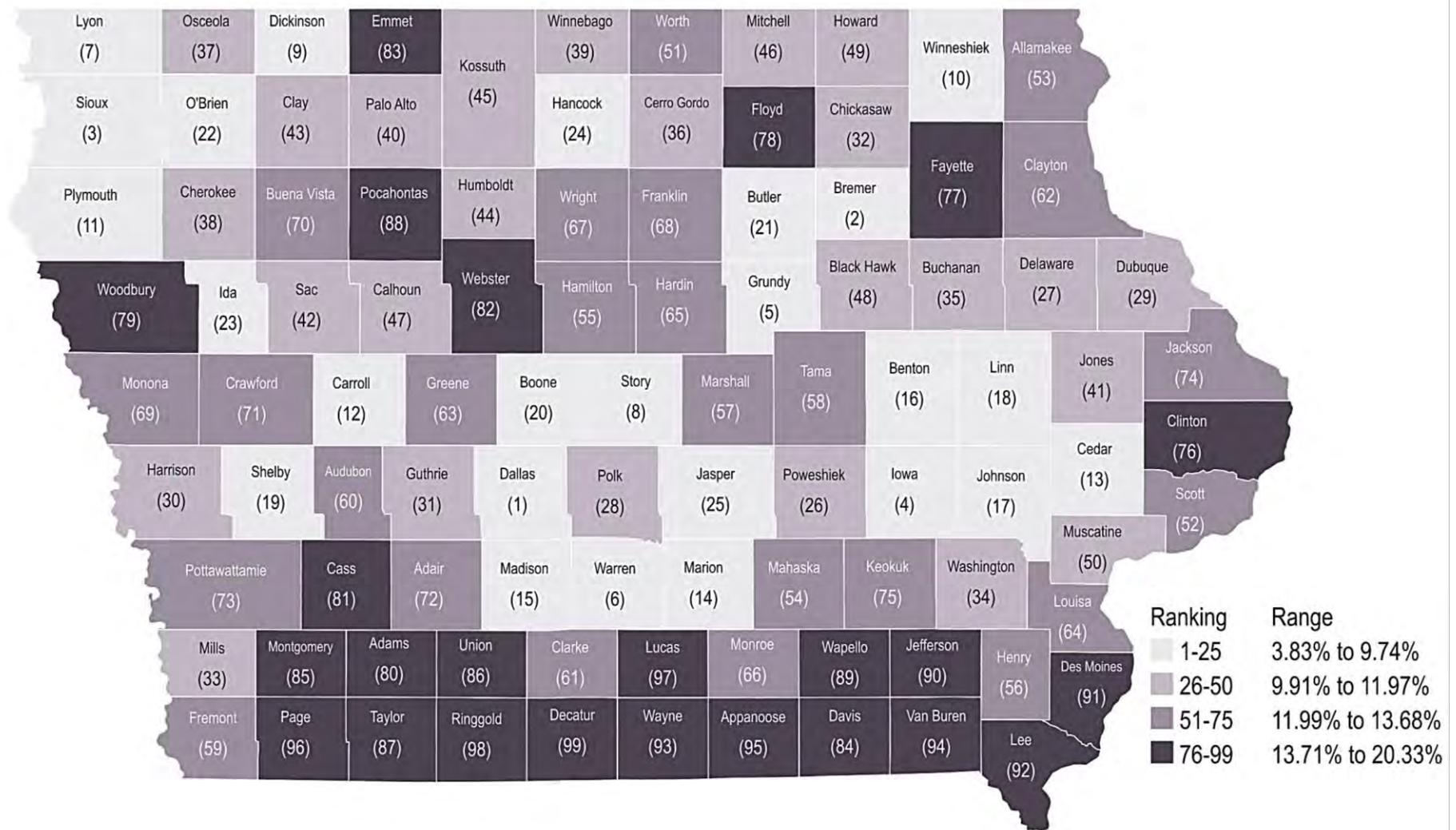


Counties with higher rankings (the darkest colors) have higher rates of neglect.

Child neglect rates per 1,000 by county range from a low of 4.3 to the highest rate of 35.3.

The child neglect map ranks counties according to the average number of confirmed or founded reports of neglect over three years (2014–2016) per 1,000 children ages zero to 17. Confirmed or founded reports of neglect, mental injury, presence of illegal drugs in a child’s system, exposure to methamphetamine manufacturing, and allowing access to child by a registered sex offender were included (IDHS, 2016).

## County Risk Rank: Children Living in Poverty

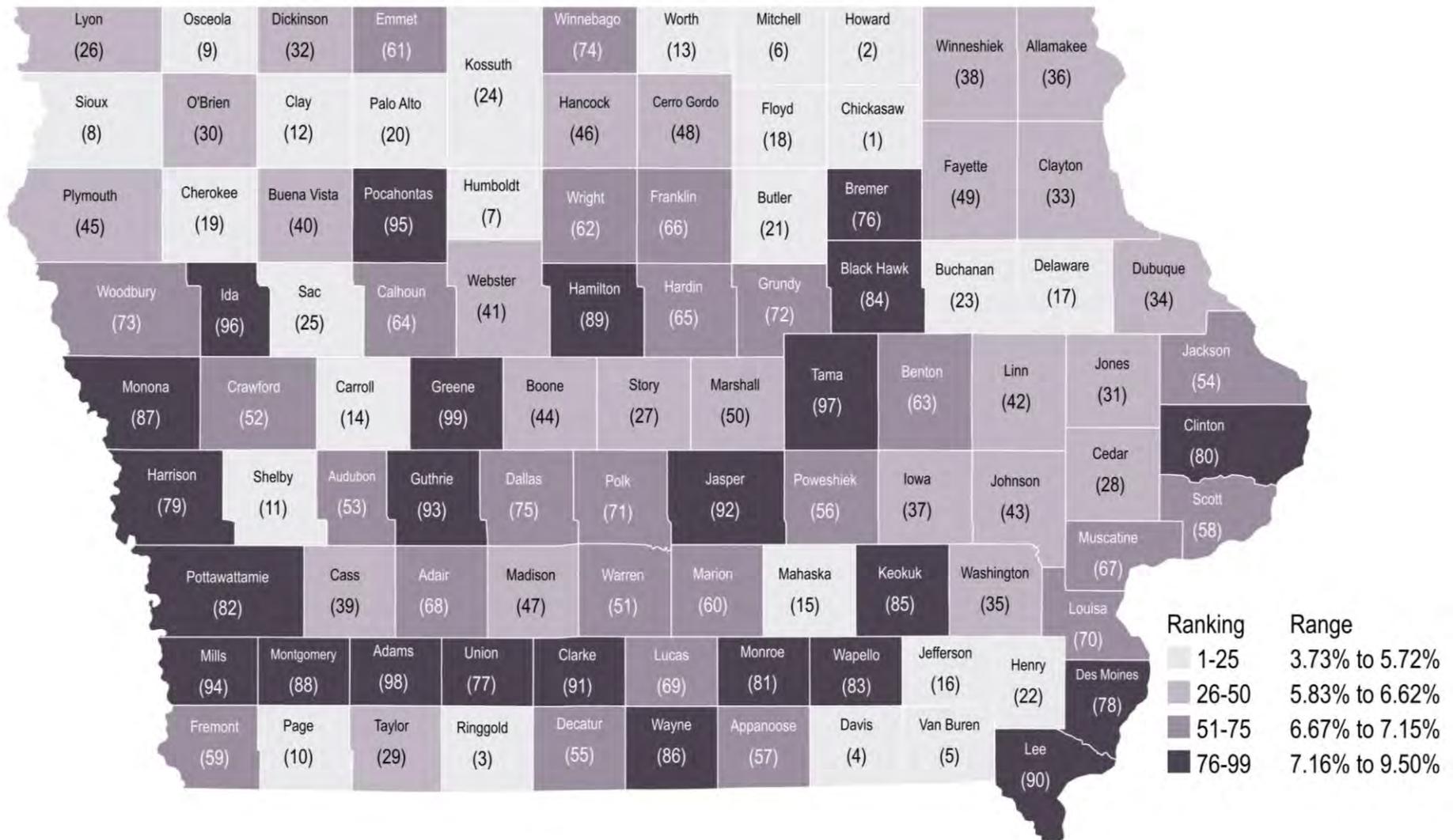


Counties with higher rankings (the darkest colors) have higher percentages of children living below the Federal Poverty Level (FPL) of \$24,600 for a family of four (U.S. Census, 2015).

The percentage of all children ages zero to 17 years old in Iowa who live in poverty ranges from a low of 3.8 percent of children in a county to 20.3 percent, with a state average of 10.8 percent.



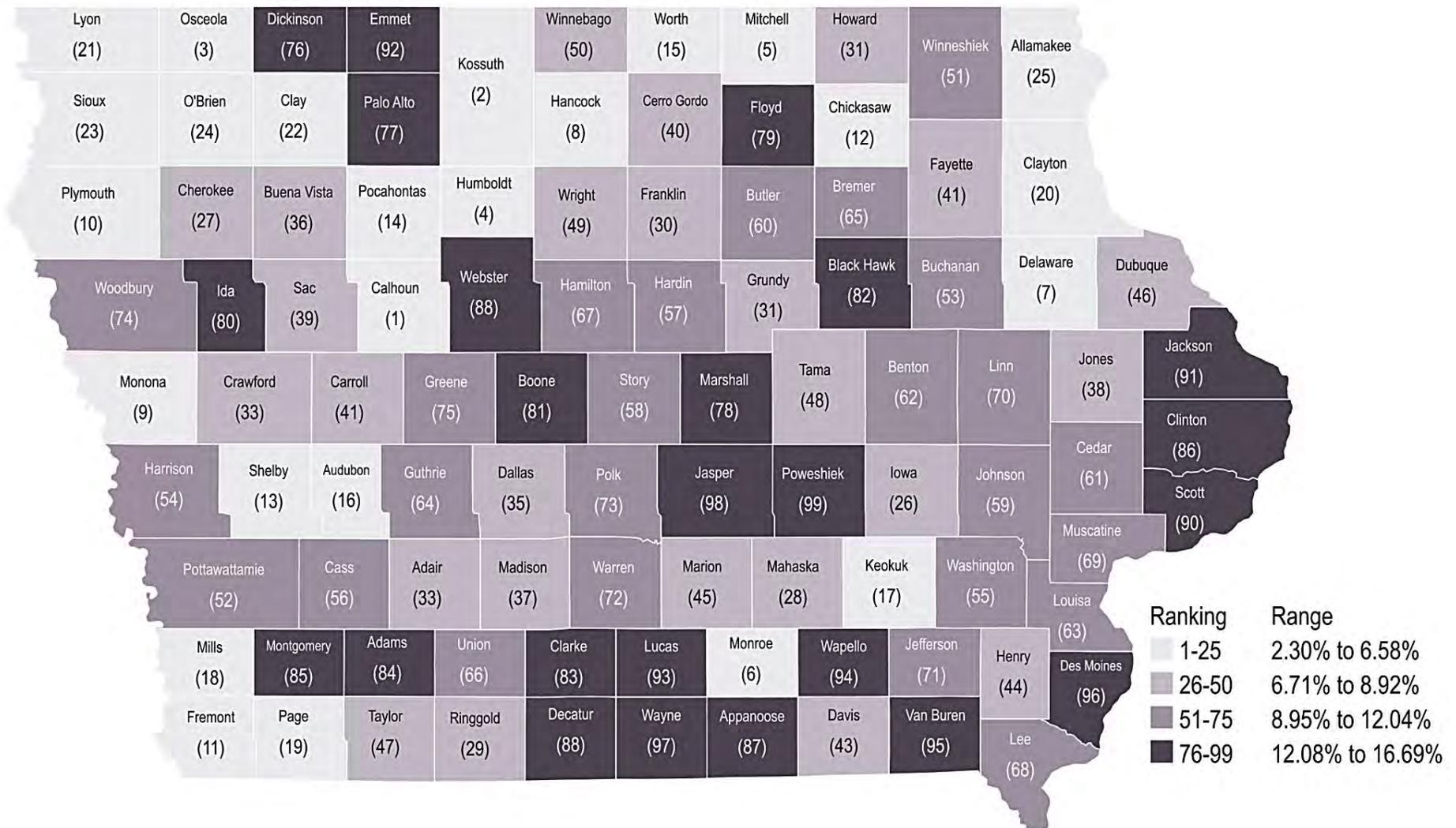
## County Risk Rank: Low-Birthweight Births



Counties with higher rankings (the darkest colors have higher percentages of live births with infants below 5.51 pounds, based on Robert Wood Johnson County Health Rankings data (University of Wisconsin Population Health Institute, 2016).

The percentage of low birthweight births, calculated as a percent of all live births, ranges from a low of 3.7 percent to a high of 9.5 percent, with an Iowa state average of 6.7 percent.

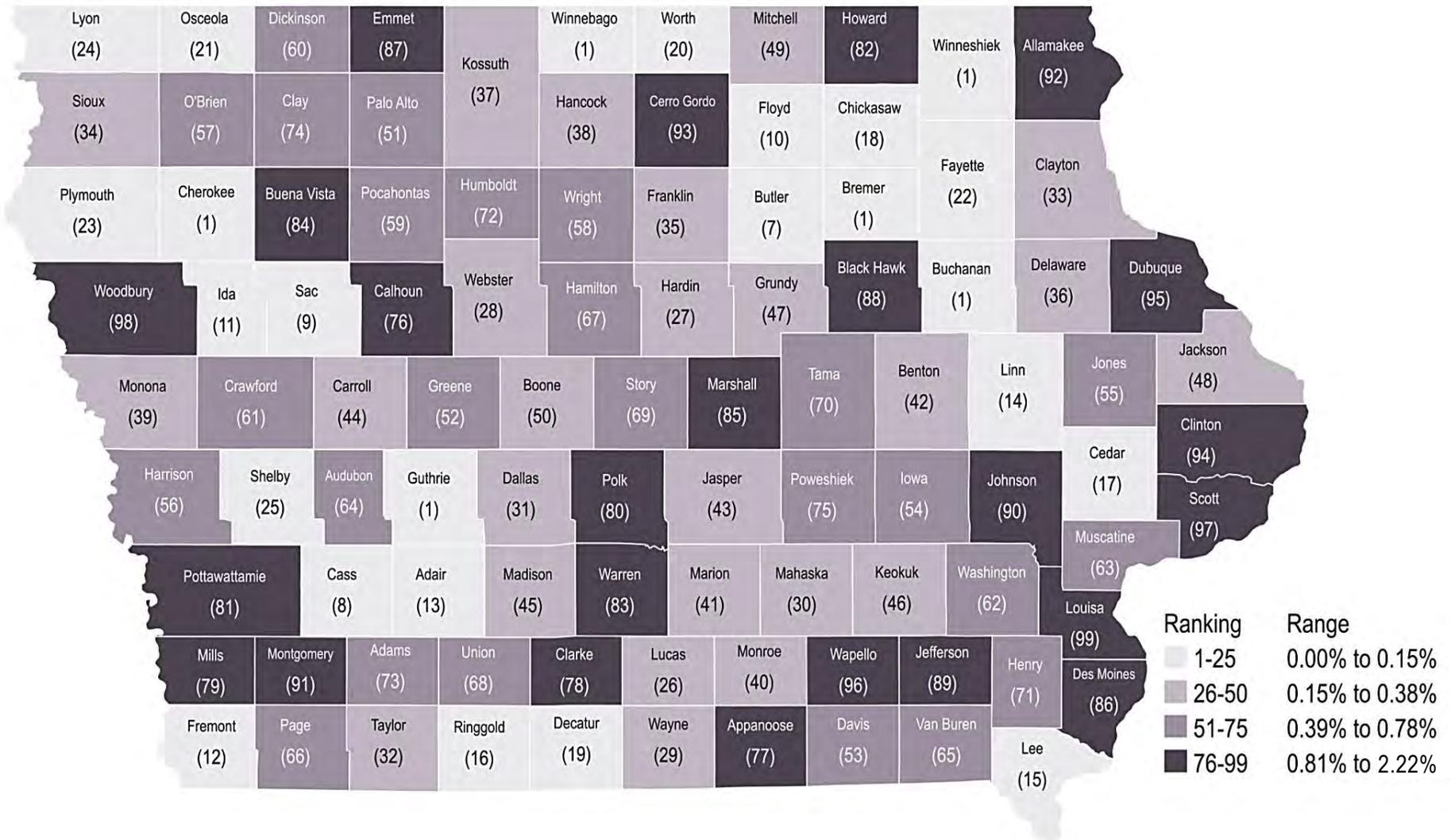
## County Risk Rank: Adults with Four or More Adverse Childhood Experiences (ACEs)



Counties with higher rankings (the darkest colors have higher percentages of adults reporting four or more adverse childhood experiences (ACEs). Results are based on the Iowa Behavioral Risk Factor Surveillance Study data collected from 2012 to 2015 (Iowa Department of Public Health, 2017).

The percentage of adults reporting four or more adverse childhood experiences ranges from a low of 2.3 percent to a high of 16.7 percent, with an Iowa state average of 9.2 percent.

## County Risk Rank: Children Who Experienced Domestic Violence

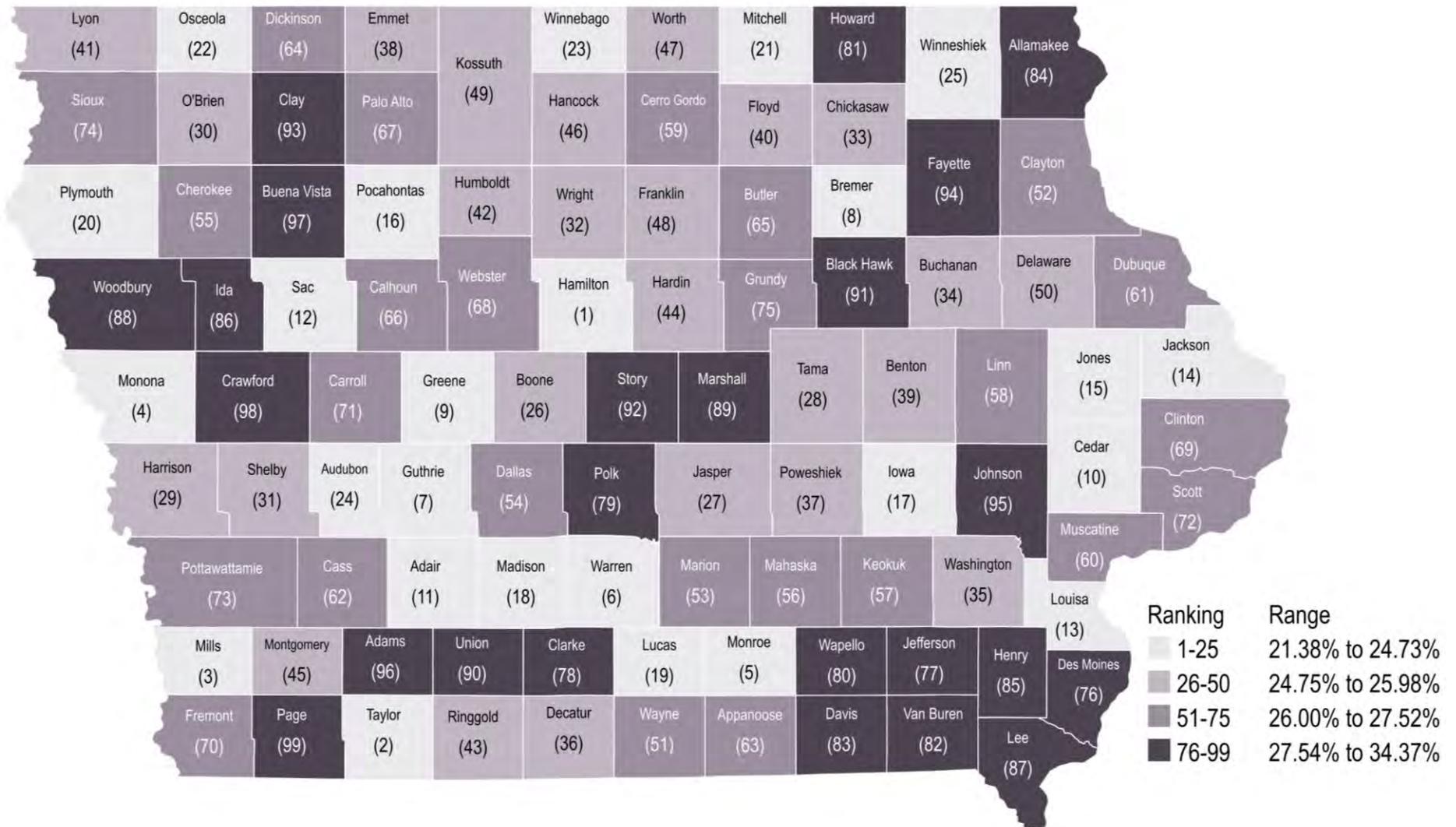


Counties with higher rankings (the darkest colors) have higher percentages of children who have experienced domestic violence in their household (Iowa Department of Public Safety, 2016). The percentage of all children (0 to 17 years old) in an Iowa county who have experienced domestic violence in their household ranges from a low of 0.0 percent to a high of 2.2 percent, with an average across counties of 1.0 percent.

*Please note: Multiple counties are ranked "1" – these counties had no reports of domestic violence.*



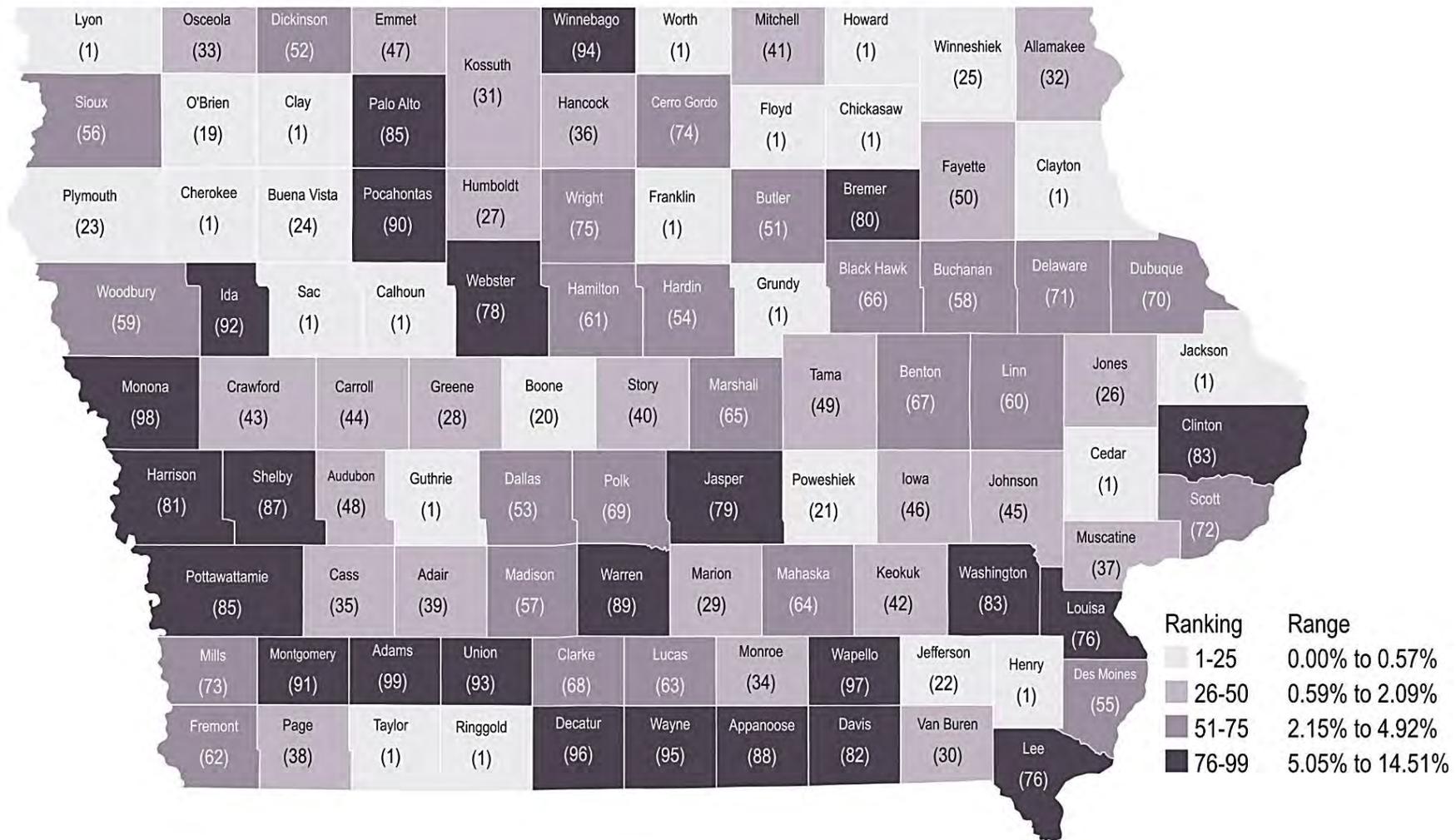
## County Risk Rank: Child Ages Zero to Five



Counties with higher rankings (the darkest colors) have higher percentages of children ages zero to five (U.S. Census, 2015).

The percentage of all children (0 to 17 years old) in an Iowa county who are between the ages of zero and five ranges from a low of 21.4 percent to a high of 34.4 percent, with a state average of 26.9 percent.

## County Risk Rank: Serious Mental Illness



Counties with higher rankings (the darkest colors) have higher percentages of serious mental illness among adults based on estimates from the Iowa Behavioral Risk Factors Surveillance data collected from 2012 through 2015 (IDPH, 2017).

The percentage of adults reporting serious mental illness symptoms ranges from a low of 0.0 percent to a high of 14.5 percent, with an average among counties of 3.1 percent.

*Please note: Multiple counties are ranked “1” – these counties had no reports of serious mental illness.*





# Iowa Maltreatment Prevention **STRATEGIC PLAN**



**November 2017**

**Iowa Department of Human Services • Prevent Child Abuse Iowa  
Hornby Zeller Associates, Inc.**



# Iowa Maltreatment Prevention STRATEGIC PLAN



**All of Iowa's  
children will be  
healthy and  
safe from child  
maltreatment**

PREPARED FOR  
THE IOWA DEPARTMENT OF HUMAN SERVICES

Prevent Child Abuse Iowa  
2704 Fleur Drive  
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IN COLLABORATION WITH  
Hornby Zeller Associates, Inc.  
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**November 2017**



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Boys and Girls Clubs of Central Iowa  
Child Abuse Prevention Councils  
Child Abuse Prevention Program Advisory Committee  
Community Partnerships for Protecting Children sites  
Early Childhood Iowa  
Iowa Department of Human Services  
Iowa Department of Public Health  
Parents and children of Iowa  
Prevention professionals  
The Coalition for Family and Children's Services in Iowa  
Youth & Shelter Services, Inc.

**Contents**

---

Executive Summary..... i

    The Strategic Plan..... i

Background..... 1

    Child Maltreatment in Iowa..... 1

    Overview of the Needs Assessment and Strategic Planning Process..... 1

Child Maltreatment Prevention Strategic Plan ..... 3

    Vision & Guiding Principles ..... 3

    Goals & Activities ..... 4

Strategic Plan Implementation ..... 13

    Review and Revisions of the Plan ..... 13

Funding Notes..... 13

Implementation Plan ..... 14



## Executive Summary

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In July 2017 the Iowa Department of Human Services (IDHS) tasked Prevent Child Abuse Iowa (PCA Iowa) with conducting a comprehensive needs assessment and developing a strategic plan to guide future maltreatment prevention efforts in Iowa. This strategic plan aims to offer specific guidance for the administration of IDHS' prevention program, Iowa Child Abuse Prevention Program (ICAPP) and serve as a communication tool and action plan for local communities to direct prevention programming in Iowa. The incidence of child maltreatment in Iowa remains above the national rate, despite decreases in recent years. Research shows an increased risk for long-term physical, mental, and financial health outcomes for people exposed to household dysfunctions such as domestic violence, substance abuse, or mental illness, or who have suffered child abuse or neglect without meaningful social supports. Risk factors for these social determinants of health are reduced when systems work together to implement trauma-informed practices that support the well-being of children and families.

### The Strategic Plan

**Vision** All of Iowa's children will be healthy and safe from child maltreatment.



# STRATEGIC PLAN GOALS



To achieve these goals, IDHS, PCA Iowa and the Child Abuse Prevention Program Advisory Committee (CAPPAC) will work with Child Abuse Councils and Community Partnerships for Protecting Children, prevention providers, and other prevention funders to carry out the activities specified in the plan. PCA Iowa will annually review progress on the plan with IDHS and CAPPAC.

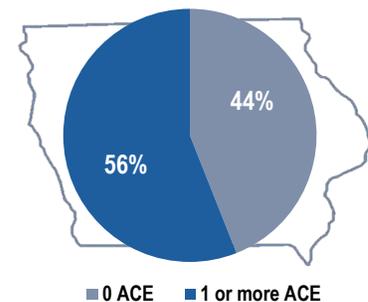
## Background

In July 2017 the Iowa Department of Human Services (IDHS) tasked Prevent Child Abuse Iowa (PCA Iowa) with conducting a needs assessment and developing a strategic plan to guide future prevention efforts in Iowa. Prevention of child maltreatment is a central component of the mission of the Department. IDHS has historically funded prevention services through two programs: the Iowa Child Abuse Prevention Program (ICAPP), established in Iowa Code in 1982 and funded through a mix of state and federal funding; and the Community-Based Child Abuse Prevention (CBCAP), funded through a provision of the federal Child Abuse Prevention and Treatment Act (CAPTA). The two programs were combined in fiscal year 2018 which is referred to in the strategic plan as ICAPP.

In addition to IDHS prevention funding, numerous other federal, state, and local entities support prevention services, including Iowa Department of Public Health (IDPH), Early Childhood Iowa (ECI), and Iowa Coalition Against Sexual Assault (ICASA). This strategic plan aims to offer specific guidance for the administration of IDHS' prevention program and serve as a communication tool and action plan for local communities on the direction of prevention programming in Iowa.

### Child Maltreatment in Iowa

The incidence of child maltreatment in Iowa remains above the national rate, despite decreases in recent years coinciding with the implementation of a differential response structure in the Iowa child protective services system. The rate of neglect in the state is four times that of physical abuse and ranges widely from county to county. While an average of 4.3 per 1,000 children experienced neglect in Winneshiek County between 2014 and 2016, 35.3 per 1,000 children in Lee County were neglected. In addition, Iowa's Adverse Childhood Experiences (ACE) data indicates that 56 percent of adult Iowans report experiencing one of the eight ACEs measured in the study, which includes physical, sexual, and emotional abuse, and neglect. The needs assessment of Iowa's maltreatment prevention efforts conducted in 2017 found relationships between abuse, neglect and numerous risk factors, including teen births, poverty, low-birthweight births, domestic violence, high ACE scores and mental illness.



Research shows an increased risk for long-term physical, mental, and financial health outcomes for people exposed to household dysfunctions such as domestic violence, substance abuse, or mental illness, or who have suffered child abuse or neglect without meaningful social supports. Risk factors for these social determinants of health are reduced when systems work together to implement trauma-informed practices that support the well-being of children and families.

### Overview of the Needs Assessment and Strategic Planning Process

Before undergoing the strategic planning process, PCA Iowa contracted with Hornby Zeller Associates, Inc. (HZA), a longtime collaborator and evaluator of maltreatment prevention programs, to collaborate on a needs assessment of prevention services. The needs assessment included conducting an inventory of existing prevention programs sponsored by IDHS and other federal, state, local, and private sources of funding, identifying the evidence-based prevention

practices used by ICAPP grantees, analyzing the need for prevention services using a social indicator approach, and collecting stakeholder feedback on initial findings and challenges faced by parents, youth and prevention providers. **In total over 900 prevention professionals, parents, and youth provided feedback.**

The needs assessment found **a need for a coordinated public health approach** to reduce the risk of children’s exposure to toxic stress and improving protective factors through early access to concrete supports, evidence-based parenting education, and social supports for parents and children. Three recommendations for child maltreatment prevention efforts in Iowa were identified:

- **Coordinate maltreatment prevention funding sources across multiple service sectors (e.g., public health, early childhood, human services) to use each source strategically in combatting abuse and neglect.** Work collaboratively across funding sources to identify common goals, services and quality standards using the needs assessment and strategic plan as a starting point.
- **Reduce child maltreatment by targeting risk factors presented by families which are most closely correlated with abuse and neglect.** Make information available and accessible about services that address the conditions of poverty, teen births, low birthweight, domestic violence, adverse childhood experience, mental illness, and substance abuse.
- **Increase workforce development in cultural competence, evidence-based practices, and trauma-informed prevention and care.** Embed culturally responsive, evidence-supported and trauma-informed practices into all systems that help families.

**Based on these recommendations the strategic plan lays out the overall vision, guiding principles, goals, activities, and an implementation plan to guide the next five years of prevention work in the state.**



The strategic planning process involved numerous stakeholders to inform the development of each component of the plan. PCA Iowa worked with HZA to develop the content and representatives from around the state were asked for feedback. Stakeholders included the Child Abuse Prevention Program Advisory Committee (CAPPAC), representatives at IDHS, Iowa Department of Public Health and Early Childhood Iowa, and the CBCAP technical assistance provider at Family Resource Information, Education, and Network Development Service (FRIENDS) National Center for Community-Based Child Abuse Prevention.

# Child Maltreatment Prevention Strategic Plan

## Vision & Guiding Principles

The vision and guiding principles were developed in collaboration with PCA Iowa, IDHS and CAPPAC members. They inform all aspects of the plan including the goals, activities and the process through which they are to be carried out.

**Vision** All of Iowa’s children will be healthy and safe from child maltreatment.

### Guiding Principles

#### Impact

We prioritize prevention work that has the greatest impact on families and communities, including approaches that reach those most vulnerable to maltreatment and services that provide the strongest evidence of effectiveness.

#### Cultural Competence

We engage diverse stakeholders to plan, implement, and evaluate prevention activities and provide services that meet the social, cultural, and linguistic needs of families.

#### Collaboration

We stretch our universe to encompass various disciplines and providers working together and target interventions based on the needs and risk factors identified by each community to prevent child maltreatment.

#### Data-informed decision-making

We use data to evaluate prevention services for their effectiveness and modify programs to achieve continuous quality improvement.

#### Innovation

We support innovative practices and new, emerging interventions.

## Goals & Activities

Goals outline how the strategic plan will be accomplished. Seven overall goals were developed based on the recommendations of the needs assessment and the guiding principles. Along with each goal, the plan includes specific activities to be carried out and the measures that will be used to track progress on the plan.

## STRATEGIC PLAN GOALS



## Goal 1: Reduce child maltreatment by targeting risk factors presented by families which are most closely correlated with abuse and neglect.

- Identify resources for addressing poverty, teen births, low birthweight, domestic violence, adverse childhood experiences, living with a disability, homelessness, mental illness, and substance abuse throughout the whole state and provide them to all prevention organizations to share with families.
- Coordinate with the 2-1-1 United Way and Family Support Network services available throughout Iowa to connect parents and caregivers to support services.
- Develop innovative strategies and partnerships to reach families, such as integrating prevention services into existing programming and removing barriers to services such as child care and transportation.
- Conduct outreach to fathers, families with a parent or child with a disability, families that are homeless, and unaccompanied homeless youth.

### Measures of success

- Prevention organizations have been provided an index of resources that address poverty, teen births, low birthweight, domestic violence, adverse childhood experience, mental illness, disabilities, homelessness, and substance abuse.
- Prevention providers have a process for identifying client needs and making referrals to appropriate services with consistency.
- Prevention organizations have identified new strategies for reaching families and integrating prevention into other services.
- Families and prevention professionals report that barriers to services have been mitigated.
- Recipients of child abuse prevention funding report on their outreach to target populations of: fathers, families with a parent or child with a disability, families that are homeless, and unaccompanied homeless youth.

### About Goal 1

Poverty, teen births, low birthweight, domestic violence, adverse childhood experiences, living with a disability, mental illness, and substance abuse are related to and increase the risk of child maltreatment in Iowa. Prevention providers can act as brokers by connecting families to available community resources.

Infrastructure and existing referral pathways already exist (such as United Way 2-1-1 and the Family Support Network website [www.iafamilysupportnetwork.org](http://www.iafamilysupportnetwork.org)); however, providers may not be fully equipped to refer families to those services or even perceive that as their role.



## Goal 2: Coordinate maltreatment prevention funding sources across multiple service sectors (e.g., public health, early childhood, human services) to use each source strategically in combatting abuse and neglect.

- Streamline the funding application process for provider organizations by developing a common application process serving multiple funding streams.
- Use ICAPP funding to complement the programming funded by other sources (e.g., parent education and home visiting).
- Promote Community Partnerships for Protecting Children (CPPC) and council membership so that families and stakeholders from all service sectors are represented and active throughout the state.
- Build the capacity of parents and other family members to contribute to the planning, implementation and evaluation of prevention services in their communities.

### Measures of success

- PCA Iowa and IDHS work with other prevention funders to identify similarities and differences in their funding applications and strategies for streamlining the process.
- A common funding application process is developed
- CPPC members and councils demonstrate regular attendance at meetings by stakeholders from wide variety of service sectors.
- CPPC members and councils demonstrate engaging consumers in the planning and implementation of prevention services in their communities.

### About Goal 2

The needs assessment identified 13 programs which provide funding for prevention in Iowa across six state agencies, and a number of local entities and private organizations. **These 13 prevention programs make up less than one percent of the Iowa's investment in programming for children.** Collaboration across programs is critical to achieving Iowa's vision that all of Iowa's children be healthy and safe from child maltreatment.

Parental leadership should be promoted in all areas of planning, implementation and evaluation of prevention. This means organizations, funders, and families need to work collaboratively across funding sources to identify common goals, services, and quality standards. One example of this will be the development of a common application process serving multiple funders to reduce administrative costs, improve collaboration, and reduce prevention providers' duplication of effort in securing funding.



### Goal 3: Balance funding between primary and secondary prevention with a greater emphasis on reaching more vulnerable families.

- Employ a 70–30 split for ICAPP funding between programs that target high risk groups and those with universal audiences.
- Target some primary prevention activities to the reduction of stigma associated with seeking help.
- Use Child Abuse Prevention Month to disseminate strategies for targeting vulnerable families and engaging communities in prevention through webinars and technical assistance to prevention providers.
- Expand the adoption of Child Abuse Prevention Month activities beyond ICAPP grantees to other prevention organizations.

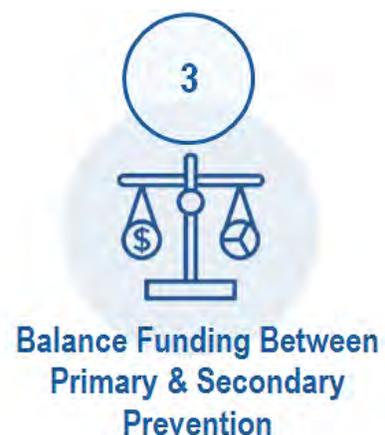
#### Measures of success

- ICAPP Requests For Proposals (RFPs) clearly communicate the proportion of funding available for primary and secondary prevention strategies.
- ICAPP RFPs clearly identify reduction of stigma as a focus for primary prevention strategies.
- ICAPP grantees document their Child Abuse Prevention Month activities.
- Child Abuse Prevention Month materials are disseminated by IDPH, ECI, ICASA and IDHS-funded prevention programs.

#### About Goal 3

Drawing on the guiding principle Impact (“*We prioritize prevention work that has the greatest impact on families and communities...*”) CAPPAC, IDHS and PCA Iowa have identified the need to focus most prevention funding towards families most at risk of abuse and neglect.

In addition, focus groups and surveys with families and prevention providers indicated that stigma associated with participating in a child abuse prevention program and asking for help were barriers preventing parents from participating in services, so it is important that funds targeted to universal audiences focus on addressing overall attitudes towards abuse and neglect and ways of getting help.



## Goal 4: Embed culturally competent practices in prevention services.

- Expand the prevention service work-force so that it is more culturally representative of the people being served.
- Provide services in settings that are culturally representative of the people being served.
- All ICAPP grantees should:
  1. Do a cultural competence self-assessment.
  2. Adopt and demonstrate culturally competent standards of practice.
  3. Conduct a trauma-informed agency assessment to assure that they are not compounding the harm of ACES.

### Measures of success

- ICAPP grantees complete cultural competence self-assessments and trauma-informed agency assessments.
- Grantees identify areas for improvements in cultural competence goals based on their self-assessment and report on their work to meet those goals.
- ICAPP grantees demonstrate culturally competent standards of practice through improvements in subsequent administrations of the cultural competence and trauma-informed assessments.

### About Goal 4

Families served by current prevention programming are diverse and can best be served by those from the same culture or who are culturally proficient in their practice. Due to the high number of prevention providers with adverse childhood experiences, staff and services must also be trauma-informed.

Self-assessment is an important tool that organizations can use to evaluate the extent to which their services and environment meet the needs of their clients. ICAPP grantees can serve as examples for other prevention organizations seeking to improve upon and adopt inclusive, effective practices in line with the guiding principles of the strategic plan.



## Goal 5: Increase the use of informal and non-stigmatizing supports for families and youth.

- Develop or adopt evidence-based or innovative peer mentor or family support programs that improve informal supports.
- Promote community events which involve all family members that are fun and non-stigmatizing.
- Help communities engage and support families in a manner that addresses their identified needs.
- Regularly get feedback from parents and families on the types of support that they need to meet their needs and get help.

### Measures of Success:

- ICAPP RFPs clearly communicate the proportion of funding available for peer mentor or family support programs to improve informal supports and community events.
- ICAPP grantees identify their methods to assess families' needs and how those needs are addressed.
- The proportion of families reporting that their needs were met by prevention services increased.

### About Goal 5

Findings from the needs assessment suggest that when families need help they trust family members and friends rather than formal support services. Prevention services can be strengthened by supporting those informal networks, identifying and/or developing best practices and hosting community events where positive healthy relationships can be fostered.

Part of this also involves hearing regularly from parents and family members about their perceptions of programs and needed improvements.



## **Goal 6: Increase the use of evidence-based practices (EBPs) in child maltreatment while introducing and evaluating innovative approaches.**

- Increase the proportion of ICAPP funding allocated to EBPs to 75 percent.
- Identify a single standard or rubric to identify evidence-based practices and innovative interventions and adopt it across funding sources.
- Develop a menu of EBPs for selection by ICAPP grantees.
- Develop standards for identifying and selecting innovative approaches.
- Provide funding to support evidence-based curricula at a group rate for all groups that want to implement common programs, thus reducing the cost for individual programs.
- Assure prevention programs and practices are delivered with fidelity.
- Build the capacity of prevention providers to monitor and report on fidelity.

### **Measures of Success:**

- Increased proportion of ICAPP grantees using an evidence-based curriculum as part of their programming
- ICAPP RFPs identify a single rubric to define evidence-based practices and a menu of programs that qualify.
- ICAPP RFPs identify criteria for defining “innovative programs” which qualify for funding without being EBPs.
- ICAPP grantees identify the critical components of their programs and include in their reporting evidence that the components are being delivered to fidelity.
- Annual technical assistance on fidelity monitoring is provided to grantees.

### **About Goal 6**

Increasing the use of EBPs and monitoring fidelity to those models is important to continuing to improve the overall quality of the interventions offered to families. However, in focus groups and a survey of prevention providers and other stakeholders, practitioners said determining which EBPs to use, and paying for training were challenges. In addition, no process is currently in place for monitoring model fidelity.

The strategic plan seeks to address these gaps by increasing the proportion of programs using EBPs, establishing a common benchmarks or definitions, and establishing processes for fidelity monitoring.



## Goal 7: Engage in a robust statewide evaluation of prevention services' effectiveness, monitoring protective and risk factors at the organization and community-level.

- Use fidelity and evaluation data for continuous quality improvements.
- Use one or more common measurement tools (*e.g.*, the Protective Factors Survey, Life Skills Progression) across all child maltreatment prevention services and share data for statewide evaluation.
- Establish data sharing agreements between programs and a common set of standards for administration of the surveys.
- Collect information on risk factors of child abuse and neglect from families participating in prevention programming.

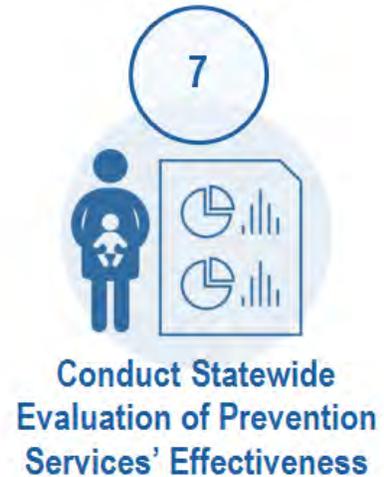
### Measures of Success:

- A data sharing agreement is in place between prevention programs to measure the impact of services on a state-wide level.
- A common measurement tool is identified and used across prevention organizations.
- Add questions collecting information about families' risk factors of child maltreatment to supplement what is tracked in DAISY or to the data management tool.

### About Goal 7

A statewide evaluation is currently conducted of ICAPP-funded programs and other prevention programs engage in a wide variety of data collection, performance measurement, and evaluation activities. These programs have a commitment to evaluation and continuous quality improvement; however, the number and wide variety of methods makes it difficult to determine the cumulative impact of prevention.

Establishing common measurement tools and sharing data across programs will help bolster the other collaborative efforts identified in this plan.





## Strategic Plan Implementation

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This strategic plan will serve as a communication tool and action plan on the direction of prevention programming in the state for both state-wide activities and local community-based efforts. The implementation plan starting on page twelve describes the timelines, activity leads and other responsible parties for each component of the plan's goals.

### Review and Revisions of the Plan

PCA Iowa will review the strategic plan with IDHS and the CAPPAC annually along with evaluation results to advise IDHS and CAPPAC on the state's progress towards the goals and gather feedback.

If updates to the strategic plan are identified during these reviews, PCA Iowa will first outline the change needed and the reason. In the outline PCA Iowa will identify qualitative and/or quantitative data to support the proposed revision and submit the change to CAPPAC for consideration. If approved, the changes will be confirmed in writing and submitted to CAPPAC prior to submission to IDHS.

### Funding Notes

Many goals and activities outlined in this plan call for changes in prevention practices or the administration of funding. For example, there are goals outlining changes in the types of services funded and the relationships between funders to promote collaboration, coordination, and shared decision-making. These recommendations are grounded in the vision and guiding principles of the plan; partners will need to work together to identify the next steps to accomplishing these goals in the way that best fits the needs of the children and families of Iowa.

**4%** of prevention funding was awarded by ICAPP and CBCAP in 2017

ICAPP and CBCAP were among 13 sources of maltreatment prevention funding in Iowa in fiscal year 2017 and accounted for four percent of the funds awarded for prevention services. Within this context, the strategic plan incorporates many goals to help ensure the highest and best use of ICAPP funds, including specifying the 70/30 split in secondary and primary prevention services, targeting funds to evidence-based practices, and calling for the continued use of funds to support the types of prevention programs that currently are not as well supported by other funders (*e.g.*, Fatherhood, Crisis and Respite Care and Sexual Abuse Prevention).

The maltreatment prevention needs assessment that preceded the strategic planning process included a long-term recommendation to unify prevention programming and funding within a single state department. As stated in the needs assessment,<sup>1</sup> “A single department managing prevention programming would minimize duplication of costly administrative oversight, improve collaboration, and direct more prevention dollars to the community.” The call to streamline the funding process for organizations by developing a common funding application serving multiple sources, developing common standards of practice, and sharing evaluation data are all intermediary steps in that direction.

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<sup>1</sup> Review the findings and a complete set of the recommendations from the needs assessment here: <http://www.pcaiowa.org/downloads/library/2017-iowa-child-maltreatment-prevention-needs-assessment.pdf>

## Implementation Plan

**Responsible Parties:** X indicates a responsible party involved in the activity and L indicates the lead agency.

Goal 1: Reduce child maltreatment by targeting risk factors presented by families which are most closely correlated with abuse and neglect.							
Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
Identify resources for addressing poverty, teen births, low birthweight, domestic violence, adverse childhood experiences, living with a disability, homelessness, mental illness, and substance abuse throughout the whole state and provide them to all prevention organizations to share with families.	Short-term		L				
Coordinate with the 2-1-1 United Way and Family Support Network services available throughout Iowa to connect parents and caregivers to support services.	Short-term	L	X			X	
Develop innovative strategies and partnerships to reach families, such as integrating prevention services into existing programming and removing barriers to services such as child care and transportation.	Long-term		L	X	X	X	
Conduct outreach to fathers, families with a parent or child with a disability, families that are homeless, and unaccompanied homeless youth.	Short-term		L	X			

**Goal 2: Coordinate maltreatment prevention funding sources across multiple service sectors (e.g., public health, early childhood, human services) to use each source strategically in combatting abuse and neglect.**



Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
<b>Streamline the funding application process for provider organizations by developing a common application process serving multiple funding streams.</b>	<b>Long-term</b>	L	X	X			X
<b>Use ICAPP funding to complement the programming funded by other sources (e.g., parent education and home visiting).</b>	<b>Short-term</b>	X	L	X			
<b>Promote CPPC and council membership so that families and stakeholders from all service sectors are represented and active throughout the state.</b>	<b>Short-term</b>		L	X	X		
<b>Build the capacity of parents and other family members to contribute to the planning, implementation and evaluation of prevention services in their communities.</b>	<b>Long-term</b>		L		X		

**Goal 3: Balance funding between primary and secondary prevention with a greater emphasis on reaching more vulnerable families.**



Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
Employ a 70–30 split for ICAPP funding between programs that target high risk groups and those with universal audiences.	Short-term	X	L	X			
Target some primary prevention activities to the reduction of stigma associated with seeking help.	Short-term		L	X	X	X	
Use Child Abuse Prevention Month to disseminate strategies for targeting vulnerable families and engaging communities in prevention through webinars and technical assistance to prevention providers.	Short-term	X	L	X	X	X	X
Expand the adoption of Child Abuse Prevention Month activities beyond ICAPP grantees to other prevention organizations.	Short-term	X	L	X	X	X	X

**Goal 4: Embed culturally competent practices in prevention services.**



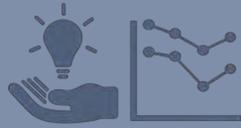
Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
Expand the prevention service work-force so that it is more culturally representative of the people being served.	Long-term	X	L	X	X	X	X
Provide services in settings that are culturally representative of the people being served.	Long-term	X	L	X	X	X	X
<p>All ICAPP grantees should:</p> <ol style="list-style-type: none"> <li>1. Do a cultural competence self-assessment.</li> <li>2. Adopt and demonstrate culturally competent standards of practice.</li> <li>3. Conduct a trauma-informed agency assessment to assure that they are not compounding the harm of ACES.</li> </ol>	Short-term		L	X	X	X	

**Goal 5: Increase the use of informal and non-stigmatizing supports for families and youth.**



Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
<b>Develop or adopt evidence-based or innovative peer mentor or family support programs that improve informal supports.</b>	<b>Long-term</b>		L	X	X	X	X
<b>Encourage community events which involve all family members that are fun and non-stigmatizing.</b>	<b>Long-term</b>		L	X	X	X	X
<b>Help communities engage and support families in a manner that addresses their particular identified needs.</b>	<b>Short-term</b>		L		X	X	
<b>Regularly get feedback from parents and families on the types of support that they need to meet their needs and get help.</b>	<b>Short-term</b>		L	X	X	X	X

**Goal 6: Increase the use of evidence-based practices (EBPs) in child maltreatment while introducing and evaluating innovative approaches.**



Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
Increase the proportion of ICAPP funding allocated to EBPs to 75 percent.	Long-term	X	L	X			
Identify a single standard or rubric to identify evidence-based practices and innovative interventions and adopt it across funding sources.	Short-term	X	L	X			
Develop a menu of EBPs for selection by ICAPP grantees.	Short-term	X	L	X			
Develop standards for identifying and selecting innovative approaches.	Short-term	X	L	X			
Provide funding to support evidence-based curricula at a group rate for all groups that want to implement common programs, thus reducing the cost for individual programs.	Long-term	L	X	X			
Assure prevention programs and practices are delivered with fidelity.	Short-term		L				
Build the capacity of prevention providers to monitor and report on fidelity.	Long-term		L				

**Goal 7: Engage in a robust statewide evaluation of prevention services' effectiveness, monitoring protective and risk factors at the organization and community-level.**



Action	Timeframe	Responsible Parties					
		IDHS	PCA Iowa	CAPAC	CPPCs/ Councils	Prevention providers	Other prevention funders
Use fidelity and evaluation data for continuous quality improvements.	Short-term		L		X	X	
Use one or more common measurement tools (e.g., the Protective Factors Survey, Life Skills Progression) across all child maltreatment prevention services and share data for statewide evaluation.	Long-term	L	X	X			X
Establish data sharing agreements between programs and a common set of standards for administration of the surveys.	Long-term	L					X
Collect information on risk factors of child abuse and neglect from families participating in prevention programming.	Long-term	L	X				X







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**Achieving Maximum Potential (AMP)** is a youth-driven, statewide group that seeks to unleash the full potential for personal growth among foster and adoptive children in Iowa. AMP works to help youth become independent adults who can successfully educate others about the child welfare system and take an active role in making life better for themselves and others in state care.

### AMP 2019 LEGISLATIVE AGENDA

**Collected from all 14 AMP Foster Care Youth Councils:** Ames, Mt. Pleasant, Cedar Rapids, Council Bluffs, Davenport, Des Moines/Des Moines Mobile, Dubuque, Eldora State Training School, Fort Dodge, Marshalltown, Mason City, Ottumwa, Sioux City and Waterloo

### STATE OF IOWA LEGISLATION

#### 1. AMP youth request more foster homes for teens.

- + Youth deserve to grow up in a family. Families First Prevention Services Act (FFPSA) will restructure child welfare to decrease congregate care. Family foster homes are not prepared for the high level of care needed. Resource families need specialized training (basic, therapeutic, enhanced) to match youth's needs.
- + Recruit more resource families willing to commit to teens.

#### 2. AMP youth request safe and affordable housing for young adults aging out of the foster care system.

- + Tax incentives /tax breaks for landlords who rent to transitioning youth

#### 3. AMP youth request when a young adult turns 18, they need contact information for their adopted siblings.

- + Educate adoptive parents on the value of sibling contacts
- + Consider cooperative adoption for youth adopted out of Iowa's child welfare system

#### 4. AMP youth request that each judge ask a youth age 12 and older if they want to have their own legal representation (in addition to their Guardian ad Litem - GAL).

- + The youth can waive this if not needed
- + It tends to be needed when the perception of "best interest" varies

#### 5. AMP youth request to get their driver's license before they age out of care.

- + Work with insurance companies to decrease liability for the person signing for the license
- + Underwrite state liability insurance for these situations

**LEGISLATION FROM LAST YEAR**

- 1. AMP youth request additional specialized housing options be available for youth; for minors with mental health needs and for all youth transitioning out of foster care. This would include:**
  - + Emergency shelters are not staffed or trained as treatment centers, creating risky situations for youth with, and without, extreme mental health issues who reside in shelter care. AMP youth request safety, protection and continued family and community connections in our shelters while our peers who need mental health services get their services at treatment facilities with trained staff.
  - + Independent housing options for youth, age 18-24, who would benefit from structure and supervision to further prepare them for adulthood.
  
- 2. AMP youth request that all youth in the state of Iowa, who are educated in their homes, be dual- enrolled in a local community school for at least physical education or extra-curricular activities. This is for safety.**
  - + Education Oversight / Regulation for all educational settings.



# Foster Care TO ADULTHOOD IN IOWA

## FFY 2018 Report



Released: January 2019



**Taylor Barry**, NYTD Coordinator

Iowa National Youth in Transition Database (NYTD)

Iowa Department of Human Rights

Division of Criminal and Juvenile Justice Planning

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## *Acknowledgements*

This report was made possible by the Chafee Foster Care Program for Successful Transition to Adulthood grant, which is federal funding from DHS.

The Iowa Department of Human Rights, NYTD Coordinator, under contract with DHS, collected NYTD data and partnered with other child serving agencies to enhance the relevant transition data provided in this report.

Partners include Iowa Aftercare Services Program, who provided data from their Annual Report; Achieving Maximum Potential (AMP), who provided data from their year end report; and the Iowa College Student Aid Commission (Iowa College Aid), who provided data on their Education and Training Voucher (ETV) program.

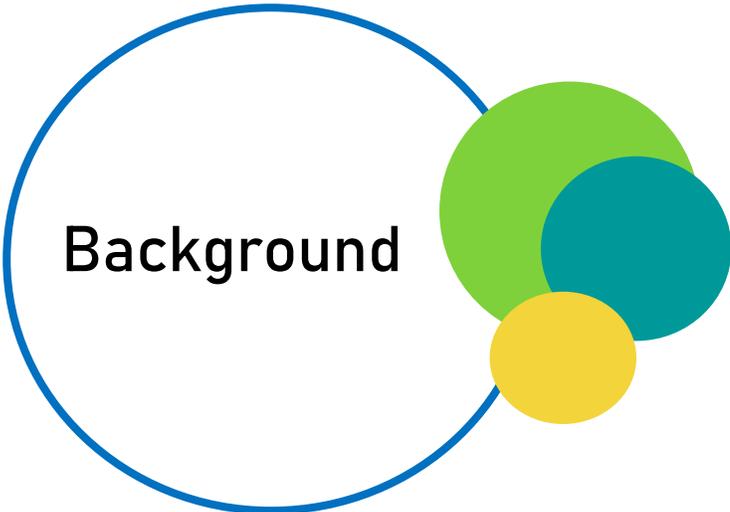
Final edits and reviews were completed by the Department of Human Rights and the Department of Human Services. Both extend their appreciation to all coordinating efforts for this report.

Finally, a special thanks is extended to the youth who answered the NYTD questions, and all youth who utilize the many services Iowa offers. Without their contributions, this report would not be possible.

# Content

*The purpose of this report is to continue to highlight areas where child serving agencies and service providers can continue effective transition work, while also pointing to service deficits which can be developed or enhanced in coming years.*

BACKGROUND.....	1
I. DEFINITIONS.....	2
II. DATA SOURCES.....	3
AGING OUT OF FOSTER CARE IN IOWA.....	5
OVERVIEW OF IOWA'S FOSTER CARE SYSTEM.....	6
I. OUT-OF-HOME SERVICES.....	6
NATIONAL YOUTH IN TRANSITION DATABASE.....	7
I. NYTD OUTCOMES REPORTED SUMMARY.....	8
A. OUTCOME 1: POSITIVE CONNECTIONS.....	9
B. OUTCOME 2: FINANCIAL SELF-SUFFICIENCY.....	9
C. OUTCOME 3: ACCESS TO HEALTH INSURANCE.....	10
D. OUTCOME 4: EDUCATIONAL ATTAINMENT.....	10
E. OUTCOME 5: EXPERIENCES WITH HOMELESSNESS.....	11
F. OUTCOME 6: HIGH-RISK OUTCOMES.....	11
II. NYTD LIFE SKILLS SERVICES REPORTED.....	12
III. CONTRACTED TRANSITION SERVICES AND OUTCOMES.....	14
A. EDUCATION AND TRAINING VOUCHER (ETV).....	14
B. IOWA AFTERCARE SERVICES NETWORK.....	16
C. ACHIEVING MAXIMUM POTENTIAL (AMP).....	18
CONSIDERATIONS & UPDATES.....	20
LEARN MORE.....	21



# Background

## CHAFEE FOSTER CARE PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD

Public Law 106-169 established the Chafee Foster Care Program for Successful Transition to Adulthood (formerly the John H. Chafee Foster Care Independence Program) at section 477 of the Social Security Act, providing States with flexible funding to carry out programs that assist youth age 14 or older in making the transition from Foster Care to self-sufficiency. The law also required the federal Administration for Children and Families (ACF) to develop a data collection system to track the independent living services States' provide to youth, and develop outcome measures that may be used to assess States' performance in operating their independent living programs. The law requires ACF to impose a penalty between one and five percent of the State's annual allotment on any State that fails to comply with the reporting requirements.

To meet the law's mandate, ACF published a proposed rule in the Federal Register on July 14, 2006 and a final rule on February 26, 2008. The regulation established the National Youth in Transition Database (NYTD) and required that States engage in two data collection activities. First, States are to collect information on each youth who receives independent living services paid for or provided by the State agency. Second, States are to collect demographic and outcomes information on certain youth in Foster Care whom the State will follow over time to collect additional outcome information.

Pursuant to the regulation, the Iowa Department of Human Services began collecting data for NYTD on October 1, 2010 and reports data to ACF semi-annually. The first submission of data to the ACF was May 15, 2011. The most recent submission was November 15, 2018. Iowa has been in full compliance with NYTD reporting requirements since implementation. Federal compliance requires a response rate of 80% for the Baseline (age 17) population, and 60% for the Follow-Up (age 19 and 21) populations.

DHS and other state child welfare agencies are required to collect outcome data and information describing services provided to youth in Iowa Foster Care or who have exited. DHS case managers and juvenile court officers report quarterly Life Skills services provided to youth age 14 and older, when the service is paid for or provided by DHS. Then, to measure the outcomes of youth who were formerly in Foster Care, Iowa DHS contracts out survey data collection. Since 2016, DHR has completed these activities, and in addition to surveying youth, also watched trends and created reports. Youth are surveyed at age 17 (in cohorts every three years), then 25% of those surveyed are contacted again when they are age 19 and 21.

The survey was administered to the second baseline cohort of Foster Care youth who reached age 17 in federal fiscal year 2014 (FFY 2014). The follow-up populations for that baseline cohort received follow-up surveys as they reached age 19 (FFY 2016) and 21 (FFY 2018). This report represents the full NYTD cohort of individuals transitioning from age 17 through age 21. Reports on the interim NYTD populations can be found on Iowa NYTD's website<sup>1</sup>.

The purpose of this report is two-fold. One, the following highlights compare the outcomes reported by youth in the second NYTD cohort at ages 17, 19 and 21. Additional Foster Care demographic information and relevant service information has been provided to complement the NYTD data. This data is provided from other Chafee funded programs such as Iowa Aftercare Services Network (IASN); Achieving Maximum Potential (AMP); and the Education and Training Voucher (ETV) Program.

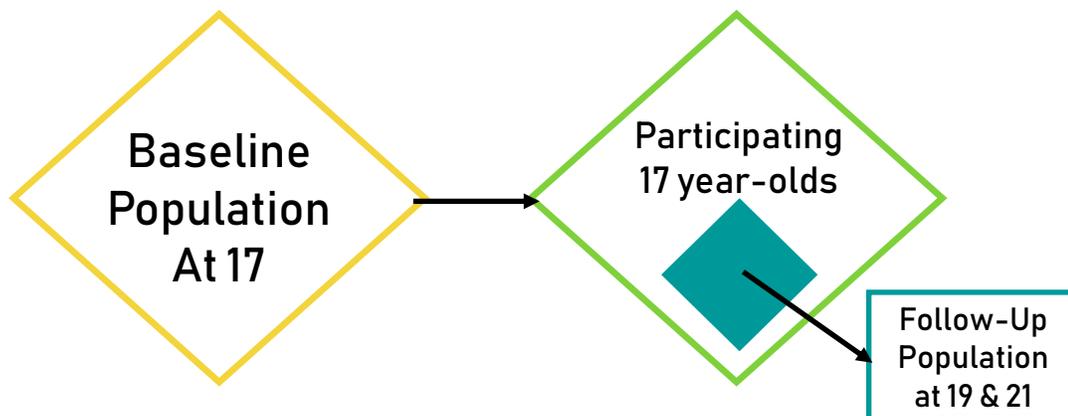
Secondly, Iowa DHR hopes to continue to highlight areas where child serving agencies and service providers can continue effective transition work, while also pointing to service deficits which can be developed or enhanced in coming years. With a full cohort of data collection completed for Iowa NYTD, Iowa youth and advocates can better understand the experiences of young people currently and formerly in Foster Care as they age and transition into adulthood.

### *Definitions*

When a definition is used in this report, it will be capitalized to alert the reader a definition is available in this section.

**Baseline Population** refers to youth in Foster Care, as defined in 45 CFR 1355.20<sup>2</sup>, who reached his or her 17th birthday in FFY 2011, or reaches age 17 in every third fiscal year following 2011. For example, youth in the Baseline Population will reach age 17 during FFY 2011, FFY 2014, FFY 2017, etc. The Baseline Population includes all 17 year-old youth who are in Foster Care or other out-of-home placement that are eligible to take the Iowa NYTD survey. A youth is considered to have participated at age 17 if he or she provided at least one valid answer to a question in the outcomes survey. A youth may not participate in the survey for various reasons including: not in sample; runaway/missing; unable to locate/invite; youth declined; youth incapacitated; youth incarcerated.

**Follow-Up Population** refers to a sample of 17 year-olds who participated as a part of the Baseline Population, who are identified for another outcome survey as they reach age 19 and 21, regardless of whether or not they remain in Foster Care or ever received Life Skills services. A youth is considered to have participated at age 17 if he or she provided at least one valid answer to a question in the outcomes survey.



<sup>1</sup><https://sites.google.com/a/iowa.gov/national-transition-youth-database-nytd/annual-report>

<sup>2</sup><https://www.law.cornell.edu/cfr/text/45/1355.20>

Foster Care is defined in 45 CFR 1355.20 as a 24-hour substitute care for all children placed away from their parents or guardians and for whom the Department of Juvenile Court Services (JCS) has placement and care responsibility either through court order or voluntary agreement. This includes, but is not limited to, placements in foster family homes (whether the foster parents are relatives of or unrelated to the youth), group homes/residential facilities, shelter care and child care institutions (regardless of whether such homes or institutions are licensed, approved, or paid), emergency shelters, and preadoptive homes. This definition does not include placements in detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent. The definition also excludes youth who are in the placement and care responsibility of a tribal agency unless the conditions specified above regarding title IV-E agreements apply.

Life Skills Services, also referred to as independent living services, are services paid for or provided by the Department of Human Services, intended to support a youth in Foster Care preparing for adulthood. Services are inclusive of those provided through a foster parent, contracted service provider, other public agency, etc..

National Youth in Transition Database (NYTD) refers to a federal law which requires States to engage in two data collection activities. First, the State is to collect information on each youth who receives Life Skills Services paid for or provided by the State, and transmit this information to the ACF, biannually. Second, the State is to collect demographic and outcomes information on certain youth in Foster Care whom the State will follow over time to collect additional outcomes information. This information is also transmitted to the ACF biannually. Outcomes information collected includes educational attainment, financial self-sufficiency, access to health insurance, experience with homelessness, and positive connections with adults.

### ***Data Sources***

The Adoption and Foster Care Analysis and Reporting System (AFCARS) requires states to collect and report case-level information to the federal ACFS on all children in Foster Care and those who have been adopted with title IV-E agency involvement. Examples of data reported in AFCARS include demographic information on the foster child as well as the foster and adoptive parents, the number of removal episodes a child has experienced, the number of placements in the current removal episode, and the current placement setting. Title IV-E agencies are required to submit the AFCARS data twice a year based on two six month reporting periods.

Achieving Maximum Potential (AMP) is a DHS contracted Foster Care Youth Council for youth ages 13 through 20 who have been involved in foster care, adoption, or other out-of-home placements. Local councils organize and offer leadership opportunities, service learning projects, speaking opportunities, and educational/vocational assistance. AMP also provides the life skills youth need to become self-sufficient, independent adults. The purpose of AMP is to empower young people to become advocates for themselves and give them a voice in system-level improvements in child welfare policies and practices. Data pertaining to AMP can be found on page 18.

The National Youth in Transition Database (NYTD) requires Iowa DHS to collect data regarding youth transitioning from Foster Care to adulthood. First, Iowa DHS collects information on each youth who receives Life Skills Services paid for or provided by either the DHS, or contracted service providers, and transmits this information to the ACF, biannually. Second, DHR collects demographic and outcomes information on certain youth in Foster Care whom the State will follow over time to collect additional outcome information. This information is also transmitted to the ACF biannually. All NYTD data provided in this report pertains to youth who participated at age 17 in FFY 2014, 19 in FFY 2016, and 21 in FFY 2018, and can be found on page 7.

The Iowa College Student Aid Commission (Iowa College Aid) serves as Iowa's higher education student financial aid agency, assisting Iowa students and families as they plan, prepare, and pay for education. Through its efforts, Iowa College Aid seeks to realize its vision that all Iowans can achieve education beyond high school. Iowa College Aid, under contract with DHS, administers the Education and Training Voucher (ETV) Grant Program, which provides funding for housing and tuition of youth formerly in Iowa Foster Care, who are pursuing higher education at an accredited education institution. The 2018 Family First Prevention Services Act (FFPSA) extends the eligibility to youth ages 14 to 26, but limits the youth's participation to five years total.

The Iowa Aftercare Services Network (IASN) is a DHS contracted service to serve young adults age 18 through 21 who have aged out of Foster Care and other court ordered placements. To assess its effectiveness, IASN tracks progress of participants in six key areas: education, employment, housing, health, life skills, and relationships. Results are reported annually to DHS. The Youth Policy Institute of Iowa (YPII)<sup>3</sup> leads the quality assurance and evaluation efforts of the Network, working closely with IASN agencies and DHS to collect and analyze data, and report services outcomes. Annual Aftercare reports include trend information from intake interviews with youth when they first access Aftercare services; demographic and other characteristics of all participants served by Aftercare each year; and outcomes of participants who exit services during the year. Data pertaining to IASN can be found on page 16. Full Aftercare reports can be found on their website<sup>4</sup>.

<sup>3</sup><http://www.ypii.org/>

<sup>4</sup><http://www.iowaaftercare.org/ProgramResults.html>

An estimated **450** youth per year age out of the foster care system. As young people begin to transition from Foster Care to adulthood, they should have experiences that nurture their growth and independence. Youth in care are met with obstacles that can thwart a smooth transition. Survey results from the second cohort of NYTD, as well as other Chafee funded programs, and basic child welfare data, provide a statewide glimpse of how these youth are doing as they transition to adulthood.





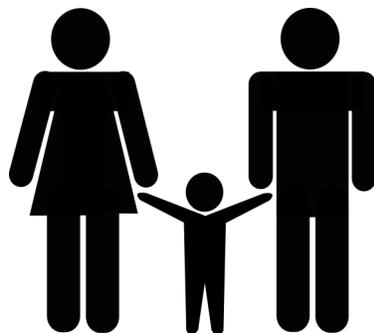
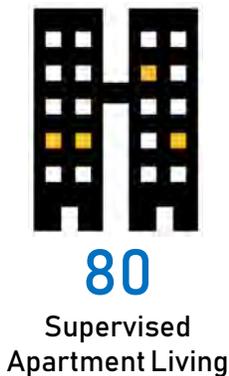
# Foster Care

Foster Care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.

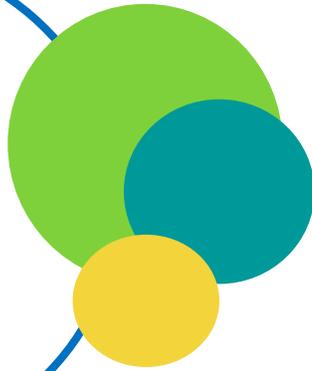
This includes placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes.

However, the ideal place for children is with their families; thus, DHS strives to ensure children remain in their own homes whenever safely possible. In fact, 55% of children placed in foster care in SFY 2018<sup>5</sup> were discharged due to reunification, with an additional 34% of children who were removed from their home in SFY 2018, placed in the care of an extended family member.

The following snapshot further displays the average number of youth served *per month* by Foster Care programs in SFY 2018.



# National Youth In Transition Database



Public Law 106-169 established the Chafee Foster Care Program for Successful Transition to Adulthood (formerly the John H. Chafee Foster Care Independence Program) at section 477 of the Social Security Act, providing States with flexible funding to carry out programs that assist youth age 14 or older in making the transition from Foster Care to self-sufficiency. The law also required the federal Administration for Children and Families (ACF) to develop a data collection system to track the independent living services States provide to youth and develop outcome measures that may be used to assess States' performance in operating their independent living programs.

The regulation to implement the law established the National Youth in Transition Database (NYTD), which required states to engage in two data collection activities. First, in federal fiscal year (FFY) 2011<sup>6</sup>, states began to collect information on each youth who received Life Skills services during the year, which were paid for or provided by the state. Life Skills Services in Iowa include a range of services intended to help the youth in Foster Care age 14 and older, or alumni, learn life skills. These supports may be anything from contracted life skills for teens in Foster Care, to funding for books and tuition of a college student. Second, states are to collect demographic and outcome information on certain youth in Foster Care, and the states are expected to follow these youth over time to collect additional outcome information. In FFY 2011, Iowa DHS began to survey each youth in Foster Care who reached age 17. DHS then follows up with a sample of these youth within the reporting period of their 19th and 21st birthday, regardless of whether or not they are still in Foster Care or other out-of-home placement. States are required to repeat this process with a new Baseline population of 17 year-olds every three years.

More on the National Youth in Transition Database can be found on the Iowa NYTD website:

[bit.ly/iowaNYTD](http://bit.ly/iowaNYTD)

<sup>6</sup>Federal Fiscal Year (FFY) 2011=October 1, 2010 to September 30, 2011

The graphic features the text "NYTD Outcomes Reported" in a large, bold, black font, centered within a blue circular outline. To the right of the text are three overlapping circles: a large light green circle at the top, a medium teal circle in the middle, and a small yellow circle at the bottom.

# NYTD Outcomes Reported

DHS contracted with the Department of Human Rights (DHR) in 2016 to survey youth, track data, and create reports for the NYTD federal requirements. Specifically, DHR is contracted to collect and report outcomes information on youth who are or were in Foster Care or other out-of-home placement.

Iowa's current survey includes up to 24 questions that collect demographic information and measure youth outcomes across six domains:

- Financial Self-Sufficiency
- Educational Attainment
- Positive Connections with Adults
- Experience with Homelessness
- High-Risk Behavior
- Access to Health Insurance

The survey data must be collected directly from the youth (and not administrative records). Iowa offers three methods for completing the survey. The survey may be taken via phone, mail, or online:

- **Mail:** Return or request the paper copy, and return a completed survey in a business reply envelope.
- **Online:** Go to [bit.ly/lowaNYTD](http://bit.ly/lowaNYTD), Click on 'Take the Survey', and then click on the respective survey option.
- **Phone:** Call the toll free hotline at 1-888-228-4912 or the NYTD Coordinator at 515-725-4050.

Most youth choose the phone option. All survey responses are voluntary, as youth have the option to decline a question, or the survey itself, at any time. Collected responses are always confidential, and are not connected to a specific youth. Completing the survey at Baseline or Follow-Up, regardless of format, earns them a gift card.

The following pages display NYTD survey results from the second cohort of youth at ages 17, 19 and 21. Specifically, this section includes the results of the surveys of Iowa's second cohort of NYTD Baseline youth—youth in the Baseline are those who reached age 17 in Foster Care during FFY 2014. Again, Baseline refers to the 394 youth in Foster Care who were surveyed at age 17, and the Follow-Up refers to a sample of those youth (259) who were surveyed again at age 19 (N=131) or 21 (N=128). Iowa is currently surveying the third Follow-Up Population of 19 year-old youth. This Follow-Up cohort will be complete no later than November 15, 2019.

Overall, the following data provides a statewide glimpse of how these young people are doing in certain outcome areas as they age.

## Outcome 1: Positive Connections with Adults



- At age 17, 98% (N=388) of youth reported having at least one adult in their life, other than their caseworker, to whom they can go for advice and emotional support. By age 21, that percentage decreased to 87% (N=111).

Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Has positive connection to an adult	98%	96%	87%

## Outcome 2: Financial Self-Sufficiency



- At age 17, approximately 44% (N=172) reported experiences in at least one employment-related category (full- or part-time employment; paid or unpaid apprenticeship, internship, or other on-the-job training).
- By age 19, 60% (N=79) reported some employment-related experience, which increased from the 54% reported in the first cohort (FFY 2016).
- 52% (N=68) of 19 year-olds reported receiving public assistance.

Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Employed full-time	1%	21%	34%
Employed part-time	17%	31%	26%
Receiving Employment related skills training	38%	22%	34%
Receiving Social Security	8%	11%	9%
Receiving educational aid	3%	14%	22%
Receiving other financial support	10%	20%	11%
Receiving public assistance (financial, food & housing)	N/A	52%	45%

## Outcome 3: Access to Health Insurance



- 88% (N=345) of youth at age 17 reported having Medicaid insurance coverage. 8% (N=31), however, reported not knowing if they currently had Medicaid coverage.
- 2% of participating 17 year-olds (N=6), 13% of participating 19 year-olds (N=17), and 11% of participating 21 year-olds (N=14) reported not currently having Medicaid or some other health insurance.

Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Has Medicaid	88%	67%	71%
Has health insurance other than Medicaid	13%	18%	29%

## Outcome 4: Educational Attainment



- 35% (N=46) of 19 year-olds were enrolled in and attending some type of educational programming. Of these, 67% (N=31) reported having achieved a high school diploma or GED.
- By age 21, nearly 75% (N=96) had received a high school diploma or GED, and 7% (N=9) had received an associate's degree or vocational certificate.

Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Received high school diploma or equivalency/GED	4%	76%	75%
Enrolled and attending an educational program	97%	35%	27%

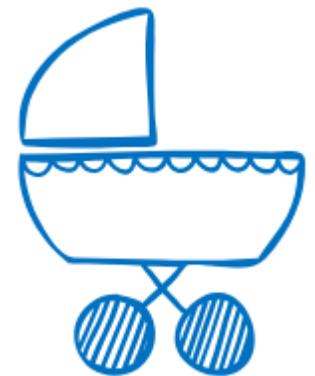
## Outcome 5: Experiences with Homelessness



- At age 17, 20% (N=77) had experienced homelessness at some point in their lifetime.
- 27% (N=34) of 21 year-olds reported having been homeless at some point within the past two years.
- At age 17, female youth comprised 44% (N=34) of youth who reported being homeless. By age 21, 53% (N=18) of the youth who reported having been homeless at some point in the past two years were female.

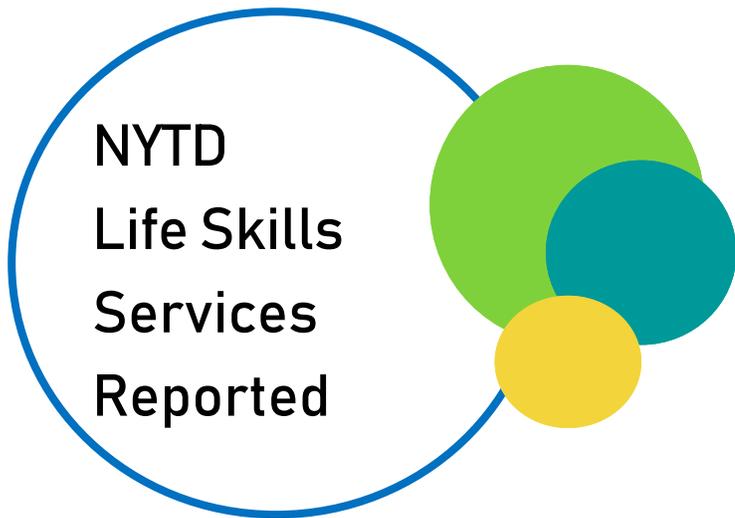
Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Homeless at some point (in past two years for ages 19 and 21)	20% (in lifetime)	23%	27%

## Outcome 6: High-Risk Outcomes



- 24% (N=31) of 19 year-olds reported experiencing confinement in a jail, prison, correctional facility, or juvenile or community detention facility within the last two years.
- More females than males reported having children. By age 21 specifically, 41% (N=27/65) of participating young women reported having given birth to a child within the past two years, while 13% (N=8/63) of participating young men reported fathering a child.

Outcome area	Age 17 (N=394)	Age 19 (N=131)	Age 21 (N=128)
Referred for substance abuse assessment or counseling (in past two years for ages 19 and 21)	38% (in lifetime)	18%	13%
Confined at some point* (in past two years for ages 19 and 21)	51% (in lifetime)	24%	21%
Had children (in past two years for ages 19 and 21)	5% (in lifetime)	10%	27%



States are required to deliver and report on Life Skills Services or financial assistance provided to youth within 11 broad service categories:

- |   |   |
|---|---|
| 1. Independent Living Needs Assessment        | 7. Housing Education and Home Management Training |
| 2. Academic Support                           | 8. Health Education and Risk Prevention           |
| 3. Post-Secondary Educational Support         | 9. Family Support and Healthy Marriage Education  |
| 4. Career Preparation                         | 10. Mentoring                                     |
| 5. Employment Programs or Vocational Training | 11. Supervised Independent Living                 |
| 6. Budget and Financial Management            |   |

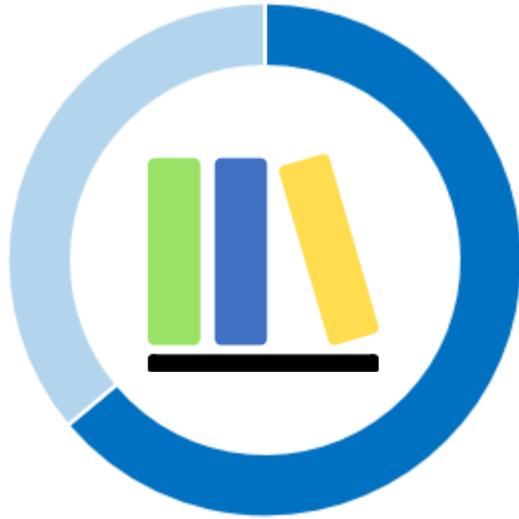
The following data provides a statewide glimpse of the Life Skills Services provided by DHS to Foster Care youth age 14 and older in Iowa.

# Life Skills Services Reported in FFY 2018

# 3,920

## YOUTH AGE 14 AND OLDER AND ALUMNI RECEIVED A LIFE SKILL SERVICE IN FFY 2018

### TYPES OF SERVICES RECEIVED



2,502

ACADEMIC SUPPORT



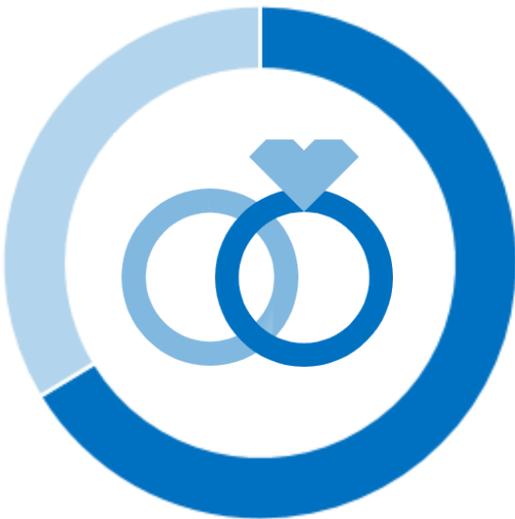
2,914

HEALTH EDUCATION &  
RISK PREVENTION



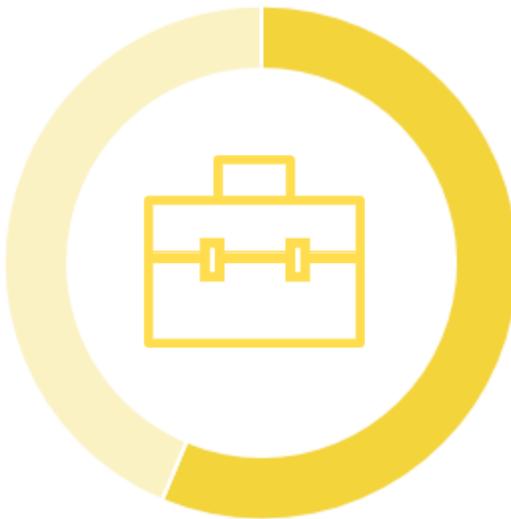
2,552

BUDGET & FINANCIAL



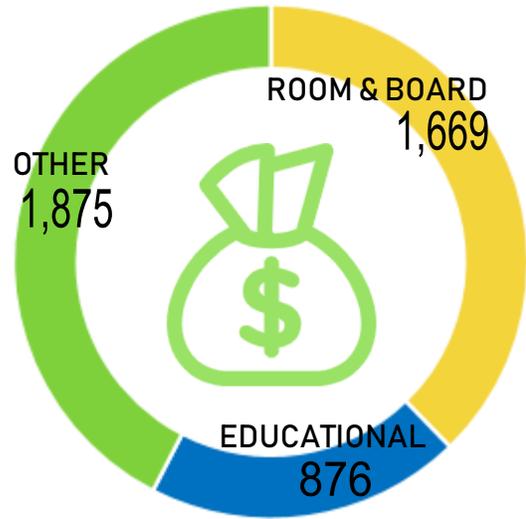
2,600

FAMILY SUPPORT &  
HEALTHY MARRIAGE



2,208

CAREER  
PREPARATION

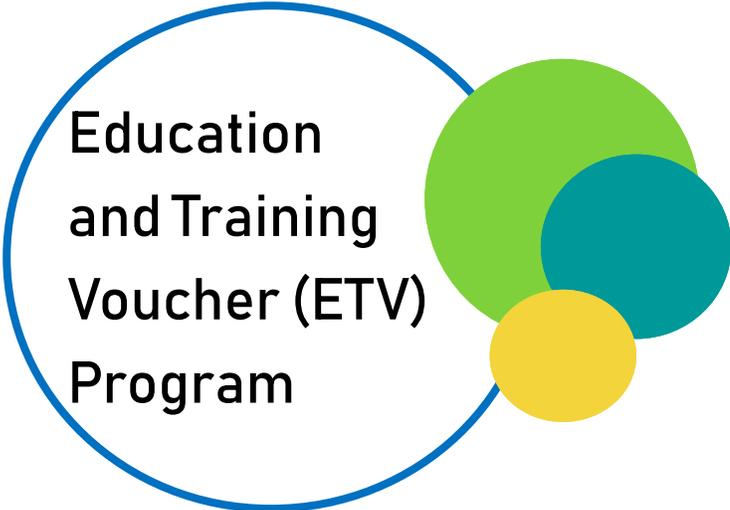


ROOM & BOARD  
1,669

OTHER  
1,875

EDUCATIONAL  
876

FINANCIAL  
ASSISTANCE

The logo for the Education and Training Voucher (ETV) Program features the text "Education and Training Voucher (ETV) Program" in a bold, black, sans-serif font, arranged in four lines. To the right of the text is a graphic consisting of three overlapping circles: a large light green circle at the top, a medium teal circle to its right, and a smaller yellow circle at the bottom. The entire graphic is enclosed within a thin blue circular border.

## Education and Training Voucher (ETV) Program

The Iowa Department of Human Services (DHS) partners with the Iowa College Student Aid Commission (Iowa College Aid) to administer the Education and Training Voucher (ETV) program. The ETV program in Iowa provides educational awards of up to \$5,000 per year to students who age out of Foster Care and students who are adopted after age 16 to help pay for tuition/fees, room/board, book/supplies, and personal/living expenses<sup>7</sup>.

Each year Iowa's ETV application is available online beginning on October 1 to coincide with the Free Application for Federal Student Aid (FAFSA) release. Students must submit both a FAFSA and the Iowa Financial Aid Application annually with awards made until funds are expended. Students renewing their awards prior to March 1st receive priority consideration. Once all funds for a particular academic year are committed, a waiting list begins. Students enrolled less than full-time receive a prorated amount.

Former foster youth may also qualify for the All Iowa Opportunity Scholarship (AIOS). The State of Iowa funds this scholarship and it is available to students who have financial need and are attending an eligible Iowa college or university within two years of graduating high school. Students who self-identify as a current or former foster youth have first priority for the AIOS. This scholarship is renewable for four years as long as the student is enrolled continuously.

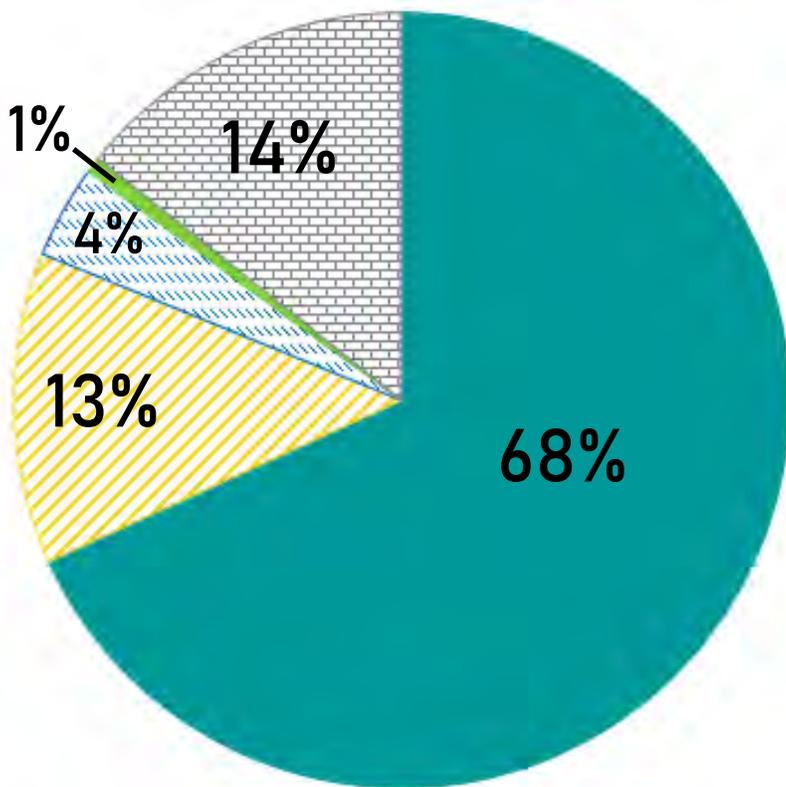
Although children and youth in Foster Care may experience challenges that adversely affect educational progress, some young people attending college through the ETV program reported that school was their solace, and that educational success became a pattern for them and a defining characteristic. Education supports and services for youth experiencing Foster Care create opportunities for improved outcomes, including educational and career attainment.

Collaboration between DHS and educators has improved information sharing and system level problem solving capacity, as their continued goal is to ensure all youth in Foster Care likely to be eligible for the ETV program are given information about the program. In fact, recent federal policies provide obligations for state agencies to use Foster Care and education data to better inform educators, child welfare, and the public.

The following section contains ETV data sourced from Iowa College Aid, which provides a more detailed look at the 2017-2018 academic school year.

<sup>7</sup><https://www.iowacollegeaid.gov/content/education-and-training-voucher-etv-grant>

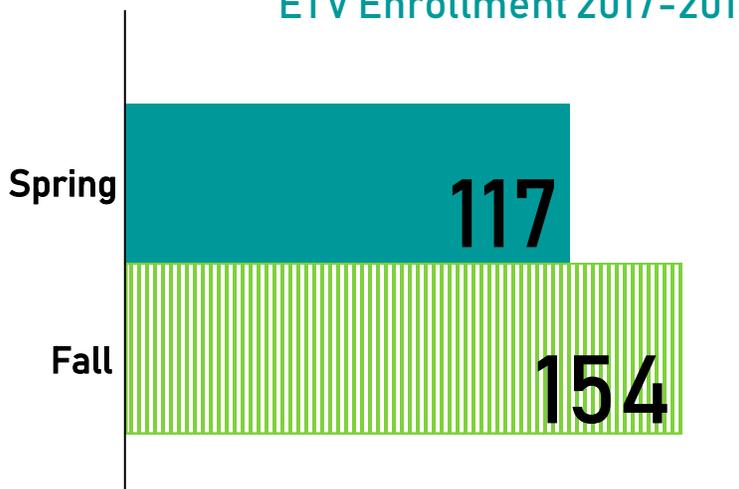
# Higher Education at a Glance



- The Education and Training Voucher (ETV) program is funded by the Federal Department of Health and Human Services to assist foster care alumni with expenses for post-secondary education and job training.
- Iowa College Aid administers the DHS funded ETV program.
- 154 ETV students in fall 2017 enrolled in a post-secondary education program.

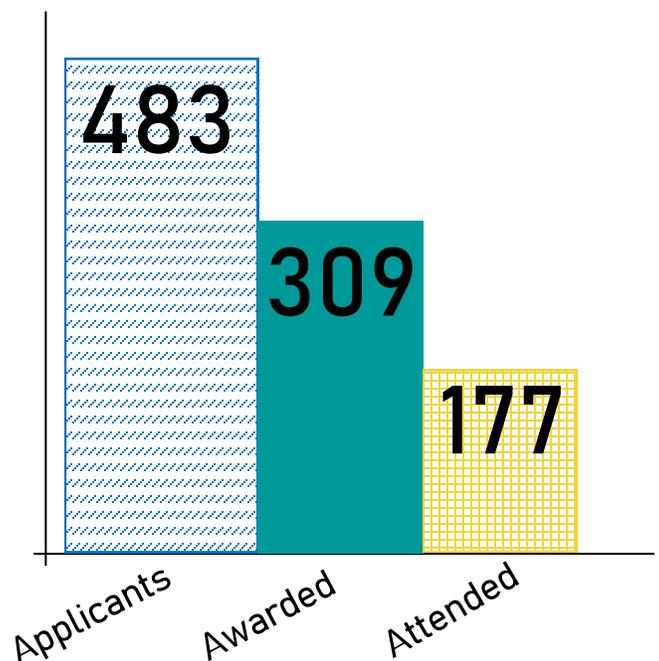
■ Community College    
 ■ Barber/Cosmetology School    
 ■ Out of State Colleges/Universities  
■ Regent Universities    
 ■ Independent Colleges/Universities

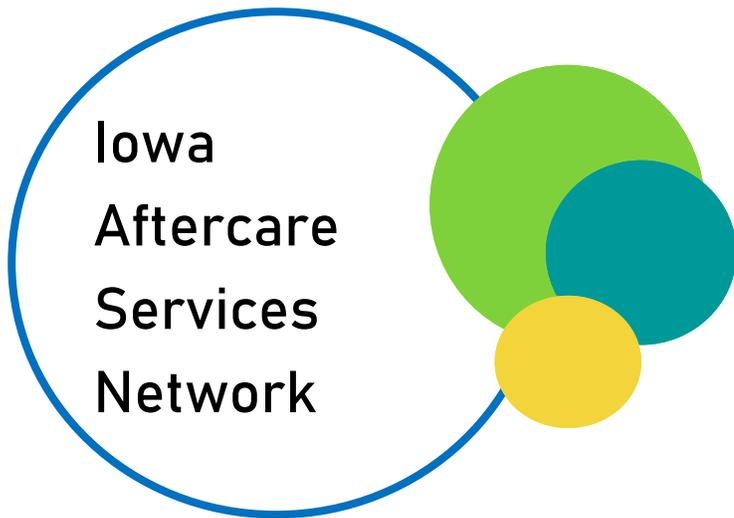
### ETV Enrollment 2017-2018



- Fall 2017 enrollment is up 10% compared to the 140 ETV youth enrolled in a post-secondary education program in the fall of 2016.

### ETV Application Cycle 2017-2018





DHS is committed to ensuring teens who exit the Foster Care system at or around age 18 are prepared for adulthood. Transition planning should begin well before the youth prepares to exit Foster Care in order to have a solid discharge plan when the time comes to leave Foster Care.

The Iowa Aftercare Services Program (Aftercare) is designed to help the youth see that plan through, even as the youth aging out Foster Care enters adulthood. The primary goal of Aftercare is for participants to achieve self-sufficiency, and ensure that they recognize and accept their personal responsibility to prepare for and transition from adolescence to adulthood. Aftercare services is a voluntary program to provide case management, life skills training, goal planning, and limited financial support for youth who have been placed out-of-home (due to family problems or delinquent behaviors), and who have been unable to return home before reaching the age of majority. These youth, referred to as youth aging out of the system, need help transitioning from out-of-home placement to their chosen adult living situation (e.g. college, apartment). Individualized plans are used to ensure the six life domains are addressed; including:

- |              |           |                 |
|--------------|-----------|-----------------|
| • Employment | • Health  | • Life Skills   |
| • Education  | • Housing | • Relationships |

Through a contract with Youth and Shelter Services Inc. (YSS), seven youth-serving agencies deliver aftercare’s developmentally appropriate support and services to eligible youth throughout the Iowa, and certain youth leaving the State Training School or court-ordered detention placements. Youth are also eligible if they exited Foster Care for a subsidized guardianship, or adoption, at age 16 or older. Services are available in all of Iowa’s 99 counties when the youth is age 18 through 21. Eligible youth may apply or return for services until age 21.

Full Program Rules for Aftercare can be found in 441 Iowa Admin. Code Chapter 187<sup>8</sup>.

The following section contains outcome data sourced from the Iowa Aftercare report, developed primarily by Youth Policy Institute of Iowa (YPII). Collected for youth in Aftercare during the 2018 State Fiscal Year (SFY 2018), this data provides a glimpse into how youth who have exited Foster Care around the age of 18 are now being served by Iowa Aftercare Services.

<sup>8</sup><http://www.iowaaftercare.org/PDF%20files/Iowa%20Administrative%20Rules.pdf>

# Aftercare Services Provided To Youth In SFY 2018



**798**  
YOUNG ADULTS  
RECEIVED AFTERCARE SERVICES

**251**  
ACCESSED SERVICES FOR  
THE FIRST TIME IN SFY 2018

THE MEDIAN LAPSE BETWEEN EXIT FROM FOSTER CARE OR STS/DETENTION TO AFTERCARE INTAKE IS

 **13 DAYS** 

## ENTERED

## EXITED



71% of youth who entered had a high school diploma or equivalent.

26% of new intakes were enrolled in high school or an equivalency program in SFY 2018.

87% of youth had earned at least a high school diploma or higher degree or certification upon exiting Aftercare.



92% of youth reported having Medicaid.

64% of youth reported having a primary care physician.

95% of young people who exited Aftercare report having Medicaid.

99% of youth have health insurance when they exit Aftercare Services.



Among females, 18% reported having had an unintended pregnancy prior to accessing Aftercare.

5% of youth entered Aftercare as parents.

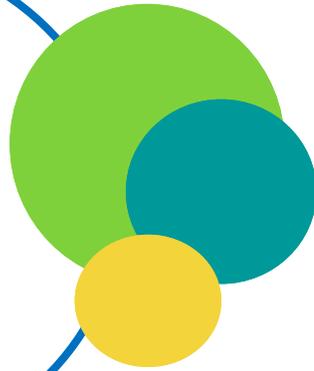
26% of youth are parenting upon exiting Aftercare. 75% of these youth have their children living with them.



21% of youth reported having been referred for an alcohol or substance abuse assessment or counseling.

43% of youth exiting Aftercare indicated that they use tobacco, 27% use alcohol to intoxication, and 22% use Marijuana, which is up 14% from the 8% reported in SFY 2016.

# Achieving Maximum Potential (AMP)



AMP (Achieving Maximum Potential) is Iowa's Foster Care Youth Council. Contracted through DHS, AMP helps further achieve their goal of ensuring teens who exit the Foster Care system are prepared for adulthood. The primary goal of AMP is to empower current and former Foster Care youth, adoptive youth, and youth who have been involved in other out-of-home placements, aged 13 through 20, to utilize self-advocacy skills, and know that they can have a voice in system-level improvements in the child welfare policies and practices. Through supportive, productive partnerships with adults, youth are authoritative advocates for making Foster Care more responsive and effective. Specifically, AMP offers youth the following :

- Leadership Opportunities;
- Service Learning Projects;
- Speaking Opportunities;
- Educational/Vocational Assistance;
- Opportunities to Learn Various Life Skills;
- Resources for Transition from Foster Care to Adulthood; and
- More!

AMP allows youth to participate in normal adolescent activities with their peers in a safe and supportive environment. Members of AMP also encourage others to open their homes to teens in Foster Care or to adopt, and educate legislators, child welfare professionals, juvenile court representatives, foster parents, and the public about foster care and adoption from a youth perspective.

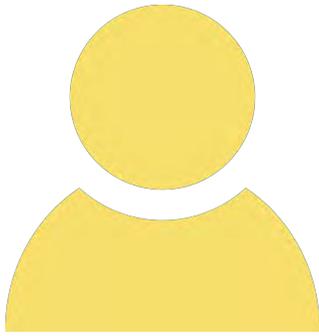
The Iowa Department of Human Services (DHS) is the primary grant funder for AMP. Youth and Shelter Services Inc. (YSS) subcontracts with eight, non-profit youth-serving agencies to make up the Partnership of Iowa Foster Care Youth Councils, which provide AMP Youth Councils to fourteen locations across the state. Donations, grants, and local community supports help supplement local youth AMP councils. AMP also partners with other agencies such as ISU –RISE (Research Institute for Studies in Education) to conduct program assessments; the Child and Family Policy Center (CFPC) to help with legislative advocacy; the Youth Policy Institute of Iowa (YPII) for data collection and reporting assistance; and many other child serving networks.

For more information on AMP, visit their website:

[www.ampiowa.org/en/who\\_we\\_are/](http://www.ampiowa.org/en/who_we_are/)

The following section contains outcome data sourced from AMP's yearly SFY 2018 report, developed primarily by YPII. The selected data specifically provides a glimpse into the membership and activities of AMP during the 2018 State Fiscal Year.

# AMP Membership Characteristics for SFY 2018



**1,300**

Attended One or More AMP Meetings

**42%**  
Became AMP Members



26%  
OF MEMBERS  
ARE 14 OR YOUNGER



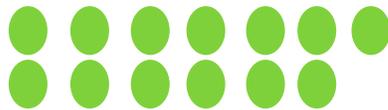
61%  
OF MEMBERS  
ARE MALE



69%  
OF MEMBERS  
LIVE IN A CONGREGATE  
CARE SETTING

## DEMOGRAPHICS OF MEMBERS

65%  
WHITE



20%  
AFRICAN-AMERICAN



11%  
HISPANIC



7%  
MULTIRACIAL



● = 5 Percent (%)

According to AMP's Youth Satisfaction Survey, over 80% of youth agree or somewhat agree that *because of AMP*, they have positive relationships with peers (86%) and have developed skills for later in life (88%).

# Considerations & Updates



The Division of Criminal and Juvenile Justice Planning (CJJP) and the Iowa Department of Human Services (DHS) are proud to release the FFY 2018 Foster Care to Adulthood in Iowa Report as of December 12, 2018. On January 16, 2019, CJJP and DHS will host a webinar to officially release the report.



An update on this report, including community response, will be included in the 2019 Annual Performance and Services Report (APSR)<sup>9</sup>. Feedback on the FFY 2018 Report will also be collected and used to improve the quality for the next release.

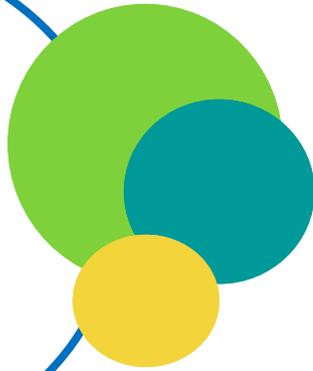
## Considerations:

- Data in this report may benefit DHS efforts to implement the Family First Prevention Services Act (FFPSA), and should be reviewed by those implementing the change.
- Transition Planning Specialists, in their role as DHS transition planning practice champions, will review this report to identify areas of need and recommend casework practice changes accordingly.
- Data will be used to inform training of DHS and Juvenile Court Services (JCS) staff.
- Utilize the Summary Report provided during future meetings this upcoming year.

## Updates:

- The John H. Chafee Foster Care Independence Program has been renamed as the Chafee Foster Care Program for Successful Transition to Adulthood.
- The 2018 Family First Prevention Services Act (FFPSA) extended the ETV eligibility upper age to 26, but limits the youth's participation to five years total.
- CJJP and the following partners, Iowa NYTD, AMP, the Iowa State Training School (STS), the Iowa Department of Public Health (IDPH), and Iowa Workforce Development (IWD), produced seven videos and a resources webpage designed to help assist youth who are transitioning into adulthood. The videos and additional resources can be found at [bit.ly/IAYouthResources](http://bit.ly/IAYouthResources).

# Learn More



For additional information and to learn more about the topics presented in this report, visit the Iowa Foster Care Transition web page at <http://dhs.iowa.gov/transitioning-to-adulthood>, or contact Iowa's Independent Living Coordinator:

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# NYTD TALKING WALL

# RESULTS AS OF 5 • 1 • 19

YOUTH FROM ACROSS THE STATE OF IOWA USED THEIR VOICE AS A TOOL FOR CHANGE TO START CONVERSATIONS ABOUT THE FOLLOWING TOPICS:



## COMMUNICATION (N=76)

- "I WISH MY JCO WOULD TALK TO ME MORE"
- "MORE CONTACT WITH WORKERS"
- "I WANT THEM TO CHECK IN MORE"

## MANAGING RELATIONSHIPS (N=34)

- "BEING ABLE TO SEE FAMILY MORE"
- "BUILDING BETTER RELATIONSHIPS WITH CLIENTS"
- "CONGRATULATE US MORE ON OUR IMPROVEMENTS"

## FOSTER CARE EDUCATION (N=60)

- "WHY DOES IT TAKE SO LONG TO FIND A PLACEMENT?"
- "HAVE YOUTH HELP TRAIN NEW FOSTER PARENTS ALONGSIDE ADULT TRAINERS"

## JUVENILE JUSTICE SYSTEM (N=34)

- "I WISH THEY HAD MORE PLACEMENTS AVAILABLE"
- "A BETTER UNDERSTANDING OF CRIMES AND SITUATIONS BEFORE THROWING THE BOOK AT FOLKS"

### AND MORE:



- Community Engagement
- Cultural Competency/Implicit Bias Training
- Education
- Financial Assistance
- Foster Care (System Change)
- Funding
- Mental Health
- Siblings
- System Related
- Teen Foster Care
- Transitioning



IF YOU ARE INTERESTED IN HOSTING A WALL OR FOR MORE INFORMATION, PLEASE CONTACT THE NYTD COORDINATOR AT 515-725-4050 OR [NYTD@IOWA.GOV](mailto:NYTD@IOWA.GOV)



Department of  
**HUMAN SERVICES**

***FFY 2020-2024 Child and Family  
Services Plan  
Foster and Adoptive Parent Diligent  
Recruitment Plan***

**June 2019**

# FFY 2020-2024 Child and Family Services Plan Foster and Adoptive Parent Diligent Recruitment Plan

State of Iowa  
Iowa Department of Human Services  
Division of Adult, Children and Family Services

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## Background

The Iowa Department of Human Services (DHS) has five geographic service delivery areas. In 2017, the DHS awarded a contract for the Recruitment, Retention, Training and Support for Resource Families (RRTS) to one agency in each service area. The awarded contracts were as follows:

- Western Service Area – Lutheran Services in Iowa
- Northern Service Area – Four Oaks Family Services
- Eastern Service Area – Four Oaks Family Services
- Cedar Rapids Service Area – Four Oaks Family Services
- Des Moines Service Area – Four Oaks Family Services

While Four Oaks received contracts in four service areas, they are responsible for independently meeting the requirements of the contract and achieving service area specific performance measures.

The contracted providers are responsible for the following activities:

- Developing service area specific plans that include strategies and numerical goals for each service area based on the needs of the service area for the following criteria:
  - Families that reflect the race and ethnicity of the children in care in the service area;
  - Families who have the ability to take sibling groups of two or more;
  - Families who have the ability to parent older children, especially teens;
  - Families who are geographically located to allow children to remain in their neighborhoods and schools;
  - Families who have the skills to care for children who exhibit difficult behaviors or have significant mental health, behavioral, developmental or medical needs;
  - Families who can provide a continuum of care including respite, short term placements, transitioning children to permanency and adoption;
  - Families who will mentor and work collaboratively with birth parents; and
  - Families who understand the importance of maintaining a child's connections to their family, school, community and culture and will help maintain those connections.
- Conducting licensing activities for foster families and approval activities for adoptive families including:
  - Providing orientation sessions for interested families;
  - Providing pre-service Trauma Informed Partnering for Safety and Permanence - The Model Approach to Partnerships in Parenting (TIPS-MAPP);
  - Completing all background checks according to state and federal law;
  - Completing an initial home study and all other required paperwork; and
  - Completing renewal activities and updating home studies.
- Providing service area specific matching services for children in need of foster home placement. Matching criteria is established based on the needs of each child but may include:
  - Keeping siblings together;

- Keeping children in their home school and neighborhood;
- The family's ability to parent older children;
- The family's ability to meet the child's cultural needs;
- The family's ability to meet the child's emotional and behavioral needs; or
- The child's permanency goal.
- Providing support services to foster families and pre-adoptive families. The contract requires providers' staff to:
  - Assign one caseworker to a foster family in the beginning of the licensing process who will remain with the family until the family no longer provides care. The caseworker:
    - Is the family's primary contact for questions and when a need or concern arises.
    - Conducts licensing renewal activities.
    - Is actively involved in the matching process.
    - Monitors compliance with rules and corrective action plans to come into compliance when needed.
    - Monitors training completion.
  - Visit a family within 5 days of the first time a child is placed in their home;
  - Contact each family within 3 days of the arrival of a new child;
  - Visit each foster family who has a child in their home at least every other month with one visit unrelated to licensing renewal or adoption approval activities, and have a meaningful phone contact in any month a visit was not required;
    - Foster families who do not have a child placed in their home have monthly phone contact.
  - Provide support services based on the foster/pre-adoptive family's needs that may include:
    - Providing crisis interventions;
    - Assisting families with the transition of teens to adulthood;
    - Assisting families with the transition of children to permanency through reunification;
    - Partnering, coordinating and collaborating with other service providers;
    - Providing services in a culturally competent manner;
    - Coordinating and collaborating with service providers to assist families in the transition from foster care to adoption;
    - Assisting families in understanding the difference between foster care and adoption.
- Providing in-service trainings to foster families that are timely, relevant, and intentional to increase a family's skills and abilities to parent children in care.
- Providing post-adoption support to all adoptive families who adopted children that receive or eligible to receive adoption subsidy. Support services are voluntary and families can self-refer or have DHS staff refer them. Services are free of charge to the family and may be provided in the family's home. Service providers tailor the support services to meet the needs of the family, which may include:
  - Crisis intervention;
  - Providing assistance in developing behavior management plans;
  - Assisting and supporting the family's relationship with the birth family;

- Advocating for the family with school, DHS or other service providers; and
- Assisting families in securing community resources.
- Assisting DHS in finding adoptive families for waiting children by:
  - Registering children on the national exchange through AdoptUSKids;
  - Providing adoptive families with AdoptUSKids registration information;
  - Facilitating information sharing between adoptive families and DHS adoption workers;
  - Managing the state Heart Gallery; and
  - Collaborating on or coordinating adoption month events.
- Recruiting, training, and supporting enhanced foster families. These specially identified foster families have the skills, ability, capacity and willingness to care for children coming from a congregate care setting who have behaviors and needs that make it difficult to find a foster family home.
  - Enhanced foster families will receive additional training beyond the required 6 hours a year.
  - Enhanced foster families will receive a higher maintenance payment rate of \$50.00 per day.
  - Enhanced foster families will be limited to caring for no more than two children in care.

The RRTS contract is a performance based contract. Performance measures are the same for each of the five contracts, but baselines and targets are specific to each service area. The performance measures are:

**Performance Measure 1 – Stability:** Children placed into a licensed foster family home from their removal home or shelter within the quarterly reporting period will experience stability in placement. A child's first placement should be the child's only placement. The contract payment for performance will be based on the percent of a cohort of children who remain in the same licensed foster home 180 days after placement or:

- will have exited the licensed foster home to a trial home visit working towards reunification; or
- will have exited to a relative home; or
- will have exited to a pre-adoptive placement working toward permanency; or
- will have attained permanency through adoption or guardianship.

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

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

The table below shows the achievement for the past 5 quarters:

Table 1: Stability in Family Foster Care										
Service Area	FY18 Q1		FY18 Q2		FY18 Q3		FY18 Q4		FY19 Q1	
	%	N	%	N	%	N	%	N	%	N
Western	70.2	40/57	73.3	63/86	51.7	31/60	76.6	74.97	80.0	44/55
Northern	69.0	29/42	67.2	45/67	75.0	21/28	76.2	32/42	81.8	36/44
Eastern	58.3	28/48	60.4	32/53	45.8	11/24	55.8	24/43	51.4	18/35
Cedar Rapids	57.9	22/38	61.4	27/44	66.7	16/24	55.6	15/27	60.9	42/69
Des Moines	81.1	30/37	66.7	42/63	71.4	35/49	72.2	31/43	76.6	34/49
Data Source: DHS CWIS										

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

- Available for matching means a family that is not providing respite only, or is licensed for a specific child, or has accepted a child within the previous 12 months. Baseline numbers were provided for each service area in September 2017. The contract payment for performance is based on the following increases in net number of families during each year per Service Area.

The chart below shows achievement towards the targets:

Table 2: RRTS Performance Measure 2				
Service Area	Baseline	Standard	SFY 2018 Target Net Increase	SFY 2018 Achieved
1 (Western)	251	Gold	280	388 Met Gold
		Silver	271	
2 (Northern)	205	Gold	232	272 Met Gold
		Silver	224	
3 (Eastern)	154	Gold	169	175 Met Gold
		Silver	165	
4 (Cedar Rapids)	207	Gold	239	293 Met Gold
		Silver	230	
5 (Des Moines)	222	Gold	258	335 Met Gold
		Silver	247	
Data Source: DHS CWIS and CareMatch				

**Performance Measure 3 – Recruitment and Retention (Increase in Non-White Families):** The contractor shall increase the net number of licensed non-white foster families available for matching on an annual basis. The contractor’s net increase in number of licensed non-white foster families will be based on the number of licensed non-white foster families available for matching on July 1<sup>st</sup> at the beginning of that contract year and the number of licensed non-white foster families available for matching on June 30<sup>th</sup> at the end of that same contract year. The contract payment for

performance is based on the following increases in net number of non-white families during each year per Service Area:

Table 3: RRTS Performance Measure 3				
Service Area	Baseline	Standard	SFY 2018 Target Net Increase	SFY 2018 Achieved
1 (Western)	16	Gold	26	26
		Silver	23	
2 (Northern)	8	Gold	19	15
		Silver	16	
3 (Eastern)	23	Gold	31	19
		Silver	29	
4 (Cedar Rapids)	29	Gold	37	32
		Silver	35	
5 (Des Moines)	35	Gold	53	44
		Silver	49	

Data Source: DHS CWIS and CareMatch

**Performance Measure 4 – Enhanced Foster Family Homes**

- Performance Measure 4a. *Contract Year One Only*: The contractor shall increase the number of enhanced foster family homes available for matching during the first contract year. The contract payment for performance is based on the following number of enhanced foster family homes in the Service Area during the first contract year (note: the Gold and Silver Standards are mutually exclusive by year and both cannot be earned for the same year):
  - Gold Standard (payment of 2.5% of annual eligible contract value) – Greater than or equal to six (6) unique approved enhanced foster family homes in the contractor’s Service Area at the end of the first contract year
  - Silver Standard (payment of 1.5% of annual eligible contract value) – Greater than or equal to three (3) unique approved enhanced foster family homes in the contractor’s Service Area at the end of the first contract year
- Performance Measure 4b. *Starting Contract Year Two*: During the second contract year, the contractor shall be measured on stable placement of children in enhanced foster family homes on an annual basis. The contract payment for performance is based on the following number of stable placements (placements with children who remain in the same enhanced foster family home for three (3) months in the Service Area during the second contract year (note: the Gold and Silver Standards are mutually exclusive by year and both cannot be earned for the same year):
  - Gold Standard (payment of 2.5% of annual eligible contract value) – Greater than or equal to twelve (12) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year

- Silver Standard (payment of 1.5% of annual eligible contract value) – Greater than or equal to six (6) unique children placed and remaining in an enhanced foster family home for greater than or equal to three (3) months during the second contract year

**Table 4: RRTS Performance Measure 4**

Service Area	July 2018		April 2019	
	Enhanced homes	Children Placed	Enhanced Homes	Children Placed
<b>1 (Western)</b>	3	0	2	0
<b>2 (Northern)</b>	3	0	2	0
<b>3 (Eastern)</b>	3	0	2	1
<b>4 (Cedar Rapids)</b>	3	0	1	1
<b>5 (Des Moines)</b>	8	0	6	2

**Data Source: DHS CWIS and CareMatch**

The RRTS contract shifted focus from increasing the number of foster families to increasing the number of foster families available to take children. Review of available data found a significant number of families who did not have a child placed in their home for over a year; who were licensed to care for relatives or a specific child; who only provide respite; or who have asked or been asked to take a break for six consecutive months or longer. When the DHS and contractors removed these families from the total, a 25% to 40% capacity reduction occurred. While licensing relatives and kin was important in order to provide financial and other supports, it was not an accurate portrayal of actual capacity. The focus of recruitment shifted from overall recruitment, to also working with families providing only respite to consider taking children for longer terms or in an emergency, or to counsel out families not accepting children.

The one caseworker model strengthened retention efforts. RRTS caseworkers receive assignment of licensed foster families from the time of initial licensure until license expiration. Contract requirements expect that caseworkers have face to face visits every other month and phone call support in months when a face to face visit did not occur. Families and caseworkers expressed satisfaction with this model. Families know who to call when they have questions or need assistance, and caseworkers know their families strengths and skills.

Iowa also uses the one caseworker model to match children who need foster family care. CareMatch is a tool the RRTS contractors use to match a child with the family who can best meet the child's needs based on the family's strengths, skills, geographic location, age and gender of the child. CareMatch identifies the families but the caseworkers are the contact to the family. This model provides families with the assurance of support, and the caseworkers know what supports their families need.

The premise of the one caseworker model was that better matching would enhance stability for children in care. Stability is a paid performance measure and the rate of success varied significantly between service areas and quarters. Table 1 above shows the rate of stability over the last five years.

Iowa completed the CFSR Round 3 in 2018. The final report found Iowa to be in substantial conformity in:

- Systemic Factor - Foster and Adoptive Parent Licensing, Recruitment and Retention. Iowa receive a “strength” in the following areas:
  - Item 33 – Standards Applied Equally;
  - Item 34 – Requirements for Criminal Background Checks; and
  - Item 35 – Diligent Recruitment of Foster and Adoptive Homes.

However, the final report noted the following deficiencies:

- Permanency Outcome 1 - Item 4 – Stability of Foster Care Placements;
- Permanency Outcome 2 - Item 7 – Placement with Siblings;
- Well-Being Outcome 1 - Item 12c – Needs Assessment and Services to Foster Parents; and
- Systemic Factor - Staff and Provider Training - Item 28 – Foster and Adoptive Parent Training.

The federal Children’s Bureau made the CFSR findings through data, case review and stakeholder interviews. Stakeholder interviews were mixed regarding the quality of pre-service training to prepare them for foster parenting, changes in the RRTS contract from the previous contract, the relationship between DHS and foster parents, and interactions with birth families.

## **Foster and Adoptive Parent Diligent Recruitment Plan**

### ***A description of the characteristics of children for whom foster and adoptive homes are needed***

DHS provides data to the contractor in order to determine recruitment and retention goals and targets. Each service area has a recruitment plan based on the needs of their service area, including data specific to that service area. Recruitment and retention targets for specific populations of children may include:

- Teens
- Sibling groups including those with very young children
- Non-white children
- Children with difficult behaviors (physically aggressive, sexual acting out, impulsivity, etc.)
- Children with significant needs (mental health concerns, developmental disabilities, intellectual disabilities, medically fragile, etc.)

The data on capacity shows the state has a sufficient number of homes in relation to the number of children in care. However, some children wait in shelter, residential care or other settings while the search for a foster home is in process. Having the right foster homes in the right areas at the right time is a challenge. This is especially true for sibling groups of three or more, even if the children are very young. The emphasis of recruiting and retaining families for older children and discouraging families who want to

“foster to adopt” very young children resulted in an unintended consequence of not having a sufficient number of foster families for children ages 0 to 5. The data clearly shows just over half of the children in foster care are between 0 and 5 years of age. Iowa needs foster families for young children in sibling groups who respect and participate in reunification efforts.

Another challenge is developing foster families who have the skills, ability and willingness to care for older youth coming out of congregate care who have difficult behavioral or mental health needs. The RRTS contract included a new level of foster family care – Enhanced Foster Homes. RRTS contractors and DHS jointly selected enhanced foster families based on the family’s experience and skills in caring for children with challenging mental health and behavioral needs who were either leaving residential care or were in shelter and a foster home could not be found. Iowa experienced several challenges in implementing Enhanced Foster Family care including families who do not want to be limited to only 2 children; sufficient supports to help families manage children with high needs; the location of families in relation to the children in need of care; and the need to match a family to the child. As of April 30, 2019, there were 13 approved Enhanced Foster Family Homes, with four children in those homes.

While each area saw gains in recruiting and retaining families from more diverse racial, ethnic, and cultural backgrounds, challenges remain in gaining trust in non-white communities. RRTS contractors found this to be particularly true in the Latino communities for a variety of reasons including immigration concerns, distrust of government, and economic stress. RRTS contractors continue to explore ways to engage all communities and to have staff with diverse backgrounds to assist with recruitment and retention.

The Family First Preservation Services Act (Family First) significantly impacts family foster care. Foster families will be needed to keep children from entering residential care, and to care for children leaving residential care. Foster families who will partner with and mentor a child’s family to fully support reunification will also be an increased focus of recruitment and retention. As part of Family First implementation, the DHS will consider models of foster family care to provide care to children with high needs.

Additionally, the DHS strongly supports keeping children within their families, and will encourage more relative caregivers in becoming licensed foster parents. Licensure brings increased financial assistance, concrete supports and training that unlicensed caregivers do not receive. The DHS does waive non-safety standards for relatives to promote licensing. The DHS, in collaboration with RRTS contractors, would like to develop a process that will expedite the licensing process for relatives while maintaining consistency in licensing standards for all foster families.

The RRTS contractors receive age, race and ethnicity data for every child who exited or entered a foster home each week. The RRTS contractors also use a database called CareMatch that records demographic information on foster and adoptive families and on

children placed in foster or adoptive homes. They use this data when developing service area specific recruitment plans.

The most recent data regarding age, race and ethnicity for the children in family foster care are in the tables below:

<b>Table 5: Children in Licensed foster Family Care as of 5/31/19 by Service Area, County Size and Age</b>											
Service Area	County Size	# of Counties	0 to 5	% of County Size	6 to 11	% of County Size	12 to 14	% of County Size	15+	% of County Size	Total
Western	Rural	14	40	45%	28	31%	12	13%	9	10%	89
	Small	14	66	46%	37	26%	18	13%	21	15%	142
	Metro	2	119	55%	51	23%	21	10%	27	12%	218
	All Counties	30	225	50%	116	26%	51	11%	57	13%	449
Northern	Rural	15	25	38%	17	26%	6	9%	18	27%	66
	Small	11	108	53%	47	23%	23	11%	27	13%	205
	Metro	1	51	62%	21	26%	5	6%	5	6%	82
	All Counties	27	184	52%	85	24%	34	10%	50	14%	353
Eastern	Rural	2	1	9%	3	27%	4	36%	3	27%	11
	Small	6	58	50%	36	31%	8	7%	14	12%	116
	Metro	2	55	52%	26	25%	6	6%	18	17%	105
	All Counties	10	114	49%	65	28%	18	8%	33	14%	232
Cedar Rapids	Rural	6	16	53%	5	17%	4	13%	5	17%	30
	Small	9	88	53%	50	30%	13	8%	15	9%	166
	Metro	2	111	54%	46	22%	19	9%	29	14%	205
	All Counties	17	205	51%	124	31%	35	9%	59		401
Des Moines	Rural	7	14	37%	15	39%	6	16%	3	8%	38
	Small	6	25	37%	17	25%	10	15%	15	22%	67
	Metro	2	208	58%	91	25%	30	8%	30	8%	359
	All Counties	15	263	55%	118	25%	38	8%	57	12%	476
Statewide	Rural	45	96	41%	68	29%	32	14%	38	16%	234
	Small	46	345	50%	187	27%	72	10%	92	13%	696
	Metro	8	544	56%	235	24%	81	8%	109	11%	969
	All Counties	99	985	52%	490	26%	185	10%	239	13%	1899

Data Source – DHS CCWIS

Table 6: Children in Licensed Family Foster Care as of 4/1/19 by Service Area, County Size and Race																	
Service Area	County Size	# of Counties	American Indian/Alaskan Native	% of County Size	Asian	% of County Size	African American	% of County Size	Native Hawaiian/Pacific Islander	% of County Size	Multi-Race	% of County Size	White	% of County Size	UTD	% of County Size	Total
Western	Rural	14	1	0%	0	0%	6	7%	0	0%	0	0%	82	92%	0	0%	89
	Small	14	2	1%	7	5%	5	4%	0	0%	2	1%	124	87%	2	1%	142
	Metro	2	22	10%	0	0%	18	8%	1	0%	36	17%	141	65%	0	0%	218
	All Counties	30	25	6%	7	2%	29	6%	1	1%	38	8%	347	77%	2	0%	449
Northern	Rural	15	0	0%	1	0%	2	3%	0	0%	0	0%	55	83%	8	12%	66
	Small	11	3	0%	1	0%	21	10%	0	0%	9	4%	156	76%	15	7%	205
	Metro	1	0	0%	2	0%	32	39%	0	0%	3	4%	40	49%	5	6%	82
	All Counties	27	3	0%	4	0%	55	16%	0	0%	12	3%	251	71%	28	8%	353
Eastern	Rural	2	0	0%	0	0%	0	0%	0	0%	0	0%	11	100%	0	0%	11
	Small	6	1	0%	0	0%	19	16%	0	0%	7	6%	87	75%	2	2%	116
	Metro	2	0	0%	0	0%	29	28%	0	0%	11	10%	64	61%	1	1%	105
	All Counties	10	1	0%	0	0%	48	21%	0	0%	18	8%	162	70%	3	1%	232
Cedar Rapids	Rural	6	1	3%	0	0%	0	0%	0	0%	0	0%	29	97%	0	0%	30
	Small	9	0	0%	0	0%	3	2%	1	1%	5	3%	156	94%	1	1%	166
	Metro	2	2	1%	0	0%	49	24%	0	0%	19	9%	131	64%	4	2%	205
	All Counties	17	3	1%	0	0%	52	13%	1	0%	24	6%	316	79%	5	1%	401
Des Moines	Rural	7	0	0%	0	0%	3	9%	0	0%	0	0%	34	97%	1	3%	35
	Small	6	2	0%	1	1%	10	13%	0	0%	3	4%	50	64%	1	1%	78
	Metro	2	5	1%	1	0%	73	20%	0	0%	30	8%	206	57%	44	12%	363
	All Counties	15	7	2%	2	0%	86	19%	0	0%	33	7%	290	63%	46	10%	464
Statewide	Rural	45	2	1%	1	0%	11	5%	0	0%	0	0%	211	91%	9	4%	231
	Small	46	8	1%	9	1%	58	8%	1	0%	26	4%	573	81%	21	3%	707
	Metro	8	29	3%	3	0%	201	21%	3	0%	99	10%	582	60%	54	6%	975
	All Counties	99	39	2%	13	1%	270	14%	4	0%	125	7%	1366	72%	84	4%	1899

**Table 7: Children in Licensed Family Foster Care as of 4/1/19 by Service Area, County Size and Ethnicity**

Service Area	County Size	# of Counties	Hispanic	% of County Size	Not-Hispanic	% of County Size	Unable to Determine	% of County Size	Totals
Western	Rural	14	10	10%	79	81%	0	0%	97
	Small	14	34	17%	106	52%	2	1%	204
	Metro	2	28	10%	190	68%	0	0%	278
	All Counties	30	72	16%	375	84%	1	0%	449
Northern	Rural	15	11	17%	47	71%	8	9%	66
	Small	11	27	13%	168	82%	10	5%	205
	Metro	1	6	7%	73	89%	3	4%	82
	All Counties	27	44	12%	288	82%	21	6%	353
Eastern	Rural	2	0	0%	11	100%	0	0%	11
	Small	6	5	4%	109	94%	2	2%	116
	Metro	2	5	5%	99	94%	1	1%	105
	All Counties	10	10	4%	219	94%	3	1%	232
Cedar Rapids	Rural	6	0	0%	30	100%	0	0%	30
	Small	9	13	8%	152	92%	1	1%	166
	Metro	2	13	6%	188	92%	4	2%	205
	All Counties	17	26	6%	370	92%	5	1%	401
Des Moines	Rural	7	1	3%	36	95%	1	3%	38
	Small	6	6	9%	60	90%	1	1%	67
	Metro	2	16	4%	300	84%	43	12%	359
	All Counties	15	23	5%	396	85%	45	10%	464
Statewide	Rural	45	22	9%	203	86%	9	4%	235
	Small	46	85	11%	595	75%	16	2%	795
	Metro	8	68	6%	850	78%	51	5%	1095
	All Counties	99	175	9%	1648	87%	76	4%	1899

**Table 8: Licensed Foster Families as of May 31, 2019 by Service Area, County Size and Race**

Service Area	County Size	# of Counties	American Indian/Alaskan Native	% of County Size Total	Asian	% of County Size Total	African American	% of County Size Total	Native Hawaiian/Pacific Islander	% of County Size Total	Multi-Race	% of County Size Total	White	% of County Size Total	Unable to Determine	% of County Size Total	Total
Western	Rural	14	0	0%	0	0%	0	0%	0	0%	3	2%	127	98%	0	0%	130
	Small	14	1	0%	0	0%	2	1%	0	0%	3	1%	227	97%	0	0%	233
	Metro	2	4	3%	0	0%	1	1%	0	0%	11	7%	142	90%	0	0%	158
	All Counties	30	5	1%	0	0%	3	1%	0	0%	17	3%	496	95%	0	0%	521
Northern	Rural	15	0	0%	0	0%	0	0%	0	0%	1	1%	121	99%	0	0%	122
	Small	11	1	0%	0	0%	0	0%	1	0%	3	0%	248	98%	0	0%	253
	Metro	1	0	0%	1	0%	10	8%	0	0%	3	3%	103	87%	1	0%	118
	All Counties	27	1	0%	1	0%	10	2%	1	0%	7	1%	472	96%	1	0%	493
Eastern	Rural	2	0	0%	0	0%	0	0%	0	0%	0	0%	15	100%	0	0%	15
	Small	6	0	0%	0	0%	2	1%	0	0%	4	3%	148	96%	0	0%	154
	Metro	2	1	1%	0	0%	5	4%	0	1%	6	4%	121	90%	2	1%	135
	All Counties	10	1	0%	0	0%	7	2%	0	0%	10	3%	284	93%	2	0%	304
Cedar Rapids	Rural	6	0	0%	0	0%	0	0%	1	0%	4	7%	56	92%	0	0%	61
	Small	9	0	0%	0	0%	2	0%	0	0%	6	3%	188	95%	1	0%	197
	Metro	2	0	0%	3	1%	15	5%	1	0%	15	5%	272	88%	4	1%	310
	All Counties	17	0	0%	3	1%	17	3%	2	0%	25	4%	516	91%	5	1%	568
Des Moines	Rural	7	0	0%	0	0%	0	0%	0	0%	0	0%	20	100%	0	0%	20
	Small	6	1	0%	0	0%	1	1%	0	0%	4	3%	137	96%	0	0%	143
	Metro	2	0	0%	0	0%	26	7%	0	0%	13	3%	360	90%	0	0%	399
	All Counties	15	1	0%	0	0%	27	5%	0	0%	17	3%	517	92%	0	0%	562
Statewide	Rural	45	0	0%	0	0%	0	0%	1	0%	8	2%	339	97%	0	0%	348
	Small	46	3	0%	0	0%	7	1%	1	0%	20	2%	948	97%	1	0%	979
	Metro	8	5	0%	4	0%	57	5%	1	0%	48	4%	998	89%	7	0%	1120
	All Counties	99	8	0%	4	0%	64	3%	3	0%	76	3%	2285	93%	8	0%	2448

**Table 9: Licensed Families as of May 31, 2019 by Service Area, County Size and Ethnicity**

Service Area	County Size	# of Counties	Hispanic	% of County Size Total	Not Hispanic	% of County Size Total	Unable to Determine	% of County Size Total	Total
Western	Rural	14	2	2%	128	98%	0	0%	130
	Small	14	4	2%	224	96%	5	2%	233
	Metro	2	12	8%	146	92%	0	0%	158
	All Counties	30	18	3%	498	96%	5	1%	521
Northern	Rural	15	4	3%	110	90%	8	7%	122
	Small	11	4	2%	230	91%	19	8%	253
	Metro	1	4	3%	110	93%	4	3%	118
	All Counties	27	12	2%	450	91%	31	6%	493
Eastern	Rural	2	0	0%	15	100%	0	0%	15
	Small	6	4	3%	149	97%	1	1%	154
	Metro	2	8	6%	125	93%	2	1%	135
	All Counties	10	12	4%	289	95%	3	1%	304
Cedar Rapids	Rural	6	1	5%	59	97%	1	2%	61
	Small	9	2	1%	189	96%	6	3%	197
	Metro	2	8	3%	294	95%	8	3%	310
	All Counties	17	11	2%	542	95%	15	3%	568
Des Moines	Rural	7	0	0%	20	100%	0	0%	20
	Small	6	2	1%	138	97%	3	2%	143
	Metro	2	17	4%	376	94%	6	2%	399
	All Counties	15	19	3%	534	95%	9	2%	562
Statewide	Rural	45	7	2%	332	96%	9	3%	345
	Small	46	16	2%	930	95%	34	3%	980
	Metro	8	49	4%	1051	94%	20	2%	1120
	All Counties	99	72	3%	2313	103%	63	3%	2248

***Specific strategies to reach out to all parts of the community***

Service area recruitment plans cover the entire area; however, prioritized areas are identified based on the demographics and geographic location of children coming into care. Service areas analyze data to determine which geographic locations children are removed from, and prioritize those areas to have a sufficient number of foster/adoptive families, while also recruiting throughout the area.

Research and experience shows the best form of recruitment is family to family. RRTS staff consistently engages current foster and adoptive parents to act as ambassadors for foster care in their home communities. Ambassadors use their personal and professional networks to raise awareness of the need for foster families in their communities.

Strategies common to all service areas include:

- Engaging faith based organizations and houses of worship in all communities, especially non-white communities;
- Partnering with local media outlets, especially non-white;
- Partnering with local businesses and civic organizations;
- Reaching out to schools, child care providers, and other agencies that serve families;
- Family to family resources such as “tool kits” with recruitment information, and educating current foster families on the needs in their own communities to assist in outreach;
- Partnering with schools to provide information on foster and adoptive parenting in children’s Virtual Backpacks;
- Use of social media such as Facebook to provide information both publically and through designated groups;
- Collaborating with community partners to host National Adoption Month and National Foster Care Month activities; and
- Partnering with Pridefest organizers to raise awareness of the need for foster families for LGBTQA+ children in care as well as to recruit prospective foster and adoptive parents from the LGBTQA+ community.

RRTS contractors also identified service area specific partners to assist in planning retention activities as well as provide donations of funds and goods. Examples of these activities include:

- Western Service Area – Participation in the March to Honor Lost Children with the American Indian community.
- Northern Service Area – Development and distribution of informational material targeted to specific audiences such as the African/American community, LGBTQ community and Hispanic communities.
- Eastern Service Area – Presented to the League of United Latin American Citizens to uplift the need for Latino foster/adoptive families.
- Cedar Rapids Service Area – Holding information sessions on foster and adoptive parenting at a local coffee shop.
- Des Moines Service Area – Joined the Asian and Latino Coalition to partner in recruiting in those communities.

### ***Diverse methods of disseminating both general information about being a foster/adoptive parent and child specific information***

Recruitment plans combine general recruitment activities with targeted recruitment activities based on the needs of the service area. Examples of general recruitment activities are:

- Recruitment teams engage local media outlets by providing staff or resource families for interviews;
- Use of print and electronic media for general recruitment such as the use of public service announcements (PSAs), and promotions for upcoming events;
- Providing brochures and conducting presentations to businesses, churches, child care centers, medical facilities or other entities who serve families;
- Providing information in children's virtual backpacks;
- Conducting presentations at cultural, faith based, service organizations, schools, and other community organizations;

Child specific recruitment through the recruitment and retention contract for a child in foster care is more difficult due to the time it takes to license a family. The child's team, including the contractor, works together to identify any currently licensed families, relatives, or other people in the child's life who may be placement resources. However, the RRTS contractors provide relative and kin caregivers referred by DHS to information on becoming licensed and the supports that comes with licensure.

RRTS contractors also provide information to DHS on families interested in adoption when a child's current caregivers are not a permanency option. The DHS is often not aware of families only approved to adopt. These families provide profile information to the RRTS contractors who then assist DHS in matching a child in need of permanency with a family who can meet the child's needs.

Four Oaks has a contract with Wendy's Wonderful Kids to provide assistance in finding adoptive homes for children in need of permanency through a statewide recruiter. Adoption staff can refer a child who needs a permanent family when other options have been exhausted.

### ***Strategies for assuring that all prospective foster/ adoptive parents have access to agencies that license/approve foster/adoptive parents, including location and hours of services so that the agencies can be accessed by all members of the community***

Each contractor has a website and toll-free number for any prospective foster or adoptive family to contact to receive information and to enroll in an orientation. Orientations occur in groups and individually to explain the licensing/approval process, begin the record check process, and enroll families in pre-service training. The contract requires pre-service training to be available to interested families within 60 days of completing orientation and within 60 miles of the family's home. Families may choose

to attend later trainings due to preference or scheduling, or training in another area if space is available.

RRTS contractors began using TIPS-MAPP for pre-service training on October 1, 2017. Below is the number of trainings held in each service area from May 2018 through April 2019:

<b>Table 6: Pre-Service Trainings Held May 2018 through April 2019</b>	
<b>Service Area</b>	<b>#TIPS-MAPP</b>
<b>Western</b>	24
<b>Northern</b>	9
<b>Eastern</b>	18
<b>Cedar Rapids</b>	21
<b>Des Moines</b>	18
<b>Total</b>	90
<b>Data Source: RRTS monthly reports</b>	

Pre-service trainings occur in various locations in each service area to meet the contract requirement that prospective families receive training within 60 miles of their home. In addition, contractors offer Caring for Our Own in each service area for relatives fostering or adopting kin children. RRTS contractors also completed Training of Trainers for Deciding Together. This curriculum is MAPP but geared toward individual or very small group use. Deciding Together uses one trainer, and can occur in family homes, smaller venues than TIPS-MAPP which allows for greater flexibility and timely training. Rural areas may use the training so families do not have to wait or travel, and in urban areas to get smaller community specific groups.

Each service area offers ongoing training several times a month. RRTS contractors allow families from other areas to attend training when there is space available. This allows flexibility for families to find training in another service area that may be closer, more convenient, and specific to a skill or information the family needs. Each contractor's website lists the trainings with information on how to register.

***Strategies for training staff to work with diverse communities including cultural, racial, and socio-economic variations***

Please see the DHS training plan for DHS staff training on working with diverse communities.

Contractor staff receives ongoing training provided by experts or specialists in areas of racial, ethnic, and cultural diversity. Examples of these trainings include LGBTQ training by an advocacy and educational organization or representatives from refugee communities who discuss the culture specific to their homeland.

Native American TIPS-MAPP pre-service training occurs in northwest Iowa to provide more culturally responsive training to prospective Native American foster and adoptive families. Three staff members with Meskwaki Family Services are certified trainers in Native American TIPS-MAPP. Meskwaki Family Services plans to hold three pre-service trainings a year for families on and off the settlement.

RRTS contractors also engaged African American, Latino, and LGTBQA+ foster and adoptive parents to act as Ambassadors. Ambassadors are the face of foster parenting and participate in presentations, outreach, training and other recruitment and retention activities. RRTS contractors also worked to have employed recruiters of diverse cultural, racial and ethnic backgrounds.

### ***Strategies for dealing with linguistic barriers***

TIPS-MAPP forms are available in Spanish and English.

Interpreters are available through the RRTS contractors for all language groups, from inquiry through completing the licensing/approval process.

### ***Non-discriminatory fee structures***

Families who apply to become foster parents or adoptive parents through the DHS are not charged any fees for a home study or to attend pre-service training. The recruitment and retention contract includes the cost of record checks and home studies. Families must take CPR and First Aid training prior to initial licensure and must keep their certification current after licensure. Families also may have fees for water testing in rural areas. Families receive a \$100.00 stipend each year to help cover the costs of required ongoing training. However, most of the training offered by the RRTS contractors is free.

***Procedures for a timely search for prospective parents for a child needing an adoptive placement, including the use of exchanges and other interagency efforts, provided that such procedures ensure that placement of a child in an appropriate household is not delayed by the search for a same race or ethnic placement.***

The RRTS contractors are responsible for child specific recruitment for waiting children. Examples of these recruitment activities include:

- Registering waiting children on the national adoption exchange through AdoptUSKids;
- Displaying the Heart Gallery throughout the state;
- Partnering with a local television station to present a waiting child on a regular segment called “Wednesday’s Child”; and
- Partnering with Wendy’s Wonderful Kids.

DHS is responsible for selecting the adoptive family that will best meet the needs of the child, not the race or ethnicity of the family in relation to the child. Transracial adoptions are common and children do not wait for a home based on the race or ethnicity.

Children in need of an adoptive home have their photos listed on the Iowa Adoption Exchange on the Lutheran Services in Iowa and the Four Oaks websites, as well as on the AdoptUSKids website. A child must be registered on the Iowa exchange within 60 days of termination of parental rights unless the child meets a deferral reason. Reasons to defer a child are:

- The child is in an adoptive placement.
- The child’s foster parents or another person with a significant relationship is being considered as the adoptive family.
- The child needs diagnostic study or testing to clarify the child’s needs and provide an adequate description of them which is limited to 90 days.
- The child receives medical care or mental health treatment, and the child’s care or treatment provider determined that meeting prospective adoptive parents is not in the child’s best interest and deferral is limited to 120 days.
- The child is 14 years of age or older and will not consent to an adoptive plan, and the consequences of not being adopted have been explained to the child.
- The termination of parental rights is under appeal by the birth parents and foster parents or other persons with a significant relationship continue to be considered as the prospective adoptive family.

RRTS contractors work with DHS staff to arrange photos for registration on AdoptUSKids, for the Heart Gallery, and to photo list children on the respective websites. DHS staff is responsible for referring children for photo listing. RRTS staff list children on the state and nation exchanges, and manage the Heart Gallery.

Please see Attachment 7A(1): Diligent Recruitment Five Year Plan.

**Table 1: Strategies and Activities to Develop Diligent Recruitment Plan**

<b>Goal:</b> To have sufficient statewide capacity in family foster care in order to improve stability and keep children close to their home communities.			
<b>Year</b>	<b>Strategies</b>	<b>Activities</b>	<b>Benchmarks</b>
FFY 2020 (10/1/19 to 9/30/20)	<p>Propose models of family foster care for children with high needs.</p> <p>Use a needs assessment to identify gaps in services and supports for children and foster families.</p> <p>Develop a process to expedite licensing relative caregivers.</p> <p>Develop consistent messaging to support the role of foster families as service providers to achieve reunification between children and their families.</p>	<ul style="list-style-type: none"> <li>• Form a collaborative group between RRTS, family centered service providers, congregate care providers, foster/adoptive parents and DHS develop a work plan.</li> <li>• Use available data to identify reasons for instability.</li> <li>• Explore ways congregate care providers and RRTS contractor can collaborate and support children and caregivers to implement the Family First Preservation Services Act.</li> <li>• Research available models of therapeutic foster family care.</li> <li>• Determine resources needed to implement a therapeutic model.</li> <li>• Review the licensing process to find ways to shorten the process for relatives and kin caregivers.</li>   <li>• Identify barriers for family to family interactions.</li> <li>• Research models of engagement such as Icebreaker meetings.</li> <li>• Put together talking points on the role of foster parents to mentor a child’s parents and support reunification for use by DHS, RRTS, and other stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>• Team members will be identified by 12/1/2019</li> <li>• Goals and strategies will be identified by the team by 3/31/2020</li> <li>• Provide recommendations to DHS leadership on to improve overall stability in family foster care by 9/1/2020.</li> </ul>

<b>Goal:</b> To have sufficient statewide capacity in family foster care in order to improve stability and keep children close to their home communities.			
<b>Year</b>	<b>Strategies</b>	<b>Activities</b>	<b>Benchmarks</b>
FFY 2021 (10/1/2020 to 9/30/2021)	Prioritize recommendations from the workgroup for implementation.	<ul style="list-style-type: none"> <li>• Develop an implementation timeline.</li> <li>• Develop tools, training, and communication to implement recommendations.</li> <li>• Establish baseline data to determine progress</li> </ul>	Documents and training completed according to the implementation timeline.
FFY 2022 (10/1/2021 to 9/30/2022)	Continue to monitor progress toward identified outcomes.	<ul style="list-style-type: none"> <li>• Revise annual recruitment and retention plans as needed to meet goals.</li> <li>• Review data to assess effectiveness of strategies</li> <li>• Make modifications to the plan and strategies based on assessment of progress.</li> <li>• Hold quarterly meetings in each service area to address strengths, needs, and strategies to improve performance.</li> </ul>	Increased stability in family foster care from the baseline.
FFY 2023 (10/1/22 to 9/30/23)	Continue to monitor progress toward identified outcomes.	<ul style="list-style-type: none"> <li>• Revise annual recruitment and retention plans as needed to meet goals.</li> <li>• Review data to assess effectiveness of strategies</li> <li>• Make modifications to the plan and strategies based on assessment of progress.</li> <li>• Hold quarterly meetings in each service area to address strengths, needs, and strategies to improve performance.</li> </ul>	Increased stability in family foster care from the baseline.

<b>Goal:</b> To have sufficient statewide capacity in family foster care in order to improve stability and keep children close to their home communities.			
<b>Year</b>	<b>Strategies</b>	<b>Activities</b>	<b>Benchmarks</b>
FFY 2024 (10/1/23 to 9/30/24)	Continue to monitor progress toward identified outcomes.	<ul style="list-style-type: none"> <li>• Revise annual recruitment and retention plans as needed to meet goals.</li> <li>• Review data to assess effectiveness of strategies</li> <li>• Make modifications to the plan and strategies based on assessment of progress.</li> <li>• Hold quarterly meetings in each service area to address strengths, needs, and strategies to improve performance.</li> </ul>	Increased stability in family foster care from the baseline.



Department of  
**HUMAN SERVICES**

***FFY 2020-2024  
Child and Family Services Plan  
Health Care Oversight and  
Coordination Plan***

**June 2019**

# FFY 2020-2024 Child and Family Services Plan Health Care Oversight and Coordination Plan

State of Iowa  
Iowa Department of Human Services  
Division of Adult, Children and Family Services

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### **A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice**

If a child coming into care has not had a physical health screening prior to placement, scheduling of the initial physical health screening occurs within 14 calendar days of the child coming into care. After the initial physical, children in foster care have physicals on an annual basis, or in accordance with applicable Medicaid periodicity schedule for health exams, according to the age of the child. While aware that not all social work case managers (SWCMs) ask the foster home or foster group care facility at monthly visits about the foster child's health care, Iowa Department of Human Services (DHS) central office staff plans to obtain an Iowa Medicaid Enterprise (IME) report that separates out the children in foster care from the total number of children in the Core Set of Children's Health Care Quality Measures, which is one way to measure health outcomes for children insured under Medicaid. A SWCM's supervisor would receive the report to provide and discuss with the SWCM, as necessary.

### **How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home**

Children have a physical upon removal with a medical professional, which identifies their health needs including emotional trauma associated with their abuse and removal from the home. SWCMs engage medical professionals in screening for the child's health needs. Considerations, include but may not be limited to:

- What behaviors are we seeing?
- Do they need behavioral health intervention services (BHIS)?
- What does the needs assessment tell us?
- Why is DHS involved with this child and family?
- What issues for specific children are noted and from what source, i.e. caregiver, FSRP, DHS, FTDM participants, therapist, or the child him or herself?

All of this information helps to determine the child's treatment plan. SWCMs rely on the child's medical professionals' expertise and recommendations for treatment.

SWCMs monitor the child's health care needs identified in the child's screenings, through documentation of medical care received and the effectiveness of their treatment plan, including appropriateness and sufficiency of the therapeutic services for meeting their needs. The SWCM monitors the child's health care treatments and therapy by reviewing the foster parent's documentation and the foster group care provider's health reports sent to them, and through discussions with the child and foster care provider.

### **How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record**

Most health care providers have electronic medical records. The foster care provider may ask for a "summary of the visit" or discharge/referral form at the end of the health care visit, if it is not automatically provided. If the health care provider does not have electronic medical records, the foster care provider can give the provider the Physical Record form and request it be completed and returned to them. The Physical Record

form includes a list of previous diseases that can be checked and dated, chronic illnesses and an area to list medications prescribed, physical examination information including vision, hearing, dental and mental health, and an area to complete preliminary diagnosis and recommendations, including any recommendations for further assessment or evaluation. The foster parent provides the Physical Record form, “summary of the visit”, and other additional documentation of the child’s health care to the SWCM.

**Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care**

The DHS continues to work on assuring that the health care records follow the child when they move to another placement outside of their medical home, or leave foster care.

The Integrated Health Home (IHH) continues if the MCOs approve it. An IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). Care coordination is provided for all aspects of the individual’s life and for transitions of care the individual may experience. Children with a serious emotional disturbance (SED) and their families receive IHH services using the principles and practices of a System of Care model. The IHH serves individuals enrolled in Medicaid, which includes those receiving targeted case management (TCM) and case management through Medicaid-funded habilitation as well as those not currently receiving care coordination.

**The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications**

*Medication monitoring at the agency level*

IME staff sends a quarterly report to the Bureau Chief for Service Training and Supports for each of the five DHS Service Areas for agency level medication monitoring. IME staff also sends a similar report to the Chief JCO for distribution to the other Chief JCOs for agency level medication monitoring of JCS children in foster care. The psychotropic medication report serves as a “red flag”. It identifies any children who are under age 6 and prescribed psychotropic medications, and children over age 6 prescribed two or more psychotropic medications. This information is conveyed to the assigned worker for specific case management duties as outlined in Attachment 7B1. If the situation does not involve a child under age 6, or a child prescribed two or more psychotropic medications, Iowa does not have a specific indicator to identify off label uses at this time.

The previous state plan showed seven tables that provided psychotropic medication data for several fiscal years. The source for all tables was IME. The highest psychotropic medication use for foster care was in state fiscal year (SFY) 2014 of 3,354 and psychotropic medication usage decreased each year to 2,426 in SFY 2017. The

data for SFY 2018 fiscal year showed a continued decrease in psychotropic usage to 2,323.

### *Medication monitoring at the client level*

#### Foster parent level

The DHS works with the five recruitment, retention, support and training (RRTS) providers to provide training to foster parents on medications; understanding what the medication is; what the medication is used to address; possible side effects of the medication; when to contact the child's doctor if there is a problem with the medication or the child's reaction to the medication; description for what a psychotropic medication is; when to contact the child's SWCM; possible alternatives to medications; and how the foster parent can advocate for the best interest regarding the child's health care needs.

Foster parents are part of Iowa's collaborative team in monitoring medications and the health care needs of children in foster care. The foster parent monitors for side effects and contacts the prescribing doctor if there are side effects or the medication does not address the issue for which it was prescribed. The foster parent also keeps the child's case manager informed of the medications and any issues with it. Additionally, some DHS SWCMs go with the foster parent when the child goes to their health care provider.

#### SWCM level

The Social Work Administrator (SWA) distributes a quarterly psychotropic medication report to the SWCM's supervisor who reviews the report before disseminating it to each SWCM.

The juvenile court services (JCS) quarterly psychotropic medication report is similar in structure and content as the DHS quarterly report. The Chief JCO ensures their quarterly report gets to the appropriate JCO supervisors who review them prior to disseminating to each JCO.

The psychotropic medication report (Attachment 7B1) outlines the response expectations for SWCMs and JCOs, which central office staff sends to the local office for regular follow-up. Staff has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- 1) Ensuring that a child is seen regularly by a physician or psychiatrist to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- 2) Regularly following up with foster parents/caregivers about administering medications appropriately, and about the child's experience with the medication(s), including any side effects.

Oversight of the medication by the worker requires teamwork, including coordination and communication amongst caregivers, service providers, parents, medical/mental health providers and, when appropriate, the child. Parental involvement in decision-making is encouraged to the greatest extent possible. When the worker receives the medication report, they are to verify that it is accurate and reflects the current medications of the child. The worker documents in the case narrative if the medication is working well, if there are any side effects, or if the child or others report concerns about the medication. Workers may also consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information website. Also, if appropriate, the worker advocates on the child's behalf to have the medications reviewed by the physician and explore alternatives. The worker places the medication report in the case file and any corresponding case management activities documented in the visitation notes or contact notes.

These quarterly psychotropic medication reports along with the DUR Commission letters to providers contributed to the lowering of the usage of psychotropic medication. The Drug Utilization Review (DUR) Commission examines the use of multiple antipsychotics and sends notification letters to prescribers and pharmacies stating they identified a member as having a drug related issue and makes a suggestion regarding medication therapy. Currently, based upon 6 months of pharmacy claims data, the DUR Commission sends the provider notification letters only to Medicaid fee-for-service providers. The DUR Commission sends these letters to providers that meet a certain set of criteria, either through regular profile reviews (which consist of 1,800 profiles over a 12 month period) or a targeted intervention (specific population, member count varies). The DUR does not send letters to **all** prescribers who prescribe two or more psychotropic agents simultaneously. Additionally, the DUR reviews 300 member (of all ages) profiles identified with the highest level of risk for a drug related issue at each meeting; a small portion is for children for whom not all are on psychotropic medications.

*Response to U.S. Health and Human Services, Office of Inspector General (OIG)  
Report*

Stakeholder Workgroup

In the fall/winter of 2019, the DHS plans to engage internal and external stakeholders, including pediatricians, other experts in health care, and experts in and recipients of child welfare services, in a robust discussion of Iowa's Health Care Oversight and Coordination Plan to:

- discuss and develop better treatment planning and medication monitoring for children in foster care with mental health disorders;
- discuss and further develop, if necessary, efforts to ensure that children entering foster care are not misdiagnosed with disorders that would result in non-foster family home placements; and
- evaluate more fully Iowa's current Health Care Oversight and Coordination Plan for potential improvements.

### Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

All children in foster care enrolled in Medicaid are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Iowa has an EPSDT Care for Kids stakeholder workgroup comprising representatives from IME, Iowa Department of Public Health, managed care organizations (MCOs), and the University of Iowa. This workgroup focuses on the benefits, coverage, and education around the EPSDT for all Medicaid children.

The IME completes the required annual EPSDT Participation Report that reflects all eligible participants. However, the Report does not delineate the foster care population. The last annual EPSDT report was for fiscal year 2017. This report shows all eligible individuals for EPSDT, the state periodicity schedule, age groups, the expected number of screenings per eligible and total screenings received, categorized into two eligibility groups of Categorically Needy (CN) and Medically Needy (MN).

DHS child welfare staff also is working with IME to pull out of the Core Set of Children's Health Care Quality Measures, the foster care population child core set to assist us in monitoring the physical health, behavioral/mental health, and dental health care of children in foster care. However, it may be FFY 2020 or 2021 before the information is available.

### Workforce

The 2019 legislative session approved additional funds to hire more child protective workers (CPWs) and SWCMs. Hopefully, this will help lower some of the high caseloads of SWCMs thereby enabling them to complete treatment plans for all children in foster care and to better monitor their medications and their physical and mental health at their monthly visits with the children.

The DHS is in the process of updating our employee manual, with projected publication by the end of September 2019. The employee manual will combine policy, practice, and procedures in one program manual to eliminate duplication and add revisions that took place in the last few years. The case management manual includes a new section on monitoring medications of children in foster care (Attachment 7B2), as well as Parent Partners, Family Safety, Risk and Permanency (FSRP) services, family team decision-making (FTDM) meetings and youth transition decision-making (YTDM) meetings not currently in the manual.

### **How Iowa actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.**

DHS SWCMs assess the physical, dental, and mental health, and substance abuse needs, if applicable, of children in foster care. SWCMs consult with physicians or other appropriate medical or non-medical professionals for initial and ongoing medical exams, mental health evaluations, substance abuse evaluations, and necessary follow-up treatment, if determined needed by the health professional. DHS' SWCMs also

participate in Joint Treatment Planning Conferences (JTTPC) with DHS field operations support unit (FOSU) staff, DHS Mental Health and Disability Services (MHDS) staff, and medical professionals to discuss complex cases in an effort to ensure that children in foster care receive the most appropriate services for their needs. SWCMs submit a request for a JTTPC, which includes the following information in the request:

- Name of child
- State ID
- Date of birth
- Summary of the child's current situation and the purpose of the call. (Please keep in mind that the calls are not intended to discuss funding issues, level of care decisions, etc. The call's focus is on the need for case management and assistance in setting up services to support the child and family.)
- List of names, phone numbers, and email for each of the individuals that need to be invited to the call.

The SWCM sends the request to a dedicated staff person located in the Bureau of Service Support and Training.

**Outline the procedures and protocols the State established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.**

When children placed in foster care come into the child welfare system, SWCMs look for the nearest care provider in order to continue their medical home and their existing treatment plans. DHS staff completed and submitted pre-file language for the Iowa 2019 legislative session, to include in the child's case plan documentation of:

- Efforts to retain professional providers for children entering/in foster care and
- Activities to evaluate service needs in order to avoid inappropriately diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities.

The 2019 legislative session resulted in amending Iowa Code § 232.2, Definition of "Case permanency plan" to add plans for retaining any suitable existing medical, dental, or mental health care providers of the child when the child enters foster care. House File 644 (Attachment 7B3) also included that the DHS amend its administrative rules to provide that a case permanency plan for a child placed in foster care, shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities. The DHS is in the process of changing the administrative rules to reflect the amended law.

**Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care**

**proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.**

Iowa utilizes the streamlined procedure for youth automatically continuing on Medicaid used previously for the Medicaid for Independent Young Adults (MIYA) program (reviewing first for any other Medicaid coverage groups the youth may be eligible for), once their foster care case is closed; Extended Medicaid for Independent Young Adults (E-MIYA) uses a passive annual review to ensure location of the participant and any changes in household which may make the participant eligible for other Medicaid coverage groups rather than E-MIYA.

The DHS transition planning specialists train workers on educating youth on the review procedure prior to discharge from care; additionally Aftercare workers were educated on the procedure to assist those youth on their caseload with the review process as were foster families; the reapplication process is stressed in new worker training; and youth who are automatically placed on E-MIYA or any other type of Medicaid coverage group at the point of discharge receive a letter from the DHS explaining the Medicaid coverage and the renewal process. Aftercare staff continues to receive monthly lists of youth participating in the Aftercare program who have a Medicaid annual review due the following month. This process greatly enhances youth participating in the Aftercare program to have continued Medicaid coverage.

In 2017, the Service Business Team (SBT), as planned, developed a written charter that identified goals, objectives and membership of a workgroup to evaluate and make recommendations for necessary and desired enhancements to the Transition Plan sections of the case permanency plan.

A workgroup (12 members) convened in early 2018. The workgroup capitalized on combined experience from child welfare policy, field social work, information systems, and juvenile justice. Information technology (IT) experts explained how and if desired changes may occur to the information systems. Supervisors and caseworkers attended. A foster care alumni representative captivated the team with her story. She was a great resource for the team, particularly during discussions about the real impacts and perceptions of case planning.

Preparation materials for the workgroup included the *Fostering Connections to Success and Increasing Adoptions Act*, the *Preventing Sex Trafficking and Strengthening Families Act*, the Children's Bureau's information memorandum regarding Family First, as well as new adoption and foster care analysis and reporting system (AFCARS) data reporting requirements.

The value of workgroup membership was readily apparent. For example, when in DHS care, the youth representative was fortunate to have foster parents and contracted services that promoted and created new opportunities around her passion, photography. With the appropriate support, her photography hobby later led to a career and startup business in wedding and graduation photos. Her story showcased on the DHS website earlier this year. The results of input from this young person and others

on the workgroup led to recommendations, which contemplated not only the information required by policy, but the usability and readability of our customers.

The information systems expert gave the group an idea of how much work certain changes would take. For example, the current transition plan is not organized by the “five fostering connections areas”, and the group thought it should be so similar items are combined. Re-organizing the whole plan by domains is a big undertaking. The specialist suggested less time intensive changes that also got the necessary information in the plan.

The workgroup completed their recommendations in March 2018. They successfully explored format changes and highlighted errors. They made recommendations for training structure and training content needed to implement changes. The workgroup facilitator captured the notes and formal recommendations of the workgroup, and then sent them to SBT for review and decision-making. SBT approved the changes recommended. DHS intends to align the case plan revisions with other case plan changes or information system upgrades.

Part C of the case permanency plan is in final development and will roll out along with training to staff no later than the end of FFY 2019. We plan to release a recorded video training and written instructions for all staff and supervisors.

The health care needs of youth aging out of foster care were one of the five priority areas identified and improved for the new transition plan, including the requirements to include options for health insurance, information about a health care power of attorney, and a health care proxy. As a result of new policy, DHS included more emphasis on keeping children with their current health care providers to mitigate misdiagnosis. On the Health Records section of the Records tab, for example, we added the following question.

- “Was the child able to maintain current health care provider (mental, physical, dental)?”
  - “If no, describe efforts made to maintain continuity of care”:

## **Psychotropic Medication Report**

You are receiving the attached report because one or more of your clients in out-of-home care:

1. Has been prescribed two or more psychotropic medications and/or
2. Is under the age of 6 and receiving at least one psychotropic medication

DHS has the responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of medication prescribed for mental health. Appropriate oversight includes, but is not limited to:

- Ensuring that a child is seen regularly by a physician to monitor the effectiveness of the medication, assess any side effects and/or health implications, consider any changes needed to dosage or medication type, and determine whether medication is still necessary and/or if other treatment options would be more appropriate.
- Regularly following up with foster parents/caregivers about administering medications appropriately and about the child's experience with the medication(s), including any side effects.

Given increasing research regarding potential negative effects of prescribing multiple psychotropic medications concurrently or for very young children, oversight is critical. Providing appropriate oversight of medication at the DHS worker level requires teamwork, including coordination and communication amongst DHS, caregivers, service providers, parents, medical/mental health providers, and when appropriate, the child. Parental involvement and decision-making should be encouraged to the greatest extent possible.

You are being asked to verify that the attached report accurately reflects the medications the child is currently taking. If the report is accurate:

- Does everything appear to be going well (e.g., are there adverse side effects, etc.)? Does the child or others report concerns about the medications?
- If you have questions regarding the medication and possible side effects, consult the child's physician, pharmacist, or the National Institutes of Health's Drug Information Website at [U.S. National Library of Medicine](http://www.nlm.nih.gov/medlineplus/medlineplus.html).
- If appropriate, advocate on the child's behalf to have the medications reviewed by the physician and explore alternatives.
- Ensure the child's parents are aware.

Place the attached medication report in the case file and document any corresponding case management activities in Visitation Notes (under the Child Well-Being section) or Contact Notes.

If you have any questions, please contact the [Service Help Desk](#).

## **Monitoring the Health Care and Mental Health Care Needs of Children in a Foster Care Placement**

It is critical to monitor any health care and mental health care needs of a foster child to assure these needs are being met. Any child coming into the child welfare system has more health care and mental health care needs. It is important that each foster child has been assessed by a clinician for their mental health needs and preferably a Pediatrician for their health care needs. A mental health diagnosis needs to be by a clinician, psychologist or a psychiatrist. There are not many psychiatrists in the state but there are many good clinicians that can accurately assess a foster child's mental health needs.

One of the major responsibilities you have is the monitoring of psychotropic medications prescribed for a foster child. Psychotropic medications are used to treat emotional and behavioral health symptoms and disorders. They mostly act on the central nervous system and affect mood, thoughts, behaviors, and how a person processes information and perceives his or her surroundings.

Most children in foster care never need psychotropic medications. While they are traumatized by abuse and may show negative behaviors or signs of emotional stress, these are normal reactions to what they have been through. All children act out at different stages of their lives and most children will gradually heal in an appropriate environment and with consistent interventions. But some children need medication to cope with the trauma of abuse initially and temporarily to treat emotional stress and while they are seeing a therapist or mental health clinician, though other children may need medication to treat behavioral health disorders that they inherited or developed, such as Attention Deficit Hyperactivity Disorder (ADHD), severe depression, or psychosis. It is important that a clinician, psychologist or a psychiatrist assess the child as often a physician may see the child and give out a psychotropic medication without the child having had a complete evaluation and an assessment by a mental health professional. In most cases, other interventions should be tried before psychotropic medications are prescribed.

The caregivers of a foster care placement need to be patient, understanding, and gentle with the child placed with them and know that many children will gradually heal in an appropriate and stable environment. Initially the child needs to adjust to a new placement which takes time and the caregiver's acceptance and appropriate support to help the child learn to feel safe, trust, and ultimately learn how to control their emotions and behaviors appropriate for their developmental age.

The caregiver needs to understand that a child may respond by "flight, fight or freeze" behavior when the child does not feel safe. The child's perception of feeling safe is critical for them to develop a positive attachment and relationship

with the caregiver. This process can take a long time depending upon the interventions provided to assist the child in learning to feel safe, to trust, and to being able to control their emotions and behaviors.

### **Consenting to Medications**

If the Department is the custodian of the child in a foster care placement, the SWCM should contact the child's parents or guardian to inform them of the medication the mental health clinician or Psychiatrist wants to prescribe for their child. The best practice is to invite the child's parents or guardian to the child's evaluation or medical appointment so they can ask questions regarding the medication recommended for the child and discuss any concerns they have. If the child's parents or guardian do not attend the evaluation or medical appointment, contact them and discuss the medication recommendation to obtain their consent. Foster care group care providers need to also discuss medication recommendations with the child's parents or guardian before the prescribed medication is obtained and given to the child.

When the Department is the guardian of the child in a foster care placement, the SWCM should discuss with their supervisor if they should consent to the recommended medication before the caregiver fills the medication prescription and administers it to the child.

### **Monitoring Medications**

The SWCM needs to inquire of the caretaker at each visit as to over-the-counter and prescribed medications that have been administered to the child, including any negative reactions (side effects) to the medication by the child or if the medication is helping the child. Any medications prescribed or over-the-counter administered needs to be documented in the case permanency plan, court report narrative, and the case narrative. Document the medication prescribed for the child, what the medication is prescribed for (e.g. mental health diagnosis), and the dosage. Also document any new medication prescribed or if a medication changed.

It is required that psychotropic medications be monitored, especially if a child is under age 6 and prescribed one or more psychotropic medications. A quarterly report of psychotropic medications prescribed to foster children is sent out to the social work administrators to distribute to the applicable supervisors and then to the SWCM. This report is part of the department's responsibility to ensure the mental health needs of children in out-of-home care are met, including the oversight of the medication prescribed for mental health. It shows a child who has been prescribed two or more psychotropic medications and any child under the age of six who is receiving at least one psychotropic medication. Providing appropriate oversight of medication by the SWCM requires teamwork, including coordination and communication with caregivers, service providers, parents, medical and mental health providers

involved with the child. Place a copy of the medication report in the case file. The oversight includes, but is not limited to:

- ◆ Ensuring that a child is seen regularly by a physician and also by a mental health provider as appropriate to monitor the effectiveness of any medication, including psychotropic medication, to assess any side effects, health implications, any needed changes to dosage or medication type, and determination of whether medication is still necessary or if other treatment options are more appropriate.
- ◆ Regularly following up with foster parents, caregivers, and foster care providers about administering medications appropriately and the child's experience with the medications such as side effects or adverse reactions.
- ◆ Verify that the quarterly report is accurate and reflects the medications the child is currently taking.
- ◆ Does the child or others report concerns about the medications and if so, you must advocate on the child's behalf to have the medications reviewed and explore alternatives to medication.
- ◆ An addition resource of medications:  
<http://www.nlm.nih.gov/medlineplus/druginformation.html>



KIM REYNOLDS  
GOVERNOR

**OFFICE OF THE GOVERNOR**

ADAM GREGG  
LT GOVERNOR

May 10, 2019

The Honorable Paul Pate  
Secretary of State of Iowa  
State Capitol  
Des Moines, Iowa 50319

Dear Mr. Secretary,

I hereby transmit:

House File 644, an Act relating to juvenile justice, including provisions relating to child foster care and parent visitation in child in need of assistance proceedings.

The above House File is hereby approved on this date.

Sincerely,

A handwritten signature in black ink that reads "Kim Reynolds".

Kim Reynolds  
Governor of Iowa

cc: Secretary of the Senate  
Clerk of the House



House File 644

AN ACT

RELATING TO JUVENILE JUSTICE, INCLUDING PROVISIONS RELATING TO CHILD FOSTER CARE AND PARENT VISITATION IN CHILD IN NEED OF ASSISTANCE PROCEEDINGS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 232.2, subsection 4, Code 2019, is amended by adding the following new paragraph:

NEW PARAGRAPH. *Of.* Plans for retaining any suitable existing medical, dental, or mental health providers providing medical, dental, or mental health care to the child when the child entered foster care.

Sec. 2. Section 232.2, subsection 4, paragraph f, subparagraph (7), Code 2019, is amended to read as follows:

(7) ~~Provision~~ The transition plan shall include a provision for the department or a designee of the department on or before the date the child reaches age eighteen, unless the child has been placed in foster care for less than thirty days, to provide to the child written verification of the child's foster care status, and a certified copy of the child's birth certificate, social security card, and driver's license or government-issued nonoperator's identification card. The fee for the certified copy of the child's birth certificate that is otherwise chargeable under section 144.13A, 144.46, or 331.605 shall be waived by the state or county registrar.

Sec. 3. Section 232.107, Code 2019, is amended to read as follows:

**232.107 Parent visitation.**

If a child is removed from the child's home in accordance with an order entered under this division ~~based upon evidence indicating the presence of an illegal drug in the child's body,~~ unless the court finds that substantial evidence exists to believe that reasonable visitation or supervised visitation would cause an imminent risk to the child's life or health, the order shall allow the child's parent reasonable visitation or supervised visitation with the child.

Sec. 4. Section 237.1, subsection 4, paragraph f, Code 2019, is amended to read as follows:

*f.* Care furnished by a relative of a child ~~for more than twenty days in one calendar year,~~ or an individual person with a meaningful relationship with the child where the child is not under the placement, care, or supervision of the department.

Sec. 5. Section 237.8, subsection 2, paragraph a, subparagraphs (1) and (2), Code 2019, are amended to read as follows:

(1) If a person is being considered for licensure under this chapter, or for employment involving direct responsibility for a child or ~~with access to a child when the child is alone in a facility where children reside,~~ by a licensee under this chapter, or if a person will reside in a facility utilized by a licensee, and if the person has been convicted of a crime or has a record of founded child abuse, the department and the licensee for an employee of the licensee shall perform an evaluation to determine whether the crime or founded child abuse warrants prohibition of licensure, employment, or residence in the facility. The department shall conduct criminal and child abuse record checks in this state and may conduct these checks in other states. The evaluation shall be performed in accordance with procedures adopted for this purpose by the department.

(2) ~~For an individual~~ If an individual is being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or if an individual will reside in a facility utilized by a licensee, or if an individual is subject to licensure under this chapter

as a foster parent, in addition to the record checks conducted under subparagraph (1), the individual's fingerprints shall be provided to the department of public safety for submission through the state criminal history repository to the United States department of justice, federal bureau of investigation for a national criminal history check. The cost of the criminal history check conducted under this subparagraph is the responsibility of the department of human services.

Sec. 6. Section 237.8, subsection 2, paragraph a, Code 2019, is amended by adding the following new subparagraphs:

NEW SUBPARAGRAPH. (02) If the criminal and child abuse record checks conducted in this state under subparagraph (1) for an individual being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or for an individual who will reside in a facility utilized by a licensee, have been completed and the individual either does not have a record of crime or founded child abuse or the department's evaluation of the record has determined that prohibition of the individual's licensure or employment is not warranted, the individual may be provisionally approved for licensure or employment pending the outcome of the fingerprint-based criminal history check conducted pursuant to subparagraph (2).

NEW SUBPARAGRAPH. (002) An individual being considered for licensure under this chapter, or for employment involving direct responsibility for a child or in a facility where children reside, by a licensee under this chapter, or for an individual who will reside in a facility utilized by a licensee, shall not be granted a license or be employed and an evaluation shall not be performed under this subsection if the individual has been convicted of any of the following felony offenses:

(a) Within the five-year period preceding the application date, a drug-related offense.

(b) Child endangerment or neglect or abandonment of a dependent person.

(c) Domestic abuse.

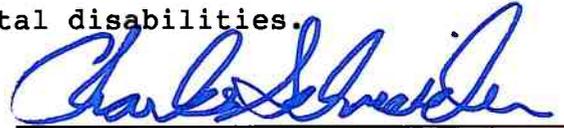
(d) A crime against a child, including but not limited to

sexual exploitation of a minor.

(e) A forcible felony.

Sec. 7. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES — FOSTER CARE CASE PERMANENCY PLAN. The department of human services shall amend its administrative rules pursuant to chapter 17A to provide that a case permanency plan for a child placed in foster care shall include information describing efforts to maintain suitable mental health care and medical health care for the child to avoid inappropriate diagnoses of mental illness, other emotional or behavioral disorders, medically fragile conditions, and developmental disabilities.

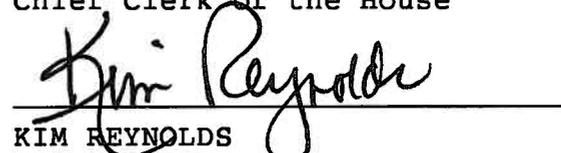
  
LINDA UPMEYER  
Speaker of the House

  
CHARLES SCHNEIDER  
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 644, Eighty-eighth General Assembly.

  
CARMINE BOAL  
Chief Clerk of the House

Approved May 10<sup>th</sup>, 2019

  
KIM REYNOLDS  
Governor



Department of  
**HUMAN SERVICES**

***FFY 2020-2024 Child and Family  
Services Plan  
Disaster Plan***

**June 2019**

# **Title IV-B Child and Family Services Plan Federal Fiscal Years 2020-2024 Disaster Plan**

State of Iowa  
Iowa Department of Human Services  
Division of Adult, Children and Family Services

## Contact Person

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## **Introduction to the Department's Child Welfare Disaster Plan**

The state of Iowa uses a Continuity of Operations (COOP) and Continuity of Government (COG) plan; re-written across state government in 2013, updated in 2014, and overhauled in 2017. This overhaul initiated new safety measures in state government buildings.

The Iowa Department of Human Services' (DHS or Department) COOP and COG plan is a part of the state's government implementation plan that allows the DHS to maintain an ability to continue services for persons, under its care, displaced or adversely affected by a natural or man-made disaster. Descriptions of the procedures and actions taken by the DHS Division of Adult, Children and Family Services (referred to as Division or ACFS, and working along with other DHS Divisions or state departments) in response to a crisis are in the COOP/COG Plan.

## **Changes to previous child welfare plans**

This plan for the years 2020 – 2024 is not significantly different than recent years' updated versions. Fortunately, a full test of its application to a major emergency has not occurred and no significant changes were necessary.

Over the last five years, many weather related events affected Iowa. Many Governor-declared disaster proclamations for multiple counties in the state occurred annually due to extremely wet and stormy weather that resulted in damaging winds, heavy rains, thunderstorms, flash flooding, and long term flooding. There has been significant damage to public and private property.

Yet, the operations of both the state offices (and its local affiliates) and its private contractors throughout Iowa were not affected to the extent of isolation from help or inability to operate. Entities experiencing predicaments successfully continued programs or used alternative methods of communication or temporarily relocated children or adults in care depending on what occurred and the need at the time.

A couple of examples of this from the past include:

- A contracted child welfare provider reported to the Division of ACFS that a lightning strike took out its telephone system. The local telephone utility tied into one working line so that phone capabilities were available in each residential unit and the office for one day until installation of a new telephone system. All phone lines were up and running within two days. Neither incoming nor outgoing calls were unavailable during this time.
- Flooding affected two of Iowa's most populous counties and caused evacuation of the children from the emergency juvenile shelter located in one of them. Anticipation regarding the need to move occurred as water rose and the children efficiently moved from the juvenile shelter to another foster care facility not threatened with high water. Accommodation of all the children needing alternative, temporary housing occurred relatively quickly and most moved back to their respective premises within a reasonable amount of time. When it was determined the long term flood damage to the juvenile shelter was so extensive that the building was

ultimately scheduled for demolition, the contractor, working with the DHS and the Department of Inspections and Appeals (the agency contracted to do licensing work for DHS), was able to occupy another licensed location on a temporary basis while the county evaluated its options.

The continuing emergence of new or improvements to existing technologies eased efforts required to respond to these occurrences. The availability of cell phones, email, and video conferencing at our fingertips plays an increasingly important role in instant communications.

It is the intent of the DHS to continue with the plan and its role in the statewide COG plan while continuing to assess its applicability each year. An annual review of this plan will occur, with updates occurring as needed.

### **The DHS Child Welfare Disaster Plan**

This section includes child welfare planning information for the Iowa COOP/COG Plan and descriptions of supplemental procedures that relate to the federal requirements for disaster planning. These procedures describe how Iowa would:

- Identify, locate, and continue availability of services for children under state care or supervision displaced or adversely affected by a disaster;
- Respond, as appropriate, to new child welfare cases in areas adversely affected by a disaster, and provide services in those cases;
- Remain in communication with caseworkers and other essential child welfare personnel displaced because of a disaster;
- Preserve essential program records; and
- Coordinate services and share information with other states.

Operationally, the COOP/COG Plan focuses on the following: emergency authority in accordance with applicable law; safekeeping of vital resources, facilities and records; and, establishment of emergency operating capacity. It also follows executive and legal directives under Iowa law. Additionally, the Division developed supplemental procedures related to communications with local, state, and federal entities.

Iowa Code, Chapter 29C.5 and 29C.8 both require comprehensive evacuation planning. In addition, the Iowa Severe Weather and Emergency Evacuation Policy, adopted December 2001, states: *“It is the Governor’s philosophy that there must be plans to ensure that State Government can operate under exceptional circumstances. Therefore, Executive branch departments must deploy plans to ensure staffing and provisions of essential services to the public during severe weather or emergency closings.”*<sup>1</sup>

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<sup>1</sup> State of Iowa Continuity of Operations (COOP) & Continuity of Government (COG) Implementation Plan, page 2 (Approved July 30, 2013)

The Foster Care and Protection of Adults and Children sections of the COOP/COG Plan concentrate on individuals and families who receive services provided by the DHS and provide guidelines for foster care providers to develop emergency procedures responsive to accidents or illness, fire, medical and water emergencies, natural disasters, acts of terror and other life threatening situations for children in out-of-home care. Since state fiscal year (SFY) 2012, contracts for foster group care and child welfare emergency services have required contractors to collaborate with the DHS and implement written plans for disasters and emergency situations, including training plans for staff and volunteers. These contractor plans focus on: situations involving intruders or intoxicated persons; evacuations; fire; tornado, flood, blizzard, or other weather incidents; power failures; bomb threats; chemical spills; earthquakes; events involving nuclear materials; or, other natural or man-made disasters.

### **Disaster Communications with Federal Department of Health and Human Services (DHHS) Partners**

If Iowa is affected by either a natural or man-made disaster that affects the clients of the DHS or inhibits the ability of the DHS to provide services, the following communication steps shall be followed.

- The Director of the Iowa Department of Human Services or the Director's designee(s), the Administrator of the Division of Adult, Children and Family Services, or the Chief of the Bureau of Child Welfare and Community Services shall call Deborah Smith, Region VII Program Manager in the DHHS Regional Office, at her office (816) 426-2262 or other emergency preparedness staff available at any hour at the cell phone number (816) 518-8630 329-9078, at the earliest possible opportunity.
- If there is no response from the Regional Office, the Director or designee shall call Joe Bock, Deputy Associate Commissioner, Children's Bureau, at (202) 205-8618.
- The content of the call shall be a summary of the situation and a request for any assistance that may be necessary or appropriate.

### **Disaster Communications with Other State and National Organizations**

If Iowa is affected by a natural or man-made disaster that affects the clients of the DHS or inhibits the ability of the DHS to provide services, the following communication steps shall be followed related to notification of other states and national groups.

- The Director of the Iowa Department of Human Services or the Director's designee(s), the Administrator of the Division of Adult, Children and Family Services, or the Chief of the Bureau of Child Welfare and Community Services shall call the administrative office of the American Public Human Services Association (APHSA) at (202) 682-0100 and the Child Welfare League of America (CWLA) at (703) 412-2400.
- The content of the calls shall be a summary of the situation and a request for any assistance that may be necessary or appropriate.

**The information below is referred to in the COOP/COG plan and the following table:**

- Gerd Clabaugh, Interim Director, Iowa Department of Human Services, (515) 281-5452
- Mikki Stier, Deputy Director, Iowa Department of Human Services, (515) 281-6360
- Matt Highland, Chief Information Officer, (515) 281-4848
- Laverne Armstrong, Administrator of the Division of Field Operations, (515) 281-8746
- Steven Campagna, Chief of the Bureau of Child Welfare Systems, (515) 281-6894
- The Division or Bureau Policy Team:
  - Jana Rhoads, Administrator of the Division of Adult, Children and Family Services, (515) 281-5521
  - Janee Harvey, Chief of the Bureau of Child Welfare and Community Services, (515) 281-6802
  - Julie Allison, Chief of the Bureau of Child Care Services, (515) 281-6177
- Central Abuse Hotline, (800) 362-2178

### **State Procedures Related To Identified Federal Requirements**

The actions reported in the following table are from Iowa's COOP/COG Plan or are supplemental to the plan, and they identify the personnel, equipment, vital records and databases, and facility and infrastructure needed for each action. These actions encompass the four federal requirements identified at the beginning of this section.

**Table 1: State Procedures**

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
<b>Foster Care</b>						
1 Communicate with foster care providers regarding status and assistance needs and any initial instructions; Determine if there is an initial need to relocate clients through the Deputy Director.	Division/ Bureau Policy Team	Foster Care Database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet	DHS field staff, Juvenile Court Officers, child welfare services contractors, Dept. of Inspections and Appeals	Employees manual, foster care licensing information
2 Determine potential relocation sites (other institutions or foster care homes) to use if needed and offer assistance with placement and transportation logistics if needed.	Division Policy Team/ Institution/foster care providers (DHS Field Office responsibility)	Foster Care Database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet	DHS field staff, Juvenile Court Officers, child welfare services contractors, Dept. of Inspections and Appeals	Employees manual, foster care licensing information
3 Contact IT to transfer the Central Abuse Hotline to the alternate location	Administrator of the Division of Field Operations	JARVIS database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
4 Support staff and providers by making policy clarification available through the Central Abuse Hotline Help Desk.	Bureau Policy Team	JARVIS database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
5 Coordinate responses to staffing needs for abuse allegations identified through the Central Abuse Hotline; Coordinate with the Division of Field Operations for response. Respond to abuse allegations; assign local staff to respond to local site	Administrator of the Division of Field Operations, IT Manager	JARVIS database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
6 Coordinate staffing and assign as necessary to back-up inoperable service areas to respond to foster care providers' needs.	IT Liaison, Chief of the Bureau of Child Welfare and Community Services	Foster Care Database	Mainframe	Telephone, Cell Phone, Email, Internet, Intranet	Division of ACFS	Employees manual

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
7 Ensure care provider payment system continues by contacting IT and transferring system to alternate location (ensure client/server JARVIS database and mainframe FACS application are operational); Implement paper back-up payment system if necessary.	Chief of the Bureau of Child Welfare and Community Services	Foster Care Database, FACS and/or JARVIS database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet	Division of Data Management	Employees manual
8 Provide staffing to back-up inoperable service areas to respond to foster care providers' needs.	Chief of the Bureau of Child Welfare and Community Services	Foster care database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet	DHS field staff, Juvenile Court Officers, child welfare services contractors	Employees manual

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
<b>Protection of Children and Adults</b>						
1 Determine status of group homes or institutions in affected area; Assess the affected area and determine the nearest institution that's able to accept persons if needed.	Bureau of Child Welfare and Community Services	Foster care database		Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
2 Coordinate with CWIS team and ICN to ensure the Abuse Hotline Phone Number is transferred to alternate location site; Provide staffing to receive abuse allegations. Forward reports to the specific area where abuse may have occurred. If no local phone lines, phone assessment will be completed by policy division.	Division of Field Operations	JARVIS database		Telephone, Cell Phone, Email, Internet, Intranet		Employees manual

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
3 Contact CWIS team to ensure foster care payroll system continues to issue monthly payment checks to care providers; if not available, implement paper issuance system using the most recent database backup.	Division or Bureau Policy Team, Chief Information Officer	Foster care database/Main frame, payroll list, JARVIS database	Mainframe	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
4 Organize and provide emergency responders to respond to providers requesting assistance or policy clarification.	Bureau of Child Welfare and Community Services and Field Operations Offices	Foster care database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
5 Ensure access to the Central Abuse Registry and MIS systems are available (JARVIS); Determine need to modify current policies regarding child abuse allegation response times.	Bureau of Child Welfare and Community Services and Division of Field Operations, Chief Information Officer	JARVIS database	Central Abuse Hotline, Servers, Mainframe	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual

<b>Essential Functions</b>	<b>Personnel/Special Skills</b>	<b>Application(s) Necessary for Function</b>	<b>Other Processes &amp; Interfaces Needed</b>	<b>Essential Communication Needed</b>	<b>Customers /Vendors</b>	<b>Documents/Vital Records Needed</b>
6 Provide staffing to respond to abuse allegations; Assess the availability of field staff to conduct abuse assessments and make staff re-assignments as needed.	Bureau of Child Welfare and Community Services and Division of Field Operations	JARVIS database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual
7 Assist new placement of children and provide transportation if required	Division or Bureau Policy Teams/ Division of Field Operations	Foster Care database	Central Abuse Hotline	Telephone, Cell Phone, Email, Internet, Intranet		Employees manual



Department of  
**HUMAN SERVICES**

***FFY 2020-2024 Child and Family  
Services Plan  
Training Plan***

**June 2019**

# **Title IV-B Child and Family Services Plan Federal Fiscal Years 2020-2024 Disaster Plan**

State of Iowa  
Iowa Department of Human Services  
Division of Adult, Children and Family Services

## Contact Person

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## **New Worker Training Requirements**

The DHS requires newly hired social work staff to complete the New Worker Training Plans by the timeframes specified for each course (Attachment A for SW2/SW2 Supervisors and Attachment B 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 DHS contracts with the Child Welfare Research and Training Project at Iowa State University (ISU) to perform many of the necessary day-to-day activities related to the coordination of training. One of ISU's responsibilities is to review the New Worker Training Plan with learners during their New Worker Orientation phone call.

*SW2 training prior to caseload assignments is as follows:*

New Social Worker 2s must complete the initial three days of *SW 020 Foundations of Social Worker 2 Practice* before they're assigned any cases. Following this classroom time, learners will participate in the month-long field learning experience before they return to class for the final 3.5 days of SW 020. Newly hired staff will work with their mentors on no more than 10 cases during their field learning experience prior to the completion of SW 020. Suggested types of cases to avoid assigning during the field learning experience timeframe include:

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

*CPW training prior to caseload assignments is as follows:*

New Social Worker 3s must complete the initial three days of *CP 200 Basic Training for Child Protective Workers* before they are assigned any cases. Following this classroom time, learners will participate in the month-long field learning experience before they return to class for the final 3.5 days of CP 200. Newly hired staff will be assigned no more than six Family Assessment or CINA cases during their field learning experience prior to the completion of CP 200. Additionally, new Social Worker 3s must complete *DA 202 Dependent Adult Abuse Fundamentals* before they are assigned any dependent adult abuse cases.

*Supports provided during the in-service training period*

Within the CFSR reporting period, the DHS will develop a formalized mentoring program with the goal of supporting new workers as they transition into their role. Attachment C is the draft of the framework for this program. The Field Learning Experience Guides are Attachments D1 for SW2 and D2 for SW3, which detail tasks performed to supplement classroom learning.

Another level of support provided to new staff is access to the DHS help desks. During the orientation coursework, new staff receive an introduction to this specialized team of personnel, who answer practice, policy, and technical questions that arise.

ISU plays a role in providing support during the initial service training period by conducting a training orientation call with each new worker to discuss the training requirements, walk-through the Learning Management System (LMS), and help new staff acclimate to the mentoring program.

### **Ongoing Worker Training Requirements**

DHS requires social work staff to complete a minimum of 24 training hours each state fiscal year (e.g., July 1, 2016 – June 30, 2017).

#### *Training Hour Reminder Emails*

One of ISU's contracted services is to send out a bi-annual email to all staff to reiterate the 24 hour training hour requirement.

#### *Learning Needs Surveys*

DHS distributes a bi-annual statewide Learning Needs Survey to SW2s, SW3s, Supervisors, as well as to Policy and Service Help Desk staff. The purpose of the survey is to identify the ongoing training needs of staff. These results serve as a basis for the DHS Training Committee to select and align training initiatives for the upcoming fiscal year with the learning needs of staff.

#### *DHS Training Committee Feedback*

The DHS Training Committee members include a Supervisor, SW3, and SW2 from each of the five Service Areas; as well as DHS leadership, Service Help Desk staff, Policy program managers, and contracted training personnel. Incorporating feedback from the DHS Training Committee helps to ensure that ongoing training addresses skills and knowledge needed by staff to carry out their duties.

#### *Focus Group Feedback*

Focus groups occur for newly developed or significantly updated ongoing courses. The focus groups comprise DHS Training Committee members as well as additional key stakeholders and staff. These focus groups assist in refining the course objectives and reviewing the curriculum during development.

#### *Pilot Offerings for Newly Developed/Revised Ongoing Coursework*

Any newly developed or significantly updated course includes a pilot offering before introduction to frontline staff. This practice ensures course content meets the needs of ongoing workers before implementing training.

#### *Levels of Proficiency*

Structuring coursework by levels of proficiency is one method further to better target staff's ongoing training needs. The fundamentals-level coursework is designed for

acquiring basic skills and knowledge, while the progressive-level trainings focus on building intermediate to advanced skills for more tenured staff.

#### *Post-Training Phone Surveys and Analysis*

ISU staff conducts post-training surveys 60 days after training for ongoing coursework. Due to the number of ongoing training offerings, DHS determines which courses to survey based on statewide initiatives or newly developed trainings.

#### *Post-Training Evaluation of Ongoing Training*

Learners complete a standardized electronic post-training evaluation after attending training. This 16-question evaluation includes a number of questions designed to measure how well the training addresses basic skills and knowledge needed by staff to carry out their duties.

### **Training to Support the FFY 2020-2024 Child and Family Services Plan (CFSP) Goals and Objectives**

Due to Iowa's planned implementation of the Family First Prevention Services Act (Family First), DHS will train on the Family First implementation in the coming year. The training will prepare staff for the resulting changes in practice and service. This will be an opportunity to partner with providers, judges, and others across disciplines.

As a result of Iowa's 2018 Child and Family Services Review (CFSR) and program improvement plan (PIP) development, the training plan addresses associated training needs by providing the following coursework for DHS staff.

- *Safety Trainings:* All of the trainings below relate to CFSR Items 2 and 3 (Safety Outcome 2), which address assessment of a child's circumstance to determine if the child is unsafe and removal is necessary or if there are services DHS can provide to protect the child while keeping them in their home. These interrelated topics may be provided individually or as elements of a single training.
  - Danger vs Risk – This terminology is new language for assessment of safety versus risk. The CFSR results indicated that Iowa was not consistently distinguishing between imminent safety and risk issues; this assessment directly impacts case planning decisions. The term “danger” replaces “safety” which seems more urgent; this terminology is now common in child welfare. Training will focus on defining the differences between danger and risk and how that translates to child welfare services. The accurate understanding of danger versus risk also impacts whether a child can remain in their home, possibly with services, rather than needing to be removed from the family (Items 2 and 3).
  - Safety Assessment – To continue improving the quality of assessment of children and families, Iowa will explore current best practice around assessing safety to determine if current procedures/forms would benefit from updating. This directly ties to CFSR Item 3, Risk and Safety Assessment and Management. An accurate assessment of a child's safety could mean the difference between remaining in the home, possibly with services, versus being

- placed in foster care. This training will focus on content of the assessment and application of the assessment to families.
- Safety Planning – The CFSR on-site results clearly identified that safety plans are not used as effectively as they could be. Training will focus on what an “actionable” safety plan incorporates, including what constitutes active intervention rather than relying on promises from parents. This training will cover the important role safety plans can play in keeping children safely in their homes.
  - *Engagement*: CFSR on-site case reviews as well as focus group feedback indicated that parents and children are not consistently engaged in development of their case plan. Engagement of the family with the social worker impacts all stages of a case from assessment of needs/provision of services (CFSR Item 12) to buy-in/ownership of the case plan expectations (CFSR Item 13), to productive discussions about progress (CFSR Items 13, 14, and 15). This training will focus on the definition of “active involvement” and ways to promote involvement. Feedback from the CFSR results indicates that involvement is tied to the relationship between the family and worker so factors influencing this will also be covered in the training.
  - *How to Achieve Best Practice – CFSR*: This training provides an overview of the CFSR expectations and how they intersect with Iowa practice. It is focused on providing information directly related to the mandatory participants, activities to promote the sharing of experiences as well as opportunities to practice new skills. Trainees will receive multiple resources with concrete ideas for helping to implement best practices that they will take with them for future use; this training emphasizes not only the “what” but the “how to” in everyday practice.

## **Current or planned activities to improve performance**

### Item 26: Initial Staff Training

*Goal 1: Improve new staff completing training within the required timeframes*

Strategy to reach this goal is:

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

*Goal 2: Improve the perceived effectiveness of the trainings*

Strategies to reach this goal include:

- Analysis of Training Effectiveness: Starting in fiscal year 2020, DHS will partner with ISU to conduct an in-depth analysis to evaluate the effectiveness of the trainings. An ISU graduate student will be hired with the goal of conducting the in-depth evaluations. These evaluations will analyze how effectively field staff implements the knowledge and skills learned in the trainings and how effectively they apply the lessons learned to actual practice. In addition, the analysis will identify barriers in learning/practice and will propose modifications based on the findings. These

evaluations will begin with the two new worker courses of SW 020 and CP 200 and will be based on the work of the California Social Work Education Center (SWECE).

- Improved Facilitator Model: The facilitator model that DHS will employ starting in fiscal year 2020 consists of pairing an internal DHS trainer with a carefully selected subject matter expert (SME) co-facilitator. In the past, ISU facilitators who lacked direct DHS field experience trained DHS staff. Under the new model, DHS will employ two full-time internal trainers with significant DHS background in the field. Direct line experience is critical for establishing facilitator credibility to the audience. A second component of this model is that DHS will be more selective in finding qualified subject matter experts, seeking to partner with leaders across disciplines to keep training relevant and fresh.
- Summative Evaluations for Fundamentals Training: Fundamentals training will have post-tests. These summative evaluations will measure if the learning objectives of the training were met. After each session of a course that has a post-test, the post-test results are analyzed to determine if a certain topic area is missed frequently, which will enable us to keep a pulse on areas where more training time should be spent and to discuss this information with the trainers to improve the training.
- Enhanced technology: During the CFSP period, DHS intends to incorporate more effective technology into training. A new learning management system would greatly benefit learners by providing a streamlined and enhanced webinar and eLearning experience.

*Goal 3: Establish or improve support and education in non-classroom settings*

Strategies to reach this goal include:

- Mentoring program: DHS will develop a mentoring program for new child protection workers (CPW)(SW3s) and social work case managers (SWCM)(SW2s) in the DHS. Field mentoring is being developed to reinforce learning with practice in real life situations. This framework will formalize an informal system that is already in place and improve statewide consistency. The objectives of this program include:
  - Recognize mentoring as a valued element of the staff development framework
  - Ensure mentoring is not confused with, or substituted for, the performance evaluation
  - Support and encourage mentoring in staff and team development
  - Establish that mentoring relationships are consistent with existing policies on quality, equal opportunity, inclusiveness, code of conduct and privacy
  - Identify staff that are willing and able to mentor new employees
- Masters of Social Work Stipend Program: DHS will explore drawing down title IV-E funding and partnering with state universities to provide financial assistance to current DHS staff interested in earning a Masters of Social Work. A recent survey of staff indicates great interest in such a program, viewing it as an opportunity to enhance skill level and overall career path.

Item 27 – Ongoing Staff Training

*Goal 1: Improve staff completing the required ongoing training hours within our established timeframes*

Strategy to reach this goal is:

- Enhanced Reporting: Starting fiscal year 2020, DHS will develop quarterly reporting for Social Work Administrators (SWAs) and Service Area Managers (SAMs) indicating in brief:
  - Which of their workers have and have not met the minimum 24 hours of training for the current fiscal year;
  - The percentage of workers under each supervisor that have not met the minimum 24 hours of training for the current fiscal year;
  - The percentage of workers under each Social Work Administrator that have not met the minimum 24 hours of training for the current fiscal year; and
  - The percentage of workers under each Service Area Manager that have not met the minimum 24 hours of training for the current fiscal year.

Providing quarterly at-a-glance reports will make it easier for supervisors and administrators to identify which of their staff are not on target to meet minimum training hours by the end of the fiscal year and address issues as appropriate. Additionally, an overview of the report will be provided quarterly, after the report has been released, at both the SAM meeting and SWA meeting.

*Goal 2: Address the need for supervisory training that promotes the development of child welfare supervisory and management skills.*

Strategies to reach this goal include:

- Provide supervisory specific webinars: DHS will develop topic-specific webinars specifically targeted for supervisors. These webinars will often be co-facilitated by a field supervisor and will be recorded for on-demand access. The topics will vary to include trending issues as well as overall best management practices. This strategy allows supervisors to enhance their management skills in short and simple increments of time.
- Additional face-to-face coursework offerings specifically designed for supervisors: The plan over the next five years is to offer additional courses designed specifically for supervisors. A good example of this type of training is the recently developed trauma course for supervisors. Participants of SP 810 Trauma Stewardship for Supervisors learn supervisory approaches to address worker secondary trauma, dealing with the aftermath of a critical incident, and create a plan of action to implement with their team.
- Advanced level course offerings: A strategy to engage supervisors in training is to provide the field with more advanced-level curriculum. Most supervisors are tenured staff who are beyond the fundamentals level of curriculum. By offering additional training that incorporates complex case studies and takes a deeper dive into trending issues, the intent is to reinvigorate and challenge senior staff members with new information and tools.
- Provide Supervisors with “The Essential Handbook for Highly Effective Human Service Managers”: All supervisors and top leadership will receive literature that promotes the development of child welfare supervisory and management skills. “The Essential Handbook for Highly Effective Human Service Managers” emphasizes an innovative approach to equip managers at all levels with the

strategies and tools necessary to maximize employee commitment, performance and client care. Chapters that are 3-5 pages in length cover 30 vital skills, which makes for easy reading and immediate skill building and implementation. Each chapter provides an opportunity for growth and development with critical thinking questions designed to challenge your insight and perspective. The SWAs in each Service Area will develop a plan of how to deploy and implement the use of the book with his or her supervisors.

- Promoting External Training Opportunities for Supervisors: Many external organizations that partner with DHS offer supervisory specific training that is open to DHS supervisors. These courses allow DHS supervisors to earn credit for trainings on topics other than what is offered internally. Additionally, supervisors are exposed to new facilitators. Two key organizations that offer this type of coursework are The Department of Administrative Services as well as the Child Welfare Provider Training Academy. A strategy to increase participation in supervisory training offered by outside organizations is to develop a communication plan with these partners. The aim is to do a better job of promoting external supervisory training opportunities to DHS supervisors.
- Phased Training for New Initiatives: A training model effective for DHS is to initially train just supervisors on new initiatives/practices, followed by a second wave of training for frontline staff. This method allows supervisors to ask management-specific questions and creates buy-in for the initiative. By providing supervisors with knowledge in advance of their staff, they are better able to plan and anticipate the questions they may receive from frontline staff. Training on new initiatives will frequently be rolled out in this manner.

I/initial	Aud.	Provider of Training	Course #	Course Title	Brief Course Syllabus	Funding Sources & Benefiting Program	Administrative Function	Estimated Annual Cost	Estimated 5 Year Cost	FY 20-24 # of Times Offered Annually	# of Days
I/O; Short-Term	SW 2, 3, Supervisors & Others	ISU	CC 364	Confidentiality and Dissemination	This course will teach learners the major categories of confidential information and associated statutes, legal and ethical considerations, and key elements of dissemination.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Case Reviews</li> <li>Case management and supervision</li> </ul>	\$1,678	\$8,390	Ongoing	Recorded webinar, 1.75 hours
I/O; Short-Term	SW 2, 3, Supervisors	ISU	CC 368	ICWA Update	Prepares participants to understand the policy and procedures of ICWA and its importance in maintaining Native American cultural identity, utilizing best practice strategies in casework, establishing meaningful partnerships among all stakeholders, and complying with the federal and state ICWA	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Eligibility determinations and re-determinations</li> <li>Referral to services</li> <li>Placement of the child</li> <li>Development of the case plan</li> </ul>	\$719	\$3,595	Ongoing	Recorded webinar, 1 hour
I; Short-Term	SW 2, 3 & Supervisors	DHS	CP 200	Basic Training for Child Protective Workers	Provide an in depth study of the assessment and engagement process that initiates the development of the case plan, safety plans, preparation for Juvenile Court and referral to services.	60% All Child Welfare & 40% State Only	<ul style="list-style-type: none"> <li>Eligibility determinations and re-determinations</li> <li>Referral to services</li> <li>Preparation for and participation in judicial determinations</li> <li>Development of the case plan</li> </ul>	\$95,923	\$479,615	4	6 days
I/O; Short-Term	All Staff	ISU	DS 169	Mandatory Child Abuse Reporter Training	Understand the role and responsibilities of a mandatory reporter; identify the specific criteria of child; recognize indicators of abuse; learn reporting procedures; and understand the assessment/evaluation process	IV-E All Child Welfare & State Funds*	<ul style="list-style-type: none"> <li>Eligibility determinations and re-determinations</li> <li>Referral to services</li> </ul>	\$1,917	\$9,585	on-going	0.3 day
I/O; Short-Term	All staff	Iowa State University (ISU)	HS 001	Confidentiality is Key	Explains the regulations and procedures related to confidentiality at DHS. Covers client confidentiality, release of information and best practices regarding confidentiality of information.	IV-E All Child Welfare and State Funds*	Pertains to all functions; specifically fair hearings and appeals.	\$1,917	\$9,585	on-going	0.3 day
I; Short-Term	SW 2 & 3	ISU	SP 100	Overview of Child Welfare	Provides foundational training on the management of cases in child welfare.	IV-E All Child Welfare and State Funds*	Case management and supervision	\$3,858	\$19,290	Ongoing	0.3 day
I; Short-Term	SW 2, 3, Supervisors	ISU	SP 103	Legal eLearning	Becomes familiar with the legal process as it relates to basic court proceedings and DHS services.	IV-E All Child Welfare and State Funds*	Preparation for and participation in judicial determination	Not offered this year.	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.	web	0.3 day
I; Short-Term	SW 2, 3, Supervisors	ISU	SP 104	Medical eLearning	Identify the different types of abuse and identify the emotional and behavioral indicators of each type of abuse assessment information needed for the case plan development.	IV-E All Child Welfare and State Funds*	§ Development of the case plan and placement of the child	Not offered this year.	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.	web	0.3 day
I; Short-Term	SW 2, 3, Supervisors	ISU	SP 105	Substance Abuse eLearning	Understand addiction and what it does to the brain, identify indicators of substance abuse, identify the effects of various substances on the body, and identify the different types of substance abuse treatment. Learners will use this information to facilitate the case plan development.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Case reviews</li> </ul>	\$3,863	\$19,315	web	0.3

I; Short-Term	SW 2, 3, Supervisors	ISU	SP 106	Domestic Violence eLearning	Becomes familiar with the dynamics of domestic violence, the indicators of domestic violence, and identify various domestic violence resources and referral to services. Learners will use this information to facilitate the case plan development.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Placement of the child</li> <li>• Development of the case plan</li> <li>• Case Reviews</li> </ul>	\$1,917	\$9,585	web	0.3
I; Short-Term	SW 2, 3, Supervisors	ISU	SP 107	Child Development eLearning	Learn the impact of neglect and abuse on child development, the indicators of neglect and abuse, various resources and referral to services. Learners will use this information to facilitate the case plan development.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Placement of the child</li> <li>• Case Reviews</li> </ul>	\$1,917	\$9,585	web	0.3
I; Short-Term	SW 2, 3 & Supervisors	ISU	SP 150	Child Welfare Practice in Iowa	Provides the basic knowledge of the social worker role and principles of permanency for children and the role for achieving safety, stability and permanency in the referral to services and the development and review of the case plan.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Placement of the child</li> <li>• Case Reviews</li> <li>• Case management and Supervision</li> </ul>	\$33,746	\$168,730	8	0.75
O; Short-Term	SW 2, 3 & Supervisors	ISU	SP 202	Quality Case Documentation & Worker Visits	Enhances participants' knowledge around quality case documentation and worker visits and increases their ability to develop case plans addressing safety, well-being, and permanency.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Case management and supervision</li> <li>• Case Reviews</li> </ul>	\$1,917	\$9,585	on-going	Recorded Webinar, 1 hour
I/O; Short-Term	SW 2, 3 & Supervisors, Community Provider staff	DHS + ISU Subcontractor	SP 270	Mental Health Fundamentals	This course is designed to equip staff with a fundamental mental health knowledge base for working with families when behavioral indicators of mental health issues are present. It teaches participants how to connect behavioral indicators to child safety and provides guidance for workers in addressing risks related to mental health issues in planning	IV-E All Child Welfare and State Funds	Referral to services; Development of the case plan; Case reviews; Case management	\$26,762	\$133,810	4	1 day
O; Short-Term	SW 2, 3 & Supervisors	UNI	SP 304	Case law, Statutes, and Federal law	To provide opportunities for staff to build on their basic legal foundation and expand their knowledge base relative to the laws.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Preparation for and participation in judicial determination</li> <li>• Fair hearings and appeals.</li> </ul>	\$7,868	\$39,340	2	1 day
O/I; Short-Term	SW 2, 3 & Supervisors	ISU	SP 305	Mental Health Intermediate	Teaches participants how to evaluate the risks to the child when the parent, parents, or caregivers are diagnosed with one or more of the most commonly occurring mental health disorders, and to identify ways that these risks can be ameliorated.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case Management and Supervision</li> </ul>	\$16,084	\$80,420	2	1 day
I; Short-Term	SW 2, 3 & Supervisors	DHS	SP 309	Domestic Violence Fundamentals	Focus on importance of identifying domestic violence dynamics in child welfare cases. Utilize case example and case consultation techniques to provide participants with an opportunity to translate the principles to the case plan process.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case management and supervision</li> </ul>	\$17,020	\$85,100	4	1

I; Short-Term	DHS Staff, Community Provider staff	ISU's Subcontracted trainers + DHS	SP 310	Substance Abuse Fundamentals	Training on what kids are doing today to get high. This training reflects the dramatic changes that have taken place the past few years. This training features up-to-date "real" photos and videos to help gain essential knowledge about different substances of abuse, what they look like, how they are used and their effects. The training will also cover behavioral indicators of substance and drug testing protocol.	IV-E All Child Welfare and State Funds*	Referral to services; Development of the case plan; Case reviews; Case management	\$27,673	\$138,365	4	1
I; Short-Term	DHS Staff, Community Provider staff	ISU's Subcontracted trainers	SP 311	Trauma Fundamentals	This course gives an overview of trauma and how it affects brain development, family functioning, and child safety. Participants will learn to identify coping responses, strengths, and protective factors that promote resilience and reduce risk. Participants will also recognize how secondary trauma impacts	IV-E All Child Welfare and State Funds	Referral to services; Development of the case plan; Case reviews; Case management	\$27,326	\$136,630	4	1
I; Short-Term	DHS Staff, Community Provider staff	ISU's Subcontracted trainers	SP 312	Medical Fundamentals	The foundational medical course will provide new Social Worker 2s, 3s, and Supervisors with the knowledge base to make quick and accurate assessments for safety-risk. The medical perspectives of many types of child abuse and the implications for case plan	IV-E All Child Welfare and State Funds	Referral to services; Development of the case plan; Case reviews; Case management	\$55,001	\$275,005	4	1
I; Short-Term	DHS SW3s and Supervisors	UNI	SP 313	Legal Fundamentals for Child Protective Workers	This course is designed to equip staff on the fundamentals of the judicial system that assist in preparation for and participation in judicial determinations through careful review of the Iowa Code.	IV-E All Child Welfare and State Funds	Development of the case plan; Case reviews; Case management	\$11,022	\$55,110	3	1
I; Short-Term	DHS Staff and Community Providers	DHS	SP 334	Family Team Decision Making Fundamentals	Understand the Family Team Decision Making (FTDM) process so the learner can evaluate and utilize in daily practice to develop the case plan and make referrals to services.	IV-E All Child Welfare and State Funds	<ul style="list-style-type: none"> <li>•Referral to services</li> <li>•Development of the case plan</li> <li>•Case reviews</li> <li>•Case management and supervision</li> </ul>	\$24,192	\$120,960	4	1
I/O; Short-Term	DHS Staff and Community Providers	DHS	SP 337	Maintaining Connections	This course focuses on the parents' rights in terms of family interactions, the caseworker's role and responsibility in supporting family interactions, creating a Family Interaction Plan, and shared parenting. Contents include best practices for planning and implementing family interactions,	IV-E All Child Welfare and State Funds	Referral to services; Development of the case plan; Case reviews; Case management	\$33,925	\$169,625	4	1

I; Short-Term	DHS Staff, Community Provider staff	ISU's Subcontracted trainers + DHS	SP 410	Substance Abuse Intermediate	Training on what kids are doing today to get high. This training reflects the dramatic changes that have taken place the past few years. This training features up-to-date "real" photos and videos to help gain essential knowledge about different substances of abuse, what they look like, how they are used and their effects. The training will also cover behavioral indicators of substance and drug testing protocol.	IV-E All Child Welfare and State Funds*	Referral to services; Development of the case plan; Case reviews; Case management	\$17,826	\$89,130	2	1
I; Short-Term	SW 2, 3 & Supervisors	DHS	SP 535	Assessing Throughout the Case	Review decision-making in child welfare assessment to ensure case plan development, appropriate services, safety and permanency for the child.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Placement of the child</li> <li>• Development of the case plan</li> <li>• Case Reviews</li> <li>• Case Management and Supervision</li> </ul>	\$27,486	\$137,430	5	1
I/O ; Short-Term	SW 2, 3, Supervisors & Others	ISU subcontracted trainer	SP 542	Motivational Interviewing	Prepares participants for understanding change, learning the spirit of and principles of motivational interviewing, and identifying how staff might apply what they learn to case management.	IV-E All Child Welfare and State Funds*	Case management and supervision	\$26,944	\$134,720	4	1
O; Short-Term	SW 2, 3, Supervisors & Others	ISU Subcontracted trainer	SP 642	Advanced Motivational Interviewing	Prepares the participant at a more advanced level in client-centered counseling style for eliciting behavior change by helping the client explore and resolve ambivalence. Participants will be able to apply what they learn to case management.	IV-E All Child Welfare and State Funds*	Case management and supervision	Not offering this year	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.		1
I; Short-Term	SW Supervisors	DHS	SP 806	Iowa Child Welfare Supervisory Model of Practice	Enhances supervisory skills in case management and implementation of the Supervisory Model of Practice in Child Welfare Practice.	IV-E All Child Welfare and State Funds*	Case management and supervision	\$19,805	\$99,025	3	1
I/O; Short-Term	Supervisors & Others	ISU's Subcontracted trainers	SP 810	Supervisor's Role in Addressing Secondary Trauma	To provide a framework and tools for Social Work Supervisors to identify and address risk factors and assist workers to develop and implement strategies around safety planning. Also to assist workers in dealing with critical incidents and create a plan of action.	IV-E All Child Welfare and State Funds	Development of the case plan, Case reviews, Case management and supervision	\$10,545	\$52,725	1	1
O; Short-Term	SW Supervisors & Others	ISU	SP 842	Motivational Interviewing for Supervisors	Prepares supervisory staff for understanding change, learning spirit of motivational interviewing, learning the principles of motivational interviewing, and identifying how staff might apply what they learn to their work.	IV-E All Child Welfare and State Funds*	Case management and supervision	Not offering this year.	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.		

I; Short-Term	SW 2 & Supervisors	DHS	SW 020	Foundations for Social Worker 2 Practice	Provides an understanding of case management social work and the tools with which to do strength based assessments and develop the case plan, on-going case management and case closure. Provides information on how to refer for services, place a child, and prepare for judicial determinations.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Eligibility determinations and re-determinations</li> <li>• Referral to services</li> <li>• Placement of the child</li> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case management and Supervision</li> </ul>	\$173,178	\$865,890	6	6.5
I; Short-Term	SW 2 & Supervisors	UNI	SW 071	Legal Aspects of Social Work for Case Managers	Provides a basic overview of the legal issues surrounding cases involved in the juvenile court system. Provide service workers and supervisors with a working knowledge of the legal system and skills necessary to begin to effectively interact with attorneys and the Court on behalf of their clients in judicial determination.	IV-E All Child Welfare and State Funds*	Preparation for and participation in judicial determination	\$26,274	\$131,370	4	2
I; Short-Term	SW 2, Supervisors & Others	UNI	SW 072	Testifying in Juvenile Court	Prepares for testifying in judicial determinations for Removal, Adjudicatory, Disposition, and Termination of Parental Rights Hearings. Become familiar with Iowa Code Chapter 232 and IAC Chapter 175 and will practice testifying in a mock Juvenile Court on an actual, de-identified, case.	IV-E All Child Welfare and State Funds*	Preparation for and participation in judicial determination	\$25,272	\$126,360	4	1
I; Short-Term	SW 2 & Supervisors	UNI	SW 073	Permanency and Termination of Parental Rights	Prepares for the goal of family intervention and participation in judicial determinations to see that children grow up in a permanent family environment, either through timely reunification with their parents or placement in a new family	IVE Foster Care & Subsidized Adoption & State Funds*	<ul style="list-style-type: none"> <li>• Preparation for and participation in judicial determination</li> <li>• Placement of the child</li> </ul>	\$1,921	\$9,605	4	1
O; Short-Term	SW 2, 3, Supervisors & Admin	DHS	SW 321	Legislative and Appellate Court Decisions Update	Informs on appellate court decisions that impact child welfare case law, and legislative changes that have affected Iowa code Chapters 232, 235A and 600.	IV-E All Child Welfare and State Funds*	Case management and supervision	\$1,921	\$9,605	1	0.3
O; Short-Term	All Staff	UNI	SW 500	Social Work Ethics	Focuses on case management decision making in the development and implementation of the case plan that is ethical, in the best interest of the family and compliant with <i>NASW Code of Ethics</i> .	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case management and supervision</li> </ul>	\$1,530	\$7,650	1	0.75
O; Short-Term	SW 2, SW 3, Supervisors & Others	UNI	SW 504	Beyond the Basics: Real Life Ethics for the Child Welfare Professional	From a diversity standpoint focus on case management decision making in the development and implementation of the case plan that is ethical and in the best interest of the family.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case management and supervision</li> </ul>	Not offering this year.	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.		

I/O; Short-Term	SW 2, 3 & Supervisors	UNI	SW 505	Changing Faces of Iowa: Culturally Competent Practice with Families & Communities	From a diversity standpoint focus on case management decision making in the development and implementation of the case plan that is culturally sensitive and in the best interest of the family.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Development of the case plan</li> <li>Case Reviews</li> <li>Case management and supervision</li> </ul>	Not offering this year	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.	2	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	DHS	SW 506	Reaching Higher: Increasing Competency in Practice with LGBTQ Youth in Child Welfare Systems"	Identify the needs of children in the LGBTQ population and their families, foster parents and develop appropriate case plans and services.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Development of the case plan</li> <li>Case Reviews</li> <li>Case management and supervision</li> </ul>	Not offering this year	Not sure as this course is not being offered this year but we plan to pick it up again within this reporting period.		
I/O; Short-Term	SW 2, 3, Supervisors & Others	ISU Subcontracted Trainer	SW 507	Race: Power of an Illusion	Join co-workers and colleagues in a day of learning, listening and courageous conversations. Understand how racial/ethnic disparities manifest across a broad spectrum of child and family well-being indicators and the importance of having "courageous conversations" about race, equity, and child welfare.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Development of the case plan</li> <li>Case Management and Supervision</li> </ul>	\$117,883	\$589,415	18-22	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	ISU Subcontracted Trainer	SW 508	Understanding Implicit Bias	Brings together professionals, volunteers, and community members to have conversations about the development and impact of implicit bias – in particular, racial bias. Defined as a learning exchange, rather than as a training, UIB is both a guided educational experience which uses a standard curriculum and a facilitated discussion that encourages and supports participants' active involvement in the learning exchange. A team of intensively-trained facilitators with a background in child and family welfare and a commitment to understanding and reducing implicit bias lead the learning exchange.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Development of the case plan</li> <li>Case Management and Supervision</li> </ul>	\$117,833	\$589,165	18-22	1
O; Short-Term	<ul style="list-style-type: none"> <li>SW 2, 3</li> <li>Community Partnerships</li> <li>DHS Supervisors</li> <li>Current or prospective parents or relative guardians</li> <li>Child care institutions providing care</li> <li>Child welfare agencies providing services</li> <li>Courts</li> <li>Attorneys</li> <li>Guardians ad litem</li> <li>Child welfare community-based programs</li> </ul>	ISU	TBD	Community Partnerships for Protecting Children	<ul style="list-style-type: none"> <li>CAP Meetings</li> <li>Breakthrough Series</li> <li>Collaborative</li> <li>CPPC work</li> <li>Intermediate &amp; Advanced Domestic Violence eLearning</li> </ul>	IV-E All Child Welfare, and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Development of the case plan</li> <li>Case reviews</li> <li>Case Management and Supervision</li> </ul>	\$412,993	\$2,064,965	On-going	TBD

O; Short-Term	Supervisors & Others	DHS	TBD	Supervisory Seminars	Provides multiple offerings on a variety of topics pertinent to child welfare practice from the supervisory perspective.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case Management and Supervision</li> </ul>	\$9,266	\$46,330	6	0.3
I/O; Short-Term	SW 2, 3 & Supervisors	DHS	TBD	Worker Seminaros	Multiple offerings on a variety topics pertinent to child welfare practice	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case reviews</li> <li>• Case Management and Supervision</li> </ul>	\$2,596	\$12,980	8	0.3
I/O; Short-Term	SW 2 & Supervisors & Community Providers	DHS	TBD	CFSR Training	Understand the basic content of the CFSR and develop best practice commitment plan.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case Reviews</li> <li>• Case management and supervision</li> </ul>	\$80,663	\$403,315	16	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	DHS	TBD	Danger Versus Risk	Assure all child welfare stakeholders (court, providers, etc.) are trained on, and able to apply, definitions of "danger" versus "risk" as they pertain to decision-making (including removal and reunification) when work with families, youth, and children.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case Reviews</li> <li>• Case management and supervision</li> </ul>	\$55,389	\$276,945	11	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	DHS	TBD	Engagement	Train DHS staff on the new practice skills assure demonstrated understanding of what it means to "actively engage" parents and children in case planning during routine visits.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Referral to services</li> <li>• Development of the case plan</li> <li>• Case Reviews</li> <li>• Case management and supervision</li> </ul>	\$55,389	\$276,945	11	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	ISU Subcontracted Trainer	TBD	Advanced Microaggressions	Because DHS social workers and supervisors deal with the community on a regular basis, secondary trauma can settle in and lessen tolerance for certain groups. By addressing field exhaustion and the level of compassion toward the work, supervisors can assess the following: <ul style="list-style-type: none"> <li>• what their staff needs</li> </ul>	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>• Development of the case plan</li> <li>• Case Management and Supervision</li> </ul>	\$31,181	\$155,905	6	0.5

I/O; Short-Term	SW 2, 3 & Supervisors	ISU Subcontracted Trainer + DHS	TBD	Problematic Sexual Behavior in Children	1. Increase knowledge of best practices in addressing problematic sexual behavior in children & adolescents for families 2. Increase knowledge of child welfare workers role in addressing problematic sexual behavior in youth 3. Increase knowledge of effective treatment components	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Development of the case plan</li> <li>Case Reviews</li> <li>Case management and supervision</li> </ul>	\$55,389	\$276,945	11	1
I/O; Short-Term	SW 2, 3, Supervisors & Others	DHS	TBD	Safety Assessment and Planning	Train DHS staff on the new practice skills for evidence-based tools and how they inform decision-making, including initial and on-going safety assessment, removal, and writing actionable safety plans consistent with safety expectations.	IV-E All Child Welfare and State Funds*	<ul style="list-style-type: none"> <li>Referral to services</li> <li>Development of the case plan</li> <li>Case Reviews</li> <li>Case management and supervision</li> </ul>	\$55,389	\$276,945	11	1
<b>TOTAL</b>								<b>\$1,722,918</b>	<b>\$8,614,590</b>		
The Funding Sources and Benefitting Program definitions are:											
<ul style="list-style-type: none"> <li>IV-E All Child Welfare refers to courses that are reimbursed at 75% rate with the FY 20 Eligibility Rate of All Child Welfare Programs 73.62% except for those listed below*</li> <li>State Funds refers to the use of State Funds F001 except for those listed below*</li> </ul>											
*Basic Training for Child Protective Workers, only 60% of reimbursable costs are reimbursed at 75% rate with the FY 20 Eligibility Rate of All Child Welfare Programs 73.62%											
*Permanency and Termination of Parental Rights are reimbursed at 75% rate with the FY 20 Eligibility Rate of Foster Family & Subsidized Adoption 76.20%											
*Race: Power of an Illusion and Understanding Implicit Bias are reimbursed at 75% rate with the FY 20 Eligibility Rate of All Child Welfare Programs 73.62% with State Funds F996-02 RPI											
* Community Partnerships for Protecting Children are reimbursed at 75% rate with the FY 20 Eligibility Rate of All Child Welfare Programs 73.62% with State Funds F908 CPPC											

## SW2s and SW2 Supervisors –New Worker Training Plan

Required Coursework				
Completion Timeframe	#	Course	Modality	Hours
Within the 1st month		Pathway to Learning	Online	-
	CC 364	Confidentiality and Dissemination	Recording	1.75
Within the first 3 months	CC 368	ICWA Update	Recording	1
	DS 168	Mandatory Dependent Adult Abuse Reporter Training	Online	2
	DS 169	Mandatory Child Abuse Reporter Training	Online	2
	HS 001	Confidentiality is Key	Online	1
	HS 003	Confidentiality: HIPAA Privacy & Security	Online	1.25
Within the first 6 months	SP 100	Overview of Child Welfare eLearning	Online	2
	SP 105	Substance Abuse eLearning	Online	4.5
	SP 106	Domestic Violence eLearning	Online	2
	SP 107	Impact of Abuse on Child Development eLearning	Online	2
	SP 150	Child Welfare in Iowa	Webinar	4.5
	SP 270	Mental Health Fundamentals	Classroom	6
	SP 309	Domestic Violence Fundamentals	Classroom	6
	SP 310	Substance Abuse Fundamentals	Classroom	6
	SP 311	Trauma Fundamentals	Classroom	6
	SP 312	Medical Fundamentals	Classroom	12
	SP 334	Family Team Decision Making Fundamentals	Classroom	6
	SP 337	Family Interactions Fundamentals	Classroom	6
	SW 020	Foundations of Social Worker 2 Practice	Classroom	42
	SW 071	Legal Aspects of Social Work	Classroom	12
	SW 072	Testifying in Juvenile Court	Classroom	6
Within 12 Months	SW 073	Permanency & Termination of Parental Rights	Classroom	6
	SP 535	Assessing throughout the Case	Classroom	6
	SP 542	Motivational Interviewing	Classroom	6
	SW 500	Social Work Ethics	Webinar	3
	SW 507	Race: The Power of an Illusion	Classroom	5.5
	SW 508	Understanding Implicit Bias	Classroom	6
	New	How to Achieve Best Practice – CFSR	Classroom	6
			<b>Total Hours</b>	<b>170.5</b>

### SW3s and SW3 Supervisor - New Worker Training Plan

Required Coursework				
Completion Timeframe	#	Course	Modality	Hours
Within the 1st month		Pathway to Learning	Online	-
	CC 364	Confidentiality and Dissemination	Recording	1.75
	CC 370	Interview of Alleged Perpetrators During Protective Assessments	Recording	.5
Within the first 3 months	CC 360	Authoring Domestic Violence-Informed Allegations	Recording	1
	CC 368	ICWA Update	Recording	1
	DS 168	Mandatory Dependent Adult Abuse Reporter Training	Online	2
	DS 169	Mandatory Child Abuse Reporter Training	Online	2
	HS 001	Confidentiality is Key	Online	1
	HS 003	Confidentiality: HIPAA Privacy & Security	Online	1.25
First Six Months	CP 200	Basic Training for Child Protective Workers	Classroom	40
	CP 201	Basic Training for <b>Intake Workers Only</b>	Classroom	6
	DA 202	Fundamentals of Dependent Adult Assessments	Classroom	12
	SP 100	Overview of Child Welfare eLearning	Online	2
	SP 105	Substance Abuse eLearning	Online	4.5
	SP 106	Domestic Violence eLearning	Online	2
	SP 107	Impact of Abuse on Child Development eLearning	Online	2
	SP 150	Child Welfare in Iowa	Webinar	4.5
	SP 270	Mental Health Fundamentals	Classroom	6
	SP 309	Domestic Violence Fundamentals	Classroom	6
	SP 310	Substance Abuse Fundamentals	Classroom	6
	SP 311	Trauma Fundamentals	Classroom	6
	SP 312	Medical Fundamentals	Classroom	12
	SP 313	Legal Fundamentals for Child Protective Workers	Classroom	6
	SP 334	Family Team Decision Making Fundamentals	Classroom	6
Within 12 Months	SP 337	Family Interaction Fundamentals	Classroom	6
	SP 535	Assessing throughout the Case	Classroom	6
	SP 542	Motivational Interviewing	Classroom	6
	SW 500	Social Work Ethics	Webinar	3
	SW 507	Race: The Power of an Illusion	Classroom	5.5
	SW 508	Understanding Implicit Bias	Classroom	6
	New	How to Achieve Best Practice – CFRS	Classroom	6
			<b>Total Hours</b>	<b>170</b>

## **MENTORING FRAMEWORK**

### **Overview**

This framework provides a standard definition and a consistent approach to mentoring new child protection workers (CPW) and social work case managers (SWCM) in the Department of Human Services. Field mentoring is being developed to reinforce learning with practice in real life situations. This framework will formalize an informal system that is already in place and improve statewide consistency.

### **Objectives**

- Recognize mentoring as a valued element of the staff development framework
- Ensure mentoring is not confused with, or substituted for, the performance evaluation
- Support and encourage mentoring in staff and team development
- Establish that mentoring relationships are consistent with existing policies on quality, equal opportunity, inclusiveness, code of conduct and privacy
- Identify staff that are willing and able to mentor new employees

### **Recognition of mentoring as a valued element in staff development**

The Department recognizes the value of mentoring skills and encourages mentoring by:

- Providing support to staff who mentor through training from their supervisors on what the role entails
- Providing a service agreement
- Providing a field learning guide that will assist mentors in carrying out the role of mentor
- Providing an assessment tool for discussions on learning
- Acknowledging the workload implications for the mentors by:
  - The supervisor approving a mentee to observe a CPW mentor's assessment interview which includes the mentee taking notes and narrating the interview with the mentor reviewing
  - The supervisor approving up to 10 of the SWCM mentor's cases be "managed" by the mentee with the mentor available to guide the mentee - and the supervisor making final case decisions
  - The supervisor acknowledging the significant individual contributions and good practice in a mentor's annual performance evaluation

### **Relationship of mentoring to staff appraisal and performance management**

- The mentor has no
  - supervisory responsibility or authority over the mentee
  - role in dealing with issues of non-compliance or under-performance
- The mentoring relationship provides a confidential and non-judgmental environment
- The partners in a mentoring relationship are equal within it and share responsibility for the relationship
- Mutual learning is an integral aspect of the mentoring relationship
- The overall developmental needs of the mentee is the main focus within the mentoring relationship
- The mentoring relationship needs to support the integration of the mentee into the local service team

## **Role of Supervisor**

- Nurtures and develops the skills of the staff reporting to them
- Ensures mentoring relationships are consistent with existing policies on quality, equal opportunity, inclusiveness, code of conduct and privacy
- Identify staff that are willing and able to mentor new employees
- Matches the mentor and mentee
- Defines the expectations for the mentoring relationship
- Defines the communication expectations for meeting with mentor and mentee
- Addresses issues of non-compliance and performance
- Identifies and addresses training needs
- Makes final decisions on all cases

### Criteria for Mentor Selection

- Recommend at least two years of experience as a CPW or SWCM, preferably in the location where they are mentoring
- Meets or exceeds expectations in all areas of their performance evaluation
- Demonstrates proficiency in Model of Practice and policy
- Good attendance
- Supervisor approval

### Attributes of Mentor

- Knowledge of co-workers strengths
- Willing to make time and be accessible
- Work experience
- Good relationships with the community
- Respected
- Patient
- Straight-forward communication
- Encouraging and motivating
- Time management skills including completing work timely
- Good understanding of the work culture
- Good listener
- Demonstrates professionalism
- Flexible

### **Role of Mentor**

- Model best practice
- Coach and provide constructive feedback
- Training
- Provide support and encouragement
- Connecting mentee to staff to shadow
- Acclimate to the culture of the team
- Help engage with community partners

### **Role of Mentee**

- Participate in formal mentoring up to 6 months
- Maintain open communication among mentor, mentee, and supervisor
- Take ownership and responsibility for learning
- Be open to ideas and accept feedback
- Actively seek information
- Self-assess practice
- Be punctual and respectful
- Observe various work approaches and integrate into practice what works best for the mentee



**SWCM - Field Experience Learning Guide for New Workers**

Newly hired Social Work Case Managers:

Utilize the Field Experience Learning Guide during the assigned field experience timeframe.

Social Work Supervisor:

Review with staff, sign and date when completed.

**Required Intentional Learning Tasks for New Social Worker II**

<b><u>FACS</u></b>	<b>Date Completed</b>
Review the FACS Blue Sheets and Green Sheet as guidance when shadowing a co-worker entering FACS and/or when making first FACS entries.	
Observe co-workers making entries in FACS, opening case, RELL, SERL, SPIL, FCTL, PAYA.	
Open a case in FACS (complete as many steps in FACS as able to with assistance from supervisor/mentor/co-worker).	

<b><u>Jarvis- initial navigation</u></b>	<b>Date Completed</b>
Observe and discuss navigation of Jarvis – child services section - case narrative, enter child visit, IV-E	
Provider portal	
Relative notices	
Drug testing	
Case plan	
Child abuse report	
CPS assessment	
Alerts	

<b>Jarvis- initial navigation (continued)</b>	<b>Date Completed</b>
My Links in Jarvis connects to Drug Testing, Drug Testing Policies and Protocols, the Safety Plan (in PDF), Care Match, Wellness Check/TOP, CWIS Help Desk and JARVIS System Manual	
Rejected intake on open case	
Discuss how Jarvis communicates with FACS	

<b>Handoff</b>	<b>Date Completed</b>
Review Transfer Packet Face Sheet	
Observe a hand-off between SWIII and SWII.	
Shadow the first meeting between a SWII and the family at handoff and/or complete first meeting with family after receiving handoff.	
Receive first assigned case from CPW via a hand-off.	
Review JARVIS and needed information from intake and assessment with SWIII.	
Observe an initial contact with family by CPW	

<b>FSRP</b>	<b>Date Completed</b>
Observe actions in FACS and JARVIS needed to assign the provider and generate the 3055 authorization of service.	
Observe the process of making a FSRP referral. Discuss what information is included on the referral form, note additional information sent to the FSRP provider, such as additional documentation, reports, etc.	
Discuss expectations of contracts with FSRP (give handout)	

<u>Engagement</u>	Date Completed
Prior to observing the family, ask the mentor how the mentor envisions your role, and what you should do if the family appears uncomfortable with your presence.	
Observe engagement strategies utilized by the worker such as: genuineness, empathy, respect, open ended questions, solution focused, etc.	
Shadow a co-worker engaging a family followed by receiving first case and beginning to practice engagement strategies.	
Demonstrate engagement skills with a family upon receiving a case. Note the listening skills, reflective listening and engagement strategies utilized.	

<u>Monthly Visit &amp; Case Notes</u>	Date Completed
Show local visit template, if used, and/or Jarvis template (domains)	
Observe a SWII using assessment questions with a family to gain information needed.	
Complete a case note regarding a family that addresses safety, permanency, child well-being, academic skill and preparation, and the five functional domains	
Complete case notes in JARVIS using the template in JARVIS. <b>Ask for</b> feedback from co-worker/supervisor regarding case note <b>documentation and level of detail.</b>	
Observe a co-worker utilizing Dragon and discuss other time management strategies.	
Tips and tricks for tracking visits. FACS tip -F7 from main screen – list of all families / kids and dates of last visit. Can print	

<b><u>Safety Assessment &amp; Risk Re-Assessment</u></b>	<b>Date Completed</b>
Observe a co-worker completing a Safety Assessment in JARVIS. Discuss how they came to the conclusion of safe, conditionally safe, or unsafe. When to complete the assessment form: prior to starting unsupervised visits, prior to reunification, prior to case closure, whenever child may be in an unsafe situation.	
Assess for domestic violence, mental health, and substance abuse	
Observe a co-worker completing a Risk Re-Assessment in JARVIS prior to Case Plan Update. Discuss how the tool assisted them in preparing to write the case plan, as well as the final score.	

<b><u>Case Plan</u></b>	<b>Date Completed</b>
Request from supervisor case plans to review (paper file or Jarvis) to help in gaining understanding of what constitutes relevant content, language and structure to provide a reader the salient facts in the family's case.	
Review case plan goals and look for behaviors in those goals. Discuss writing behavioral goals with supervisor. Review example behavioral goals chosen by supervisor.	
If possible, observe co-worker completing FACS entry for INAL (initial case plan) or review/update case plan.	

<b><u>Court</u></b>	<b>Date Completed</b>
Attend as many court hearings as possible during the field learning experience period. If possible, attend a removal hearing, adjudication, disposition, review hearing, and TPR hearing.	
Review court reports written for your area, what is the content, and what is your court requesting, etc.	
Review court documents and note reasonable efforts language. Take note of information documented as reasonable efforts 1 services and reasonable efforts 2 services.	
Preparing for court / testifying (local / service area info)	
Discuss local practice for completing social histories	

<b><u>Electronic Data Management System (EDMS)</u></b>	<b>Date Completed</b>
Observe co-worker utilizing the EDMS filing system.	
Observe and note what documents are used in the EDMS system and how to navigate the system, etc.	
Upload documents in EDMS.	

<b><u>Family Team Decision Making Meeting</u></b>	<b>Date Completed</b>
Observe SW II complete FTDM referral form (discuss junctures – change of placement, LOC change, removal, first 30 days, case closure)	
Attend a FTDM meeting, noting the SWIII and SWII role in the meeting.	

<b><u>Out of Home Placement/Removal</u></b>	<b>Date Completed</b>
Observe a SWIII or SWII completing out of home placement/removal steps including: <ul style="list-style-type: none"> <li>○ relative search,</li> <li>○ relative notices,</li> <li>○ paperwork related to out of home placement,</li> <li>○ FACS screens related to out of home placement,</li> <li>○ other</li> </ul>	
Observe how/who is involved in creating the family interaction plan and how it is carried out.	
TOP	
ESSA	
Transition Planning	
YTDM / Transition Meeting	
Adoption checklist	
Child study	

<b><u>Foster Care</u></b>	<b>Date Completed</b>
Accompany the SWII or SWIII meeting with child/ren in a foster home. Take note of questions covered with foster parents and assessment of safety, stability of placement, in foster care, etc. Ask your mentor or supervisor if you have questions about what you observed or heard.	
Accompany the SWII or SWIII meeting with child/ren in relative placement home or kinship care. Take note of questions covered with caregivers and assessment of safety, stability of placement, in foster care, etc. Ask your mentor or supervisor if you have questions about what you observed or heard.	
Referral to Care match –local practices	

<b><u>Foster Care (continued)</u></b>	<b>Date Completed</b>
Birth Certificate – discuss local practice (out of state / international BC handled by help desk)	
Discuss foster parent support worker's role.	
Discuss how to handle unsafe foster / relative / kinship placement.	

<b><u>Shelter/Psychiatric Medical Institute for Children (PMIC) Placements/Group Care</u></b>	<b>Date Completed</b>
Discuss / review a PMIC referral, steps involved in the referral process. Take notes on the steps involved.	
Discuss / review a group care referral, steps involved in the group care referral.	
If possible, accompany a SWII completing a child visit at shelter, group care, and/or PMIC placement. Learn the names of the shelters/PMIC/Group Care in your area, the placement process, etc.	

<b><u>Case Consultation</u></b>	<b>Date Completed</b>
Observe what the worker did to prepare for the case presentation.	
Attend individual case consultation and/or group supervision. Participate and request clarification, if needed.	
Discuss with the supervisor key areas to be prepared to present/ discuss in group or individual case consultation.	

<b><u>IV-E</u></b>	<b>Date Completed</b>
IPI	
Change form	
Discuss what needs to be uploaded into Jarvis.	

<b><u>General</u></b>	<b>Date Completed</b>
Travel claims	
State cars	
HRIS	
Where to find forms	
What you should have with you /Bag of tricks	
Resource guide	
User shares	
Safe Plan of Care	
Paternity testing	
Court ordered service funding	
After Hours Protocols	

<b><u>Statewide / Local Services</u></b>	<b>Date Completed</b>
DCAT	
Income Maintenance	
Drug testing	
Early Access	
CSRU	
Completing Service Referrals	
ICPC	
Community Care	
Prison Protocol	
Worker Safety - Ask the supervisor or mentor about your safety if the family information relates a past history of aggression toward the department or authority figures.	
New case checklist / other local checklists	
ICWA	
Mexican Consulate	
CAP Team / Safe and Together model – observe a CAP consultation	
Parent Partners – how to refer to PP's	
Family Treatment Court – if applicable, observe FTC	

<b><u>Statewide / Local Services (continued)</u></b>	<b>Date Completed</b>
SO Registry	
DOC Website	
Iowa Courts Online	
Assessor website	
Fed Parent Locator	
Protective child care vs cca	
Many service questions can be answered by accessing the Service Help Desk and CWIS Help Desk in sharepoint: <a href="http://dhssp/fo/fosuhelp/Lists/Service%20Help%20Desk%20Tidbits/AllItems.aspx">http://dhssp/fo/fosuhelp/Lists/Service%20Help%20Desk%20Tidbits/AllItems.aspx</a>	

<b><u>Other service area information</u></b>	<b>Date Completed</b>

Please review your completed checklist with your supervisor and sign.

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DRAFT



**CPW Field Experience Learning Guide For New Workers**

Newly Hired Child Protective Workers:

Utilize the Field Experience Learning Guide by completing the intentional learning tasks. CPW's will cover this material with their mentor and then their supervisor will ensure this has been completed.

Child Protective Worker Supervisor:

Review with staff and date when completed.

**Required Intentional Learning Tasks for New Social Worker III**

<b><u>Intake</u></b>	<b>Date Completed</b>
Review the Child Protective Services Intake forms on cases you have been assigned to shadow.	
The new worker and supervisor will arrange to spend a half day in Des Moines observing the centralized intake team.	
With guidance of mentor, enter an intake, including all system checks (child abuse registry, criminal record, sex offender registry, dependent adult abuse registry). Discuss protection of reporter.	
Only take suppressed intakes into the field, as you do not want to disclose reporter information.	

<b><u>Worker Safety</u></b>	<b>Date Completed</b>
Consider the risk of the situations on cases assigned to you to shadow, discuss with your supervisor.	
Discuss when to request Law Enforcement assistance on cases.	

<b><u>Assessment</u></b>	<b>Date Completed</b>
With mentor's assistance, discuss initial case file set up (paper, service application, safety plan, domain information, etc.)	
Discuss whether confidential access is needed and when it can be utilized.	
Observe an experienced Child Protective Worker engaging with a family and using assessment questions to gain information needed. Take notes, compare documentation and discuss your observations.	
Observe engagement strategies utilized by the worker such as: Genuineness, empathy, respect, open-ended questions, solution-focused questions, etc. when assessing child safety.	
Review assessments in JARVIS to gain an understanding of content, language, safety constructs, etc.	
Review factoring and discuss how to reach conclusions.	
Review Non-custodial parent contact protocol and practice strategies.	
Contact reporter unless not appropriate.	
Observe a co-worker utilizing Dragon and discuss other time management strategies.	
<p>Observe at least one of the following types of assessments:</p> <ul style="list-style-type: none"> <li>○ Denial of Critical Care</li> <li>○ Physical Abuse</li> <li>○ PID</li> <li>○ Sex Abuse</li> <li>○ Dangerous Substance</li> <li>○ Dependent Adult</li> <li>○ Child In Need of Assistance</li> </ul>	
(Requesting medical records, use of CPC, how to take photos, how to document photos)	

<b><u>Assessment (continued)</u></b>	<b>Date Completed</b>
Observe Child Protection Center interview process.	
Work with mentor to approve a drug screen in system.	
Observe a Courtesy Interview	
Accompany a worker to a jail interview	
Discuss ICWA and how this applies to Child Protective cases.	
Discuss when to contact the DHS Service Help Desk and how they can assist on cases.	
Discuss On Call expectations and develop an on call referral book (with area specific resources).	
Discuss protocols for cases involving facilities or in out of home settings.	

<b><u>Safety Assessment</u></b>	<b>Date Completed</b>
Observe a co-worker completing an initial and subsequent Safety Assessment in JARVIS. Discuss how they came to the conclusion of safe, conditionally safe, or unsafe.	
Observe the development of a safety plan if a child is determined to be conditionally safe and what information should be included and possibility of safety services.	

<b><u>Risk Assessment</u></b>	<b>Date Completed</b>
Observe a co-worker completing a Risk Assessment in JARVIS. Discuss how the tool assisted them in determining the disposition of the case.	
Complete a Risk Assessment on a case you have shadowed and compare this to the worker's completed risk assessment.	

<b><u>Service Referral</u></b>	<b>Date Completed</b>
Observe the process of making a service referral to an FSRP/SAFE provider. Review the information included on the referral form, note additional information sent to the FSRP provider such as additional documentation, reports, etc.	
Observe the process of making a Community Care referral. Observe the discussion of the program with the family, note the information included in the assessment when making a referral, as well as the information sent to the provider.	
Discuss any service referral needs for the case.	

<b><u>Court</u></b>	<b>Date Completed</b>
Attend as many court hearings as possible during the field learning experience period. If possible, attend a removal hearing, adjudication, disposition, and a review hearing.	
Observe a co-worker utilizing the EDMS filing system, including searching for court orders. Observe and note which documents are used in the EDMS system.	
Discuss Emergency Removal Process/VPA for your area. Gather all necessary supporting documents for removal, gather all contact information for during work hours and after hours.	

<b><u>JARVIS</u></b>	<b>Date Completed</b>
Observe a co-worker entering case information into JARVIS to complete Family Assessment, Child Protective Assessment, Child in Need of Assistance Assessments, Dependent Adult Assessment.	

<b><u>Handoff/Transfer Process</u></b>	<b>Date Completed</b>
Review Transfer Packet Process and discuss utilizing the form.	
Observe a hand off between a SW III and SW II and discuss the timeframes on when this occurs.	

<b><u>Family Team Decision Making Meeting</u></b>	<b>Date Completed</b>
Observe an FTDM meeting and discuss local practice for SW III.	

<b><u>Out of Home Placement</u></b>	<b>Date Completed</b>
Observe a SWIII completing out of home placement/removal steps including: <ul style="list-style-type: none"> <li>○ relative search</li> <li>○ relative notices</li> <li>○ paperwork related to out of home placement</li> <li>○ FACS screens related to out of home placement</li> <li>○ IV-E</li> <li>○ TOP</li> <li>○ ESSA</li> <li>○ Rights of Youth</li> <li>○ Financial Assistance for Caregivers</li> </ul>	

<b><u>Out of Home Placement (continued)</u></b>	<b>Date Completed</b>
Observe creation and implementation of a family interaction plan.	
Observe making a referral for placement to foster care (CareMatch) or shelter.	
Observe a SWIll making a placement.	

<b><u>Case Consultation</u></b>	<b>Date Completed</b>
Discuss key areas to be prepared to present/discuss in group or individual case consultation.	
Observe individual case consultation and/or group supervision.	

<b><u>Tasks to be Completed Once a Family Assessment is Assigned (Review with Mentor and Supervisor must be briefed.)</u></b>	<b>Date Completed</b>
Review the Child Protective Services Intake form on the case assigned to you and discuss with mentor, emphasizing the critical information to review. For example, the Additional Information Section and review DHS history. Follow Supervisor Direction on first case.	
Send Parental Notification. Work with your supervisor or an assigned staff to send the Parental Notification within five working days to all custodial and non-custodial parents of all alleged victims. Document the notification as well as efforts to identify non-custodial parents and discuss with your supervisor.	
Consider the risk of the situation on your Family Assessment assigned case before making initial contact with the family.	
Contact reporter and gather any police report/medical report necessary.	
Complete timely contact with the child/family and clearly document reasonable efforts to see children within assigned timeframes.	

<b><u>Tasks to be Completed Once a Family Assessment is Assigned (Review with Mentor and Supervisor must be briefed.) (continued)</u></b>	<b>Date Completed</b>
Complete the home visit. Interview household members and observe all child subjects required for a Family Assessment. Clearly document the evaluation of the home environment where the child's safety was assessed. Gather domain information.	
Complete an initial Safety Assessment on the assigned family within the appropriate time-frames.	
Present this case to your Supervisor to determine safety decision. Utilize your Safety Constructs.	
Assess any need for reassignment to Child Protective Assessment.	
Offer/conduct interview with the alleged person responsible. Clearly document interviews that were offered / conducted with all alleged persons responsible.	
Contact/interview all necessary collaterals and non-custodial parents. Clearly document contact and interview every collateral who may be able to contribute credible/relevant information. Document contact and interview non-custodial parents, including incarcerated parents.	
Complete a Risk Assessment in JARVIS on your assigned Family Assessment. Discuss how the tool assisted you in determining the recommendations of the case with your supervisor.	
Complete Additional Process Information.	
Utilize JARVIS to enter assessment information on your case.	

<b><u>Service Area Tasks:</u></b>	<b>Date Completed</b>
Meet all Community Partners- <ul style="list-style-type: none"> <li>○ Law Enforcement</li> <li>○ Court partners</li> <li>○ CPC</li> <li>○ Drug testing</li> <li>○ Domestic violence advocates</li> <li>○ schools</li> <li>○ others</li> </ul>	

Please review your completed checklist with your supervisor and sign and date.

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_