ADMINISTRATION FOR
CHILDREN & FAMILIES
Administration on Children, Youth & Families | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/acyf

September 28, 2023

Kelly Garcia
Director
Iowa Department of Health and Human Services
1305 East Walnut
Des Moines, Iowa 50319

Dear Director Garcia:

Thank you for submitting Iowa's Annual Progress and Services Report (APSR), including the annual report on the use of funds under the Child Abuse Prevention and Treatment Act, and the CFS-101 forms requesting funding for fiscal year (FY) 2024 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 (MaryLee Allen 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 state child welfare agencies ensure safety, permanency, and well-being for children, youth and their families. The APSR facilitates continued assessment, development, 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 use of federal funds with its work relating to the Child and Family Services Reviews and continuous program improvement activities to ensure better, more equitable outcomes for all children, youth and families.

Approval
The Children's Bureau (CB) has reviewed your APSR for FY 2024 and the annual report on the use of CAPTA funds and finds they comply with applicable federal statutory and regulatory requirements. Therefore, we approve FY 2024 funding for the programs listed above. For the Chafee program, your state has elected to serve eligible youth up to age 23.

Counter-signed copies of the CFS-101 forms are enclosed for your records.

The Administration for Children and Families' Office of Grants Management (OGM) will issue a grant notification award letter with pertinent grant information, which will be sent to the email

address listed on the FY 2024 CFS-101s. 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
This approval for the FY 2024 funding for title IV-B, subpart 1; title IV-B, subpart 2; CAPTA; Chafee; and ETV programs 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 2023 caseworker visit data must be submitted to the Regional Office by December 15, 2023. 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 Kendall Darling, Child Welfare Regional Program Manager in Region 7, at (816) 426-2262 or by e-mail at kendall.darling@acf.hhs.gov. You also may contact Amy Hance, Child and Family Program Specialist, at (816) 426-2230 or by e-mail at amy.hance@acf.hhs.gov.

Sincerely,

Aysha E. Schomburg, Esq.
Associate Commissioner
Children's Bureau

Enclosure(s)

cc: Gail Collins, Director; CB, Division of Program Implementation; Washington, DC
Kendall Darling, Child Welfare Regional Program Manager; CB, Region 7; Kansas City, MO
Amy Hance, Child and Family Program Specialist; CB, Region 7; Kansas City, MO
Lori Frick, Child Protective Services Director, IA DHHS; Des, Moines, IA
Dawn Kekstadt, Bureau Chief of Child Welfare and Community Services, IA DHHS; Des Moines, IA
Erica Wenzl, IV-B Program Manager, IA DHHS; 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 2024: October 1, 2023 through September 30, 2024

1. Name of State or Indian Tribal Organization AND Department/Division:		**3. EIN:**	1-426004568-A7
Iowa	Health and Human Services / Fiscal Management	**4. UEI:**	Q7P9B28J8BY4
2. Address: (insert mailing address for grant award notices in the two rows below)			
321 E. 12th St. Des Moines, IA 50319		**5. Submission Type:** (mark X next to option)	
		- New	X
a) **Contact Name and Phone** for Questions:	David Philmon, Jr 404-345-1088	- Reallotment	
b) **Email address** for grant award notices:	dphilmo@dhs.state.ia.us		

REQUEST FOR FUNDING for FY 2024:

The annual budget request demonstrates a grantee's application for funding under each program and provides estimates on the planned use of funds. Final allotments will be determined by formula.

Hardcode all numbers; no formulas or linked cells.

6. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:		$2,908,033
a) Total administrative costs (not to exceed 10% of the CWS request)		$286,000
7. Requested title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds and estimated expenditures:	**% of Total**	$2,396,037
a) Family Preservation Services	3.0%	$71,529
b) Family Support Services	20.6%	$493,916
c) Family Reunification Services	28.1%	$672,831
d) Adoption Promotion and Support Services	20.0%	$479,363
e) Other Service Related Activities (e.g. planning)	20.9%	$499,690
f) Administrative Costs (*STATES: not to exceed 10% of the PSSF request; TRIBES: no maximum %)*	7.5%	$178,708
g) Total itemized request for title IV-B Subpart 2 funds: NO ENTRY: Displays the sum of lines 7a-f.	100.0%	*$2,396,037*
8. Requested Monthly Caseworker Visit (MCV) funds: *(For STATES ONLY)*		$151,456
a) Total administrative costs (not to exceed 10% of MCV request)		$0
9. Requested Child Abuse Prevention and Treatment Act (CAPTA) State Grant: (*STATES ONLY*)		$945,386
10. Requested John H. Chafee Foster Care Program for Successful Transition to Adulthood: (Chafee) funds:		$1,462,460
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of Chafee re quest).		$35,000
11. Requested Education and Training Voucher (ETV) funds:		$487,159

REALLOTMENT REQUEST(S) for FY 2023:

Complete this section for adjustments to current year awarded funding levels. This section should be blank for any "NEW" submission.

12. Identification of Surplus for Reallotment:

a) Indicate the amount of the State's/Tribe's FY 2023 allotment that will not be utilized for the following programs:

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$0		$0

13. Request for additional funds in the current fiscal year (should they become available for re-allotment)**:**

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$0		$0

14. Certification by State Agency and/or Indian Tribal Organization:

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, Chafee 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.

Signature of State/Tribal Agency Official		***Signature of Federal Children's Bureau Official***
Jess Benson Digitally signed by Jess Benson Date: 2023.08.03 12:31:48 -05'00'		Joseph Bock for Aysha E. Schomburg
Title Chief Financial Officer		***Title***
Date 08/3/2023		***Date*** 9/28/2023

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

Name of State or Indian Tribal Organization: Iowa

For FY 2024: OCTOBER 1, 2023 TO SEPTEMBER 30, 2024

No entry required in the black shaded cells

SERVICES/ACTIVITIES	(A) IV-B Subpart 1-CWS	(B) IV-B Subpart 2-PSSF	(C) IV-B Subpart 2-MCV	(D) CAPTA	(E) CHAFEE	(F) ETV	(G) TITLE IV-E	(H) STATE, LOCAL, TRIBAL, & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served (narrative)	(L) Geographic Area To Be Served
1.) PROTECTIVE SERVICES	$ -			$ 945,386				$ 33,696,441	N.A	1309 / month	Reports of Abuse/Neglect	'statewide
2.) CRISIS INTERVENTION (FAMILY PRESERVATION)	$ 725,863	$ 71,529		$ -				$ 2,710,976	N.A	432 / month	Families and Children	'statewide
3.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	$ -	$ 493,916		$ -				$ 68,023,855	N.A	21,920 / month	Families and Children	'statewide
4.) FAMILY REUNIFICATION SERVICES	$ 972,297	$ 672,831		$ -				$ 10,614,200	N.A	8585 / month	Families and Children	'statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES	$ -	$ 479,363						$ 4,397,083	N.A	N.A	Adoptive Families	'statewide
6.) OTHER SERVICE RELATED ACTIVITIES (e.g. planning)	$ -	$ 499,690						$ 953,631	N.A	N.A	N.A	'statewide
7.) FOSTER CARE MAINTENANCE: (a) FOSTER FAMILY & RELATIVE FOSTER CARE	$ 724,000						$ 5,000,784	$ 23,356,334	1476 / month	N.A	All Eligible Children	'statewide
(b) GROUP/INST CARE	$ 199,873						$ 483,817	$ 111,878,381	1783 / month	N.A	All Eligible Children	'statewide
8.) ADOPTION SUBSIDY PYMTS.	$ -						$ 45,725,576	$ 32,051,049	9815 / month	N.A	All Eligible Children	'statewide
9.) GUARDIANSHIP ASSISTANCE PAYMENTS	$ -						$ 121,176	$ 449,221	64 / month	N.A	All Eligible Children	'statewide
10.) INDEPENDENT LIVING SERVICES	$ -				$ 1,462,460			$ 3,124,363	444 / month	N.A	-Eligible Youth	'statewide
11.) EDUCATION AND TRAINING VOUCHERS	$ -					$ 487,159		$ 155,282	133 / month	N.A	-Eligible Youth	'statewide
12.) ADMINISTRATIVE COSTS	$ 286,000	$ 178,708	$ -				$ 7,297,410	$ 11,242,380				
13.) FOSTER PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 3,096,062	$ 4,443,747				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ 3,020,496	$ 4,368,903				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	$ -						$ 1,016,243	$ 4,174,171	N.A	1541 / month	Eligible Families	'statewide
16.) STAFF & EXTERNAL PARTNERS TRAINING	$ -	$ -		$ -	$ -	$ -	$ 856,727	$ 598,316				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	$ -	$ -	$ 151,456				$ -	$ 211,743				
18.) TOTAL	$ 2,908,033	$ 2,396,037	$ 151,456	$ 945,386	$ 1,462,460	$ 487,159	$ 66,618,291	$ 316,450,076				
19.) TOTALS FROM PART I	$2,908,033	$2,396,037	$151,456	$945,386	$1,462,460	$487,159						
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 $0.00 in Row 20, adjust amounts on either Part I or Part II. red value in parentheses ($) means Part II exceeds the amount on Part I.)

21.) Population data required in columns I - L can be found: (mark X below the option)

On this form	In the APSR Narrative
	X

CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Program, and Education And Training Voucher

Reporting on Expenditure Period For Federal Fiscal Year 2021 Grants: October 1, 2020 through September 30, 2022

No entry required in the black shaded cells

1. Name of State or Indian Tribal Organization:	**2. Address:**				**3. EIN: 1-426004568-A7**
Iowa	321 E. 12th St. Des Moines, IA 50319				**4. UEI: Q7P9B28J8BY4**
5. Submission Type: (type New or Revision) New	0				

Description of Funds	**(A) Actual Expenditures for FY 21 Grants** (whole numbers only)	**(B) Number Individuals served**	**(C) Number Families served**	**(D) Population served** (narrative)	**(E) Geographic area served**
6. Total title IV-B, subpart 1 (CWS) funds:	$ 2,865,189	8,709	8,427	eligible children & families	statewide
a) Administrative Costs (not to exceed 10% of CWS allotment)	$ 150,000				
7. Total title IV-B, subpart 2 (PSSF) funds: Tribes enter amounts for Estimated and Actuals, or complete 7a-f.	$ 2,512,330	53,081	8,430	eligible children & families	statewide
a) Family Preservation Services	$ 75,000				
b) Family Support Services	$ 517,888				
c) Family Reunification Services	$ 705,487				
d) Adoption Promotion and Support Services	$ 502,629				
e) Other Service Related Activities (e.g. planning)	523943				
f) Administrative Costs *(FOR STATES: not to exceed 10% of PSSF spending)*	$ 187,383				
g) Total title IV-B, subpart 2 funds: NO ENTRY: This line displays the sum of lines a-f.	*$ 2,512,330*				
8. Total Monthly Caseworker Visit funds: *(STATES ONLY)*	$ 158,807				
a) Administrative Costs *(not to exceed 10% of MCV allotment)*					
9. Total Chafee Program for Successful Transition to Adulthood Program (Chafee) funds: *(optional)*	$ 1,777,654	2,764	-	eligible youth	statewide
a) Indicate the amount of allotment spent on room and board for eligible youth *(not to exceed 30% of Chafee allotment)*	$ 36,683				
10. Total Education and Training Voucher (ETV) funds: *(Optional)*	$ 594,311	137	-	eligible youth	statewide

11. Certification by State Agency or Indian Tribal Organization : 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.

Signature of State/Tribal Agency Official		***Signature of Federal Children's Bureau Official***	
Jess Benson Digitally signed by Jess Benson Date: 2023.08.03 12:31:27 -05'00'		Joseph Bock for Aysha E. Schomburg	
Title	***Date***	***Title***	***Date***
Chief Financial Officer	08/3/2023		9/28/2023

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 2024: October 1, 2023 through September 30, 2024

1. Name of State or Indian Tribal Organization AND Department/Division:		**3. EIN:**	1-426004568-A7
IOWA		**4. UEI:**	Q7P9B28J8BY4
2. Address: (insert mailing address for grant award notices in the two rows below)			
		5. Submission Type: (mark X next to option)	
321 E. 12th St. Des Moines, IA 50319		- New	
a) **Contact Name and Phone** for Questions:	David Philmon, Jr 404-345-1088	- Reallotment	X
b) **Email address** for grant award notices:	dphilmo@dhs.state.ia.us		

REQUEST FOR FUNDING for FY 2024:

The annual budget request demonstrates a grantee's application for funding under each program and provides estimates on the planned use of funds. Final allotments will be determined by formula.

Hardcode all numbers; no formulas or linked cells.

6. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:		$0
a) Total administrative costs (not to exceed 10% of the CWS request)		$0
7. Requested title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds and estimated expenditures:	**% of Total**	$0
a) Family Preservation Services	#DIV/0!	$0
b) Family Support Services	#DIV/0!	$0
c) Family Reunification Services	#DIV/0!	$0
d) Adoption Promotion and Support Services	#DIV/0!	$0
e) Other Service Related Activities (e.g. planning)	#DIV/0!	$0
f) Administrative Costs (*STATES: not to exceed 10% of the PSSF request; TRIBES: no maximum %)*	#DIV/0!	$0
g) Total itemized request for title IV-B Subpart 2 funds: NO ENTRY: Displays the sum of lines 7a-f.	#DIV/0!	*$0*
8. Requested Monthly Caseworker Visit (MCV) funds: *(For STATES ONLY)*		$0
a) Total administrative costs (not to exceed 10% of MCV request)		$0
9. Requested Child Abuse Prevention and Treatment Act (CAPTA) State Grant: (*STATES ONLY*)		$0
10. Requested John H. Chafee Foster Care Program for Successful Transition to Adulthood: (Chafee) funds:		$0
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of Chafee request).		$0
11. Requested Education and Training Voucher (ETV) funds:		$0

REALLOTMENT REQUEST(S) for FY 2023:

Complete this section for adjustments to current year awarded funding levels. This section should be blank for any "NEW" submission.

12. Identification of Surplus for Reallotment:

a) Indicate the amount of the State's/Tribe's FY 2023 allotment that will not be utilized for the following programs:

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$0		$0

13. Request for additional funds in the current fiscal year (should they become available for re-allotment)**:**

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$366,992		$151,459

14. Certification by State Agency and/or Indian Tribal Organization:

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, Chafee 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.

Signature of State/Tribal Agency Official		***Signature of Federal Children's Bureau Official***
Title Chief Financial Officer		***Title***
6/28/2023		
Date		***Date***

STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

FFY 2024

Annual Progress and Services Report (APSR)

June 2023

IOWA
HHS

FFY 2024

Annual Progress and Services Report (APSR)

STATE OF IOWA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FAMILY WELL-BEING AND PROTECTION

CONTACT PERSON

Name: Erica Wenzl, MPA
Title: Federal Programs Program Manager
Address: Iowa Department of Health and Human Services
Division of Family Well-Being and Protection
Hoover State Office Building – 5th Floor
1305 E. Walnut Street
Des Moines, IA 50319
Phone: 515-377-0334
E-Mail: ewenzl@dhs.state.ia.us

Once approved by the Federal Children's Bureau, the Iowa Department of Health and Human Services will post the approved FFY 2024 Annual Progress and Services Report (APSR), with attachments to the Iowa Department of Health and Human Services' website, https://dhs.iowa.gov/reports/child-and-family-services-plan.

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Section 1: Collaboration

Provide an update on how the state agency has engaged in substantial, ongoing and meaningful consultation and collaboration with families, children, youth, Tribes, and 13 other system partners in the implementation of the 2020-2024 CFSP and subsequent APSRs (45 CFR 1357.16(a)). Provide information on how the agency ensured that the engaged communities represented the racial diversity of the families and youth/young adults being served and how the state included those who have been historically underserved or marginalized, and those adversely affected by persistent poverty and inequality in the child welfare system.

Examples of system partners include: frontline workers, the CBCAP lead agency and other prevention partners, such as Children's Trust Funds; the CJA grantee, service providers, faith-based and community organizations; kinship navigator programs; and representatives of state and local agencies administering other federal or federally assisted programs serving children and families, such as Head Start, child care, Temporary Assistance for Needy Families (TANF) and state and local education agencies.

As outlined in ACYF-CB-IM-19-03, parent, family, and youth/young adult voice is critical to understanding how well the child welfare system is achieving its goals. In support of this goal, in the 2024 APSR, specify how families, children, youth, and young adults; Tribes; courts; and other system partners were involved in:

o Assessment of agency strengths and areas needing improvement including those identified from the Statewide Data Indicators and Supplemental Context Data in the "Update to the Assessment of Current Performance in Improving Outcomes," Section C2.

o Review and modification of the Goals, Objectives, and Interventions in the "Update to the Plan for Enacting the State's Vision," Section C3, based on available data and information; and

o Monitoring of CFSP progress including the "Update on Progress Made to Enact the State's Vision," Section C3.

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

Child and Family Services Review (CFSR)

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

- *Attachment 3A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of June 30, 2022*
- *Section III, Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Updated Progress Made to Improve Outcomes, Progress Benchmarks*, later in this report.

Collaboration with Other Partners

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

- *Section V, Updates Services Descriptions, Parent Partners*
- *Section V: Updated Services Descriptions, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) (section 477 of the Act).*
- *Section VI: Consultation and Coordination between States and Tribes, Discussions with Meskwaki Nation and Discussion with Nebraska Tribes*

Additional Collaboration

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

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

The annual statewide meeting did not occur for SFYs 2020, 2021, and 2022 due to the impact the coronavirus pandemic had on the ability to have large group gatherings. During this time, efforts focused on adjusting the information sharing process in other joint HHS and child welfare services contractor meetings to continue to strengthen relationships and to identify initiatives and activities across the service array that may improve child welfare outcomes. The annual statewide meeting will not occur again this SFY 2023. Instead, during the month of September, which is National Child Welfare Workforce Development Month, there will be meetings held in each Service Area which will focus on relationship building. The objective of the meetings will be to create stronger community partnerships between HHS and provider leadership.

Child Welfare Partners Committee (CWPC): The Child Welfare Partners Committee (CWPC) exists because both public and private organizations recognize the need for a strong partnership. It sets the tone for collaborative public/private workgroups and ensures coordination of messages, activities, and products with those of other stakeholder groups. The CWPC promotes, practices, and models the way for continued collaboration and quality improvement. The vision of the CWPC is the combined experience and perspective of public and private organizations to provide the best opportunity to reach our mutual goals: child safety, permanency, and well-being for Iowa's children and families. The CWPC unites individuals from Iowa and private organizations to create better outcomes for Iowa's children and families.

Through collaborative public and private efforts, a more accountable, results-driven, high quality, integrated system of contracted services has been created that supports achieving results consistent with federal and state mandates and the Child and Family Services Review (CFSR) outcomes and performance indicators. The committee serves as the State's primary vehicle for discussion of current and future policy/practice and fiscal issues related to contracted services. The committee proposes, implements, evaluates, and revises new collaborative policies and/or practices to address issues identified in committee discussions. Both the public and private child welfare organizations have critical roles to play in meeting the needs of Iowa's children and families. A stronger public-private partnership is essential to achieve positive results. The committee meets on a regular basis throughout the year. Other means of communication regarding statewide initiatives and progress have been built out to fill the void left by the statewide meeting. There are service area all-contractor meetings where information regarding statewide initiatives is shared.

During the period of April 2022 - April 2023, members of the CWPC utilized a Results-Based Conversation approach to identify gaps in services, policies, and communication and then collectively work toward an outcome to address those concerns.

The CWPC focused on two primary project areas. These included:

- CWPC membership
- HHS realignment

CWPC members had several in-depth discussions regarding CWPC membership needs. Members considered current needs in order to balance regional leadership and members from across the entire child welfare service continuum. Several new members joined the committee over the last year, including the Director of Juvenile Court Services, the Cultural Equity Statewide Coordinator, the President & CEO of Four Oaks, and the Supervisor of Program Support Services at Boys Town in the Western Service Area.

CWPC members have had conversations about data/accountability amongst providers including discussing the Family Centered Services (FCS) dashboard and the future state of such dashboards for other providers. Providers indicated that they were fearful that accurate data may not be reflected, however they are willing to take accountability on areas that need improvement. HHS leadership shared that the data pulls would occur the week following the first Friday of each month to allow for HHS system processes to run prior to data pulls for the FCS Provider dashboard. The dashboard includes Key Performance Measures (KPI) and Continuous Quality Improvement (CQI) measures. There are on-site audits pulling random cases. FCS Providers are able to do their own review which will give them an opportunity to talk with other providers about areas they are doing well in and what is working for them.

The implications of the CCWIS project (VISION) on providers was a topic of discussion and providers were given a presentation on the system. Providers will be expected to enter their documentation directly into the VISION system.

Members have discussed the state of residential care and acuity needs of youth. Members have also discussed the importance of establishing service area standing meetings that are more standardized. The HHS realignment has been a topic of conversation during each CWPC meeting over the last year. Providers were able to view the new Table of Organization charts during CWPC meetings. Providers were also given the opportunity to give input on Service Area changes. Positive feedback was received regarding the new leadership positions that were created as well as the service area changes.

Expected projects moving forward include:

- Plan the agenda items for the Service Area meetings to be held in September during National Child Welfare Workforce Development Month.
- HHS realignment and Service Area changes

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

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

Recruitment, Retention, Training and Supports (RRTS)

RRTS Contractors, Four Oaks Family Connections and Lutheran Services in Iowa, recognize the importance of engaging families, youth, community organizations and other state contractors to work together in addressing the safety, well-being and permanency needs of the children in the child welfare system. Lutheran Services in Iowa is the contractor for the Western Service Area – Service Area 1 (SA1) of the state and Four Oaks Family Connections is the contractor for the other four service areas: Northern Service Area (SA2), Cedar Rapids Service Area (SA3), Eastern Service Area (SA4), and Des Moines Service Area (SA5).

They engage Iowa foster, adoptive and kinship providers by providing direct service in their homes for licensing and support, having monthly contact at a minimum for all licensed foster homes. These contacts include face-to-face and virtual meetings in their homes, as well as additional face-to-face or virtual contacts at support group meetings and trainings. Resource families are additionally engaged with their support caseworkers by using the methods determined to be most convenient for that specific family. Those may include e-mails, phone contacts or messaging.

Support Caseworkers assist resource families (as needed) in connecting with schools to help with schedules and in helping to educate school personnel about trauma or help with communication. When the Resource Families need further assistance with childcare resources, the Support Caseworkers assist in coordinating with the Child Resource and Referral Centers. They have also reached out to childcare centers to help find a spot for a child and helped childcare providers with some behaviors or triggers they may be having with a child at the center.

RRTS providers partnered with the Agency to consider the best way to introduce biological parents and foster parents immediately after a child is placed in the foster home. Ultimately, it was determined that the best way to facilitate better interactions between biological and foster parents was through the implementation of Bridge Meetings. The goal of these meetings is to facilitate a structured and safe introduction that helps for future communication and collaboration in the interest of supporting the child. It was ultimately determined that RRTS personnel would not have a direct role in the meetings, but the input of the RRTS providers was helpful in developing the model for the meetings.

The Bridge Meetings/Comfort Calls were a collaboration between HHS and RRTS staff with a mutual goal of helping to meet the basic needs of youth and families during the transition into foster care. This initiative is another example of the critical collaboration between HHS and RRTS in strengthening the service delivery, communication/feedback loops, and the development of trainings and initiatives.

Iowa Health and Human Services has placed a particular emphasis on teaching and promoting Safe Sleep practices across the state. The Agency has pulled together and conducted a working group of diverse professionals and stakeholders to create and implement Safe Sleep training opportunities, culturally and linguistically appropriate materials promoting Safe Sleep practices, and to identify specific guidance and standards for Resource Families and childcare providers. Four Oaks Family Connections and Lutheran Services in Iowa staff have participated in this collaborative project since its inception. HHS has

developed a Tool Kit that has been shared with RRTS providers to share as they work to support resource families.

Resource Family Advisory Council: Iowa Health and Human Services is keenly aware of the importance of hearing foster/adoptive family voice as Iowa's child welfare system continues to evolve in its efforts to improve policy (legislation and rules), practice (how legislation and rules are implemented), and the lived experiences of birth families, children, resource families, and child welfare professionals. Therefore, HHS made the decision to put together a Resource Family Advisory Council who will work with HHS leadership, child welfare professionals, and the general public to offer advice, suggestions, and serve as the voice of the Resource Families across Iowa.

Foster and adoptive parents have first-hand experience of the effects of foster care laws, policies and procedures, recruitment and retention, and foster parent support. Advisory groups are a vehicle for foster parents to be active participants in policy development and refinement at the agency as well as legislative level. This council's purpose is also to provide regular input regarding the needs and concerns of foster families as well as recommendations of actions that can be taken to meet the needs and concerns to Iowa Health and Human Services (HHS) and the current Recruitment, Retention, Training, and Support (RRTS) provider.

Members are to consider participation as a minimum with a one-year time commitment, bi-monthly phone/Zoom conference calls, and follow up time to volunteer to research items requested. The advisory council group was developed to be diverse and represent all areas of foster/adoptive/kin care. Urban and rural, seasoned and new, and culture/families of color/LGBTQI+ and disabilities were also considered.

The Foster Advisory Council of Iowa currently has 15 members and has already been consulted on issues involving new amendment language for a Foster Parent Bill of Rights, two documents from the Psychotropic Medication Advisory Committee regarding a one pager on psychotropic medications and Iowa Informed Consent document, as well as Iowa administrative rules that were moving through the legislative process.

RRTS, HHS, and Resource Families: Over this previous year there has been an increased level of collaboration and partnership between the RRTS Contractor, the Agency, and Resource Families. Agency leadership partnered with Judicial system leadership to conduct in-person and virtual "listening sessions" in multiple locations around the state. Contractors, Resource Families, Providers, and Stakeholders were invited to attend and share their ideas, experiences, concerns, and suggestions. This intentional demonstration of public/private partnership prefaced a waterfall of collaboration opportunities at every level of the child welfare system. For example, during the 2022 Summer Listening Sessions with Chief Justice Christensen and Director Garcia, Resource Families, providers, and other stakeholders expressed concerns regarding childcare availability and a cumbersome multi-step reimbursement system which inhibited Resource Families from accepting child-care aged children into their homes. This issue had already been elevated to HHS Leadership via the Foster Squad and as a result, the Agency made significant changes internally and with the Iowa Legislature to improve Resource Family access and funding to state licensed or registered childcare providers. More information on the issues and changes that were made can be found later in this section.

Relative/Kinship Caregivers: A key priority for collaborations focused on Relative/Kinship Caregivers. Four Oaks Family Connections and Lutheran Services in Iowa personnel met monthly with agencies/organizations providing Kinship Navigator services, a voluntary participation program offering Relative/Kinship Caregivers who have children placed with them a Navigator to provide information, support, and referrals to stabilize the placement. While providing this service, the RRTS provider works with the Relative/Kinship Caregivers to encourage them to become licensed foster care providers, or to assist them in engaging with the initial home study evaluation process to obtain an adoption approval. Meetings between Four Oaks Family Connections, Lutheran Services in Iowa, and Kinship Navigators are utilized to trouble-shoot problems or barriers with the process to licensure/approval and to discuss specific Caregiving families and the supports/resources they will likely need.

LSI RRTS continues to have Western Iowa Kinship Service monthly meetings with the Kinship Navigators, FCS (Family Centered Service) supervisors, RRTS Kinship Intake specialist, RRTS supervisors and the HHS Program Managers. The Kinship Navigators and Family Centered Service providers in Western Iowa are Boystown and Family Access Center. These meetings continue to keep the communication open and results in strong communication and teamwork in helping kinship caregivers proceed towards licensing. A focus on assisting kinship families through the completion of the orientation packets by working with the Kinship Navigators and follow up with RRTS caseworkers in the area where the family resides has been helpful.

A key component of this success has been the partnership between the Kinship Navigators and the RRTS Kinship intake worker. When the Navigator service is implemented prior to RRTS Kinship Licensing referral being sent there is a natural and more comfortable transition of services. The Navigator also helps pave the way so that it doesn't feel like RRTS is making a "sales pitch" when the benefits of licensing are being discussed and explored.

In Western Iowa, a specific Kinship Intake Specialist position was developed in July 2021 allowing for a relationship to be developed with HHS workers as well as the Kinship Navigators. The intake specialist schedules kinship orientations and is also willing to travel to meet families for the kinship orientation as needed if they do not have internet access or ability to get on Zoom. The process to collect the initial orientation paperwork has improved as we utilize staff in the area to help gather the paperwork. As kinship services continue to grow, it is evident that having a consistent RRTS Kinship intake staff to help them families smoothly proceed from the point of inquiry, to completing paperwork, to starting their home study is important.

The Kinship Navigator/RRTS meetings have also been beneficial in re-establishing ongoing communication with Family Centered Service Contractors from Boystown and Family Access Center. As a result, collaborative efforts in providing ongoing training for foster parents was able to be established during FY23 and training to Resource families and RRTS staff on Strength Based Services and Family Centered Services was able to be provided. Ongoing communication between RRTS providers and Family Centered Service providers is beneficial and is emphasized as an ongoing component to betters serve resource families. Informal staffing/ meetings between RRTS Support Caseworkers and Family Centered Service staff help ensure that the child and family's needs are met with resource family involvement. When needed RRTS staff includes the family centered service worker in the stability staffing's to address what accommodations and efforts can be made to help maintain a child's foster care

placement and create an environment of stability for the child until reunification or permanency is possible.

Four Oaks Family Connections: Other valuable collaborations exist between Four Oaks Family Connections and shelter providers throughout the state. Four Oaks Family Connections team members have begun to meet regularly with shelter staff and children/youth in need of a foster home in several of the service areas to learn which type of home environment is best suited for that particular child/youth. The goal in the next year is for all service areas to have this collaboration. Four Oaks Family Connections can serve as a liaison between prospective Resource Family "match" homes and the shelter to provide opportunities for the child/youth and prospective "match" family to meet and begin to get to know one another. Four Oaks is also discussing the possibility of having matching staff work in shelters or QRTP's to build stronger relationships and get to know the children in which they are searching for homes.

At the local Service Area level Four Oaks Family Connections and Lutheran Services in Iowa staff routinely participate in "stability staffing's," which are meetings initiated by any provider for all providers working with a specific child in danger of a placement disruption to problem solve and brainstorm services, supports, and resources to enable the Resource Family and the child avoid a potential placement disruption. Additionally, Four Oaks Family Connections often collaborates with provider organizations or topic experts to provide training for Resource Families, or to provide training about topics relevant to Foster Care and Adoption to child welfare professionals and other providers. One such example is a collaboration with Blank Children's Hospital in central Iowa, host of a clinic for children entering care/in care. Medical and mental health providers who staff the clinic will provide Resource Family training on topics such as eating disorders, assessing child well-being, etc. Similar collaborations routinely occur with Prevent Child Abuse Iowa, particularly in joint events to recruit Resource Families, provide training, and identify resources and supports to Relative/Kinship Caregivers.

Additional collaborations commonly occur between Four Oaks Family Connections and the statewide youth-in-care peer support program known as AMP (Achieving Maximum Potential). Some AMP youth undergo training to learn to share their own personal stories in a meaningful and impactful way to prospective Resource Families during pre-service training or at Resource Family recruitment events. Other joint collaborations at the local level connect Resource Families to clothing closets, meal providers, and Respite Caregivers.

Four Oaks Family Connections has experienced some success in recruiting diverse Resource Families, including Resource Families of Color, LGBTQI+-identified or affirming Resource Families, bi-lingual or multi-lingual Resource Families, Resource Families of varied faith traditions, and Resource Families who identify as or have expertise in caring for or working with people with disabilities. There have been three primary approaches that have enabled this success: family-to-family recruitment, using Ambassadors to raise awareness of the need for additional Resource Families with specific communities, and strategic community outreach in which Family Connections team members work to build and maintain trusting relationships with meaningful and/or influential community members or gathering spaces such as faith communities.

Four Oaks Family Connections partnered with the NAACP to provide a 4-part training series for Resource Families around the state focused on recognizing and meeting the needs of children of color in

care in a culturally responsive manner, particularly for Caregivers who are parenting trans-racially. Additionally, Four Oaks Family Connections has established a statewide network of individuals and professionals who provide training and coaching on the topic of African American hair and skin care.

Four Oaks Family Connections staff are members of the statewide Cultural Equity Alliance and participate in localized Breakthrough Series Collaborative groups working to address disparity and disproportionality in child welfare. Additionally, Four Oaks Family Connections works closely with the Iowa State University Child Welfare Training and Research Project to host and conduct Racial Equity Learning Exchanges to community members, Resource Families, child welfare professionals and stakeholders. Each of these efforts provide meaningful and substantive opportunities to not only recruit additional Resource Families, but to participate in activities that promote child stability and Resource Family Retention. Two examples of the benefits of these efforts are: highlighting the disparities in placement stability of children of color versus their white counterparts during Resource Family pre-service training to encourage new Resource Families to use a culturally sensitive lens in responding to children's behavior; and providing training to professionals and Resource Families about caring for and working with LGBTQI+-identified youth.

Moving forward, particular emphasis will be placed on continued innovations such as establishing localized Cultural Advisory Councils to assist Four Oaks Family Connections in continuing to improve in delivering culturally responsive services, recruiting a more widely diverse workforce, and providing affinity support groups led by and for specific communities or populations.

Foster Parent Advisory Board: In the Western Service Area, the RRTS contractor finalized their plans to implement a Foster Parent Advisory Board with seven resource families identified by staff to strategically represent all geographic areas of Western Iowa (30 counties). This Advisory Board was already in existence when the Foster and Advisory Council of Iowa began in December of 2022. During Q1 this Advisory Board Met for the first time and began to consider goals and objectives for the group. They were also able to meet with the SA1 Department of Health and Human Services, Service Area Manager to provide input relating to their needs and ask questions. All the Resource Families involved are very appreciative of having the opportunity to be heard and have some of their questions answered by Iowa HHS management. The RRTS Resource Family Advisory Board in Western Iowa meets over zoom monthly for the board meetings. A RRTS Supervisor guides this ongoing engagement and helps obtain the primary objective statement and the top three goals that the group intends to focus on. From that point, allowing that group to go back to their community and surrounding counties to talk at support groups will be encouraged in providing resource families with a voice and feeling of increased partnership.

Two representatives from Western Iowa serve on the Statewide Iowa Foster and Adoptive Advisory Council which was officially formed in December of 2022 and represents a diverse group of resource families throughout Iowa. This group will function independently from the HHS or RRTS Contractor influence, with representatives from the State of Iowa's child welfare system providing guidance and assistance in the initial organization of the group. Once established it was agreed that Iowa Health and Human Services and RRTS Contractor leadership would be available to provide updates at the beginning of each of the state advisory board's meetings and then dismiss for the remainder of the business meeting so that the needs of Resource families could be addressed without influence. Area Representation is important to be maintained and the representation of resource parents across the

service area will continue. Currently there are approximately three representatives in each area, with 15 resource parents participating. This Advisory Board will provide substantial input decisions that will impact resource families and the children coming into care across the state of Iowa. In July of 2023, Four Oaks Family Connections will be implementing a Statewide RRTS contract. During the first year of this contract, there will be discussions about having only one Statewide Advisory Council and combining the two groups.

Collaboration in Youth Emergency Shelters: The collaborative relationship between Crittenton Center Emergency Youth Shelter and LSI RRTS was established after the re-opening of the Crittenton Center Shelter with monthly collaboration meetings occurring on the 3rd Thursday of the month starting in April 2022 and continuing regularly since that time. The consistency has allowed for team members consisting of shelter staff, RRTS matching staff, RRTS supervisors and leadership from both programs to have ongoing discussion about the wellbeing and permanency needs of each youth served. This collaboration has led to transition planning discussions when youth have not wanted to leave the shelter environment. Crittenton Center staff and RRTS staff have been able to brainstorm ways to help youth feel comfortable with meeting potential foster families. As a result, several youth have transitioned or begun the transition to a stable foster care placement. RRTS Staff work closely with shelter staff and take opportunity to meet the youth if possible, making sure that the child's strengths and personality is captured so that the child is no longer just a "referral", but a child RRTS staff eagerly want to serve and locate families for.

The same type of collaboration is established with Children's Square Emergency Youth Shelter in Western Iowa. RRTS services have a natural connection with Children's Square as the RRTS Contractor in Western Iowa also subcontracts with Children's Square for RRTS staffing and services specifically in the Council Bluffs area. There are three RRTS Support Caseworkers and on Post Adoption Specialist with offices on the Children's Square Campus. This allow for ongoing collaboration, shelter communication, visitation, and opportunities to meet the youth who are placed in shelter. This allows RRTS to learn about the needs of the child on a personal level, knowing the child as an individual and not just a referral on paper. The voice of the child is valued and RRTS Recruitment and Retention Staff and supervisors are reaching out to shelter staff to obtain de-identified action shots of youth doing an activity or hobby and adding a brief description of the child's interests that can be used in preservice training, orientation sessions and with licensed families as a targeted recruitment opportunity.

LSI RRTS supervisors and matching staff and the Crittenton Center Emergency Shelter staff meet monthly to address the needs of youth who are in the emergency shelter and in need of foster care placement. During those meetings staff explores strategies for placement of the children and discuss the children's strengths, hobbies and interests that can be used in engaging families and create a safe transition for children as they go into a foster care setting. During the past year LSI has implemented a child specific recruitment opportunity with Crittenton Center by getting de-identified photos of the children engaging in their hobbies and activities and then LSI recruitment staff added short profiles to share with existing resource families, and potential resource families who attend pre-service training and information sessions.

The Managed Care Organizations in Iowa also assist in facilitating Managed Care Meeting for children who have higher needs and are waiting in shelter placement for extended periods in order to identify

the additional services and programs that can be sought to better meet a child's needs and allow for placement opportunities. RRTS supervisors and matching staff regularly participate in these meetings.

Collaboration with older youth: In the past year, the state of Iowa has extended the age of foster care for youth to 21 to allow for a more positive transition to adulthood and prevent homelessness. One specific example where this has had an impact on a youth's life is with a foster child who graduated early from high school and turned 18 years old but would not be entering college until the fall. She did not have any other stable living arrangements other than foster care. Because the age for youth to qualify for continued foster care placement had been increased to 21 years of age, she was able to have a safe, stable, and connected relationship and home with her foster parents maintained while making plans to continue her education. This opportunity prevents youth from feeling pressured to move out on their own or return to unhealthy living situations before they are emotionally or financially ready to do so. Four Oaks Family Connections has been heavily involved in educating Resource Families of this new opportunity/benefit through pre-service training, in-service training, social media, newsletters, and in other routine communications. All Four Oaks Family Connections facilitated pre-service training classes utilize AMP youth as panel speakers and provide prospective and current Resource Families with materials specific to youth transitioning to adulthood in Iowa.

Family Connections team meetings in all service areas invite Transition Specialists, Aftercare providers, and other young adult-oriented organizations to present to Caseworkers. For example, Family Connections caseworkers in the Des Moines Service Area have received education on helping their families request transition meetings and contacting Iowa Aftercare. They are reaching out to the HHS transition specialist to help in assuring a transition plan has been started and foster parents are also educated on the process and what that may look like. In the Eastern Service Area, the IASN provider presented a training to Family Connections Caseworkers regarding supporting youth transitioning and/or "aging out" of care.

LSI Supervisors also participate in the ongoing Transition Planning Review Meetings with the Department of Health and Human Services. These are held in three areas in Western Iowa including Council Bluffs, Sioux City and attend the transition meetings set up by HHS for children aging out of the system.

LSI RRTS Services in Western Iowa are pursuing giving youth "a voice" and continue to work with AMP (Achieving Maximum Potential -Children's Square provider) to have youth be involved in panel discussion for Pre-Service training and also participated in the webinar training for resource families. This is a vital training to assist resource families in becoming more comfortable providing foster care to teens and will be continued regularly at the pre-service training and annually for ongoing in-service training to resource families.

Collaboration in Training: In Western Iowa, the LSI RRTS Director is offering training to resource families every other month that includes another partner within the child welfare system. Family Centered Services (Boystown and Family Access Center), AMP (Achieving Maximum Potential, Children's Square), HHS Transition Planning Specialist and Parent Partners were all involved in this training during FY23 to help keep resource families informed of key partnerships, contract requirements and opportunities for youth in foster care or adoptive placements. The "Training with the RRTS Director" learning

opportunity for resource families across Western Iowa has been well attended through zoom during FY 23.

RRTS staff has also worked with the Transition Planning Specialist at HHS and the local AMP facilitator to provide training for resource families and RRTS staff as well. Continued collaboration with contractors to help educate Resource families on the different contracts in Iowa will continue. RRTS Referrals for Matching of older youth and teens continues to be complicated by an increase in the number of children on the Matching list who need Adoptive Homes. LSI is contracted to provide matching for foster care placement and assist with placement options for adoption. LSI RRTS proceeds with the search for both foster care and/or adoption simultaneously. The LSI Adoption Photo Listing has been a positive tool in initiating interest in finding out more information and meeting the child. LSI has asked to attend Adoption Unit meetings more regularly again now that meetings are back to be held in person.

Post Adoption Collaboration: The LSI Post Adoption Specialists (PAS) have collaborated with many different people and organizations to support adoptive parents. PAS collaborates with area agencies such as IHH (mental Health), Heartland Families (Chemical dependency) and Lutheran Family Services (R-Safe program), ASK Resource (educational supports) to provide resources to families and promote the stability of adoptive and guardianship families. The Post Adoption Specialists in Western Iowa provide both online and in-person support groups which give families the opportunity for fellowship and networking among people with similar family situations. PAS provides families with knowledge and resources regarding educational support that assist them in partnering with the school for the best educational outcomes for their children.

Post Adoption Support Specialists have teamed up with the Crittenton Center to provide educational opportunities for foster and adoptive partnerships. We also provide other opportunities to learn through the Bi-Annual Book Club, Facebook support groups, as well as in-person support groups, some specifically for kinship caregivers. Post Adoption staff serves as a member of the Season Center Advisory Board. They also work closely with families, schools, AEA, and the ASK resource center to ensure that children are getting the educational assistance to be successful. Additionally, our LSI Post Adoption staff collaborate with North American Council on Adoptable Children, Disability Rights Iowa, Siouxland Mental Health, Plains Area Mental Health Center, Seasons Center, Integrated Health Homes, and the Brain Injury Alliance to provide resources, support, and guidance for adoptive parents throughout the adoption process, as well as offer ongoing support to maintain stability for youth in their adoptive families. These collaborations also help to raise awareness and understanding of adoption-related issues and provide a network of support for adoptive families.

In Western Iowa the first Customary Tribal Adoption also took place for Iowa, and this is a significant and important opportunity for Native American Culture to be maintained. RRTS Support Caseworkers and Post Adoption Specialists have been educated on Tribal Customary Adoption and have embraced the implementation of this process led by HHS and the Iowa Attorney General's office.

Tribal connections have been strengthened and ongoing collaboration with the Winnebago, Omaha, Ponca, and Santee Tribes have continued by RRTS Contractor and Director being involved in the Nebraska Indian Child Welfare Coalition. The original NF4NC (Native Families for Native Children) grant ended in 2018 however the sustainability of those connections that were formed through the

tribes and states of Nebraska and Iowa has continued to be vital. Monthly orientations focused on Native American Culture as well as ongoing training opportunities for resource families to learn more about Native American Culture is being established on a quarterly basis. The Native Focused training occurring in January continued to provide resource families in Western Iowa important information on Native American Culture. The training was provided through collaboration between LSI RRTS, an Omaha Tribal representative and Resource Parent who specializes in Cradle Boards who presented. Information on Iowa Administrative Code addressing safe sleep and the need to pursue an Exception to Policy before using Cradle Boards was provided along with the history and significance of Cradle Board use. The importance on maintaining Native American Culture and traditions was emphasized through viewing and discussion of the Documentary, Daughter of a Lost Bird.

Community Collaborations: There has been a continued need for our community partners to come together and support one another as well as enhance the services that the LSI RRTS staff provides for resource families. Through connections within the community and with key organizations our RRTS staff has identified who "community anchors" are in each area that they serve. These community anchors include churches, businesses and organizations that assist in providing informal support by allowing RRTS staff to use their facilities for training and recruitment events or providing donations, assisting in recruitment efforts, and sharing their appreciation for the work that resource families do.

Some of the Western Iowa organizations include the Katelyn's Fund Support group, Kings and Queens Inc. (Support groups, training and foster care closet), Season's Center (training, support programs and camps for youth), Jane's Closet – Buena Vista University (Foster Care Closet), Setting Anchors Support Group, Beauty Amidst The Ashes (Training and donations), Iowa State Extension Services (training), Children's Square (training and recruitment partnerships) and the Crittenton Center (training and recruitment partnerships). Boystown and Family Access Center are the Family Centered Service providers in SA1 and provide the Kinship Navigator services. This partnership strengthened through Kinship Caregiver services and relations with the Navigator is utilized several times through each week in helping kinship families as they become licensed as foster parents. As LSI RRTS programs have collaborated with key organizations the value for resource families and the positive impact that these families play in the life of children and families has allowed for continued interest in foster care, adoption, and kinship care in the areas where more resource families are needed. Resource families also feel valued and appreciated for the critical work they do in meeting the needs of children and families in the Western Service Area when community organizations recognize the work that they do.

In FY 23 the Recruitment and Retention Plan identified that RRTS staff would identify key "anchor groups" in their communities who support, recruit and or advocate for Resource Families. Fliers were distributed and community engagement reinforced. In August there were three Back to School Events held in SA1 specifically providing Backpacks and School Supplies to Foster and Adoptive children in SA1. The donations were provided in Community drop boxes at churches in SA1 in the area around Spencer and Sioux City. In Sioux City 90 children were served and in Spencer over 70 children were served. In Council Bluffs LSI RRTS caseworkers partnered with Church of Christ providing over 100 back packs to youth in foster and / or adoptive homes. There are numerous churches, businesses and agencies across Western Iowa who have assisted in recruitment and retention events as well as providing donations to support resource families. As a result, LSI is able to provide $20 - $50 gift cards to families through the year who provide extra transportation or assistance in going above and beyond in the care that they

provide to foster children. Additional donations have been provided to foster children through various organizations such as:

- Numerous church affiliations across the service area provide donations from Sunday school and bible school offerings as well as clothing donations for foster care closets. Gift Cards are requested in preference over monetary donations so that they can be used as incentives and appreciation to foster parents and kinship caregivers.
- Beauty Amidst the Ashes conducted the 100 Bikes – 100 Kids campaign, donating bikes for foster children across Iowa. They facilitated a 3 day "HOPE 22" Conference with training for foster and adoptive parents as well as resource tables.
- Share My Smile (SMS) has received a few small grants to help start a County Ambassador program. These grants are for Crawford, Page, Harrison, and Pottawattamie counties. They have hired ambassadors in the Pottawattamie and Harrison counties thus far to plan and execute family strengthening events in their local area for foster and adoptive families. The plan is for each County Ambassador to host two events per year, such as a picnic or fun local activity, for families to attend.
- Share My Smile organization in Council Bluffs has held the Holiday Dinner for years consisting of a Turkey dinner, crafts, and gifts four children and a visit from Santa Claus. They also conduct a toy drive for local foster children.
- The LSI RRTS staff conducts two Back to School event each year consisting of local churches, organization and individuals from Northwestern Iowa donating school supplies and backpacks for the foster children in that area.
- Denison High School Student Senate collected donations for gift cards to be provided to area foster families as they take in foster children.
- Westside Fortnightly Organization donated financially and provided clothing for the LSI Foster Care Closet.
- Kings and Queens Inc. provides a foster care closet as well as donates food to families who take in new placements and also provides support and training opportunities that include childcare.
- Season's Center is providing training and has programming to support foster and adoptive parents. Their Autumn camp provides a camp setting to children to attend and gives foster, adoptive and kinship parents daytime respite care.
- Lakeside Lutheran Camp offers 20 free spots for foster children in Northwestern Iowa to attend camp in Okoboji.
- Culvers provided an opportunity for RRTS staff to work for an evening in Sioux Center and Sioux City to raise funds for and then provided gift cards for foster families.
- Pampered Chef conducted a party and gave a percentage of their earnings for foster parent appreciation gift cards.
- All Things New Therapy has requested to provide training opportunities to resource families and especially Kinship care providers in the northern corner of western Iowa.
- Season's Center in the northern part of the western service area is also proposing additional services for foster and adoptive parents to assist in providing respite care opportunities for resource families that would train and prepare respite providers to go into a resource families home to assist with care.
- Kaden's Kloset in Sheldon, Iowa provides a foster care closet and supplies for resource families.
- Setting Anchors Support Group in Sioux and Plymouth County provided gift cards to resource families to express appreciation for the care they provide and encourage them to attend their support group for foster and adoptive parents.

- First Lutheran Church in Milford, Iowa conducted a "Noisy Offering" to collect donations and bought gift cards to provide to foster parents.
- Foster Care Closets have also been established in the Logan and Harlan areas in Iowa.

Many other organizations and individuals have reached out to provide donations and when asked how they can help LSI RRTS requests that they share information about the need for resource parents and gift cards for resource families are always appreciated. Recruitment fliers and brochures have been provided to these individuals and organizations to share within their communities.

The current RRTS contract will end on June 30, 2023. HHS began preparing for the next round of procurement for the contract in early 2021. During the past two years, HHS has been in the process of drafting an RFP for a new RRTS contract. There was a three-phase approach to the drafting of this RFP. Each phase consisted of drafting, gathering feedback and review by the core drafting team and the report out team (which included subject matter experts and stakeholders) and a larger group review. Additionally, agency leadership conducted nine listening sessions to gather stakeholder feedback.

The procurement was posted to the bid opportunities page in April of 2022. Bidders' questions and requested changes as well as a vendors' conference were held in May and June of 2022. All bids were due in July of 2022. The notice was issued to the successful bidder in November of 2022 awarding Four Oaks Family Connections. This new RRTS contract will begin July 1, 2023.

Several themes emerged from stakeholder feedback. The current one caseworker model was not working for a variety of reasons including staff turnover and staff capacity/caseloads. The new contract is moving to a specialized caseworker model positioning the contractor to select and train staff to roles that meet their interest and abilities and allow staff to be accessible, specially trained and dedicated to working with families.

Families shared consistently that the current support requirements were not enough and therefore we doubled the amount for the upcoming contract. Support caseworkers will be required to meet with families face-to-face (45-minute minimum) once per month (when there is a child placed in the home) as well has have one meaningful phone contact (15 minute minimum). If there is not a child placed in the home the requirement will shift to a monthly phone contact and bi-monthly face-to-face. These efforts will strengthen the relationship between caseworkers and resource families and provide the support necessary for stability in the home.

Another significant change in the upcoming contract is moving from five separate service area contracts to a single statewide contract and a statewide matching process. Both changes will promote increased consistency across the state. There will be a streamlined kinship caregiver licensing process in the new contract as well as an extensive post adopt and subsidized guardianship outreach program that includes increased supports for post adopt families as well as adopt only families. The new contract includes increased respite days for adoptive families, a stability grant for each family if necessary, and an intensive case management service to support and prevent disruption and/or dissolution of adoption or subsidized guardianship homes.

Performance Measures for the upcoming RRTS contract include stability for children, increased numbers of licensed non-white foster homes, timely licensure of kin/fictive kin families, children in licensed foster or pre-adoptive families are safe from abuse and supports are provided to adoptive and subsidized guardianship families to prevent disruption.

Disproportionality/Disparity in the Child Welfare System

The Iowa data shows disproportionality in the child welfare system at various decision points. The following cultural equity-focused efforts and county teams described below continue to assess the specific needs of overrepresented communities and focus collaborative efforts to elevate recommendations to Iowa Health and Human Service (HHS) Family Well-being and Protection senior leadership to support more measurable changes.

Statewide Cultural Equity Alliance Steering Committee (CEASC)

The primary purpose of the Cultural Equity Alliance Steering Committee (CEASC) is to develop recommendations for implementing systemic changes focused on reducing racial and ethnic minority children and families who are disproportionality represented and experiencing disparate outcomes in the child welfare system. This statewide collaborative includes the following representatives: HHS (leadership and field staff), contracted service providers, courts, Parent Partners, foster care alumni, immigrant and refugee services providers, legal and Tribal representatives, juvenile justice, public health, diversity and inclusion advocates, universities, as well as prevention and diversion partners. The CEASC mission and vision were updated at the June 2020 meeting to reflect the continued sense of urgency around pursuing racial equity and social justice. The updated statements are as follows:

> *Vision:* Eliminating racism and achieving racial and cultural equity in Iowa's child welfare system.
> *Mission:* Create an antiracist and culturally responsive child welfare system through the growth of an equity-focused workforce, cross-sector collaboration, and policy and practice reform to eliminate disproportionality and disparity in Iowa's child welfare system. The CEA has three key strategic priority areas: Workforce, Practice, and Centering Equity.

In 2016, legacy Iowa DHS adopted the Guiding Principles based on the Office of Minority Health Standards for Culturally and Linguistically Appropriate Services (CLAS). The adopted Guiding Principles have provided the framework for action planning since initial efforts to recruit, promote and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service areas; provide effective, equitable, understandable, and respectful quality supports, services and interventions that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs; establish culturally and linguistically appropriate goals, policies, and management accountability, and work to infuse them throughout the organizations' planning and operations. All strategies led by the Cultural Equity Alliance (CEA) focus on the access and utilization of accurate and reliable disaggregated data to monitor and evaluate the impact of principles on equitable outcomes to inform service delivery.

Cultural Equity Learning Exchanges

HHS has invested in the development and promotion of Cultural Equity Resources over the past 10 years through training and learning opportunities, community presentations, and tools. These resources include the Guiding Principles for Cultural Equity, Continuing Courageous Conversations Toolkit, Race: The Power of an Illusion (RPI) & Understanding Implicit Racial Bias (UIRB) learning exchanges, and Introduction to Cultural Equity Resources.

RPI/UIRB Learning Exchanges Race: The Power of an Illusion (RPI) Learning Exchange is a 1-day Learning Exchange designed to increase understanding of the intersections of race, equity, and child welfare. In a brave space environment, community partners, colleagues, and stakeholders in the child welfare system gather to explore a historical context of race and child welfare, current data, and develop shared terminology to have courageous conversations about how the notion of race affects attitudes, beliefs, and behaviors.

Understanding Implicit Racial Bias (UIRB) is a 1-day Learning Exchange developed by the Iowa HHS Family Well-Being and Protection Division and brings together professionals, volunteers, and community members to have conversations about the development and impact of implicit bias, specifically racial bias. The purpose of UIRB is to build the capacity to recognize and reduce implicit bias by providing participants the opportunity to explore and challenge their own beliefs and attitudes about racial bias, to practice better ways of talking to one another about microaggressions and individual levels of racism, and to begin to have courageous conversations with one another about how implicit bias affects our attitudes, beliefs, and behaviors.

In SFY 2023, the Cultural Equity Learning Exchanges (CELE) Training Coordinator, trained facilitators, members of the Child Welfare Research and Training Project Team with Iowa State University team, and HHS staff updated the RPI curriculum course content and design utilizing the Learning Outcomes Improvement Plan (LOIP). The LOIP utilizes tools and processes to evaluate training content, design, and delivery through an equity lens. One of the tools utilized was the Training Observation Rubric. Having firsthand knowledge of the curriculum, facilitators provided a rating for each of the areas under the four elements of the rubric. Ratings ranged from Highly Skilled, Developing Skill, to Needs Strengthening. Based on the feedback from the facilitators and others, it was determined the course design needed to be improved to meet the needs of all learners (accessibility) which included:

- Closed captioning was added to the video, and information regarding accessibility services and available accommodations was included in communications to participants, to be provided upon request.
- Data slides were updated with current statistics and information, and newer and more relevant studies replaced those that had become outdated.
- Images of cartoon or inanimate objects were replaced with diverse people. This change specifically works to challenge stereotypes, especially about those belonging to a marginalized group, while continuing to humanize the discussion about race and increase connection between curriculum content and delivery.
- Greater attention was placed on updating the RPI curriculum in FY2023, with only minor updates occurring with the UIRB curriculum as more in-depth updates were made the previous year.

In strategically planning for SFY 2024, the LOIP process and tools will again be utilized for continuous quality improvement of the content, design, and delivery of the curricula. Additionally, focus will be

placed on the instructional management of the facilitators and assessment of course content and design by participants (evaluation process).

Facilitation of the RPI and UIRB Learning Exchanges have shifted back to being offered primarily in person. During the period of April 16, 2022 – April 15, 2023, facilitators have delivered 17 RPI sessions (16 in person and 1 virtually) and 15 UIRB sessions (13 in person and 2 virtually) across the state. To date, 47 HHS workers have participated in RPI and UIRB Learning Exchanges this year, alongside 498 community members who have participated. Ten slots for attendance are reserved for HHS workers in each Learning Exchange. The maximum capacity for Learning Exchanges is 40 for in-person and 30 for virtual exchanges.

The number of HHS child welfare staff in attendance continues to be lower than that of community members. Participation in the RPI and UIRB Learning Exchanges is optional for HHS staff. HHS staff receive email notifications at minimum twice a month of upcoming Learning Exchanges through the HHS Service Training Newsletter and from the RPI/UIRB Learning Exchanges promotions. If HHS staff enrollment is low for a specific Learning Exchange, the Cultural Equity Learning Exchanges (CELE) Training Coordinator sends an event specific email promotion to the SWA, Supervisors, CPWs, and SWCMs in the service area, to provide awareness of the upcoming learning opportunity.

In SFY23, two Train the Facilitator Cohorts were held to diversify the pool of facilitators. The LOIP process was again utilized for recruiting, interviewing, and onboarding new facilitators to ensure it was equitable. A Train the Facilitator Workday will be held early in SFY 2024 to complete the training for Cohort 3. Currently, there are 16 facilitators from a diverse range of backgrounds and lived experiences. This includes individuals identifying as Black, white, Latinx, bi-racial, male, female, and/or as members of the LGBTQI+ community. Several have worked professionally in child welfare, education, mental health, substance abuse, and refugee services, while others have lived experiences of growing up in foster care, being adopted, and navigating the juvenile justice system and even the adult prison system. The most resounding feedback received from Learning Exchange participants is that they appreciate the diversity in facilitators and the sharing of personal stories and experiences. Having a large pool of facilitators also helps to ensure that all contracted Learning Exchanges will occur each SFY.

Participation feedback through evaluations during the period of April 16, 2022 – April 15th, 2023, indicate participants have increased their knowledge base through participation in a Learning Exchange.

- 96% of the RPI participants strongly agree or agree they know the definitions of disparity, disproportionality, equality, and equity.
- 98% of RPI participants strongly agree or agree they know ways to create more equitable outcomes for children and families in the child welfare system.
- 99% of UIRB participants strongly agree or agree they know the definition of microaggression, implicit bias, and explicit bias.
- 99% of UIRB participants also report they strongly agree or agree they can have a courageous conversation about race after participating in UIRB.

In both RPI and UIRB exchanges, participants overall scored the facilitator performance at 3.8 or above on a 4-point scale.

During this reporting period an Iowa State University (ISU) Graduate Research Assistant was able to complete Evaluation Survey Reports for both RPI and UIRB. The RPI report analyzed participant survey

responses for RPI's facilitated October 2021 through April 2022 while the UIRB analyzed the UIRB's held November 2021 through April 2022. Both reports showed participants walked away from the day having increased their knowledge of the learning objectives presented. Many participants described RPI as eye opening, as they learned latest information that inspired them to be more aware of racism and inequities within systems and institutions in the United States. Facilitator delivery skills were rated especially high by UIRB participants. Considering the findings presented in the evaluation reports, the following are considerations for the future direction of the Learning Exchanges:

- Update both curricula to include current and relevant information.
- Incorporate additional interactivity and discussion time for RPI.
- Develop a Second/Follow-up UIRB or a "Part Two"

Strategic planning for SFY 2024 will continue to promote delivery of the RPI and UIRB Learning Exchanges in each service area, specifically in those communities where the Learning Exchanges have not occurred in the past two years. This will give equitable access to new HHS staff, leadership, and community partners, including Community Partnerships for Protecting Children (CPPC), the Parent Partner Program, and other child and family service providers for the first time, our youth population. Emphasis will be placed on promoting collaboration within communities by having CPPC sites, local county equity teams and community organizations hosting Learning Exchanges jointly. These efforts aim to promote interdisciplinary and cross-sector discussion as well as future collaboration within individual communities around race and child welfare. The Learning Exchanges continue to be an opportunity to bring together HHS staff and community members to have courageous conversations about the intersections of race, equity, implicit bias, and child welfare by examining our institutions, policies, and practices from a data-informed and historical lens.

Cultural Equity Presentations

The Introduction to Cultural Equity Resources (ICER) was developed in 2019 as a presentation to promote full utilization of the cultural equity resources developed. These varied sessions focus on cultural equity resources, building cultural competency, centering child welfare equity data to audiences in attendance, and considering the next steps, such as hosting additional training and courageous conversations within communities. The ICERs were delivered virtually and in person to enhance awareness and utilization of the equity resources invested by HHS, understanding the function of the CEASC, centering racial/ethnicity data in decision making, and identifying potential next steps of continued learning or action planning. In this reporting period, six ICERs were requested and held. The hosts are provided with a feedback summary or evaluation of outcomes from each ICER to inform future learning requests and practice considerations from participants. In June 2022, the Community Partnerships for Protecting Children hosted three ICERs for their regional meetings with approximately 50 participants. In January 2023, an ICER presentation included the Hawkeye Area Community Action Program (HACAP) to 11 Family Learning Connection program staff providers in Linn County; 36 attorneys for Child Support Recovery; and a virtual session to the HHS staff via a Lunch and Learn training opportunity to approximately 20 participants in March 2023. Some responses identified a commitment to continued learning and strategizing around diversity of workforce, enhancing cultural responsiveness, or practice changes within the organization. Pre and post response on surveys from participants included the importance of considering own identity and identities of the families served; awareness of equity, diversity, inclusion, cultural competence, and cultural humility within their organization or state; data availability to learn and better understand disproportionality and disparate outcomes in the child welfare system; comments and reflections including future training, learning or

action steps they intend to take as individuals or organizations. Feedback to the ICER presentations has been overwhelmingly positive regarding learning growth and knowledge of available resources.

Additionally, a specific cultural equity focused presentation was developed to incorporate into the new HHS Social Work Case Manager (SWCM) training (SW 020) beginning in SFY23. From October 2022 – April 2023, every other month, presentations were made to 84 new SWCMs. An additional presentation to SW 020 is scheduled in June and will develop a plan for presentations to occur in SFY24.

Utilizing cultural equity focused presentations such as the ICER across the state has promoted a greater understanding of the cultural equity resources available to better identify culturally responsive practices, sharing access to public-facing child welfare data, and greater community engagement in understanding how HHS Family Well-Being and Protection is working to identify and address disproportionality and disparity of children and families in child welfare.

Beyond the Breakthrough Collaborative

Iowa Beyond the Breakthrough Series Collaborative (BSC) is composed of convening the ten local county Equity Teams, community partners, and Health and Human Services leadership from across the state. Teams are to meet regularly in their local service areas to develop, implement and track practice change efforts to reduce disproportionality and disparity for children and families of color. The BSC model, introduced in 2009 to Iowa by Casey Family Programs, is contingent on stakeholder engagement and shared leadership by the team core members. Core members of the Equity Teams are responsible for working together to develop and rapidly test strategies designed to improve a prevailing issue and practice challenges in child welfare. All team members (including HHS leadership and front-line staff, Judges, court partners, parent and youth representatives with lived experience, and other community partners) engage in the development process by testing, improving, implementing, and spreading successful strategies to address local-level disproportionality and disparity.

Equity Teams share action plans, challenges, and lessons learned via bi-annual meetings called the Equity Learning Session to provide participants with the content, skills, capacities, and connections to identify and sustain racial and cultural equity-focused practices. Teams, community leaders, and collaborative partners center lived experiences and learn concrete practice strategies for engaging youth, parents, caregivers, and community members as partners in this work on the community and system level.

Equity Learning Sessions: In May 2022, the Spring Annual Iowa Equity Learning Session on Reducing Disproportionality & Disparate Outcomes for Children & Families of Color was held with over 100 participants. The speakers at the session included:

- Health & Human Services Director, Kelly Garcia providing updates on the alignment of Iowa Departments of Public Health and the Department of Human Services, and the cross systems equity focus on practice and policy.
- Janee Harvey, Division Administrator for Adult, Children, and Family Services spoke of updates on Family First and Iowa Code 232 (HF2507) changes and continued efforts on addressing disproportionality and disparity, although still present, the total numbers have declined:

Between SFY19 and SFY 21:

- 26% reduction in the number of Black children in foster care;
- 23% reduction in the number of Native American children;
- 25% reduction in the number of Hispanic children;
- 31% reduction in the number of white children.

- Woodbury County Equity Team Spotlight focused on disproportionality for native children was shared by two groups of speakers on Resilient Communities (Iowa Child Abuse Prevention Program) and Tribal Customary Adoption sharing the process of utilizing the Plan-Do-Study-Act (PDSA)to work towards the goal to allow Indian children to maintain their Tribal heritage while simultaneously achieving permanency.

Affinity groups and county equity teams participated in focused conversation around the presentations to inform implementation of learning and impact on next steps for their organization or team strategies as it related to the four quadrants of action and alignment for impactful results and were tasked to respond and the following:

1. Provide an overview of your self-assessed action plan to identify:
    a. barriers and note progress and updates;
    b. where you have high or low alignment/ action; and
    c. one Guiding Principle your action step aligns with.
2. How have you measured progress on your action plan in past 6 months and additional strategies or steps your team is planning for the next 6 to 12 months in any areas of the continuum (team building, data, planning, implementation, spread) you have made locally.

In response, four of the ten Equity Teams (Black Hawk, Webster, Johnson, and Linn County) identified challenges of meeting regularly and the need for team building in the recruitment, retention, and role clarity. Their feedback reflected low alignment/low action. Wapello County identified high action and high alignment as it related to shared learning through Courageous Conversations modeling, but low action, low alignment when looking at team building and PDSA development.

The Woodbury County Equity Team, noted low action/high alignment based on increased collaboration across judicial and legal partnership with the Attorney General, Tribes, and the County Equity Team and Community Partnership for Protecting Children (CPPC) efforts focused on the PDSA of Tribal customary adoption but needing to redefine steps within Iowa code to move it forward.

In contrast, Polk County Equity Team stated high action due to several strategies being moved forward through the African American Case Consultation Team engaging community members, child protection case managers, and supervisors. The Workers of Color support group for child welfare staff has continued to help address cultural inclusion as a more diverse workforce is joining the Polk County child welfare staff.

Eastern Iowa Service Area (EISA) counties have identified they meet regularly but are not able to identify specific improved results for some of the PDSAs as most of their efforts are focused on shared learning and focused conversations. Scott County has a more active team and is in the process of collecting results in looking at decision making in cases around removals in child welfare cases by race. The team has expressed this is a more intensive collaborative process, with the end goal to share their findings at conclusion of the review along with any recommendations based on their findings.

The county Equity Teams also provided feedback on identified needs to better support their work:

- Additional HHS leadership to provide guidance and support to teams and can influence system and policy/practice changes.
- Community organizations and families/youth/parents with lived experience as partners and power sharing, in the work.
- Additional funding, resources, and alignment from local to state level.
- Increase in open lines of communication and collaboration.
- Ability to have a full-time staff person dedicated to the county equity teams to engage with community partners and advance PDSAs.

In November 2022, the Equity Learning Session returned to in-person, with over 115 participants attending, including 44 state employees and 68 community partners who attended the session. The session provided opportunity to amplify lived experiences, including opening remarks by a young adult who transitioned into adulthood and now is the state coordinator for the Iowa Youth Council of AMP (Achieving Maximum Potential). Goals and objectives for participants at this session included to:

- Create a shared learning environment with county Equity Teams and collaborative partners to develop clear plans for action and shared commitment to continue strategizing and measuring progress and challenges.
- Learn, practice, and model how to have courageous conversations about eliminating racial and cultural disproportionality and disparities in child welfare at multiple levels.
- Deepen understanding of how to authentically engage children and families, caregivers, and community members as true partners in this work.
- Share successful strategies, including data-centering practices, equity outcome-focused protocols, and policies for eliminating disproportionality and disparate outcomes at key decision points.

Speakers at the fall session incorporated lived experience throughout the session, including Healing Centered Engagement in partnership with Iowa ACEs 360 and a young adult that experienced the child welfare system; LGBTQI+ Youth in Out of Home Care with a contracted service provider, Four Oaks, and a foster parent; a panel of legal representatives including a judge, attorney general, a young adult with lived experience, and the Department of Human Rights moderating a discussion on centering equity in practice and policy; a spotlight on the Easter Iowa Service Area (Scott, Des Moines, and Dubuque County teams) blind removals assessment project; and a session led by a Social Work Administrator and other Quality Assurance/Improvement staff in understanding and analyzing disaggregated data to better utilize locally. HHS leadership and other community partners made keynote remarks.

The planning team for the Equity Learning Session includes Day-to-Day Managers representing their county equity team, CEA members, and HHS leadership in preparing for each learning session. The virtual spring Equity Learning Session was held on May 24, 2023. This session was focused on the integration of racial and cultural equity into the Kinship Navigator Program, Black Hawk County Equity Team Spotlight on entry data into the system from mandatory reporting to intake to key decision points of disproportionality specific to African American children, and an HHS update from the new Child Protection Services Director. There were 86 participants in attendance including CEA and county Equity

Team Members, HHS leaders and staff, Parent Partners, Youth, and other guests at the session. Survey outcomes from the sessions included:

- Experience a shared learning environment with others during the session to develop action plans (66%).
- Learn how others have courageous conversations about eliminating racial and cultural disproportionality and disparities in child welfare at multiple levels and apply the learning to a team or collaborative efforts (72%).
- Learn how to implement data-centering practices, equity-focused protocols, and policies for eliminating disproportionality and disparate outcomes as key decision points (70%).

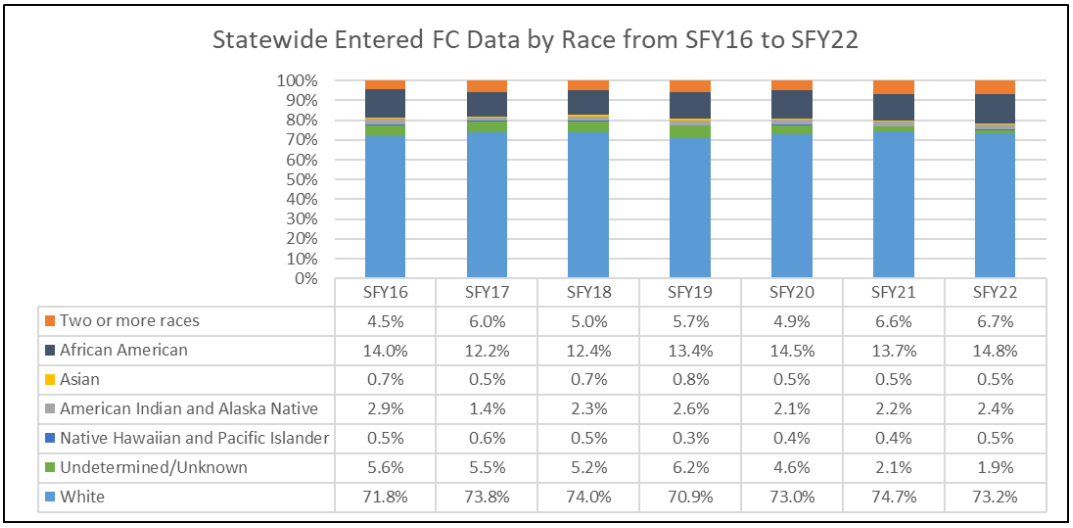
Survey respondents further indicated the following summarized comments about what they learned by attending the session:

- Consideration of re-creating the Black Hawk Co. PDSA, or using it to develop a similar approach (to assess calls reported to child welfare and mapping out by neighborhood and non-white by permissive and mandatory reporters with outcomes of the assessments whether confirmed/founded);
- With the Black Hawk Co. PDSA, identifying next steps in what would they be interested in committing to whether it is joining in the work, RPI training, supervisory training conversations about when to report and what it is like for Black families to be interviewed for unfounded/unconfirmed cases;
- Better utilization of data and rethinking data analysis at a geographic level, i.e., neighborhood/zip code;
- Importance of utilizing the PDSAs framework for project planning to change practices or outcomes that may be contributing to disproportionality and disparity, and
- The Kinship Navigator Program was very intentional in their selection of panelists and the panel had such great insight through vulnerable sharing.

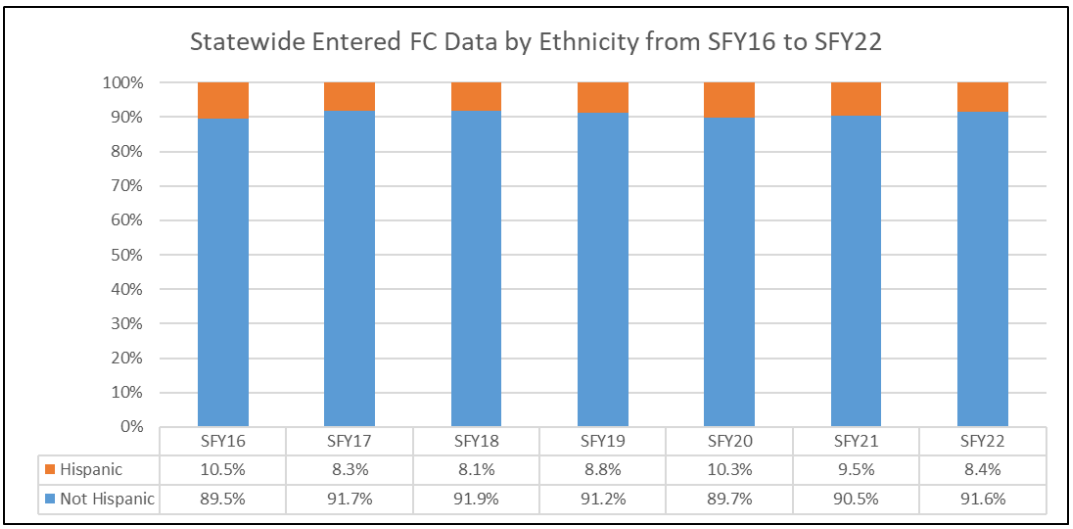
County Equity Teams: Annually, Equity Teams are provided statewide and county specific data packets regarding statewide child population by race: two or more races, African American, Asian, American Indian and Alaskan Native, Native Hawaiian, and Pacific Islander, and White) and by ethnicity (Hispanic and non-Hispanic) based on Woods and Poole data 0-17. Central HHS Quality Assurance/ Improvement office provides disaggregated data specific to the following decision points:

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

An example of data provided to the Equity Teams is shown below regarding Statewide Entered Foster Care data by race and ethnicity from SFY 2016 – SFY 2022:



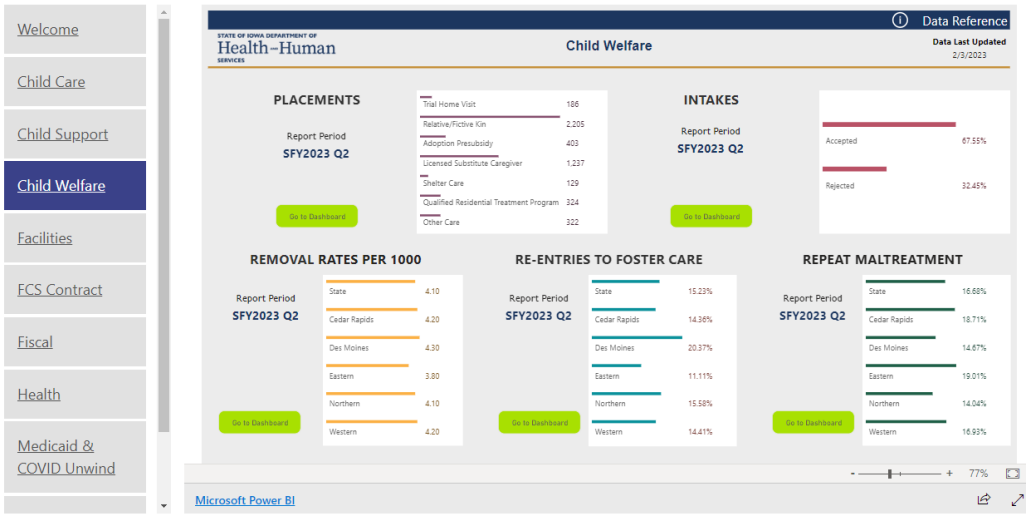
	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22
Two or more races	4.5%	6.0%	5.0%	5.7%	4.9%	6.6%	6.7%
African American	14.0%	12.2%	12.4%	13.4%	14.5%	13.7%	14.8%
Asian	0.7%	0.5%	0.7%	0.8%	0.5%	0.5%	0.5%
American Indian and Alaska Native	2.9%	1.4%	2.3%	2.6%	2.1%	2.2%	2.4%
Native Hawaiian and Pacific Islander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

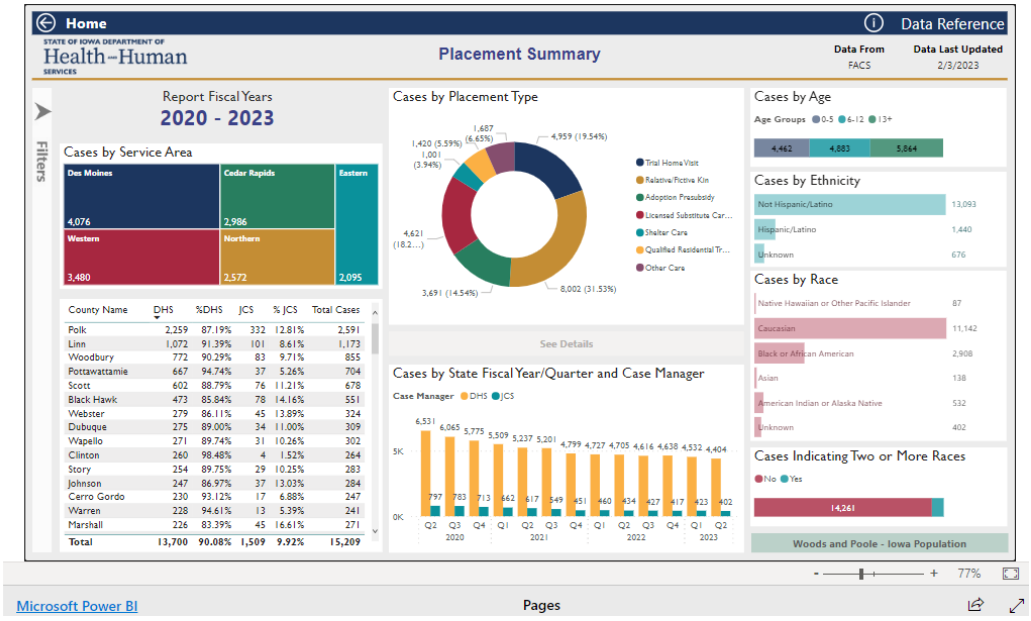


	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22
Hispanic	10.5%	8.3%	8.1%	8.8%	10.3%	9.5%	8.4%
Not Hispanic	89.5%	91.7%	91.9%	91.2%	89.7%	90.5%	91.6%

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

Child Welfare





At each Equity Learning Session, County Equity Teams reported on a range of activities and their self-assessment on the development continuum for their teams, which includes team building; data gathering, understanding, assessing, and clarifying local disparity data; planning efforts; and implementation, testing, and spread of developed strategies. Seven of the ten County Equity Teams completed the self-assessment and action plan for the remainder of FY23. Most teams are onboarding and have new team members or leads, identifying a need for support in role clarity and guidance to lead the teams and the need for localized leadership with the ability to engage community representation on the team to identify and conduct PDSAs.

Cedar Rapids Service Area teams of Linn and Johnson County had Social Work Supervisors in leadership positions that have undergone increased workload over the past couple of years and they

have identified challenges in the time, skills, and support to continue to lead consistent meetings to move forward team building, looking at data, and developing and reporting on PDSAs. There has been an effort to collaborate between the various equity focused efforts in Johnson County across HHS and County Decategorization, Community Partnership for Protecting Children (CPPC), Disproportionate Minority Contact (DMC) partner leading their meetings and intersecting strategies to support equity focused efforts. Wapello County has been more stable with leadership of the Social Work Supervisor and working towards team building of additional members of the community to focus PDSAs on changing demographics and thinking proactively in engagement efforts (see below details). Four County Teams have experienced changes in leadership, Black Hawk, Linn, Webster, and Polk. This has also impacted cohesive teaming, understanding county specific data to develop PDSAs to better assess impactful strategies for practices or processes in prior months, but they are identifying ways to move forward new or existing PDSAs and workgroups asses impactful equity focused efforts.

Technical assistance by the Cultural Equity Statewide Coordinator has been provided to focus on leveraging potential collaborations and identifying the next steps in their efforts. Several teams have progressed from team building to data analysis and into planning. Data packets are intended to assist the county Equity Teams in driving their team action planning and development of PDSAs. Below is a summary of each county Equity Team on their current activities:

- **Polk County** (Des Moines Service Area) received Casey funding (Jan.-Dec. 2021- 2022 and partial funding for 2023) to assess their African American Case Consultation Team (AACCT) for best practices and assessing recommendations that contribute to improved outcomes for Black or multi-racial children in child welfare or impact disproportionate representation in key decision-making points in the system; professionalization, retention and promotion of AACCT membership; and supporting best practices through cultural competence building with child welfare staff. Since its inception in October of 2014, and the result of a PDSA after a series of Courageous Conversations in Polk County in the Spring of 2014, this effort has been a joint project for HHS leadership, DECAT staff and community volunteers.

AACCT is a team of community representatives who identify as Black or African American to provide consultation and case review with HHS staff in Polk County regarding child welfare cases involving Black children and families to reduce child/family separation, increase reunification, and address causes of disparities. This effort has had commitment to keep it impactful, however, it has long been recognized that this project needs to lead to systemic change. The opportunities created by the Casey funding has allowed the team to take steps towards that systemic change.

- In 2022-23, this work aimed to analyze the recruitment and retention of the case consultant team, assessing outcome data on cases consulted by the AACCT to evaluate outcomes and to consider spreading this case consultation practice to other counties in Iowa.
    - Funding from Casey was utilized to compensate the AACCT members and participating in training opportunities about Juvenile Justice, and future vicarious trauma training for team and Black staff, HHS overview of changes and court processes and appeal rights. Some of the members declined compensation or were not permitted due to state or local employment.
- There was a change in leadership mid SFY23, and ongoing team building continues to assess and address inequities and support a diverse workforce.

- A key goal in FY22-23 funding was to develop a system of data collection that can be maintained and updated to assure that goals are being met, and to provide training to team members and to HHS supervisors and workers to address vicarious trauma and issues that impact disproportionality and disparate treatment of workers of color and children and families of color.
    - In 2023, first quarter, five cases were referred, 3 cases were reviewed. Based on scheduling and team availability, the team is defining if can effectively review more than 1 case at a consultation.
    - Staffing and capacity issues have created a challenge in timely data tracking in the tool developed for the cases staffed. Although there is an openness to staffing and workers see the benefit of the staffing, an adjustment proposed is to have new HHS team members assist in facilitation and program implementation efforts.
- Challenges identified in this project assessment included AACCT team turnover to finalize the recruitment materials, Child Protection staff turnover to be able to follow up specific to impact on practice or decision-making and outcomes, and limited resources to collect and input data into the tracking tool. Spread of the case consultation practice to other communities or statewide has not yet occurred.

- **Des Moines, Dubuque, and Scott Counties** (Eastern Iowa Service Area) Equity Teams Day to Day Manager through Scott County Kids ended in FY23 due to time commitment and resources needed. Continued funding was also needed to secure an Equity Team facilitator position to serve the three counties through Decategorization beyond FY23, but the approved position went unfilled. Technical assistance by the Cultural Equity Statewide Coordinator has included site visits to provide facilitation support and guidance to the teams and leadership as they navigate forward into FY24.
    - The Scott County Equity Team case review project resulted through team discussion about the process of removals in their area, and how the team could evaluate and reflect on local practice through the case review project. The case review workgroup presented at the Equity Team Spotlight for the Fall 2022 Learning Session. The case reviews focused on African American children within child protection from point of referral, entry, and decision points or primary reason of removals and placements. This included review of case notes and reports, assessing whether the language used is fair or biased, and incorporating the Four Questions/Seven Judges and documentation.
    - Next steps for the remainder of FY23 into FY24 will be for the subcommittee to review 5 files of white children who were removed and to work toward facilitating case reviews in other service areas or counties. The team hopes to utilize what is learned from this process to proactively engage organizations that are entry points in mandatory reporting systems (education, law enforcement, health, social services, etc.) and continue to look at data and resources available and offered, such as Parent Partners, family preservation prior to removal, and offering concrete supports. Although there has been service area leadership change, there is a commitment to seeing through the second part of the project for shared learning and potential spread depending on resources and ongoing commitment on a statewide level.

- **Woodbury County** (Western Service Area), through the Attorney General's office, the PDSA framework was utilized to build the strategy around Tribal Customary Adoption (TCA) utilizing existing Iowa Code 232. The purpose of the PDSA is to honor the Tribal custom of avoiding termination of parental rights while allowing for the customary adoption of a child as a permanency

option successfully implemented with several children. TCA is a culturally appropriate option for Native American children and provides a permanent home for children but does not require termination of parental rights. The Woodbury County Equity Team, tribes from surrounding states and Iowa, Attorney General's Office, and HHS informed the development and implementation of this PDSA as it rolls out this year and continues to be tracked for improvements.

- Success in these efforts provides Tribes with an option for their tribal children to be involved in State proceedings when looking at long-term placement. The outcome is geared to reduce the number of Native terminations of parental rights in the WSA, specifically Woodbury County, and the plan is to spread statewide in 2023.
- The Woodbury team continues to look at cross-strategy collaboration with the Iowa Child Abuse Prevention Program (ICAPP) Resilient Communities Demonstration Project grant to Siouxland Human Investment Partnership (SHIP) & Siouxland Council on Child Abuse and Neglect (SCCAN). The project is entitled "Native Resilient Communities" and engages various partners, including CPPC, county Equity Team, service providers, AGs office, Native Unit, JCS, the School District, Police, Probation, and many others to inform their efforts focused on Native children and families. They continue to elevate education and endorse proactive concrete support for children and families, especially within the K-12 education system, to connect with tribal resources for diversion to child protection system referrals.

- **Black Hawk** and **Webster Counties** (Northern Service Area) each had a new Day-to-Day Manager assigned to the teams in 2022.
  - Black Hawk is working to establish team building and data analysis to develop PDSAs based on their county disproportionality data. They are working through data disaggregation of reports into child protection by various systems, assessing decision points at intake, and determining founded/confirmed and placement decisions by zip code. Black Hawk will present at the May 2023 Learning Session and share resources other teams can utilize to develop their PDSA.
  - Webster County team has had challenges in consistently meeting and identifying its own self-assessment and action plan.

- **Johnson, Linn, and Wapello Counties** (Cedar Rapids Service Area)
  - Johnson County Equity Team is hosting various community conversations to align equity efforts across Juvenile Court Services, Early Childhood Education, child welfare, CPPC, and city/county efforts to support children and families. The primary community focus is proactively engaging the Congolese community though informal community and trust building sessions.
  - Linn County has new leadership, and members are focused on youth voices in the courtroom and developing a worksheet to be shared with the court. Linn County Decat - CPPC and the Equity Team co-hosted a Housing Services community learning opportunity. And are determining funding resources for PDSAs for FY24.
  - The Wapello County team is consistently meeting and working to respond to changing demographics and proactively engage Pacific Islanders- Marshallese community members. This team had a similar approach to their initial strategies to engage the Latino/ Hispanic community in previous Plan-Do-Study-Act (PDSA) efforts. The team is also working to build data collaborations with K-12 education and the main local employers to better assess new

community members' linguistic and cultural needs and identify resources for accessible and reliable language assistance when needed.

Cultural Equity Alliance Steering Committee (CEASC)

The CEASC has three strategic focus areas of Workforce, Practice and Centering Equity, with each workgroup aligned around the key strategies to move forward action items based on the CLAS Standards/ Guiding Principles. The CEASC works to collaborate with shared outcomes of assessing disproportionality and disparity, policies, and outcomes with the Office of Equity within workgroups.

The **CEASC Workforce Workgroup** has the goal to recruit, retain, and promote a culturally and linguistically diverse governance, leadership, and workforce that is responsive to the communities served. The specific focus areas are workforce support enhancements, training, and learning. In 2022 through 2023, the core team members have worked to obtain data and specific information about the recruiting, hiring, onboarding, and retaining practices across the state. Interviews were conducted with frontline and leadership staff, including supervisors, a Social Work Administrator (SWA) and key findings are described below:

- Recently the job descriptions for field staff were updated, which may have resulted in an increase of applicants and individuals being onboarded with more diverse backgrounds (i.e., medical background) and speaking another language other than English. However, a cultural equity lens was not specifically applied in developing the questions.
- Within the discussion groups, there is no clear standard practice for conducting exit interviews. The lack of clarity of data from exit interviews can potentially cause a barrier in analyzing trends for why staff is leaving their positions, specifically the staff of color.
- In SFY 2024, the workgroup will focus on gathering more concrete data to determine trends, researching promising practices being used to recruit, onboard, and retain a diverse workforce in other areas, and engaging with internal HHS groups working on recruitment and retention to develop specific steps to improve the outcomes in the focus areas.

The **CEASC Practice Workgroup** facilitated a review of linguistic related policy and resources available to HHS child welfare staff providing child abuse assessments and ongoing case management to families involved in the child welfare system. This included review of the Non-Discrimination Policy and facilitated input from HHS child welfare staff and community organizations who support parents and families who may intersect with the child welfare system and English is not their first or preferred language. In addition, the workgroup reviewed available training and staff development and support opportunities on linguistic supports to child protection and case management staff.

As a result of the linguistic resources review, the CEA Practice Workgroup developed summary recommendations and action items in April 2023 to include addressing areas such as review of the existing Non-Discrimination Policy and provision of additional training on requirements for child welfare staff regarding translation, interpretation and reasonable accommodations for families involved with the child welfare system. The workgroup further recommended bolstering knowledge of available local resources and supports available to staff by identifying service area liaisons as point persons for responding to questions and providing resources for linguistic supports. Additional recommendations included increasing data collection efforts to track the known languages of families entering the child welfare system, and steps to strengthen accountability in practice and policy to ensure families are receiving the necessary linguistic supports and resources during the life of a case, as well as a clear and

accessible process for families to file a grievance when these supports were not made available to the family. The workgroup also included consideration of assistive technologies for persons who are deaf or hard of hearing and for persons who are blind or have low vision in the recommendations.

The **CEASC Centering Equity Workgroup's** goal is to establish culturally and linguistically appropriate goals, policies, and accountability throughout the organizations' planning, operations, and outcomes. Key focus areas are to analyze, understand and effectively use equity data, and a fusion of an equity lens across child welfare. In 2022-2023, the workgroup continues to work with central HHS Quality Assurance/Improvement to pull statewide and county Equity Team data packets for race and ethnicity (Hispanic/Non-Hispanic) of children aged 0-17 for each county and statewide decision points over the past five years. The workgroup also secured speakers from QA/QI to support and a Social Work Administrator in a breakout at the learning session with county Equity Team members to better understand and utilize the data in their forward action planning.

In addition, part of the goal of this workgroup is to deliver individual walkthroughs to County Equity Teams, the Cultural Equity Alliance, and other community partners of the local county data and promote utilization of the public facing HHS child welfare dashboard and how to better disaggregate the data by key areas of placements, intakes, removal rate (per 1000), re-entries to foster care, and repeat maltreatment. The Service Area Manager and Social Work Administrator from the Cedar Rapids Service Area delivered a presentation of the HHS dashboard to the Cultural Equity Alliance in March. Across all the workgroups a parent engagement tool was reviewed with HHS staff, Parent Partners, and CEA leadership to elevate recommendations of updates, utilization, and tracking of accessible HHS child protection trifold resource.

Through the work of the CEA, HHS has invested in developing and promoting Cultural Equity Resources over the past ten years through training, learning opportunities, and community presentations. These resources include the Guiding Principles for Cultural Equity, Continuing Courageous Conversations Toolkit, Race: The Power of an Illusion (RPI) & Understanding Implicit Racial Bias (UIRB) learning exchanges, statewide annual learning sessions, and Introduction to Cultural Equity Resources (ICER).

Strengths

Statewide Cultural Equity efforts encompass the following strengths:

- The CEA has been able to meet consistently and maintain support for the learning sessions and county teams. The workgroups have aligned around the key strategies and are moving forward action items based on the CLAS Standards/ Guiding Principles and recommendations for statewide implementation of promising strategies, recommendations for updates to resources to HHS Senior Leadership.
- 100% of the 10 county Equity Team Day to Day Managers have been engaged in learning session planning and have received site visits and/or technical assistance and guidance to strengthening their teams or shared learning to develop PDSAs to track in their action plans.
- The Statewide Annual Equity Learning Sessions uplift and amplify equity focused efforts from a local to state level to maintain shared learning, action, and accountability. The focus on data-centered information, lived experience, and localized decision making to impact statewide change informs collaboration across various systems including leveraging data from other partners across the decision-making continuum.

- Continued efforts to strengthen membership and shared leadership on the CEA and workgroups around the strategic priorities for measurable outcomes and accountability to center racial and cultural equity.
- Intentional partnerships have been built with the HHS Office of Equity to inform mutually reinforcing activities and projects.
- Senior leaders have committed to meeting with CEA and the Office of Equity to review recommendations and determine sustainability of equity focused strategies across Family Well-being and Protection.

Opportunities for Improvement

- Continued elevation of CEA recommendations to have measurable outcomes and impact across all of Family Well-being and Protection strategies when analyzing and understanding disaggregated data, spreading promising PDSAs and continuing to build community collaboration across the continuum of prevention to intervention strategies.
- Assessing the evolution of the Breakthrough Series Collaborative framework to inform equity focused efforts reflective of systems analysis, workforce capacity, and integration across HHS.
- As the Family First Prevention Services Act continues to progress in Iowa, CEASC will continue efforts to apply an equity lens to practice and policy changes and measure impacts on outcomes for children and families of color. This will continue in learning sessions and project or team specific efforts.
- Additional partnering with Equity Teams and local CPPCs to support centering equity in analyzing, understanding, and using data as a component to drive decision making.
- The CEA will continue to gather input from the county Equity Teams in supporting and innovating enhanced outcomes focused team building, data analysis, and PDSA development to inform policy and practice change across counties, service areas, and statewide.
- The CEA will continue collaborative efforts within the Health and Human Services alignment process to synthesize already established efforts by the CEA and build further opportunities to center equity and continue work to eliminate disproportionality and disparity in the child welfare system and across HHS.

Provide an update on how the state agency has demonstrated substantial, meaningful and ongoing collaboration with state courts and members of the legal and judicial communities, including the CIP, in the development and implementation of the CFSP/APSR and, if applicable, any active state CFSR PIP or title IV-E PIP (section 422(b)(13) of the Act).6 The state and CIP may share a common goal to improve the diversity and inclusion of the community and the workforce. CB encourages states to engage in conversations with the CIP to determine if there are opportunities to collaborate. Resources to support states in strengthening collaboration and improving outcomes for children and families include the Technical Bulletin on Independent Legal Representation and the Judicial, Court, and Attorney Measures of Performance (JCAMP) project set of measures and suite of tools.

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

- CIP provided data for this APSR and collaborated with HHS through various activities in implementing Iowa's CFSR PIP as well as activities with Tribes.
- HHS memorandum of understanding (MOU) with the Office of the State Public Defender (SPD), dated February 2020, for legal representation of children and parents at all stages of child welfare proceedings, including pre-petition, continues into the foreseeable future.

- For information on HHS' collaboration with the courts, the legal and judicial community, and CIP, please see:
    - *Section VI: Consultation and Coordination Between States and Tribes* and
    - *Attachment 3A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of June 30, 2022*

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

Since 2021 the Chief Justice of the Iowa Supreme Court Christensen and HHS Director Kelly Garcia had been discussing issues impacting the judicial branch and HHS. In order to best address the issues that were impacting both the judicial branch and HHS, Chief Justice Christensen and Director Garcia planned a statewide listening session tour across Iowa to meet with judges, JCS staff, HHS staff, attorneys, providers, foster parents, Parent Partners, and families. The purpose of the visits would be to listen to people most involved in the child welfare and juvenile justice systems as well as to discuss things that are going well and opportunities for improvement.
Chief Justice Christensen and Director Garcia visited 11 communities in 5 months, starting July 2022 through November 2022, to listen to almost 700 people who attended these listening sessions. The 11 communities visited were:

- Council Bluffs
- Davenport
- Sioux City
- Des Moines
- Dubuque
- Waterloo
- Cedar Rapids
- Webster City
- Storm Lake
- Burlington
- Osceola

Some of the common themes around opportunities for improvement in all 11 locations include:

- Judicial Branch:
    - FFPSA (Families First Prevention Services Act) – Attorneys and Judges are not Family First friendly, i.e., not supportive of family or fictive kin placements.
    - Remote hearings – through the pandemic remote hearings were utilized; some parties appreciated the ability to appear remotely while others prefer hearings in the courtroom. This continues to be a topic that is debated. The judicial branch currently has a task force gathering more information on this issue with the expectation that they will make recommendations to the Iowa Supreme Court for future hearings.
    - Permanency and Termination of Parental Rights Hearings – In some areas of the state, the initial permanency hearing was combined with the TPR hearing. ICJ, along with the Chief Justice, have been trying to stop this practice because it interferes with the due process

rights for the parents since they are two separate headings with different goals and expectations.
    - Paper Reviews, Waived Hearings, Untimely Orders, Continuances – In some areas of the state, judges have completed paper reviews which does not include any of the parties and it is not considered a court hearing. This is not a widespread practice, but it is one that we are trying to discontinue. In terms of waived hearings, some jurisdictions routinely waive certain hearings. It is unclear whether all parties were consulted, or if this has become the standard practice. Some judges do not issue their orders in a timely manner with some being issues many months later. In these circumstances, the previous court order is in effect and can create conflicts or prevents parties from moving forward in accessing services or achieving permanency for a child. The same can be true of continuing hearings; it can create delays in permanency or connecting families with services. This is an area ICJ staff monitor in our case reviews and assessments to see if this has an adverse effect on permanency.
    - No record being made (lack of recording or reporting)
    - Lack of interpreter services.
- HHS:
    - Communication between foster families and HHS – Families told not to bring kids to court, not informed about change in dates or about the court dates, and HHS altering reports.
    - HHS/FCS staff turnover
    - Timely reports to the court – This has been an issue in many areas of the state. Reports have been filed the day before or day of a court hearing. When this occurs, the judge, attorneys, and parties have not had an opportunity to read the report. Everyone takes time away from the court hearing to read the report and sometimes this has required the author of the report to testify instead. When reports come in late, attorneys do not have time to meet with their clients before the hearing. There is no statewide standard for what is considered timely submission. As such, some judges are requesting reports be filed in real time instead of waiting for the next court hearing. This allows everyone to address issues in real time instead of delaying it for several months.
    - Limits placed on professionally supervised family interactions.
    - Concerns about the use of sweat patches for drug testing and accuracy/reliability of the sweat patch results.
    - Lack of placement options
    - Recruitment challenges for Parent Partners
    - Support for Kinship placements
    - Navigating ICPC and the barriers those regulations can create for potential placements
    - Lack of or long waiting lists for mental health services in rural areas
- General:
    - Lack of services (quality, specialization, and accessibility)
    - Children and youth not in court
    - People don't understand that the court process can be adversarial if parties are not in agreement
    - Lack of involvement by Parent Partner
    - Adoption and guardianship changes
    - The need for regular meetings between SAMs and Chief JCOs regarding dual system youth
- State Public Defender (SPD):
    - Lack of attorneys and high caseloads
    - Guardian ad Litem (GAL) reports – Some reports are complete and add valuable information and others are incomplete or do not provide any new information

- The added work has caused GALs covering many counties to cut back on workload. Among the added work, GALs have also experienced issues with Attorney reimbursement and quality of representation.

Each meeting also identified local needs that could be addressed, such as lack of interpreter services and redesigned court scheduling.

These meetings reiterated the importance of communication, not only between the judicial branch and HHS, but with all of the players in the child welfare and juvenile justice systems. In order to make a different in the lives of Iowa's kids and families, the stakeholders in the child welfare and juvenile justice systems need to be fully resourced and communicate effectively with each other.

Directly following these meetings, Iowa's judicial branch began working on issues that were related to the court. Some examples of this include connecting the court's statewide coordinator for interpreter services with the area of the state that raised this issue and separating permanency and termination hearings. Chief Justice Christensen issued an order regarding remote hearings and as mentioned previously, there is a task force on remote proceedings. The Executive Director of Iowa's Judicial Branch has been meeting with the judges in each judicial district and plan to discuss the possibility of joint meetings between the judicial branch and HHS in the near future.

Going forward, Chief Justice Christensen and Director Garcia expect local judicial branch and HHS leaders to continue these regular meetings with all of the local stakeholders in order to develop and maintain ongoing communication and collaboration.

ICJ Multi-Disciplinary Committees: There are two opportunities for collaboration with ICJ (Iowa Children's Justice) Multi-Disciplinary Committees. The first group is the ICJ Advisory Committee. This committee is a requirement to receive federal Court Improvement Program funding. Membership includes two representatives from HHS, State Public Defender's Office, a judge from the Court of Appeals, Judges who serve on the juvenile bench, a representative from the County Attorney's Association, Chief Judge of the Meskwaki Tribal Court, two representatives from the Parent Partner Program, a representative for youths' voice and two representatives from provider agencies.

The second committee is the ICJ State Council. This council is made up of representatives with decision-making capabilities from organizations that are involved in the child welfare system. The focus of this council is to address cross-system issues and barriers. The council is chaired by the Chief Justice of the Supreme Court. Members also include: State Court Administrator, chair of the Juvenile Division of the Iowa Judge's Association, the Director over Family Well-Being and Protection from HHS, the State Public Defender, a representative from the Attorney General's Office, chair of the Family and Juvenile Division of the Iowa State Bar Association, the chair of the County Attorney's Association, a representative from the Department of Education, Director of the Governor's Office on Drug Control Policy, Administrator for the Child Advocacy Board, Director of a substance abuse treatment agency and a director from a provider agency.

Juvenile Court Services (JCS)

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

To participate in FFPSA, JCS engaged in a significant number of program, policy, and practice changes, including statewide standardization of FFPSA policies, procedures, forms, and training. This standardization included the development of a Candidacy Determination process, which included creation of the Candidate for Foster Care Screening Tool (CFST) and the Child Prevention Case Plan (CP2). The CFST, which was developed utilizing current research, not only screens youth for candidacy but assists in identifying youth who are most at risk of out of home placement, enabling JCOs to concentrate resources where they are most needed. The CP2, while initially developed for FFPSA purposes, has been revised and is now utilized as a comprehensive case plan for all JCS involved youth. This change aligned JCS with best practice approaches to case management. The adoption of the CFST and CP2 have benefitted youth by allowing JCOs to target specific risk factors, thereby decreasing recidivism and out of home placement.

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

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

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

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

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

Through its participation in FFPSA, JCS hopes to accomplish a number of goals. These goals include increasing JCOs ability to identify youth at greatest risk of out of home placement, increasing JCOs ability to match youth's needs to evidence based services, reducing recidivism, out of home placement, and trauma, improved community safety, and increased family engagement.

Although JCS has faced a number of challenges stemming from an absence of infrastructure and a lack of knowledge and experience related to Title IV-E and federal claiming, their leadership has prioritized working on overcoming these challenges. As a result, JCS expects to see improvement in youth outcomes through reductions in recidivism, out of home placement, and trauma, increases in family engagement, and decreases in family conflict and child removal.

For more information regarding HHS' substantial, ongoing and meaningful collaboration with families, children, youth, tribes, courts and other partners, please see the following sections:

- *Section II: Updated Performance Assessment in Improving Outcomes, Systemic Factors*
- *Section III: Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes*
- *Section IV: Quality Assurance System*
- *Section V: Updated Services Descriptions*
- *Section VI: Consultation and Coordination Between States and Tribes*
- *The Child Abuse Prevention and Treatment Act (CAPTA) report*

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Section II: Updated Performance Assessment in Improving Outcomes

In the 2024 APSR the state must review and update the data and information provided in their 2020-2024 CFSP and subsequent APSRs. The state must identify strengths and concerns related to performance on each outcome and systemic factor, including evidence of disproportionality and disparities in services and outcomes. States are encouraged to include an analysis of data regarding significant areas of concern, with particular focus on those areas that may impact current goals, objectives, interventions and target populations. For each outcome and systemic factor, states must provide a brief update on any current or planned activities targeted at improving performance or addressing areas of concern identified.

In developing these updates, states are encouraged to supplement use of the Statewide Data Indicators and supplemental context data, with additional current administrative data (CCWIS and other sources), as appropriate. Those administrative data resources should be combined with case record review data and other quantitative and qualitative data for this assessment to provide relevant and reliable performance data on each of the seven CFSR child and family outcomes and each of the seven CFSR systemic factors. (See 45 CFR 1355.34(b) for the seven CFSR outcomes and 1355.34(c) for the seven CFSR systemic factors.)

In developing updates specific to the systemic factors, states are also encouraged to review CFSR Technical Bulletin 12 which describes CB's intention to emphasize reliance on rigorous evidence to assess systemic factor functioning. As noted in Technical Bulletin 12, in CFSR Round 4, CB will continue to rely on quantitative and qualitative information to assess whether systemic factors are functioning statewide, and a stronger emphasis will be placed on generating empirical evidence that demonstrates functionality. As with prior CFSR rounds, when empirical evidence is unavailable or insufficient to illustrate performance on a systemic factor, qualitative 15 data can be used (e.g., emerging themes from focus groups with those with lived experience and community partners). CB encourages states to use the 2024 APSR to identify and use evidence to demonstrate the state's ability to assess and routinely monitor statewide functioning of systemic factors. If this evidence is not currently available, states will want to put processes in place to develop and implement data collection and measurement.

Iowa continues to monitor services for disproportionality within the child welfare system and increase awareness of unconscious bias. The first opportunity to decrease disproportionality is at the front door to the system, child protective intakes; over-representation begins with substantiated reports of abuse and race data regarding substantiated child protective reports indicate:

- Native American children are over-represented in the child welfare system by approximately 4 times their prevalence in the child population;
- Black children over-represented in the child welfare system by approximately 3 times the prevalence in the child population;
- White children are under-represented in the child welfare by approximately 10% of their prevalence in the child population.

Iowa's Results Oriented Management data system (ROM) provides reports of racial disproportionality; in addition, the Bureau of QA&I routinely provides requested data to partners, both internal and external, to assist in the analysis of progress. Iowa recognizes disproportionality as an issue and has many initiatives in place to attempt to address this through training, education, and collaborative efforts.

See section on Disproportionality/Disparity in the Child Welfare System for more information.

CHILD AND FAMILY SERVICES REVIEW (CFSR)

Performance on statewide data indicators, case reviews, and PIP key activity outcomes can be found below.

HHS also updated information on the systemic factors (see below). The updated case review and systemic factors information provides context for understanding the *Updated Plan to Enact Iowa's Vision* in *Section III*, which comprises the goals, objectives, and benchmarks of Iowa's approved CFSR Program Improvement Plan (PIP).

OUTCOMES

National Safety and Permanency Data Indicators

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

Indicator Name	Indicator Description	National Performance Requirement	FFY 2016-2017*	FFY 2017-2018**	FFY 2018-2019**	FFY 2019-2020**	FFY 2020-2021
Recurrence of Maltreatment	Of all children who were victims of a substantiated or indicated maltreatment report during a 12-month reporting period, what percent were victims of another substantiated or indicated maltreatment report within 12 months of their initial report?	9.7% or less	15.6%	18.4%	19.4%	18.8%	21.8%
Maltreatment in Care	Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care?	9.07 or less victimizations per 100,000 days in foster care	FFY 2016 only – 26.12	FFY 2017 only – 28.06	FFY 2018 only – 34.37	FFY 2019 only – 33.67	FFY 2020 31.25

Sources:
*Iowa, Child and Family Service Review (CFSR 3) Data Profile Context Data, February 2021 provided by federal Children's Bureau; Data Used - Submissions as of 12-15-20 (AFCARS) and 12-15-20 (NCANDS)
**Iowa, Child and Family Service Review (CFSR 3) Data Profile Context Data, provided by Children's Bureau each February

Table 2B: Iowa Risk Standardized Performance on National Permanency Data Indicators								
Indicator Name	**Indicator Description**	**National Performance Requirement**	**FFY 2017**	**FFY 2018**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**
Permanency in 12 months (entries)	Of all children who enter foster care in a 12-month period, what percentage are discharged to permanency within 12 months of entering foster care?	35.2% or higher	37.7%	38.8%	39.8%	37.8%	36.9%	37.2%
Permanency in 12 months (12-23 months)	Of all children in care on the first day of a 12-month period who had been in care (in that episode) between 12 and 23 months, what percentage are discharged to permanency within 12 months of the first day?	43.8% or higher	64.8%**	62.9%*	66.2%	66.9%	65.8%	64.7%
Permanency in 12 months (24+ months)	Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percentage are discharged to permanency within 12 months of the first day?	37.3% or higher	41.3%**	43.0%*	41.0%	46.3%	46.4%	49%
Re-entry to foster care in 12 months	Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percentage reentered foster care within 12 months of their discharge?	5.6% or lower	7.2%	8.2%	8.9%	8.2%	9.2%	8.1%

Table 2B: Iowa Risk Standardized Performance on National Permanency Data Indicators								
Indicator Name	**Indicator Description**	**National Performance Requirement**	**FFY 2017**	**FFY 2018**	**FFY 2019**	**FFY 2020**	**FFY 2021**	**FFY 2022**
Placement Stability	Of all children who enter foster care in a 12-month period, what is the rate of placement moves per 1,000 days of foster care?	4.48 or lower	3.12**	3.14*	2.82	2.63	3.09	2.68
Sources: Iowa, Child and Family Service Review (CFSR 3) Data Profile Context Data, February 2022 provided by federal Children's Bureau; Data Used - Submissions as of 01-12-2022 (AFCARS) and 01-12-2022 (NCANDS) *Iowa, Child and Family Service Review (CFSR 3) Data Profile Context Data, February 2021 provided by federal Children's Bureau; Data Used - Submissions as of 12-15-20 (AFCARS) and 12-15-20 (NCANDS) **Iowa, Child and Family Service Review (CFSR 3) Data Profile, provided by Children's Bureau each February								

National Data Indicators

Recurrence of Maltreatment

Iowa continues to significantly exceed the nationwide expectation regarding recurrence of maltreatment, and this has long been a focus area. Iowa has reviewed data regarding types of abuse for both initial and subsequent, age of victim, and circumstances surrounding the recurring incident. Analysis indicates that neglect and substance abuse are the most frequent initial and subsequent categories of abuse.

Contextual data provided with Iowa's Data Profile is reviewed to identify trends and serves as a resource to assess areas of performance more thoroughly. Much of the type of information contained in the contextual data is already incorporated into the ongoing review of key performance measures. Recurrence of maltreatment and maltreatment while in foster care are two specific areas on which Iowa has chosen to focus. Below is a brief description of those efforts.

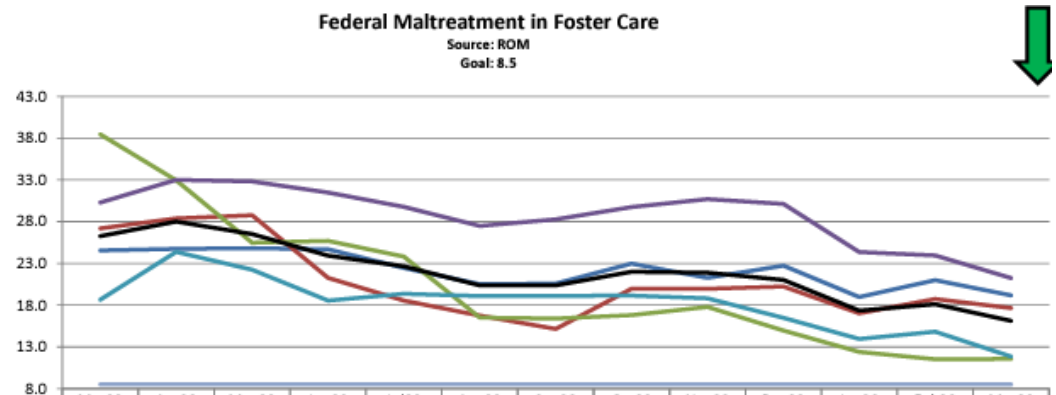
Iowa continues regular review of data both statewide and within service areas to identify trends resulting in this high rate of re-abuse. Years of data analysis, case review, and supervisory staffings has not yielded substantive insights to reasons Iowa would be so significantly higher in this area than other states. Iowa is researching performance across all states to determine if there could be a practice difference resulting in the disparity, such as criteria for a new allegation on cases open for services. This is a complex issue and Iowa continues to strive to understand factors influencing performance. To aid in exploration around this performance, Iowa entered into a consulting agreement with Change and Innovation Agency (C!A) to evaluate key areas in our child welfare practice; the purpose is to answer the questions: Are children and families better off after involvement with HHS? And how can we continue to improve? In order to answer these questions, C!A completed activities such as: focus groups with staff and stakeholders; mapping of the intake and assessment process; review of policy and procedure; and assessment of data related to all aspects of services. Recommendations are pending but initial discussions have already occurred regarding some potential strategies around intake and assessment. C!A has worked with many states and is bringing that experience to the evaluation of Iowa.

A preliminary Findings Progress Report was completed in February 2023 and can be found here [Preliminary Findings Progress Report (iowa.gov)](). Formal recommendations are anticipated in May 2023 with additional follow up completed after that, culminating in an overall report in August 2023.

Maltreatment in Foster Care

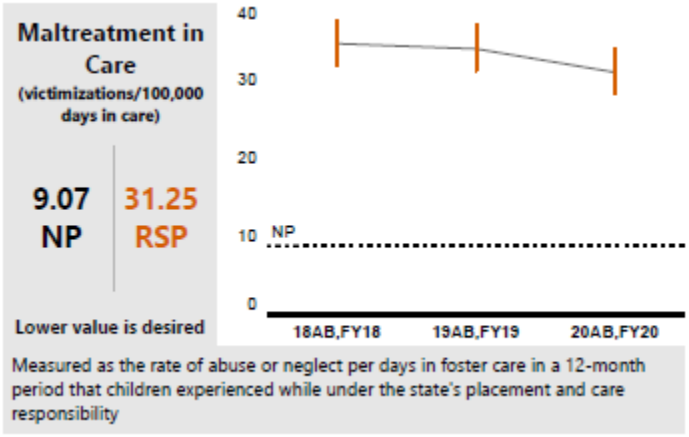
Maltreatment in foster care has been a focus of continuous improvement over the last two years. After conducting multiple sequential reviews to baseline then measure progress following implementation of strategies, this area has shown significant improvement by lowering the rates from 26.3% to 16.1% in the last year. The QI bureau reviewed cases identified as a child experiencing abuse in foster care to fully explore the circumstances; based on those findings the primary trends were identified:

1. The perpetrator type most prevalent was Parent, indicating children were experiencing abuse when on home visits.
2. Dates of receipt of a positive drug test was being used as the date of abuse rather than when the testing/incident occurred. This made children who entered foster care due to the incident appear to have been abused while in foster care rather than the incident prompted the placement. Consistent protocol for dates associated with positive drug tests was implemented.
3. In a variation of the above and as reported in previous APSR updates, Iowa's CWIS system is unable to record times of events; therefore, if a child abuse assessment was initiated and the child subsequently placed in foster care the same day, this would inaccurately be counted as abuse while in care.



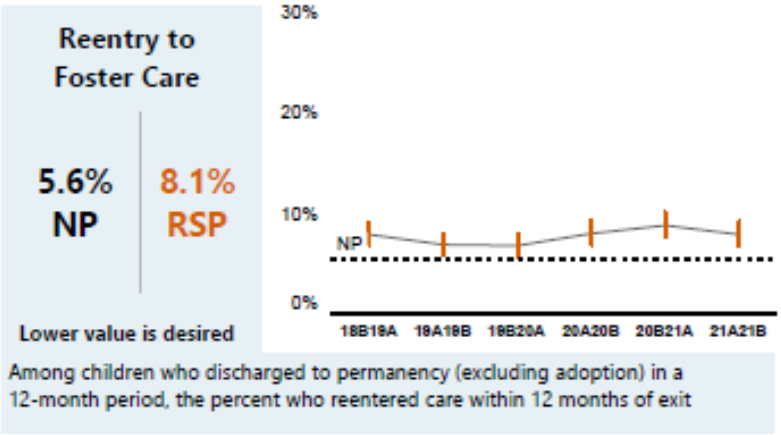
Initial Maltreatment Period	Mar22 Apr21 Mar22	Apr22 May21 Apr22	May22 Jun21 May22	Jun22 Jul21 Jun22	Jul22 Aug21 Jul22	Aug22 Sep21 Aug22	Sep22 Oct21 Sep22	Oct22 Nov21 Oct22	Nov22 Dec21 Nov22	Dec22 Jan21 Dec22	Jan23 Feb22 Jan23	Feb23 Mar22 Feb23	Mar23 Apr22 Mar23
Western	24.6	24.7	24.8	24.7	22.5	20.5	20.6	23.0	21.3	22.7	19.0	21.0	19.2
Northern	27.2	28.4	28.8	21.3	18.5	16.8	15.2	20.0	20.0	20.2	17.0	18.7	17.7
Eastern	38.5	33.0	25.5	25.7	23.8	16.5	16.4	16.8	17.8	15.0	12.4	11.5	11.6
Cedar Rapids	30.3	33.0	32.8	31.5	29.8	27.5	28.3	29.8	30.7	30.1	24.4	24.0	21.3
Des Moines	18.7	24.4	22.2	18.5	19.4	19.1	19.1	19.2	18.8	16.5	14.0	14.8	11.9
State	26.3	28.0	26.5	23.9	22.7	20.4	20.4	22.0	21.9	21.0	17.4	18.1	16.1
Goal	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5

Although using slightly different timeframes and definitions, both Iowa's key performance measure and Iowa's data profile, both support an overall decrease of maltreatment in care.



Re-Entry to Foster Care

While Iowa's performance has been steady and very close to national targets, it's noteworthy that as of January 2021 the use of Trial Home Visits (THVs) was discontinued as a regular practice unless court ordered. Due to the formal discharge from foster care occurring at the point the child goes home rather than the end of a THV, Iowa anticipated a potential increase in the numbers indicating children re-entering foster care due to the change in definition rather than performance. Iowa's data profile indicates a gradual increase in re-entry, although Iowa continues to perform within 3% points of the national performance target.



Trial home visits traditionally lasted for 6 months, then formal discharge from foster care occurred; due to this, an analysis of timeframes children return to a placement setting was completed. Historically the trend of re-entering placement in less than 6 months has been increasing:

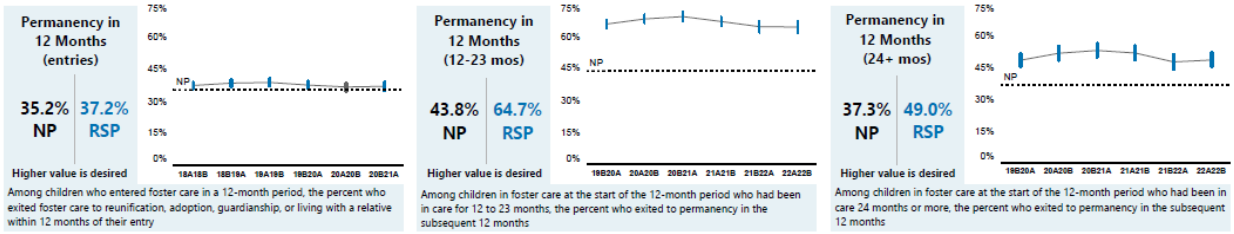
Re-Entry to Foster Care	*June 2021	*June 2022	*June 2023
Re-Entry <6 Months	37%	54%	71%

ROM Federal Re-Entry

Due to the change in the definition of "foster care discharge" these cases now impact re-entry rates. Iowa has focused on steps to support successful reunification, implementing a reunification process to clearly guide considerations for a family prior to a child's return from care. A study is planned to

evaluate and identify trends following the initial implementations; this will look at current data and specific case circumstances.

While this increase in re-entry is not unexpected, it is noteworthy that Iowa has not seen anticipated complementary increases to performance on timely permanence. Iowa's performance continues to be steady and to exceed goals for achieving permanence for children; at this time, it does not appear the trial home visit has had an inverse impact on timely permanence.



Iowa has established companion key performance measures that are reviewed by each service area monthly within leadership teams and staff meetings, with follow up occurring as needed. Re-entry to foster care is an item that is monitored closely to determine impact of the elimination of common use of the home visit.

To further explore how re-entry can be reduced and successful reunification increased, Iowa brought Field, Policy, and Training staff together to establish standard protocols for preparing children and families for reunification. New practices focusing on targeted milestones to prepare for reunification in a structured and gradual process were trained in the Fall of 2021 and implemented as of February 2022.

Case Reviews

Iowa has continued to complete case reviews in teams of two, consisting of a Supervisor and QI Coordinator; each team reviews cases based on a random statewide sample. Below are the most current data resulting from the case reviews:

Table 2C: Case Reviews					
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022**	**SFY 2022/2023SFY 2022/2023 (4/1/2022-3/31/2023)******
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.					
1: Timeliness of Initiating Investigations of Reports of Child Maltreatment	71%	72%	76%	82%	64%

Table 2C: Case Reviews					
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022**	**SFY 2022/2023SFY 2022/2023 (4/1/2022- 3/31/2023)******
Safety Outcome 2: Children are safely maintained in their homes, whenever possible and appropriate.					
2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care	86%	36%	67%	80%	79%
3: Risk and Safety Assessment and Management	51%	33%	43%	46%	52%
Permanency Outcome 1: Children have permanency and stability in their living situations.					
4: Stability of Foster Care Placement	80%	77%	61%	83%	83%
5: Permanency Goal for Child	85%	73%	80%	88%	85%
6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	60%	53%	63%	70%	73%
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.					
7: Placement with Siblings	88%	72%	92%	74%	96%
8: Visiting with Parents and Siblings in Foster Care	74%	54%	62%	83%	72%

Table 2C: Case Reviews					
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022**	**SFY 2022/2023SFY 2022/2023 (4/1/2022-3/31/2023)*****
9: Preserving Connections	63%	67%	85%	88%	98%
10: Relative Placement	78%	69%	84%	86%	87%
11: Relationship of Child in Care with Parents	66%	73%	72%	82%	77%
Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.					
12: Needs and Services of Child, Parents, and Foster Parents	45%	35%***	45%	57%	62%
• 12A: Needs Assessment and Services to Children	66%	63%	68%	82%	83%
• 12B: Needs Assessment and Services to Parents	44%	37%***	54%	59%	68%
• 12C: Needs Assessment and Services to Foster Parents	85%	66%	72%	89%	87%
13: Child and Family Involvement in Case Planning	49%	42%	53%	64%	80%
14: Caseworker Visits with Child	51%	35%	43%	55%	71%

Table 2C: Case Reviews					
Item	**FFY 2018 CFSR* (4/1/2018 – 9/30/2018)**	**SFY 2020 (7/1/2019 – 3/31/2020)****	**SFY 2020/2021 (4/1/2020 – 3/31/2021)****	**SFY 2021/2022 (4/1/2021 - 3/31/2022**	**SFY 2022/2023SFY 2022/2023 (4/1/2022-3/31/2023)******
15: Caseworker Visits with Parents	25%	24%***	30%	44%	54%
Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.					
16: Educational Needs of the Child	84%	85%	86%	88%	89%
Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.					
17: Physical Health of the Child	59%	37%	52%	63%	55%
18: Mental/Behavioral Health of the Child	56%	66%	63%	64%	58%
Source: *Child and Family Services Review, Iowa, Final Report, 2018 available at https://dhs.iowa.gov/sites/default/files/IA_CFSR_Final_RPT_2018.pdf?062520201554 **HHS Case Reviews utilizing standardized process for period of time indicated.					

CFSR case reviews have continued throughout the period since the last APSR. At this time, Iowa has implemented multiple strategies as outlined in the CFSR PIP, resulting in improved performance. Iowa has successfully met the following PIP targets:

- Timeliness of face-to-face contact (item 1);
- Safety and Risk Assessment and Management (item 3);
- Stability of Foster Care Placement (item 4);
- Appropriate and timely permanency goals (item 5);
- Efforts to achieve timely permanence (item 6);
- Assessment and services to children, parents, and foster parents (item 12);
- Child and family involvement in case planning (item 13);
- Worker visits with children (item 14); and
- Worker visits with parents (item 15).

These areas continue to be monitored; performance continues to improve and sustain beyond targets. Following are additional updates regarding case review performance:

Safety Outcome 1

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

Iowa met the PIP coal for this item at the end of SFY 2021 at 82%; since that time, there has been a decrease in performance, most recently reporting 62%. When analyzing reasons for the ANI scores over the last seven quarters, the primary reasons were found to be:

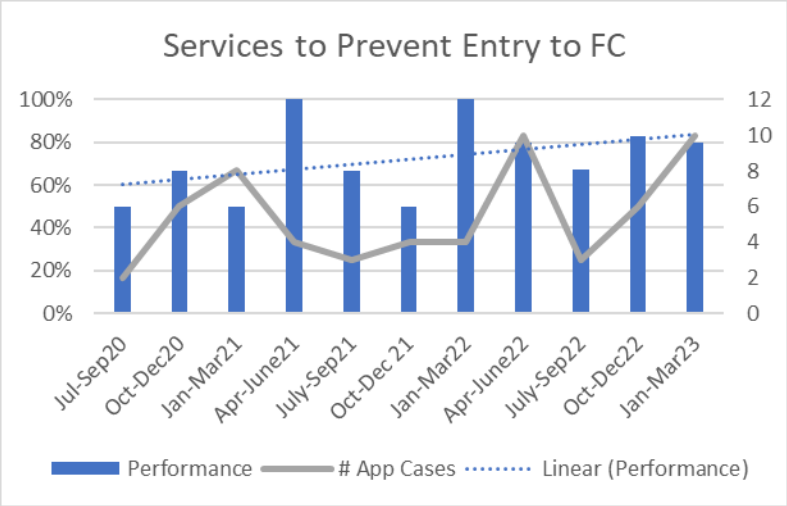
- An initial delay was approved by the supervisor, but the face-to-face follow up to that was not timely (21%)
- Not using all resources available to locate child(ren) (21%).

It is noteworthy that during the PIP period, Iowa clarified guidelines around delays in the contact to include specific timelines for communication with the supervisor and for follow up with the family; previously there were not standard timeframes stated for when a child had to be seen following an initial approved delay. This change in practice that was made during our PIP period increased the expectations and potentially impacted the CFSR performance. Iowa expects to see improvement in this area as the practice becomes more integrated.

Safety Outcome 2

Preventing entry to foster care (Item 2)

While Iowa's performance in this area continues to be below the baseline of 85% from the 2018 on-site review, performance overall is showing a trend of improvement. Multiple factors may be influencing this performance including the revised and retrained safety assessment tools and ongoing focus on safety plans and increased flexibility in the use of safety services. Iowa's PIP included multiple strategies that targeted standardizing processes and providing clear guidance on such things as reasonable efforts to see a child victim timely, how to assure safety if unable to meet the timeframe, questions to ask families when considering a safety plan in order to keep a child in the home, and more; all of these strategies have impact on services provided to families starting immediately upon referral. Child Safety Conferences are another tool that has been extended statewide that is utilized when safety issues are identified and involve the entire team problem-solving to find ways to assure child safety within the home. Iowa continues to focus on this area and analyze case review data to assess specific situations for trends.



Risk and safety assessment (Item 3)

Performance on assessment of risk and safety for families has shown steady improvement over the last five reporting periods, resulting in achieving the PIP target in CY2022. Iowa believes this is the result of ongoing training and use of guidance developed during implementation of the PIP regarding safety assessment and safety plans. Protocol regarding safety assessments requires discussion between social worker and supervisor during regular meetings; this includes reviewing the initial assessment as well as ongoing assessments, discussion of danger versus risk, safety plan effectiveness, etc. Case review data indicates continued improvement overall, notably a continued increase in completion of ongoing assessments:

Item 3: Accurate assessment of all risk and safety concerns

Timeframe of case reviews completed	Initial Assessment	Ongoing Assessment
April 2021-March 2022	71%	57%
April 2022 – March 2023	90%	63%

*Practice Performance Report, CFSR Portal

At the time of development of the PIP, Iowa noted that just 9% of cases (3/32) were rated as a strength regarding ongoing assessment during the 2018 on-site review; this was the driving force impacting overall performance on OSRI item 3. Efforts targeting safety assessment have become integrated into practice and ongoing assessment continues to improve.

Permanency Outcome 1

Placement stability (Item 4)

Federal placement stability data continues to validate that Iowa is consistently below the federal threshold of 4.1 moves per 1,000 days of foster care, most recently 2.7 as indicated in Iowa's Data Profile. Although reflection of this performance took longer to demonstrate through case review data, Iowa showed steady progress over seven reporting periods, successfully achieving the PIP target of 88% during the CY2022 reporting period. Iowa continues to focus on relative and fictive kin placement, reducing the use of shelter; as data demonstrates a steady decrease in its use, placement stability case review data has shown a complementary increase.

Item 4: Placement Stability

SFY	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
# Shelter Placements	2143	1988	1715	1535	1282	1087	941

Iowa has also just completed a pilot for utilization of Bridge meetings, which are intended to establish a relationship between birth parents and foster parents at the time of placement. Early communication about a child's routine, likes/dislikes, effective interventions, and other important information is important to east the child's transition and for the birth and foster parents to begin a process of working together; it is hoped that this will then positively impact placement stability. This practice will be spread statewide this Fall 2023.

Appropriate and Timely Permanency Goals (Item 5)

In May 2023, Iowa was informed this PIP item was successfully completed. Although Iowa's performance has been consistently high in this area, generally between 85% and 88%, it has been just short of the 90% PIP target. The Children's Bureau applied established criteria for high performing items as outlined in their procedure manual which consisted of meeting the baseline performance for three separate reporting periods; this resulted in Iowa successfully completing this PIP item as of the reporting period for calendar year 2021. Additional information regarding Iowa's observations on performance to this point in this area: the timeliness of implementing concurrent goals for children has shown improvement but continues to drive performance in the small sample of cases (40) applicable to this item per year. Iowa actively promotes an environment of continuous improvement, including work groups of Field representatives to address prioritized focused areas; multiple work groups that were focused on areas that abut concurrent planning (example: the transfer process between an ongoing case manager to an adoption case manager) have identified concurrent planning as a focused improvement area to streamline permanency for children; this led to facilitation of a Lean process targeting concurrent planning that was held in June 2023.

Timely Performance (Item 6)

Iowa met this item at 71% during the first PIP reporting period and has continued a positive upward trend; most recently, performance for 4/1/22 – 3/31/23 was reported at 73%. Iowa has continued to focus on timely permanency through evaluating process steps for: successful reunification, the handoff of information from the ongoing case manager to the adoption case manager, and, most recently, standard expectations and guides for concurrent planning. All of these initiatives work together to continue promoting timely permanency for children.

Permanency Outcome 2

Placement with siblings (Item 7)
Visiting with parents and siblings in foster care (Item 8)
Preserving connections (Item 9)
Relative placement (Item 10)
Relationship of child in care with parents (Item 11)

Overall, Iowa's performance on Permanency Outcome 2 has continued to steadily improve since the 2018 baseline period. Notably, the most current reporting period indicates significant strengths in the areas of placement with siblings (96%), relative placements (87%), and preserving connections (98%). Visiting with parents and siblings in foster care (Item 8) is the only item that has shown a decline in the most recent period as compared to baseline. Analysis of the case review data indicates that, while Iowa consistently placed siblings together, when possible, if siblings were not placed together, frequency of visits was insufficient at times. Issues in this reporting period primarily include coordination with placements to assure scheduled visits occurred and one situation where the relative foster parent was facing transportation barriers, but this was not identified or mitigated to assure the sibling visits took place. The importance of sibling visits continues to be an area of emphasis.

Well-Being Outcome 1

Assessment and services (Item 12)

When analyzing Iowa's 2018 on-site review performance a clear trend emerged regarding lack of engagement with fathers, especially during assessment, case planning, and visits with the assigned social worker. Many key activities within Iowa's PIP focused on looking at involvement in a child welfare case through a father's perspective, the benefits of having fathers involved, and ways in which we can more effectively reach out. See PIP Strategy 2.1 narrative for more details on these efforts.

The PIP goal for assessment and services was met during the reviews conducted between January and December 2021. It's noteworthy that data comparison from the onsite review to the current reporting period indicates a significant increase in performance with fathers (see father-specific data below); this has been a primary driver in Iowa's increased performance.

Item 12: re Father	Assessment	Services
2018 OnSite	61%	40%
Jan 2021-Dec 2021	68%	64%
Jan 2022- Dec 2022	70%	73%

Child and family involvement in case planning (Item 13)

This goal was met during the 10/1/20-9/30/21 reporting period. Iowa's performance continues to steadily increase. Iowa attributes this to the full implementation of PIP strategies; consistent with results reported in item 12, the engagement of fathers has shown significant increase since Iowa's baseline period and is a strong contributing factor to the increased performance overall.

Item 13 re Father: Active involvement in Case Planning	
2018 OnSite	50%
Jan 2021-Dec 2021	61%
Jan 2022-Dec 2022	78%

Iowa also believes Families First initiatives implemented in July 2020 are only now being accurately represented in the case reviews due to the retrospective period under review. It is noted that progress on involvement of families and the assessment of needs and services are running on parallel trends over the last five reporting periods, demonstrating the inter-connectedness of these items; performance in both of these exceeded the targets established in the PIP.

Worker visits with child(ren) (Item 14)

Performance in the area of social worker visits with children continues to show steady improvement over time.

Item 14: Social Worker Visits with Children		
Timeframe of Case Reviews Completed:	Frequency	Quality
April 2021 – March 2022	87%	60%
April 2022 – March 2023	89%	72%

*Practice Performance Report, CFSR Portal

This is improvement on both frequency and quality of visits. Iowa attributes this continued increase in part to federal clarification of the written instructions in the OSRI for scoring this item regarding visits with children; in each applicable interview, reviewers now explore potential barriers to meeting with a child alone and take that into consideration when assessing this area. In addition, Iowa has dedicated significant time and resources to training that incorporates key initiatives with indirect impact on the quality of visits. Ongoing monthly monitoring of administrative data regarding completion of visits continues, as does the availability of tools to identify and plan for children to be visited.

Social Worker Visits with Parents (Item 15)

Iowa met the PIP target for this item in the first reporting period at 33%; since that time performance has continued to consistently rise, most recently reporting 56%. This increase may be attributed to strategies, resources, and instruction regarding the importance of engaging fathers developed within the PIP. Of note, performance in frequency and quality of visits with both parents significantly improved since the baseline period, as the table below illustrates:

Worker/Parent Visits	2018	SFY22	SFY23
Both the frequency and quality of caseworker visitation with the mother were sufficient.	43%	62%	69%
Both the frequency and quality of caseworker visitation with the father were sufficient	44%	41%	60%

*OMS: Practice Performance Report

Wellbeing Outcome 2

Educational needs of the child (Item 16)

Assessment and provision of educational services continues to be a strength for Iowa, currently performing at 89% based on CFSR case reviews.

Wellbeing Outcome 3

Physical health of the child (Item 17)

Mental/Behavioral health of the child (Item 18)

Iowa has maintained performance on these two items since the 2018 baseline period. Identified struggles with physical health services center on dental exams, especially for very young children. Best practice is for children to get their first exam when they get their first tooth or at 12 months of age; Iowa continues to have capacity limitations for pediatric dental services which impact the ability to meet this. This is a known systemic issue for service array.

SYSTEMIC FACTORS

CB encourages states to use the 2022 APSR to begin identifying and using evidence that shows functioning of the systemic factors. If this evidence is not currently available, states will want to consider how to put processes in place to assist with future data collection and measurement. Developing this approach for the APSR review will support states in preparing for their Round 4 CFSR.
Information System (45 CFR 1355.34(c)(1))

Statewide Information System (Item 19)

Iowa's statewide Child Welfare Information System (CWIS), also known as Joining Applications and Reports from Various Information Systems (JARVIS), comprises two important components, Family and Child Services (FACS) and Statewide Tracking of Assessment Reports (STAR). FACS is the child welfare case management and payment system for HHS. It applies to children remaining in the home and in foster care and collects demographic data, caseworker information, household composition, services provided, current status, status history, placement information, and permanency goals, among other information. It tracks the services provided to a monthly average of approximately 18,000 children and automates issuance of over $160 million annually to foster and adoptive parents and other child welfare providers. STAR collects information related to child protective assessments, which includes both child abuse assessments and family assessments.

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

Several years ago, HHS implemented a case review process for assuring data accuracy, which continues on an annual basis. HHS' Bureau of Quality Assurance and Improvement (QA&I) staff examine data accuracy for 100 cases randomly selected from all children served in out of home care. This process compares FACS/AFCARS data with case narrative and file documentation from sources other than FACS/AFCARS (i.e., court orders and narratives, social history, case plan narratives, etc.). The process explores basic demographics (race, sex, and ethnicity), foster care placement data (latest removal, manner of removal, current setting, discharge date, discharge reason), and case plan goal, etc. For the FACS/AFCARS review, data counts as "accurate" when it is consistent with case file documentation. Data counts as "inaccurate" when there is clearly an inconsistency between FACS/AFCARS and case file documentation. Individual data counts as "unable to verify" when data comparison cannot occur because there is no independent paper file source for comparison. Reviewers communicate with case managers when an inconsistency is found; case managers follow up and correct or clarify information as needed. Annually, a statewide report, as well as service area-specific reports, are generated and distributed. These are reviewed at leadership and staff meetings to identify any trends that may need additional action. Performance on the AFCARS reviews remains high overall, but trends continue

regarding the difficulty to verify race and ethnicity; this is an area that is expected to be positively impacted by CCWIS.

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

Element	AFCARS Data Validation Review - Item Description	CY 2017	CY 2018	CY 2019	CY 2020 Data Not Available	CY 2021	CY 2022
FC-06	Does the child's DOB in FACS accurately reflect what is listed in paper file documentation?	99%	100%	98%	-----	100%	99%
FC-07	Does the child's Gender in FACS accurately reflect what is listed in paper file documentation?	100%	100%	99%	-----	99%	100%
FC-08	Does the child's Race in FACS accurately reflect what is listed in paper file documentation?	99%	97%	94%	-----	51%	83%
FC-09	Does the child's Hispanic or Latino Ethnicity in FACS accurately reflect what is listed in paper file documentation?	99%	92%	98%	-----	41%	65%
FC-21	Does the child's Date of Latest Removal in FACS accurately reflect what is listed in paper file documentation?	96%	96%	95%	-----	91%	96%
FC-25	Does the child's Manner of Removal in FACS accurately reflect what is listed in paper file documentation?	99%	95%	99%	-----	100%	100%
FC-41	Does the child's Current Setting in FACS accurately reflect what is listed in paper file documentation?	98%	94%	96%	-----	99%	99%
FC-43	Does the child's Case Plan Goal in FACS accurately reflect what is listed in paper file documentation?	90%	93%	96%	-----	96%	96%
FC-56	Does the child's Discharge Date in FACS accurately reflect what is listed in paper file documentation?	97%	95%	96%	-----	91%	94%

Source: HHS AFCARS Case Reviews

AFCARS PIP: Iowa's AFCARS PIP was closed out in April 2022. Ongoing efforts to develop the new CCWIS functionality will incorporate fixes for those areas in which Iowa is currently not in compliance; lack of compliance is primarily due to limitations of capabilities within the current system. CCWIS will provide data for additional robust analysis of the child welfare system, helping to identify those areas in which improvement efforts should be prioritized.

Current or Planned Activities to Improve Performance

- During FFY 2021-2024, Iowa will continue collaboration with the federal Children's Bureau in implementing its CCWIS.
    - FFY 2021 – HHS will continue the following planning activities on an ongoing basis:
        - Continue development of HHS 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 2022-2025: Design, develop, and implement CCWIS by user role.
    - FFY 2022-2025: Social Worker 2s/3s
    - FFY 2023: Supervisors, Service Area Leaders, Support Staff, and Specialized Staff (DoIT, Fiscal, ICPC)
    - FFY 2024: IV-E Staff, Management Analyst/Quality Assurance Staff, Program Managers, Providers, External Partners, and Citizens (reports)
    - FFY 2024-2025: Ongoing monitoring and upgrading, as necessary

CASE REVIEW SYSTEM (45 CFR 1355.34(C)(2))

Written Case Plan (Item 20)

Iowa's policy requires the joint development of a written case plan with the child's parents and the child, if appropriate. The initial case plan is due within 25 days of the child entering foster care. The *Family Case Plan*, form 470-3453, is the official record of HHS' 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 assist the family in self-directed change.
    - How HHS 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 timeframes 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;
    - HHS 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 services provided and the date the child's placement caregiver or provider received the information. This information may reflect the status of the child's immunizations, medical problems, or medications prescribed.
    - Educational records, such as:
        - Early ACCESS or Area Education Agency (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 six months as part of the six-month periodic case review or more frequently as required by juvenile court.

Periodic Reviews (Item 21)

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

Timeliness of Dispositional Review Hearings
March 2022 through March 2023

	April '22 – June '22	**July '22- September '22**	**October '22- December '22**	**January '23 – March '23**
Statewide (% that met the timeliness goal)	84.89 %	90.11 %	86.81 %	88.85 %

Permanency Hearings (Item 22)

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. This has been an area of focus for the courts. According to the most recent Quarterly Federal Timeliness Measures Report, compliance with the time to the first permanency hearing was 75% during the past quarter, which is an increase of 10%. The time to the subsequent permanency hearing was met 98% of the time. This was a specific topic that was covered at the last training for the judges on the juvenile bench.

Quarterly Federal Timeliness Measures Report					
Court Function Indicator *[Specific, observable, and measurable indicators to track change towards the desirable outcomes]*	**For the Period (4/2022 - 6/2022)**	**For the Period (7/2022 - 9/2022)**	**For the Period (10/2022 - 12/2022)**	**For the Period (1/2023 - 3/2023)**	**Difference From Baseline** *[Difference in the annual level from the baseline. if appropriate, note significant changes.]*
Timeliness Indicators					
Time to First Permanency Hearing (T4) - (From DHS Placement Date to issuance of the Permanency Hearing Order in 365 days.)	66% (179.00 / 273.00)	66% (165.00 / 250.00)	65.00% (155.00 / 239.00)	75.00 % (179.00 / 238.00)	10%
Time to Subsequent Permanency Hearing (T12) - (From permanency order file date to the date of the last permanency review hearing in 365 days.)	98% (330.00 / 336.00)	96% (320.00 / 332.00)	96.00% (299.00 / 310.00)	98.00 % (319.00 / 324.00)	2%
Time to Permanent Placement (P2) - (Time from filing of the original petition to permanent placement in 730 days.)	241.7 days (23.00 / 108.00)	412.7 days (28.00 / 95.00)	474.70 days (20.00 / 90.00)	382.70 days (26.00 / 92.00)	-92 days
Time to TPR Petition (T6) - (From CINA petition filing to termination petition filing in 455 days.)	72% (257.00 / 357.00)	75% (220.00 / 295.00)	78.00% (199.00 / 255.00)	78.00 % (144.00 / 184.00)	0%
Time to TPR (T5) - (From CINA petition to termination order filing in 545 days.)	66% (139.00 / 212.00)	69% (204.00 / 294.00)	75.00% (162.00 / 217.00)	78.00 % (156.00 / 199.00)	3%
2) Q2 - Report run Date - May 1st of this year - Date range - (1/2023 - 3/2023)					
*** P2 - Permanent Placement Includes - Reunification, Adoption, Guardianship and Aged-Out**					

Source: Iowa Children's Justice
There are no known limitations for the data.

Termination of Parental Rights (Item 23)

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

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

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

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

Quarterly Federal Timeliness Measures Report					
Court Function Indicator *[Specific, observable, and measurable indicators to track change towards the desirable outcomes]*	**For the Period (4/2022 - 6/2022)**	**For the Period (7/2022 - 9/2022)**	**For the Period (10/2022 - 12/2022)**	**For the Period (1/2023 - 3/2023)**	**Difference From Baseline** *[Difference in the annual level from the baseline. if appropriate, note significant changes.]*
Timeliness Indicators					
Time to First Permanency Hearing (T4) - (From DHS Placement Date to issuance of the Permanency Hearing Order in 365 days.)	66% (179.00 / 273.00)	66% (165.00 / 249.00)	65.00% (155.00 / 237.00)	76.00 % (179.00 / 237.00)	11%
Time to Subsequent Permanency Hearing (T12) - (From permanency order file date to the date of the last permanency review hearing in 365 days.)	98% (331.00 / 337.00)	96% (322.00 / 334.00)	96.00% (301.00 / 312.00)	98.00 % (326.00 / 331.00)	2%
Time to Permanent Placement (P2) - (Time from filing of the original petition to permanent placement in 730 days.)	0 days (18.00 / 86.00)	0 days (0.00 / 0.00)	0 days (0.00 / 0.00)	days (0.00 / 0.00)	days
Time to TPR Petition (T6) - (From CINA petition filing to termination petition filing in 455 days.)	72% (257.00 / 357.00)	75% (219.00 / 293.00)	80.00% (199.00 / 250.00)	82.00 % (144.00 / 176.00)	2%
Time to TPR (T5) - (From CINA petition to termination order filing in 545 days.)	66% (139.00 / 211.00)	70% (204.00 / 290.00)	77.00% (162.00 / 211.00)	81.00 % (156.00 / 192.00)	4%
2) Q2 - Report run Date - May 1st of this year - Date range - (1/2023 - 3/2023)					
*** P2 - Permanent Placement Includes - Reunification, Adoption, Guardianship and Aged-Out**					

Time to Permanent Placement (P2) - (Time from filing of the original petition to permanent placement in 730 days.)	372.7 days (10.00 / 34.00)	262.9 days (8.00 / 34.00)	168.80 days (8.00 / 35.00)	404.80 days (4.00 / 19.00)
Time to TPR Petition (T6) - (From CINA petition filing to termination petition filing in 455 days.)	65% (154.00 / 238.00)	73% (166.00 / 226.00)	77.00% (214.00 / 277.00)	84.00 % (168.00 / 200.00)
Time to TPR (T5) - (From CINA petition to termination order filing in 545 days.)	63% (125.00 / 199.00)	66% (125.00 / 188.00)	74.00% (128.00 / 173.00)	82.00 % (170.00 / 207.00)

Source: Iowa Children's Justice
There are no known limitations for the data.

Notice of Hearings and Reviews to Caregivers (Item 24)

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. Through the clerk of court, the court uses its' automated system to send notices of upcoming hearings to foster parents and other caretakers. A data match between HHS foster parent or other caretaker contact information, i.e., name and address, and the court data is the source of information by which the automated system sends the hearing notices. A limitation of this data may be timely HHS staff data entry to ensure the foster parent's name and address is current. However, with implementation of the requirement to enter the placement within three business days, HHS believes this will improve accuracy in the system. The court also monitors the automatic notification process to assure it runs timely. Attachment 2B 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.

Strengths and Opportunities for Improvement

- Item 20: Written Case Plan: Data for item 20 continues to show more collaboration needs to occur for developing the case plan jointly with the parents, with data showing the lowest performance for inclusion of fathers in case planning.
- Item 22: Permanency Hearings: Data continues to show that initial permanency hearings are not as timely as subsequent permanency hearings. During Iowa's FFY 2018 CFSR, stakeholders noted the practice of combining permanency hearings and termination of parental right hearings (TPR) jointly, which may negatively affect timeliness of the permanency hearings. We have been addressing this with judges and we have seen an improvement in the last quarter.
- Item 23: Termination of Parental Rights: Timely TPR petitions fluctuated some over the last four quarters, but we have seen an improvement from 72% to 82% timely. Although there isn't a certain

reason for an increase in compliance, we believe it is from judges and other parties monitoring the timeliness of achieving permanency more closely.

- Item 24: Notice of Hearings and Reviews to Caregivers: Iowa does not currently have a good way of determining compliance with this requirement. HHS implemented a requirement that staff must enter all placements, including placement changes, into the information system within three business days of the placement. Having up-to-date caregiver information increases the likelihood that the caregivers will receive the notices timely. The next focus will be developing a valid mechanism for determining caregivers received the notice and understood they have a right to be heard during the hearing.

Current or Planned Activities to Improve Performance

- Please see *Section III: Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Updated Plan for Enacting Iowa's Vision*:
  - Item 20: *Goal 3, Strategy 3.1* - planned activities to improve joint case planning with parents
  - Items 22 and 23: *Goal 2, Strategy 2.2* - planned activities to improve permanency for children and youth in foster care
- For Item 24: Notice of Hearings and Reviews to Caregivers
  - In FFY 2024, HHS and ICJ staff will develop a quality assurance process to determine compliance with this requirement.

QUALITY ASSURANCE SYSTEM (45 CFR 1355.34(C)(3))

Please see *Section IV: Quality Assurance System* for an update on this systemic factor.

STAFF TRAINING (45 CFR 1355.34(C)(4))

Initial Staff Training (Item 26) and Ongoing Staff Training (Item 27)

Please see Iowa's FFY 2020-2024 Child and Family Services Plan (CFSP), Training Plan, Attachments 8D and 8D1 through 8D9, referenced in *Section VIII: Targeted Plans* of this report.

Foster and Adoptive Parent Training (Item 28)

Foster and Adoptive Parents: Each RRTS contractor completes pre-service and in-service training in their Service Areas. Pre-service training consists of the National Training and Development Curriculum for Foster and Adoptive Parents (NTDC). This new curriculum which transitioned from TIPS-MAPP, began July 1, 2022. The NTDC training is based on research and input from experts, families who have experience with fostering or adopting children and former foster and adoptive youth. It is a classroom and online program that prepares foster and adoptive parents with the information and tools needed to parent a child who has experienced trauma, separation, or loss.

The NTDC curriculum consists of three components that help to prepare and provide ongoing development for parents who want to adopt. The first component is a self-assessment which is a self-discovery tool to help prepare applicants the opportunity to identify their strengths and areas they need additional support. The second component is the classroom-based training. Each classroom-based training theme has clearly delineated competencies. This content is also adaptable for a remote training platform. The third component is the Right-Time Training. These trainings' themes contain information

that is specific to parents who are already fostering and adopting on a variety of topics to support them as families encounter new challenges.

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. 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. RRTS caseworkers help families find training that will enhance their skills and are timely and relevant to providing care to children in their home.

The primary on-going impacts related to COVID have been evident in the need to occasionally use virtual video conferencing to complete face-to-face visits, and in the need to occasionally conduct pre-service or in-service trainings virtually to accommodate the health needs of facilitators, attendees, or due to training venues which have yet to re-open for public use since the onset of the pandemic.

Foster parent required trainings are tracked as part of the home study submission process. For example, CPR and mandatory reporter must be completed prior to submitting home studies, and families must be able to show 6 hours of on-going training completed at license renewal. The RRTS Caseworker uses the Foster Parent Training Plan to identify training topics that would be beneficial to individual families based on their needed skill development. All training completed by foster parents should be documented in the home study reports as well as in Care Match.

The focus on support and development has been an emphasis with RRTS Staff during the past year, during each of the monthly contacts RRTS are now encouraged to also explore training needs of the resource families. The use of podcasts, videos and you tube videos are now available to all RRTS staff through the NTDC (National Training and Development Curriculum) as well as on the RRTS Resource Guide that is shared on the LSI Foster Care and Adoption Website. RRTS staff is encouraged to view important topics relating to the resource families and the children that they care for. In turn the support caseworker can then share the information or view the video with the resource family to allow new strategies to be applied in the resource home to better meet the needs of the foster child.
All RRTS Post Adoption Specialists are trained through the NTI, National Training Initiative: National Adoption Competency Mental Health Training Initiative. RRTS Supervisors are also completing the NTI Child Welfare Curriculum which includes downloadable free resources featuring key information on Child Welfare and Mental Health that are then able to be shared with staff and resource families. As resource families enter into their foster care experiences it is believed that by placing value on training and development and by having staff who are also trained in these areas, families are better prepared to address the needs of the youth coming into care in Iowa. As a result, we have found that RRTS staff is also more confident in their abilities to help resource families walk through their stability plans as well.

Contractors have added a quarterly report pull that shows how many hours of training foster parents have completed during that licensing year and we provide that to caseworkers so they can prompt their families. Contractors have also started to do monthly random sampling quality reviews of contact/progress notes to make sure caseworkers document their discussions with families about training. (The random sample is 25% of all families in a service area) Iowa HHS and RRTS are currently collaborating with to Five Points develop a tracking mechanism for foster parent trainings.

Staff of State Licensed or Approved Facilities

Iowa's emergency juvenile shelter (CWES), foster group care (QRTP), and supervised apartment living (SAL) contractors regularly participate in ongoing training, e.g., internal training, training offered by HHS, 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. HHS 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, all of the current CWES, QRTP, and SAL contractors are members of this Coalition. Attendance to training under the Training Academy contract is also open to others as space allows, such as HHS staff, foster parents, JCS staff, non-contracted providers, schools, etc.

In addition, licensure standards require training for staff (with a designated staff person responsible for staff development). The Department of Inspections and Appeals (DIA) staff reviews the training licensure standards in the contractor's files, during annual reviews and unannounced visits. The designated HHS program manager receives the number of reviews/unannounced visits completed by DIA. Each report received identifies any deficiencies that need remedied. Licensure standards include:

- Staff records: Records of training sessions attended, including dates and content of the training.
- Staff development: Staff development shall be appropriate to the size and nature of the facility. There shall be a written format for staff training that includes:
    a. Orientation for all new employees to acquaint them with the philosophy, organization, program practices, and goals of the facility.
    b. Training of new employees in areas related to their job assignments.
    c. Provisions for all staff members to improve their competency, which could occur through such means as:
        (1) Attending staff meetings.
        (2) Attending seminars, conferences, workshops, and institutes.
        (3) Visiting other facilities.
        (4) Access to consultants.
        (5) Access to current information and evidence-based practices relevant to the facility's services.
    d. An individual designated responsible for staff development and training, who will complete a written staff development plan, and update it annually.

Internal training includes, but is not limited to, agency policies and procedures, mandatory reporter training and safe use of restraints.

New CWES, QRTP, and SAL contracts that are in their final year and began on July 1, 2017, require HHS 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. The providers review and update annually their training plan. Collaboration and discussion occur on an ongoing basis between HHS and the providers to identify trainings relevant to the ever-changing needs of youth in care. The Service Contract Specialist for each site also reviews this plan upon completion. The Service Contract Specialist also reviews the training plans and individual training information for each site during onsite reviews. These plans 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

The Child Welfare Provider Training Academy (Training Academy) is a partnership with the Iowa Department of Health and Human Services (HHS) and the Coalition for Family and Children's Services in Iowa. The purpose of the partnership is to research, create, and deliver quality trainings supportive to child welfare frontline staff 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 agencies and HHS in their efforts to train and retain child welfare workers and positively affect job performance that is in the best interest of children and families. Please refer to the Attachment 9A CWPTA Training Plan Live and Attachment 9B CWPTA Training Plan Relias for more information on the training plans.

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

During the reporting period of April 2022 – March 2023, the Training Academy delivered a total of 86 in-person or live virtual trainings in various regions throughout the state. The Training Academy reached a total of 1,152 staff. In comparison to the previous reporting period, the Training Academy delivered eighteen (18) more courses and reached two hundred and eighty-five (285) more staff.

In-Person Trainings

Trainings during the reporting period, April 2022 – March 2023, were a mix of in-person and live virtual on Zoom. This offered a variety of ways for participants to interact with trainers in real time. This also allowed flexibility for the workforce to attend without travel. The courses offered were for all levels of

child welfare staff, such as new workers, intermediate workers, advanced workers, and supervisory workers.

During the reporting period, April 2022 – March 2023, of the completed evaluations received from the in-person trainings, 90.35% of attendees reported the information they received at the training was relevant to their jobs, while 96.77% reported they would be able to apply the knowledge they learned.

On-line Learning

Relias is an online learning management system designed to provide healthcare related professional development opportunities to staff with 24/7 availability. Relias is a comprehensive system that provides opportunities for individualized training plans and compliance monitoring to track employee's compliance. The current Training Academy contract with Relias provides 600 user slots divided amongst the child welfare providers in Iowa interested in participating.

Providers utilize Relias to train new hires and ongoing professional development to retain current staff. During the reporting period, April 2022 – March 2023, 13 of the 19 active child welfare service contractors, currently utilizing the slots through the Training Academy, completed 6,312 courses (391 unique courses) for a total of 8,533.87 credit hours earned by 889 users. In comparison to the previous year's reporting, the total number of courses, unique courses, and unique users increased.

Since the Coronavirus pandemic began, a shift was made from the majority of workers attending in-person trainings, to those workers finding ways to do trainings remotely. There has been an uptick of contractors better utilizing Relias by using training plans for onboarding new staff and for annual trainings. The Training Academy continues to explore methodologies to deliver course content to be relevant and available to staff.

Solution Focused Meetings (SFM) Training and Youth Transition Decision-Making (YTDM) Meeting Training

The Training Academy partnered with HHS to manage the delivery of the SFM and YTDM training series. Additional courses include Solution Focused Meetings – Facilitation Essentials Training. The Solution Focused Meeting Trainings began in April 2021. Solution Focused Meetings – Facilitation Essentials training began in March 2022. This training must be taken within a year of completing the Solution Focused Meeting Training. This year, it was determined that the trainings should be taken back-to-back in order for providers to fully grasp the facilitation model. With the ever-changing workforce, it was determined that facilitators are often new to the field and having the trainings back-to-back, helps with their facilitation skills.

YTDM trainings are being requested more often due to some contract changes. YTDMs will now be facilitated by providers, instead of HHS in residential facilities, SAL facilities, those with CISR contracts, and CWES facilities.

All versions of Solution Focused Meetings, Solution Focused Meetings – Facilitation Essentials, and YTDM trainings are offered in person.

Web Site Maintenance

The Training Academy continues to maintain a web site to host training information, which includes easy access to online registration. This is also a valuable tracking tool for the Training Academy to determine the availability of courses in the community.

The web site is also a hosting mechanism for the necessary SFM and YTDM meeting forms. This information is updated within a timely fashion, as determined by the contractor.

The Training Academy also updates the website with recorded trainings put on by HHS. In the last year, the Safe Sleep Webinar was added, as well as Family Interaction Training. In order for providers to view these trainings, they must log into their account on the Coalition Website. These trainings are available for providers anytime once they are logged in.

Ongoing Training Plan Maintenance

During the reporting period, April 2022- March 2023, a mixture of live trainings and live virtual trainings took place. In talking with different work groups, providers, and agencies, it is clear that virtual trainings are preferred. Supervisors and agencies no longer need to pay staff mileage and drive time when trainings are virtual. More people are able to attend virtual trainings, and the Training Academy pays less expenses to trainers, which translates to additional training offerings that can be held.

Training Academy Workgroup

The Training Academy workgroup includes representation from the various child welfare contracts and geographical regions across the state. The workgroup meets quarterly and their mission is to inform and guide the direction of the Training Academy to ensure offerings meet the needs of the direct line and supervisory staff. This workgroup has turned into a group of HR staff and the heads of training for agencies. It has been stated that they have more availability to meet and are able to help the Training Academy narrow down the courses that need to be offered. The group is also able to discuss Relias and help agencies learn to utilize it more. This workgroup is a public-private collaboration to provide insight, ideas, and feedback in development and implementation of training across the private sector. The workgroup provides feedback on current training needs.

Agency Contract Manager

The HHS Contract Manager and Training Academy Coordinator, continue to meet regularly to address the scope of the work in SFY 2023 and 2024 to adjust to the potential training needs relating to Family First and contracting. The Training Academy Coordinator and Contract Manager are able to review and discuss any needed changes or modifications to the training plans.

Residential/Shelter Training Series

The Training Academy is working with QRTP contracted agencies to find a training to provide new staff more understanding and development when it comes to work with youth. The Training Academy worked with Meraki Institute of Learning with Tanager Place to utilize their RISE Framework training. This training has 13 modules, and they can be held in-person, live virtual, and recorded and placed within Relias. These modules cover topics such as relationships, well-being for youth and staff, social and emotional development, how trauma effects the brain, and helps to identify biases staff may have and how they can include staff's relationship with youth. This RISE Framework was given to HHS to be

reviewed and approved for Title IV-E funding. Unfortunately, some modules did not meet eligibility for Title IV-E funding and therefore the training could not be placed in the training plan. HHS provided the Training Academy with some educational material regarding Title IV-E funding. This now gives the Training Academy a better understanding of Title IV-E requirements. The Training Academy will now ensure that the RISE Framework meets Title IV-E eligibility and moving forward with a new training plan and contract, can ensure that all trainings submitted on the training plan can meet that eligibility.

RFP/New Ongoing Contract

In November 2022, the Training Academy RFP was released. The Coalition communicated their intention to bid on the proposal. From November 2022 through February 2023, the Coalition staff worked diligently on the response to the RFP. The Coalition was the only bidder on the RFP. An evaluation team met to score the bid and unanimously recommended that The Coalition be selected as the successful bidder. The Notice of Intent to Award was released in March 2023 and a contract negotiation meeting was held in April 2023. The new contract will begin on July 1, 2023.

The Training Academy will be working with other agencies, Prevent Child Abuse Iowa (PCA Iowa), Meraki Institute of Learning at Tanager Place (Meraki), and Project Harmony. The Training Academy will be able to professionalize trainings in order to not have providers training other providers. PCA Iowa is subcontracting with the Training Academy to help create multiple matrices that will help create a system to score curriculums to ensure that all curriculums on the training plan will meet Title IV-E standards and DEI requirement. This will also help the Training Academy choose the best trainer for each topic by taking each trainer's background, expertise, education, and experience into consideration.

The Training Academy will also be working to update and streamline evaluations. Evaluations will still happen after each training; however, they are looking at doing things digitally and adding questions to gather more information about the training attendee and about the training itself.

The Training Academy will also continue to provide the required trainings, such as the SFMs and YTDMs. They will be working with Project Harmony to see how they can be revamped with all the same information but making them accessible to agencies and providers when they need them.

Strengths and Opportunities for Improvement

Iowa continues to offer a variety of trainings to meet the needs of staff, foster and adoptive parents, and staff of our CISR contractors. While tracking of trainings occur to ensure meeting licensure requirements, there remains a need to determine more formally whether training courses adequately prepare foster and adoptive parents and staff of childcare institutions for their roles in the child welfare system. HHS Contract Manager will work with CWPTA to explore breaking down the evaluations by provider type so we can better track information to work on addressing this.
Please see the *FFY 2020-2024: Child and Family Services Plan (CFSP), Training Plan*, for information on strengths and opportunities for improvement for initial and ongoing staff training.

Current or Planned Activities to Improve Performance

- Initial and ongoing staff training:
    - Please see *Section III: Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Updated Plan for Enacting Iowa's Vision, Goal 3, Strategy 3.3* – planned activities to continuously improve the knowledge and skills of social work supervisors.

- Please see *Attachment 8D: Iowa's FFY 2020-2024 Child and Family Services Plan (CFSP), Training Plan*

- Foster and adoptive parent training, which includes staff of state licensed facilities (CISR contractors):
  - HHS will work with RRTS and CISR contractors to conduct the following improvement activities:
    - Training Data:
      - In FFY 2021-2024, develop and implement a tracking mechanism to ensure completion of required training within specific timeframes.
    - Training Content:
      - In FFY 2021, in coordination with considering models of therapeutic family foster care:
        - 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 2022, implement revised training and training requirements, if applicable
      - In FFY 2023-2024, monitor progress so that foster care providers, which include staff of state licensed facilities, have the knowledge base and skills needed to carry out their duties regarding foster and adopted children.

In regard to the Therapeutic Foster Care (TFC) plan, the Department has work underway to design a TFC model program for Iowa to be implemented by Iowa HHS as a pilot program in 2023. The project is intended to enhance the child welfare foster care service array, including providing highly skilled family settings for children placed in foster care under Chapter 232 and who have needs exceeding what can safely and properly be addressed in a traditional family foster home setting. The youth served will be identified because they cannot be served due to significant emotional, behavioral, or social issues or medical needs. In SFY 2022, Director Garcia identified a project coordinator out of her office to organize a workgroup to create a TFC model. The project coordinator has been identified and worked over the past year to welcome and coordinate extensive work of the workgroup. The workgroup remained on track to have a model in place for leadership to consider in the fall of 2022. Implementation of a Therapeutic Foster Care pilot program is scheduled to begin October 1st in the Cedar Rapids Service Area.

SERVICE ARRAY (45 CFR 1355.34(C)(5))

Array of Services (Item 29) and Individualizing Services (Item 30)

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, which 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.

Please see ***Error! Reference source not found.*** *Descriptions* of this report for information regarding Iowa's child welfare service array.

Strengths and Opportunities for Improvement

Iowa continues to improve its service array through implementation of evidence-based services, e.g., SafeCare®. Contractors implemented HHS' family-centered services (FCS), described in full in *Section V: Services Description Updates*. HHS continues to work with its partners to address the need for mental health and substance abuse services, disability services, and domestic violence services, especially in rural areas. Other systemic issues identified through CFSR case reviews include a lack of sufficient dental providers who accept Title XIX, waiting lists for PMICs which can impact permanency timeframes, and collaboration with other states in the use of ICPC.

Current or Planned Activities to Improve Performance

- Kinship Caregiver Payment Program: Effective July 1, 2021, kinship caregivers who have their kin placed with them for two months will receive $10/day per child for six months, which will provide financial support to unlicensed relatives/kin and keep more children with relatives. Please see information about this program in *Section V: Updated Services Descriptions*.
- In FFY 2023, HHS will continue its efforts to collaborate robustly 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. As HHS continues to evolve and reorganize from the merger between the Department of Human Services and Department of Public Health, continued conversation and improved collaboration between systems is imperative to reduce barriers for those in rural areas.
    - Mental health services – HHS' MHDS Division, Community Mental Health Centers, Rural Health Centers, use of "telehealth" services and opportunity for continuation of telehealth post-pandemic, 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 - HHS' MHDS Division, Iowa Department of Human Rights, Office of Persons with Disabilities, etc.
    - Transportation services – local transportation authorities
    - Drug testing – Please see *Section V: Updated Services Descriptions, Intervention, Drug Testing* for planned services' improvements
    - Foster care placement resources – Please see *Attachment 8A – FFY 2020-2024 Diligent Recruitment Plan* for activities to improve foster care placement resources

Please see *Section III: Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Updated Plan for Enacting Iowa's Vision, Goal 3*:

- *Strategy 3.1* - planned activities to improve joint case planning with parents
- *Strategy 3.2* – planned activities to improve engagement of parents with substance abuse

AGENCY RESPONSIVENESS TO THE COMMUNITY (45 CFR 1355(C)(6))

State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR (Item 31)

Please see ***Error! Reference source not found.***; *Section III: Updated Plan for Enacting Iowa's Vision and Progress Made to Improve Outcomes, Updated Plan for Enacting Iowa's Vision; Section IV: Quality Assurance System;* ***Error! Reference source not found.***, for information regarding this systemic factor item.

Coordination of CFSP Services with Other Federal Programs (Item 32)

Coordination of services or benefits within HHS

HHS 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 daycare 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 for a referral to these services. The social workers then work with the family and if needed HHS 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, coordination of case planning activities, etc.

For example, the social worker may have concerns about the child's safety and, working with the family, requests protective daycare assistance by working with daycare 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 disconnected from each other. HHS 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. HHS Bureau of Refugee Services provides PROMISE JOBS services for individuals with limited English proficiency.

Children in foster care may have caregivers who need daycare assistance because the caregiver works. HHS requires that daycare provided to children in foster care is a licensed or registered provider when:

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

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

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, with parental liability paid to the Collections Services Center. Referrals to the FCRU are required for all children in family foster care, group care, shelter care, or supervised apartment living. However, referrals are not required for children in PMIC placements, other Medicaid placements (i.e., Iowa Plan), non-licensed relative placements, or subsidized

adoption. Child welfare and child support staff work together to ensure referral of parents are appropriate and that child support staff have all the documentation they need.

Child welfare staff continues to collaborate with HHS 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.

Child welfare staff submits a form to HHS' child support unit for their staff to conduct searches for child welfare staff. This was the same procedure as before HHS' MOU with OCSE.

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

- Child Protective Assessments: HHS utilizes TANF funds to assess reported incidents of child abuse and neglect when the family is ineligible for funding under the Title IV-E of the Social Security Act.
- Child Welfare Services: Iowa uses TANF funds for a number of child welfare services. These services include but are not limited to social casework, protective daycare, Family Centered Services (FCS), which includes Family Preservation Services, Solution Based Casework, SafeCare®, Child Safety Conferences, Solution Focused Meetings, Kinship Navigator Services, and drug testing.
- *Community Adolescent Pregnancy Prevention Program:* Iowa uses TANF funds 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 18 or older may continue beyond the adolescent's eighteenth birthday under certain circumstances.
- *Child Abuse Prevention Program:* In SFY 2018, the state merged the state prevention program (ICAPP) with CBCAP funding, combining the administration of the programs into one single contract. This allowed for a streamlining of funds and greater administrative efficiencies. In addition, at the direction of HHS, Prevent Child Abuse Iowa (PCA Iowa) completed the following:
    - **Needs Assessment** (available at: https://pcaiowa.org/content/uploads/2019/02/2017-iowa-child-maltreatment-prevention-needs-assessment.pdf)
    - **Risk Analysis Data Update, 2019** (available at: https://pcaiowa.org/content/uploads/2019/11/Attachment-P-2-IA-Child-Maltreatment-Prevention-Needs-Assessment-Data-Update_2019.pdf)
    - **Strategic Plan** (available at: https://pcaiowa.org/content/uploads/2019/02/2017-final-cap-strategic-plan.pdf)

The alignment of the two programs, and development of the Strategic Plan, resulted in more targeted efforts to combat child abuse and strengthen families through evidence-based practices in high-need areas of the state. Seven primary goals were developed based on the recommendations of the Needs Assessment and the vision and guiding principles established for the Strategic Plan, including:

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

3. Balance funding between Primary and Secondary Prevention with a greater emphasis on reaching more vulnerable families
4. Embed culturally equitable practices in prevention services
5. Increase the use of informal and non-stigmatizing supports for families and youth
6. Increase the use of evidence-based practices (EBPs) in child maltreatment while introducing and evaluating innovative approaches
7. Engage in a statewide evaluation of prevention services' effectiveness, monitoring protective and risk factors at the organization and community level

In response to the merger, HHS, in partnership with PCA Iowa, also facilitated increased collaboration of the state's CAP councils and CPPC sites. Prior to the merger of the programs, ICAPP funds were only available to community-based volunteer CAP councils and CBCAP funds were only available to CPPC sites. In most areas of the state, these two groups worked together closely and often included many of the same members. However, this was not the case in all of Iowa's 99 counties. Therefore, HHS asked that CAP councils and CPPC sites increase collaboration and combine their efforts to determine the needs in their community related to child abuse and to develop a plan for addressing prevention. Formalization of this coordination occurred through a CAP Council/CPPC Memorandum of Understanding (MOU) for each of Iowa's 99 counties. This process repeated in 2019 before release of a new request for proposal (RFP) for SFY 2021-2025.

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

Legacy DHS initiated an interagency advisory committee of relevant stakeholders at the statewide level. The CAPP program manager convenes the committee. The committee includes representatives from the following agencies or disciplines:

- Legacy Iowa Department of Human Services (DHS)
    - This includes the DHS Prevention Program Manager
- Legacy Iowa Department of Public Health (IDPH)
    - Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) Program Managers
- Legacy Iowa Department of Human Rights, Division of Criminal & Juvenile Justice Planning (CJJP)
- Legacy Iowa Department of Human Rights, Office of Latino Affairs
- Iowa Department of Education (DoE), Nursing and Health Curriculum
- Local Public Health Executive Director

LEAHP Leadership Exchange for Adolescent Health Promotion: On behalf of the advisory committee, the CAPP program manager applied for acceptance into the Center for Disease Control (CDC) LEAHP program. The overarching goal of this leadership opportunity is to build out better state-wide communication strategies that impact Iowa adolescents. Continued conversations and implementation are planned for FY23. The LEAHP committee expanded to include representation from Legacy Iowa

Department of Public Health Bureau of HIV, YRBS leadership, and Legacy Iowa Department of Human Services Foster care. During FY23, the committee continued to collaborate and share adolescent health resources and training via emails and scheduled meetings. The committee met in-person in May 2023 to review and brainstorm ways to support Iowa's youth in the midst of legislative restrictions. The work of the committee will continue into FY23, specifically as legislative guidance is provided to schools and educators. The LEAHP national leaders plan to continue work with the Iowa cohort in FY24 pending any federal fiscal changes.

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 HHS in the planning and implementation of the Iowa Child Abuse Prevention Program (ICAPP), HHS' 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 Health and Human Services and the Administrator of the Division of Family Well-Being and Protection 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 plays an important role in decision making around the ICAPP, including changes in the scope of services and the manner by which HHS set funding limits. The CAPPAC participated in the recruitment and review of new member applicants, with five new members beginning their terms on January 1, 2021. Three members who joined the committee in 2021 are no longer participating in the committee. New members are anticipated to begin terms in August 2023. The committee reviewed and approved contract renewals for SFY 2024. More information on the CAPPAC is available here: https://dhs.iowa.gov/cappac

Collaboration with Foster Care Review Board:

A pilot citizen foster care review board in Polk County was implemented in July 2021 to review the cases of youth who have legal permanency established as another planned permanent living arrangement (APPLA). The focus of the reviews was on transition planning and services for the youth. Due to a lower-than-expected number of youth with an established APPLA goal, the population reviewed by the pilot program expanded to include the case of some 12–15-year-olds identified by HHS.

The foster care review board received additional training on case permanency planning and the juvenile court process for this age group. The board will continue to review this population in FY2024.

The top three barriers being monitored for with an APPLA goal include:

- youth needs employment or job experience,
- youth needs a housing plan as part of the transition plan, and
- youth needs certified personal documents (photo ID, social
- security card and/or a birth certificate)

Collaboration with educators and transportation services:

Fostering Connections to Success and Increasing Adoptions Act (2008) and Every Student Succeeds Act (ESSA, 2015) 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 may face education challenges before, during, and after their experiences with child welfare. HHS identified lead staff in policy and field operations at central office, as well as Points of Contact (POC) in each of HHS' 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 enrolled immediately.
- HHS maintains designated service area points of contact (POC) for all school districts; and
- Districts and local HHS have a Memorandum of Agreement (MOA) that identifies key aspects of the law, transportation guidelines, and dispute resolution processes.

HHS maintains a contract with the Department of Education (DoE) to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. HHS wrote the contract with a maximum of $300,000 per year, but it was hard to gauge how much it would cost. HHS spent $83,992 on transportation in SFY2022. This is approximately half what it was in 2021, likely due to decreasing foster care numbers and lack of busing available in the districts.

HHS sends helpdesk blasts out at the end of the school year and prior to the beginning just to remind workers about ESSA and that they need to reach out to points of contact to plan for the new school year and report any changes. Staff changes at the Department of Education have created challenges getting funds out to the districts. This is difficult for districts since they are short teachers and bus drivers. HHS continues to educate about policy expectations and offers creative solutions when a bus driver is unavailable, such as paying a caretaker to transport the child.

Early Childhood Iowa

Early Childhood Iowa (ECI)'s founding was 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. 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. Early Childhood Iowa, in collaboration with the Iowa Department of Health and Human Services and with technical assistance from Opportunities Exchange, is launching a multi-phase Shared Services project with proven success in other states. The collaboration is in response to the Governor's Child Care Task Force Report (November 2021)

https://governor.iowa.gov/sites/default/files/documents/IGOV_ChildcareTF_Report_112021.pdf . Information on ECI is available here: https://earlychildhood.iowa.gov/ At the time of this report, there are no updates to provide.

- ECI – Results Accountability: The ICAPP Administrator participates with the ECI Results Accountability (RA) component group. The workgroup's purpose and responsibilities stem from the ECI Strategic Plan, which identifies RA as a key workgroup in meeting the following objectives:
    - Create a data culture as we develop an integrated data system, to improve access to quality of programs and services and to inform decision-making and 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.
    - Review and document current funding/spending trends by state departments.

The group serves as an advisory group for Iowa's Integrated Data System for Decision-Making (I2D2). https://i2d2.iastate.edu/

Iowa became a network partner 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 in 2019 Iowa received a Preschool Development Grant (PDG) to assist in the planning and implementation process for future data integration work. PDG funds allowed for the initial integration project supported by a comprehensive Memorandum of Agreement signed in 2018, authorizing the implementation of Iowa's integrated data system, including signatures from Iowa Departments of Management, Public Health, Education, Human Services, Human Rights, Workforce Development, and Economic Development with Iowa State University. A history of I2D2 is available: https://i2d2.iastate.edu/history/

The RA continues to support Implementation of Iowa's early childhood system strategic plan, "We Are ECI", adopted in 2019 and participated in discussions related to the updated strategic plan created during FY 2023. The group will continue to focus on improving data literacy through training and technical assistance. In addition, with the development of the Early Intervention and Support team within Iowa's Family Well-Being and Protection Division, there will be additional focus on developing the analytic capacity and use data to direct prevention efforts. The group's current focus is improving data literacy through training and technical assistance. This group will contribute to the development of associated desired strategies, action steps, and associated outcomes for the strategic plan goals. The current plan is available here: https://earlychildhood.iowa.gov/document/we-are-eci-strategic-plan-2023-2026

Infant and Early Childhood Mental Health Consultation/Young Child Wellness Council

Iowa struggles with a fragmented mental health system and a shortage of psychiatrists. Iowa often ranks as one of the lowest states in the nation when it comes to mental health treatment services and accessibility. This is, at least in part, due to our geography and the increasing decline in population in many of our rural areas. Understanding what we know now about mental health and the correlation between childhood trauma and chronic disease, we know that perhaps the best way to prevent mental

illness in adults is to screen for and treat mental health concerns in early childhood. However, as noted, providers and services are sometimes scarce in certain parts of the state.

One way 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. The Iowa Association for Infant and Early Childhood Mental Health (IAIECMH) was established in 2013 for the purpose of supporting Iowa's early childhood professionals in promoting children's healthy mental development. The IAIECMH exists to promote optimal social-emotional development of infants, young children, and their families by fostering a competent workforce which values nurturing child/caregiver relationships and promotes community awareness of the importance of early childhood development.

Iowa HHS recognizes the critical nature of early childhood, and the impact that early relationships, experiences, and environments have on a child's brain development, mental health and life outcomes. The Department actively promotes infant and early childhood mental health by supporting Iowa's early childhood workforce in developing professional competencies.

Professional Endorsement

Each year, Iowa HHS utilizes a portion of Early Childhood Iowa (ECI) professional development funds to support implementation of Iowa's *Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health* Endorsement. This professional credential is a competency-based model that recognizes individuals with extensive skill and expertise in the field of infant and early childhood mental health. Developed in Michigan in 2002, and currently adopted by 35 state and 2 international Infant Mental Health Associations, this credential utilizes consistent language and standard professional competencies across all participating geographic regions and cultures.

Iowa's license for Endorsement is owned by the Iowa Association for Infant and Early Childhood Mental Health (IAIECMH), a professional association dedicated to supporting the workforce with access to resources, training, and networking opportunities. Iowa HHS collaborates with the IAIECMH to support an experienced Endorsement Coordinator who is able to provide technical assistance to all potential applicants, helping them better understand both the purpose and process of Endorsement. The Coordinator is available to assist applicants directly via phone, email and Zoom, and frequently provides presentations to Iowa groups about the benefits of Endorsement. As of December 31, 2022, a total of 29 Endorsements have been successfully completed in Iowa, with 7 applications in progress. The fundamental goal of this work is to develop professional competencies, thereby improving the quality of services provided.

The contract with the IAIECMH provides financial support to host up to 11 Reflective Supervision/Consultation (RSC) sessions each month, with a maximum of 6 early childhood professionals per session. RSC is identified as a best practice in the field of infant and early childhood mental health, prompting participants to reflect and explore how their own personal experiences, thoughts and biases potentially impact their work with young children. Additionally, the contract with the IAIECMH supports numerous training opportunities for early childhood professionals on topics that align with and support the Endorsement competencies, such as trainings on the importance of attachment, impact of trauma, and child development.

Infant and Early Childhood Mental Health Consultation

Since 2016, staff within Iowa HHS have been working to build infrastructure for Infant and Early Childhood Mental Health Consultation (IECMHC). IECMHC is a strategy that pairs licensed mental health clinicians with early childhood professionals (such as childcare providers, home visitors, and early intervention specialists) to build professional competencies in understanding and fostering young children's healthy mental development. Iowa's model for IECMHC, which was developed with technical assistance from the federally funded Center of Excellence for Infant and Early Childhood Mental Health Consultation, prompts early childhood professionals to take a step back and consider underlying causes of behavior, employ promotion strategies that foster healthy mental development, identify potential warning signs of a mental health disorder, and make referrals when indicated.

In August of 2019, the Iowa Department of Public Health's Bureau of Family Health (now under Iowa HHS) was awarded funding through SAMHSA's Project LAUNCH initiative to further expand this work. This five-year grant of more than $3.8 million is supporting the implementation of IECMHC services within Drake University's Head Start and Early Head Start programs in six counties in central Iowa and supporting infrastructure building for mental health consultants statewide. Infrastructure building activities during the reporting period include a virtual consultant orientation training, regular monthly informal networking sessions, and monthly Reflective Supervision/Consultation (RSC) sessions for interested consultants. In addition, a virtual conference for healthcare providers was offered on the topic of infant and early childhood mental health. This professional development opportunity was offered free of charge, and providers received free Continuing Medical Education credits as an incentive to participate. A total of 434 professionals registered to participate in this virtual event.

Infant Mental Health Endorsement® (IMH-E®) and Early Childhood Mental Health Endorsement® (ECMH-E®) are two separate credentials that can be earned by anyone working with, or on behalf of, very young children and their families, with a focus on strengthening and supporting early relationships that are crucial to a child's social and emotional development. Endorsement® signifies that an applicant has acquired competencies to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers, and families. During this contract year, ECMH-E® and IMH-E® were supported by multiple funding sources, including $70,450 from the ECI State Professional Development funds. For FY21 Annual Report information: https://earlychildhood.iowa.gov/document/eci-2021-annual-report

Iowa Collaboration for Youth Development (ICYD)

The Iowa Collaboration for Youth Development (ICYD) council members are leaders of twelve state agencies with the vision that "All Iowa youth will be safe, healthy, successful, and prepared for adulthood." Iowa HHS 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 effective policies, practices, and programs. HHS representatives are members of ICYD's State Council and the Results teams.

In 2021 and 2022, the focus of ICYD Council shifted to authentic youth engagement. Multiple strategies are being developed that will provide state agency staff the skills to recruit and engage young people with lived experience on specific topics that will provide additional insight and contribute to policy decisions. The ICYD Council hopes to embed youth voice in decisions affecting youth issues and work

together as a team by making the best use of existing resources to maximize efficiency in state government in order to create substantial and lasting positive changes for Iowa's youth.

For more information about collaborative activities to benefit children in foster care, please see *Section V: Updated Services Descriptions, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) (section 477 of the Act)*.

Iowa College Aid Partnership

Since 2004, HHS contracted with the Iowa College Student Aid Commission (College Aid) to implement and administer the Chafee Education and Training Voucher (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.

HHS 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 the Free Application for Federal Student Aid® (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 receive education about colleges and career opportunities. The coordinator attends other trainings and meetings as requested by HHS and other partners.

For more information, please see *Section V: Updated Services Descriptions, Education and Training Vouchers (ETV) Program (section 477(i) of the Act)*.

Iowa Department of Health and Human Services Align, Creates Opportunity

As the Iowa Department of Human Services and Public Health have combined into the single agency, Iowa Department of Health and Human Services. Long time colleagues are becoming new team members and are continuing the work while seeking ways to increase the connections and opportunities. Foster care program managers participate in provider groups to address sexual health and has leveraged these relationships to create a strong partnership with Prevent Child Abuse Iowa (PCA). Recently, PCA provided fliers with pregnancy prevention tips and a teen line to share with new social workers so they can discuss with the teens on their caseload. The Leadership Exchange for Adolescent Health Promotion advisory committee (LEAHP) is underway with different departments in leadership roles. Iowa's Independent Living Coordinator participates to connect services for children transitioning from foster care to adulthood. The overall goal of LEAHP is to recruit, train and provide support to the state leadership teams, building their capacity to develop actionable strategies and make research-informed policy decisions to address adolescent health in three priority areas: sexual health education (reduction of unplanned teen pregnancies and STIs), sexual health services, and safe and supportive environments. More information can be found here: https://www.leahp.org/

Iowa Family Support

For many years, the State of Iowa has focused on bolstering state level policy infrastructure for family support services. The State of Iowa has been awarded the Federal Maternal Infant Early Childhood Home Visitation (MIECHV) funding, which provides an opportunity to significantly advance this work.

Additionally, one of the goals of the IDPH and IDHS alignment is to promote interagency sharing of resources and responsibilities implementing services to improve child and family outcomes through intentional collaboration. All home visiting programs will be in the same division with Child Protection (Family Well Being) and intentional connections and processes built out. HHS has released an RFP to complete a full assessment of Child Protection services and processes. It is anticipated that identifying recommendations for building out these connection points will be part of the child protection assessment.

The Iowa Family Support Program 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 – federal funding for various evidence-based home visitation models used in a number of "high risk" communities in Iowa
    - ECI-Early Childhood Iowa-state funding for programming and system infrastructure to address maltreatment prevention, support child development and school readiness, and promote positive health outcomes for families with children aged 0-5 (as discussed above)
    - Shared Visions-preschool and parent support programming to support early development and school readiness
    - ICAPP-Iowa Child Abuse Prevention Program-federal and state funds allocated to prevent child maltreatment and promote strong families, discussed further below

Iowa HHS Division of Family Well-Being and Protection staff continue to be actively involved in many of these efforts by participating on the Family Support Leadership Group and serving on the MIECHV State Advisory Committee. In addition, child abuse, prevention programs are now utilizing Iowa's Family Support Statewide Database (FSSD).

DAISEY Users Group (DUG)

IDPH approached DHS again in 2015 to ask if we would be interested in using the state's Family Support Statewide Database known as Data Application and Integration Solutions for the Early Years (DAISEY) managed by University of Kansas (KU). This system already included data from the following programs (many of which also fund some of the DHS prevention programs):

- **MIECHV** – a federal home visitation program managed under IDPH
- **HOPES/HFI** – a state funded home visitation program managed under IDPH

- **Shared Visions** – a state funded family support program managed under the Iowa Department of Education (DoE)
- **ECI Family Support** – a state funded initiative to fund Early Childhood Iowa family support programs throughout the state and managed through the Department of Health and Human Services

Following the negotiation of an MOU between DHS and IDPH, and a change to Iowa Administrative Code Chapter 441-155, ICAPP grantees began entering data in DAISEY in 2018. Feedback from grantees about the migration to one data collection system for multiple family support funders has been positive. The integration has also been helpful in sorting through programs with blended funding to get a more complete picture on how funds/services are blended or braided.

However, there have also been some challenges and areas the system could be enhanced to meet the needs of the various agencies. In order to address these challenges, the DUG, established in 2019 with partners from DoE, IDPH, IDHS, and DOM, will address data gaps/needs with the shared data system. The group meets quarterly and is currently working on a platform redesign, with implementation in tiers/phases over the next several years. Additions to the data system platform to track family support workforce, including information about supervisors and family support professionals were launched in FY 2023. The addition to data includes information about family support professionals and supervisors related to experience, education, and languages spoken to better understand the workforce. The additional data has not yet been analyzed.

Iowa Finance Authority Partnership for Housing

HHS 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. We are in the third year of a six-year contract. Rent subsidies (100% Chafee funded) can go as high as $450 per month. IFA collects applications, lease agreements, a monthly budget, and a statement regarding the client's current status on the section 8 waiting list. At this time, there is no data collection regarding the gap between the rent and the payments. The client's rent is based on 30% of their monthly gross income.

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. HHS 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 collaborates 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 includes a goal with specific activities to address this need.

In May 2021, HHS directed additional funds to IFA for the Rent Subsidy program from the Consolidated Appropriations Act, Division X funds for foster care youth. This allowed a temporary increase in the amount of the subsidy available to each recipient, up to the full cost of their rent. During this time, eligibility was also extended to participants up to the age of 23. As a result, there was an overall increase in overall rent subsidy expenditures toward the end of FY 2021 and into SFY 2022. This additional help surely prevented homelessness for youth. It was used as long as was permitted by Division X, through September 2021.

Room and Board: According to the Iowa Finance Authority, $216,973 in rent subsidies were distributed during FFY2022, including $83,127 pandemic funds. We have seen increases in rent payments due to needs of youth through the pandemic. An average of 64 young people received a subsidy each month, an increase from a monthly average of 44 rent subsidy recipients in the previous year, for a total of 560 youth assisted. In addition, Iowa aftercare spent $36,683 during the same period, for one time housing related funding. Total room and board for federal fiscal 2022 is $253,656.

For more information, please see *Section V: Updated Services Descriptions, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) (section 477 of the Act)*.

Iowa Head Start

A couple of years ago the Bureau of Child Welfare took a more active role in collaborating 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. Due to significant turnover at DoE, the team has yet to reconvene. When the team resumes its work, their work will assure various disciplines (education, child welfare, law enforcement, medical, etc.) are cross-trained and collaborate around the issue of opioid and other substance use. At the time of this report, there has not been any updates to report on.

Prevent Child Abuse Iowa: The Annual National Youth in Transition Database Annual Report

The Department of Human Rights NYTD/Youth Development Coordinator and Youth Development Specialist submitted an application for the Prevent Child Abuse Iowa virtual conference, held May 11th-12th 2022. The presentation covered the state of youth in Iowa's foster care system, including data from the most recent NYTD report as well as a summary of the Talking Wall project. The audience was very interested and appreciative of the information, in particular the Talking Wall project which highlights voice of youth and has resulted in policy and practice changes. The presentation was tremendously successful, drawing requests for repeat performances, including from Community Adolescent Pregnancy Prevention members.

For more information about collaborative activities to benefit children in foster care, please see *Section V: Updated Services Descriptions, John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee Program) (section 477 of the Act)*.

Strengths and Opportunities for Improvement

The Early Intervention and Support team will develop a strengths-based blueprint for prevention in the Family Well-Being and Protection Division. The team has adopted a mission: "We leverage resources

and utilize data to customize services that meet the needs of families." The team's vision is: "We connect families with systems and programming that support healthy and successful futures." The North Star goal is "More Good Days for Families."

The team's blueprint will include renewing and bolstering current relationships and developing new relationships with stakeholders within and outside of HHS. Key external partnerships are the child welfare policy and field teams, programs within the Division of Behavioral Health where Iowa's substance abuse prevention programs are housed, and programs within our Community Access Division where our economic support programs and maternal and child health prevention programs are housed. Our external partners include Head Start and Early Head Start programs, Community Partnerships for Protecting Children, ACEs 360, child care centers, K-12 schools, and Area Education Partnerships among others. Activities within the blueprint for Early Intervention and Support include a statewide assessment to discover the key areas of need for families and pathways for offering support, targeted partnership development, establishing surveillance and a system for measuring progress and outcomes, and implementation of new initiatives.

Current or Planned Activities to Improve Performance

On July 1, 2022, HF2578 was enacted, merging IDPH and DHS together to form the Department of Health and Human Services (HHS) here in Iowa. Public Consulting Group (PCG) was contracted to identify shared program goals and align and integrate programs, practices, and policies to improve delivery of services and most effectively leverage funding. Through this alignment, HHS will be able to achieve several goals including opportunities to better leverage funding sources and the ability to identify potential for expanded funding sources; break down siloes to create a unified, integrated behavioral health system; and better access to services and easier navigation of the system for those we serve. This alignment will lead to improved outcomes for individuals, communities, and the state.

At the beginning of the alignment process, there was identified community-based stakeholders (organizations and community members) and other stakeholders that provided input and guidance on the departments' programmatic and policy efforts. The transition process to combine both departments has taken a year, with alignment milestones continuing to happen along the way. Details of the more prominent milestones are explained below.

In July 2022, a joint executive team drafted the new vision statements, mission statement, guiding principles, and branding. These were shared with staff and stakeholders through a series of town hall sessions, with over 2,000 individuals attending. Prior to finalizing language, comments received from those sessions were taken into consideration. An official launch of the HHS vision, mission, guiding principles, and branding was released in September 2022.

Mission Statement: Iowa HHS provides high quality programs and services that protect and improve the health and resiliency of individuals, families, and communities.

Guiding Principles:

- *Accountability: We use public resources responsibly to improve lives through the programs and services we provide.*
- *Collaboration: We facilitate meaningful partnerships that focus on the voices of the individuals and communities we serve.*
- *Communication: We communicate in a thoughtful and coordinated way to ensure individuals are well informed about our work.*

- *Data-Driven: We make informed, data-driven, and evidence-based decisions to drive quality and improve results.*
- *Equity: We actively identify and remove barriers to access and inclusion so that we can provide all individuals an opportunity to succeed.*
- *Integrity: We generate trust through honest, respectful, and reliable work that we can be proud of.*

Between August 2022 and October 2022, a combined website and social media presence accounts were launched. In the newly combined website, content from both current websites were brought together, with content cleanup and scaling back as much as possible since over 14,400 webpages were reviewed. Existing social media accounts were merged if the platform was able to allow this; for sites that did not allow the merging of accounts, the most active account was kept, and followers of the closed accounts were sent invitations to the new accounts. By combining both of the website accounts and the social media accounts, this allows for better functionality as well as improved accessibility to website users.

Throughout this alignment, significant effort has been expended in creating a new organizational structure. The new Table of Organization can be found here: HHS-Table-of-Organization.pdf (iowa.gov)

Office space and infrastructure was also taken into account throughout the alignment process. An office space planning initiative was created, and a vendor assisted in designing a space plan that meets the needs of the combined department. Staff are currently housed at either the Lucas State Office Building or the Hoover State Office Building, both of which are located on the Capitol Complex. At the time of this report, staff located in the Hoover State Office Building will be moving to the Lucas State Office Building in summer of 2024. Throughout the evaluation of the Capitol complex office space, an office space initiative came through to allow Capitol complex staff, specifically IDPH and DHS staff, to be located together in one state office building. It was through this evaluation that determined HHS to be housed in Lucas State Office Building. Office renovations of the Lucas State Office Building will begin fall 2023; the renovated office space will have new cubicles, private meeting areas, and other features that create a light and airy atmosphere. Each division will have an assigned area that will continue to rely on the hybrid work model. This model came about as a response to the COVID pandemic; it has shown to assist in meeting important objectives for an efficient and effective HHS system, including cost savings, improved performance, effective recruitment and retention tool, and provides employees the support to achieve success in their careers and personal lives.

Information regarding the process, including sharing resources of activities to date can be located at this website, https://hhsalignment.iowa.gov/, with updates to the website regularly occurring.

FOSTER AND ADOPTIVE PARENT LICENSING, RECRUITMENT, AND RETENTION (45 CFR 1355.34(C)(7))

Standards Applied Equally (Item 33)

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

annually and must have six hours of in-service training annually. All licensed foster families and approved adoptive families have the same licensing/approval duration.

HHS 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.

The Kinship Caregiver Program began July 1, 2021, and continues to provide financial assistance of $10/day for any relative/fictive kin that have a child court ordered to their care. With implementation of Family First, and the goal of keeping children with kin/fictive kin, HHS is committed to a process that will assist them financially until they can become licensed foster parents. As stated above, HHS has a process to waive non-safety standards tor relatives who apply to become foster parents for a child in their care which may include bedroom space, TIPS-MAPP/NTDC training, or siblings sharing a room to promote licensure.

Currently the Kinship Caregiver Program is being funded through 100% state dollars. HHS is currently exploring the possibility of transitioning this program to a TANF funding structure. A workgroup was established in June 2022 to complete a thorough analysis of the policy, practice, and system changes needed to shift the Kinship Caregiver Program to TANF funding. Using TANF funds would enable a higher payment for families.

In SFY 2022, Iowa licensing data for foster homes indicate that 0% of foster homes were approved without meeting full licensing standards. This may include families that may have an approved exception to policy to allow licensure of a family pending a specific delay such as well testing results. The exception would allow the licensing of the home and require a safety plan until the well testing had been completed, no foster children being placed in the home, and a written statement that foster children will be provided potable water, including where the water will be obtained and how it will be transported and stored. 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.

Shelter and Group Care Facilities:

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

Licensing data indicates that HHS issued zero provisional licenses in calendar year (CY) 2022.

Requirements for Criminal Background Checks (Item 34)

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
- Physician's report for foster and adoptive parents
- Communicable Disease 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. HHS staff monitors the safety of children in care through ongoing safety and risk assessments conducted during monthly visits with the child and foster parents as part of the case planning process. Service providers also monitor safety of the child through the provision of services and report any concerns to HHS for follow-up.

The RRTS contractors have an HHS approved checklist of all required documents that need to be in a packet. HHS 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 HHS. HHS Central Office staff reviewed the tracking tool, and no licenses were issued to any family who did not have complete record checks in SFY 2021 through 2022. A packet would be returned, or the contractor notified if any document, especially a record check, was missing. RRTS contractors have a 2-step quality review process for all families being studied initially or for licensing/approval renewal. For renewing families this includes reviewing all record check results obtained during the initial home study as well as any renewal years that have occurred prior to the current renewal period.

Caseworkers learned quickly to make adaptations as needed to ensure that consultations with applicants did not delay licensure. HHS and RRTS have continued to work well together to allow for modifications for in home or virtual visits due to COVID-19 related issues in a home. Fortunately, there have been minimal delays in licensing families since the State of Emergency from COVID ended due to criminal background testing. RRTS contractors have continued to struggle this past year with staffing issues requiring juggling of caseloads and prioritizing of tasks to ensure that families were licensed timely but have seen improvement recently as the workforce stabilizes.

Shelter and Group Care Facilities

The HHS has a MOU with the 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. As of July 2019, this includes the use of federal fingerprint-based background checks for employees, as described in Family First legislation. Family First applies the same national background check requirements currently applied to foster and adoptive parents and relative guardians to any adult working in a childcare institution, including adults who do not work directly with children. These requirements are the fingerprint-based criminal records checks of national crime databases and child abuse and neglect registry checks from the state or tribe where the adult resided in the preceding five years (collectively referred to as the national background check requirements). Childcare institutions include group homes, residential treatment centers, shelters, and other congregate care settings for which Iowa draws down Title IV-E funding.

Per Iowa Code, the Department of Public Safety (DPS) receives these fingerprints for submission through the state criminal history repository to the United States Department of Justice, Federal Bureau of Investigation (FBI). During the COVID-19 pandemic, Iowa and other states received flexibility on this requirement via the Stafford Act Flexibility for Criminal Background Checks. Iowa chose to exercise this flexibility, which states:

"During the major disaster period, a title IV-E agency that wishes to exercise this flexibility must:

- Conduct all available name-based criminal background checks for prospective foster parents, adoptive parents, legal guardians, and adults working in childcare institutions, and
- Complete the fingerprint-based checks of NCID pursuant to §471(a)(20)(A), (C), and (D) of the Act as soon as it can safely do so, in situations where only name-based checks were completed."

For childcare institutions, an Exception to Policy process was instituted and used to document applicants who utilized this flexibility. For prospective foster parents, the designated licensing agency has been asked to document foster parents who utilized this flexibility. As the flexibility ends, both childcare

institutions and prospective foster parents will return to completion of all necessary record checks prior to employment or licensure.

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

HHS central office staff took all child welfare, facility contracts that were up for review from January 1, 2022, through March 31, 2023, and reviewed the contractors' DIA licensing review and unannounced visit reports. For that period, there were 56 reports completed. Of these 56 reports, 47 indicated completion of the criminal background checks in accordance with the federal requirement. 8 of the 9 reports that did not meet requirements were lacking information regarding child abuse checks in states where new hires lived in the past five years. This continues to be a problematic process, as each state carries out these checks differently, and some states will not complete the checks for employment purposes.

Diligent Recruitment of Foster and Adoptive Homes (Item 35)

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 HHS requires that RRTS contractors collaborate with HHS 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. HHS 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 HHS. It is an annual target with progress towards the target being tracked and reported quarterly to the service areas.

Below is related RRTS contract performance measures:

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 fictive kin home; or
- will have exited to a pre-adoptive placement working toward permanency; or
- will have attained permanency through adoption or guardianship or;
- will have exited the emergency foster care placement within 48 hours of placement.

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

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

The table below shows the achievement for the past 5 quarters:

Table 1: Stability in Family Foster Care					
Service Area	**FY22 Q1 %**	**FY22 Q2 %**	**FY22 Q3 %**	**FY22 Q4 %**	**FY23 Q1 %**
Western	75	82.7	90	75	79.1
Northern	65	47.8	73.7	70.8	61.1
Eastern	60	84.6	71.4	61.1	35.7
Cedar Rapids	54.3	75	70	70.6	36.8
Des Moines	79.1	50	71.4	76.5	67.5
Data Source: Iowa HHS 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 1st at the beginning of that contract year and the number of licensed foster families available for matching on June 30th at the end of that same contract year.

Available for matching means a family that is not providing respite only, or is licensed for a specific child, or has accepted a child within the previous 12 months. Baseline numbers were provided for each service area in September 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: RRTS Performance Measure 2				
Service Area	**Baseline**	**Standard**	**SFY 2022 Target Net Increase**	**SFY 2022 Achieved**
1 (Western)	391	Gold	424	376 Not met
		Silver	414	

2 (Northern)	280	Gold	304	263 Not met
		Silver	297	
3 (Eastern)	175	Gold	190	163 Not met
		Silver	185	
4 (Cedar Rapids)	375	Gold	407	338 Not met
		Silver	398	
5 (Des Moines)	410	Gold	445	400 Not met
		Silver	435	
Data Source: Iowa HHS CWIS and Care Match				

RRTS (Recruitment, Retention, Training and Support) Providers continue to recognize and promote the value of Resource Families (Foster, Adoptive and Kinship Care providers) and their critical role in strengthening connections with children and birth families. By providing consistent ongoing support and development to resource families, those families are willing to accept the children that are coming into care and are better prepared to provide a safe and stable family setting until the child can be reunified with their parents or another permanency option is established for the child.

Contractors continue to utilize their social media pages to reach out and build connections in addition to in-person activities. A prior recruitment strategy was to focus on medical professionals, teachers and people who had professional experience working with children with special needs including medical, mental health and behavioral special needs. Currently, due to more flexibility with orientation and information sessions being available through webinars, these targeted recruitment populations are opening once again.

The importance of basic precautions surrounding not only COVID but also in mitigating the spread of other illnesses has become a standard in services. Caseworkers practice call ahead protocol and assessments of health or exposure when there are increased cases of illness in that community. RRTS Support Caseworkers continue to mitigate the spread of illness by requesting to modify a face-to-face visit and meet virtually when it is determined with a supervisor that it is not safe to meet in person. The Iowa Department of Health and Human Services has continued to allow for the modification of visitations on a case-by-case basis when a foster child, foster parent or RRTS Caseworker is ill and at risk of that illness being contagious. The plan for continuation of services is then to conduct a virtual visit with a follow up visit being conducted in person as soon as safely possible.

RRTS contractors recognize the overwhelming benefit of webinar training continuing to be a viable option to meet the preservice training needs and ongoing training needs of resource families. Although in person training is encouraged, Iowa Department of Health and Human Services continues to allow webinar training to be implemented for resource parents. This strategy that was developed during the COVID pandemic is a practice that continues to be a very important opportunity for Resource Families to receive quality training that can be easily accessed across the entire state of Iowa.

Measure 3 – Recruitment and Retention (Increase in Non-White Families)
The contractor shall increase the net number of licensed non-white foster families available for matching on an annual basis. The contractor's net increase in number of licensed non-white foster families will be based on the number of licensed non-white foster families available for matching on July 1st at the

beginning of that contract year and the number of licensed non-white foster families available for matching on June 30th at the end of that same contract year. The contract payment for performance is based on the following increases in net number of non-white families during each year per Service Area:

Table 3: RRTS Performance Measure 3

Service Area	Baseline	Standard	SFY 2022Target Net Increase	SFY 2022 Achieved
1 (Western)	41	Gold	51	36 Not Met
		Silver	48	
2 (Northern)	19	Gold	30	20 Not Met
		Silver	27	
3 (Eastern)	16	Gold	24	16 Not Met
		Silver	22	
4 (Cedar Rapids)	43	Gold	51	53 Met Gold
		Silver	49	
5 (Des Moines)	54	Gold	72	69 Met Silver
		Silver	68	
Data Source: Iowa HHS CWIS and Care Match				

Four Oaks Family Connections has implemented an approach to recruiting diverse Resource Families that utilizes "active efforts", i.e., those efforts that are made to get out of our offices and away from the more passive habits of waiting for prospective Resource Families to come to us and instead embed ourselves within the communities and populations we are attempting to recruit. As indicated above, recruitment of diverse Resource Families has experienced some success with three primary strategies: family-to-family recruitment, using Ambassadors to raise awareness of the need for additional Resource Families with specific communities, strategic community outreach in which Family Connections team members work to build and maintain trusting relationships with meaningful and/or influential community members or gathering spaces such as faith communities.

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.

Measure 4 – Enhanced Foster Family Homes

The Enhanced Foster Family Home Performance Measure was eliminated in an amendment with RRTS contractors on July 1, 2022. Reflected in the data below, this was a program that service areas were not able to recruit the foster homes necessary to maintain the enhanced status.

Current numbers of enhanced homes/children are in the chart below:

Table 4: RRTS Performance Measure 4

Service Area	July 2022		April 2023	
	Enhanced homes	Children Placed	Enhanced Homes	Children Placed
1 (Western)	2	2	2	3
2 (Northern)	0	0	0	0
3 (Eastern)	1	1	1	0
4 (Cedar Rapids)	1	0	1	0
5 (Des Moines)	0	0	0	0
Data Source: Iowa HHS CWIS and Care Match				

HHS continues to collaborate with Iowa Medicaid Enterprises (IME), Mental Health and Disability Services (MHDS) and Targeted Case Management (TCM) on a Therapeutic Foster Home Pilot Project funded through the American Rescue Plan Act (ARPA). The project is intended to enhance the child welfare foster care service array, including providing highly skilled support in family settings for children placed in foster care under Chapter 232 and who have needs exceeding what can safely and properly be addressed in a traditional family foster home setting. A Therapeutic Foster Care (TFC) model program for Iowa plans to be implemented by HHS as a pilot TFC program in July of 2023 in the Cedar Rapids Service Area.

For more information regarding diligent recruitment of foster and adoptive parents, please see *Attachment 8A – FFY 2020-2024 Diligent Recruitment Plan* referenced in *Section VIII: Targeted Plans*.

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

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

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

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

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

Below is information from the RRTS providers on timely completion of Iowa ICPC home studies for CY22.

Reg Type	Total completed	Total timely
Reg 1 & Reg 2	116	108
Reg 7	36	36

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

Type of Request	SFY'21 number placed in Iowa	SFY'22 number placed in Iowa
Reg 1	5	10
Reg 2	71	93
Reg 4	9	6
Reg 7	8	16
Reg 12	11	11

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

Type of Request	SFY'21 number Iowa placed	SFY'22 number Iowa placed
Reg 1	6	5
Reg 2	74	74
Reg 4	38	40
Reg 7	13	19
Reg 12	5	6

While a regular timeliness report regarding ICPC processing timeframes is still not readily available in the NEICE system, APHSA and Tetrus have been willing to provide Iowa ICPC with timeliness data

when requested. Given resource limitations, the data may not be available immediately upon request. The following is timeliness data for Iowa ICPC's processing of outgoing requests based upon the date the request is sent to Iowa's ICPC unit from our local field staff to the date it is sent to the sending state. This processing time includes the review of the outgoing request and gathering of any additional information to ensure the request is complete.

Type of Request	SFY'21 average calendar days	SFY'22 average calendar
Reg 1	2.3	3.7
Reg 2	1.6	1.5
Reg 4	2.5	24
Reg 7	0.3	1.7
Reg 12	0.5	0.7

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

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

Strengths and Opportunities for Improvement

Iowa continues to have a process in place to ensure effective use of cross-jurisdictional resources. Iowa ICPC put together a "tool kit" for Iowa HHS field staff use to assist staff when preparing or handling an ICPC case. Additionally, Iowa ICPC has worked with field staff in developing a more structured process in ensuring complete licensing information is obtained for out of state licensed placements. Iowa ICPC has recently been involved in the beginning stages of Tribal Customary Adoptions (TCA). In working with other states involving Iowa children placed there and our field staff are pursuing a TCA, we found that not a lot of other states have dealt with this process nor are they using TCA's. Iowa ICPC has included the ICPC National Office into the discussions to increase awareness within the ICPC community as well as assist with discussions. Thus far, other states have been very interested and open to the TCA process.

Current or Planned Activities to Improve Performance

- Item 36:
    - Continue to work with field staff ICPC liaisons to ensure SW field staff have access to and utilize necessary information including required timeframes when working on an ICPC case, including both sending and receiving cases
    - Pursue possible border agreements with border states and review current border agreement in place for possible changes and improvements
    - Continue discussions within the ICPC community re: use of TCA.

TITLE IV-E ELIGIBILITY REVIEW UPDATE

Iowa's Title IV-E Review (IV-E Review) occurred the week of August 26, 2019. The IV-E Review[1] encompassed a sample of Iowa's foster care cases in which Iowa claimed a title IV-E maintenance payment for an activity that occurred in the six-month period under review (PUR) of October 1, 2018,

[1] "Final Report, Iowa Department of Human Services, Primary Review Title IV-E Foster Care Eligibility, Report of Findings for October 1, 2018 – March 31, 2019" (Attachment 2C)

to March 31, 2019. Utilizing data from Iowa's Adoption and Foster Care Analysis and Reporting System (AFCARS) submission, the CB drew a computerized statistical sample of 100 cases for the PUR. The review team reviewed 80 cases, which comprised 79 cases from the original sample plus 1 case from the oversample cases. Due to no title IV-E foster care maintenance payment during the PUR, the review team excluded a case from the original sample.

Recommendations for improvement from the IV-E Review were:

1. Develop and implement policies and procedures, including staff training, to ensure changes in a child's placement status in Iowa's child welfare information system (CWIS) occurs in a timely manner.
2. Implement a quality assurance mechanism to monitor the accuracy of information in the CWIS.
3. Review payment process from foster care parent payment for childcare to payment entry into CWIS, including assessing the need for additional financial controls and edits to prevent improper payments.
4. Add an automated quality assurance (QA) module to the CWIS to periodically review and track payments to ensure compliance with federal and state requirements. Until then, conduct parallel testing of automated system claims processing against current manual processing.
5. Consider standardizing the required receipts from foster family homes to include certain information:
    a. Child's name,
    b. Provider's name,
    c. Dates of Services,
    d. Number of Units, and
    e. Amount of Payment
6. Make immediate adjustments to capture service dates in the payment history.

HHS Response to Recommendations:

1. Please see the statewide information system systemic factor earlier in this section for Iowa activities that addressed the first two recommendations.
2. For the third and sixth recommendations: In April of 2021, a work group was established to review the childcare payment process for foster children and came up with a revised process. The Department of Health and Human Services implemented a streamlined process on 9/1/2021 for paying childcare for children placed in foster care homes. There had not been a consistent process statewide for paying childcare for foster children and this process ensured that foster parents would be reimbursed timely for the childcare expense they have paid, and that HHS did not reimburse over the approvable state rate. A long-term recommendation from the work group that developed the process was that HHS develop a new system or utilize the current Kinder Track system to handle automated payments for childcare for foster payments. The work group came together again in May 2022 to develop a standardized workflow and supporting forms that facilitated approved providers to directly bill into Kinder Track for foster children in their care. The benefits of this include foster parents not having to pay providers up front or complete reimbursement forms, childcare providers could directly bill for these children and would be paid within 10 days, and this process would remove some of the administrative burden on the social work case manager. Effective 9/1/2022, childcare providers now have the ability to bill directly to the system for reimbursement in the existing Kinder Track program is the provider is CAA eligible. If not, foster

parents will continue to use their existing process of turning in the Child Care Expense Form 470-5612 to their ongoing worker for reimbursement.

3. HHS anticipates implementation for the fourth recommendation to occur with implementation of our new comprehensive child welfare information system (CCWIS).

HHS policy staff updated *Form 470-5612, Child Care Expense Statement*, (Attachment 2D) to address recommendation number five.

IOWA HHS

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

UPDATED PLAN FOR ENACTING IOWA'S VISION

Revisions to Goals, Objectives, and Interventions

The state must review, update and revise, as necessary, the goals, objectives, and interventions identified in the 2020-2024 CFSP and subsequent APSRs to ensure that they are consistent with their CFSR PIP or to sustain improvements for successfully completed PIPs. States must also incorporate any additional areas needing improvement that were identified in a title IV-E, AFCARS, NYTD, or other program improvement plan or in the "Update on Assessment of Current Performance," Section C2 identified above (45 CFR 1357.16(a)(2)). States should include information on how the state CQI/QA system was utilized to identify and inform revisions needed to the goals, objectives, and interventions.

Due to the July 1, 2020 implementation of Iowa's CFSR PIP, which comprised the revised goals, objectives, and interventions identified in last year's report, Iowa did not revise its goals, objectives, and interventions this year.

Implementation and Program Supports

To promote successful implementation of its current or revised 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 achieve and sustain each goal and objective; and
3) plan a timeline for ensuring the supports are or will be put in place. 16 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. In the 2024 APSR, states are encouraged to provide an update to implementation supports as needed.

Below is information regarding the supports needed to achieve and sustain each goal and objective:

- Training and coaching (as outlined in Attachment 8D, FFY 2020-2024 Child and Family Services Plan (CFSP), Training Plan and referenced in *Section VIII: Targeted Plans*):
    - Please see Attachment 8D for updates related to implementing a mentoring program for new workers, a Master of Social Work (MSW) stipend program for staff, and supervisory specific training.
    - Continue to encourage staff usage of HHS HelpDesks, when needed
    - Continue Iowa State University's training orientation call with new workers
- Financing:
    - Federal funding continues to provide an opportunity for Iowa to implement Iowa's title IV-E prevention services, kinship navigator program, etc. Please see *Section V: Updated Services Descriptions* for more information on these services.
- Data Systems: Please see *Section II: Performance Assessment in Improving Outcomes, Systemic Factor, Statewide Information System* for description of our implementation of a comprehensive, child welfare, information system (CCWIS) by persona (role).

- Memoranda of Understanding with Tribes: Please see *Section VI: 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 (Meskwaki Nation) and in establishing intergovernmental agreements with Tribes domiciled in Nebraska. These intergovernmental agreements will support achievement of safety, permanency, and well-being for Native children served by Iowa's child welfare system.

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

Describe the state's training and technical assistance provided to counties and other local or regional entities that operate state programs and its impact on the achievement of CFSP/CFSR goals and objectives since the submission of the 2020-2024 CFSP and subsequent APSRs. Describe training and technical assistance that will be provided by the state in the upcoming fiscal year (see 45 CFR 1357.16(a)(5)).

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

The Bureau of Quality Assurance and Improvement (QA&I) conducts case reviews and provides statewide trend feedback to state and local leadership. In addition, following each case review, the review teams meet with the social worker and supervisor involved in the case management. This is used as an opportunity to share practice strengths and/or ideas for areas that could be explored further; this interaction is intended to be informal and has been successful with promoting beneficial discussion. QA&I provides support for custom reports from the administrative data system (CWIS) to assist staff in managing their workflow and caseloads. The QA&I also facilitates program and process improvement sessions to assist staff in identifying problems and developing specific solutions for implementation and monitoring. The Division of 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 Family Well-Being and Protection (FWBP) provides answers to policy questions that field staff have. HHS holds a bi-monthly meeting with policy staff and front-line supervisors to advise, inform and gather feedback regarding policy changes and their impacts on practice in Iowa.

Please also see *Attachment 8D, FFY 2020-2024 Child and Family Services Plan (CFSP), Training Plan*, for information on how HHS' training supports achievement of Iowa's CFSP and CFSR goals.

These activities will continue in FFY 2024 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 2024 in support of the CFSP/CFSR goals and objectives. Describe how capacity building services from partnering organizations or consultants will assist in achieving the identified goals and objectives. (See 45 CFR 1357.16(a)(5).) States that have engaged with the Capacity Building Center for States, the Capacity Building Center for Courts, and/or the

Capacity Building Center for Tribes are encouraged to reference needs and planned activities that were documented during assessment and work planning.

In FFY 2024, Iowa anticipates receiving the following technical assistance to support our CFSP/CFSR goals and objectives:

- HHS' contract with the Evident Change, will continue to assist Iowa on the creation and implementation of a new and validated structured decision-making (SDM) tool for safety assessment and planning.
- Casey Family Programs: HHS began receiving technical assistance from Casey Family Programs (CFP) in October 2009. The initial focus was to decrease foster care entries and lengths of stay, particularly for minority children, which continued and evolved over the last ten (10) years. Today, technical assistance (TA) from CFP focuses on the following areas:
    - Increase permanency for children of color who have been in care 24+ months
    - Promote reunification and reduction of foster care population
    - Increase exits to entries ratio (foster care)

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

- Breakthrough Series Collaboration with focus on Race Equity teams.
- Rapid response review team looking at fatality and near fatality cases
- Western Service Area AG collaboration to promote system transformation through Family First Implementation, with a focus on racial equity - especially in Woodbury County, IA.
- Child Safety Conferences
- Policies supporting improvements in front-end safety and risk assessments and decision-making

- Center for the Study of Social Policy (CSSP): HHS has maintained contact with CSSP regarding updates to progress on efforts regarding changes with CPPC but are not working directly with CSSP at this time.
- Iowa HHS has received technical assistance from representatives from Florida and Washington State, regarding Division X efforts to provide transportation supports to youth in foster care. The past six months has been used to meet monthly and discuss the experiences in Florida (Key to Success) and Washington. The main input received from these meetings has been encouragement for HHS to expand opportunities for youth.

Provide information on activities carried out since submission of the CFSP/APSR or planned for the upcoming fiscal year in the areas of research, evaluation, or management information systems in support of the goals and objectives in the CFSP. This may include activities carried out under discretionary grants awarded by the Children's Bureau. (See 45 CFR 1357.16(a)(5).)

- Iowa received approval for its Title IV-E Prevention Services and Programs Plan, which includes a well-designed and rigorous evaluation of SafeCare®, one of Iowa's Title IV-E prevention services.
- Parent Partner: Researchers from the University of Nebraska-Lincoln's Center on Children, Families and the Law (UN-L) provide semi-annual and annual reports on participants involved with the Parent Partner Program. These reports present data retrieved from the Online Parent Partner Database. The Online Parent Partner Database stores data from seven forms: intake, contact log, client registration form, family self-assessment (entry), family self-assessment (exit), family feedback,

and fidelity checklist. The quarterly and annual reports provide analyses of the number of participants completing the entrance and exit Parent Partners participant self-assessments and fidelity to the Parent Partner model.

UPDATED PROGRESS MADE TO IMPROVE OUTCOMES

The state must report on the amount of progress made since the 2020-2024 CFSP/previous APSR submission to improve outcomes for children and families and to provide a more comprehensive, coordinated and effective child and family services continuum (45 CFR 1357.16(a)(1)).

Progress Measures: States must cite relevant state and local data supporting the state's assessment of the progress toward meeting each goal and objective of the 2020-2024 CFSP and subsequent APSRs. States should include information on how the states' CQI/QA system was utilized in determining and measuring progress.

States using the OMS (Online Monitoring System) for case reviews are asked to describe the extent to which they use the range of reports available to assist in analysis of case review results to understand case practice strengths and areas needing improvement, factors contributing to performance, and to monitor progress of improvement plans.

Measures of progress may be stated in terms of improved performance on the CFSR statewide data indicators for safety and permanency, case review items, or other available data, and may reference data provided in the "Update on Assessment of Current Performance," Section C2 of the 2024 APSR. Because the state will be reporting on the 17 fourth year of the five-year plan, the objectives and interventions associated with the goals should be fully implemented and the state should be measuring the improvements. States are encouraged to assess and report in the 2024 APSR on the amount of progress made in any geographic areas or populations that have experienced the intervention during the past year, including evidence of disparities in services and outcomes for historically underserved and marginalized populations.

In reviewing the measure of progress, states are urged to identify questions that may assist in understanding how disparities are impacting progress. For instance, are there differences across racial and ethnic groups for entry and reentry rates? Permanency in 12 months? 24 months? Placement stability? Maltreatment in care? Recurrence of maltreatment? If so, how has the state explored the differences and what steps have been taken to address?

- Please see *Attachment 3A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of June 30, 2022*

Progress Benchmarks: For each objective/intervention identified in the 2020-2024 CFSP and subsequent APSRs the state must report on the progress it is making in meeting its timeframes and benchmarks for implementing the intervention. Benchmarks may be stated in terms of implementation milestones, such as key activities completed or process measures.

If the state is not making progress as indicated by its measures or benchmarks, the state should indicate in the 2024 APSR the reasons for the lack of progress, including whether sufficient implementation supports are in place and whether the intervention is being implemented as intended. The state should report any adjustments to the intervention or implementation to increase effectiveness.

CFSP PIP-RELATED GOALS

Iowa's PIP was completed as of 6/30/2022. Summary information on the strategies addressed in the PIP are below.

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

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

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

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

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

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

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

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

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

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

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

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

As indicated in the narrative regarding case review performance, Iowa's PIP focuses specifically on increasing the department's efforts to engage fathers in services. Progress occurred regarding

standardizing technical aspects of this, such as locators, practice timeframes to contact fathers, and expectations of efforts, etc. In addition, Iowa worked closely with fathers in the Parent Partner program to:

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

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

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

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

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

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

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

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

Following the development of a standard expectation for timeframes to enter changes into the IT system, Iowa has continued to steadily improve in this area. In the 2021 APSR, performance was reported at 53.5%; 2022 APSR reported performance at 73.4%; as of March of SFY23 performance is 97.6%.

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

Table 3(a): HHS Workers' Compliance with 3 Business Day Entry Requirement									
Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	Average Total
89.6%	99.7%	99.9%	99.4%	99.3%	98.7%	97%	100%	98.5%	97.6%

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

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

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

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

Iowa began a pilot program on Bridge Meetings in two service areas in the state in January 2023, completed at the end of March. These meetings serve to keep parents involved if their child does have to temporarily reside in foster care. The meetings are designed for the biological parents to have structured conversation with the foster parent to communicate important information about their child in order to ease the transition from one home to the other. This resulted in establishing communication between the biological parents, the worker, and the foster parents, which is anticipated to impact involvement in general. In addition, a comfort call has been added to the standard process so parent and child can connect immediately upon removal and child can get much needed reassurance. Evaluation of this pilot is occurring at this time, but preliminary results are very promising.

Strategy 3.2: Effectively engage with substance using parents

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

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

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

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

Iowa collaborated with NCWWI representatives to implement a Leadership Academy for Supervisors (LAS) specific to Iowa. A focused curriculum was developed which included participation of multiple HHS leaders. Supervisors completed the first module between January and September 2021; Iowa is

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

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

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

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

Feedback loops: In monitoring and reporting on progress, the state should also continually consult with families, children, youth/young adults, and other partners (including Tribes; the legal and judicial communities; kinship navigation programs; and the prevention community) who are involved in implementing the intervention or who are impacted by the intervention for information/data about effectiveness. If available, provide information obtained using feedback loops to support progress made to improve outcomes. (For instance, provide information on who the state engaged in providing feedback related to a particular objective or intervention, how those partners were engaged, and the nature of the feedback provided.)

- Please see *Attachment 3A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of June 30, 2022*

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Section IV: Quality Assurance System

Building on information provided in the 2020-2024 CFSP and subsequent APSRs, address the following in the 2024 APSR:
Assess the progress in making planned enhancements in capacity to the state's current CQI/QA system. Include information on training or other supports to enhance the capacity of CQI/QA staff to develop analytic questions, generate appropriate measures, understand how to evaluate outcomes during the phases of implementation, and account for variation in populations that impact the ability to observe improvements over time. Provide any relevant updates on how CCWIS enhancements or updates have or will be used to support CQI/QA.

Provide any relevant updates on how CCWIS enhancements or updates have or will be used to support CQI/QA and how the agency ensures coordination of CCWIS Data Quality Plan and Biennial Review strategies with ongoing CQI/QA activities.

The QI Bureau is a support system for field to collect data, analyze, explore, and structure work groups to identify barriers and solutions. Information regarding this is shown below.

One area historically identified as a gap with Iowa's QI system relates to closing the loop on feedback; Iowa's program has not been consistent in an approach to provide child welfare stakeholders with opportunity to share their experiences. Significant changes related to Families First legislation, changes in contracted services, and implementation of multiple CFSR PIP strategies highlighted the need to hear how these were impacting our stakeholders.

A new Director of HHS was hired in 2019 just prior to COVID restrictions being implemented; these delayed efforts to make personal contact with stakeholders across the state. With the reduction of risk, the Director of HHS, leadership of Family Well-Being and Child Protective Services, and the Court Improvement Project coordinator were able to interact with a wide range of stakeholders in order to understand their perspective of the child welfare system's strengths, gaps, and opportunities. Iowa leadership held 11 listening sessions across the state with stakeholders between July 2022 and November 2022; this included Courts, Tribal leadership, Foster Parents, Relative Caregivers, Service Contractors, Education representatives, Attorneys, GALs, Community Providers, etc. This information gathered has already impacted decisions within the Department and will be incorporated into strategic planning as well.

Collaboration has also been integrated with continuous improvement initiatives through participant involvement. In the Fall of 2022, Iowa designed a process to implement and evaluate Bridge meetings. The team consisted of Field social workers, supervisors, training representatives, policy representatives; in addition, the team included a foster parent representative and a current parent partner and foster parent who previously was involved in the child welfare system with her own family. The diversity of this group prompted robust conversations and problem-solving from multiple perspectives, ultimately resulting in a plan that worked for everyone. The pilot of this program was just completed at the end of March 2023 and is currently undergoing evaluation of effectiveness; feedback has been overwhelmingly positive and this could not have been accomplished without participation of key stakeholders.

Additional examples of inclusion of stakeholders in continuous improvement are efforts that have been made to assure the CCWIS project is fully vetting the needs of Field staff and stakeholders during this planning process. Design groups have been chartered for revamping the Case Permanency Plan and the Case Notes template. The goal of each was to create a document that was easily navigated, the content reflected the essential information needed, and that information was not buried within the documents. Regarding the case permanency plan, surveys were sent to stakeholders (Court, Field, Families) to gather feedback; at the completion of the design, the draft will be demonstrated for stakeholders and facilitated discussion regarding their feedback. A similar approach will be taken with the case notes draft template.

Use of technology is now part of the QI Bureau's tool kit and will continue to be used; projects will be evaluated when planning to determine if it's necessary to meet in person (example, the size of the group could impact effectiveness) or if virtual participation would be as effective. This allows for greater participation from representatives across the state and for streamlined work.

There have been numerous workgroups over the last year focusing on topics such as:

- Continued work on the hand-off criteria and process from the Ongoing Case Manager to the Adoption Case Manager
- Engagement of fathers and measurement of progress
- Maltreatment in foster care
- Re-design of Iowa's Case Permanency Plan to be implemented in coordination with CCWIS
- Re-design of Iowa's Case Note to be implemented in coordination with CCWIS
- Guidelines to address medical marijuana use in child welfare cases
- Preparation for concurrent planning improvement efforts
- Adoption records archiving

The QI bureau's role in these activities is to serve as the neutral party that facilitates the workgroup using Lean tools to identify gaps, barriers, and ultimately solutions prioritized by anticipated impact and difficulty. Each of these efforts resulted in team recommendations for improving processes and increasing positive outcomes. HHS' Service Business Team prioritized these projects. Group outcomes include a plan for communication, implementation, and training to assure comprehensive planning. This allows for coordinated implementation, clear timeframes to understand changes seen in practice, and coordinated follow up review of impact statewide.

The workgroups referenced above were facilitated by two members of the QI bureau; generally, experienced facilitators are paired with less experiences facilitators to set up a learning environment. This pairing is beneficial to both as discussions center on "why" and "how", making facilitators think about best ways to achieve outcomes, sometimes utilizing that fresh perspective to adjust the approach. Through this type of mentoring, staff are able to benefit from experiential, hands-on learning; this unit promotes all members working as a team and sharing their expertise. As members of the QI team attend trainings, such as Iowa Lean Consortium, Iowa Department of Management classes, community college class, or come across tips learned individually, learning is regularly shared with the rest of the bureau through monthly meetings.

Each service area routinely reviews Iowa's Key Performance Measurement (KPM) reports, Results Oriented Management (ROM) reports, case review data, and a selection of additional reports relevant to service area-specific focuses. The QI role in this generally is to provide answers to data-related questions as able, to coordinate with peers as needed, and to coordinate a plan for exploration, case review, additional data, analysis, etc. Quarterly each SA QI Coordinator presents the CFSR case review information at the Supervisory Meeting; this includes a review of performance, trends identified, statewide performance, and discussion regarding how to move practice forward.

Members of the QI bureau had the opportunity to participate in classes at the local community college that focused on data collection, analysis, and presentation. As a direct result of that training, the QI bureau has been actively involved in establishing data dashboards for the Department. This data is used to share performance information with:

- Public stakeholders to be aware of key indicators of how the child welfare system is functioning;
- Service Contractors to monitor their performance on service-related expectations;
- Internal HHS staff regarding current performance, both of HHS and service contractors;
- HHS Leadership for current performance and strategic planning purposes.

These dashboards are developed through Power BI and are very user-friendly. The layout, visuals, and data selected were all created through collaboration with the stakeholders who would be using the data. In some cases, the data content was based on the foundational purpose of an area (such as child protection) or through routinely asked questions from the public.

If not already addressed in the "Update to the Plan for Enacting the State's Vision and Progress Made to Improve Outcomes" in Section C3, describe how the CQI/QA system was used to revise goals, objectives, and interventions.

If not already addressed in "Progress Made to Improve Outcomes" in Section C3, describe how information generated or acquired as part the CQI/QA system or for specific projects was used to measure progress on achieving goals, objectives, and interventions.

- Please see *Section II: Update to the Plan for Enacting the State's Vision and Progress Made to Improve Outcomes*.

If not already described in "Collaboration" in Section C1, describe how feedback loops are being utilized as part of the CQI/QA process to provide information that parents, families, youth, young adults and other system partners and stakeholders will find useful to assist the state in system improvement efforts.

- Please see *Section I: Collaboration*.

Describe the state's current case review instrument and the extent to which the state is using the data collected through federal Onsite Review Instrument (OSRI), and made available in OMS reports or data extracts, as part of the state's ongoing QA/CQI process.

Iowa implemented statewide random case review assignments with the quarter beginning October 2021. This change in process has proven beneficial in a number of ways:

1. Supervisor reviewers are able to observe practice differences across geographic areas, resulting in sharing of new ideas within their own teams.
2. Objectivity of reviewers is maximized because they are reviewing outside of their assigned service area.
3. Reviewers are more easily able to cross-train and have the opportunity to create impromptu review teams to assist as needed.

Iowa has continued to review 65 cases per rolling 12-month quarter to assess outcome performance on the CFSR items addressed in the PIP. The process for these reviews has continued to function as intended, and consistent with the state-led process utilized in the 2018 on-site review. Iowa continues with annual training of new supervisor reviewers identified in each service area. This not only provides for additional depth and back-up abilities for reviewers, but also is an effort to intentionally spread CFSR standards and definitions, making connections between application of the tool and Iowa's practice.

When discussing the timeframe for completion of the non-overlapping year (December 31, 2023) and whether this would affect training of new reviewers, Social Work Administrators felt the benefits of continued training outweighed any convenience of finishing out CFSR Round 3 with currently trained reviewers. They highlighted the impact the reviewers have had on other supervisors with their increased understanding of CFSR and ability to drive conversation in a way that combines CFSR and practice standards. The long-term goal of Social Work Administrators is to rotate all supervisors through the training, acknowledging the number of years this would take, the impact of turnover, etc. but believing it is a worthwhile effort. Supervisor reviewers have expressed the significant benefits they have gained by participating in the training and case reviews; they recommend this involvement be maintained in future process designs.

Iowa continues to focus on completion of the CFSR PIP for Round 3 but is also preparing for Round 4. We need to assure the infrastructure of case reviews and continuous improvement is sustainable. There is internal agreement that the process requires significant time and effort for all reviewers and has been especially difficult with the current state of workforce turnover. In addition, although the quality of the reviews is exceptional, reviewing only 65 cases per year has several drawbacks including limited generalization of the information and significant variation in data. Iowa will gather additional feedback from participants, reviewers, and other field staff to further inform discussions as they move forward. The next reviewer quarterly meeting will focus on developing a SWOT (Strengths, Weaknesses, Opportunities, Threats) of the current process, followed by brainstorming possible options. Options will be identified to streamline the process, increase usefulness of the data, and assure sustainability.

HHS utilizes OMS reports to share data on case reviews quarterly in each of the service areas, comparing the specific service area performance to the statewide performance, generally during unit meetings; this allows for active collaboration on ways to improve performance as well as sharing practices working well. This data is integrated with other key performance data that have been identified in Iowa in order to provide multiple perspectives on performance. In staff meetings performance trends are discussed as relevant to each service area and statewide. The statewide trends are compiled based on case review summaries as well as systemic issues that are identified as gaps during the reviews. Service area leadership has expressed the benefits they have seen from these discussions, not only to understand trends but to build teams through sharing ideas among the supervisors.

Current or Planned Activities to Improve Systemic Factor Performance

Provide an update on the state's efforts to move towards or sustain the ability to conduct a State-Led Review Process for future rounds of CFSRs and to inform ongoing CQI/QA processes. (See Appendix A of Technical Bulletin 12 for more information.)

- Please See *Section I: Collaboration, Child and Family Services Review (CFSR)*

IOWA
HHS

Section V: Updated Services Descriptions

Provide an update on the services provided to support the vision and goals since the submission of the 2020-2024 CFSP and subsequent APSRs and how the services will continue to assist in achieving program goals.

CB recognizes that the COVID-19 pandemic and national public health emergency continues to impact the delivery of child welfare services. CB encourages states to include information in the service updates below on how programs or service delivery have been impacted or modified due to the COVID-19 pandemic and national public health emergency.

In providing updates on the provision of services under the programs addressed in the APSR, CB urges states to use their data to examine disparities in services and outcomes to understand how families who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality in the child welfare system fare. This may include families of color, non-English-speaking families, immigrant families, LGBTQI+ youth/ young adults and parents, families and children with disabilities, and families living in rural areas. It is important to examine the characteristics of families for whom services were developed, who is benefitting and the outcomes they are achieving. It is also essential to take a careful look at the families the agency has not been successful in engaging in services to determine program improvement efforts to meet the needs of underserved populations.

Finally, as plans for funding services are developed it is important to use the data collected to inform the development of culturally relevant, inclusive and accessible services. For instance, the state may consider the degree to which service providers reflect the racial, ethnic and social diversity of the families served, and whether community-based organizations located in the communities where families have opportunities to receive funding and deliver services the service array and the services available. As states start planning for the submission of the next CFSP for FYs 2025-2029, it is important to engage partners to provide input on steps the state can take to expand the array of culturally relevant and inclusive services.

CHILD AND FAMILY SERVICES CONTINUUM - PREVENTION

Iowa Child Abuse Prevention Program (ICAPP)

Overview

The Iowa Child Abuse Prevention Program (ICAPP) is the Department of Health and Human Services' (Iowa HHS) foremost approach to the prevention of child maltreatment. ICAPP is based on the premise that each community is unique and has its own distinct strengths and challenges in assuring the safety and well-being of children, depending upon the resources available. Therefore, ICAPP is structured in such a way that it 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% ($731,000 annually) of PSSF, Family Support category, for the ICAPP program. In addition to the local projects, HHS contracts with an external administrator to provide technical assistance, contract monitoring, and program evaluation services.

2023 Annual Service Review

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 Resilient Communities. Full descriptions are included 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 paraprofessionals provide education, support, referrals to community-based services, and model appropriate caregiving strategies. To apply under this category, programs must be using a nationally recognized evidence-based home visitation model. The two primary models funded in Iowa include:

- *Healthy Families America (HFA)*: 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 were separated out and funded 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).

One significant change under the SFY 2019-2020 contracts was the decision to eliminate funding for respite childcare under ICAPP. This decision was made with input from various stakeholders including providers, advisory committee members, and program level staff. One of the biggest reasons for this

decision was the lack of research suggesting respite care is effective as a primary prevention method (i.e., providing care with no eligibility criteria for participation). The studies available primarily focus on the impact for very specific populations, such as children with disabilities and foster/adoptive children. An analysis of other state/federal funded programs also identified several other opportunities for funding for these specific populations including:

- Children At Home – a state funded program that provides financial support for services for children with disabilities (including respite),
- Home and Community-Based Services (HCBS) Waiver Program – a variety of Medicaid waivers available for support services, and
- Recruitment, Retention, Training, and Support (RRTS) Program – state child welfare contracted services that include support to foster and adoptive parents.

In addition to the potential duplication, the program had been tracking outcome data in respite care programs for more than 5 years (including analysis of demographic data and pre/post survey data on protective factors) and was unable to show any significant improvements for families participating in the respite programs funded. In fact, most respite program participants entered the program in a much better situation than participants in all other project types. Households utilizing respite were significantly more likely to include two parents, homeowners, higher income, and higher educational attainment. That is not to suggest abuse is not possible in those conditions, but rather to note that these participants were among the lowest risk for abuse and the service did not appear to have any significant impact on risk/protective factors. So, although the decision was not popular with some of our long-funded programs, we felt confident with the decision made based on the data.

Resilient Communities Demonstration Projects

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

- **Asset-Based Community Development** (Source: DePaul University)
    - The Asset-Based Community Development Institute (ABCD) was co-founded by two professors at Northwestern University in the early 1990s. Challenging the traditional approach to solving urban problems, which focuses service providers and funding agencies on the needs and deficiencies of neighborhoods, the model developers demonstrated that community assets are key building blocks in sustainable urban and rural community revitalization efforts. These community assets include:
        - the skills of local residents
        - the power of local associations
        - the resources of public, private, and non-profit institutions
        - the physical infrastructure and space in a community
        - the economic resources and potential of local places
        - the local history and culture of a neighborhood
- **Community Readiness Model** (Source: Tri-ethnic Center for Prevention Research)

  - The Community Readiness Model was developed at the Tri-Ethnic Center to assess how ready a community is to address an issue. The basic premise is that matching an intervention to a community's level of readiness is absolutely essential for success. Efforts that are too ambitious are likely to fail because community members will not be ready or able to respond. To maximize chances for success, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.
- **Community Toolkit** (Source: KU Center for Community Health and Development)
  - The Community Tool Box is a free, online resource for those working to build healthier communities and bring about social change. Their mission is to promote community health and development by connecting people, ideas, and resources.
- **Collective Impact** (Source: Collective Impact Forum)
  - The Collective Impact Forum exists to support the efforts of those who are practicing collective impact in the field. While the rewards of collective impact can be great, the work is often demanding. Those who practice it must keep themselves and their teams motivated and moving forward.
  - The Collective Impact Forum, an initiative of FSG and the Aspen Institute Forum for Community Solutions, is the place to find the tools and training that can help achieve success. It is an expanding network of like-minded individuals coming together from across sectors to share useful experience and knowledge and thereby accelerating the effectiveness, and further adoption, of the collective impact approach as a whole.
- **Essentials for Childhood** (Source: Centers for Disease Control & Prevention)
  - Young children experience their world through their relationships with parents and other caregivers. Safe, stable, nurturing relationships and environments are essential to preventing child abuse and neglect. The Essentials for Childhood Framework includes strategies to promote relationships and environments that can help create neighborhoods, communities, and a world in which every child can thrive.
  - The Essentials for Childhood Framework is intended for communities committed to both, promoting the positive development of children and families and preventing child abuse and neglect. The framework has four goal areas and suggests strategies based on the best available evidence to achieve each goal. The four goal areas include:
    - Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect.
    - Goal 2: Use data to inform actions.
    - Goal 3: Create the context for healthy children and families through norms change and programs.
    - Goal 4: Create the context for healthy children and families through policies.
- **Strengthening Families and Protective Factors Framework** (Source: Center for the Study of Social Policy)
  - Strengthening Families is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five key Protective Factors.
    - Parental resilience
    - Social connections
    - Knowledge of parenting and child development
    - Concrete support in times of need
    - Social and emotional competence of children

- **Positive Community Norms (Source: The Montana Institute)**
  - Positive Community Norms is an approach to prevention, manage change and foster transformation, and grow healthy norms and positive protective factors. The Science of the Positive focuses on how to measure and grow the positive by transitioning from a problem-centered frame to growing healthy, positive protective factors that already exist in communities. While acknowledging that suffering and harm does occur, the approach seeks to promote values and strengths of a community, thereby impacting culture and perceptions and creating transformation towards health promotion.

Resilient Communities Demonstration Projects (RCDP) spent SFY 2021 undergoing a community wide comprehensive Needs Assessment, due June 30, 2021. Communities underwent a Strategic Planning initiative during FY 2022 to plan for the remainder of the five-year project period. Projects were able to shift funding to direct services to families in years 3-5 of the project, though services must align with the finding of the Needs Assessment and the Strategic Plan developed in the first two years. A baseline community survey, looking at RCDP communities and other communities throughout the state, began in FY 2022 to gather baseline data assessing awareness of resources, the issue of maltreatment, parenting behaviors, perceptions of community attitudes, and resources/supports in communities. Findings from over 600 survey responses included the following:

- Just over half (52.3%) of respondents) agreed or strongly agreed with the statement, "Spanking is considered an acceptable parenting practice in my community."
- When asked about judgement/perceived judgment from others surrounding accessing food assistance, treatment for substance use disorders, or treatment for mental health, most (72%, 70%, and 68%) respectively stated they would judge others "not at all." However, when asked if they would feel judged, a much smaller number (32%, 36%, and 30%) felt they would feel negatively judged by others.
- The overwhelming majority of respondents (95%) indicated positive perceptions of parents in their community by agreeing with the statement, "Parents in my home community care about their children."
- Most participants (90%) agreed that their community was a good place to raise children.
- 83% agreed they were somewhat or very connected to their community.
- Over three quarters (78%) suggested a hopeful outlook for their community by agreeing with the statement, "In 10 years, my community will be a better place to raise children than it is today."
- Respondents were also asked about leadership support for programs. Of those listed, the ones with highest perceived support included food/nutrition programs and paid sick/vacation time off with 35% of respondents indicating support. Employee Assistance Programs and Paid Family Leave were the programs with lowest perceived support at 20% and 19%, respectively.

All four communities that received funds for building community capacity through Resilient Communities Demonstration Projects have completed their Needs Assessments, Strategic Plans, and annual work plans that include benchmarks and goals specific to the unique needs of each community. A follow up survey is planned for FY 2025 to indicate any changes in the four communities or across the state in awareness, behaviors, or perceptions.

Service Outputs

Grant funding for ICAPP was awarded for Fiscal years 2021-2025 through a competitive grant process. Although the application was the same regardless of funding stream, CBCAP funding was isolated out (for reporting purposes) to fund 14 programs utilizing an evidence-based home visitation model, either Healthy Families America or Parents as Teachers. Other funds, including PSSF, CAPTA, TANF, and state check-off funds were allocated for the Parent Development and Resilient Communities Projects, while Sexual Abuse Prevention projects were allocated funds in alignment with a state funding appropriation. Table 5A details all the services that the local ICAPP/CBCAP funded sites provided in SFY 2022. During SFY 2022, 1,428 families with 1,469 children participated in parent development and home visitation programs. Another 758 adults (parents, caregivers, teachers, and other youth-serving professionals) and 4,229 children participated in sexual abuse prevention programs. Data is gathered by program providers and compiled through quarterly service reports to the ICAPP administrator, Prevent Child Abuse Iowa. The only limitations to keep in mind with service numbers are that these may reflect full program numbers, whereas ICAPP may only be a portion of the local program budget.

Table 5A. Level of Funding and Families Served by ICAPP

Program Type	Funds Awarded	No. of Projects	Families Served	Children Served	Adults Served
Resilient Communities Demonstration Project	$389,000	4			
Home Visitation	$448,834	14	599	767	
Parent Development	$657,281	18	727	671	
Sexual Abuse Prevention	$235,517	14		4,820	1,647
Total	**$1,730,632**	**50**	**1,326**	**6,258**	**1,647**

Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 2021–June 30, 2022, Prevent Child Abuse Iowa, September 2022

ICAPP/CBCAP Demographics and Evaluation

As reported in the overview section, ICAPP and CBCAP have undergone significant structural changes in the programs. In SFY 2018, a new administrative contract began with Prevent Child Abuse Iowa. New deliverables in this contract included:

- Inclusion of community-based child abuse prevention (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.

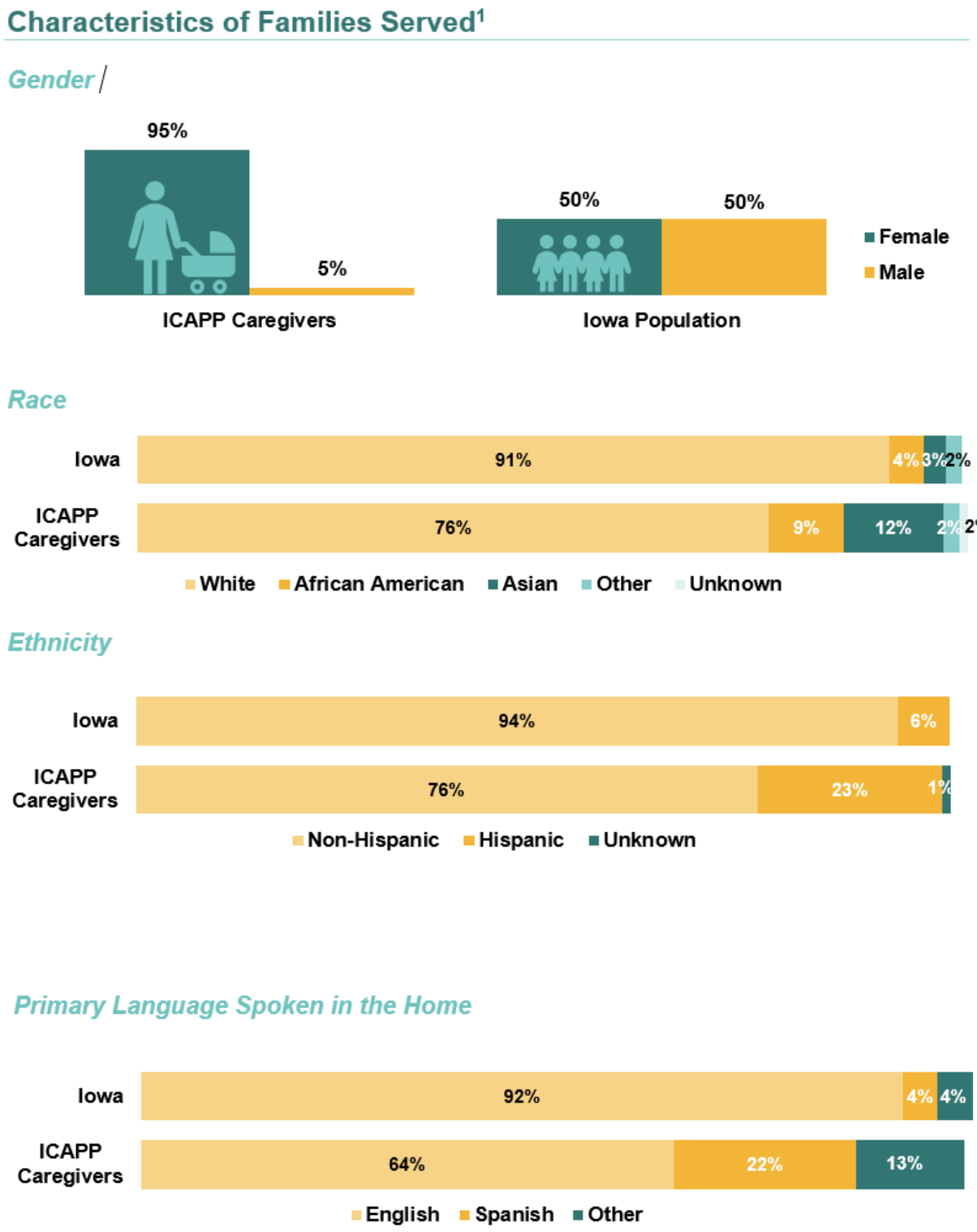
Given the merger of the two funding sources, the annual evaluation of these programs was wrapped into a single report beginning in SFY 2018 and will continue to be (with CBCAP numbers isolated out only in that specific federal report). Therefore, demographics and evaluation data will be provided for all community-based child abuse prevention programs combined in the following sections.

ICAPP/CBCAP Demographic Data

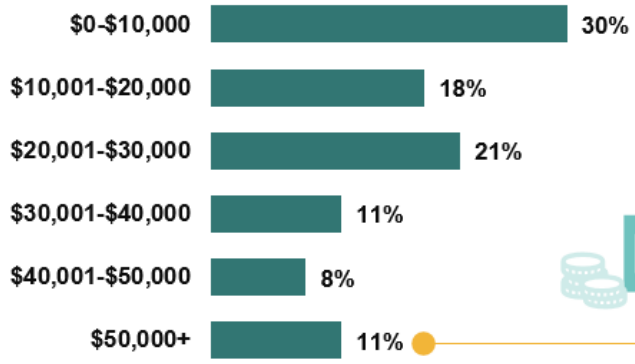
For nearly a decade, programs have been required to complete pre/post surveys and provide basic demographic information. This was a key step in determining whether the families served by programming were those more "at risk" for child maltreatment. Demographic data reported below represent surveys collected from July 1, 2021, through June 30, 2022 (SFY 2022). The data represents information from program participants who voluntarily shared demographic information and responses to the protective factors survey questions.

Statewide, in SFY 2022, surveys completed by 874 families, including matched surveys (indicating post a pretest and at least one follow-up) from 524 families were analyzed. Demographic information gathered from those surveys (for both ICAPP and CBCAP funded projects) can be found in Figure 5B.

Figure 5B. ICAPP and CBCAP Demographics SFY 2022



Income and Financial Assistance Utilization

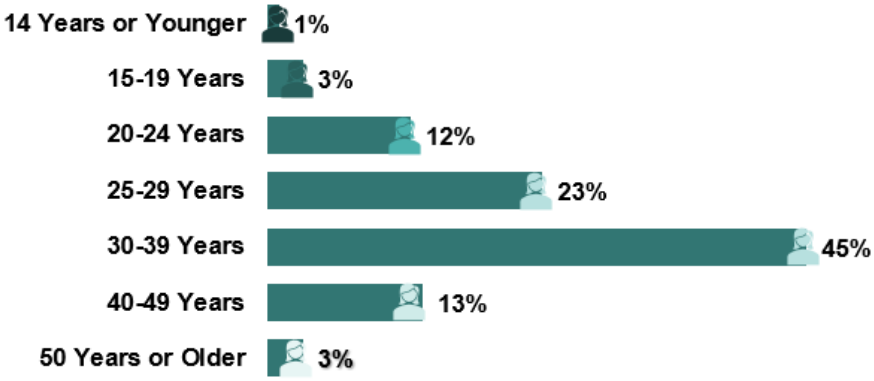


60% of all Iowa families earn $50,000 or more

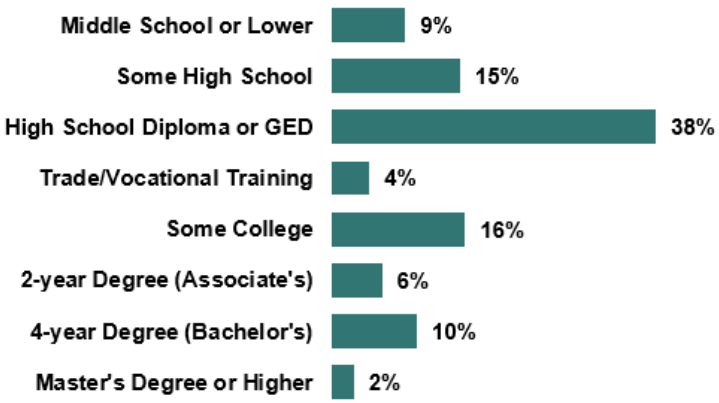
compared to

11% ICAPP families

Age of Participant Caregivers



Participant Caregiver Education



93% of Iowans have *at least* a high school diploma or equivalent

compared to

76% of ICAPP Caregivers

Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 2022–June 30, 2022), Prevent Child Abuse Iowa, September 2022

ICAPP and CBCAP Evaluation Background Information

Since SFY 2012, HHS prevention programs have used the Protective Factors Survey-2 (PFS), an evaluation tool developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention, to evaluate the effectiveness of local programming. This tool is the only valid and reliable tool currently available to specifically measure protective capacities known to mitigate the risk of child maltreatment (see Table 5C for a description of each protective factor). The 20-question tool includes a Likert Scale of 1-7 (with 1 being the lowest and 7 being the highest). More information on the tool can be found through the FRIENDS website (http://friendsnrc.org/protective-factors-survey). The tool has been customized for the ICAPP program and has been made available through a web-based data entry program.

Table 5C. Definitions of Protective Factors by FRIENDS, NRC

Protective Factors Domains	Definition
Child Development and Knowledge of Parenting	Understanding and utilizing effective child management techniques and having age-appropriate expectations for children's abilities.
Concrete Support	Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.
Family Functioning and Resilience	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.
Nurturing and Attachment	The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.
Social Emotional Support	Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs.

Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 2021–June 30, 2022), Prevent Child Abuse Iowa, September 2022

In addition to PFS, evaluators utilized the Life Skills Progression (LSP), developed by Linda Wollesen and Karen Peifer (Wollesen & Peifer, 2006). A caregiver's life skills can be measured using this instrument to assess a parent's strengths, needs, and ability to provide for and take care of their children. The LSP measures eight domains through a 43-question assessment that service providers complete at program enrollment and every six months as long as a caregiver is participating in the program. Not all domains are addressed by all programs, meaning that not all 43 questions are answered for all caregivers. Using a Likert-style agreement scale, service providers rate a series of statements about the caregiver's relationships with family, friends, and their children, they and their child(ren)'s health care, basic needs, and other skills. Table 5D provides a summary of the life skills measured by the survey.

Table 5D. Definitions of Life Skill Domains

Life Skill Domains	Definition
Relationships with Family and Friends	This section describes the caregiver's primary support system.
Relationships with Child(ren)	This section describes how the parent relates to all of their children, not just the most recent infant.
Relationships with Supportive Services	Support services assessed in this section include home visitors, use of information provided, and resources available.
Education and Employment	This section includes issues related to language, education, employment, and immigration (when applicable).
Health & Medical Care	This section covers parent and child health care issues.
Mental Health & Substance Use/Abuse	Mental health diagnoses and substance use issues experienced by the caregiver are addressed in this section.
Basic Essentials	This section assesses with the caregiver's abilities to provide for the basic needs in life. It contains what are perhaps the most concrete areas of life skills.
Child Development	The LSP child scales summarize developmental data gathered from visit observations, parental report, and use of standardized screening tools such as the ASQ, ASQ:SE, or Denver II.

In January 2018, a transition was made to the collect data through the University of Kansas's DAISEY (Data Application and Integration Solutions for the Early Years) system. This was the result of a partnership between DHS and IDPH (Iowa Department of Public Health), who manages the use of DAISEY for Iowa's Family Support Statewide Database (FSSD). The use of DAISEY will continue in FY 2024 and PCA Iowa will continue its long-time partnership Public Consulting Group (formerly Hornby Zeller & Associates) to evaluate program efficacy through analysis of PFS and LSP data as well as demographics of program participants. Public Consulting Group will continue to analyze data, extracted from DAISEY, to determine whether programs are reaching underserved populations and families in areas of the state where the risk of abuse is higher. Additionally, Public Consulting Group will explore the data to identify any variations in the effectiveness of different types of programing and models. Next year's evaluation will include descriptive statistics reporting the number of families receiving services that enrolled prenatally.

Table 5E depicts the number of caregivers participating in each program that completed at least one PFS and/or LSP survey. The PFS is used by Parent Development projects providing group-based services or short-term in-home services. The LSP is used by programs providing in-home parent support in which service duration is more than 6 months. This is consistent with other statewide family support programs.

Table 5E. Survey Completion by ICAPP Program

Program	Tool	Number of Participating Caregivers
Parent Development	PFS	762
Parent Development	LSP	290
Home Visitation	PFS	112
Home Visitation	LSP	632

Table 5F breaks down each domain by the number of families for whom a pre- and post-survey were matched. The number of pre/post score matches may vary by domain because caregivers do not necessarily answer all questions on the survey. Families served prenatally are not asked to respond to questions in the domains of Nurturing and Attachment or Child Development and Knowledge of Parenting.

Table 5F. PFS Survey Pre/Post Matches

Protective Factor	Tool	Number of Matches
Family Functioning and Resilience	PFS	523
Social Emotional Support	PFS	524
Concrete Support	PFS	523
Nurturing and Attachment	PFS	420
Child Development and Knowledge of Parenting	PFS	410

There were a greater number of assessment matches for the Life Skills Progression tool than the Protective Factors Survey. Table 5G identifies the number of families that completed both a pre- and post-assessment. The number of pre/post score matches may vary by domain because programs, as noted earlier, do not necessarily use all domains of the LSP. There was a large range in the number of assessment matches across the domains. The domain with the greatest number of matches was Relationships with Family and Friends (1,076) and the domain with the fewest was Education and Employment (159). This domain has a few questions that only apply to specific populations (e.g., non-English speakers, immigrants).

Table 5G. LSP Survey Pre/Post Matches

Domain	Tool	Number of Matches
Relationships with Family and Friends	LSP	1,076
Relationships with Child(ren)	LSP	652
Relationships with Supportive Services	LSP	837
Education and Employment	LSP	159

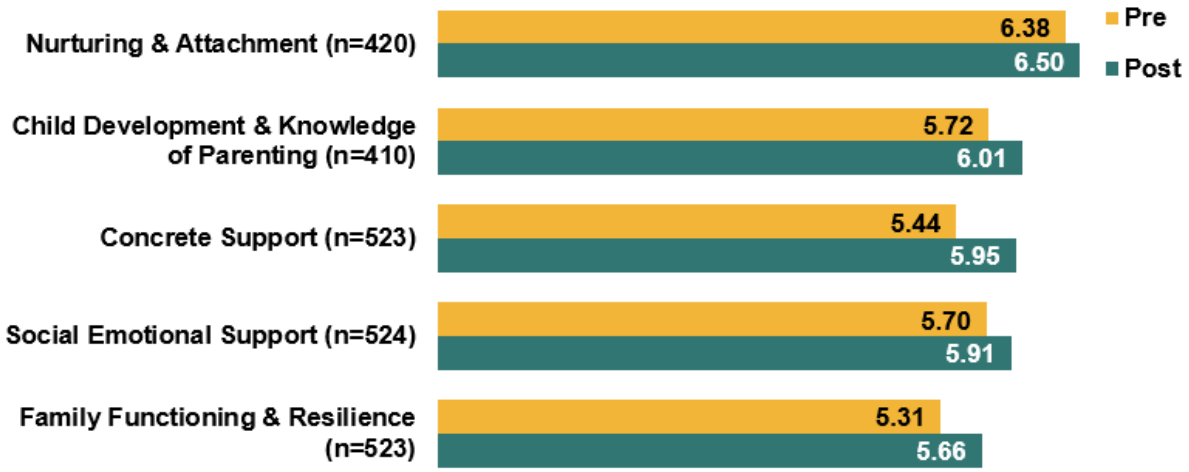
Health & Medical Care	LSP	477
Mental Health & Substance Use/Abuse	LSP	779
Basic Essentials	LSP	819
Child Development	LSP	296

Home Visitation and Parent Development Evaluation Data

For PFS surveys able to be matched, the results for all programs combined, by domain, are illustrated below in Figure 5H. The survey responses from the state's matched group reflect the overall change from pre to post for each protective factor. All protective factors showed statistically significant positive change.

The only limitations to this data are that it is often challenging to get a good number of "matched" surveys. This is because individuals may leave the program early, move, or did not answer all questions on the survey.

Figure 5H. Average Pre/ Post- Protective Factors Scores by Domain Among Matched Surveys

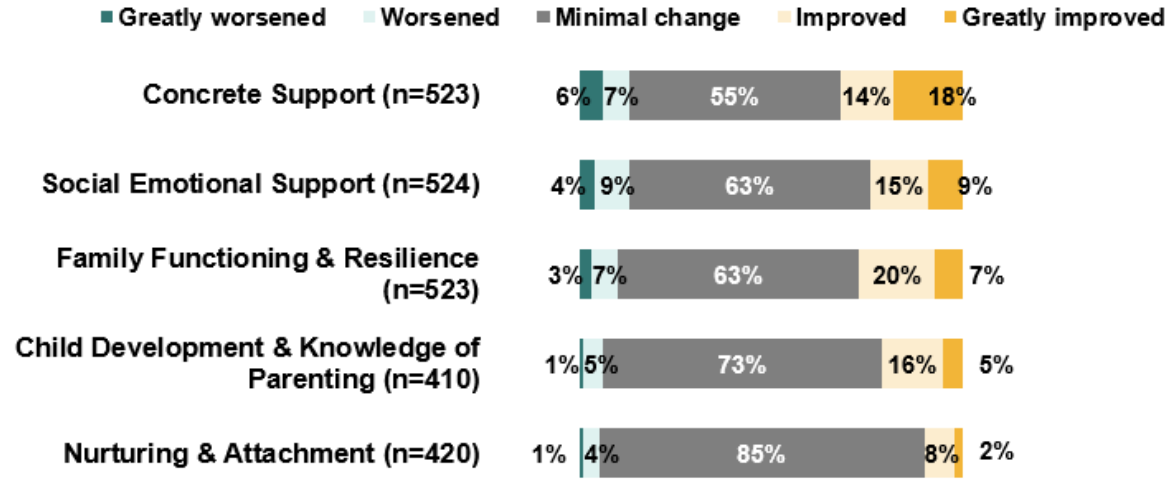


*All improvements between pre- and post-surveys are statistically significant (p<0.05).

Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 2021–June 30, 2022), Prevent Child Abuse Iowa, September 2022

In addition to describing the change in protective factors scores, evaluators examined the percentage of participants whose scores changed. Figure 5i shows the amount of change reported from pre- to post-program survey. Concrete Support had the greatest percent of caregivers with improved scores; 14 percent of respondents improved their scores by one point and 18 percent improved their scores by two or more points. Interestingly, this was the domain where the greatest percentage of respondents showed worsened scores (by one or more points). The domain with the greatest percentage of minimal score changes was Nurturing and Attachment. This is likely because scores were already quite high prior to program involvement, meaning there is less room for improvement after participation in the program.

Figure 5i. Changes in Protective Factors Scores Among Matched Surveys

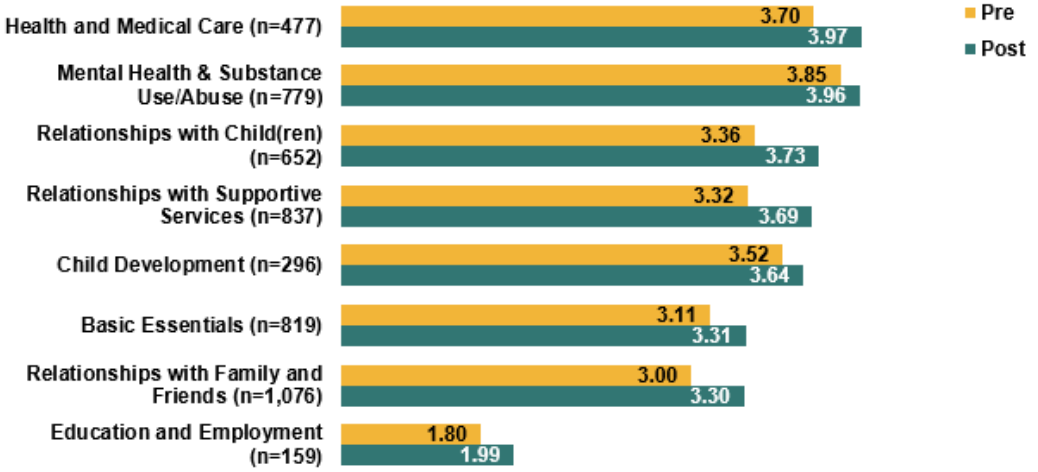


Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 202–June 30, 2021), Prevent Child Abuse Iowa, February 2022

The statistically significant changes in the protective factors scores, and high percentage of clients whose scores improved in a number of domains indicate that families across programs are showing changes in protective factors. Furthermore, families who stay in programs longer and/or successfully complete the program have significantly better outcomes, making program retention critical to outcome measures.

Life Skills Progression analyses assessed changes in program participants' life skills and accomplishments over the course of participating in a Home Visitation or Parent Development program. Statistically significant improvement in scores occurred across all domains (Figure 5J). The largest score improvement was in the Relationships with Children domain (0.37 points). In comparison to the other domains, the Education and Employment scores reported were quite low at both pre- and post-survey, but there was still an average improvement of 0.19 points.

Figure 5J. Average Pre/ Post- Life Skills Scores by Domain Among Matched Surveys



*All improvements between pre- and post-tests are statistically significant ($p<0.05$).

Source: ICAPP Evaluation Report to Iowa Department of Human Services (July 1, 202–June 30, 2021), Prevent Child Abuse Iowa, February 2022

Future Direction of the Program/Goals for 2022-2023

HHS, with the support of a contracted administrator (Prevent Child Abuse Iowa), will continue its role providing oversight and leadership for prevention services in FFY 2024. In State Fiscal Year (SFY) 18, HHS combined the state's ICAPP (Iowa Child Abuse Prevention Program) with CBCAP funding, merging the programs into one for the first time, creating greater administrative efficiencies at the state and local levels. Of Iowa's 99 counties, 44 counties have child abuse prevention services funded through the ICAPP program.

PCA Iowa also completed a statewide needs assessment and strategic plan in 2018 to identify priorities and strategies to advance prevention efforts. The Needs Assessment risk factor data was updated in 2019 and the strategic plan continues to be reviewed annually to assess changes needed for program priorities Alignment of the two programs and development of a strategic plan has reduced duplication and resulted in more targeted efforts to combat child abuse and strengthen families through evidence-based practices in high-need areas of the state. As the program continues to evolve to align with the goals of the Strategic Plan, the program will continue to produce a more comprehensive response to child abuse prevention and family support across the state.

It is the goal of the HHS and our partners to utilize the Needs Assessment and Strategic Plan to shape future programs and to shift policy related to the prevention of child maltreatment to best address the needs of families and communities across the state. Further systemic change efforts will continue at the state level through the Iowa Child Maltreatment Prevention Strategic Plan in the coming year, with an updated needs assessment to be completed with work beginning July 2023. It is anticipated the HHS alignment will create opportunities to examine how funding can be better utilized across state programs to reduce duplication and more efficiently address gaps in service needs.

The program administrator, with the support of a consultant (Public Consulting Group), continues to evaluate the results of the Protective Factors Survey and Life Skills progression to explore efficacy of programs. The evaluation results of SFY 2023 will be discussed and analyzed in next year's report. 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.

In recent years, the ICAPP program has increasingly focused on outreach to adults to reinforce the importance of adult responsibility to keep children safe from sexual abuse. Additionally, by building the capacity of parents and adults working or volunteering at child serving organizations, the program can maximize the reach of these efforts. Parents and other trusted adults have the potential to significantly impact a child's perception of healthy relationships and reinforce concepts through modeling and repetition over time.

In fiscal year 2022, many programs provided a nationally recognized adult-focused program called *Stewards of Children*, which teaches participants the scope of sexual abuse, the impact of sexual abuse, and how it is ultimately an adult's responsibility to keep children safe. *Nurturing Healthy Sexual Development* focuses on children's normal (and abnormal) sexual behaviors, how to talk to children about these behaviors, and how to recognize potential warning signs, is also frequently used. It is anticipated programs will begin utilization of an updated *Stewards of Children* curriculum being rolled out the spring of 2023. HHS will continue to be involved in the planning and development of additional

family-centered services and outreach to adults through partnerships with community-based providers to reinforce the importance of adult responsibility to keep children safe from sexual abuse.

Service Contracts (SFY 2021-2025)

HHS and the ICAPP Administrator released a new competitive procurement for grantees for SFY 2021-2025. This RFP continued with implementation of the goals of the statewide strategic plan by incorporating the following elements:

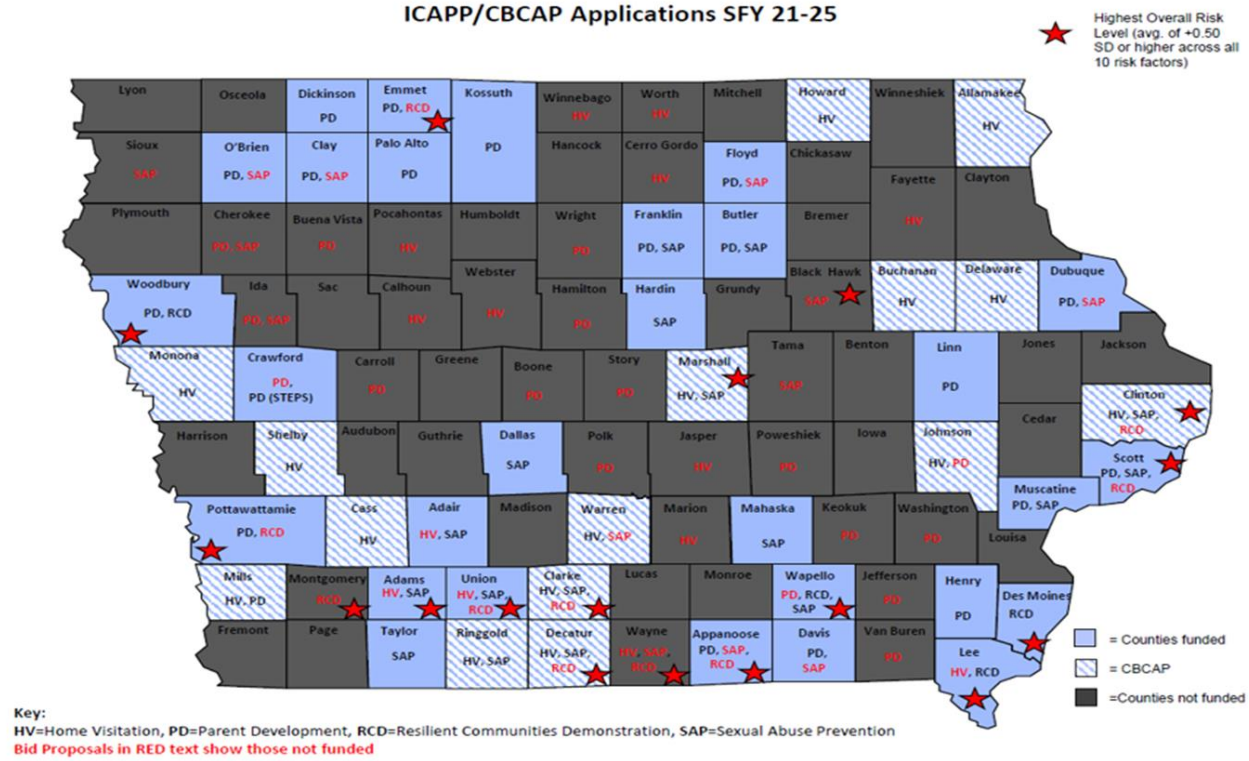
- Funding for up to 5 years to provide consistency and to better measure outcomes,
- A new category of funding for "Resilient Communities Demonstration Projects",
    - This new project type was modeled off of the Federal Community Collaborations to Strengthen and Preserve Families grant and is an attempt address some of the community/systemic factors that may impact maltreatment rates.
- Funding limitations were based on a county risk analysis (updated in 2019)
- For the first time, not all counties were deemed eligible to apply for funds,
    - 19 counties with the lowest risk of maltreatment (based on regression analysis of 10 factors correlated to maltreatment) were not eligible to apply.
- Elimination of respite/crisis care as a funded project,
- An objective scoring measure based on the level of evidence for a particular family support program/model, and
- Better alignment by funding intent.
    - For example, Sexual Abuse Prevention projects were limited to the state appropriated fund specifically for those services.

The 50 new service contracts took effect July 1, 2020, and included contracts covering 44 Iowa counties, including 14 of the 17 highest risk counties in the state. Table 5K below illustrates the programs and services funded, while Figure 5L shows the specific counties covered under these contracts and the services funded in each county.

Table 5K. ICAPP/CBCAP Funded Projects SFY 2022-2025

Project Type	# Of Projects	# Of Counties	Total Awarded Fy22	Total Awarded Fy23	Total Awarded FY 24	Total Awarded FY 25
Home Visitation	14	15	$448,854	$448,834	$450,370	$450,370
Parent Development	18	20	$657,281	$657,281	$677,707	$677,707
Resilient Communities	4	4	$389,000	$389,000	$389,000	$389,000
Sexual Abuse Prevention	14	17	$235,517	$235,517	$236,480	$236,917
Total	**50**	**56**	**$1,730,652**	**$1,740,473**	**$1,753,557**	**$1,753,994**

Figure 5L: FY 2021-2025 ICAPP and CBCAP Funded Projects



Source: HHS Program Manager

The full RFP and all associated documents can be found here:
https://bidopportunities.iowa.gov/Home/BidInfo?bidId=e4f819c0-3ab8-4b09-ac84-f85d4babb268

Community Adolescent Pregnancy Prevention (CAPP)

Overview

In 1987, the IDHS, 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 is currently funded entirely through federal Temporary Assistance for Needy Families (TANF) block grant dollars and housed within the IDHS Bureau of Child Welfare and Community Services, given the correlation between young parenting and risk of maltreatment.

The HHS 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. Not more than 25 percent of a community grant may be used for these services.

2022 Annual Service Review

Services provided by local grantees and subcontractors use various evidence-based curricula associated with prevention of adolescent pregnancy and other associated sexual health risk factors. Grantees offered services primarily through area schools. 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:

- Implementations of evidence-based programming with outcomes associated with the prevention of pregnancy
- Comprehensive sexual health curriculum implementations
- 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
    - Puberty
    - Social media safety
    - Human trafficking
- Expectant and parenting adolescent 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.

CAPP grantees were required to submit online fidelity logs for the curriculum implementations they conducted during FY22. Grantees were provided paper workbooks to track the fidelity of each implementation and links to online submission forms to submit the data once each implementation finished. Fidelity monitoring submission requirements are calculated using a tiered system that depends on the total number of implementations conducted annually by each grantee as a way to reduce burden on those implementing a large number of programming.

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

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

- Adherence is the degree to which an implementation is delivered as intended by program developers.
- Exposure refers to the amount of the program to which participants are exposed in comparison to the amount intended.
- Quality of delivery refers to the presentation quality of the educator/facilitator.

- Participant responsiveness is the degree to which participants are engaged in the program or the way they react to the program.
- Program differentiation refers to whether the program's critical components are present and identifies those components that are critical to the success of the program.

In total, 214 fidelity logs were submitted by 14 grantees for 13 evidence-informed curricula (Table 5M). Six curricula were represented by five or fewer fidelity logs and were not included in this analysis to avoid identifying a specific grantee or educator. Only seven percent of the fidelity logs (14), covering nine curricula, specifically cited having disruptions due to COVID-19, compared to 55% in FY21. Six grantees met the requirements for fidelity log submissions using the tiered system above, and all but three grantees needed fewer than five additional submissions to meet the requirement. Overall, fidelity log scores generally improved over FY21 scores. Quality of delivery (93%), program differentiation (87%), and participant responsiveness (87%) had the highest average score among the domains. Adherence had the lowest average score among all domains at 77%.

Table 5M: Number of fidelity logs	
Curriculum	**Total logs**
DTL 6th	69
DTL 7th	47
DTL 8th	29
Love Notes	23
FLASH High School	13
FLASH Middle School	12
3Rs 8	6
Making Proud Choices	4
3Rs 10	3
3Rs 7	3
SiHLE	3
3Rs 9	1
3Rs 6	1
Total	**214**

Teen Birth Data – FY22
Teen birth rates are declining in CAPP counties over time, as well as across the state and nation. Even so, 31 of 58 counties served by the CAPP grant program have five-year teen birth rates below the 2020 national average of 15.4 births per 1,000 teen girls ages 15-19. Among the 32 CAPP counties with available data, 22 experienced reductions in teen birth rates.

Future Direction of the Program/Goals for 2023-2024

- Provide additional professional development for CAPP grantee educators utilizing evidence-based textbook, Sexuality Education, Theory and Practice.

- LEAHP/ Advisory committee will continue to recognize and involve state-wide agencies and organizations that work with adolescents to forward the goals of comprehensive sexual health education for Iowa youth.
- Design and distribute multi-generational program materials to encourage and engage parent and youth communication and further the work to include parents/grandparents the expectant and parenting adolescent.

Community Partnerships for Protecting Children (CPPC)

Community Partnerships for Protecting Children (CPPC) is an approach that neighborhoods, towns, cities, and states can adopt to improve children's protection from abuse and/or neglect. Communities develop partnerships across collaborative networks to implement prevention strategies, provide early interventions, and share responsibility for the well-being and success of all children and families. The State of Iowa recognizes that the child protection agency, working alone, cannot keep children safe from abuse and neglect. It aims to blend the work and expertise of professionals and community members to bolster supports for vulnerable families and children with the goal of preventing maltreatment or if maltreatment occurred, repeat maltreatment. CPPC is not a "program;" it is a way of working with families and communities to help services and supports to be more inviting, need-based, accessible, and relevant. CPPC incorporates prevention strategies as well as those interventions needed to address abuse, once identified. CPPCs work to reduce negative childhood experiences, promote everyone's responsibility in supporting children and families around safety, permanency, including both family and kinship connections, and well-being, and is of significant value to Iowa's communities.

The Community Partnerships Executive Committee has updated the CPPC vision, values, and core principles to reflect language that is more family friendly, engaging and aligned with current language and trends in child welfare practice. The updated CPPC philosophy statements include:

- Families and youth are the experts in what they need to be successful.
- Children do best in families, and should be with their own families, whenever possible.
- Families are stronger when all members, including caregivers, are safe from abuse.
- Local communities benefit from shared decision-making among families, youth, and community partners to shape their own strategies in response to community needs.
- Integration of equitable and culturally responsive approaches to resources, programs, and supports is essential to meeting the needs of diverse families, youth, and communities.
- Supports and services should be linked and accessible in the communities in which families live.
- Parents, caregivers, and youth are vital to making local and statewide policy and practice changes to services and systems which impact them.
- Efforts to reduce abuse and neglect must be closely linked to broader community initiatives and priorities to strengthen protective factors and improve child/family well-being.
- Families and youth need supportive communities to authentically engage with them for healing, connection, and to offer a sense of belonging.

The long-term focus of CPPC is to support children and families to be safe, remain intact, and enhance child and family well-being by changing the culture around social norms and attitudes to improve child welfare processes, practices, and policies. The approach involves four key strategies implemented together to achieve desired results: Shared Decision Making, Community Neighborhood Networking, Family and Youth Centered Engagement, and Policy and Practice Change. It is through this philosophy,

and many years of dedication to the development of the four strategies and implementation, that initiatives flourished with CPPC's support and through CPPC Shared Decision-Making teams who partnered locally to tailor the CPPC approach to meet their community's needs.

Many of HHS child welfare statewide initiatives started with CPPC sites piloting innovative ideas focused on child welfare policy and practice changes. These initiatives have included but are not limited to Family Team/Youth Transition Decision-Making, Parent Partners, Cultural Equity Resources, Parent Cafes, and the development of the Connect and Protect consultation teams and the infusion of the Safe and Together™ model, which is a paradigm shift towards a more domestic violence informed child welfare system.

One of the most noteworthy aspects of CPPC is the structure to engage both professionals and community members, including parents and youth with lived experiences, in helping to create safety, permanency and well-being supports for children and families in their own communities. Statewide for SFY 2022, there have been approximately 2,700 (86%) professionals and 448 (14%) community members involved in the implementation of the four CPPC strategies. Throughout this SFY 2022-year period, CPPC sites held 406 events and activities with 53,545 individuals and families participating in community awareness activities to engage, educate and promote community involvement in strengthening safety, stability and well-being for children, youth, and families, and increase and build linkages between professional and/or informal supports.

CPPC sites collect performance outcome data on the implementation of all four CPPC strategies. Transition from the former Individualized Course of Action (ICA) strategy to the new Family and Youth Centered Engagement Strategy (FYCE) took effect for the CPPC sites to begin utilizing with their planning for SFY 23. The change from the ICA strategy to FYCE coincided with an overhaul of the annual plan and reporting form the CPPCs are required to complete regarding their annual plan for implementation of the four strategies and subsequent reporting on progress submitted to the HHS Program Manager each year. The first full year of reporting on the new Family and Youth Centered Engagement strategy using the revised planning and reporting template for SFY23 will be submitted by CPPC sites to HHS in August 2023. As a result, the below reporting on the implementation of the four strategies by the CPPC sites is based on reporting for SFY 2022, the former ICA strategy, and the previous report form and implementation levels.

Currently, forty CPPC local decision-making groups, involving ninety-ninety counties, guide the implementation of CPPC. Data detailed below on the four key strategies of the CPPC Approach is summarized from the annual reporting period of July 1, 2021, through June 20, 2022:

1) *Shared Decision-Making (SDM):* Community Partnerships' foundation is the principle of shared responsibility for the safety of children. Organized shared decision-making committees guide the partnerships, which include a wide range of community members and organizations, public and private child welfare and juvenile justice, parents, youth, and HHS to work collaboratively.
    - Eighty-eight (88%) of the sites had community member representatives involved with SDM or one or more of the four CPPC strategies.
    - Ninety-five (95%) of the sites had a former client and/or Parent Partner representative involved with the SDM team or one more of the four CPPC Strategies.
    - Ninety-three (93%) of the sites had representatives from domestic violence, substance use, and mental health agencies.

- One hundred (100%) of the sites had representatives from public and private child welfare agencies, and/or child abuse prevention.

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

2) *Neighborhood/Community Networking (N/CN):* Focuses on engaging and educating partners and promoting community involvement to strengthen families and create safety nets for children. Partnerships build linkages and relationships among professionals and informal supports.
   - One hundred percent (100%) of the sites involved in community awareness activities and/or increased linkages between professionals and informal supports.
   - Seventy-seven percent (77%) of the CPPC sites developed and/or increased organizational networks, linkages, and collaborations in the community to support families. Examples include but are not limited to: Neighborhood Hubs, 24/7 Dads, Community Equity Teams, Parent Cafes, and Community Events/Activities/Programs. Additional examples of Neighborhood/Community Networking Activities include:
     - Scott County CPPC supported the Apartment in a Suitcase program to provide youth who are transitioning to adulthood from system involvement an opportunity to utilize funding to prioritize items they needed for their own household. Youth worked on budgeting choices with their Aftercare Coordinator to prioritize what they needed most.
     - Mahaska CPPC supported a community wide event to provide resources and awareness for unhoused services and supports in the county with volunteers through their CPPC.
     - Woodbury County CPPC funds Essential Kits for pregnant and parenting teens, which include items not covered by SNAP or WIC benefits such as paper products, hygiene items, household supplies, diapers, and wipes.
     - Cass, Mills and Montgomery CPPC supports the STEPS program, which strives to utilize the cooperative and collaborative planning efforts of communities, parents, courts, and providers to improve the child welfare system and to support families involved in Family Treatment Court. Program supports include providing sober, family-friendly activities to build informal supports and reward successful transition to a sober lifestyle for the safety and benefit of children.
     - Hardin County Helps, started as a social media page, or hub through the Hardin County CPPC, as an online opportunity to identify donations of items such as household goods for families in need. The social media site grew into an onsite warehouse for residents to donate goods such as housewares, clothing, and appliances, and for individuals and families in need to have access to goods free of cost.
     - Polk County CPPC Coordinator met with new HHS child welfare staff in Polk Co. to present on CPPC and the benefits of being connected with CPPC. Provided a similar presentation to the local housing authority on CPPC strategies and ways the CPPC can support local providers.

- Cass, Mills, and Montgomery Counties CPPC provide Circles of Support to individuals and families through weekly Circles meetings, sharing resources and support, and a shared meal.
- Numerous community trainings hosted by CPPCs throughout the state on topics such as Trauma Informed Supervision, ACEs 360 Learning Circles, Youth Mental Health First Aid, Crisis Intervention and Stabilization, Anxst (Anxiety) awareness, domestic violence awareness, Connections Matter, CPPC informational presentations, racial and cultural equity focused training, Human Trafficking, Caring and Working with LGBTQI+ Identified Individuals, etc.

3) *Community-Based Family Team Decision-Making Meetings (CBFTDM) and Individualized Course of Action (ICA):* Individualized Course of Action genuinely engages families and youth to identify strengths, resources and supports to reduce barriers and help families succeed. Family team approaches seek to identify and build on strengths so the family can successfully address issues of concern. (*Note: HHS transitioned away from FTDM model and to the utilization of Solution Focused Meetings in July 2021. CPPCs transitioned to the Family and Youth Centered Engagement Strategy as of July 1, 2023. The below reporting is on the SFY22 reporting year.*)
   - Three (8%) of the CPPC sites implemented Community Based FTDM/YTDM meetings in the community (non-child welfare involved families).
   - Fourteen (14) Community Based FTDM/YTDM meetings occurred in the community (non-child welfare involved families).

A few CPPCS have continued to hold CB-FTDM meetings in their area. One example is Cass, Mills, and Montgomery Counties CPPC continues to support CBFTDM's through Mills County Public Health. Family-Team Meetings. Support through CBFTDMs is focused on housing instability; poor home conditions, child hygiene, co-parenting issues, child safety, child with special needs, parent/child interactions, and building healthy support systems.

4) *Policy and Practice Change (PPC):* Community partnerships test innovative approaches, promote best practices, and influence system changes to serve better families and children. Policy and Practice Change involves community members, as well as youth and families directly impacted by the child welfare system, to develop and implement plans to address specific barriers and incorporate best practice approaches in the delivery of services.
   - One hundred percent (100%) of the sites identified a policy and/or practice change.
   - Fifty-five percent (55%) of the sites developed plans to address policy and practice changes.
   - Twenty-five (25%) of the sites implemented policy and practice changes. Policy and practice changes include: addressing service gaps; strengthening communication between HHS and community partners; prevention of re-abuse; stronger collaborations with domestic violence agencies; addressing community needs such as transportation, food security, housing, human sex trafficking, disproportionality, and disparity in child welfare; and increasing community culturally responsive services and supports.
   - Additional examples of local CPPC Policy and Practice Change activities include:
     - Wapello CPPC utilized a Plan Do Study Act in conjunction with their county Equity team to implement a community awareness campaign called "No Hate Ottumwa"
     - Youth and parents with lived experience serving on CPPC teams to provide input and voice into policy and practice changes.

- Utilization of the CPPC SDM team to share organization surveys and questions to gather information regarding the need for policy and practice change.
- Parent feedback on policy and practice changes, as well as strengths and needs of available services and supports in the community, through avenues such as Parent Cafes.
- Utilizing training and planning efforts in the community through a Healing Centered Engagement framework for ensuring equity focused services, responding to the needs of immigrant and refugee families, and hosting parent listening sessions and Parent Cafes to engage with families, providers, and policymakers on needs and concerns of families in the community.

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. To achieve desired results, simultaneous implementation of each of the four strategies must occur.

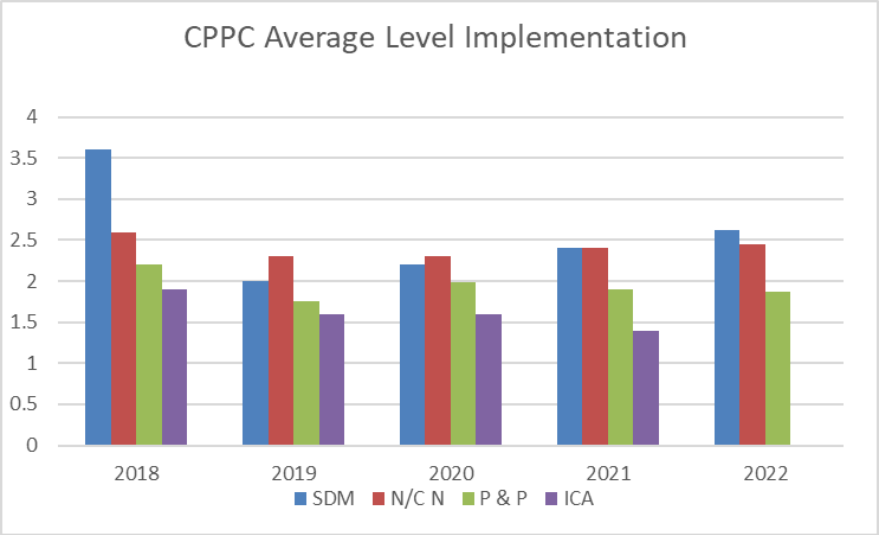
Moving through the levels of each strategy involves the CPPC sites first identifying or developing plans for activities to identify community needs and plan strategies within the lower levels, and then move toward implementation of their plans as the sites advance through the levels. CPPC sites must 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 reflected through current or previous involvement in the child welfare system. Parent Partners are routinely included on Shared Decision-Making Teams to:

- provide input and parent voice in the local CPPC through lived experience,
- educate other members and the community on the Parent Partner program,
- lead or participate in collaborative programs in the community, and
- participate in policy and practice changes in child welfare.

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. As HHS practice and services have shifted to incorporate systemically many concepts that CPPC started and implemented (e.g., Family Team Decision-Making (FTDM), Youth Transition Decision-Making, and Parent Partners), there was a shift in the responsibility of the CPPC network, and thus modifications occurred to the expectations of the levels.

Chart A summarizes the average level achieved for each strategy based on reports from 40 sites for the last 5 years. CPPC sites fluctuate in level of implementation based on several factors such as CPPC Coordinator transition, Shared Decision-Making Team membership changes and transition, changes in collaborative relationships with related community coalitions and an identified need to reconfigure and reset the local CPPC structure and associated strategic goals and planning. HHS anticipates that CPPC sites will fluctuate through the levels in achievement over time with these changes, in addition to changes in community needs and starting new collaborations and initiatives. The averages reflected in Chart 5N includes data from reporting for 2022 and for the previous four years.

Chart 5N: Average Level for Each Strategy for all CPPC Sites Reporting



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

CPPC Coordinators have received training and guidance on completion of their CPPC Annual Plan and Progress Summary report, which reflects their planning and assessment of level achievement and progress in each strategy. The reporting document was updated in SFY 23 to be more user friendly and applicable to capturing the progress and impact of the CPPCs.

Collaborations

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

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

The ability to host virtual or hybrid meetings provides additional equitable opportunities for those who have access to virtual spaces to join into meetings. Continued guidance is provided to CPPCs to focus their efforts on equitable planning of activities and ensuring parents, youth, and diverse members of communities are engaged for their input, feedback, and involvement. Opportunities to learn more about how to engage youth and parents with lived experience, and the benefits, have been highlighted at the

CPPC statewide learning convenings and the CPPC Regional Meetings. The transition to the Family and Youth Centered Engagement strategy amplifies this focus.

CPPC Education, Training and Support 2022-2023

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

CPPC Immersion Training: CPPC Immersion training provides an enhanced understanding of the four strategies of the CPPC Approach. Hosted by local CPPCs, participants learn how to utilize implementation of the four strategies to meet local community needs. The primary audience members for CPPC Immersion 101 are:

- New CPPC coordinators
- New Decat coordinators
- Individuals involved in their local CPPC, such as those serving on the Shared Decision-Making Team
- New CPPC participants such as HHS staff, community members, practice partners, parents, Parent Partners, kinship caregivers, foster parents, agency providers, community leaders, and AmeriCorps members.
- Local city and county government representatives.

The Immersion 101 curriculum has been under revision during this year, because of the need to transition from the Individualized Course of Action to the Family and Youth Centered Engagement strategy. It is in final revisions and will be offered to two CPPC sites in May 2023. Immersion 101 training will be offered to CPPC sites on a more frequent basis in SFY24.

CPPC Regional Meetings: CPPC Regional meetings are held bi-annually for CPPC Coordinators and/or members of Shared Decision-Making Teams in the fall and spring each year. A total of six CPPC Regional meetings were held in June, and in September 2022 with an average of 20 CPPC Coordinators and members of Shared Decision-Making Teams in attendance at each meeting. One Regional Meeting was held in person, the remainder of the meetings were held virtually.

For the June 2022 Regional Meetings, Polk County CPPC spotlighted a recent Policy and Practice change implemented through their presentation on Addressing Disparate Outcomes through Partnerships and Shared Decision Making. This presentation highlighted their CPPC's process to review their grant application to be more inclusive for ethnic and culturally based organizations to complete funding requests. As a result, the number of ethnic and culturally based organizations awarded funding increased. Through this process, the Polk County CPPC has continued to build relationships with diverse community organizations to build trust and partnerships. The presentation provided a useful illustration of how Polk CPPC utilized the four CPPC strategies to implement a valuable local policy and practice

change for their community. Cultural Equity State Coordinator also presented at the Regional Meetings on Applying an Equity Lens to Community Partnerships.

In September 2022, the CPPC Fall regional meetings were held in collaboration with the Iowa Child Abuse Prevention Program (ICAPP) on the topics of community engagement strategies through shared partnerships and strategic planning by Linn County CPPC, Decat and ECI, and a spotlight on the Resilient Communities pilot project in Wapello County. Each presentation provided examples of how to leverage existing resources to meet community needs, utilizing the CPPC Approach for community engagement and strategic planning, and emphasis on engaging parents, youth, and community members in identifying needs and working to meet gaps. Linn County CPPC provided insights on engaging with rural businesses in their county in new ways and utilizing local funding resources to develop an initiative to meet the needs of refugee and immigrant families through transportation, ESL programming, and parent/child programming at a local library. Wapello County illustrated their strategies for engaging youth and community feedback through their community needs assessment process. Both spotlights provided CPPC and ICAPP grantees opportunities to learn how to engage with their communities in new ways to identify needs, frameworks for strategic planning, leverage existing resources and funding streams for projects, and move initiatives forward.

CPPC Statewide Learning Convenings: The CPPC Statewide Learning Convenings occur on a bi-annual basis, in the spring and fall each year. A statewide planning committee includes CPPC coordinators and drives the framing of Convenings. The Fall 2022 Statewide Convening was held in person on November 2, 2022, and the theme was Impacting Families through Partnerships: Concrete supports as a Way Forward. This event marked the first time since 2019 that the convening was held in-person. With over 100 people in attendance, the day kicked off with an introduction to the work from Chapin Hall at the University of Chicago on the need for economic and concrete supports for families involved, or at risk of involvement, in the child welfare system. The Chapin Hall work summarizes and provides historical policy context and an overview of policy, programmatic, analytic, and engagement strategies for leveraging economic supports in communities to promote child and family well-being and prevent maltreatment.

Opening remarks at the Fall Convening were provided by the Iowa HHS Director Kelly Garcia. The keynote for the event was Amal Barre, Director, and Founder of unevictIA who spoke on her work in unevictIA and their focus on affordable housing in Iowa. CPPCs learned about strategies to connect in their communities, such as engaging with local property owners, to address local housing issues and problem solve challenges to housing in the community.

The Identifying Strengths Through Empathy and Action panel included topic experts Melvin Gaye (Youth Advocate / Opportunity Passport), Dr. Nalo Johnson (Director, Mid Iowa Health Foundation), Jackie White (Parent Partner / Iowa Parent Partner), Minouche Bandubulia (Community School Coordinator / Cedar Rapids Hoover Elementary), and Stephanie Hernandez (Director of Foster Group Care, Family Resources). The panel focused on their professional and lived experiences to provide emphasis that parents and youth are more likely to have positive outcomes during challenging times when they feel they are listened to and when they have supportive persons to help connect them to readily available and accessible supports and resources in the community. Panelists also offered perspectives on how communities and individuals can challenge themselves to do more to support families through networks that emphasize the importance of concrete supports in the child and family wellbeing system.

A CPPC Community Networking Event was held in the afternoon. Using conversation starter items and We! Connect cards, attendees were able to connect with each other in dyad conversations. The activity gave an opportunity for both self-reflection on the importance of community connections and access to supports and provided an exchange of ideas and resources utilized in CPPC communities all around Iowa.

Breanne Ward, Licensed Mental Health Clinician, gave the closing remarks for the event. Her message was of an empathetic approach to reframing how those working in child welfare and community support organizations view their work. She posed reflective questions aimed to not only recap what was discussed throughout the Convening, but to help attendees think critically on how they can apply their new knowledge to strengthen their communities.

The Spring 2023 CPPC Statewide Learning Convening was hosted on April 19 with approximately 140 in attendance. The theme for the 2023 Spring Convening was Mental Health Matters: Engaging Youth. The convening provided an opportunity for individuals to discuss, consider, and learn about ways in which communities can work towards suicide prevention and engaging youth in issues around mental health, and to connect with other CPPCs experiences to continue to build community safety networks. Eric Preuss, Project Director with Your Life Iowa kicked off the event to illustrate how Your Life Iowa, an initiative of Iowa HHS, is a source of online support for information, resources, referrals and help for challenges related to gambling, substance use, suicide, mental health. Attendees learned about supports are available through the Your Life Iowa website, supportive text messaging, and through opportunities for connection with experts in the field.

The focus of the keynote presentation by Dr. Anthony Santiago and Dr. David N. Brown with Iowa State University Extension and Outreach was focused on three initiatives focused on mental health and suicide prevention in communities. Data was shared on the statistics of suicide in Iowa in 2021, as well as data and statistics on the status of youth mental health. Question, Persuade, and Refer or QPR is a training offered throughout Iowa State Extension to train Gatekeepers for Suicide Prevention. Gatekeepers can be anyone but include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, supervisors, police officers, advisors, caseworkers, firefighters, and many others strategically positioned to recognize and refer someone at risk of suicide. Additional programming was highlighted on Youth Mental Health First Aid, and Mindful Teen programming. The presenters provided community planning guides for each program highlighted to help CPPCs consider how they can implement these programs in their communities.

The Convening concluded with a panel of young adults and professionals on the topic of engaging youth in suicide prevention. Panelists included two students from the University of Iowa, Ainsley Shird and Olivia Wright, lead the Green Bandana Project at the University of Iowa. The Green Bandana Project is a mental health awareness and suicide prevention campaign that uses backpacks and bandanas to support peers in getting help. Additional panelists included Leah Gehlsen Morlan, Director of Crisis Response Services at Crisis CommUnity and Joyce Morrison, Director of Project Development at Vera French Mental Health. Panelists weighted in from their expertise and perspectives to the most significant mental health challenges for youth, how mental health needs have evolved, what advice they have for communities implementing a suicide prevention program, and what do youth need to feel safe and supported to talk about their mental health.

Attendees of the Convening had opportunity to share what information was resonating with them throughout the Convening through a virtual Mentimeter, and shared comments such as "Community Networks can help promote Your Life Iowa as an important resource for support", "The statistic resonated with me about youth in schools who have high rates of anxiety/depression" to "Glad to have offering of actual services we can implement in response to rising suicide rates", and "Talk to youth and parents about what their needs are!"

CPPC Support: CPPC site visits were on hold in fall 2022 due to the CPPC State Coordinator position being vacant. A new CPPC State Coordinator was hired in February 2023 through a contract with Iowa State University (ISU), Child Welfare Research and Training Project (CWRTP), and 8 site visits were held with the CPPCs resumed this spring both virtually and in person. Though the new CPPC State Coordinator is focused initially on building connections and learning about the work of the individual CPPC sites, site visits are primarily intended to provide an opportunity for guidance and instruction to the CPPC Coordinators and their Shared Decision-Making Teams regarding furthering implementation of the CPPC Approach and the Four Strategies. This includes a review of the CPPC site annual plan and report, review of the annual site budget, attendance of a Shared Decision-Making Team meeting, feedback, and guidance on CPPC site initiatives, member representation, strategic planning, and problem-solving challenges. Additional technical support and consultations are held with CPPC Coordinators/CPPC Sites in throughout the year to provide guidance and support on planning, implementation and reporting, orientation for new CPPC Coordinators on roles and responsibilities, and addressing transitions as teams bring on new core members to the CPPC.

Four CPPC quarterly newsletters were created by ISU, CWRTP and distributed to the CPPC sites throughout the year. Newsletter content is focused on promotion of upcoming CPPC meetings and events, resource and information sharing relevant to the work of the CPPCs, recap of CPPC activities, and opportunities to spotlight local CPPC strategies and successes.

In SFY 22, additional support and guidance were provided to CPPCs through collaboration with the Cultural Equity Statewide Coordinator to focus on increased efforts for planning of activities to address disproportionality and disparity in identified counties. Counties included in these efforts included Johnson, Cedar, and Black Hawk. An update to the work in these counties for SFY 23 includes:

- Johnson County Equity Team is hosting various community conversations to align equity efforts across Juvenile Court Services, Early Childhood Education, child welfare, CPPC, and city/county efforts to support children and families. The primary community focus is proactively engaging the Congolese community though informal community and trust building sessions.
- Linn County has new leadership, and members are focused on youth voices in the courtroom and developing a worksheet to be shared with the court. Linn County Decat/CPPC and the Equity Team co-hosted a Housing Services community learning opportunity. They are working to determine available funding resources for advancing PDSAs in SFY24.
- Black Hawk is working to establish team building and data analysis to develop PDSAs based on their county disproportionality data. They are working through data disaggregation of reports into child protection by various systems, assessing decision points at intake, and determining founded/confirmed and placement decisions by zip code. Black Hawk will present at the May 2023 Equity Learning Session and share resources other teams can utilize to develop a PDSA for their county.

AmeriCorps Partnering to Protect Children (APPC)

HHS has partnered with Iowa State University since 2014 to implement the APPC program through the involvement of AmeriCorps members at CPPC host sites across Iowa. The APPC members activities center on capacity-building around the four CPPC strategies to create or improve tools and processes that will lead to increased effectiveness and reach at both the host site and within the community. Emphasis is on increasing community outreach, collaboration, and resource sharing at the various host sites. A statewide AmeriCorps Program Director provides oversight to APPC members and site supervisors serving within each of the host sites. The AmeriCorps Program Director retained a dual role as the Community Partnerships Liaison in SFY 2022, which provided opportunity for increased collaboration with the CPPC sites around advancing the four CPPC strategies.

At the conclusion of the 2022 Program Year, APPC hosted a total of 12 members at CPPC sites, and a total of 126 volunteers recruited by APPC members, totaling 1,051 combined volunteer hours contributed towards the CPPC strategies in Iowa's communities. APPC members made 96 unique partners across Iowa, primarily with nonprofit organizations. Notable partnerships included the African American Family Resiliency and WeCanProsper Resilience Training. Seven organizations received capacity-building services.

HHS made the decision to no longer provide the match funding for the APPC Program for SFY23. Despite this, the APPC Program and CPPC have continued to maintain a collaborative partnership. As the APPC Program has continued with an alternative funding match, three CPPC sites hosted an APPC member for 2022-2023, utilizing their local CPPC annual allocation for funding the cost to host a member.

Parent Cafés

Parent Cafés is an initiative which has been piloted and promoted through CPPC. CPPC sponsored the initial rollout of Parent Café facilitator and host training through working with the Be Strong Families organization in Illinois. In 2018, over 150 individuals were initially training in the Parent Café model. The Parent Café model allows participants "individual deep self-reflection and peer-to-peer learning, opportunity for participants to explore their strengths, learn about the Protective Factors, and create strategies from their own wisdom and experiences to help strengthen their families." (https://www.bestrongfamilies.org/). Parent Cafés occur in a variety of locations across the state and includes parents in family preservation courts, Parents as Teachers participants, parents of children at various ages and stages, teen parents, fathers, refugees, kinship caregivers, and others.

An Implementation Guidebook was developed in 2019 through a local CPPC well experienced with hosting Parent Cafes. The Guidebook provides tools and resources for both interested and current Parent Café sites as sites plan to implement a Parent Café. Information includes focus population for cafes, location considerations, cost calculator, sample budget, potential funding sources, childcare considerations, décor and food costs, data collections and tracking tools, and range of options to consider based on funding. https://www.cppconline1.com/uploads/3/7/7/2/37725789/final_guidebook.pdf Plans for the next year are to update the Implementation Guidebook to bring the information current and add in updated strategies and resources for hosting Parent Cafes, as well as lessons learned from those with experience hosting Cafes around the state.

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

A PCTI "crossover" training was scheduled to be held in June 2022 to provide an offering to be trained to host virtual Cafes to those trained last spring to host Cafes in person. The crossover training was cancelled due to lack of enrollment. The Parent Café Certified Trainers are exploring additional opportunities to provide the crossover one day training for next year.

As part of additional guidance provided to the Certified Parent Cafe Trainers in Iowa, quarterly meetings were held to provide an opportunity for the Trainers to give feedback, share knowledge, plan for trainings to be held within local CPPCs, and discussion regarding data collection. This included creating a Smartsheet for organized submission of inquiries for those interested in hosting a local PCTI. Information has also been provided to local CPPCs regarding Parent Cafes through the Statewide Convening and in specific communications, such as newsletters. to CPPC coordinators.

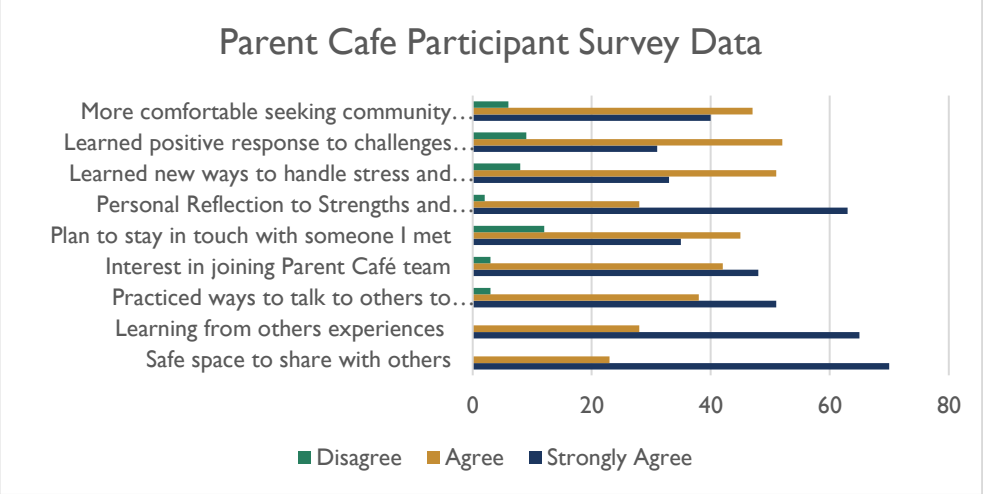
Throughout the reporting period of April 2022-May 2023, four local Parent Café Trainings have been hosted and facilitated by the Certified Trainers. In the Polk County area, the CPPC has supported Cafes geared towards the unique needs of refugee and immigrant communities.

The CPPC Program Manager and ISU, CWRTP as the Certified Training Partner to Be Strong Families to provide training on the Parent Café Model, continue to work with the Certified Trainers and Be Strong Families to explore how to best track data on both the number and type of Parent Cafes held across the state, as well as tracking outcomes and impact of utilizing Parent Cafes to bolster protective factors.

From May 2022 to May 2023, CPPC networks reported hosting 60 Cafés in their local communities, with approximately 755 attendees and 41 trained Café hosts. Parent Cafes are being held both virtually and in person, with a variety of attendees including, parents of pre-school age children, young parents, grandparents, schools, parents who are being supported in the Parent Partner Program, Family Treatment Court, faith-based groups, and general parents in the community.

Be Strong Families collects survey data from local sites hosting Parent Cafes. Café hosts enter participant post survey responses into an online data entry hosted by Be Strong Families. The data provided in the chart below from Be Strong Families is from the period of March 2022-September 2022 from local Cafes hosted in Iowa who entered in their participant survey results to the Be Strong Families online data collection site. The data reflects level of agreement by participants of Parent Cafes around strengthening protective factors through participation in Café.

Table 5o: Parent Café Participant Survey Data



- 9 Parent Cafes in Iowa provided survey entry results
- 95 participants attended Cafes via survey entries

As Parent Cafés continue to diversify materials for a variety of audiences and both in-person and virtual formats, this initiative is at the forefront of new opportunities to move forward for CPPC sites across the state in building formal and informal supports for families to strengthen protective factors.

CPPC Modifications

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

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

CPPC Survey/Focus Group Project

In Fall 2021, the CPPC Survey/Focus Group project began in effort to collect information and feedback from CPPC stakeholders across the five service areas. Inquiries were sought through online surveys and focus groups to glean current views of stakeholders who are actively involved with their local CPPC sites. The main goals of the survey/focus group project were to evaluate the status of the CPPC to inform potential program improvements, assessment of how the CPPC Approach aligns with the current prevention context in Iowa and contributes to meaningful change for children and families, and to identify ways to advance the CPPC Approach to further impact positive outcomes for children and families in the community around safety, permanency, and well-being, including preventing children and families from entering or re-entering the child welfare system. Over 100 respondents participated in the survey from all five HHS service areas. Two follow up focus group sessions were held with a total of 8

participants. Involvement in the local CPPC ranged from 1-10+ years, with the highest number of respondents indicating 4-6 years of time involved in their CPPC.

Common findings upon evaluation of the survey and focus group results included the following:

- Families should have access to supports and services in the same communities in which they live, and local partnerships should help formulate strategies and offer those services based on the resources and cultures exclusive to that community.
- The desire for increased resources/funding in local CPPCs to do a number of things such as: expand the reach/access more families who are in need or at risk; fund translators and materials that cater to families whose native language is not English; and compensate community members for their time and input.
- The ICA strategy is currently very limiting and should be re-imagined to better meet the changing needs of families and children, in a way that is community-specific, as "one size does not fit all".
- Although a commitment to serving marginalized families and communities of color is articulated in the shared vision, there are some barriers linked to these populations that make it difficult for the shared vision to be efficiently implemented in practice.
- The desire for increased financial resources/funding in local CPPCs to do a number of things such as: expand the reach/access more families who are in need or at risk; fund translators and materials that cater to families whose native language is not English; and compensate community members for their time and input.
- The Family First Prevention Services Act of 2018 aligns very well with the current CPPC Approach/Model and is an opportunity for CPPC members to further partner with HHS and utilize each other's expertise in navigating local community networks to support families to prevent child welfare system involvement.

Key Takeaways from the Survey/Focus Group Project included the following:

- Commitment and accountability from community partners in facilitating family engagement in a collaborative way are a key strategy in prevention of children and families who are most at risk to enter or remain in the Child Welfare System (CWS).
- A shared vision among CPPC stakeholders, local community members, and families is necessary to avoid silos and make it easier for families to navigate systems that should help them avoid CWS involvement. "It takes a village."
- The ICA strategy should be revised to focus on community-specific needs with more flexibility and a better coordination of all available resources such as a menu of options/programs /flow chart, a universally understood referral process, and trained facilitators and family navigators to better assist families.
- Financial resources drive what is feasible for local CPPCs to accomplish. CPPC stakeholders understand the current gaps and have a desire to obtain necessary means to fill them.
- Accessing and engaging families and communities of color in local activities and decision-making and finding ways to work with cultural and language barriers within those communities, must both be high priorities.
- One size does not fit all when it comes to planning and implementing CPPC efforts to serve communities and families in the ways they need.

In response to the findings from the CPPC survey project, priorities this year have been focused on support to the CPPC sites in the transition to the new, more flexible Family and Youth Centered Engagement Strategy, updates to the CPPC logic model and CPPC materials, and to provide learning opportunities and support to the CPPC sites to align with the new FYCE strategy and the revised CPPC plan and reporting document which has increased focus on tracking impact and outcomes of CPPC activities.

Transition to FYCE Strategy

In response to review of the four strategies guiding the CPPC approach, and to support innovative activities built from the community to fill the gaps in the prevention continuum, the Family and Youth Centered Engagement (FYCE) strategy has rolled out as the next iteration of the Individualized Course of Action strategy. The FYCE strategy is defined similarly to Individualized Course of Action, which is to genuinely engage individual families and youth to identify strengths, resources, and supports to reduce barriers and help families and youth succeed.

The FYCE strategy provides the CPPC sites increased flexibility to plan, support and implement local activities based on identified needs for children, youth, and families in CPPC communities, and to authentically engage youth and families alongside planning, input, co-design, and evaluation of CPPC activities through the FYCE strategy. The strategy further provides new opportunities for local innovation to fill gaps in the prevention continuum through an equity lens and to facilitate community-based approaches to strengthen Protective Factors, support activities and programs which are culturally responsive, and meet the well-being needs of children, youth, and families.

The purpose of the FYCE to genuinely engage individual families and youth to identify strengths, resources, and supports to reduce barriers and help families and youth succeed. The FYCE strategy provides increased flexibility for activities while centering family and youth engagement; allows site opportunities for innovation and to tailor activities to meet local needs; supports activities that promote Protective Factors and equitable child and family well-being for families at increased risk; and provides opportunity for community resource coordination approaches.

Within the FYCE strategy, CPPCs have increased opportunity to plan and facilitate activities to build trust and connection with under resourced communities, engage with parents and youth with lived experience as key partners in decision making, co-creation and participation in activities to build community connections, strengthen protective factors and resilience, and provide input into policy and practice changes. Parent Cafes, Circles of Support, peer mentoring programs, activities connected to Family Treatment or Wellness courts, and youth/parent led councils and committees are all examples of potential activities within this strategy. As Youth Transition Decision Making (YTDM) training continues to be available for interested community facilitators to attend, Community Based YTDMs are also an activity for the CPPCs to implement under the FYCE strategy. The menu of activities for the FYCE strategy is not all inclusive and allows for increased flexibility to the approach for CPPCs to meet local needs.

One example of how a CPPC has demonstrated initial implementation of the FYCE strategy is through a collaboration between local youth involved in AMP (Achieving Maximum Potential) and students attending a local alternative school engaged with local Shared Decision Making (SDM) members to form a combined committee of SDM team members and youth held at the school. The group works together

on community projects and to build connections within the community. This has included creative arts projects for community beautification, working with the local library to set up a youth game check out, and youth on the committee teaching adults how to use the design platform Canva. This work has also included a survey distributed by the youth on the committee to youth in the local public school and alternative school to learn more about youth mental health needs and how this may impact school attendance and performance. The results of the survey and subsequent presentation of the data by the youth to key decision makers in the community resulted in the hiring of a school-based therapist. The committee has also attended Understanding Implicit Racial Bias together and is opening their meetings using activities from the Courageous Conversations Toolkit.

CPPC Plan/Report Revisions

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

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

As the CPPC sites have not yet completed a full reporting year on the new plan and report template, information on the outcomes of the reporting changes is not available at the time of the writing. The CPPCs have utilized the new template to submit their CPPC plans for SFY 23. Included in the revised plan and reporting template is the ability for the CPPCs to capture their planning priorities for the year. In analyzing the plans for SFY23 year, CPPCs identified priorities in the below summarized category areas for planning (not all inclusive):

- Parent/Youth Engagement/Programing
- Community Recruitment/Engagement
- Cultural Equity/Diversity Equity and Inclusion/Disproportionality in Child Welfare
- Mental Health/Mindfulness/Trauma Informed
- Child Well-Being/Family Stability/Safety
- Community Resource Coordination
- Family Centered Programming/Parent Education/Parent Cafe

Upon submission of the summary reports for SFY23 in the updated template, CPPCs will be tasked with identifying progress on their priority planning areas for the year, and how their completed activities advanced their identified priorities and met intended outcomes to address identified needs in their communities.

The revised plan and report template has also provided opportunity for CPPCs to provide in their plans requests for training and support around specific areas such as cultural equity focused training or to host an RPI or UIRB learning exchange, assistance with connecting to other CPPCs for resources and consultation, support on how to increase engagement with youth and parents, growth and development strategies for SDM teams, and request for provision of materials such as the Courageous Conversations Toolkit or the CPPC Brochure. Work has occurred this year to track on requests from the CPPC plans and respond through consideration of topics for shared learning opportunities such as the CPPC regional and statewide convenings, reaching out to the CPPC sites directly to provide support, and determining next steps for strengthening how support and technical assistance can provided to the CPPCs directly from the CPPC state team around requests in the CPPC plans over the next year.

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

CPPC Revised Logic Model/Brochure

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

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

CB FTDM Pilot/Family Connections Gathering

A workgroup was convened in July 2021 to develop a pilot of revised model and process for Community Based Family Team Decision Making (CB FTDM) meetings. The CB FTDM meeting pilot was developed with the intention to provide an opportunity to connect with parents who have experienced safe HHS case closure in identifying ongoing formal and informal supports in the community. The initial goal of the pilot was to facilitate a supportive family meeting with parents exiting the HHS child welfare system to build community supports to prevent re-abuse and re-entry into the child welfare system and support overall family well-being through strengthening Protective Factors. Represented on the workgroup for the pilot included the local CPPC Coordinator, Parent Partners, HHS supervisor and an HHS SWCM, APPC member, CPPC Program Specialist, HHS Program Manager, a Community Practice Partner, and former facilitators of Family Team Decision Making meetings who agreed to facilitate the initial pilot meetings with families. The workgroup's intention was to move the pilot meeting model and process from a service orientated perspective, to a more family friendly approach around strengthening Protective Factors. As a result, the pilot meeting model was renamed to be called a Family Connections Gathering (FCG). The workgroup developed a brochure for professionals explaining the purpose of the FCG and how to make a referral. A brochure for parents was also developed and translated into Spanish.

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

In February 2022, the facilitators began accepting referrals for the pilot project. HHS referred 2 families. One family was not interested after the facilitators spoke with the parent further. The second parent initially expressed interest in participating in the FCG, however the facilitators were unable to maintain contact with the parent to coordinate the gathering to take place. The facilitators spoke with a local school district in Spring 2022 about interest in offering the FCG opportunity to families in the school system who may be identified as needing additional support. One parent in crisis was referred by the school district and the facilitators were able to provide crisis support and resources to the parent. However, the parent was not interested in participating in the full FCG process.

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

SFY 2024 Planning

The CPPC Program Manager will continue to initiate strategic development and guidance regarding the Family and Youth Centered Engagement strategy to continue to bolster CPPC efforts to embrace the strategy across the state. Work will continue over the next year to revise key informational materials for the CPPC, revisions to the CPPC Practice Guide, and facilitation of training and learning opportunities through the CPPC Statewide Convenings and Regional meetings, and CPPC Immersion Trainings to enhance these efforts through local examples of implementation, collaborative opportunities for leveraging resources, and site to site networking. The CPPC State Coordinator will also increase direct support and technical assistance to the CPPC sites in the next year.

Strengths:

- Engaged diverse network of state agencies, community-based programs, Parent Partners, and community members to review services and supports and work towards addressing the gaps in services and supports.
- CPPC builds linkages between formal and informal supports, bridges prevention and tertiary approaches, strengthens awareness and streamlines community resources.
- CPPC networks provide opportunities to pilot, support, and implement child welfare policy and practice changes (e.g., Parent Partners, Cultural Equity, and Parent Cafes).
- After collecting feedback from the sites regarding a basic framework for CPPC approaches to grow locally, CPPC Coordinators and CPPC sites across the state received an extensive manual and the CPPC Practice Guide. The CPPC Practice Guide is a tool used in the introductory (Immersion 101) and advanced sessions to increase the knowledge base of local coordinators and key decision-making members in the communities they serve.
- Community Partnership Executive Committee reviews the CPPC level data, program initiative progress and determines educational and technical assistance needed by the sites to advance the CPPC Approach.
- Regular updates to the CPPC brochure for distribution among communities to increase awareness of the CPPC approach and to continue to educate sites on the four strategies' revised levels and the CPPC practice manual.
- Further expansion of the Parent Café model to for building formal and informal supports for families in communities.
- CPPC sites collaborate with Iowa HHS Cultural Equity Resources and county Equity Teams for child welfare to educate child welfare systems, practice partners and community members on utilizing available tools for promoting systemic changes to reduce minority and ethnic disproportionality in the child welfare system.
- Evaluation of the CPPC Approach through a statewide survey and focus groups project has helped guide and shape re-envisioning of CPPC to modernize the Approach and align with current child welfare trends.
- Implementation of the new Family and Youth Centered Engagement strategy, based on feedback extensive feedback from CPPCs, stakeholders and partners on how to improve upon the former ICA strategy by more flexible to meet the needs of communities rather than a one size fits all approach with CB FTDMS.
- FYCE strategy will increase focus on authentic engagement of parents and youth with lived experience at the local level.
- The revised CPPC plan/report document has an increased focus on capturing the work of the CPPCs, and on outcomes of their activities.

- Opportunities for collaboration and service mapping with the Early Intervention Services area of the Family Well-Being and Protection Division.

Opportunities for Improvement:

- Work to increase sites' understanding of child welfare data and utilizing this data to assess community needs, drive planning and decision making and track changes and outcomes.
- Develop additional resources for sites to understand how to identify and implement policy, practice changes, and engage youth and parents with lived experience in this process.
- Continue to identify opportunities for collaboration and community engagement through CPPCs around Family First Implementation.
- Continued evaluation of the CPPC Approach as all stakeholders stand in partnership with HHS and communities to best support children and families. This will ensure alignment of CPPC within the prevention continuum and further contribute to positive outcomes for children and families in the community.
- Continued support to CPPC sites implementation of the revised Family and Youth Centered Engagement Strategy (formerly Individualize Course of Action) to be successful in their efforts.
- Provide continued guidance and support to CPPC sites to center equity and develop/support culturally responsive approaches in their communities.
- Evaluation analysis of the revised CPPC annual plan and report.

CHILD AND FAMILY SERVICES CONTINUUM – ASSESSMENT & INTERVENTION

Child Protective Assessments

When the HHS 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), HHS 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 HHS 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.

HHS 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 Family Assessment are less serious allegations of abuse or neglect. During the course of a Family Assessment, the HHS child protection worker (CPW):

- Visits the home and speaks with individual family members to gather an understanding of the concerns reported, what the family is experiencing, and engages collateral contacts in order to get a holistic view;
- Evaluates safety and risk for the child(ren);
- Engages the family to assess 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. CPWs make recommendations for services available in the community for families with low risk; they offer families at moderate and high risk nonagency voluntary (state-purchased) services. To align with the HHS efforts to implement the Family First Prevention Services Act, these non-agency voluntary services are encouraged to use the Solution Based Casework approach and are required to complete service plans for each case.

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 HHS staff reassigns the case to the Child Abuse Assessment pathway. The same CPW continues to work the case.

The Child Abuse Assessment is Iowa's traditional path of assessing reports of suspected child abuse. The HHS CPW utilizes the same family functioning, safety, and risk assessments as under the Family Assessment pathway. However, by the end of 20 business days, the CPW must make a finding of whether abuse occurred, consider whether a perpetrator's name meets criteria for placement on the Central Abuse Registry, and determine whether to request court intervention. Findings include:

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

If a report of suspected child abuse does not meet the criteria for acceptance as an assessment, HHS intake staff reject the report. HHS 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). HHS uses CINA Assessments to determine whether to recommend juvenile court intervention for a child and 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.

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

Table 5P: HHS Child Protective Assessments (CY 2016-2022)

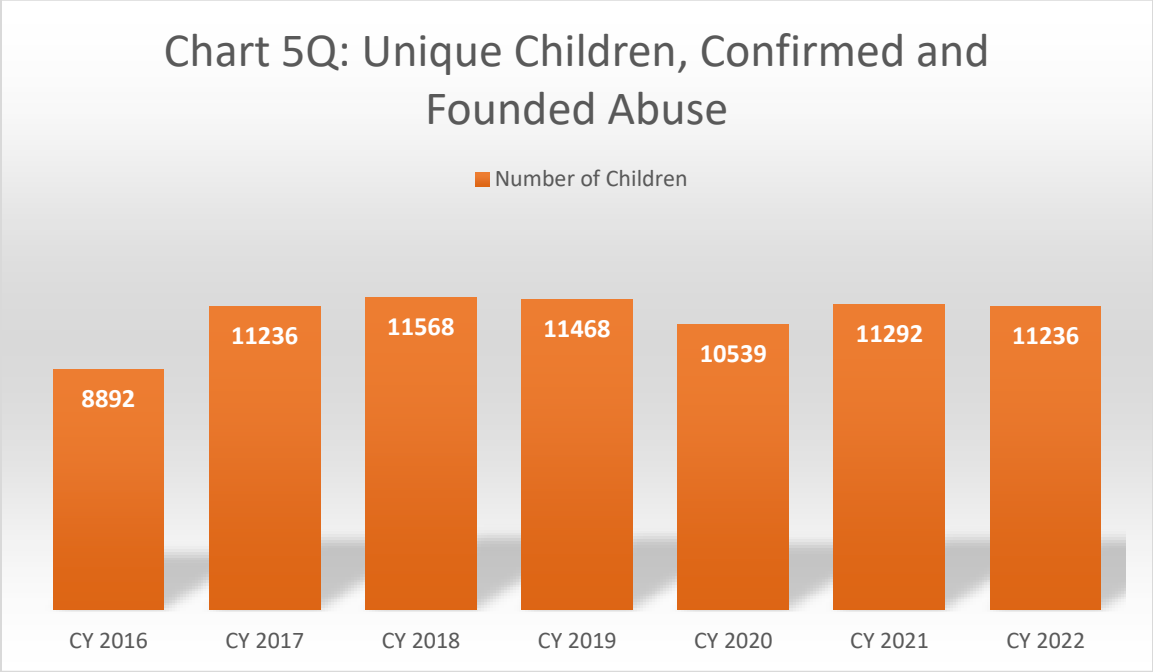
Calendar Year (CY)	Total Assessed Reports	Family Assessments (Percentage)	Assessments Not Confirmed (Percentage)	Assessments Confirmed & Founded (Percentage)
2022	34,512	6,302 (18%)	19,693 (57%)	8.517 (25%)
2021	35,593	6,727 (19%)	20,323 (57%)	8,543 (24%)

2020	30,151	6,450 (21%)	15,766 (52%)	7,935 (27%)
2019	33,004	6,543 (20%)	17,947 (54%)	8,514 (26%)
2018	35,029	6,958 (20%)	19,328 (55%)	8,743 (25%)
2017	33,418	7,136 (21%)	17,724 (53%)	8,558 (26%)
2016	25,707	7,457 (29.0%)	11,766 (45.8%)	6,484 (25.2%)

Source: SACWIS

The number of total assessed reports increased 11% in 2017 and increased slightly again in 2018 due to factors that included a practice change resulting in new allegations being addressed in a separate report as well as additional reports resulting from a number of high-profile cases. This practice change was in place from February 2017 through September 2018. A process to link intakes was implemented September 2018 to allow new allegations to be addressed in a report that was already open for assessment. The linked intakes process was a factor in the decline of total assessed reports in 2019. The decrease in total assessed reports in 2020 is believed to be a result of the global pandemic from COVID-19, as children were not being seen as regularly when schools closed and in-person non-emergency medical and mental health appointments ceased for many months.

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



Source: SACWIS

The number of unique children who experienced confirmed or founded abuse increased slightly in CY 2017, remained steady through CY 2019, saw a bit of a dip in CY 2020, returned to pre-pandemic totals

in CY 2021 and remained in CY 2022. In CY 2022, the 11,236 unique children with Confirmed or Founded abuse made up 29% of all unique children whose family received a child protective assessment (either a Family Assessment or a Child Abuse Assessment). 8,069 unique children were part of a Family Assessment, which made up 21% of all unique children whose families received a child protective assessment. The remaining 50% had a Not Confirmed outcome and included 19,190 children.
See the full calendar year statistics at: https://hhs.iowa.gov/reports/child-abuse-statistics

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

In SFY 2023, three bills were signed into law relating to child welfare:

- HF 113 was signed into law on March 22, 2023. This bill extended the state public defender pilot project for child welfare legal representation another year (through June 30, 2025) and expanded the project from six to sixteen counties throughout the state.
- HF 176 was signed into law on April 28, 2023. This bill amended the definition of *continuous sexual abuse of a child* to include any person 18 years of age or older who engages in any combination of three or more acts of sexual abuse with the same child and at least thirty days have elapsed between the first and last acts of sexual abuse. Previously, this definition only included any combination of three or more acts of sexual abuse in the second or third degree. The amended definition includes all acts of sexual abuse.
- HF 474 was signed into law on April 28, 2023. This bill added adoption service providers as one of the options that a parent of a newborn infant may voluntarily release custody of the newborn infant to, in accordance with the Newborn Safe Haven Act. This bill also requires adoption service providers who will be involved in the surrender of newborns to have CPR and first aid training for infants and adults.

Child Advocacy Centers

CAC/CPC Services

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

CAC/CPCs employ staff that specializes in the emotional and physical needs of children who have experienced sexual abuse, severe physical abuse and/or substance use related maltreatment or neglect. Services include forensic interviews, medical exams, treatment, and follow-up services for alleged child victims and their families. These specialized services strive to limit the amount of trauma experienced by child victims and non-offending family members.

In addition to providing services to assist HHS in the assessment of child abuse, the CAC/CPCs coordinate with law enforcement and county attorneys in the prosecution of criminal cases involving child endangerment, child fatalities, sexual abuse, and human trafficking. CAC/CPC staff also offer court

testimony in legal proceedings involving cases in which the CAC/CPC provided services. In this way, the CAC/CPCs have assisted HHS, District Court, and Juvenile Court in numerous child abuse cases. Other services provided by CAC/CPCs include multidisciplinary trainings for professionals involved in child welfare services. In addition to services for children, the CAC/CPCs provide an array of coordinated services for Dependent Adults who experienced abuse or neglect.

CAC/CPC Locations

Currently, there are six CAC/CPCs and one satellite CAC/CPC in Iowa. The names and locations of the CAC/CPCs are as follows:

- Child Protection Response Center, Davenport, Iowa;
- Mississippi Valley CAC/CPC, Muscatine, Iowa;
- St Luke's CAC/CPC, Hiawatha, Iowa;
- Blank Children's STAR Center, Des Moines, Iowa;
- Mercy CAC/CPC, Sioux City, Iowa
- Allen CAC/CPC, Waterloo, Iowa
- Allen's Satellite CAC/CPC, Mason City, Iowa.

In addition to Iowa's CAC/CPCs, there is also Project Harmony, a CAC/CPC that is located in Omaha, Nebraska that provides services to children and families for the southwestern area of Iowa.

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

Child Protection Center Grant Program

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

Last year, Blank Children's Hospital, on the behalf of the CAC/CPCs in Iowa, made a request to the Governor's Office for additional funding for the Child Protection Center Grant Program to help address rising costs associated with operating the centers and implementing quality services. The proposal included potential areas where additional funding could support operations and expand services within the Centers.

The proposed areas of support and expansion included the following:

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

Additional funding in the amount of $300,000 had been requested for the Child Protection Grant Program to implement these initiatives. The request was to retain the current $245,000 base formula with an additional $300,000 which would have been distributed to each grant funded center using the current funding formula which is based upon the volume of children that have been served during the previous year. By distributing the additional funding based on this formula, CAC/CPCs would be encouraged to continue their outreach efforts to HHS and law enforcement in surrounding communities who may not currently access CAC/CPCs services for their assessments of allegations of child abuse or neglect.

Unfortunately, the proposed funding bill for an additional $300,000 for the Child Protection Center Grant Program did not pass last year.

CAC/CPC Contracts & MOUs

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

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

- The addition of services to include federally recognized Indian Tribes.
- The need to include the Representative or Protective Service Worker from a federally recognized Indian Tribe in consultations and in staffing's.
- Clarity on what child abuse information and related material is considered to be part of the HHS case file and what information can be shared, how it may be shared, and with whom.
- Expanded information and directions on Confidentiality.
- An explanation on the use of a Child Protection Assistant Team.
- A section regarding parental consent for an interview at a Child Protection Center.
- An update to the Business Associate Agreement and the Qualified Service Organization sections of the MOU.
- Expanded data requirements regarding security certification, security risk assessment, compliance with Cloud services, and the need to complete an HHS Vendor Security Questionnaire.

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

This year's 2023 MOU amendment included the following items:

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

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

New Platform for Sending CPC Reports and Recordings

In April 2023 three of Iowa's Child Protections Centers (CPCs) under UnityPoint Health (St Luke's, Allen and Blank Children's STAR Center) began rolling out a new platform to share forensic interview reports and recordings as well as medical reports and images with the HHS Service Areas. The new e-mail-based platform is called MOVEit. There were a number of reasons that the Centers decided to use this type of platform.

- MOVEit allows for the Child Protection Centers to email bigger data files. By contrast, the current email system has limits that do not allow for larger files to be sent, like forensic interview recordings or medical images, in a user-friendly way.
- MOVEit provides the most secure way to send sensitive child abuse information. MOVEit is more secure than relying on fax or "snail" mail, which takes more time and is less secure. Under MOVEit the Child Protection Centers can track who is receiving the information as it provides information on when it was sent, received, and opened. Currently, in sending information via fax or mail, the Centers cannot be assured who will open it and/or view the confidential information.
- Previously, DVDs were used. The DVD technology is now outdated. Most computers do not come with a DVD player and copying the DVD has been a challenge when MDT partners want to provide copies to other agencies and judicial entities.
- The MOVEit platform is budget friendly by eliminating the cost for postage and reducing waste by eliminating the use of DVDs and paper.

To facilitate the move to this new platform HHS worked with the IT Division to ensure that any technical issues were addressed and resolved. For HHS field staff, a Guidance Document was produced with instruction on the use of the new email-based platform. In addition, a presentation of the platform was made by HHS policy staff on the statewide CIDS call (May 4, 2023) to all supervisors.

CAC/CPC Annual Report

Each year, the Iowa Chapter of Children's Advocacy Centers prepare an Annual Report. The Annual Report includes information on the services that Iowa's Child Protection Centers provide, the type of cases they handle, the funding of the Centers, background information and the trainings they have provided through the year. Results and highlights from the satisfaction survey that the Chapter conducts annually is also included. A copy of this Annual Report can be found here: 2022ICCACAnnualReport.pdf (iowacacs.org)

CAC/CPC Data

Below is data for Iowa's six CAC/CPCs, followed by data from Project Harmony. The Child Protection Center Grant Program collects and provides the Iowa's CAC/CPC data. Each of the Iowa CAC/CPCs submits their data to IDPH who then combines the data and issues one report to HHS. There are no known data quality issues or limitations with the data.

Table 5R: SFY 2022 Child Protection Center Totals

Data Requirements	**SFY 2022 (July 1, 2021 – June 30, 2022) Child Protection Center Totals**						
Alleged Child Victim Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Children served:							
Total number of children served at the CAC during the reporting period	**900**	**669**	**704**	**287**	**265**	**1,348**	**4173**

Male	281	196	178	85	76	415	**1231**
Female	619	473	526	202	189	933	**2942**
Total	**900**	**669**	**704**	**287**	**265**	**1348**	**4173**
0-6 years	337	150	239	59	111	495	**1391**
7-12 years	284	266	223	119	98	410	**1400**
13-18 years*	279	253	242	109	56	443	**1382**
Total	**900**	**669**	**704**	**287**	**265**	**1348**	**4173**
White (Non-Hispanic)	647	388	448	201	156	829	**2669**
Black/African American	65	31	47	9	74	133	**359**
Hispanic/Latino	30	106	60	30	14	78	**318**
American Indian/Alaska Native	9	98	2	0	1	6	**116**
Asian/Pacific Islander	10	11	8	3	0	17	**49**
Other	139	35	46	44	12	285	**561**
Unknown	0	0	93	0	8	0	**101**
Total	**900**	**669**	**704**	**287**	**265**	**1348**	**4173**
**Individual was a child (0-17 years) at time of alleged abuse and/or neglect*							
‡ Suppression of data to protect privacy rights established in IDPH policy							

Data Requirements							
Alleged Offender Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Total number of alleged offenders:							

Total	**739**	**528**	**497**	**245**	**204**	**1280**	**3493**
Parent	274	161	130	53	75	452	**1145**
Stepparent	28	28	25	12	4	48	**145**
Parent's boy/girlfriend	94	34	36	22	39	98	**323**
Other relative	102	144	128	58	19	232	**683**
Other known person	191	149	173	80	38	230	**861**
Unknown	67	16	5	32	29	220	**369**
Total	**756**	**532**	**497**	**257**	**204**	**1280**	**3526**
Under 13 years	25	31	31	17	15	40	**159**
13-17 years	105	91	92	48	18	140	**494**
18+ years	474	364	312	155	144	767	**2216**
Unknown	137	32	62	25	27	333	**616**
Total	**741**	**518**	**497**	**245**	**204**	**1280**	**3485**
Gender of alleged offenders:							
Male	N/A	N/A	419	188	134	519	**1260**
Female	N/A	N/A	73	33	35	541	**682**
Unknown	N/A	N/A	5	24	35	220	**284**
Total	**N/A**	**N/A**	**497**	**245**	**204**	**1280**	**2226**

Data Requirements	**SFY 2022 (July 1, 2021 – June 30, 2022) Child Protection Center Totals**						
Incident & Disposition Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Sexual Abuse	618	494	561	256	195	892	**3016**
Physical Abuse	84	151	28	36	36	101	**436**
Neglect	41	30	7	2	10	17	**107**

Witness to Violence	63	42	11	20	12	74	**222**
Drug Endangerment	183	39	56	5	3	148	**434**
Other	10	27	9	0	9	217	**272**
Total Allegations	**999**	**783**	**672**	**319**	**265**	**1449**	**4487**
Unfounded	278	168	211	125	94	478	**1354**
Founded	190	137	155	86	84	292	**944**
Confirmed, not placed on registry (i.e., minor, isolated, unlikely to reoccur)	0	5	0	0	0	17	**22**
Unknown/Pending	0	0	5	0	87	0	**92**
Total CPS Dispositions	**468**	**310**	**371**	**211**	**265**	**787**	**2048**
Number of cases with charges filed	**33**	**29**	**122**	**91**	**16**	**10**	**301**
Cases accepted for prosecution	6	4	118	86	16	0	**230**
Number of convictions	1	5	16	26	0	0	**48**
Number of pleas	14	2	106	38	1	0	**161**
Number of acquittals	0	0	3	4	0	0	**7**
Charges Dismissed	N/A	N/A	5	0	N/A	0	**5**
Total Prosecution Dispositions	**21**	**11**	**248**	**245**	**17**	**0**	**542**
Data Requirements	**SFY 2022 (July 1, 2021 – June 30, 2022) Child Protection Center Totals**						

Services Provided	St. Luke's	Mercy	Allen	MV	CPRC	Blank	Total
Services to Children							
Initial Medical Exams/Treatment	563	125	455	117	107	632	**1999**
Counseling/Therapy	0	405	79	4	0	967	**1455**
Referral to Counseling/Therapy	438	364	308	250	95	939	**2394**
Onsite/Offsite Forensic Interviewing	677	569	516	276	205	992	**3235**
Total Core Services	**1678**	**1463**	**1358**	**647**	**407**	**3530**	**9083**
Follow-up Counseling/Therapy	0	3	743	0	0	1037	**1783**
Follow-up Medical Exams/Treatment	77	2	31	3	17	576	**706**
Foster Care Physicals	16	0	0	0	0	123	**139**
Multidisciplinary Team Meetings	12	6	12	36	14	280	**360**
*Case Management/Coordination** *	0	14	1	48	136	0	**199**
Victim Advocacy	583	414	1849	287	224	590	**3947**
Child Abuse Prevention Services (to Adults)	0	0	5	679	N/A	0	**684**
Child Abuse Prevention Services (to Children)	0	0	2	0	3073	1008	**4083**
Professional Trainings							
Number of Presentations	13	2	26	46	10	52	**149**
Number of Individuals Provided Training	141	45	568	74	330	1842	**3000**
Professional Case Consultation	117	8	353	0	58	0	**536**

Inpatient	0	0	0	N/A	0	23	**23**
Initial Medical Exam	0	0	0	N/A	0	9	**9**
Follow-up Medical Exams/Treatment	0	0	0	N/A	0	11	**11**
Medical exams for DD Adults	1	0	5	0	0	0	**6**
Forensic interviews for DD adults	2	0	19	3	0	0	**24**
Total Other Services	**962**	**494**	**3614**	**1176**	**3862**	**5551**	**15659**
***This refers to case coordination provided by the CAC for children who are not seen at the CAC. This may be for physical abuse cases or other types of cases that don't present to the CAC.*							

Table 5S: SFY 2023 Child Protection Center Totals

Data Requirements	**SFY 2023 (July 1, 2022 – December 31, 2022) Child Protection Center Totals**						
Alleged Child Victim Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Children served:							
Total number of children served at the CAC during the reporting period	**462**	**264**	**352**	**62**	**121**	**612**	**1873**
Male	160	78	96	17	39	186	**576**
Female	302	185	256	45	82	426	**1296**
Total	**462**	**263**	**352**	**62**	**121**	**612**	**1872**
0-6 years	171	79	113	16	50	245	**674**
7-12 years	160	105	118	24	47	176	**630**
13-18 years*	131	80	121	22	24	191	**569**

Total	**462**	**264**	**352**	**62**	**121**	**612**	**1873**
White (Non-Hispanic)	331	148	243	51	77	361	**1211**
Black/African American	54	10	31	2	15	45	**157**
Hispanic/Latino	16	40	20	3	11	53	**143**
American Indian/Alaska Native	6	48	0	0	0	5	**59**
Asian/Pacific Islander	3	8	1	1	0	12	**25**
Other	52	7	57	5	12	136	**269**
Unknown	0	0	0	0	6	0	**6**
Total	**462**	**261**	**352**	**62**	**121**	**612**	**1870**
**Individual was a child (0-17 years) at time of alleged abuse and/or neglect*							
‡ Suppression of data to protect privacy rights established in IDPH policy							

Data Requirements							
Alleged Offender Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Total number of alleged offenders:							
Total	**301**	**200**	**283**	**62**	**88**	**581**	**1515**
Parent	89	56	79	16	39	212	**491**
Stepparent	11	21	15	1	5	25	**78**
Parent's boy/girlfriend	24	11	21	6	11	41	**114**
Other relative	67	47	65	12	6	106	**303**
Other known person	91	54	99	19	21	92	**376**
Unknown	33	17	4	11	6	105	**176**
Total	**315**	**206**	**283**	**65**	**88**	**581**	**1538**

Under 13 years	14	10	19	2	4	21	**70**
13-17 years	47	28	56	11	8	57	**207**
18+ years	179	138	170	39	70	354	**950**
Unknown	61	17	38	10	6	149	**281**
Total	**301**	**193**	**283**	**62**	**88**	**581**	**1508**
Gender of alleged offenders:							
Male	N/A	N/A	219	45	64	338	**666**
Female	N/A	N/A	51	8	18	147	**224**
Unknown	N/A	N/A	13	9	6	96	**124**
Total	**N/A**	**N/A**	**283**	**62**	**88**	**581**	**1014**

Data Requirements	**SFY 2023 (July 1, 2022 – December 31, 2022) Child Protection Center Totals**						
Incident & Disposition Data	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Sexual Abuse	320	189	294	57	83	403	**1346**
Physical Abuse	43	53	28	7	14	53	**198**
Neglect	16	11	3	1	12	18	**61**
Witness to Violence	46	25	12	4	4	55	**146**
Drug Endangerment	101	19	27	0	7	72	**226**
Other	7	2	1	0	1	88	**99**
Total Allegations	**533**	**299**	**365**	**69**	**121**	**689**	**2076**
Unfounded	81	74	141	27	68	223	**614**
Founded	50	37	76	22	56	145	**386**

Confirmed, not placed on registry (i.e., minor, isolated, unlikely to reoccur)	0	0	0	0	0	8	**8**
Unknown/Pending	0	0	26	0	0	0	**26**
Total CPS Dispositions	**131**	**111**	**243**	**49**	**124**	**376**	**1034**
Number of cases with charges filed	**28**	**4**	**59**	**25**	**N/A**	**29**	**145**
Cases accepted for prosecution	0	4	59	26	9	0	**98**
Number of convictions	1	1	6	15	N/A	0	**23**
Number of pleas	7	3	77	14	N/A	0	**101**
Number of acquittals	0	0	2	0	N/A	0	**2**
Charges Dismissed	N/A	N/A	N/A	0	N/A	0	**0**
Total Prosecution Dispositions	**8**	**8**	**144**	**55**	**9**	**0**	**224**

Data Requirements	**SFY 2023 (July 1, 2022 – December 31, 2022) Child Protection Center Totals**						
Services Provided	**St. Luke's**	**Mercy**	**Allen**	**MV**	**CPRC**	**Blank**	**Total**
Services to Children							
Initial Medical Exams/Treatment	301	47	246	44	39	280	**957**
Counseling/Therapy	0	5	26	2	0	404	**437**
Referral to Counseling/Therapy	213	0	137	54	34	434	**872**

Onsite/Offsite Forensic Interviewing	343	197	291	57	93	443	**1424**
Total Core Services	**857**	**249**	**700**	**157**	**166**	**1561**	**3690**
Follow-up Counseling/Therapy	0	0	265	0	0	422	**687**
Follow-up Medical Exams/Treatment	70	0	28	3	14	304	**419**
Foster Care Physicals	0	0	0	0	0	80	**80**
Multidisciplinary Team Meetings	0	5	6	12	6	176	**205**
*Case Management/Coordination** *	0	0	0	0	0	0	**0**
Victim Advocacy	538	274	1375	62	81	552	**2882**
Child Abuse Prevention Services (to Adults)	0	0	0	233	0	0	**233**
Child Abuse Prevention Services (to Children)	0	0	0	0	1563	277	**1840**
Professional Trainings							
Number of Presentations	178	0	14	12	8	9	**221**
Number of Individuals Provided Training	N/A	0	296	15	199	411	**921**
Professional Case Consultation	52	0	0	0	16	14	**82**
Medical exams for DD Adults	N/A	0	0	0	0	N/A	**0**
Forensic interviews for DD adults	N/A	3	3	1	0	N/A	**7**
Total Other Services	**838**	**282**	**1987**	**338**	**1887**	**2245**	**7577**
***This refers to case coordination provided by the CAC for children who are not seen at the CAC. This*							

may be for physical abuse cases or other types of cases that don't present to the CAC.					

Project Harmony compiles its own data and submits their data report directly to HHS. The contract requires Project Harmony to keep statistical records of services provided. There are no known data quality issues or limitations with the data.

Table 5T: Project Harmony Child Protection Center Data

	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Children Served:	324	275	251	298	258
Age of children: 0-6 yrs.	105 (32%)	106 (39%)	66 (26%)	85 (28%)	64 (25%)
7-12 yrs.	120 (37%)	83 (30%)	103 (41%)	130 (44%)	87 (34%)
13-18 yrs.	99 (31%)	86 (31%)	82 (33%)	106 (36%)	107 (41%)
Total number of new children served:	324	197	197	255	235
Categories of abuse:					
Sexual abuse	289	227	211	266	229
Physical abuse	27	22	21	29	38
Neglect	26	27	21	14	23
Witness to violence	7	5	2	8	13
Other	27	31	34	21	11
Services provided:					
Medical/Physical exam:	102	138	114	169	150
Counseling/Therapy:					
In-house:	42	11	0	0	5
Number referrals:	114	89	25	95	20

HHS Drug Testing Services

HHS uses drug testing services as a means to better protect children. Drug testing results help staff to identify and/or eliminate substance abuse as a possible contributing factor or risk in a child abuse case. It can also be used to either confirm or contradict what HHS staff has learned through direct observation. As such, drug testing results are viewed as one component of the accumulated information to be considered when determining issues of safety and danger for a child.

In terms of practice, HHS drug testing protocols and policies promote a strengths-based approach to drug testing in which the role of the HHS child welfare worker is to support the client's recovery and to reduce barriers to substance abuse treatment services. HHS policy endorses the use of strength-based language and strategies to assist the parent/caretaker in moving to a more functional level of behavior through abstinence. Substance Abuse training is available to all HHS staff to increase their knowledge of substance abuse and the potential risk it poses to child safety. In addition to trainings, field staff is

encouraged to collaborate with substance abuse and mental health providers who may be involved in the case and who may be able to offer additional information that can improve child safety.

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

Drug Testing Contracts

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

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

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

On July 1, 2019, two new statewide Drug Testing Collections and Laboratory Services Contracts became effective. Revisions and improvements were added to these contracts based on the knowledge and experience gained with the application of the statewide drug testing system. New and improved elements under the contracts included additional testing sites across the state and an increase and flexibility in the hours of operation at the sites; increased randomization in the drug testing process; system upgrades; adjusted the drug testing panels based upon a conducted review and improvements in the tracking and collection of data.

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

Redesign of the HHS Drug Testing Authorization System

Over the past number of years, HHS drug testing numbers have continued to increase. As such, HHS recognized that a more targeted research-based approach to drug testing was needed and that the implementation of such an approach should include additional guidance for workers regarding the type of drug test to use and the frequency and duration of testing that should be followed. Work began with an HHS workgroup researching different approaches to drug testing. Ultimately, it was found that the observation of behavioral indicators is an effective approach as it is based on findings that certain types of drugs have specific observable physiological effects and that those effects may be either behavioral, relational, psychological and/or physical in nature. Under this approach the observation of behavioral indicators offers a gateway for approving drug testing. As such, the decision was made to redesign the HHS Drug Testing Authorization system to limit testing to cases in which there are behavioral indicators that support the need for a drug test.

HHS Drug Testing Authorization System

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

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

- A description of the different drug testing funding sources to ensure that the worker is checking the correct funding stream.
- A list of the detection times for different types of drugs.
- Information along with cautionary notes regarding each specific type of test.
- Detection times for different types of drugs.

The redesigned HHS Drug Testing Authorization System was also built to allow for the collection of additional drug testing data. The new drug testing data is to include:

- Drug testing for children
- Length of time a case has been opened
- Substance abuse treatment services
- Supervisory data

As of this reporting, the additional data listed above is not yet ready to be shared as enhancements to the system are still needed. These involve removing system barriers to allow for workers to create new authorizations in order to make corrective entries for errors or when circumstances have changed

regarding the initial authorization that was submitted. Work on these enhancements is currently on the list of HHS IT projects to be completed.

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

With the implementation of the redesigned HHS Drug Testing Authorization System, a three-month grace period was enacted to allow workers to become familiar with the new policy and the authorization system. During this transition period, HHS workers were allowed to authorize limited testing without the observation of behavioral indicators as they transitioned over to the new policy and system. The three-month grace period was also used to identify and address issues relating to the functioning of the system.

Drug Testing Guidelines in Response to COVID-19

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

During COVID guidelines and procedures were put in place at all of the drug testing Fixed-Sites. These guidelines and procedures included:

- Hand sanitizer is available in the lobby and in all other appropriate areas.
- Prescreening questions are asked of the client.
- The six-foot rule is followed when conducting the prescreening.
- The Fixed-Site may limit, if needed, the number of persons allowed in the lobby or waiting area which may require a client to wait in their car until called.

Drug Testing Data

Just over the past year, with the implementation of the new Drug Testing Authorization System, we are able to capture additional data that we have not had previously. This includes drug testing data around court ordered funding. This data became available at the time of our merger and the reconfiguration of the HHS Service Areas. As such, we are still in the early stages of reviewing it and identifying our response and strategies around it. The addition of this data provides us with the ability to refine our approach to the judicial branch based on the data we are now able to collect.

In speaking to the communication with the judicial branch, HHS has continued efforts at the administrative level to coordinate and share the volume of drug testing numbers with both the judicial branch and with the Service Areas. As part of the court process, these include efforts to educate and encourage the use of substance abuse evaluations and treatment services.

The following data tables reflect the Drug Testing Collections under each of the three funding sources from April 2020 through March 2023. The count includes instant tests and patches. Patches count as two collections, one for application and one for removal of the patch. There is no patch or instant test coverage under the Child Abuse Registry funding stream which is specific to child protective assessments. The data tables also include the percentage of court ordered drug testing to the total number of tests.

Table 5U: Statewide Drug Testing Collections (April 2022 - March 2023)

Service Area	Child Abuse Registry Funding	Child Welfare Funding	Court Ordered Funding	Total	Percentage of Court Ordered to Testing Total
Western	782	1,039	958	2,779	34.47%
Northern	545	729	851	2,125	40.05%
Eastern	470	1,006	434	1,910	22.72%
Cedar Rapids	891	2,273	5,053	8,217	61.49%
Des Moines	445	1,890	1,303	3,638	35.82%
TOTAL	3,133	6,937	8,599	18,669	46.06%

Source: Iowa Department of Health and Human Services

Table 5V: Statewide Drug Testing Collections (April 2021 - March 2022)

Service Area	Child Abuse Registry Funding	Child Welfare Funding	Court Ordered Funding	Total	Percentage of Court Ordered to Testing Total
Western	875	3,223	682	4,780	14.27%
Northern	592	2,158	324	3,074	10.54%
Eastern	530	1,840	315	2,685	11.73%
Cedar Rapids	1,006	3,665	727	5,398	13.47%
Des Moines	475	1,730	339	2,544	13.33%
TOTAL	3,478	12,616	2,387	18,481	12.92%

Source: Iowa Department of Health and Human Services

Table 5W: Statewide Drug Testing Collections (April 2020 - March 2021)

Service Area	Child Abuse Registry Funding	Child Welfare Funding	Court Ordered Funding	Total	Percentage of Court Ordered to Testing Total
Western	956	3,774	440	5170	8.51%
Northern	643	2,538	295	3476	8.49%
Eastern	518	2,044	238	2800	8.50%
Cedar Rapids	1093	4,311	502	5906	8.50%
Des Moines	516	2,035	236	2787	8.47%
TOTAL	3,726	14,702	1711	20139	8.50%

Source: Iowa Department of Health and Human Services

Upon review, the Statewide Drug Testing Collections data tables indicate an overall decrease in drug testing since March 2021. This decrease coincides with the implementation of the redesigned Drug Testing Authorization System in August of 2021. The redesign which included tighter parameters and guidelines supports the current HHS drug testing policy that testing should be based on the observation of behavioral indicators.

In looking at the percentage of Court Ordered Testing to the testing total, the tables indicate that the number of court-ordered drug tests have increased significantly from 2020 – 2023. In the last year, court ordered testing represented 46.06% of all testing statewide. In the Cedar Rapids Service Area alone, 61.49% of all testing from April 2022 – March 2023 was court ordered. This was up 13.47% from the previous year for this area. By comparison, testing under child welfare funding during the same period has decreased. Non-court ordered testing dropped form 12,616 in 2022 to 8,599 in 2023.

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

Overall, when evaluating the drug testing data, it is important to be aware that additional factors may impact or contribute to either a decrease or an increase in the number of drug tests that are conducted over a specific time period. Individual cases or situations involving multiple tests per client can impact the number of drug tests such as:

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

CHILD AND FAMILY SERVICES CONTINUUM – TREATMENT AND FOSTER CARE SERVICES

Connect And Protect (CAP) Teams and Consultations

Connect and Protect (CAP) Teams are multi-disciplinary and have membership from the Iowa Department of Health and Human Services, Family Centered Services providers, Parent Partners, and Domestic Violence advocates. CAP teams are the content experts on Safe & Together™ - the model for Domestic violence child welfare cases that HHS is responsible for serving. Teams are designed to meet to provide case consultation on DV cases in the style of Safe & Together™ to promote best practice and to assist child welfare partners in working through cases through a domestic violence-informed lens. The Safe and Together model is a perpetrator pattern-based, child-centered, and survivor strengths approach to working with domestic violence the child welfare system. In addition to consultation, CAP Teams also provide information sharing, local training, and answer questions about the model in offices and agencies. Case consultation is approached slightly different on each team, but the Safe & Together™ Mapping Tool provides the basic framework.

Table 5X: CAP Consultations (May 2022 – April 2023)

Service Area	CAP Consultations Facilitated
Area 1 – Western	2
Area 2 – Northern	3
Area 3 – Eastern	10
Area 4 – Cedar Rapids	14
Area 5 – Des Moines	20

The overall number of CAP team consultations have increased slightly from the last reporting year, with a total of 49 consultations held statewide from May 2022-April 2023, and 42 total consultations held during the previous year. Challenges to consistent facilitation of CAP teams in some areas is attributed to workforce challenges which have created some barriers with consistency and ability to facilitate CAP Team consults. However, both Northern Service Area and Western Service Area have begun to rebuild their CAP teams and have each held consultations in their respective areas this year, as opposed to not holding any consultations during the previous year.

CAP Seminars

Connect and Protect Seminars are one day training sessions for members of the service area CAP Teams to attend that are focused on implementing the Safe & Together™ Model and strengthening the knowledge and skills of the CAP teams. The fall 2022 CAP Seminar hosted CAP Team members with a presentation by Dr. Maria Corona, Director of the Iowa Coalition Against Domestic Violence (ICADV), and Kirsten Faisal, Director of Training and Technical Assistance for ICADV. Kirsten is also a CAP team member. Their presentation on Structural and Cultural Factors Impacting the Latinx Community, and specifically spoke to cultural values, gender roles. and culturally responsive approaches in supporting survivors of Domestic and Intimate Partner Violence in the Latinx Community. Following the presentation, CAP teams identified a variety of strategies to apply in CAP team consultations, further access to community resources and education, and some teams identified next steps reaching out to

ethnic and culturally based organizations in their community to collaborate with to support families and survivors moving forward.

A spring seminar is planned for the CAP teams to be held in June 2023. The topic of focus for the upcoming seminar is on brain injury and the potential impact of trauma from domestic/intimate partner violence to the brain regarding parents involved in a child welfare case. Subject matter experts in brain injury and trauma will provide a basic overview of brain injury impact, signs that brain injury may be impacting an individual's cognitive and behavioral actions, and resources available for screening and support.

For SFY23, CPPC funds were allocated to provide access to online learning on the HHS LMS through the Safe and Together™ Institute. The virtual offerings were to include the following courses:

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

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

Unfortunately, due to unforeseen barriers in the contracting process, we were not able to offer the Safe and Together™ virtual courses this year. We are working through options to address these barriers to offer the courses in the upcoming fiscal year.

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

Additional Activities of the CAP Teams

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

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

The HHS Program Manager has continued to explore additional strategies in the current year to track and evaluate the outcomes of cases who participate in CAP team consultation. One identified strategy is to request HHS case manager staff who present cases to the CAP teams to complete a survey, indicating the value of the consultation, provide opportunity to give their feedback to the team, and describe what actions they were able to take with the case and in supporting the family based on the guidance provided in the consultation. The Program Manager will continue to explore this strategy, along with other potential strategies for tracking outcomes, in SFY 24.

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

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

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

Family-Centered Services (FCS)

The prior Safety Plan Services/Family Safety, Risk, and Permanency (FSRP) Services and Community Care contracts ended June 30, 2020, for service provision. Beginning July 1, 2020, HHS entered into ten (10) Family-Centered Services contracts, two (2) per Service Area, with the following contractors:

- Western Service Area
    - Family Access Center (FAC)
    - Boys Town
- Northern Service Area
    - Mid Iowa Family Therapy Clinic (MIFTC)
    - Families First Counseling Services
- Eastern Service Area
    - Families First Counseling Services
    - Lutheran Services in Iowa (LSI)
- Cedar Rapids Service Area
    - Families First Counseling Services

  - Four Oaks
- Des Moines Service Area
  - Children and Families of Iowa (CFI)
  - MIFTC

Effective July 1, 2023, HHS has elected to not renew the contract with Lutheran Services in Iowa. Families First will provide FCS for all cases in the Eastern Iowa Service Area.

Iowa HHS is transitioning to redefined geographic Service Areas based on child population. This will impact how contractors serve families in eighteen (18) counties. These contractors are working together to plan for this change so that families experience minimal disruption to their services. HHS will provide support to contractors as needed to ensure that families experience minimal disruption in services.

The services and supports provided under these contracts include the Solution Based Casework (SBC) approach, SafeCare®, Family Preservation Services (FPS), Solution Focused Meetings, and Youth Transition Decision-Making (YTDM) Meeting Facilitation. Beginning July 1, 2021, the Department replaced Family Team Decision Making Meetings with Solution Focused Meetings (SFM). These services and supports are available to intact families (in-home), families with children placed with kin/fictive kin caregivers, and families with children placed in stranger foster care. FCS are not available for children placed in shelter or a Qualified Residential Treatment Program (QRTP) longer than 30 days; however, FCS is available for a youth exiting from a QRTP for post discharge services. The current FCS contractors provide six months of QRTP post discharge services. Kinship Navigator Services were added to the service array beginning July 1, 2021.

Solution Based Casework (SBC) is an evidence-based case management approach to assessment, case planning, and ongoing casework. The approach is designed to help the caseworker focus on the family to support the safety and well-being of their children. The goal is to work in partnership with the family to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them. This approach targets specific everyday events in the life of a family that have caused the family difficulty and represent a situation in which at least one family member cannot reliably maintain the behavior that the family needs to accomplish its goals. The model combines the best of the problem-focused relapse prevention approaches that evolved from work with addiction, violence, and helplessness, with solution-focused models that evolved from family systems casework and therapy. By integrating the two approaches, partnerships between the family, HHS worker, FCS contractor, and other service providers can be developed that account for basic needs and restore the family's pride in their own competence. The assumptions of SBC include (1) full partnership with the family is a critical and vital goal for every family, (2) partnership for protection should focus on patterns of everyday life of the family, and (3) solutions should target the prevention skills needed to reduce the risk in those everyday life situations. SBC is the core framework around service delivery.

An SBC assessment utilizes the family life cycle to frame and locate the "problem" in the difficult developmental challenges that create safety threats to the family in their everyday life (supervising young children, keeping the house clean and safe, teaching the children right from wrong, etc.).

SBC case planning organizes those challenges into efforts (Action Plans) the whole family can work on (Family Level Objectives) and those efforts (Action Plans) that certain individuals in the family need to work on (Individual Level Objectives) so that the family challenges go better. These Action Plans are not the typical service delivery plans that measure service compliance, but are behaviorally specific, and are co-developed by the family, FCS contractor, and HHS worker. These plans target needed skills in critical risk areas that can then be demonstrated, documented, and celebrated.
Throughout assessment, case planning, and casework management, SBC builds on solution-focused tenets that child welfare-involved families need significant encouragement to combat discouragement and help families see they possess usable, unrecognized skills which can be used to anticipate and prevent child maltreatment. Families are assisted within a forward-looking partnership that searches for exceptions to problems in everyday life and recreates or builds upon their social network with supportive others.

SBC has four milestones:

- Consensus Building
- Developing a Family Agreement
- Action Planning
- Noticing and Celebrating Change

All FCS contractors received initial training within the first six months of the contract. Out of the agencies contracted to provide SBC, all six have certified in house trainers and five of those six have two or more trainers. Agencies offer the trainings online or in-person based on their needs. Additionally, Families First and Mid-Iowa Family Therapy Clinic each have a staff member who is certified to provide the SBC supervisor training. These two trainers provide training for supervisors across all contractors. The rate of frontline staff and supervisors becoming certified in SBC has increased in recent months. Currently, there are 60 frontline providers and 16 supervisors certified statewide. For more information on SBC, please visit the following website: https://www.solutionbasedcasework.com/.

As a part of the current contract, there are three performance measures implemented to evaluate effectiveness of service provision. Below are the three contract performance measures:

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

Contractors may receive performance-based payment for achieving targets on all three performance measures in addition to the monthly base or unit rate. The data reflects all cases that are referred for FCS services. Referral is not automatic; it is dependent on the family's needs. There are some situations where a child is out of the home and no FCS is provided (parents are not responsive to services, child's permanency plan is APPLA or TPR and parents are no longer involved with the child, etc.) Number of cases referred is the total cases referred to SBC. The number of eligible cases is the number of cases' that met criteria to receive performance-based payments.

Table 5Y: HHS Service Cases – PM 1 July 2021 through March 2022

	Number of Cases Referred to SBC	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Southwest Iowa Family Access Center	396	296	74.75%
Father Flanagan's Boys' Home	374	293	78.34%
Western Service Area Total	**770**	**589**	**76.49%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	332	256	77.11%
Mid-Iowa Family Therapy Clinic	363	287	79.06%
Northern Service Area Total	**695**	**543**	**78.13%**
3 - Eastern Service Area			
Lutheran Services in Iowa	368	277	75.27%
Families First Counseling Services of Iowa	434	317	73.04%
Eastern Service Area Total	**802**	**594**	**74.06%**
4 - Cedar Rapids Service Area			
Families First Counseling Services of Iowa	298	222	74.50%
Four Oaks Family and Children's Services	281	205	72.95%
Cedar Rapids Service Area Total	**579**	**427**	**73.75%**
5 - Des Moines Service Area			
Mid-Iowa Family Therapy Clinic	367	292	79.56%
Children & Families of Iowa	374	294	78.61%
Des Moines Service Area Total	**741**	**586**	**79.08%**
Statewide Total	**3,587**	**2,739**	**76.36%**

Data Source: HHS – (Statewide) – The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2. Note: This data is one (1) year behind in order to provide information on cases that have remained closed for 12 consecutive months.

The target for PM 1 is to achieve 90% on all cases served by the contractor. The data above covers the time period of July 2021 through March 2022 ranges from 72.95% at the lowest to 79.56% at the highest, with a statewide average of 76.36%. While over three-quarters of children involved in Agency service cases did not experience a new incident of abuse in the 12 consecutive months following case closure, none of the contractors met the performance measure at 90% or above. Feedback from contractors and families indicate that schedule coordination, family refusal to engage in services, and completing casework activities which do not meet SBC contact duration requirements are frequent contributors to contractors not meeting this measure. Contractors continue to work on efforts of engagement with families, tracking data entry for accuracy, and building workforce capacity to increase contact with families.

Table 5Z: HHS Service Cases – PM 2 July 2022 through March 2023

	Number of Cases Referred to SBC	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Father Flanagan's Boys' Home	314	291	92.68%
Southwest Iowa Family Access Center	301	270	89.70%
Western Service Area Total	**615**	**561**	**91.22%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	290	263	90.69%
Mid-Iowa Family Therapy Clinic	270	242	89.63%
Northern Service Area Total	**560**	**505**	**90.18%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	403	375	93.05%
Lutheran Services in Iowa	321	311	96.88%
Eastern Service Area Total	**724**	**686**	**94.75%**
4 - Cedar Rapids Service Area			
Families First Counseling Services of Iowa	251	227	90.44%
Four Oaks Family and Children's Services	241	218	90.46%
Cedar Rapids Service Area Total	**492**	**445**	**90.45%**
5 - Des Moines Service Area			
Children & Families of Iowa	315	279	88.57%
Mid-Iowa Family Therapy Clinic	319	286	89.66%
Des Moines Service Area Total	**634**	**565**	**89.12%**
Statewide Total	**3,025**	**2,762**	**91.31%**

Data Source: HHS – (Statewide) – The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2.

The target for PM 2 is to achieve 90% on all cases served by the contractor. The data captured for the period July 2022 through March 2023 ranges from the lowest at 88.57% to the highest at 96.88% with the statewide average of 91.31%. The data shows children safely maintained in their own homes or with kin/fictive kin during the case. Iowa has seen an increase in reports of suspected abuse and subsequently a rise in removals over the previous fiscal year. Contractors additionally report an increase in the acuity of families, which impacts the overall safety of children in their homes. Through continued expansion and staff confidence in SBC provision, it is expected that children will continue to remain in their homes or with kin/fictive kin during the case.

Table 5A2: HHS Service Cases – PM 3 July 2021 through March 2022

	Number of Cases Referred to SBC	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Southwest Iowa Family Access Center	29	25	86.21%
Father Flanagan's Boys' Home	19	18	94.74%
Western Service Area Total	**48**	**43**	**89.58%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	20	16	80.00%
Mid-Iowa Family Therapy Clinic	20	14	70.00%
Northern Service Area Total	**40**	**30**	**75.00%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	20	17	85.00%
Lutheran Services in Iowa	15	15	100.00%
Eastern Service Area Total	**35**	**32**	**91.43%**
4 - Cedar Rapids Service Area			
Four Oaks Family and Children's Services	18	15	83.33%
Families First Counseling Services of Iowa	24	16	66.67%
Cedar Rapids Service Area Total	**42**	**31**	**73.81%**
5 - Des Moines Service Area			
Mid-Iowa Family Therapy Clinic	30	21	70.00%
Children & Families of Iowa	20	14	70.00%
Des Moines Service Area Total	**50**	**35**	**70.00%**
Statewide Total	**215**	**171**	**79.53%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2. Note: This data is one (1) year behind in order to provide information on cases that have remained closed for 12 consecutive months.

The target for PM 3 is to achieve 90% on all cases served by the contractor. The data captured for the period July 2021 through March 2022 ranges from 66.67% at the lowest to 100% at the highest, with a statewide average of 79.53%. Two contractors met this performance measure and statewide, four-fifths of children who returned home from foster care did not experience a re-entry to foster care in the following 12 months. These rates are heavily influenced by the juvenile courts' decisions around removal after a new report of maltreatment is made.

SafeCare is the evidence-based behavioral parenting intervention selected by HHS to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 years in at-risk families. It is a home visitation-based parent training program conducted over 18 sessions. Parents receive instruction on how to have positive parent-child and parent-infant interactions (PCI/PII), keep homes safe, and improve child health. SafeCare may also be utilized with kin or fictive kin caregivers who need support to maintain the child in their home. SafeCare is available on open HHS service cases in addition to SBC; however, SafeCare is not a standalone intervention. FCS contractors receive

compensation for provision of SafeCare, in addition to SBC, when referred by HHS. All six contractors are accredited in SafeCare under the current FCS contracts.
State level HHS and Georgia State University (GSU) continue to collaborate with all contracting organizations to provide them the necessary support, guidance, and technical assistance as they continue through implementation of SafeCare®. For more information on SafeCare, please visit the following website: www.safecare.org.

As a part of the current contract, there are two performance measures implemented to evaluate effectiveness of the services. Current performance measures are reflective of current data limitations. Below are the two contract performance measures:

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

Table 5B2: SafeCare - PM 1 July 2022 through March 2023

	Number of Cases Completed All 3 Modules	Number of Eligible Cases	Performance Measure %
1 - Western Service Area			
Father Flanagan's Boys' Home	26	61	42.62%
Southwest Iowa Family Access Center	14	45	31.11%
Western Service Area Total	**40**	**106**	**37.74%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	25	83	30.12%
Mid-Iowa Family Therapy Clinic	18	49	36.73%
Northern Service Area Total	**43**	**132**	**32.58%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	34	76	44.74%
Lutheran Services in Iowa	1	50	2.00%
Eastern Service Area Total	**35**	**126**	**27.78%**
4 - Cedar Rapids Service Area			
Four Oaks Family and Children's Services	22	53	41.51%
Families First Counseling Services of Iowa	16	34	47.06%
Cedar Rapids Service Area Total	**38**	**87**	**43.68%**
5 - Des Moines Service Area			
Children & Families of Iowa	37	107	34.58%
Mid-Iowa Family Therapy Clinic	40	81	49.38%
Des Moines Service Area Total	**77**	**188**	**40.96%**
Statewide Total	**233**	**639**	**36.46%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of JARVIS.

The target for PM 1 is 65% of parents receiving SafeCare will graduate from all three modules. The data captured for the period July 2022 through March 2023 shows this measure not met by any of the contractors providing SafeCare, though there has been improvement across the majority of contractors. Some of the possible reasons for not meeting this measure include the following:

- Data entry issues by the contractor
- Inappropriate referrals to SafeCare
    - Parental mental health is too unstable/too great
    - Parental substance use is too unstable/too great
- Timing of referrals
- Parents not complying with SafeCare
- HHS end dating services before the family has an opportunity to complete all three modules

HHS continues to address SafeCare referrals occurring when a family is ready for the service and ensuring that each family has the opportunity to complete all modules prior to the service referral closing. Contractors continue to coordinate across their lines of service to increase parental engagement in all services, including SafeCare.

Table 5C2: SafeCare - PM 2 July 2022 through March 2023

	Number of Cases Completed PCI/PII	Number of Eligible Cases	Performance Measure %
1 - Western Service Area			
Father Flanagan's Boys' Home	38	61	62.30%
Southwest Iowa Family Access Center	27	45	60.00%
Western Service Area Total	**65**	**106**	**61.32%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	52	83	62.65%
Mid-Iowa Family Therapy Clinic	23	49	46.94%
Northern Service Area Total	**75**	**132**	**56.82%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	56	76	73.68%
Lutheran Services in Iowa	4	50	8.00%
Eastern Service Area Total	**60**	**126**	**47.62%**
4 - Cedar Rapids Service Area			
Four Oaks Family and Children's Services	28	53	52.83%
Families First Counseling Services of Iowa	19	34	55.88%
Cedar Rapids Service Area Total	**47**	**87**	**54.02%**
5 - Des Moines Service Area			
Children & Families of Iowa	52	107	48.60%
Mid-Iowa Family Therapy Clinic	47	81	58.02%
Des Moines Service Area Total	**99**	**188**	**52.66%**
Statewide Total	**346**	**639**	**54.15%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of JARVIS.

The target for PM 2 is 85% of parents receiving SafeCare will complete the PCI or PII module. The data captured for the period July 2022 through March 2023 shows this measure not met by any of the contractors providing SafeCare, though most contractors demonstrated improvement from the prior year and the statewide total improved from 43.59% to 54.15%. Some of the possible reasons for not meeting this measure may include the following:

- Data entry issues by the contractor
- Inappropriate referrals to SafeCare
    - Parental mental health is too unstable/too great
    - Parental substance use is too unstable/too great
- Timing of referrals
- Parents not complying with SafeCare
- HHS end dating services before opportunity to complete all three modules

As with PM 1, HHS and contractors continue to work jointly on improving understanding of services for HHS and FCS staff and strengthening family engagement skills.

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

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

FPS are available to families with children at imminent risk of removal from their home of origin or from kin/fictive kin caregivers and placement in stranger foster care. FPS are available during a child abuse assessment, a CINA Assessment, and anytime during an open HHS service case. Delivery of FPS are in 10 calendar day units and a worker may not refer a family for more than three consecutive units of FPS. Data is based on units referred in JARVIS and comparing the child's placement at the beginning of the service to the end of the service. If the family is not able to reduce the risks of removal prior to the end of FPS, a Safety Plan is developed and consultation is held with the county attorney regarding possible removal.

HHS utilizes Child Safety Conferences (CSCs) during FPS to facilitate family team discussion of safety concerns and identify collaborative solutions that allow the children and family to remain together. If it is not possible for the children to remain in the home, the goal is to ensure that placement of the children occurs with kin or fictive kin caregivers rather than in a stranger foster care placement.

CSCs gather family members and their supports to make key decisions on:

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

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

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

FCS contractors assign family support specialists (FSS) to provide FPS. The FSSs utilize motivational interviewing (MI) to engage and support the family. MI is an evidence-based counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. This practical, empathetic, and short-term process takes into consideration how difficult it is to make life changes. All FCS contractors received MI training prior to the end of December 2020.

In focus group conversations with parents, FPS with CSCs have been positively received by families. Families have found benefit in having a clear plan to meet their child's safety needs and knowing the specific tasks they need to accomplish. FCS contractors and HHS field leadership both report that the services result in fewer removals and aid legal parties in recommending that a child remain in their parents' home, both during the assessment and ongoing phases of the case.

FPS is not utilized on all cases which result in foster care placement, as there are situations where the safety concerns cannot be quickly managed or the supports available cannot outweigh imminent danger to the child's safety. Though there are times that it is necessary for a child to be placed into foster care, the overall rate of removal has decreased since FPS became available in Iowa. The rate of removal during FFY22 (most recent data available) did experience an increase from mid-to-late 2021, but still remains lower than removal rates prior to FPS implementation. (Iowa Child Welfare Dashboard, accessed at Welcome | Iowa Department of Health and Human Services)

As a part of the current contract, there are two performance measures implemented to evaluate effectiveness of Family Preservation Services. Below are the two contract performance measures:

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

Table 5D2: Family Preservation Services – PM 1 April 2022 through November 2022

	Number Of Cases Not Removed And Placed In Foster Care	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Father Flanagan's Boys' Home	49	53	92.45%
Southwest Iowa Family Access Center	44	48	91.67%
Western Service Area Total	**93**	**101**	**92.08%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	58	70	82.86%
Mid-Iowa Family Therapy Clinic	66	73	90.41%
Northern Service Area Total	**124**	**143**	**86.71%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	76	81	93.83%
Lutheran Services in Iowa	63	69	91.30%
Eastern Service Area Total	**139**	**150**	**92.67%**
4 - Cedar Rapids Service Area			
Families First Counseling Services of Iowa	57	72	79.17%
Four Oaks Family and Children's Services	57	62	91.94%
Cedar Rapids Service Area Total	**114**	**134**	**85.07%**
5 - Des Moines Service Area			
Mid-Iowa Family Therapy Clinic	20	23	86.96%
Children & Families of Iowa	14	19	73.68%
Des Moines Service Area Total	**34**	**42**	**80.95%**
Statewide Total	**504**	**570**	**88.42%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2.

The target for PM 1 is to achieve 90% on all cases served by the contractor when service provision occurs during a CPS child abuse assessment. FPS provision during the life of a case is not included in the population for this performance measure. The data captured for the period April 2022 through November 2022 ranges from the lowest at 73.68% to the highest at 93.83% with the statewide average of 88.77%. The data shows a variance across the state regarding removals, with some contractors showing improvement from the prior year. Some of the possible reasons for not meeting this measure consistently may include the following:

- Timing and/or appropriateness of referrals
- Family engagement
- Court jurisdiction/removals

Table 5E2: Family Preservation Services – PM 2 April 2022-November 2022

	Number Of Cases Did Not Suffer Maltreatment	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Father Flanagan's Boys' Home	47	56	83.93%
Southwest Iowa Family Access Center	44	52	84.62%
Western Service Area Total	**91**	**108**	**84.26%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	65	71	91.55%
Mid-Iowa Family Therapy Clinic	67	85	78.82%
Northern Service Area Total	**132**	**156**	**84.62%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	72	90	80.00%
Lutheran Services in Iowa	63	77	81.82%
Eastern Service Area Total	**135**	**167**	**80.84%**
4 - Cedar Rapids Service Area			
Families First Counseling Services of Iowa	61	75	81.33%
Four Oaks Family and Children's Services	58	63	92.06%
Cedar Rapids Service Area Total	**119**	**138**	**86.23%**
5 - Des Moines Service Area			
Mid-Iowa Family Therapy Clinic	22	23	95.65%
Children & Families of Iowa	18	21	85.71%
Des Moines Service Area Total	**40**	**44**	**90.91%**
Statewide Total	**517**	**613**	**84.34%**

Data Source: HHS - The methods of data collection include reports generated out of FACS and JARVIS that identify the incident date of maltreatment.

The target for PM 2 is 80% of children served during the CPS child abuse assessment will not suffer maltreatment during provision of FPS and for three months following the end date of service. The data captured for the period April 2022 through November 2022 ranges from the lowest at 78.82% to the highest at 95.65% with the statewide average of 84.34%. As a state, this measure was met; however, one contractor did not meet the 80% threshold.

Solution Focused Meetings (SFM) and Youth Transition Decision-Making Meetings (YTDM)

Solution Focused Meetings (SFM) With SBC selected as the primary family-centered practice model of child welfare assessment, case planning, and ongoing casework, HHS transitioned from FTDM meetings to Solution Focused Meeting (SFMs) beginning July 1, 2021.

Solution Focused Meetings (SFM) are an extension of Solution Based Casework. They provide an opportunity for the family to gather with their supports to discuss and develop a plan to ensure safety for their children and that parents have a plan in place to meet their goals. Parents provide the primary voice during SFMs and choose the direction of the next steps in the case.

An initial SFM is expected to occur within 45 days of referral for an SFM. Follow up meetings, at minimum, should occur six (6) months from the date of initial referral and every six (6) months following. Families may request an SFM at any time during the case. The focus of the SFM is dependent upon the family's progress through the Milestones of SBC.

Family Centered Services contractors also participate in pre- and post-reunification meetings with HHS and families.

SFMs specifically focus on safety. The basis of SFM activities and anticipated outcome will be on which SBC milestone the family is in at the time. SBC engagement and relapse prevention strategies are utilized in the facilitation of the meeting.

In addition, the requirements to become a facilitator changed. Facilitator training involves staff first becoming trained in SBC, then attending the initial SFM training, where they receive a certificate that is maintained in their personnel file. Meeting follow-up surveys are used to monitor quality and meeting notes are monitored for documentation standards. After completion of the initial SFM training, a follow up training, SFM: Facilitation Essentials, is required within one year which covers special or challenging circumstances such as intimate partner violence, substance use disorders, etc. SFM facilitator training continues under the CWPTA contract after July 1, 2021. This process allows contractors to maintain quality while removing barriers to completion of training.

Families receive the opportunity to participate in the meeting and determine who attends their SFM based on whom they view as their natural/informal supports. Families have primary voice during Solution Focused Meetings and make their own decisions about which steps they are ready to take to move forward. Families are advised of steps that are required to achieve safe case closure. The goal of SFMs is to bring important family supports, in addition to the family, to the table with HHS and other service providers to address safety. SFMs are solution-based, draw on past successes of the family in problem solving, and work in partnership with the family.

Youth Transition Decision-Making (YTDM) is for youth transitioning into adulthood. The model has two key components: Engagement/Stabilization and the Dream Path process to promote self-sufficiency. YTDM strategy of builds teams to support youth and young adults who are at risk of homelessness, unemployment, and poor health as well as addresses the factors that threaten a successful transition to adulthood. YTDM meeting facilitation is housed under FCS to connect to trained meeting facilitators who help ensure that youth are adequately prepared in advance of the meetings and help youth identify who may be a support for the youth after transitioning to adulthood.

Under the current contract, FCS contractors provide trained SFM and YTDM meeting facilitators. Because SFMs are an extension of Solution Based Casework, contractors have the flexibility to have designated SFM facilitators or train their Family Support Specialists to facilitate SFMs. This decision is made within the individual contractor agencies. The responsibility for providing SFM and YTDM meeting facilitation training courses is that of the Child Welfare Provider Training Academy (CWPTA). (For additional information on SFM and YTDM meeting facilitation training and approved trainers, refer to the *Child Welfare Provider Training Academy (CWPTA) section* of this report). All of the current standardized statewide documents for YTDM meetings as well as family interaction are accessible on the CWPTA website at YTDM Documents (iatrainingsource.org). Effective July 1, 2021, contractors track

certification of SFM and YTDM staff within their own agencies. According to report upload data, there have been 48 YTDMs from July 2022 - March 2023. This data does not provide a breakdown between Engagement/Stabilization and Dream Path meetings. Future data systems may allow for additional breakdown of data. HHS continues to evaluate processes to ensure that youth are consistently offered YTDMs at designated case junctures.

Kinship Navigator Services.

Beginning July 1, 2021, HHS expanded Kinship Navigator Services to kin and fictive kin caregivers statewide.

Research has found there are many benefits to placing child(ren) with kin or other kinship caregivers, including increased stability and safety, as well as the ability to maintain family connections and cultural traditions. Kinship navigator program goals include creating a safe and supportive home environment for children outside of stranger foster care, including early identification of needs for additional services such as therapy, counseling, educational and/or mental health services and to close the gaps and/or delays with service delivery to kinship caregivers. HHS focuses on providing a responsive strength-based supportive role to kinship caregiver families.

Kin and fictive kin caregivers are referred to Kinship Navigator Services by the child's HHS worker when it is identified that the kin or fictive kin caregiver may benefit from additional support. The case is assigned to the same contractor that provides other FCS services to the family, which improves service coordination. Kin and fictive kin caregivers are provided a minimum of two (2) hours of services and/or supports per month, with at least two (2) thirty-minute in-person contacts per month. Services are authorized for up to four (4) months, with the ability to re-refer if there are ongoing needs or if new needs arise. Kinship Navigator Services are voluntary, and the kin or fictive kin caregiver may refuse or discontinue services at any time.

Kinship specialists utilize information compiled through risk assessments, Eco Maps, and kinship caregiver input to create a Kinship Care Plan to guide service provision. Kinship caregivers receive an offering of continued support addressing concrete goods and other needs throughout the life of the case. Kinship caregivers are provided kinship caregiver resource folders at time of the initial in-person contact with the assigned kinship specialist that occurs within five business days from referral.

Kinship Navigator Specialists receive a minimum of four (4) hours of orientation training including, but not limited to, Family Finding, importance of keeping children with their natural supports, and understanding traumatic events, such as removals. Kinship Navigator Specialists are expected to establish and maintain relationship with community services and supports to help meet the needs of kin and fictive kin caregivers.

Payment is contingent on the contractor accepting referrals, providing services in accordance with the provisions of the contract, achieving contract performance targets, and submitting invoices for each month of the contract. Accompanying the invoices are documentation necessary to support the charges. The contractor receives payment in monthly installments of 1/12 of the total contract amount.

As a part of the current contract, there is one performance measure implemented to evaluate effectiveness of the service. Below is the contract performance measure:

- **Performance Measure 1 (PM1):** 90% of Kinship Caregivers who participate in Kinship Navigator Services will receive a minimum of two contacts with the Kinship Specialist per full month the case is open.

Due to limitations on data collection, no current data is available for this measure. Contractors currently report data through Excel spreadsheets on a monthly basis. To calculate this Performance Measure, HHS contract specialists or the contractors would be required to track each child across the spreadsheets to determine whether the monthly contact requirements were met for each case. This would require considerable time and increase the potential error rate. Current IT systems do not have capacity for tracking Kinship Navigator and HHS does not have the current capacity to build additional reporting systems for this measure. This data will be measured once tracking is built into the CCWIS solution currently in development.

In the Western Iowa Service Area, monthly meetings are held between Kinship Navigator staff and foster care staff to discuss how to best serve kin and fictive kin who need to become licensed foster or adoptive parents. Barriers to progress through licensing are discussed and collaborative solutions are developed. Throughout FFY 2023, this practice has expanded statewide. Each Kinship Navigator unit meets at least once per month with RRTS licensing staff. Through this collaboration, kin and fictive kin continue to receive support from their Kinship Navigator Specialist while going through the licensing process, including help with understanding the need to become licensed, working through the paperwork and home study process, and transitioning to receiving support from a foster care support worker.

Non-Agency (HHS) Voluntary Services

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

The outcome of the CPS child abuse assessment or CPS family assessment as well as the identified level of risk determines service eligibility. The completed standardized HHS family risk assessment identifies the level of risk. The family risk assessment examines factors known to be associated with the likelihood of abuse or neglect occurring at some point in the future. Identification of risks also assists in identifying the need for individualized services. Services strive to keep children safe, keep the family intact, and prevent the need for further or future intervention by HHS, including removal of the children from the home. A family is eligible for Non-Agency voluntary services based on the following criteria:

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

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

- Any child in the household has an open HHS service case.

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

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

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

As a part of the current contract, there are three performance measures implemented to evaluate effectiveness of the services. Below are the three contract performance measures:

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

These are the same performance measures as those on open HHS service cases. Performance Measure 3 is not applicable to Non-Agency Voluntary Service cases.

Table 5F2: Non-Agency Voluntary Service Cases – PM 1 July 2021 through March 2022

	Number of Cases Referred to SBC	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Southwest Iowa Family Access Center	90	57	63.33%
Father Flanagan's Boys' Home	92	67	72.83%
Western Service Area Total	**182**	**124**	**68.13%**
2 - Northern Service Area			
Families First Counseling Services of Iowa	79	53	67.09%
Mid-Iowa Family Therapy Clinic	85	58	68.24%
Northern Service Area Total	**164**	**111**	**67.68%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	63	37	58.73%
Lutheran Services in Iowa	46	25	54.35%
Eastern Service Area Total	**109**	**62**	**56.88%**
4 - Cedar Rapids Service Area			
Four Oaks Family and Children's Services	54	37	68.52%
Families First Counseling Services of Iowa	58	42	72.41%
Cedar Rapids Service Area Total	**112**	**79**	**70.54%**
5 - Des Moines Service Area			
Children & Families of Iowa	80	56	70.00%
Mid-Iowa Family Therapy Clinic	74	51	68.92%
Des Moines Service Area Total	**154**	**107**	**69.48%**
Statewide Total	**721**	**483**	**66.99%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2. Note: This data is one (1) year behind in order to provide information on cases that have remained closed for 12 consecutive months.

The target for PM 1 is to achieve 90% on all cases served by the contractor. The data captured for the period July 2021 through March 2022 ranges from the lowest at 54.35% to the highest at 72.83%, with a statewide average of 66.99%, indicating none of the contractors met the requirements of this measure.

In conversation with contractors, family willingness to engage with services has been a significant factor in service provision. Families will agree to Non-Agency services when offered by the Child Protection Worker and then fail to respond or decline services when contacted by the provider. Through implementation of the Practice Standards for Family Centered Services (see below), specific guidelines have been set regarding warm handoffs between the CPW, provider, and family. Data for FFY24 will reflect whether these efforts result in better parental engagement and an increase in children remaining safe in their homes.

Table 5G2: Non-Agency Voluntary Service Cases – PM 2 July 2022 through March 2023

	Number of Cases Referred to SBC	Number Of Eligible Cases	Performance Measure %
1 - Western Service Area			
Southwest Iowa Family Access Center	126	126	100.00%
Father Flanagan's Boys' Home	116	116	100.00%
Western Service Area Total	**242**	**242**	**100.00%**
2 - Northern Service Area			
Mid-Iowa Family Therapy Clinic	59	59	100.00%
Families First Counseling Services of Iowa	58	58	100.00%
Northern Service Area Total	**117**	**117**	**100.00%**
3 - Eastern Service Area			
Families First Counseling Services of Iowa	53	53	100.00%
Lutheran Services in Iowa	46	45	97.83%
Eastern Service Area Total	**99**	**98**	**98.99%**
4 - Cedar Rapids Service Area			
Families First Counseling Services of Iowa	48	48	100.00%
Four Oaks Family and Children's Services	52	52	100.00%
Cedar Rapids Service Area Total	**100**	**100**	**100.00%**
5 - Des Moines Service Area			
Children & Families of Iowa	65	65	100.00%
Mid-Iowa Family Therapy Clinic	54	53	98.15%
Des Moines Service Area Total	**119**	**118**	**99.16%**
Statewide Total	**677**	**675**	**99.70%**

Data Source: HHS - (Statewide) - The methods of data collection include reports generated out of FACS and JARVIS that identify the date of removal for PM 2.

The target for PM 2 is to achieve 90% on all cases served by the contractor. The data captured for the period July 2022 through March 2023 ranges from the lowest at 97.83% to the highest at 100% with the statewide average of 99.70%. The data shows children safely maintained in their own homes or with kin/fictive kin when provided Non-Agency services.

Additional data collection

Self-Assessments: Beginning in October 2022, all FCS contractors were asked to complete self-assessments of 50 cases randomly selected by HHS and review all services attached to those cases. The cases were selected to reflect the full range of services provided under the FCS contract. Contractors are expected to review casework and documentation and score each case on a scale of 1-unsatisfactory, 2-satisfactory, and 3-excellent. To be considered in compliance, contractors needed to have 85% of the selected cases scored as a 2 or 3, with contract specialists back-checking scoring for reliability. These self-assessments are completed in the opposite quarters (October and April) of the contract specialist case reviews (January and July). Contractors are expected to complete reviews in the following quarter if they do not meet the 85% benchmark.

Table 5H2: Contractor Self-Assessment Scores October 2022 – April 2023

Service Area	Contractor	Oct 2022	Jan 2023*	Apr 2023
WISA	Father Flanagan's Boys Home	86%	N/A	94%
	Family Access Center	79%	58%	77%
NISA	Families First	88%	N/A	86%
	Mid-Iowa Family Therapy Clinic	98%	N/A	94%
EISA	Families First	88%	N/A	88%
	Lutheran Services in Iowa	70%	88%**	64%
CRSA	Families First	88%	N/A	87%
	Four Oaks	94%	N/A	88%
DMSA	Children and Families of Iowa	51%	85%	85%
	Mid-Iowa Family Therapy Clinic	92%	N/A	97%

Data: Table reflects contractor self-assessment scores for October 2022. Contractors who scored below 85% were expected to complete a follow-up self-assessment in January 2023.
*Interim quarter only required for contractors who did not meet 85% compliance in October 2022.
**HHS is not in agreement with this score based on LSI's comments regarding their case scores in this review.

Contractors reported new insights into their casework upon completing the initial round of self-assessments, including a stronger understanding of where engagement efforts with parents positively impacted case progression and where clear communication between HHS and FCS staff supported family progress. Contractors indicated that the process aids in developing future staff development and training plans. These assessments, while requiring considerable time and energy, have resulted in additional positive momentum for implementation of Solution Based Casework.

After the initial self-assessments, contractors worked together through the Coalition to develop a scoring rubric for future self-assessments, as the initial self-assessment rationales varied widely. The three contractors who completed the January 2023 self-assessments used the rubric for their scoring and provided additional input prior to the April 2023 self-assessments. Scoring across contractors reflects that staff are highly engaged in providing meaningful services to families and ensuring that documentation in cases reflects the family's progress, barriers, and next steps.

Accuracy Reviews: Beginning with the January 1, 2023, Agency reviews, contractors are now held to accuracy of reporting standards for documentation, contacts with families, and providing timely reports to HHS. These reviews are conducted at least twice per year and the next review will occur in July 2023. All contractors met or exceeded accuracy requirements for the initial review period.

FCS Contractor Dashboard: In November 2022, HHS began using a Power BI data analysis system to measure contractor performance on Key Performance Measures (KPM) and Continuous Quality Improvement (CQI) indicators. Data is gathered on a monthly basis and reviewed on a rolling 3-month average for compliance. As of April 2023, all contractors are developing Performance Improvement Plans focused on the contact requirement KPMs and CQI measures. It is believed that as contractors improve the contact requirements, the documentation KPMs/CQI will be met as well. The Dashboard is publicly available and can be found at https://hhs.iowa.gov/dashboard_welcome.

Collaboration

HHS/FCS contractor monthly meetings: The FCS program manager meets monthly with the full contractor group to discuss progress and barriers on the FCS contract. Meetings are held the second Tuesday of

each month via Zoom. Contractors and HHS work together to celebrate successes and discuss solutions to challenges contractors face. It is a critical opportunity for contractors to share how policy is working out in the field and to ensure that contract expectations are met.

February 2023 feedback meeting: The meeting held in February 2023 provided an opportunity for contractors to provide feedback on both strengths and barriers for each service in the current contract. Workforce challenges have had significant impact on FCS over the past year. While SBC developers indicate that other states have achieved SBC certification momentum earlier, frequent staff turnover has hampered Iowa's effort to have all FCS staff certified in SBC. In recent months, Iowa has started to see momentum in SBC certification, indicating some increased workforce stability.

Contractors also identified lack of communication and collaboration with HHS staff as one frequently identified issue for FCS staff retention. Joint trainings and opportunities to connect face-to-face are being prioritized for both HHS and FCS staff to build/rebuild collaborative relationships. Contractors also provided feedback on positive momentum of communication at the supervisor level and case reviews supporting safe case closure.

Contractors indicated Family Preservation Services (FPS) have mostly been positive. Families are able to come up with creative solutions to keep the children safe in their homes or in the home of kin or fictive kin while legal partners are allowing time for families to make changes to reduce imminent danger. Challenges include courts setting expectations of FPS provision and inaccurate communication of the program to families. These challenges continue to be addressed through various levels of communication.

SafeCare is also working well for families who are ready and able to engage with the service. Contractors report that when families are ready for the service, it is going well and families experience success throughout the intervention. Challenges occur when a family is referred and they are not ready or the family does not have the opportunity to complete all three modules before the case is closed.

Kinship Navigator quarterly meetings: Each quarter, the Kinship Navigator leadership of each contractor agency meet together with the Program Manager to share information, learn about additional community resources, and problem solve challenges in provision of kinship navigator services. The contractor agencies take turns coordinating the meetings and determining what topics to cover. The Program Manager assists with setting up connections with other HHS divisions and community partners. At the most recent quarterly meeting in March 2023, representatives from Iowa's MCOs presented information on their programs and services with specific focus on how kin and fictive kin caregivers can access support through the MCOs.

Site visits: On February 15, 2023, the Program Manager completed a site visit at the Boys Town office in Council Bluffs. The Program Manager was able to observe a supervised family interaction, Solution Based Casework session, and a SafeCare session, as well as meet with frontline staff and leadership. This opportunity to observe how the contract is implemented at the field level provided insight into the successes and challenges of service provision at the field level.

On April 5, 2023, the Program Manager completed a site visit at the Families First office in Cedar Rapids. The Program Manager met with supervisors of each of the programs within the FCS service

array and had an opportunity to talk with frontline staff about the successes and challenges of service implementation. This opportunity to discuss field work with frontline staff and supervisors provided insight into how differing perspectives of legal partners, HHS, and FCS staff impact families in positive and negative ways.

On April 13, 2023, the Program Manager completed a site visit at the Families First office in Muscatine. The Program Manager observed an SBC session and a Solution Focused Meeting, as well as meeting with frontline staff and their supervisor. This opportunity to observe a smaller unit of staff and their ability to collaborate with each other and with HHS partners provided important insight into the impact of open communication which aids family progress. The Program Manger also received feedback from a parent, who indicated that she had been involved in HHS services in the past and did not have clear direction throughout the case. After hearing the provider describe the SBC process, the parent indicated she felt like there was a clear path forward for her and her family.

Each of these site visits provided perspective on known tension points in the FCS contracts. Gaining understanding of the direct impact on families will aid in further collaboration between HHS and FCS contractors to continue growing a high-quality, consistent service array throughout Iowa. The Program Manager has offered site visits to all contractors and will continue to do so. Currently, the plan is for site visits to remain voluntary as the intention is for frontline staff to feel supported and visible to contract management.

Practice Standards: The first edition of the Practice Standards for Family Centered Services was published on December 1, 2022. This manual was developed jointly between HHS and representatives from each of the contractors on the FCS contract. The Practice Standards provide additional guidance and clarification of expectations and best practices around provision of Family Centered Services. Joint HHS/FCS frontline staff and supervisor trainings were held in January and February 2023 to acclimate all staff to the Practice Standards and emphasized rebuilding communication at the frontline level. The Practice Standards can be found at https://hhs.iowa.gov/sites/default/files/Comm660.pdf.

Other Communication: Email correspondence between the HHS program manager, HHS service contract specialists, and representatives of the FCS contractors occurred on a regular basis throughout the reporting period. Open, transparent, and constant communication builds trust-based relationship, addresses immediate questions and/or concerns, and provide necessary clarification. The Program Manager attended/participated in the five Service Area local HHS and contractor meetings throughout the reporting period.

Research participation

In January 2021, Dr. Shannon Self-Brown of the National SafeCare Training and Research Center (NSTRC)/Georgia State University (GSU) notified the HHS FCS program manager they received the grant for the Smoke-Free SafeCare Research Project Study. The purpose of the grant is to examine whether positive parent-child outcomes can improve and reduce the risk for secondhand smoke exposure for young at-risk children. The intervention to be tested is Some Things are Better Outside (STBO) which was developed by Michelle Kegler. The design of the six-week intervention was for easy delivery consisting of three mailings of print materials and a 15–20-minute coaching call. The intervention for testing in this study is Smoke-Free SafeCare (SFSC). Integration of STBO will occur into the first module of SafeCare provided to the participating parent. To assess the effectiveness and

implementation of SFSC, FCS contractors providing SafeCare in Iowa and Oklahoma will recruit 50 SafeCare workers. The enrollment of families in the study will begin in October 2021 and will continue through July 2024.

NSRTC has enrolled 25 of the 50 needed SafeCare workers across Iowa. Enrollment of SafeCare staff continues to be a topic of conversation with contractors to encourage more staff to participate. Finding families willing to participate has been a bigger challenge for SafeCare staff. Despite the $180 in total incentives available to families who participate, only 3 families have expressed an interest in participating. SafeCare providers indicate one of the main barriers to enrolling families is the lack of families who have a smoker in the home. HHS and NSRTC have continued to collaborate on ways to enroll both additional SafeCare staff and families in the program.

COVID-19 Impact on Provision of FCS

During the reporting period of July 2022 through June 2023, flexibility was maintained for virtual contacts with families on a case-by-case basis. Contractors were reminded in November 2022 that virtual contacts could only be used if the family's provider was ill with COVID or if the family was ill with COVID and requested a virtual contact in lieu of an in-person contact. All virtual contacts were to be approved by HHS prior to the contact occurring. HHS and contractors continue to work collaboratively to ensure families are seen regularly and that child safety is assured.

Planned Activities for FY 2024

Effective July 1, 2023, Family Interactions will be a separate line of service under the Family Centered Services contracts. This will allow HHS to better evaluate the use of Family Interactions and contractor performance related to this program. Iowa HHS has re-emphasized the importance of natural supports providing supervision for interactions whenever possible as this creates a more natural setting for interactions to occur. This also helps better leverage FCS staff resources. More information will be included in next year's report about the impact of these changes.

Iowa is working with Sivic Solutions Group (SSG) to further evaluate Kinship Navigator IV-E claimable programs to determine which model will fit best with the needs of kinship caregivers in Iowa.

HHS continues to evaluate the progress of Solution Based Casework implementation throughout Iowa. With increased momentum in FCS staff achieving certification, this has led to discussions about scaling back casework contacts with families who are in later SBC Milestones. The intent is for families to practice behavioral change on their own while still having some support from providers prior to case closure. Additional information regarding this step-down process will be available in next year's report.

Crisis Intervention, Stabilization, and Reunification (CISR)

During the period of 2020-2024, the HHS continues the evolution of the child welfare system of care. The role of the Crisis Intervention, Stabilization, and Reunification (CISR) contracts to serve youth requiring residential services also continue in this system. The current CISR contracts end June 30, 2023.

Focal points of CISR overall include the following.

- Each child is served near the child's home and/or community.

- Service delivery occurs at a local level, upon the HHS defined Service Areas, and any counties 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 coordination of services for each child.
- Each child and youth in care receives an "education specialist" to coordinate all education related matters.
- Child welfare services continue integration through collaboration across HHS child welfare contracts and community partners. In the future, the HHS will continue pursuit of a more cohesive and comprehensive array of services.
- Contractors will participate with HHS to further develop strategies for and to implement:
    - Evidence-based practices;
    - Continuity of care for children receiving child welfare services;
    - Innovative community-based services that stabilize children and the children's families so that children can return home; and,
    - Strategies to engage family members in treatment.

From July 2022 to current, the CISR contracts have continued as previously described.
The current CISR contracts will end on June 30, 2023. HHS began preparing for the next round of procurement for these contracts in early 2021. Eleven listening sessions took place to gather stakeholder feedback from June 2021 to August 2021 and several themes were identified throughout these sessions. Listening sessions were composed of youth with lived experience, Parent Partners, judicial partners, JCS staff of different levels, HHS staff of differing levels, and contractors. The next phase of procurement was the compiling of these themes and a full review of the previous Request for Proposal, Contract and Amendments, which took place from August 2021 to October 2021. Following this comprehensive review, HHS began a 3-phase approach to drafting the new RFP. In each phase, a draft is created by the core drafting team, major topics and issues are then discussed with a report out team, and then feedback is incorporated and shared with a larger group review team who also gives feedback. For CISR, the core drafting team was comprised of the Program Manager for Residential Services, 2 Contract Specialists, and an additional Program Manager representing Transition-Aged youth.

The report out team was comprised of HHS leadership from both field and policy, a JCS Director and Chief, and HHS Helpdesk staff. The larger group review team included the entire Contract Specialist team, the Bureau of Contract Support Bureau Chief, an Assistant Attorney General, HHS Privacy Officers, and other pertinent HHS leadership. The RFP was released for bid in April 2022 and proposals were due back from potential bidders in July 2022. Notice was issued to successful bidders in November of 2022 and contract drafting and negotiations began immediately after. HHS shared the first draft of the contracts in early April 2023, and anticipates having signed contracts in May 2023. The new contract begins on July 1, 2023.

Child Welfare Emergency Services (CWES)

Child Welfare Emergency Services (CWES) 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 HHS, Juvenile Court Services (JCS), and law enforcement refer eligible children.

- Scope of the service: Diversion from placement into a shelter bed will occur 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, prevent children from placement out of home, while keeping them safe in the home, or provide a safe and temporary environment when children need a place to stay as they wait for final disposition of their case by the court.
- CWES diversion services are an integral piece of the CISR contract, and the overall vision of "Family Connections are Always Strengthened and Preserved". Diversion services allow for children who may have otherwise been placed in an out-of-home care setting to receive the necessary crisis services within the home setting.
- In this calendar year, HHS was able to increase daily bed rates for CWES services on January 1, 2022, to $210.00 per day.
- A second-rate increase was able to be secured on July 1, 2022, to bring rates to $224/day. Both of these rate increases were accomplished via a collaborative effort between CWES providers, the Coalition, and HHS, to better align the costs of the services with the rate provided.
- A major challenge for CWES in this calendar year was again the workforce shortage that all residential settings within human services was experiencing. Several providers had to reduce guaranteed bed numbers temporarily due to a lack of staff to maintain ratio and safety. HHS continued with a previously implemented process to allow for these temporary reductions within the contract, and to work collaboratively with the provider to meet and get regular updates on hiring and retention efforts, staffing patterns, etc.
- Targeted work continued during this calendar year on the connection between CWES providers, Iowa Medicaid Enterprise, and Iowa's Managed Care Organizations (MCO's). All shelter contractors except one are now enrolled as Medicaid-eligible providers and many shelters have been able to secure additional funding for children who require it to better wrap services and supports around youth in shelter.

Current shelter contractors are also a part of a new initiative to better leverage HHS internal resources to support residential partners. Dr. Derek Hess, HHS Clinical Manger, has been working in partnership with The Coalition for Family and Children's Services in Iowa and the HHS Program Manager for Youth Residential Settings to tour facilities and meet with coalition members. During these meetings, Dr. Hess provides technical assistance to agencies who support at-risk children. "This public-private partnership is using a shared model of reform to improve the services and supports for youth and families in Iowa,"

said Dr. Hess. "We're collaborating – honestly and courageously – to shift our collective perspective, address our growth edges, and leverage our strengths. It is exciting to be a part of such a committed and energized team."

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.

Table 5i2: CWES Performance Measures and Data for SFY 2023 - (Q1, Q2, Q3: 7/1-2022-3/31/2023	
Divert from shelter	86.7%
Number of Children not admitted	234
Number of Children who received diversion:	270
Source: HHS	

Anticipated Changes for FFY 2023-2024

- New contracts for CWES have been secured for July 1, 2023. These contracts contain a few major shifts including:
    - Focusing the CWES contract on temporary informal shelter beds (47-hour stays with no court order) or emergency juvenile shelter care beds (court ordered). Additional diversion-type services have been removed from the contract in order to allow shelter contractors to focus solely on serving the youth placed with them.
    - In order to address the costs associated with the significant needs of youth who remain in shelter longer than 30 days, HHS will be paying an additional $20/day for youth who remain in shelter longer than 30 days.
    - Allowing for greater MCO funding and wraparound support assistance for youth in the shelter setting
    - Will be utilizing family mapping, genograms, and tools with youth to assist with identifying formal and informal supports
    - New performance measures that emphasize:
        - Preventing youth from entering further into the child welfare/juvenile justice system after temporary informal shelter care
        - Managing behaviors for youth in shelter over 30 days
        - Comprehensive discharge planning for all youth
- CWES providers and HHS are both struggling with longer than desirable lengths of stay in shelter. Collaborative work between the two has taken place to put together a protocol for HHS and Shelter staff to follow for youth who are remaining in shelter longer than desired.
- CWES providers have begun work on a proposed Shelter Exchange process for youth who are struggling at a particular location. This process would allow for a shelter to "swap" youth with another shelter in order to meet each individual youth in shelter's needs more effectively.
- CWES contractors in Iowa continue to experience significant issues related to hiring and maintaining a quality workforce. HHS continues to partner with contractors and the Coalition for Family & Children's Services in Iowa to problem-solve this very complicated issue.

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

Foster Group Care Services (FGCS)

Foster Group Care Services (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 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 HHS);
- 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.

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

Iowa defines a QRTP as a specific category of a non-foster family home setting. These placements must meet detailed assessment, case planning, documentation, judicial determinations and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive Title IV-E FCMPs for the placement (sections 472(k)(1)(B) and 475A(c) of the Act). The facility must meet the definition

of a CCI at sections 472(c)(2)(A) and (C) of the Act, including it must be licensed (in accordance with section 471(a)(10) of the Act) and that criminal record and child abuse and neglect registry checks must be completed in accordance with section 471(a)(20)(D) of the Act. Further, it must be accredited by one of the independent, not-for-profit organizations specified in the statute or one approved by the Secretary.

- Procedure in Iowa for QRTP eligibility and placement
    - First, consider placing the child in a relative or fictive kin's home. Only if no relatives or other stable, caring adults known to the child are available or willing to accept placement, or such placement would be detrimental to the child's physical, emotional, or mental well-being, will placement in a licensed foster home occur. If a youth has mental or behavioral needs that preclude him or her from residing in a family or family-like setting, then the worker pursues placement in a QRTP. The worker will document the reasons for using a more restrictive placement in the child's case permanency plan.
    - In order to receive federal reimbursement in a QRTP, the child must have an assessment by a qualified individual not associated with the public agency or the residential program, within 30 days of placement. In Iowa, the qualified individual is a Licensed Practitioner of the Healing Arts (LPHA). The preference would be for this clinician to have a working relationship with the child/family, for example a current therapist or mental health provider. If the child/family were currently not accessing this type of service, the second option would be to utilize an LPHA provided by the CWES contractors across the state. All CWES/Shelter providers have identified a clinician to assess children for QRTP placement, regardless of whether or not the child physically resides in the CWES/Shelter. Finally, through a waiver granted by the Federal government, the clinical assessment can be completed by a clinician at a QRTP if the youth is unable to secure an assessment via another option.
    - The LPHA clinician must work with a family and permanency team assembled by the agency while making the assessment. This assessment must use an age-appropriate, evidence-based, validated, and functional assessment tool to assess the child's strengths and needs. In Iowa, the chosen tool is the Treatment Outcome Package (TOP). The assessment shall determine if family members or another appropriate placement can meet the child's needs, consistent with the child's short and long-term goals, in the least restrictive setting consistent with the child's permanency plan. The assessment must also document why having the child/youth live with a foster family or one of the other acceptable non-family foster home settings cannot meet their needs and why a QRTP is the most effective and appropriate level of care for the child/youth.
        a. Note - lack of sufficient foster families is not an allowable reason. The assessment shall document the family and permanency team's placement preference that acknowledges the importance of keeping siblings together and if their preference is different from that of the assessor's, the reason why the preferences of the child and the team are not recommended. Finally, the assessment must develop a list of child-specific short- and long-term mental and behavioral health goals. This assessment is a Medicaid-billable service.
    - It is preferable for a child to have the clinical assessment completed and the recommendation for QRTP as the appropriate level of care made prior to a child being placed in a QRTP. However, some circumstances in Iowa do require a child to be placed in a QRTP and have the clinical assessment completed within 30 days of placement. In

circumstances where the assessment is completed prior to placement, the assessment will be part of the referral packet sent to QRTP providers and maintained in the HHS/JCS file through an upload into JARVIS. Follow the orders of the juvenile court when it has been determined that a QRTP placement is in the best interest of the child then follow your Service Area protocol for making a referral to a specific agency.

- If the assessment did not occur within 30 days of placement, Title IV-E reimbursement of foster care maintenance costs is unavailable for the entire placement episode and the state must incur all costs. If the assessment does not support the QRTP placement, the state has 30 days to move the child to an eligible placement or risk losing federal reimbursement. If a state opts to forego completion of an assessment, the state may still place the child into the QRTP setting but Title IV-E reimbursement for foster care maintenance costs will cease after the first 14 days of placement.
- Within 60 days of the placement in QRTP, the court must make a determination that the child's needs cannot be met in a family-like setting and that the QRTP provides the most effective and appropriate level of care in the least restrictive environment. The court must review the clinical assessment/TOP in order to make this determination. In Iowa, at the time of the issuance of the court order for QRTP, HHS/County Attorney will make a motion asking the judge to review administratively the assessment within 60 days. HHS/JCS will upload the assessment as an exhibit for the judge to access to complete this review. Upon completion of the administrative review, the judge will issue an order indicating their decision. HHS/JCS will maintain this order in a legal file, uploaded into JARVIS, and maintained in the court file.
- If at the 60-day point, the court has not approved the placement or the court disapproves of the placement, federal Title IV-E reimbursement terminates for any portion of the placement.
- A key component of QRTPs is 6 months of aftercare services after a child leaves care. In Iowa, Family Centered Service providers will be the mechanism for QRTP aftercare for HHS youth, which Iowa is calling post-discharge services, via a Memo of Understanding between FCS providers and QRTPs. One month of overlap in services will occur while QRTP provides contractual discharge support as well.
- The last major component of QRTP in Iowa is a thorough review that should take place to determine whether the youth needs to remain in QRTP and that all other options have been explored. This review must also have sign-off from the Director of HHS. In Iowa, the benchmarks at which reviews take place are: For every youth placed in QRTP for more than 12 consecutive months or 18 nonconsecutive months; Or a youth who has not attained age 13 but has been placed in a QRTP more than six consecutive or nonconsecutive months. Iowa has implemented a two-step group review process to ensure that these reviews are completed and that youth are accessing a family-like setting as soon as they are able.

Performance measures for current FGCS/QRTP contract:

After review of data limitations and ongoing discussion and collaboration with current contractors, two performance measures were removed in previous years from the contract. Recidivism of delinquent youth in its original iteration was removed due to limitations in linking youth specific data between the HHS and JCS systems, however this measure was re-added in a slightly different way in January 2022, when the Specialized Juvenile Delinquency Program was rolled out under the QRTP umbrella. The three remaining performance measures are:

- 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.
- 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.
- Reduction in Recidivism for Specialized Juvenile Delinquency Youth-Greater than or equal to 60% of youth discharging from treatment shall not recidivate within a twelve-month period after date of discharge from service.

Table 5J2: Foster Group Care Services' Performance Measures

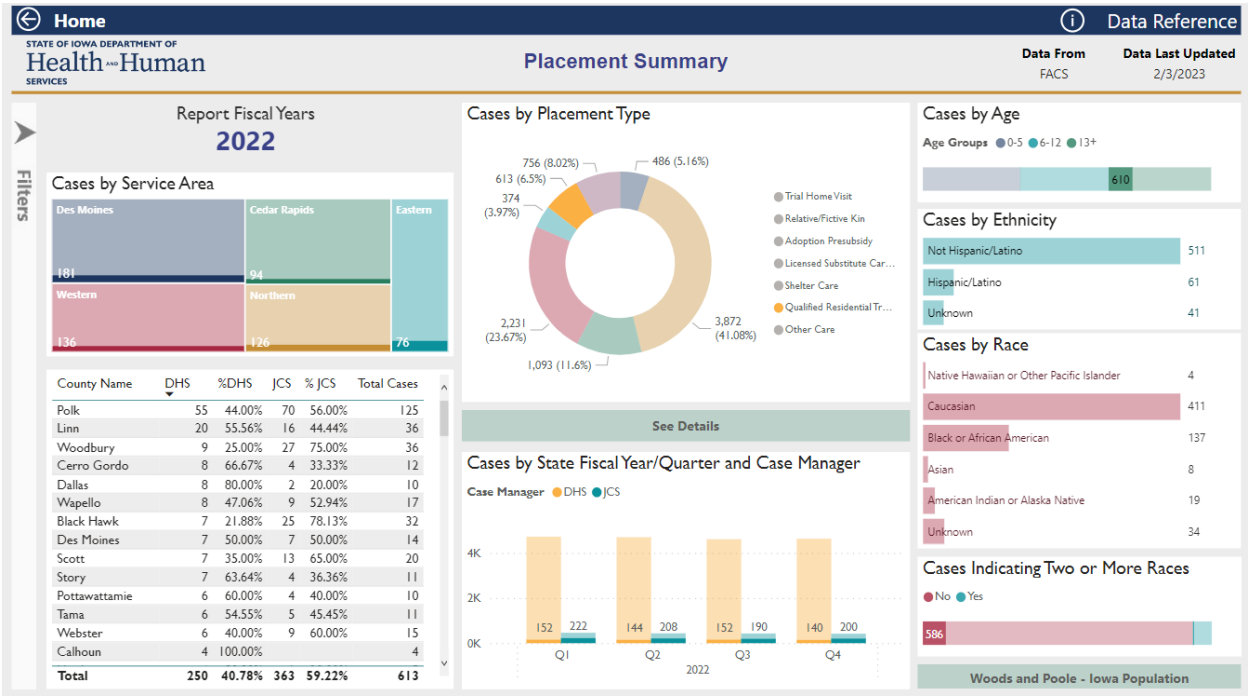
Performance Measure - 7/1/22-3/31/23	**Cumulative Outcome All Statewide Contractors**
Reduction in Recidivism (SJDP youth)- 25%	
Number of youth who exited	4
Number of youth who recidivated	3
*This data is pulled to assess one full year from date of discharge. This data reflects discharges from 1/1/2022-3/31/2022.	
Return to Group Care (CINA youth)	***61.1%**
Number of children not re-admitted	99
Number of children who exited	162
*This data is pulled to assess one full year from date of discharge. This data reflects discharges from 7/1/2021-3/31/2022.	
Discharge to family-like setting	**57.7%**
Number of children who exited to family-like setting:	184
Number of children who exited:	319

Source: HHS

- Current collaborative work during this calendar year includes:
    - QRTP contractors in Iowa are experiencing significant issues related to hiring and maintaining a quality workforce. HHS continues their work with contractors and the Coalition for Family & Children's Services in Iowa to problem-solve this very complicated issue. Several providers had to reduce guaranteed bed numbers temporarily due to a lack of staff to maintain ratio and safety. HHS implemented a process to allow for these temporary reductions within the contract, and to work collaboratively with the provider to meet and

get regular updates on hiring and retention efforts, staffing patterns, etc. Most providers were able to gain staff and return to guaranteed bed numbers within approximately 3 months. This workforce issue impacted the total number of bidders and contractors in the next round of contracts beginning July 1, 2023.

- Iowa will continue to evaluate the need for congregate out-of-home placements in light of declining group care populations. Iowa has continued to shift dramatically downward in the number of group care placements utilized (specifically on the HHS side). Current data indicates approximately 400 guaranteed beds are needed to provide the most efficient access to services for youth. The new contract period begins with 361 beds. Iowa is rare in that both JCS and HHS youth utilize the same QRTP placements, at a breakdown of usage of approximately 60% JCS and 40% HHS. Discussions about challenges with this shared usage led to the collaborative approach of the RFP and contracts beginning July 1, 2023, which include much greater separation between the two populations. See below for a snapshot of 2022 calendar year QRTP data from the Iowa HHS Family First Dashboard.



County Name	DHS	%DHS	JCS	% JCS	Total Cases
Polk	55	44.00%	70	56.00%	125
Linn	20	55.56%	16	44.44%	36
Woodbury	9	25.00%	27	75.00%	36
Cerro Gordo	8	66.67%	4	33.33%	12
Dallas	8	80.00%	2	20.00%	10
Wapello	8	47.06%	9	52.94%	17
Black Hawk	7	21.88%	25	78.13%	32
Des Moines	7	50.00%	7	50.00%	14
Scott	7	35.00%	13	65.00%	20
Story	7	63.64%	4	36.36%	11
Pottawattamie	6	60.00%	4	40.00%	10
Tama	6	54.55%	5	45.45%	11
Webster	6	40.00%	9	60.00%	15
Calhoun	4	100.00%			4
Total	**250**	**40.78%**	**363**	**59.22%**	**613**

- In January 2022, a new Specialized Juvenile Delinquency Program (SJDP) program was added under the QRTP umbrella to serve high-risk delinquent youth. Two 9-bed male programs were implemented to serve JCS youth-only at a 1:3 staffing ratio. These programs are separate from other QRTP programming and utilize staff-secure or locked units. One contractor provides a locked unit, and the other a staff-secure unit. During the course of this calendar year, the program providing a locked unit closed due to a desire to no longer offer residential services in the future. It was fortunate that the other program remaining was able and willing to absorb those beds, so the state only had to endure a short-term reduction during the transition of beds. No locked units are used after this transition. The program, which meets the criteria for a QRTP, utilizes an integrated and comprehensive treatment approach that is strength-based and focuses on positive behavior strategies. Under the contract beginning July 1, 2023, 9 female beds will be added to the existing 18

male beds. This program has its' own specific Performance Measure, JCS-led data dashboard tracking elements, and referral review process.

- Current QRTP contractors are also a part of a new initiative to better leverage HHS internal resources to support residential partners. Dr. Derek Hess, HHS Clinical Manger, has been working in partnership with The Coalition for Family and Children's Services in Iowa and the HHS Program Manager for Youth Residential Settings to tour facilities and meet with coalition members. During these meetings, Dr. Hess provides technical assistance to agencies who support at risk children. "This public-private partnership is using a shared model of reform to improve the services and supports for youth and families in Iowa," said Dr. Hess. "We're collaborating – honestly and courageously – to shift our collective perspective, address our growth edges, and leverage our strengths. It is exciting to be a part of such a committed and energized team."
- QRTP providers have created a QRTP Exchange process for youth who are struggling at a particular location. This process allows for a QRTP to "swap" youth with another QRTP in order to meet each individual youth in QRTP's needs more effectively. QRTP providers meet and propose the swap plan to field HHS or JCS staff for approval.
- Quarterly meetings continue between contractors, HHS and JCS field representatives and policy staff. These meetings are held to discuss progress or barriers in the programs overall, discuss any updates or changes that have taken place, and to have collaborative discussions about any topics members wish to bring forward. Quarterly meetings are also held between QRTP contractors and FCS contractors to discuss post-discharge services progress, barriers, etc.

Anticipated Changes for FFY 2023-2024

- New contracts for QRTP have been secured for July 1, 2023. These contracts contain a few major shifts including:
    - Greater separation between JCS and HHS youth on campuses. Providers are designated as serving JCS or HHS youth, and only certain programs will be allowed to serve both populations. Providers have articulated what curriculum/models they will use and how programming is provided differently for JCS versus HHS youth. A map of the state will identify what population each provider serves.
    - Will continue to utilize the No Eject/No Reject philosophy but will allow for a designated number of allowable rejections per year based on the size of the facility. A new protocol is being developed for staffing referrals and unplanned discharges.
    - New performance measures that address
        - Separate performance measures for JCS-involved youth focusing on recidivism
        - A focus on discharging to family-like settings for all youth (JCS and HHS)
        - An emphasis on not returning to QRTP for HHS youth
    - An increase in specialization of programs and beds within these programs. These programs address very specific populations, operate under stricter staff to youth ratios, and are compensated a different rate. Under the QRTP umbrella, specialized programs include:
        - Neurodevelopmental and Comorbid Conditions (NACC) for JCS and HHS males
        - Specialized Juvenile Delinquency Programs (SJDP) for high-risk delinquent JCS males and females
        - Problematic Sexualized Behavior for JCS and HHS males

Supervised Apartment Living (SAL)

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

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

- Scope of the service: SAL contractors provide two types of SAL setting; they are cluster sites and scattered sites. Cluster sites allow a maximum of six children to be located in the same building (such as apartments located in one building or private housing or their own rooms in a shared unit). Contractor staff must be on-site and available at any time when more than one youth is present. Scattered sites (e.g., an individual youth's apartment unit in a community) also provide access to SAL staff 24 hours a day, seven days a week and they must be available as needed. Staff supervision and guidance is flexible to meet the needs and behaviors of each individual in the program.
- Desired outcome: Youth self-sufficiency and the development of interdependence with their community and the systems that support daily living on one's own.
- SAL services and methodologies: 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. HHS' goal is to keep a child in their home whenever possible. When out-of-home placement is necessary, the placement is not to be a permanent solution, and the child's safety, permanency, and well-being are essential. HHS' and SAL contractor staff is responsible for promoting each child's relationships with family members and other persons in the child's positive support system. Protection of children occurs in the least restrictive setting necessary, and the HHS and its partners are obligated to provide a nurturing environment where children can thrive, and through SAL prepare themselves for their transition to young adulthood.
    - One major area of focus during this year was the rollout of Foster Care to 21 in Iowa. This had major implications for SAL, as it is one of two allowable levels of care for youth wishing to remain in foster care after age 18. Essentially, this opened the opportunity for HHS and JCS to allow youth to remain in SAL or licensed family foster care past age 18, up to 21, if they are at risk of homelessness or failing to graduate. The youth's juvenile court case closes and a Voluntary Placement Agreement is used. Prior to this change, SAL providers at times served youth over age 18 who were finishing up their high school education or equivalent. With this new change, youth can choose to stay in an allowable foster care setting after age 18, regardless of educational status. HHS and current SAL providers met several times to work on how to effectuate this change. During these meetings, a process was identified for both SAL providers and field HHS and JCS staff to follow, and documents that outline the process were created.
    - Quarterly meetings between contractors, HHS and JCS field representatives, and policy staff, are held to discuss progress or barriers in the programs overall, discuss any updates or changes that have taken place, and to have collaborative discussions about any topics members wish to bring forward.

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.

Table 5K2: Performance Measures	
Performance Measure 07/01/2022-3/31/2023	**Cumulative Outcome All Statewide Contractors**
Stability	66% Number of children who exited to family/family-like setting: 31 Youth who exited SAL program: 47
Aftercare	52.4% Number of children engaged in Aftercare per requirements: 11 Youth who exited SAL program: 21
Life Skills	*no data available. This Performance Measure is not currently tracked due to system limitations. This Performance Measure will not remain in the new contract beginning 7/1/23.
Source: HHS	

Anticipated Changes for FFY 2023-2024

- New contracts for SAL have been secured for July 1, 2023. These contracts contain a few major shifts including:
    - Greater statewide coverage-Clustered and Scattered Site SAL will now be offered in 4 of the 5 service areas.
    - Providers will utilize an agency-approved life skills curriculum for youth in SAL.
    - Providers will incorporate Positive Youth Development into SAL programming.
    - Providers will utilize evidence-based approaches, specifically Motivational Interviewing.
    - A daily bed rate increase was included for clustered site SAL to bring that payment to $170.00/day.
    - New Performance Measures that emphasize
        - Building the youth's informal supports while in SAL
        - Reduction in unplanned discharges
        - Encouragement of participation in Aftercare
        - Acquisition of Life Skills

STEPHANIE TUBBS JONES CHILD WELFARE SERVICES PROGRAM (TITLE IV-B, SUBPART 1)

Program Goals:

1. Protecting and promoting the welfare of all children.
2. Preventing the neglect, abuse, or exploitation of children.
3. Supporting at-risk families through services, which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner.
4. Promoting the safety, permanence, and well-being of children in foster care and adoptive families.
5. Providing training, professional development and support to ensure a well-qualified child welfare workforce.

Briefly describe the services provided since the submission of the 2023 APSR, highlighting any changes or additions in services or program design for FY 2024 and how the services assisted or will assist in achieving program goals (45 CFR 1357.16(a)(4)).

HHS will utilize title IV-B, subpart 1, funding as indicated on the CFS-101 for:

- Crisis Intervention (Family Preservation): Family Preservation Services, which is part of the Family-Centered Services (FCS) package;
- Family Reunification Services:
    - Family-Centered Services (FCS) package, except for Family Preservation Services covered above;
- Parent Partner program, which also includes title IV-B, subpart II family preservation and planning funding;
- Foster Care Maintenance:
    - Foster Family & Relative Foster Care
    - Group/Institutional Care

For more information on these services, please see the *Updated Services Descriptions*, *Child and Family Services Continuum* earlier in this section, as noted below:

- Family Preservation Services, pages 175 – 178
- Family Centered-Services, pages 167 – 188
- Parent Partner program, pages 95; 215 – 228
- Recruitment, Retention, Training, and Supportive Services (RRTS), pages 6 – 17; 58 – 60; 65; 81 – 90
- Foster Group Care Services – pages 188 – 199

SERVICES FOR CHILDREN ADOPTED FROM OTHER COUNTRIES (SECTION 422(B)(11) OF THE ACT))

Describe the activities, including provision of adoption and post-adoption supports, that the state has undertaken since the submission of the 2023 APSR to support the families of children adopted from other countries and any changes to the activities the state plans to take to support children adopted from other countries.

Families who adopt children from other countries will have the ability to access training through the Iowa Foster and Adoptive Parent Association (IFAPA) and Iowa's RRTS contractor. Support groups across the state are also open to any adoptive family, including families who adopt from other countries. Families may receive services through the child welfare system through a CINA assessment or through allegations of abuse or neglect, or through Medicaid based on Medicaid eligibility criteria.

HHS recognizes the need for strong post-adoption supports and services in order to prevent disruptions and dissolutions of all adoptions, including children adopted from other countries. Limited resources and diverse racial and cultural needs are significant barriers to expanding post-adoption services for families who adopt from other countries. Resources are not limited to available funds, but staff time to develop an array of post-adoption services that can be available to any family. However, HHS has, 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 explore creatively how services and supports can assist families who adopt from other countries within current funding and service provision constraints.

Should additional funds become available, HHS will work collaboratively with private adoption agencies to prioritize, develop, and implement services and supports to assist families who adopt from other countries.

SERVICES FOR CHILDREN UNDER THE AGE OF FIVE (SECTION 422(B)(18) OF THE ACT)

Describe the activities the state has undertaken since the submission of the 2023 APSR to reduce the length of time children under the age of five are in foster care without a permanent family.

Describe the activities the state undertook in the past year to address the developmental needs of all vulnerable children under five years of age, including children in foster care, as well as those served in-home or in a community-based setting.

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. Over the last year, these services included but were not limited to Family Centered Services (FCS), including SafeCare®, childcare, referrals to Early ACCESS (described below), referral of parents to mental health, substance abuse, domestic violence, employment, and disability services, etc. Another public service available to families was Head Start and Early Head Start. Social work case managers (SWCMs) discussed Head Start and Early Head Start services with families, with the families accessing services through direct application to the programs.

Effective July 1, 2020, Iowa's child welfare service array changed. HHS awarded contracts for family-centered services, packaged services, with community based social service providers. The different packages of services include the following:

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

Please see *Updated Services Descriptions*, *Child and Family Services Continuum* earlier in this section for more information about these services and any upcoming changes in program designs.

The HHS' child protective workers (CPWs), as part of their assessment of child abuse allegations, inclusive of safety and risk assessments, assess the strengths and needs of the children and the family. The HHS' SWCMs build upon the initial assessment of the CPW by:

- working with the family to continually assess the strengths and needs of the children and family;
- connecting the children and family to the appropriate services; and
- monitoring the effectiveness of those services to meet their needs.

The goal is to achieve safety and permanency for these children, in accordance with the Adoption and Safe Families Act (ASFA, P.L. 105-89) guidelines, and achieve child and family well-being. Through clinical case consultation with SWCMs, supervisors provide oversight of the SWCMs' assessment of and provision of age-appropriate services to children. Please see discussions of these services earlier in this section.

EARLY ACCESS (IDEA Part C)

The reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) under the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) provides Early Intervention Services for any child under the age of three who is involved in a substantiated case of child abuse or neglect. States are mandated to have provisions and procedures in place to refer these children for services. State funding for Early Intervention Services is provided under Part C of the Individuals with Disabilities Education Improvement Act (IDEA Part C).

Early Intervention Services or Early ACCESS (EA) as the program is referred to in Iowa is a collaborative partnership between two State agencies (Iowa Department of Health and Human Services (HHS) and Iowa Department of Education (IDOE)), and the University of Iowa Child Health Specialty Clinics (CHSC). These agencies and clinics promote, support, and administer Early Access services. The IDOE is the lead agency responsible for administering the program.

Eligibility & Referrals

Early ACCESS services are available to any child in Iowa from birth to three who demonstrate a 25% developmental delay or who has a known medical, emotional, or physical condition in which there is a high probability of future developmental delays.

HHS is responsible for referring to Early ACCESS all children under age 3 who: (a) are the subject of a substantiated case of abuse or neglect, or (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.

On October 1, 2018, DHS implemented an automatic referral process for children under the age of three that meet the CAPTA referral criteria. When a case meets the criteria, an email is generated and sent to Iowa Family Support Network (IFSN) with the referral information. IFSN then forwards the referral information to the Area Educational Agency (AEA) or Child Health Specialty Clinics (CHSC) who provides Early ACCESS services. A Service Coordinator (SC) from the AEA or CHSC will contact the family directly within two business days to discuss early intervention and offer a screening or evaluation.

Within HHS, Child Protection Workers (CPWs) are responsible for informing families that the child has been referred to Early ACCESS during a child abuse assessment. Social Work Case Managers (SWCM) who handle ongoing child welfare cases may inform families of Early ACCESS services at any time during the provision of case management services.
While families may have declined an evaluation when they were automatically referred to Early ACCESS, Social Workers can re-refer families at any time if a concern about a developmental delay arises. Social Workers also can refer siblings in the home who are at risk of a delay.

Referrals can be made to the Iowa Family Support Network (IFSN), CHSC, and/or at any of Iowa's nine Area Education Agencies (AEAs).

Previous state system efforts for CAPTA referrals

The following strategies have been previously used by HHS to refer families to Early ACCESS:

- Prior to 2016, letters sent by Visiting Nurse Services to families (data showed less than 3% responded and received negative feedback from families).
- July 2016-October 2018, Social Worker SWII or SWIII discuss and make referral to EA services with families.
- October 1, 2018 (current referral process), automation of process: email generated to IFSN from DHS with child and family contact information. Ensures 100% of all eligible cases are referred.

Each strategy used data decision making to inform progress and outcomes. The automatic referral has produced the best results of all the strategies even though COVID most likely affected the data (see Early ACCESS Data section for more information).

CARA

Infants that fall under the 2016 Comprehensive Addiction and Recovery Act (CARA) are also eligible for a referral to Early ACCESS. This population includes infants born and identified as being 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 being affected by all substance abuse, not just illegal substance abuse. Children who meet the criteria under the CARA Act are included in the automatic referral process.

Training

Early ACCESS training for HHS Social Workers (CPW and SWCM) focuses on potential developmental delays in children, instructions on how to encourage families to participate in eligible services, and how to make meaningful referrals to the Early ACCESS program.

Early ACCESS training is part of the basic training that all new HHS workers receive. Further training is offered in other HHS courses involving mental health and substance abuse services, and in domestic violence screening training that is mandatory for all HHS Supervisors, CPWs, and SWCMs. Early ACCESS information is provided during these trainings to assist HHS staff in referring families to Early ACCESS services, whether or not there is a substantiated case of abuse following a child abuse assessment (i.e., in the case of "Family Assessments).

In an effort to continually inform social workers about the benefits of Early ACCESS, the HHS Liaison has participated in social worker meetings, presented on a monthly call that included Social Worker Administrators, and sent Early ACCESS informational brochures to the HHS Service Areas. Additional Information on Early ACCESS has been emailed via the field communication system to all social workers, supervisors, and administrators.

State Collaborations for Early ACCESS

The Department of Health and Human Services has an HHS Liaison dedicated to work in collaboration with IDOE, CHSC, and AEA's across the state. Regularly scheduled meetings include a core State Team comprised of six IDOE employees with expertise in areas such as, early intervention federal compliance, information technology, autism spectrum disorders, professional development, and Part B special education services. The state Part C Coordinator and Administrative Consultant are among the IDOE staff. The State Team also consists of Liaisons from HHS and CHSC. This team meets twice a month to fulfill their commitment to:

1. provide early intervention services and
2. support components needed for a coordinated system.

The Iowa Council for Early ACCESS (ICEA) is a parent-led Council that advises and assists the IDOE in the planning, coordination, and delivery of services to infants and toddlers with special needs and their families. Meetings are held five times a year and consist of parents whose child have received early intervention, IDOE, HHS (including Bureau Chief and Liaison), CHSC, AEA Special Education Directors, AEA Liaison, IDOE Counsel, Iowa Insurance Division, and Higher Education, among other community partners. Membership is determined by the Governor's office through an application process.

ICEA Executive Committee meets five times a year to determine the Iowa Council meeting agendas. The agendas include federal compliance, data analysis, parent stories, and topics such as legislation for the current year that may affect early intervention. Executive Committee includes the EA signatory agency staff, Bureau Chiefs, Liaisons, IDOE Administrative Consultant, and the Early ACCESS Part C Coordinator.

Early ACCESS regional and community grantees include the nine AEA regions and CHSC. These grantees ensure EA services are carried out across the state. Meetings with AEA's are held six times a year and include the State Team, IDOE Administrative Consultant, AEA Special Education Director Liaison, and Liaisons from each of the nine AEA regions.

Early ACCESS Data

The table below represents the number of CAPTA children (those referred following a Child Protective Assessment) and the number of children that went on to receive services from Early ACCESS through an Individualized Family Service Plan (IFSP):

Table 5L2: Children who receive Early ACCESS services (following a CPA)

SFY	# of Children referred	# of Children receiving services	Percent of children on IFSP
SFY 22	2581	314	12.2%
SFY 21	2483	241	9.7%

SFY 20	2452	333	13.6%
SFY 19	2596	449	17.3%
SFY 18	2695	211	7.8%

In SFY 22, the number of children (2581) following a CPA, who were referred to Early Access increased by 98 children. The increase in the number of children referred to EA from SFY 21 to SFY 22 can be attributed to an increase in child welfare reports following the COVID-19 pandemic as children returned to schools and young children returned to preschools in the fall of 2021.

The number of children following a CPA, who were on an IFSP increased by 73 children (9.7% to 12%). HHS' efforts to increase the number of meaningful referrals to EA consisted of the HHS Liaison researching phone numbers and addresses for EA providers who were not able to contact the family. The HHS Liaison updated contact information for the EA provider utilizing the HHS child welfare system (JARVIS) and/or contacting the CPW assigned to the case. HHS has worked with Social Workers to have meaningful conversations with families prior to the Early ACCESS referral. HHS workers were also provided brochures, flyers, and post cards, as well as additional online resources that are available to families in Iowa. Overall, the meetings and trainings for the HHS field have increased awareness of the Early ACCESS program and its benefits.

There has also been increased efforts on the part of HHS to collaborate with AEA's on how to inform and encourage families to consider Early ACCESS services. While a referral is automatically generated by HHS to Early ACCESS, services are voluntary. Parents have the right to decline Early ACCESS at any time.

In Iowa, preschools, elementary and high schools all returned to in-person learning following the closure of schools in 2020 amid the COVID-19 pandemic. The "return to learning" was a focus for IDOE and AEA's across the state. It is reported that even though preschools returned to in-person learning, some families have continued to choose virtual services for EA throughout SFY 22. EA services are provided in the home or the child's natural environment (such as childcare). AEA's have cited that some families have not wanted to have providers in the home, still concerned about the COVID virus. AEA's have respected the choice of the family and were able to provide EA services remotely. Iowa's response to remote learning is discussed in the SFY 21 section below.

In SFY 21, the number of children (2483) following a CPA, who were referred to Early Access increased by 31 children. The number of children who went on to receive Early ACCESS decreased by 92 children (13.6% to 9.7%). The decreased rates for SFY 21 continue to be attributed to the COVID-19 pandemic. While SFY 20 included three and a half months of pandemic shut down, the SFY 21 consists of a full year of pandemic measures. In the state of Iowa, schools across the state varied in their schedules, from fully remote to full in person attendance. SFY 21 saw an increase in child welfare reports as children returned to schools, but young children birth to three years of age largely remained in the homes as some preschools did not return to in person until fall of 2021.

Early intervention services were provided virtually through varied strategies. Some AEA's provided electronic devices such as iPads and computers, while others relied on smart phones. Each AEA had their own process, but all still provided services virtually. AEA's found strengths in virtual services and

have some families still requesting some remote services, rather than fully in home. HHS Director provided IDOE and schools with information on how to keep school children safe in their homes virtually with ideas like asking the child to turn on their camera for attendance. The AEA's utilized this same method by asking the family to see their child on the screen at times.

The following Table indicates the number of children in foster care with an IFSP:

Table 5M2: Foster Children who receive Early ACCESS services			
SFY	**# of children in foster care below age three**	**# of Children receiving services**	**Percent of children on IFSP**
SFY 22	1494	239	16.0%
SFY 21	1574	227	14.4%
SFY 20	1835	362	19.7%
SFY 19	2103	474	22.5%
SFY 18	2049	464	22.6%

In SFY 22, the number of children (1494) below the age of three in foster care reflects a decrease of 80 children. This decrease represents the continued efforts of the child welfare system in Iowa to keep children with a substantiated case of child abuse or neglect safely in their homes and avoid the trauma of out of home placement under the provisions of the "Family First Act" as mentioned below. Children under the age of three in foster care that were referred to EA and went onto receive services increased during SFY 22 from 227 to 239, an increase of 12. While an increase of 12 may not seem substantial, taking into consideration there was a decrease of 80 children in this category that were referred, the percent of child that went on to an IFSP increased from 14.4% to 16.0.

In SFY 21, the number of children (1574) below the age of three in foster care reflects a decrease of 261 children. The data also indicates a decrease of 135 children under the age of three who received EA services. The decrease from 19.7% to 14.4% of children in foster care on an IFSP results from two identified factors:

- The COVID-19 pandemic continued to keep younger children at home and away from the eyes in the community., affecting child welfare reports.
- Another factor that may have contributed to decreased numbers of children under the age of three in foster care placement includes Iowa's implementation of the "Family First Act". While Family First in Iowa was not fully effective until July 1, 2020, the state has been moving towards the process since 2018. The Family First Act has many components, including the main goal to help families that are in crisis stay together, reducing unnecessary removal of the child/children to foster care placement. HHS efforts to reduce the number of children in foster care include:
    - Human Need for Belonging training;
    - 4 questions/7 judges pilot;
    - Use of Child Safety Conferences;
    - Replacing Family Safety Risk and Permanency Workers with evidence-based services;
    - Crisis Intervention, Stabilization and Reunification contract that requires youth in residential settings to be placed in their service area;
    - Subsidized guardianship

While this information contains data past the SFY 21, it is important to note the following data from HHS. Family Preservation Services (Results for January 1, 2021, through October 13, 2021- time frame limited due to data availability) 88.35% of children were not removed from their homes during provision of Family Preservation Services. Agency Solution Based Casework (SBC) 94.64% of families referred for services safely maintained the children within their own home or with kin/fictive kin caregivers during the case. (Iowa Department of Human Services, 2021).

SFY 20 reflects a decrease (268) in the number of children below the age of three in foster care. The data also indicates a decrease in the number of children who received Early ACCESS Services from SFY19 to SFY 20 from 22.5% to 19.7%. As stated before, Iowa has seen a decline in the number of child welfare cases reported due to the COVID-19 pandemic and would have affected the number of children removed to foster care, specifically during the months of March through May 2020. The other factor includes Iowa's implementation of the "Family First Act" as mentioned above.

Works Cited

Iowa Department of Human Services. (2021). 2021 CHILD WELFARE BY THE NUMBERS. Retrieved from Iowa Department of Human Services: https://dhs.iowa.gov/sites/default/files/childwelfarebythenumbers2021.pdf?041320222329

EFFORTS TO TRACK AND PREVENT CHILD MALTREATMENT DEATHS

Provide an update on the steps the state has taken or will take to compile complete and accurate information on child maltreatment deaths to be reported to National Child and Abuse and Neglect Data System (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

Provide an update on 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.

Iowa Child Death Review Team: 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".

HHS designates a staff liaison to assist the team in fulfilling its responsibilities. The liaison reviews data available in the HHS information systems for each child death and prepares case summaries and statistics regarding each child. The liaison also attends all review team meetings and sub-committee meetings as needed.

Additionally, the Iowa Child Death Review Team developed protocols for Child Fatality Review Committees 641 IAC § 92 , which the state medical examiner appoints on an impromptu 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.

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

- On all accepted child death cases, the HHS works with local law enforcement and/or the Department of Criminal Investigation (DCI) in a joint assessment/investigation. While law enforcement's role is to determine if a crime occurred and the HHS' role is to determine if abuse occurred, both agencies collaborate on the crime scene investigation/assessment, observations, interviews, etc.
- The CPW also works with the medical examiner's office while the medical examiner conducts an autopsy on the child victim. The CPW and medical examiner's office consult (many times through or in conjunction with law enforcement) to exchange information learned in the investigation/assessment that may assist the medical examiner in determining cause and manner of death. The ultimate findings of the autopsy can assist in the determinations made in both criminal and child abuse findings.
- Although not every county throughout Iowa has their own Child Death Review Team per se, many counties utilize a variation of multi-disciplinary teams to consult with on child death cases. These consultations assist the CPW in exploring options to barriers and processing the case thoroughly.
- In every child death case that HHS assesses for child abuse, the) Bureau of Health Statistics records all child deaths and at times births with a death occurring shortly after birth. Because law enforcement generally takes the lead on death investigations, they generally provide the documentation to Vital Statistics.

HHS does not receive reports of suspected abuse on all child deaths. The majority of Iowa children die by natural means, which includes prematurity, congenital anomalies, infections, cancers, and other illnesses. Natural manners of death are not child abuse and do not meet standards for reporting. In 2016-2018 data, for example, 392 natural deaths comprised 49.6% of all Iowa child deaths. This was a slight decline in the overall number of natural deaths over the last several decades.

The Iowa Child Death Review Team considers other manners of death, such as accidents, suicides, homicides, and undetermined deaths as preventable. Unfortunately, the 2016-2018 data suggests there has been an increase or minimal deviation in these number of deaths. Accidents claimed 174 (22.0%), an undetermined manner claimed 129 (16.3%), suicide claimed 49 (6.2%), and homicide claimed 32 (4.0%) of all Iowa child deaths. In 15 (1.9%) instances the manner of death was unknown or missing.

Iowa Code §232.70 requires mandatory reporters to report such suspected child abuse to HHS. When HHS receives and accepts a report of a child death for assessment, assignment of a one-hour response occurs for the CPW to assure the safety of siblings or any other children involved and begin collaboration with law enforcement. 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 all assessments, investigations, and data collection are completed, the Child Death Review Team typically reviews cases from the previous year, with the Annual Reports released by the Iowa Office of the State Medical Examiner thereafter. The last report released was in 2023, which was a Cumulative Annual Report for 2016-2018 distributed to the Governor's Office and to the Legislature. This report is available as an attachment.

2016-2018 CDRT
Annual report.pdf

The Iowa Child Death Review Team completed the calendar year 2016 case reviews in 2017, completion of calendar year 2017 case reviews occurred in 2018, and case reviews for calendar year 2018 began in 2019. The 2016 and 2017 annual reports were initially put on hold and remained in draft form as the result of a request from the Iowa Office of Ombudsman to take a deeper dive into the separate cases of child deaths involving two teenagers who had both died as a result of malnutrition inflicted by their adoptive parents. These case reviews took some time to plan and coordinate, involved focus on one case per meeting, and included presentations by law enforcement, HHS, and Iowa Office of Ombudsman to present the case details and answer questions. Review of one case took place on December 19, 2019, and the second case review was on February 27, 2020. The plan was to follow up with further discussion and case recommendations to be included in the 2016 and 2017 annual reports at the next 2020 meeting, however the global pandemic of COVID-19 ceased all scheduled meetings between March 2020 and August 2021. In the meantime, the Iowa Office of Ombudsman released both investigative reports, which resulted in recommendations to improve polices and practice to aid in the prevention of future child maltreatment deaths:

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

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

Recommendations in the Cumulative Annual Report for 2016-2018 included:

- Infant safe sleep support, including:
    - Funding for general education of unsafe sleep environments and the major role they play in deaths of young infants
    - Education targeting adolescents to provide foundational knowledge of how to properly and safely care for babies
    - Specific educational opportunities for licensed and private child care centers
- Prevention of violent deaths, including:
    - Information to parents/caregivers on how to deal with common parental frustrations
    - Increased referrals to home visiting programs
    - Resources for intervention to support families in crisis
    - Education of law enforcement and other professionals with interactions with children to have knowledge of appropriate resource referrals
    - Reminders of water safety and supervision around bodies of water
    - Proper storage of drugs and poisons

  - Prevention of small children as drivers of motorized vehicles
  - Use of helmets and proper restraints
  - Prevention of illicit drug use, particularly around children
- Suicide prevention, including:
  - General education of parents, caregivers, and educators as to the impulsive nature of suicides
  - How to access resources and best practices in prevention
  - Locked storage of firearms and ammunition
  - Access to mental health and grief counseling services in all schools
  - Truancy follow up
  - More school resources for students and families experiencing personal crisis

Statewide Safe Sleep Workgroup: As the Iowa Child Death Review Team convened in February 2019 to begin reviews for 2018 cases, time was spent (as done 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 effort to reduce child fatalities. Recognizing that while the team has made tremendous improvements in the way it creates recommendations, 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.

In 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 is most often attributed to unsafe sleep environments. Focus on a safe sleep initiative not only highlights recommendations by the American Academy of Pediatrics to reduce deaths in children related to unsafe sleep environments, but it also compliments the work underway by HHS to track and prevent child maltreatment deaths.

By July 2019, the Iowa Child Death Review Team, led by the Iowa Office of the State Medical Examiner, created a committee to launch a safe sleep campaign. HHS had a representative on this committee. The committee's goal was to bring forth one strong safe sleep message and resource point for the state. The committee worked with a marketing company to assist in identifying our target population and the best avenue to reach them. As a result, ten social posts providing safe sleep messages and information, created by our marketing partners and advertised on various social media platforms, occurred between October and December of 2019. All participating agencies received these promotional materials to utilize for continued and consistent safe sleep education statewide. During this time, the Child Death Review Team also recognized the importance of Safe Sleep information being provided to new parents in a manner that was different than the plethora of resources that a new parent receives in the hospital. In coordination with the Iowa Department of Public Health, it was agreed that a Safe Sleep flyer would be included along with the birth certificates sent out by Vital Records. Parents certainly pay attention when they receive their child's birth certificates in the mail and the inclusion of Safe Sleep information may be more effective if received at this time as well.

Additionally, during the September 2021 and March 9, 2022, case reviews, there was discussion regarding a lack of childcare resource information that was apparent in the case reviews. By April 2022,

a flyer with a QR Code that linked to the Child Care Resource & Referral website was added to the safe sleep information that was being sent out with birth certificates.

Since this campaign, HHS shared all promotional materials with Prevent Child Abuse Iowa (PCAI) after receiving information that they were interested in promoting additional safe sleep education. After reviewing the promotional materials and hearing about the successful safe sleep campaign that HHS was part of, the Director of PCAI collaborated with the committee to extend the campaign through their agency, in effort to continue the statewide safe sleep message.

While the Safe Sleep Committee established by the Child Death Review Team accomplished its goal to bring forth one strong safe sleep message and resource point for the state, members soon recognized the benefit in maintaining a Statewide Safe Sleep Workgroup. Members include seven representatives from various offices within the Iowa Department of Public Health as well as representatives from the Iowa SIDS Foundation, Orchard Place (Child Mental Health Services), and the Iowa Department of Human Services. Safe sleep efforts also forged a stronger collaboration between the local Safe Babies Court Teams and HHS.

HHS Safe Sleep Initiative: To follow up from the Statewide Safe Sleep campaign, the HHS added a Safe Sleep webpage to the HHS website: https://hhs.iowa.gov/child-welfare/safe-sleep. This webpage provides the very basic A, B, Cs of safe sleep and identifies additional resources to obtain more information, research, data, and educational materials. The webpage lays ground for the Safe Sleep Strategic Plan for HHS practice changes (Attachment 5B). In the meantime, HHS has made progress to implement the Safe Sleep Strategic Plan for HHS practice changes, in effort to prevent and reduce child maltreatment deaths.

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

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

Table 5N2: Child Maltreatment Deaths – FFY 2015-2022

Federal Fiscal Year (FFY)	Number of Deaths
2022	19
2021	12
2020	9
2019	25
2018	16

2017	19
2016	13
2015	12*

Data Source: SACWIS
*Prior to 2015, the data only includes child deaths that were listed as being the result of abuse.
In 2015 and the years following, the data also includes child deaths that listed abuse as a contributing factor.

Nineteen child fatalities were the result of abuse or abuse as a contributing factor in FFY22. A state review of the maltreatment death data indicated unsafe sleep made up over one-third (seven) of all child maltreatment deaths, involving infants between 10 days and 6 months of age. In five of these instances, a parent or older sibling was co-sleeping with the infant on an adult bed or couch/recliner. The other two instances involved unregulated in-home childcare providers, one who placed an infant on an adult bed to sleep and another who placed an infant on their stomach in a pack and play to sleep.

Physical abuse attributed to nearly one-quarter (four) of all child maltreatment deaths. All four of these physical abuse incidents were caused by a parent (one, which also included a paramour of the child's mother). The physical abuse incidents involved children between 19 days and 2 years of age.

Drownings accounted for three of all child maltreatment deaths, involving children between 9 months and 2 years of age, with one occurring in a residential pool and the other two in a bathtub. The persons responsible in all three of the drowning incidents were parents.

The five remaining child maltreatment deaths were single cases of inadequate medical care, motor vehicle accident, suicide, accidental gunshot, and asphyxiation. These incidents involved five children between 1 year and 13 years of age. In these incidents, three of the persons responsible were parents (responsible for inadequate supervision related to the motor vehicle accident, suicide, and gunshot), one was a foster parent (responsible for inadequate medical care), and one was an unregulated in-home childcare provider (responsible for the inadequate supervision that led to asphyxiation).

When considering whether any maltreatment deaths included a history of HHS services, it was determined that either of the child maltreatment deaths had both CPA and service history, six had CPA history only (no service history), and five had no CPA or service history.

MARYLEE ALLEN 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.[2]

Briefly describe the services provided since the submission of the 2023 APSR. Highlight any changes or additions in services or program design for FY 2024 and how the services assisted or will assist in achieving program goals, including efforts to target services to previously underserved populations. Provide an update to the services the state offers under each category in title IV-B, subpart 2: family preservation, family support, family reunification, and adoption promotion and support services (45 CFR 1357.16(a)(4)).

The services described below under the four main categories of PSSF support achievement of the PSSF goals through the provision of services to children and families to ensure child safety, family safety and stability, timely reunification, and adoptive families lifelong commitment to their children, which contributes to achieving Iowa's vision that *"Family Connections are Always Strengthened and Preserved"*.

Family Preservation

HHS allocates less than 20% of Promoting Safe and Stable Families (PSSF) funding for family preservation services. Iowa's family preservation services are currently our Family Centered Services (FCS) available statewide. Iowa utilizes a combination of state and federal IV-B, subpart 1 and subpart 2 (Family Preservation), SSBG, TANF, and Medicaid funds for FCS.

Fatherhood Programming

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

Caring Dads™ is a weekly two-hour session for 17 weeks. The primary referrals come from HHS staff and participants must sign in each week. HHS staff receives weekly attendance reports on a quarterly basis. Each 17-week cycle has a maximum capacity of 12-15 participants. Over the last five years, two sessions per fiscal year occurred in the Des Moines Service Area with approximately 60 men completing the 17-week session.

There were twenty referrals for the first cohort in the Des Moines Service Area for SFY 22. Of those twenty referred, four declined to participate in the group and eight completed all 17-weeks. In the second cohort for SFY 22, there were seventeen dads referred. Of those seventeen dads, eight dads declined to participate and five completed the group.

During SFY 2022, the Caring Dads program was expanded to Webster County in the Northern Service Area. One 17-week cohort was completed. There was a total of three dads who were referred and two successfully completed group. As a part of the expansion, there was one Licensed Independent Social Worker (LISW) formally trained in the Caring Dads program. There were also two other facilitators, one dad with lived child welfare experience and the other a community liaison with the school.

[2] 42 U.S.C. 629

Challenges in the Caring Dads program include staff in Webster County making referrals for group. Facilitators for Caring Dads continue to educate and meet with social worker staff to increase referrals.

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

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

The dads who do engage and complete Caring Dads™ demonstrate a change in their thinking patterns. This is evident by talking about their co-parent in a positive manner, having the ability to express their thoughts and feelings appropriately and their willingness to continue with contact before and after groups. These dads also find support in reaching out to the facilitators and/or each other after their group has been completed. HHS case managers have expressed positive comments about the change in males' attitudes and actions after being in the Caring Dads class.

24/7 DADS: 24/7 Dads is a 12-week curriculum Children and Families of Iowa (CFI) will provide programming to fathers involved with HHS or at-risk for involvement through the *24/7 Dads* curriculum. The curriculum-based program is a twelve-week series offered to fathers involved in or at-risk of involvement with HHS. There will be four completed 12-week groups during SFY 2024. The program will engage fathers with children 18 years or younger. Groups will be held one time per week for at a minimum of 1.5 hours and not to exceed 2 hours. Groups will be planned on a virtual platform to accommodate father's schedules and to take precautions for COVID-19. The program is designed for custodial and non-custodial fathers, as well as employed or underemployed. The group-based sessions will provide fathers with support and education on topics such as co-parenting, understanding father's roles in parenting, healthy parenting strategies, and positive mother/child(ren) relationships. These topics can be instrumental in parenting or co-parenting children. In addition to learning how to co-parent each skill learned and demonstrated can have a lifelong impact on the children. Positive outcomes include but not limited to the following for children: healthy relationships, age-appropriate discipline and learning the mother/father role in a family. Certificates will be given to those men who complete the twelve-week curriculum.

This curriculum is offered through the *National Fatherhood Initiative*. According to their website the curriculum is an evidence-based program. The Fatherhood Coordinator at CFI collaborates with community partner agencies to engage parents. Collaboration is sought from HHS, Family Treatment Court, Parent Partner Program, Community Partnerships for Protecting Children, Department of Corrections, local substance abuse and mental health organizations, and many other community agencies. CFI utilizes parents who have had lived experience to facilitate each group. CFI has been able to identify several alumni who have successfully completed the program and continue to attend

subsequent groups for additional knowledge and potential familiarity in becoming a facilitator. Alumni serve as positive role models for current participants and continue to benefit from the group environment and parenting skills provided through the curriculum.

There was a total of 240 community-based groups held in SFY 2022 and an additional 22 groups held at the Clarinda Correctional Facility. There was a total of 164 fathers in those community-based groups and 37 graduates at the Clarinda Correctional Facility who successfully completed the 12-week group and received a certificate. The completion rate for the fatherhood groups is approximately 78%. The number of children overall impacted was 782.

Promoting Opportunities for Parenting Program:
In addition to the strategies as described above, CFI continues to partner with HHS Child Support Recovery Unit to offer the *Promoting Opportunities for Parenting Program*. This opportunity is for any parent who owes back child support to the State of Iowa. They can enter into an agreement with Child Support Recovery, once they have completed the class, to fulfill the written obligations which will lead to their back-child support to be forgiven. This would be an incentive for either parent to attend and complete group. This incentive has been a highly effective engagement strategy for parents to attend and complete the curriculum.

Parent Partners

The Iowa Parent Partner Approach seeks to improve outcomes for families around re-abuse and reunification. Parent Partners are individuals who previously had their children removed from their care and were successfully reunited with their children for a year or more. They provide support to parents that are involved with HHS and are working towards reunification. Parent Partners mentor one-on-one, celebrate families' successes and strengths, exemplify advocacy, facilitate trainings and presentations, and collaborate with HHS and child welfare professionals.

Parent Partners share experiences and offer recommendations through a variety of opportunities such as foster/adoptive parent training; 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 HHS social workers, legal professionals, community-based organizations, and others to provide resources and lift voices and experiences for the parents they mentor. Parent Partners also frequent Family Treatment Court to provide support and coaching for participants. The goal of the Parent Partner Approach is to help parents be successful in completing their child welfare case plan goals by providing families with Parent Partners who are healthy, stable, and model success.

The Parent Partner Program continues to operate as a statewide contract in all 99 counties in Iowa. The average number of parent partners mentoring throughout the reported period of July 1, 2021-June 30, 2022, was 146. The number of parents who received a peer mentor in SFY22 was 1,299. The current statewide staffing structure includes seven (5) Lead Parent Partners, sixteen (16) Coordinators (7 are former Parent Partners), five (5) Service Area Coordinators (2 are former parent partners), one (1) Operational Coordinator (was a former Parent partner), one (1) Quality Assurance Coordinator, and one (1) State Director. The program has expanded to include a Parent Voice and Inclusion Coordinator position who was recently added to the state team.

HHS contracts with the University of Nebraska-Lincoln (UN-L) to host and maintain the parent partner database and provide ongoing analysis and evaluation of both the administrative and outcome data. The analysis of the administrative data is an ongoing quasi-experimental design, and the outcome data reflects surveys using the protective factors as a framework. Individuals enter the outcome data into the web-based parent partner database.

Through on-going research, UN-L found a positive statistically significant difference for parents who receive parent partner supports. Parent partner families have a higher rate of reunification and less reentry than families without a parent partner. HHS partnered with UN-L to author a research article regarding these findings.

The parent partner research study was published in the journal Child & Youth Services Review, September 2019, demonstrating that when HHS-involved parent has a parent partner, there is less re-abuse and children are more likely to return home. This publication and other materials were submitted to the California Evidence-Based Clearinghouse (CEBC) and the federal Prevention Clearinghouse to be reviewed and rated for evidence-base practice. During SFY 2021, HHS received notification that the Iowa Parent Partner Program has received Promising level evidence-based ratings from both the CEBC and the federal Prevention Clearinghouse.

Out of State Collaborations

As a result of the above ratings designations, several states have continued to reach out to Iowa throughout the last year to inquire about establishing a Parent Partner Program in their state. In spring 2021, Iowa HHS developed a letter of agreement to utilize with states and organizations who have interest in implementing the Iowa Parent Partner Program and wish to utilize program materials, training curricula, and research. This agreement was developed to ensure that other states, who were asking to implement the Iowa Parent Partner model, follow the fidelity of the program. Assistance to interested states and organizations who enter into the agreement with Iowa HHS includes sharing of program materials, and provision of technical assistance and training from the contractor for the Iowa Parent Partner Program, Children and Families of Iowa. This includes email exchanges, conference calls, providing trainings and site visits, providing workshops and panel discussion, and invitation to attend Iowa's annual Parent Partner Summit.

Due to the consultation and interest from other states, HHS, CFI, and UN-L, are working together to establish a readiness and implementation checklist. This document will be provided to other states who express interest in the Iowa model to utilize as a mechanism for assessment of readiness by the state or jurisdiction and by Iowa that they are ready to move forward with implementation of the Iowa Parent Partner model.

Casey Family Programming has reached out to the Parent Partner Program to inquire about completing a cost benefit analysis. The HHS Program Manager and State Parent Partner Director has met with representatives from Casey Family Programming to begin the work to complete this task. The anticipated completion of the cost benefit analysis will be in SFY 2024.

To date, the Iowa Parent Partner Program has been provided training, planning and implementation of a peer mentoring program include Louisiana, Oklahoma, Colorado, Wisconsin, and Ohio. Recently, other states have expressed interest in starting the planning process include New York State, Michigan,

Indiana, South Carolina, Maine, Florida, and two sites in Minnesota. One of the two Minnesota sites includes a partnership with the Red Lake tribal nation. It should also be noted that working with Ohio also brings a partnership with the University of Connecticut, QIC-R evaluation team.

Child Safety Conferences/Parent Partner Prevention Support

On July 1st, 2020, the Child Safety Conference (CSC) Parent Partner Program Pilot was implemented across the state. The Parent Partner Program is one of the engagement strategies to support families during the Child Safety Conference process and through the journey of the child welfare process. CSCs are a key component of Iowa's implementation of Family First and provide a conference facilitated opportunity for parents of children at imminent risk of removal and placement in foster care. The CSC Parent Partner Program pilot focuses on families who come to the attention of HHS, who are at risk for abuse if appropriate supports and/or resources are not provided and will participate in a CSC as a result of family preservation services. These families will potentially remain intact through the CSC process with appropriate resources and the ongoing support of a Parent Partner.

The process for a CSC referral includes the following: 1) the HHS worker makes a referral for the CSC to both the family centered services provider and to Parent Partner Program. 2) The parent partner will have up to seventy-two hours prior to the initial CSC to contact the participant. At this initial call, a parent partner can explain the program, describe the upcoming meeting, connect the individuals to community resources and simply be a supportive person. 3) The support is voluntary, and the parent can decline. At times, referrals to CSCs are made to parent partners late in the process, and the Parent Partner is introducing the program at the time of the meeting. This creates a barrier as the parent will often associate the Parent Partner as another professional at the table rather than support to the parent.

Parents whose child(ren) remain in the home following a CSC will be able to continue with support and mentoring through the Parent Partner Program on a voluntary basis. For SFY 23, the Parent Partner Program can mentor up to 250 cases where the child(ren) are able to stay in home.

There were 634 referrals during July 1, 2022, thru March 30, 2023, made to the CSC Parent Partner Program Pilot. Referrals include Parent Partner attendance to support the parent at the CSC, if the parent voluntarily agrees to have Parent Partner support during this process. Following conclusion of the CSC process and family preservations 92 parents have formally entered the pilot program for ongoing support when the child and parent remained together.

Although there continues to be some challenges regarding the standard referral process for Parent Partners to support parents during a CSC, over the last year the number of referrals to Parent Partners for CSCs have increased as referral challenges have been addressed. To address these challenges conversations with HHS front line staff, supervisors and management have taken place on a routine schedule. CSC referrals continue to be a standard conversation at each one of the five service area meetings between Parent Partner Program and HHS. The HHS Program Manager and the State Parent Partner Director have presented at an all-staff HHS Lunch and Learn, CID's call with supervisors and Social Worker Administrators, as well as working with the HHS training team to add the referral information into the social worker 020 training for new staff. The Parent Partner Coordinators continue to keep spreadsheets to track CSC referrals, where the referral came from, and the outcome of the referral. The quarterly collection of this data has been submitted to the HHS Contract Manager for

overview. The CSC Parent Partner Program will continue into SFY 2024, and HHS will continue to work with UN-L to explore evaluation measures of Parent Partner support for parents whose children remain at home in preventing subsequent removal.

Parent Partner Evaluation and Research

Researchers from the University of Nebraska-Lincoln (UNL) Center on Children, Families and the Law provide bi-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 bi-annual reports provide analyses of the number of participants completing the entrance and exit Parent Partners participant self-assessments and fidelity to the Parent Partner model.

When the statewide contract started initially, one performance measure identified at least 70% of the parents will improve at least one point on the Self-Assessment Exit scale, based on the protective factors. The first 1,200 participants to complete the survey data provided the basis for the percentage. The following information is excerpted from the UNL Iowa Parent Partner Online Database July 2021 – June 2022 Annual Parent Partner Report.

Family Entry Self-Assessments

734 family entry self-assessments were entered in the Online Parent Partner Database between July 1, 2021, and June 30, 2022. This includes assessments for both traditional and CSC cases. The average and median self-assessment for entry assessments is shown in the table below. On average, parents rated themselves the highest at entry on their ability to effectively manage their situation to keep their children safe and to make the appropriate decisions for themselves and their families. Parents rated themselves lowest at entry on their comfort talking to their HHS worker or other service providers.

Table 5o2: Family Entry Self-Assessment Data

Family Self-Assessment				
Statement Rated on a scale of 1 (*never*) to 5 (*always*)		**Entry Assessment**		
		Average	**Median**	**N**
1	I am able to find the community resources I need to keep my children safe.	4.3	5.0	733
2	I am able to complete the steps necessary to get the community resources I need.	4.3	5.0	734
3	I am able to effectively manage my situation to keep my child(ren) safe when times are stressful.	4.4	5.0	734
4	I am able to make the appropriate decisions for myself and my family.	4.4	5.0	734
5	I have others who will listen when I need to talk about my problems.	4.1	5.0	734
6	I have others who will support positive choices and changes I make.	4.3	5.0	734
7	I talk reasonably and honestly with others about my situation and problems.	4.3	5.0	734
8	If there is a crisis in my life I have someone I can talk to.	4.2	5.0	734

9	I am able to effectively speak up for myself and my family to DHS and other service providers.	4.1	4.0	734
10	I am able to listen to DHS and other service providers and understand their concerns with my situation.	4.3	5.0	733
11	I feel comfortable when talking with my DHS worker or other service providers.	3.8	4.0	732

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

Retro and Exit Comparisons

Family self-assessment scores from retrospective to exit are compared in the table below. Only self-assessments that had data for both a retrospective and an exit rating for the measure are included in each analysis; if the data are missing or the parent selected "I don't know," the data were not included. For each of the 11 self-assessment items, parents rated themselves significantly higher on the exit self-assessment than on the retrospective self-assessment. This means that parents rated themselves higher at completion of the Parent Partner program than they rated themselves when thinking back to how they were at the beginning of the program. Exit and Retro score averages remained fairly consistent with last's year's reported scores; this indicates that parents provided similar self-ratings this year to what they provided last year when thinking back to how they were at the beginning of the program. Items with an asterisk indicate a statistically significant difference between the Retro and Exit average ratings.

Table 5P2: Family Exit Self-Assessment Data

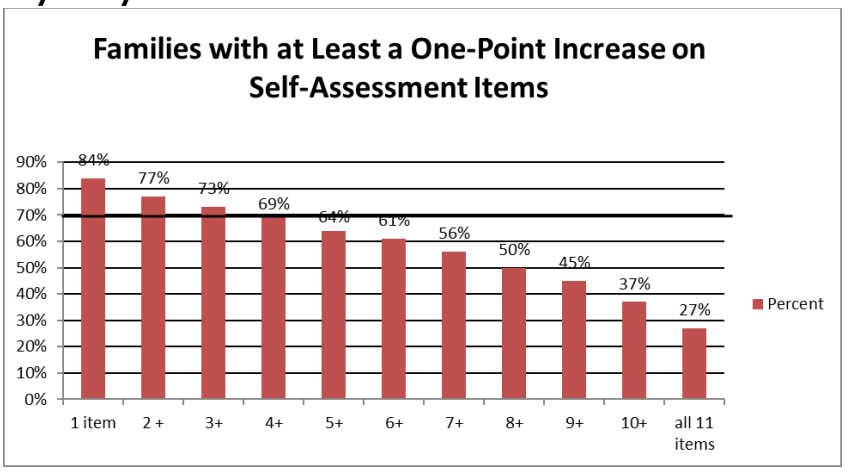
Statement Rated on a scale of 1 (*never*) to 5 (*always*)		**Exit Average**	**Retro Average**	**Number**
1*	I am able to find the community resources I need to keep my children safe.	4.7	3.8	262
2*	I am able to complete the steps necessary to get the community resources I need.	4.7	3.7	263
3*	I am able to effectively manage my situation to keep my child(ren) safe when times are stressful.	4.7	3.7	261
4*	I am able to make the appropriate decisions for myself and my family.	4.8	3.7	263
5*	I have others who will listen when I need to talk about my problems.	4.7	3.6	262
6*	I have others who will support positive choices and changes I make.	4.7	3.6	262
7*	I talk reasonably and honestly with others about my situation and problems.	4.6	3.6	263
8*	If there is a crisis in my life I have someone I can talk to.	4.8	3.6	263
9*	I am able to effectively speak up for myself and my family to DHS and other service providers.	4.7	3.5	262
10*	I am able to listen to DHS and other service providers and understand their concerns with my situation.	4.6	3.4	258
11*	I feel comfortable when talking with my DHS worker or other service providers.	4.4	3.1	258

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

Percentage of Families with At Least 1-point Increase from Retro to Exit on At Least Three Measures

263 parents fully completed both an exit self-assessment and a retrospective self-assessment between July 1, 2021, and June 30, 2022. The current performance standard is that 70% of parents must have at least a one-point increase from retro to exit self-assessment on at least three measures/items. 192 (73%) of parents with complete data met this performance measure during this annual reporting period.

Table 5Q2: Family Entry and Exit Self-Assessment Data



Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

The pattern of results for the most recent fiscal year suggests a slight increase in the number of self-assessment items with at least a one-point increase from retro to exit, when compared to the previous fiscal year's results. However, there were significantly less parents who completed exit and retro surveys.

Family Feedback: Fidelity Checklist and Family Outcomes

Parent Partners entered data for 302 Family Feedback forms for families exiting the Parent Partner program between July 1, 2021, and June 30, 2022. Parents with missing data or who responded "I don't know" were excluded from the following analyses. The number of respondents completing the Family Feedback forms decreased significantly when compared to the prior fiscal year. Average scores were largely comparable to the previous fiscal year, and the total score of family feedback on the Fidelity Checklist did not vary significantly from last year.

The overall pattern of results remained consistent when compared with the prior fiscal year. These results indicate that families are reporting similar level of improvement in their outcomes as they did during the previous annual reporting period. However, there was a significant decrease (33%) in the number of families who completed the family outcome survey.

Parent Partner: Fidelity Checklist and Family Outcomes

Parent Partners completed 792 fidelity checklists between July 1st, 2021, and June 30th, 2022. If the Parent Partner did not respond or responded, "I don't know," the data were not included in the analyses. The pattern of ratings for family outcomes were like the previous fiscal year's report. Similar to

previous years, Parent Partners reported less improvement on family outcomes compared to the parents.

The pattern of ratings for family outcomes were like the previous fiscal year's report. Similar to previous years Parent Partners reported less improvement on family outcomes compared to the parents.

Family Feedback and Parent Partner Comparisons

Pairwise comparisons were used to compare parents' responses on the fidelity checklist and family outcomes measures to Parent Partners' responses. Only parents with responses for both the family feedback and the fidelity checklist were included in the following analyses. Differences in reports of fidelity behaviors this reporting period generally followed the trend of parents reporting more fidelity behaviors than Parent Partners, although there were more instances of alignment between scores this fiscal year. The difference in scores was statistically significant for five of the ten items, as well as for the difference in total scores.

Table 5R2: Fidelity Checklist

Statement Rated on a scale of 1 (*never*) to 5 (*always*)		**Parent Partner Average**	**Participant Average**	**Number of responses**
1	Encouraged the participant to fulfill case plan activities.	4.8	4.8	270
2	Regular face to face visits.	4.6	4.5	269
3*	Other communication and contact.	4.7	4.6	270
4	Advocated for needed resources.	4.7	4.7	269
5	Encouraged the participant.	4.8	4.8	270
6*	Connected with community resources.	4.6	4.4	269
7	Helped connect with the community.	4.5	4.4	269
8	Coached on communication strategies.	4.7	4.6	269
9	Supported at FTM, court, treatment, and other gatherings.	4.5	4.5	263
10	Coached on what to expect throughout this process.	4.7	4.8	269
	Total * (out of a possible score of 50)	**46.2**	**47.1**	**253**

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

* The difference between the average participant rating and the average Parent Partner rating was statistically significant.

Parents reported greater improvement than did Parent Partners on ten of the eleven family outcome measures. The difference in ratings was statistically significant for three of the eleven items. Items with an asterisk in the table below identify statistically significant differences between participant and Parent Partner ratings. The difference in total scores was also statistically significant.

Table 5S2: Family Outcomes: Level of Improvement

Statement Rated on a scale of 1 (*decreased*) to 4 (*significant improvement*)		**Parent Partner Average**	**Participant Average**	**Number of responses**
1*	Relationship with people who are able to connect with resources.	3.3	3.3	263

2*	Relationship with people who support positive changes.	3.4	3.3	263
3	Level of communication with DHS worker.	3	3.2	263
4	Level of communication with attorney(s).	2.7	3.1	249
5	Ability to advocate appropriately.	3.4	3.4	266
6	Knowledge of what needs to be done for custody of children.	3.3	3.4	264
7	Ability to get to appointments on time.	3.3	3.3	265
8	Ability to find community resources.	3.4	3.3	266
9	Knowledge of who to contact with needs or concerns regarding the case.	3.4	3.4	265
10*	Level of personal responsibility and accountability.	3.4	3.3	266
11*	Willingness to make changes.	3.5	3.4	266
	Total* (out of a possible score of 44)	**36.4**	**37**	**220**

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

The overall pattern of results is consistent with the results reported in the previous fiscal year's report.

Relationship between Fidelity Checklist and Family Outcomes

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

Table 5T2: Relationship between Fidelity Checklist and Family Outcomes

Measure 1	Measure 2	What the relationship tells us
Parent Partner report of Fidelity Checklist	Parent Partner report of Family Outcomes	Whether Parent Partners' reports of fidelity to the model relate to Parent Partners' reports of improvement on the family outcomes
	Parent report of Fidelity Checklist	Whether Parent Partners and parents agree on fidelity to the model
	Parent report of Family Outcomes	How Parent Partners' reports of fidelity to the model relate to parents' reports of improvement on the family outcomes
Parent Partner report of Family Outcomes	Parent report of Fidelity Checklist	How Parent Partners' reports of improvement on family outcomes relate to parents' reports of fidelity to the model
	Parent report of Family Outcomes	Whether Parent Partners and parents agree on parents' improvement on family outcomes
Parent report of Fidelity Checklist	Parent report of Family Outcomes	How parents' reports of fidelity to the model relate to parents' reports of improvement on the family outcomes

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

The highlighted box above (relationship between Parent Partners' reports of family outcomes and parents' reports of fidelity) provides the most important information. The strength of this relationship

provides an indication of how closely parent's views of the treatment they received relate to their Parent Partner's assessment of the family's improvement. The table below includes the relationships between each measure. Values with an asterisk (*) are statistically significant.

Table 5U2: Relationships between Measures in Table 5T2

Measure 1	Measure 2	Correlation
Parent Partner report of Fidelity Checklist	Parent Partner report of Family Outcomes	+.31*
	Parent report of Fidelity Checklist	+.63*
	Parent report of Family Outcomes	+.15*
Parent Partner report of Family Outcomes	Parent report of Fidelity Checklist	+0.21*
	Parent report of Family Outcomes	+.69*
Parent report of Fidelity Checklist	Parent report of Family Outcomes	+.29*

Source: UN-L Iowa Parent Partner Online Database Data Summary SFY22 Report

From this table, we found that:

- With higher Parent Partner perceptions of fidelity to the Parent Partner model, there are improved family outcomes as reported by the Parent Partners.
- Parent Partners and parents strongly agree in their perceptions of fidelity to the model.
- Higher Parent Partner perceptions of fidelity to the model were significantly related to improvements in family outcomes as reported by parents.
- **Parent Partner reports of family outcomes are positively and significantly related to parent reports of fidelity to the model. This means that higher parent reports of fidelity were accompanied by improved family outcomes as reported by the Parent Partners.**
- Parent Partners and parents strongly agree in their perceptions of family outcomes.

With higher parent perceptions of fidelity to the Parent Partner model, there are improved family outcomes as reported by the parents.

Parent Partners and Diversity

Diversity within the Parent Partner Program is an ongoing conversation. The Parent Partner Program is addressing diversity, equity, and inclusion (DEI) through state/local meetings, trainings, recruitment of parent partners, referrals for parents to have peer mentors, presentations, and collaborations with other community partners. Parent Partner Coordinators and Service Area Coordinators are encouraged to have a Plan Do Study Act (PDSA) to address DEI in their covered area. Parent partners are included in Equity teams across the State of Iowa. CFI facilitates monthly a Courageous Conversation, and ongoing trainings are offered such as Race: Power of Illusion and Understanding Implicit Bias.

The local service areas implemented their recruitment plans of parent partners, with a result of increased participation by males and more diversity of racial and ethnic identities. There continues to be approximately 15 males currently serving as Parent Partners in the program, one of them is Latino. There are three (3) African American Parent Partners; four (4) Parent Partners who identify as Latino; and two (2) who identify as Native American. Ongoing recruitment is a priority for Parent Partners who are culturally diverse and represent diverse race and ethnic backgrounds.

Meskwaki Family Services has made routine referrals into the Parent Partner Program. Meskwaki Family Services has also invited the Parent Partners to local meetings such as the Red Band Meeting. The Parent Partner Program will continue to engage with the settlement to find potential peer mentors and those that need support.

The Parent Partner Program has increased their awareness and development of cultural responsiveness through training opportunities for staff and Parent Partners, and recruitment of a more diverse team. In SFY 2022, Parent Partner Program engaged in cultural equity learning opportunities, including the learning exchanges Race the Power of an Illusion and Understanding Implicit Racial Bias. With the guidance of the Cultural Equity State Coordinator and Learning Exchanges Coordinator, the Parent Partner Program has begun to revise program materials in SFY 2023 with an increased cultural equity focus within the core Building a Better Future training and the Iowa Parent Partner Handbook.

During SFY 2023 a relationship had been established with the Red Lake Tribe in Minnesota to assist them in developing a parent peer mentoring program. In April 2023, they attended the Building a Better Future training in Iowa. This opportunity will continue to develop into SFY 2024.

Parent Partners' Policy and Practice Recommendation Team

The Parent Partners' Policy and Practice Recommendation Team was implemented in SFY 2019 for incorporating statewide parent partners collective feedback on recommendations for child welfare policy and practice changes. This structure integrates feedback from the local parent partner program, Parent Partner Service Area Steering Committees, and the Parent Partner Program State Advisory Committee. The team is comprised of parent partners with representation from each of the service areas and meets quarterly to discuss and compile recommendations. Annually, formal recommendations for child welfare policy and practice changes are submitted to the HHS Program Manager.

The Policy and Practice Committee is often provided opportunity for review and feedback to potential policy and practice changes occurring within HHS. An example of this feedback is recent review of the "At a Glance" HHS trifold document that has been utilized previously in two HHS service areas to provide to parents at removal to help them understand the court process, legal terms, and information regarding right to appeal. The Policy and Practice Committee provided feedback to this document around usefulness to parents, information that should be included or revised, and feedback on when and who should be responsible for ensuring the document is provided and explained to parents when removal occurs. This feedback was provided to the workgroup tasked with review of the document and included in decision making on next steps.

The Policy and Practice Committee formally submitted recommendations to HHS at the conclusion of fiscal year 2022. These recommendations were developed and agreed upon by the Committee as the collective parent voice across the state. The recommendations included the following:

1) Parent Partners recommend that parents should have clear action plans that will support the goal of reunification.
    a. Parents should have ongoing communication with team members.
    b. Each goal should have an identified team member who will be responsible to gather, obtain, and report back information. This could include one person from the team that provides resource locations/availability.

c. Parents should be provided with a safe space to share barriers without a negative impact.
d. HHS should have in person contact with each parent monthly 100% of the time.
e. Increased time between children and their parents based on behavioral indicators.

2) Parent Partners continue to advocate for fair and accessible drug testing for those involved in child welfare.
    a. Identify and recognize barriers to drug testing in rural vs urban areas.
    b. Make in-home testing an option.
    c. Expand times for drug testing.
    d. Focus group of parents who can provide input from both rural and urban areas.

3) Parent Partners recommend a clear and transparent training/implementation plan, shared with stakeholders for new family engagement meetings.
    a. A better understanding of changes and new processes as Families First continues to shape Iowa child welfare, for example Child Safety Conferences, Solution Focused Meetings and Family Unification Meeting.
    b. Cross training opportunities to educate those who support families in the child welfare process. It is suggested by the committee to utilize parent partner(s) from the Policy & Practice committee to assist in the development of training material, as well as putting together a strategic plan to cross train staff across the state.

4) Parent Partners recommend that services/supports be offered to parents that are inclusive of race/ethnicity and gender roles.
    a. Referrals to programs that are culturally responsiveness and support a parent's race, ethnicity, religion, culture, and gender roles are key and vital to the success and reunification of our families of color. We must be intentional in the offering of services and hold each other accountable when equity is challenged. This may include but not limited to: Specialty Courts, relative/fictive kin placement, and other area specific supports that promotes the family unit or reunification.
    b. Expand the after-support pilot to the Native Tribal Unit.

The Policy & Practice Committee will submit SFY 2023 recommendations after the April 24th, 2023, quarterly meeting.

Parent Partner: Continuing Supports Efforts

Parents who have substance abuse issues may continue to receive Parent Partner mentoring and support through the Continuing Support pilot 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 participants in this pilot will have a Parent Partner during their child welfare case and the same Parent Partner will support the parent after case closure. During SFY 2021 there were nineteen (19) parents referred to this pilot. Of those nineteen (19) thirteen (13) completed the full six months of support after safe case closure. Four (4) individuals left the pilot due to the Parent Partner leaving the program and they declined support from a new Parent Partner and two (2) disengaged with the program for reasons unknown. The pilot program was expanded in SFY 2021 to support a higher capacity, from 20 to 30 parents who can be supported in the

pilot program. We have continued to see a decreased participation in the pilot, this may be due to changes in staff and Parent Partners in this area, which had contributed to the increased initial participation in the pilot in 2020. We have worked to address the decrease with CFI and the local HHS, through better clarification of the continuing support pilot process for referral and on-going support to working on referrals to the traditional parent partner program in this area.
Due to continued lack of participation and the need to recruit additional parent partners, it has been decided to discontinue the after-support program at the end of SFY 2023.

Scope of Parent Partner Activities SFY 2022

As of the annual reporting period ending June 30, 2022, there were approximately 83 Parent Partners (including Parent Partners in Training Mentoring) assigned to 1,299 individuals in 99 counties. Parent Partners continue to provide support for families involved in Family Treatment Court. The types and number of supports provided to participants in SFY 2022 this year by Parent Partners includes, but is not limited to:

- Mentoring Supports
    - Meetings to support parents (ex., Solution Focused Meetings): 596
    - Support family in Court: 1,953
    - Support parent before/after visitation: 1,754
    - Face-to-face contact (not including the items above): 14,067
- Outreach Activities
    - Connect to community resources: 1,951
    - Access to needed services: 5,461
    - Committees related to child welfare: state 161, local 315
    - Child welfare HHS new worker orientation: state 4. Local 1
    - Community Partnership for Protecting Children: state 13, local 235
    - Speaking engagements and program awareness: state 3, local 83
    - Other meetings, trainings, and activities: state 44, local 24

Building a Better Future Training (BABF): BABF has always served as the core training for the Parent Partner Program. Eight BABF trainings were held in the following service areas: three in the Western Service Area; one in the Des Moines Service Area; two in the Cedar Rapids Service Area and one in the Northern Service Area, and one in the Eastern Service Area. HHS child welfare staff attend BABF training alongside Parent Partners in training, and as a result develop empathy and understanding of each other's experience within the child welfare system, creating new partnerships for collaborative efforts working with families. Currently, there are approximately 8 approved Building a Better Future Trainers and 8 advanced trainers of the curriculum.

Annual Parent Partner Summit: With a theme of "Meet the Stars – The Iowa Parent Partners," the 14th annual Parent Partner Summit convened on June 28 & 29, 2022 at Holiday Inn & Suites Des Moines – Northwest located at 4800 Merle Hay Road, Des Moines, IA 50322. The event returned to in-person after hiatus due to COVID, and a total 109 participants attended from across the State of Iowa. Throughout the conference 5 Parent Partners shared their individual personal stories to a successful recovery. The break-out sessions were held on June 29, 2022, which were organized in 2 plenary sessions. With 6 presenters, 6 sessions and a Keynote speaker, the conference featured many topics specific to the Parent Partner Program. Topics included addressing what recovery looks like after abdication, learn current drug trends and how they can use this information, focus on self-care for

individuals in recovery, keeping healthy boundaries, and tips to help with daily stress. Additional topics included how to serve families and communities, learning the brain science of addiction and the stages of change model of treatment, and addressing the physical, mental, and spiritual disease of addiction through yoga. The conference celebrates the Parent Partners and their years of service to the Parent Partner Program.

This year's theme, "Meet the Stars – The Iowa Parent Partners," was movie inspired. Each local area picked a movie and dressed in costume. The local area Parent Partner teams work together on presentation board of the amazing work and activities they did throughout the year and honored the Parent Partners in that area. The theme to their presentation board also displayed the movie theme they chose.

Mt. Pleasant Prison Project: In 2013, the State of Iowa and the Parent Partner Program collaborated to work with males who are incarcerated to help them get involved or re-involved with the open service case, as well as providing parent skill education. CFI has provided a volunteer four-week parenting group in the Mt. Pleasant Correctional Facility (MPCF). During the four weeks, topics covered included:

- I'm HHS involved, Now What?
- Healthy Communication
- Self-Advocacy
- Re-entry Programs

As the groups were able to resume this fiscal year following hiatus during the pandemic, a total of 8 groups were completed. There was a total of 122 dads who participated in the four-week group, with 295 kids impacted. 41 of those dads had open child welfare cases and 109 kids were impacted. The number of dads who participated in group that were HHS involved was 34% of the overall group population.

Dads who participated in group gave the following summary feedback as learning opportunities in the four-weeks:

- Being aware that we have rights and that there are services for help.
- Effective communication
- Don't be afraid to ask questions.
- Knowing my rights as a father
- I can write HHS and thank them for their services and look for more opportunities for my son.
- Document things for HHS
- How to become a Parent Partner
- How to worker with your HHS worker
- Stand up and be assertive for my rights and responsibilities.
- There are people and resources out there to help parents in need.

Summary of Parent Partner Collaborative Efforts and System Impact

Strengths:

- Well trained Parent Partners successfully provide mentoring supports and engage in hundreds of committees and trainings locally and statewide.

- Systemically there is an expectation that Parent Partners have a voice in policy and practice. Service Area Steering Parent Partner Committees meet regularly to review referral and intake data and set goals for implementation.
- Parent Partner Management Team and the State Parent Partner Steering Committee regularly review outcome data and administrative data to determine impact. This data analysis serves as a feedback loop for program improvement.
- Strong partnerships for referrals for both participants and Parent Partners
- Promotion of professional and career development opportunities for Parent Partners
- Beginning to broaden mentoring supports beyond the out-of-home placement (in-home and after case closes for substance abuse issues)
- Increase funding to expand mentoring supports for in-home cases and prevention approaches
- Establish quality assurance protocol based on data and participant feedback
- Parent Partner research published and submitted for evidence-based classification
- Evidence based ratings designated as Promising by both the California Evidence Based Clearinghouse and the Federal Prevention Services Clearinghouse.

Quality Assurance is addressed through a variety of program responses such as updating the Parent Partner Program Handbook and associated materials, updating the core Building a Better Future Training for new parent partners and HHS staff, continuous fidelity monitoring by UNL through the Parent Partner Database, and feedback to policy and practice changes from the Parent Partner Policy and Practice Committee. Parent Partner feedback is utilized to review and provide input to changes in documents to ensure cleat and family friendly language for parents.

Data collected from continuous reporting on the Parent Partner Program from CFI and from UNL in monitoring and analyzing the database regarding program fidelity measures drives next steps regarding adaptations needed to best meet the needs of parents entering the child welfare system for support and mentoring of a Parent Partner, such as continuing to build capacity to support parents as a prevention to family separation.

Flex Funding

HHS has allocated funding to the Parent Partner Program for flex funding. These funds assist parents who are actively engaged in their child welfare case to either prevent removal of a child or to assist with reunification. The money allocated each year is to be spent evenly across the state. Requests are submitted and reviewed by the Parent Partner Management Team monthly. During this reporting period, 81 requests were funded by requests from parents across the state. Impact statements from individuals who have received the flex funding are provided in quarterly summaries to HHS. Flex funding will continue through SFY 2024.

Opportunities for Program Improvement:

- Parent Partners' Policy and Practice Recommendation Team, Parent Partners will have a collective voice.
- The evidence-based classifications could give Parent Partners new funding opportunities.
- Develop a method for evaluating outcomes for Child Safety Conference Parent Partner Pilot Program, as we all as the on-going mentoring support program for parents who have experienced safe case closure.
- Continue to monitor program data and utilize feedback to continually implement course corrections to strengthen model fidelity and outcomes.

- Assess opportunities for additional evaluation to increase the evidence-based ratings of the Iowa Parent Partner Program
- Continue to expand the Parent Partner Program that includes a more diverse support and inclusion of all groups.

Wrap-Around Emergency Services

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

SERVICE DECISION-MAKING PROCESS FOR FAMILY SUPPORT SERVICES (45 CFR 1357.15(R))

The Family Support Services component of the PSSF program represents an important source of funding for community-based prevention efforts. The statute specifically requires that these services be community-based (section 431(a)(2)(A)). CB also reminds states that Family Support Services may include offering information and referral services to afford families access to other community services, including legal services to help families prevent evictions, loss of benefits or other issues that may make them vulnerable to entry into the child welfare system.

In developing the 2020-2024 CFSP and planning for use of funds in collaboration with families, children, youth and young adults; Tribes, courts and other system partners, CB encouraged states to consider carefully how they target and distribute funds for family support services. In the 2024 APSR, provide an update on the agencies and organizations selected for funding to provide family support services and how these agencies meet the requirement that family support services be community-based. CB urges states to examine where family support services are located in communities and the degree to which they are or could be made more accessible to traditionally underserved populations.

HHS utilizes PSSF Family Support funding (20.61% of the PSSF grant) for the Iowa Child Abuse Prevention Program (ICAPP). Please see *Prevention, Iowa Child Abuse Prevention Program (ICAPP)* earlier in this section for more information.

Family Reunification

Iowa allocates 28.8% of the PSSF dollars to Family Reunification Services. HHS central office staff removes some of the funding, usually allocated to the five HHS services areas, to include in the Family Centered Services (FCS) contracts. HHS utilizes these funds, in addition to IV-B, subpart 1 funds, in the FCS contracts because the contracts include services to support reunification, such as facilitation of Solution Focused Meetings (SFM). Central office staff then allocates the balance to the service areas based upon historical allocations and service area needs. All services to children and their families remain traceable to the eligible child. Service areas determine utilization of the funds they receive and sub-contract with service providers. In some of the service areas, the service area's Decategorization (Decat) committee has responsibility for projects funded under Family Reunification Services.

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

Iowa's Family Reunification Services "Menu":

- **Access and Visitation Services** – Supervision of visits between the child and their parents and/or siblings that may be provided by child and family advocates or other contracted providers, including costs associated with transportation connected with the supervision of visits.
- **Child Welfare Mediation Services** – a dispute resolution process seeking to enhance safety, permanency, and well-being for children. When two or more parties are "stuck" on a position, HHS staff uses mediation to help get them "unstuck". The goal of mediation is a fair, balanced and peaceful solution that allows the parties to move forward. Child Welfare Mediation cases often involve children in the middle or children whose parents need help with establishing parenting plans, often with the custodial and/or non-custodial parent. Mediation typically involves about six hours of billable time and sixty days of service.
- **Substance Abuse Services (not paid for by public or private insurance)** – Evaluations, treatment (inpatient, residential, or outpatient), and medications, includes client's co-pays and co-insurance.
- **Mental Health Services (not paid for by public or private insurance)** – Evaluations, including psychosocial, psychological, and psychiatric, and treatment, including therapy (individual, family and/or group), medications, and client's co-pays and co-insurance.
- **Substance Abuse and Mental Health Services Combined (not paid for by public or private insurance)**. Group and home substance abuse services combined with mental health services, includes client's co-pays and co-insurance.
- **Domestic Violence Services**.
- **Daycare, Respite Care, and Therapeutic Camps (not paid for by childcare assistance, HCBS waivers, or other assistance programs)** Includes daycare settings, therapeutic camps and summer camps, crisis nurseries, respite, etc.
- **Fatherhood Programs, including Incarcerated Fathers** – more extensive, intensive and targeted services to assure that fathers, including incarcerated fathers, maintain a positive on-going presence in their child's life, includes support groups.
- **Motherhood Programs, including Moms Off Meth groups and Incarcerated Mothers** – programs and support groups specifically for mothers, including support groups for mothers with past drug usage problems.
- **Transportation Services –** Contracts with transportation service companies, gas cards, bus passes, etc. that enable children and parents to access services above, includes child and family advocates providing transportation for services above other than visits they supervise.

Table 5V2: Service Area Usage of Family Reunification* Funds

Services	State Fiscal Year (SFY)					
	2018	2019	2020	2021	2022	2023 (7/1/22 – 3/31/23)
Access and Visitation Services	42%	43%	39%	28%	45%	27%
All Other Counseling*	6%	27%	34%	26%	10%	15%

Substance Abuse (SA) Services	25%	11%	6%	3%	3%	1%
Mental Health (MH) Services	------	7%	1%	28%	31%	43%
SA and MH Services Combined	26%	10%	------	------	------	------
Transportation	------	------	------	1%	------	1%
Domestic Violence Assistance	------	------	------	------	------	1%
Fatherhood Programs	1%	3%	4%	2%	9%	------
Motherhood Programs	------	------	16%	9%	1%	------
Daycare, Respite Care, and Therapeutic Camps	------	------	------	2%	1%	1%
Source: HHS; Percentages may not equal 100% due to rounding. *Includes child welfare mediation services						

Adoption Promotion and Supportive Services

Iowa's Recruitment, Retention, Training, and Supports (RRTS) contractors Lutheran Services in Iowa and Four Oaks continue to engage Iowa foster, adoptive, and kinship providers by providing direct service in their homes for licensing and support, having monthly contact at a minimum for all licensed foster and adoptive homes when a child is placed in the home. These contacts include face-to- face meetings in their homes, as well as additional face-to-face contacts at support group meetings and trainings. Support Caseworkers assist adoptive families in connecting with needed supports and services. The Support Caseworkers also maintains contact with providers and HHS workers as needed for updates or to problem solve a situation and assist the family through the adoption process. These supports remain in place until an adoption is finalized.

Iowa HHS strongly supports keeping children within their families and communities of origin. HHS will continue to encourage more relative and fictive kin caregivers to become licensed foster adoptive parents. Licensure brings increased financial assistance, concrete supports and training that unlicensed caregivers do not receive. These additional supports make it more likely children will remain in placements in which they have strong meaningful connections. In the event a child becomes available for adoption, children in these situations are more likely to be in stable placements making adoption more likely and timely. HHS does waive non-safety standards for relatives and fictive kin to promote licensing. HHS developed a process called Kinship Caregiver Payment which assists families with a $10 a day payment for up to 6 months to assist with the time frame of unlicensed placement until the family can become licensed/approved foster/adopt caregivers. HHS continues to work in collaboration with RRTS contractor as well as Family Centered/Kinship Navigator contractors, to continue the process connecting families to the licensing process. It is hoped this process will assist in more quality and timely adoptions in the State of Iowa.

Once an adoption is finalized, RRTS have post adoption supports, which are available to all adoptive families who adopted children and receive or are eligible to receive adoption subsidy. Support services are voluntary, and families can self-refer or have HHS 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, HHS, or other service providers; and
- Assisting families in securing community resources.

The HHS adoption program manager maintains consistent communication with the post adoption frontline workers, which has included and will continue to include in-person and virtual face-to-face meetings as well as phone and email communication to assist with providing families the best and most current information and resources available to them.
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.

In the coming year, the HHS adoption program manager plans to help implement a more robust and extensive adoption support services in order to better serve Iowa's adoptive families. This will be done through the start of a new RRTS contract with Four Oaks Family Connections. Families are eligible for services who receive future or special needs adoption subsidy as well as families who received a subsidized guardianship subsidy.
The highlighted new and improved services for post adoption and guardianship supports include:

- An outreach plan to provide awareness of available support and services to adoptive and subsidized guardianship families for community partners and families.
    - Families will receive information at the time of adoption/guardianship finalization and at continued intervals until child is no longer eligible for service.
    - Outreach will target Child Welfare system partner representatives, Public and Private Schools/Educational Facilities, Mental health facilities/clinics, Hospitals and medical clinics and Faith organizations.
- Centralized statewide referral and information system.
    - Centralized statewide referral and information specific to post adoption/guardianship system with electronic and phone access for referral, questions and problem solving will be developed.
    - The referral system will be accessible to the community and able to accept referrals 24 hours a day, 7 days a week.
- Intensive case management service, or crisis stabilization to families when needed.
    - Intensive Case management can be up to six (6) home visits lasting at least 45 minutes over a 6-week period, per year/per child and includes:
        - Service plan for support to specific to an individual family's needs
        - Information about post-adoption and subsidized guardianship services
        - Information about community services, including Medicaid, Waiver Services, food assistance, workforce opportunities, mental and behavioral health supports and other as needed by the family.
        - Stress management and problem solving
        - Parenting skill development including trauma informed parenting techniques when appropriate
        - Monitoring of safety in the home
        - Providing information on the role of the schools in providing appropriate education and resources including as determined by a child's IEP.
        - Staff providing service will complete the National Adoption Competency Mental Health Training Initiative (NTI)
- Monthly support group meetings for all public and private adoptive and subsidized guardianship families.
- Adoption specific training opportunities for all adoptive families in Iowa.

- Subsidized adoptive families will be provided 10 days of paid respite per calendar year.
- $100 stability grant for subsidized adoptive and subsidized guardianship families
    - Monies can be made available for items such as weighed blankets, sensory items, equine and canine therapy, or emergency items needed for crisis stabilization within the adoption or guardianship home.

Iowa's adoption savings monies earmarked for post adoption and guardianship services will be used to help pay for the increase in novel support services in the upcoming contract in FY2024. This will assist Iowa in meeting its adoption savings obligations.

The goal of post adoption and guardianship service is to support and prevent disruption and/or dissolution of adoption and subsidized guardianship. It is hoped the increase in services as well as the outreach to adoptive and guardianship families will help reduce the number of children re-entering Iowa's child welfare system seeking congregate care settings for children. Iowa would like to reach families before they reach a crisis level and give them the supportive services, they need to be successful in a home setting, therefore reducing the number of children needing congregate care levels of service.

Collaboration

The HHS adoption program manager held an "Adoption Summit" face-to-face with HHS adoption SWCM's and supervisors in October 2022. The Summit included an exchange of information with statewide adoption SWCM's and supervisors. This assisted with providing the most accurate and current information to the persons who are working directly with families in order to support them in the most meaningful way possible. The summit also included worker collaboration and relationship building. Workers were able to share ideas and practices for difficult case situations.

The HHS adoption program manager holds bi-monthly virtual phone calls with adoption supervisors statewide in order to communicate about any latest information as well as communicate about any problematic situations. These calls were particularly helpful during the COVID pandemic and will continue to be held virtually due to distance issues.

The HHS adoption program manager has also participated in the quarterly meeting of the Iowa Association of Adoption Agencies. These meetings allow HHS to collaborate with Iowa's private adoption agencies to discuss their needs and experiences with adoption.

The HHS adoption program manager has initiated statewide adoption worker training courses, referred to as "lunch and learns" for one hour time frames. These training are as follows:

- CC 615 Changes to Iowa Code Chapter 600
- CC 617 Completing Adoption Paperwork with a Family

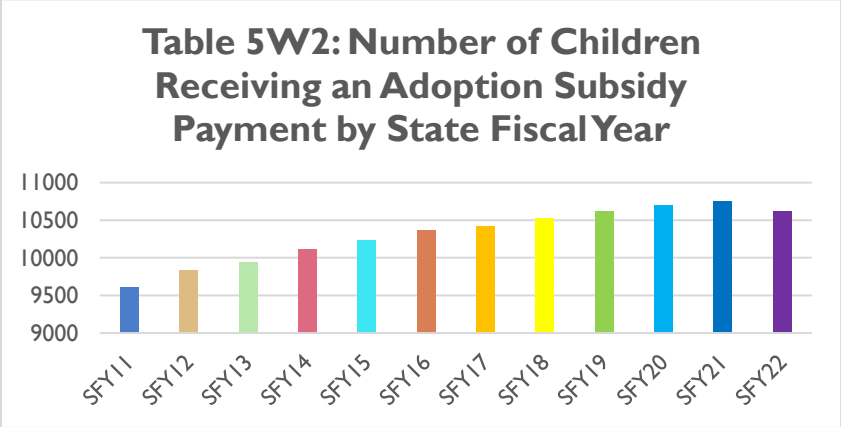
These trainings have been popular with Iowa adoption staff and will continue into the next fiscal year. Subjects for the trainings have been sought by the adoption program manager from adoption field staff and supervisors.

In March 2022 Iowa began requiring state adoption SWCM's and supervisors to participate in the National Adoption Competency Mental Health Training Initiative (NTI). Staff were asked to complete all the modules by December 31, 2022. Because of the length of the training the deadline was extended to

March 31, 2023. The NTI Child Welfare Professional curriculum is 20 hours and focuses on case work practices and professional skills for staff across the child welfare continuum to promote child well-being, permanency, and family stability for children in foster care and adoptive or guardianship families. Child Welfare Supervisors received an additional 5 hours of training and a Supervisor Coaching and Activity Guide to support staff transfer of learning in daily practice. The adoption program manager held monthly "check in's" with HHS statewide adoption SWCM and supervisory staff to discuss the training and talk about ways to implement NTI into daily work.

The HHS adoption program manager worked with HHS staff, Iowa's Attorney General office, community partners and stakeholders and assisted to develop a legal avenue for Tribal Customary Adoption (TCA) for Iowa's Native American Families. TCA would not require a termination of parental rights but would be a formal legal relationship, which could be financially supported by the adoption subsidy program when eligibility requirements are met. There is a process in place for some of Iowa's Native American tribes and nations who have the option as part of their constitutions and laws. As of April 2023, Iowa had finalized two Tribal Customary Adoptions with a third only waiting on the State's order of full faith and credit.

Adoption Subsidy Program: When a child adopted from the child welfare system has a special need, HHS provides on-going support and services through the adoption subsidy program. Approximately 86% of all children adopted through HHS have a special needs adoption subsidy agreement, and an additional 13% 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.



*Data Source FACS 5/4/23

Planning and Service Coordination

HHS utilizes the planning and service coordination category for the following programs:

- Caring Dads (Training)
- Community Partnership for Protecting Children (CPPC) (Site Development)
- Parent Café
- Safe and Together™ Model
- Parent Partners - Research, Evaluation & Database for Parent Partners

For more information about these programs, please see the following pages of this report:

- Caring Dads – pages 213 – 214
- CPPC – pages 123 – 142
- Parent Café – pages 133 – 135
- Safe and Together™ Model – pages 164 – 166
- Parent Partners - Research, Evaluation & Database for Parent Partners – pages 217 – 233

DIVISION X SUPPLEMENTAL FUNDING FROM THE SUPPORTING FOSTER YOUTH AND FAMILIES THROUGH THE PANDEMIC ACT.

In addition to the regular FY 2021 allotment, Division X of the Consolidated Appropriations Act, 2021 appropriated an additional $72,450,000 for states and territories in FY 2021 emergency supplemental PSSF funding.

Provide a final update about how the FY 2021 supplemental funding from Division X was used to strengthen the services provided by the state under the PSSF program. Describe any challenges or barriers the state faced in being able to use these funds. The supplemental funding, like regular appropriations, is subject to a requirement that a significant portion be spent on each PSSF service area: family preservation, family support, family reunification, and adoption promotion and support services (section 432(a)(4) of the Act). If the amount of supplemental funding used for each service category did not approximate 20 percent of the supplemental grant total, provide an explanation for the disproportion used in any of the service areas.

Over this last year, HHS finished the remainder of the Emergency PSSF funding. In total, HHS was able to allocate 45% of the grant into Family Reunification, 29% into Family Support, 12% into Family Preservation, and 4% into Adoption, with the remaining 10% into Administration. Iowa currently has a waiver in place that allows for the Family Preservation category to not reach the 20% minimum requirement. HHS was not able to reach the 20% minimum requirement for Adoption Support since Iowa's needs for the emergency funding feel under the Reunification and Family Support categories. While we maintained our correct percentages for the regular PSSF funding, the emergency funding was needed in these two categories the most.

HHS was able to utilize the remainder of the Emergency PSSF funding for the following:

- Community Partnership for Protecting Children (CPPC): Implement a pilot at a few CPPC sites for a revised process of training, implementation, and evaluation of Community Based family team decision-making (FTDM) meetings.
- Concrete Supports for at-risk families, families served by HHS, and tribal families:
    - Housing (if not eligible for existing housing assistance programs), until covered by the Temporary Assistance for Needy Families (TANF) American Rescue Plan (ARP) funding: rental/house payments, utilities and home repairs. Major construction is excluded from use of this funding.
    - Household items:
        - Furniture, e.g., cribs, including mattresses, beds, dressers, tables, chairs, high chairs;
        - Bedding, e.g., sheets, blankets, pillows and pillow cases;
        - Appliances, including replacements; and
        - Household safety kits, cabinet locks, and gates
    - Food, including formula (if not eligible for Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants, and Children's (WIC) program)

- Diapers, pull ups, and wipes
- Clothing, including shoes, boots, and coats
- Transportation: car seats/booster seats, car repairs, gas cards
- Technology:
  - Purposes: Access and participation in services, including telehealth (mental health, substance abuse, medicine checks, etc.) and 2) school, summer programs, and tutoring/mentoring to catch up in learning
  - Approved uses:
    - Equipment: prepaid cell phones, including emergency phones; iPad or iPad Mini; Microsoft Surface; Samsung Galaxy Tablet; Laptops
    - Headphones for using equipment
    - Cards for cell phone minutes, internet/data
    - Wi-Fi Hotspot
- Childcare (if not eligible for child care assistance), until covered by Child Care ARP funding
- Co-pays for youth children mental health services and/or funding fees for extracurricular activities for at-risk children
- Outstanding medical bills
- School supplies
- Youth mentoring programs
- Summer camps
- Personal protective equipment (PPE)
- School Based Mental Health services
- Specialized Substance Abuse Treatment

- 2022 HHS Adoption Summit: The summit was a space for the adoption program manager to meet face to face with adoption SWCM's and supervisors in October 2022. Through the summit, staff were able to exchange information, worker collaboration, and relationship building. Please see the Collaboration Section under Adoptions for more information.

HHS used the remainder of the funding for Kinship Navigator. Challenges and barriers to utilizing some funding were not noted from the different service areas or Meskwaki Family Services.

POPULATIONS AT GREATEST RISK OF MALTREATMENT (SECTION 432(A)(10) OF THE ACT)

In the 2020-2024 CFSP and subsequent APSRs, states were required to 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. In the 2024 APSR, provide an update noting any changes or emerging trends in the populations the state has identified as at greatest risk of maltreatment and how services will be targeted to these populations during the coming year.

This requirement represents a critical opportunity for states to convene community partners to determine how and where to target family support and child abuse prevention resources to ensure that services are easily accessible to underserved populations of children and families at risk. It is also an opportunity to determine how conditions of poverty contribute to the reporting of families to the child welfare agency and actions the agency can take to ensure that poverty is not equated with neglect.

There has been a recent update to Iowa Code [232.2 35(A)] regarding the definition of neglect. The new definition specifies that neglect means the failure on the part of a person responsible for the care of a child to provide for adequate food, shelter, clothing, medical or mental health treatment, supervision, or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. Inclusion of language that specifies families who are financially able to care for their child or offered financial or other reasonable means to be able to provide necessary care was added to the definition. While poverty is a risk factor, it does not equate to neglect. This definition change addresses the connection between a family's ability to access concrete resources, in conjunction with state prevention efforts, should decrease the number of families entering the child welfare system due to poverty.

Please see *Prevention, Iowa Child Abuse Prevention Program,* Resilient Communities Demonstration Projects, earlier in this section. There are no further updates about changes or emerging trends at this time.

KINSHIP NAVIGATOR PROGRAM (KINSHIP NAVIGATOR FUNDING (TITLE IV-B, SUBPART 2))

In the 2024 APSR provide an update on:

- *How the kinship navigator program is being implemented (directly or under contract to a third party).*
- *How the state has used FY 2022 funds to implement or evaluate its kinship navigator program.*
- *How kinship caregivers are made aware of kinship navigator programs and resources (e.g., through a kinship navigator hotline and/or resource website); and*
- *The accomplishments achieved with use of the funds appropriated in fiscal FYs 2018 – 2022 to develop, enhance, expand or evaluate kinship navigator programs in the state, including, if available, any estimate of families served in the previous year.*
- *Information on the state's plans for participating in the title IV-E kinship navigator program.*

Research has found there are many benefits to placing child(ren) with kin or other kinship caregivers, including increased stability and safety, as well as the ability to maintain family connections and cultural traditions. Kinship navigator program goals include creating a safe and supportive home environment for children outside of stranger foster care, including early identification of needs for additional services such as therapy, counseling, educational and/or mental health services and to close the gaps and/or delays with service delivery to kinship caregivers. HHS focuses on providing a responsive strength-based supportive role to kinship caregiver families.

Iowa HHS received federal funds to develop, enhance, or evaluate kinship navigator programs. HHS entered into a contract with Families First Counseling Services, LLC (Families First) effective October 15, 2018. The contract was renewed each year funding was available. The most recent renewal to continue development of the kinship navigator program went into effect October 1, 2021, through September 30, 2022. After September 30, 2022, funding was rolled into the Kinship Navigator program which is currently part of the Family Centered Services contract in the Cedar Rapids Service Area with Families First.

The funds allocated to this contract provide the necessary services and supports of kinship caregivers. Under this contract, the majority of the costs associated with this contract pay for the following positions:

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

In addition to payment of salaries of the supervisor and specialists, funds also purchase concrete goods, tangible items, and gift cards for the kinship caregivers. The 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

Included within the contract are any other costs associated with development of the necessary support network and provision of services to kinship caregivers referred by HHS.

The majority of services and supports provided to kinship caregivers during the reporting period of July 2022 through June 2023 included:

- Concrete supports, specifically around transportation and groceries in the form of gas/gift cards;
- Emotional Support;
- Info & Referral;
- Case Management;
- Local Resources; and
- Assessment of Needs

Additional services and supports provided include:

- Legal Services
- Parent Education
- Entitlement Applications
- Med/Dental/Mental Health
- Support Groups*

*Attendance to virtual support groups continues to be a struggle. Caregivers have been navigating change, managing increased responsibility with school, hesitant to engage with other caregivers, etc. All contractors continue to offer support groups on a regular basis. Support group attendance and participation has increased in recent months. Some contractors have coordinated with support groups for grandfamilies through Area Agencies on Aging, further increasing support and connections.

This past year, contractors have taken turns hosting quarterly meetings with all Kinship Navigator contractors. These meetings have covered progress, barriers to progress, contract issues, topics for support group meetings/training for caregivers, referral processes, and documentation. At the most recent meeting, contractors connected with Iowa's MCOs to learn about the services and supports available to children and kinship caregivers.

Payment is contingent on the contractor accepting referrals, providing services in accordance with the provisions of the contract, achieving contract performance targets, and submitting invoices for each month of the contract. Accompanying the invoices are documentation necessary to support the charges. The contractor receives payment in monthly installments of 1/12 of the total contract amount.

During the reporting period of July 2022 through March 2023, there were 83 new referrals to the kinship navigator program. During this same reporting period, 50 cases closed with the majority considered successful, meaning the kinship caregivers reported their needs were met and were able to maintain children safely in their homes or were able to support the child's return home.

Performance measures and targets are included as a part of the contract and used to 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 HHS 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.

HHS and Families First continues to work toward identifying the best method to gather data on the above performance measures as well as other desired outcomes. Minimal data is currently available due to system limitations. Additional data points will become available with the development of CCWIS. Data points regarding the Performance Measures are reported by Families First with validation on a small sample during the scheduled quarterly case file reviews.

HHS workers complete the kinship navigator program referral form and submit to the contractor on kinship caregivers who meet eligibility for these services. The kinship navigator program works in conjunction with HHS and assigned Family-Centered Services (FCS) contractors to engage kinship caregivers in services. If a referral to Kinship Navigator is not made at the time other FCS services are referred, the contractors contact the referring HHS worker and ask if a Kinship Navigator would be helpful to the caregiver. Kinship Navigator Services contractors then contact the caregiver and offer services.

Engagement is an essential part of services and includes immediate, consistent, and ongoing contact with kinship caregivers. This is evidenced by the contract requirement for the two-day, five-day, and ongoing contacts throughout service delivery. Services and supports are available to meet kinship caregiver needs and driven by the goals of the kinship family. Kinship specialists work in conjunction with the kinship placement to identify additional supportive kin for themselves and the children in their care.

In order to connect kinship caregivers with information and referral systems, including eligibility and information for federal, state, and local benefits, kinship specialists complete a screening tool as a

measure to assess and identify needs for additional resources and referrals to meet the kinship family's needs adequately. Kinship specialists utilize information compiled through risk assessments, Eco Maps, and kinship caregiver input to create a Kinship Care Plan to guide service provision. Kinship caregivers receive an offering of continued support addressing concrete goods and other needs throughout the life of the case. Kinship caregivers are provided kinship caregiver resource folders at time of the initial in-person contact with the assigned kinship specialist that occurs within five business days from referral.

Kinship specialists review contents of these resource folders with all kinship caregivers and answer any questions. They provide support for any of the immediate needs identified by the kinship caregiver during initial phone contact. In addition, the kinship specialists establish a list of identified needs for concrete goods. The kinship caregivers determine if they would like the kinship specialist to assist them in completing the entitlement applications, if they prefer to complete themselves, or if they elect not to complete at all.

Collaboration:

During the reporting period of July 2022 through June 2023, continued collaboration occurred with the HHS program manager and Families First through meetings and regular electronic and phone correspondence. Families First also continues to provide leadership and technical support to the other FCS contractors as Kinship Navigator Services continue to build statewide.

Families First is well connected with local service organizations through participation and attendance at local partnership meetings. Kinship specialists established partnerships with Families Helping Families and refers kinship caregiver families to assist with meeting clothing needs, participation in their shoe voucher program, and access to Spread Your Wings. The Spread Your Wings activity scholarship can assist kinship families working with HHS through financial support for extracurricular activities.

Families First continues to partner with Four Oaks/Fostering Connections contractor through quarterly meetings, open lines of communication, ongoing interactions with workers and supervisors, and a streamlined referral process. The timeliness and accuracy of completing foster care licensing applications increased with great success in getting missing items or additional information provided to move forward with the licensing process for interested kinship caregivers. In FFY23, KNS contractors across the state have been meeting at least every other month with Four Oaks Family Connections or Lutheran Services in Iowa RRTS staff to discuss kinship cases that are in the foster care licensing process. HHS representatives also attend these meetings which further facilitates communication about kinship caregivers' movement through the licensing process.

Kinship Navigator IV-E Participation

Iowa HHS contracted with SSG to review Kinship Navigator programs on the IV-E Clearinghouse and determine which model best fits Iowa's needs. Iowa intends to work with our Family Centered Services contractors toward implementation of the selected model during FY 2024.

MONTHLY CASEWORKER VISIT FORMULA GRANTS AND STANDARDS FOR CASEWORKER VISITS

In the 2020-2024 CFSP and subsequent APSRs states described the standards for the content and frequency of caseworker visits for children who are in foster care and described how the state plans to use the Monthly Caseworker Visit Grant over the next five years to improve the quality of caseworker visits.

HHS 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. The responsibility and frequency of the visits is negotiated between the states through the Interstate Compact on the Placement of Children (ICPC).

In light of the public health challenges related to COVID, the Children's Bureau modified its guidance regarding section 422(b)(17) of the Social Security Act to permit the use of videoconferencing to meet the monthly caseworker visit requirement. Subsequently, Iowa authorized the use of videoconferencing to meet the monthly caseworker visit requirement starting March 20, 2020. HHS developed guidelines for ensuring child well-being and safety when conducting a caseworker visit via videoconferencing. In-person caseworker visits resumed June 1, 2020, with guidelines for mitigation practices and a containment decision-making process. We have continued to follow this guidance, which is now discontinued since the federal public health emergency ended on May 11, 2023.

How the Monthly Caseworker Visit Grant is used to improve the quality of caseworker visits

HHS utilized grant funds for the following:

- Annual maintenance payment for the Dragon Naturally Speaking™ software, staff training costs, staff travel costs.
- Annual licensing fee for CareMatch, tracking system software from Five Points Technology Group, Inc. The CareMatch system:
    - Tracks beds in group care, shelter and supervised apartment living, and
    - Tracks and matches licensed foster parents and children in foster care. The license agreement contract includes system enhancements, data conversion, training, and an annual licensing fee. The tracking system assists caseworkers in determining the closest and most appropriate placement for the child. Research suggests that children placed closer to home receive more quality caseworker visits, which in turn affects caseworker's' assessment of safety, efforts to achieve timely reunification or other permanency goals, and efforts to achieve child and family well-being.
    - CareMatch upgrades to help better support contracts.

In SFY 2022, caseworkers were sent through Intercultural Development Inventory (IDI) debriefing training. However, Iowa is no longer using IDI because of workforce capacity issues. Iowa has used RPI/URIB trainings to address equity. However, due to some of the materials in the training, we are not

able to mandate this training. In SFY 2023 and 2024, Iowa will continue to use the MCV grant funds for CareMatch and supporting staff travel costs and Dragon Naturally Speaking™ software.

Over the course of SFY 2023 and 2024, Iowa utilized the Monthly Caseworker Visit (MCV) grant to reimburse HHS mentors who are a part of the statewide Mentoring program. Mentors received a one-time bonus for their mentor activities. HHS utilizes field mentoring to reinforce learning with practice in real life situations. HHS 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, and providing an assessment tool for discussions on learning. The mentor's role is to model best practice in the field, coaching that includes providing constructive feedback, implementation of knowledge gained in training, assisting in acclimation to the culture of the office and community, and scheduling shadowing opportunities to co-staff. The mentoring relationship lasts for 6 months. The criteria for mentor selection are at least two years as a SWCM, preferably in the location where they are mentoring. The mentor must meet or exceed expectations in all areas of their performance evaluation. They must demonstrate proficiency in Model of Practice and policy. The mentor must have good attendance and receive Supervisor approval.

Iowa researched additional opportunities and strategies to utilize the MCV Grant by obtaining and reviewing what the states in Region 7 have reported as well as exploring guides through CapLEARN. HHS did not identify any additional opportunities to implement through this research. However, HHS field staff are currently working with the HHS program manager to discuss their ideas for utilization of the MCV grant for the next fiscal year.

Table 5X2: FFY 2022 – Monthly Caseworker Visit Grant Reporting

Reporting Requirement	Data	Type of Data
The aggregate number of children served in foster care for at least one full calendar month	6,213	SACWIS
The total number of monthly caseworker visits for children who were in foster care	39,874	SACWIS
The total number of complete calendar months children spent in foster care	44,522	SACWIS
The total number of monthly caseworker visits with children in foster care in which at least one child visit occurred in the child's residence	32,872	SACWIS
The percentage of monthly visits by caseworkers with children in foster care under the responsibility and care of the state.	90%	SACWIS
The percentage of monthly visits that occurred in the residence of the child.	82%	SACWIS

Source: HHS

Continued action steps to ensure that statutory performance standards are met. If the state has missed previous performance standards, describe the reasons the state's performance has fallen short and the steps the agency will take to ensure compliance.
While Iowa did not meet the 95% frequency requirement for caseworker visits with children in foster care, there had been significant improvement over the last several years toward the MCV 95% goal from 86% in FFY 2019 to 90% in FFY 2020 to 93% in FFY 2021. Iowa was at 90% this past FFY.

Some of the barriers have been caseloads are much higher and there is increased staff turnover. Many times, the visits are completed, however the entries are made late or left incomplete. There is limited time to document visits given the caseload and turnover issues. Field staff have reported that it feels as though there has been an overall increase in the amount of illness in both families and workers, lending to cancelled meetings and delays in rescheduling.

Service Areas continue to work with staff on time management, asking staff to schedule all visits toward the first part of the month so there is room to reschedule in the same month if needed. HHS is also undergoing a Child Protective Assessment and one of the assessment areas is Workforce and Workload. HHS' new Child Protection Services Director as well as the Division Director in the Division of Family Well-Being & Protection are both focused on worker recruitment and retention. They are trying to identify areas where they can support workforce in order to better serve children and families of Iowa.

As applicable, information on policies, procedures, or training to support quality virtual caseworker visits to ensure children and youth's privacy and safety when in-person visits are not able to be safely conducted.
HHS initially issued the following guidance to support quality virtual caseworker visits in March of 2020: It is imperative that caseworkers continue to ensure the well-being and safety of children in care. To meet this expectation, the following guidelines have been developed. The caseworker must closely assess the child's safety on each videoconference. This includes:

- Ensuring time to talk with the child alone, if developmentally appropriate;
- Observing the child's appearance; and
- Specifically asking the child if they feel safe.

Interviews must discuss safety, food, physical and mental health, and household rules. Additional topics to be covered will vary depending on age, development, and circumstances of the case. Suggested questions for child contacts include:

- What are some of the activities or things you are doing?
- Have you experienced changes in your routine and how are coping with those?
- Have you been to the doctor/psychiatrist/therapist since I last talked to you?
- How are your family visits going?
- How are you currently feeling?
- Is anyone in your home sick?
- Who lives in your home and what do you think of them?
- What happens when you get in trouble?
- Are there any rules related to food, snacks or water in your home?
- What do you like and not like about where you are living?

- Who can you go to when you need help?
- Do you feel safe in this home?

If a concern about child safety or well-being comes up during a videoconference, the caseworker should start safety planning with the child and have a nearby supervising adult join the videoconference to assist with addressing the concern and ensuring safety. If the safety concern is regarding the child's care, protocol for child abuse reporting and assessment should be followed. The caseworker should also follow up with their supervisor.

Not being able to reach a child via videoconferencing is not a reason to waive the monthly contact.
If the difficulty is related to technical issues, the caseworker should try to reach the child by telephone to problem solve the issue. If the inability to reach the child by videoconference is not related to technology issues, the caseworker should continue to make consistent and deliberate attempts to contact the child. If these attempts are unsuccessful, the caseworker will need to complete an in-person visit to ensure child safety and well-being. Previous guidance regarding mitigating health practices should be followed.

ADDITIONAL SERVICES INFORMATION

Adoption and Legal Guardianship Incentive Payments (section 437A of the Act)

In the 2024 APSR, describe:

- *How Adoption and Legal Guardianship Incentive Payment funds received by the state have been used in the past year and the services the state expects to provide to children and families using the Adoption and Legal Guardianship Incentive funds in FY 2024.*
- *Any changes, issues, or challenges the state has encountered to the plan outlined in the 2020-2024 CFSP and subsequent APSRs for timely expenditure of the funds within the 36-month expenditure period.*

Iowa has budgeted to spend 1.2 million in Adoption and Legal Guardianship Incentives Payments by 6/30/2023. The funds will be utilized in Family Centered Services expenditures. Iowa is utilizing the FFY20 in SFY23, then FFY21 will be spent in SFY24.

Adoption Savings (section 473(a)(8) of the Act)

In the 2024 APSR:

- *Provide an update to the services the state provided to children and families using Adoption Savings since the submission of the 2023 APSR.*
- *Provide an update to the services the state expects to provide to children and families using Adoption Savings over the next year.*
- *Provide an estimated timetable for spending unused savings calculated for previous years.*
- *Discuss any challenges in accessing and spending the funds.*
- *All title IV-E agencies previously notified CB of the methodology they are using to calculate Adoption Savings. If the state wishes to make changes in its Adoption Savings methodology, complete and submit the Adoption Savings Methodology form at ACYF-CB-PI-19-02 Attachment E and return it with the 2024 APSR.*

Adoption subsidy is a financial support provided to families who adopt special needs children. The funds assist families with the cost of raising a child and costs associated with the needs of the child.

Reinvestment is the required use of state savings resulting from federal legislation that expanded eligibility for federal matching funds for children receiving an adoption subsidy. This additional federal funding reduced state expenditures. States are required to reinvest savings in specific qualified expenditures. Below is how Iowa has spent funds in the last year.

HHS continues to fund the Treatment Outcome Package (TOP), created by Outcome Referrals, which is used to:

- assess a child's current treatment needs within 12 domains;
- track a child's improvement or deterioration;
- identify data trends around stronger/better performing providers and foster parents; and
- identify other data points that would impact practice decisions made by HHS' and Juvenile Court Services' staff.

TOP provides another avenue to empower individuals involved in a child's care, including parents and the children themselves, to have a voice in the assessment and placement process through entering information into the same system. 13% of Iowa Adoption Savings Expenditures are TOP related. HHS also has designated Adoption Reinvestment funds to help support our Subsidized Guardianship program. 5% of expenditures are related to Iowa's Subsidized Guardianship program.

Iowa continues to increase the numbers of children in the Subsidized Guardianship program. Below is the number of children by Iowa's service areas in the program since its inception in 2019. The numbers represent the total number of all open subsidized guardianship cases for the fiscal year in each of Iowa's five service areas, which are cumulative over the time period represented. The "currently open" number represents a point-in-time number of open subsidized guardianship case. Thus far in SFY23, 11 cases have closed.

Table 5Y2: Number of Children in the Subsidized Guardianship Program

SFY	Service Area					
	Western	Northern	Eastern	Cedar Rapids	Des Moines	Total
	Count	Count	Count	Count	Count	Count
2023	35	19	14	25	46	139
2022	28	14	8	21	27	98
2021	20	4	4	18	10	56
2020	7	3	3	5	6	24
2021	0	1	0	0	1	2
Currently Open	31	18	13	22	44	128

*Data Source FACS 4/25/23

HHS is also using available adoption savings money to increase the purchasing of Family Centered Services which include Safe Care 13%, Solution Based Casework 28%, and Family Preservation 9%. Therefore 50% of Iowa Adoption Savings expenditures are related to family centered services. As stated previously, Iowa's adoption savings monies earmarked for post adoption and guardianship services will be used to help pay for the increase in novel support services in the upcoming RRTS contract in FY2024. This will assist Iowa in meeting its adoption savings obligations specially related to post adoption supports.

Family First programs represent 85% of Iowa's SFY22 Reinvestment funding.

FAMILY FIRST PREVENTION SERVICES ACT TRANSITION GRANTS

In the 2024 APSR, each state must report the following information on its use of FFPSA Transition Grants:

- *If applicable, how FFPSA Transition Grant funds have been used to implement each part of FFPSA, with a separate statement with respect to each such part;*
- *All programs, services, and operational costs for which the grant has been used;*
- *The characteristics of the families and children served;*
- *For states that previously operated a title IV-E waiver demonstration under the authority of section 1130 of the Act, the amounts, if any, the agency has used to continue activities previously funded under a waiver, and*
    - *the agency's plan to transition the activities so that needed activities can be provided under the agency's title IV-E plan; or,*
    - *if expenditures for the activities would not be eligible for payment under title IV-E the reason for it not being eligible and the funding sources the agency plans to use to cover the costs of needed activities.*

If the state has not yet used any funds, please provide information on the planned use of funds.

HHS

Thus far, HHS used the Family First Transition Act (FFTA) funding for the purposes of IV-B, subpart I, to assist our Family Centered Services (FCS) contractors with developing capacity to provide the new FCS service packages. These implementation costs included training and certification in Solution Based Casework (SBC) and SafeCare and IT costs associated with implementation. HHS also uses the funding for SBC licensing fees. SafeCare is HHS' only Title IV-E Prevention Service implementing FFPSA, Part I. Table 5Z2 below provides a breakdown of how the FFTA funding was utilized.

Table 5Z2

	Salaries & Wages	IT Technical Consultants	Educ & Training Supplies	Admin. Support	Other Licenses, Permits & Fees	Research	Training
IT COSTS	$47,836.75	$283,193.90					
Transition Funding		$333,517.35					
FCS Costs			$495,458.00	$141,702.48			$24,000.00
Licensing Fees - SBC					$95,812.19		
FFTA allowable costs						$47,500.00	$214,060.00
$1,513,595.43	$47,836.75	$616,711.25	$495,458.00	$141,702.48	$95,812.19	$47,500.00	$238,060.00

Characteristics of families and children served under FFPSA are families eligible for SBC and SafeCare that have a confirmed child abuse assessment and their risk assessment indicated moderate or high risk for re-abuse, or a founded child abuse assessment. The children either remain in the parental home and

are candidates for foster care or the children have been removed and their case plan goal is reunification.

SBC certification is a long process. Previously, only a couple of FCS workers applied for certification. All FCS contractors have workers trained in SBC; however, HHS does not have exact numbers at this time. Similarly, for SafeCare, all FCS contractors have trained SafeCare workers and all six contractors have certified coaches and certified trainers. It takes about six months for a SafeCare worker to receive certification in SafeCare, and then move toward coaching, etc. FCS contractors continue to work on staff development toward certification in SBC. Contractors are working with SBC developers to ensure a consistent supervisory process that leads to certification of additional staff. All contractors have certified SafeCare staff currently.

For more information about *FCS*, please see *Family Centered Services (FCS)* earlier in this section.

HHS contracts with Georgia State University (GSU) Research Foundation to evaluate our SafeCare implementation. The contract has been in place for two years now. HS utilized FFTA funding for the SafeCare evaluation, continued support of SBC and SafeCare certification, coaching, and training, and FCS associated IT costs.

Juvenile Court Services (JCS)

The Family First Prevention Services Act (FFPSA) was enacted on February 9, 2018, as part of P.L. 115-123. The law supports the use of evidence-based practices to promote the well-being of children, youth and families and to prevent unnecessary foster care placements. For children who do need to enter foster care, the law encourages use of family-based care, and places limits on the availability of title IV-E foster care funding for congregate care placements, unless they meet specific requirements. To support implementation of FFPSA and further its goals, Congress passed the Family First Transition Act (henceforth, "Transition Act") as part of P.L. 116-94, signed into law on December 20, 2019.

Juvenile Court Service began FFPSA implementation activities following the submission of Iowa's Five Year FFPSA plan in July 2020. Based on information provided to JCS by the Iowa Department of Health and Human Services, JCS was eligible to receive $425,000 of the $5.1M of Transition Grant funds awarded to Iowa. Because JCS had not previously participated in any Title IV-E activities or funding initiatives, these implementation activities focused primarily on establishing an infrastructure to deliver FFPSA across the state as well as training of staff. JCS does not currently participate in Title IV-E claiming for training activities. All training costs were calculated based upon a formula including the time spent by employees involved in training preparation or the training event times, as well as the individual branch or contracted employee's salary. Since JCS currently utilizes their portion of the FFPSA grant for staff salaries related to the implementation and activities of the Family First Prevention Services Act, funds were not used for direct services for children and families served.

In addition to the training costs incurred by JCS for Title IV-E implementation, there was also an expense associated with the implementation of a Continuous Quality Improvement (CQI) process, including the hiring of a CQI manager. Prior to its participation in FFPSA, JCS did not have a CQI process. To ensure JCS was able to meet Title IV-E requirements and begin a systematic effort at system improvement, JCS employed a CQI manager on June 1, 2021.

JOHN H. CHAFEE FOSTER CARE PROGRAM FOR SUCCESSFUL TRANSITION TO ADULTHOOD (THE CHAFEE PROGRAM) (SECTION 477 OF THE ACT)

In the 2024 APSR:

- *Provide an update on the state's activities to collaborate with and solicit feedback from diverse groups of youth and young adults about their service needs and desired outcomes for the Chafee programs (both on the individual and system level). Include information learned from Youth Advisory Boards, town halls, virtual forums, and other state activities. Provide an overview of how the information collected was used to inform service delivery and how the agency has provided feedback to participating youth/young adults on the impact of their input.*
- *Briefly describe the services provided since the submission of the 2023 APSR, highlighting any changes or additions in services or program design for FY 2023 and how the services assisted or will assist in achieving program goals (45 CFR1357.16(a)(4)). Indicate how these activities have been integrated into the state's continuum of services and align with the state's vision.*
- *Provide an update on the state's actions and plans to strengthen the collection of high-quality data through NYTD and integrate these efforts into the state's quality assurance system. CB has released annual "snapshots" using NYTD data by state and a national profile here. To the extent not addressed in "Collaboration" in Section C1 or "Quality Assurance" in Section C4, provide an update to the state's process for sharing the results of NYTD data collection with families and youth; Tribes; the legal and judicial community; Independent Living coordinators; service providers and the public. Describe how the state, in consultation with youth/ young adults and other partners, is using the state's quality assurance system, NYTD data and any other available data to improve service delivery and refine program goals. Describe efforts to improve the awareness of NYTD and cross-system collaborations to improve reporting of NYTD data.*
- *Provide an update on how the state involves the public and private sectors in helping youth in foster care achieve independence (section 477(b)(2)(D) of the Act). Provide examples of cross-system collaborations and the use of culturally specific service providers. Provide information on assessments that indicate where gaps exist in engagement of the public and private sector, including potential partner organizations identified by youth/young adults.*
- *Provide information on the services to support LGBTQI+ youth/young adults. Include information on appropriate activities and activities specific to the needs of individual youth in care. Include information on partnerships with community organizations or resources to support resources to LGBTQI+ youth and young adults.*
- *Provide an update on coordinating services with "other federal and state programs for youth (especially transitional living programs funded under Part B of Title III of the Juvenile Justice and Delinquency Prevention Act of 1974), abstinence education programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies" in accordance with section 477(b)(3)(F) of the Act.*
    - *Provide information on the actions taken to address the housing needs of young adults in transition from foster care. Outline the federal, state, local, and public/private resources utilized to support a range of safe, affordable, and age-appropriate housing options for young people.*
- *Provide an update on how the state is supporting and reaching out to youth and young adults in or formerly in foster care to promote wellness and proactively address mental health needs.*

Program Description

The Iowa Department of Health and Human Services (HHS) is intent on making significant and impactful changes occurring for Iowa's child welfare system and foster care, in particular. The FFY 2020-2024 Child and Family Services Plan forecasted and described many of these changes.

HHS is the state agency that administers, supervises, or oversees the Chafee program.

The purpose of the foster care transition 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 successfully to adulthood. The transition planning program offers a life skills assessment, youth-centered transition plan development process, and transition-related services, supports, activities and referrals to programs. Youth who age out of care (at age 17.5 or older) may receive supportive services post exit, as do those who exit to subsidized guardianship or adoption at age 16 or older.

The population served in federal fiscal year 2023, includes the following:

(1) Is currently in foster care and is 14 years of age or older.
(2) Is under the age of 23 and was adopted from foster care at 16 years of age or older.
(3) Is under the age of 23 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.
(4) Was formerly in foster care and eligible for and participating in Iowa's aftercare services program as described at 441 Iowa Administrative Code (IAC) § 187.
(5) Was formerly in foster care and eligible for and participating in Iowa's postsecondary education and training voucher (ETV) program as described at 42 U.S.C. § 677(a) (6-7).

The estimated number of youth served in SFY 2022 was 2,975, a slight decrease from 2,993 in SFY 2021.

Table 5A3: SFY 2021 & 2022 Foster Care/Aftercare Breakdown and Total

	Youth aged 14 and older in foster care (FACS payment data)	Youth participating in Iowa Aftercare Services (monthly billing claims)	Total
SFY 2022	2,237	738	2,975
SFY 2021	2,260	733	2,993

HHS is realistic and aware many of the youth who age out of foster care do so without the family support that oftentimes acts as a safety net for their transitioning peers not in foster care. Furthermore, the mental and social health needs of our transitioning youth can be a barrier. These are among the reasons HHS has a host of supports and services in place for anyone who ages out of foster care, up to the age 23 for case management services and college funding and Medicaid to the age of 26. The work includes supporting the young person to address childhood trauma and to become healthy and engaged in their community.

In order to avoid the inclination of caring adults to keep a child in care just to get the services and financial support, we also provide transition supports to youth who enter Subsidized Guardianship or adoption from foster care at age 16 or older. The host of services are federally funded; state funding has increased over the years building upon the federal funds to the point where the state funding has surpassed and doubled federal funding.

A full time Independent Living (IL) Coordinator, within the new Division of Family Well-Being and Protection, oversees Iowa's Statewide Foster Care Transition Program. This state funded position has been stable, and the IL Coordinator does not expect to see any changes in the coming year. The IL Coordinator is responsible for the following:

- Ensuring projects, policies, and practices serve transitioning youth efficiently and effectively, resulting in positive outcomes for youth formerly in foster care.
- Coordination duties for the Chafee funded Transition Planning Specialists (TPSs) as well as the regional Point of Contact (POC) for education and child welfare partnerships to implement Fostering Connections and Every Student Succeeds Act foster care stability provisions, monitored as follows:
    - Regional supervisors
    - Regional administrator oversight
    - "Lead" administrators
    - Central office activity monitoring
    - Performance tracking and monitoring
- Managing contracts for the following programs:
    - Iowa Aftercare Services Program, which utilizes combined state and federal funding to serve transitioning youth through a network of child welfare agencies.
    - Iowa Foster Care Youth Council, for children in foster care.
    - Foster Care Transportation for Education Stability Contract with the Iowa Department of Education (DE).
    - The Iowa Finance Authority Rent Subsidy Program.
- Advocating for children in foster care and alumni on committees and groups:
    - Juvenile Justice Advisory Council
    - Special Education Advisory Council
    - Juvenile Justice Re-entry Grant Project
    - Activating Youth Engagement
    - Opt-In Post Secondary Workgroup
    - Iowa Collaboration for Youth Development
    - Leadership Exchange for Adolescent Health Promotion advisory committee (LEAHP)

Transition Planning Specialist (TPS) are social workers who do not carry a caseload. Their primary goal is to help case managers engage youth and provide transition planning for young people in foster care as they transition to adulthood. HHS maintains one full time employee for each of the five service areas, who are responsible for understanding the programs, policies, and processes for foster care transition. TPS are the go-to people for HHS social work case managers and juvenile court officers who work to ensure youth under their responsibility have all 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 HHS staff, as well as youth and public and private partners. TPS will continue in their current roles in coming years.

The TPS utilize the child welfare information system (specifically FACS) to check eligibility for education and training voucher (ETV), Iowa Aftercare, and other services relying upon foster care experience for eligibility. TPS complete application forms, as needed, or direct the case manager of a child in foster care on how to do so.

The ETV Coordinator, employed through an HHS contract with Iowa College Aid, oversees college and career funding for foster care alumni. The coordinator provides a report of FAFSA and ETV applicant status every two weeks for TPS. TPS provide suggestions to case managers to meet required dates and to keep youth informed of the application process.

The NYTD Coordinator, employed through an HHS contract with the Iowa Department of Human Rights, collects outcomes data and helps Iowa maintain compliance with federal reporting. Moreover, the coordinator, having lived experience in foster care herself, has committed to engage youth in the discussion about data and services for children in foster care. Her effort goes above and beyond the reporting requirements, which is a welcome and encouraged advancement in the work around NYTD and child welfare data.

Iowa has an electronic tracking system for transition planning activities to ensure youth aged 14 and older in foster care as well as young adult foster care alumni get the support they need, and that HHS remains in compliance with all requirements for case planning of transition aged youth. TPS are responsible to record such things as, for example, completion of the Casey Life Skills Assessment; the date of the Local Transition Committee's approval of the youth's transition plan; and the date the case manager meets with the youth 90 days prior to the youth's 18th birthday. TPS send email reminders to case managers when any required item is due. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14. The intention of these emails is to ensure all youth have a viable plan whether the youth are leaving at age 18 or whenever they leave foster care.

TPS engage providers in their local areas though face-to-face and video training. TPS provide case consultation daily, via phone and email for providers or HHS. TPS attend youth centered planning meetings, as requested, to share information on all procedures, polices, and programs regarding transition planning and required activities. It is important for TPS to be involved in cases where permanency is uncertain, because they know all the "ins and outs" of eligibility for key transition programs (ETV, All Iowa, Aftercare, and PAL).

Based FACS data, the number of seventeen-year-old youth in foster care dropped from 1,177 to 625 and entries dropped 676 to 465 from SFY19 to SFY22. Family First implementation in 2020 has brought a welcome reduction in foster care. When a youth is able to return home or otherwise exit to a forever family, it is a good thing. Well-meaning teams around the child have, over the years, tried to keep a child in care so they can get transition benefits like aftercare or ETV. A decision to keep a child in foster care just to ensure eligibility for services can delay permanency for a child desperately needing their family. That being said, a decision to exit foster care before age 18 can affect eligibility for programs, so it is more important than ever to engage every youth in a meaningful conversation about services and supports available as they transition out of foster care.

Since HF2252 was passed in 2022, TPS and the Independent Living Coordinator have been actively meeting with HHS staff, youth and providers to raise awareness to the options newly available to youth transitioning from foster care to adulthood. Essentially, HHS and JCS can permit youth to sign an agreement to remain in SAL or FFC to the youth's aged 21, as long as they are pursuing work or school. This is a state funded program at this point.

As the bill was passed and the program rolled out, it may have been misleading that extended foster care was an option for all youth. It became apparent with case-by-case reviews, foster care is not always appropriate, able to meet the needs of the individual, or the most appealing option to a youth in transition. It has been helpful, then as we implement, to meet with Activating Youth Engagement (AYE) youth monthly to discuss guidance, forms and manual needed to properly and fully implement foster care to 21. AYE and AMP youth have created a "decision guide" that helps a caseworker and a youth breakdown some of the services and supports that are available and get closer to a decision about what is the best option available to the youth. HHS appreciates shared decision making with AYE and AMP youth on this particular project, as well as input we have received from Talking Wall and other engagement work described in this report.

Case managers ensure youth complete the Casey Life Skills Assessment (CLSA) at age 14 and older. After the assessment is complete, the case manager works with the youth and their team to develop the Transition Plan section of the Case permanency Plan, which lays out goals and action steps for the youth and those who will assist and may occur around the first youth centered planning meeting. The case manager, the youth, and their team update the Transition Plans every six months or more often as needed.

A necessary prerequisite to the development of the Transition Plan section of the Case Permanency Plan (also known as Part C) is a convening of the youth centered team. The team is intentionally created by the case manager, with input from the youth, so the youth has a group of people who can provide support and help youth reach their dreams. The team is comprised of persons selected by the youth, service providers, and others. Some youth centered planning meetings are formal through our Family Centered Services Program and others are less formal, conducted by a case manager or other HHS identified person, depending on the family and the needs of the child. The case manager and the youth may engage team members to review and update the plan at a minimum of every 6 months. TPS are available to assist in specific transition planning for youth who is expected to have a challenging transition, such as a youth who will need adult disability services, youth who experienced a number of placement disruptions, youth who have substance abuse issues, etc.). The case manager documents the transition team, dates, and membership in the Transition Plan section of the Case Permanency Plan (also known as Part C).

Chafee funded and other transition related programs require culturally and linguistically appropriate service standards. Program managers are intentional about engaging a diversity of individuals in workgroups and stakeholder discussions. We also use data collected from Iowa State University to demonstrate the program is reaching individuals without bias based on race, for example. Work with Iowa State University is described later in this report.

Culturally and linguistically appropriate services are to improve the quality of services provided to all individuals, which will ultimately help reduce disparities and achieve equity of results/outcomes. This is about respect; respect of the individual and for the programs working with youth in transition, the self-respect that comes with knowing the program is truly accessible to those who are eligible. The provision of services that are respectful of and responsive to the beliefs, practices and needs of all can help close the outcomes gap between white and people of color. In Chafee transition programs, the outcomes we want to see are around education, employment, health, housing and relationships. You will see more data in the NYTD section of this report on outcomes broken out by race; this was an

intentional effort to get programs to work to provide effective services for everyone and close the outcome gaps.

We also work to close the gap between individuals with disabilities and those who do not have a disability. Over 50% of the youth transitioning to adulthood (based on Iowa Aftercare data on Serious Emotional Disturbances) have diagnosed mental health challenges. Throughout this report, we have identified systemic challenges that remain a barrier for youth with mental health issues getting the services and supports they need. We are trying to overcome this by inviting Medicaid managers and SSI experts to case reviews. Case managers who do not have a good plan in place, with appropriate referrals for adult mental health services are redirected to do this important work. Identifying needs prior to the youth leaving care and getting the appropriate referrals in place increases our chances of connecting youth with the appropriate, quality service that meets their needs. We have a long way to go - lack of housing and services through Medicaid providers using their Habilitation Services (commonly called HAB Homes), waiting lists for waiver services, and lack of property managers willing to help our youth are among the formidable challenges.

The Casey Life Skills Assessment (CLSA) is the required assessment for teens in foster care. The assessment was recently added to the Iowa Aftercare Services Contract, so all youth in aftercare will be assessed for life skills prior to setting goals and action steps in the Self-Sufficiency Plan. One of the reasons for selecting the CLSA is because it is touted by the developers as culturally sensitive and appropriate for every individual regardless their living arrangement.

HHS ensures that the Chafee program serves all political subdivisions in the state by having a TPS in each HHS Service Area, designated coverage in the Iowa Aftercare program by county and local youth councils in every HHS service area. The result is that we glean information from the data specific to each area and can provide a familiar level, quality, and quantity of services across the state while maintaining flexibility in response to poor outcomes or other needed changes.

HHS will cooperate in any national evaluations of the effects of the programs in achieving the purposes of Chafee.

Out-of-home, group care placements, and long-term detention settings for youth involved in Iowa's juvenile justice system does not yield positive outcomes at and after the time of reentry, according to a report created for the Juvenile Justice Re-entry Project by Criminal Juvenile Justice Planning Division (CJJP) of the Iowa Department of Human Rights. The report relied upon data from the Talking Wall, highlighted later on in this report. The CJJP report described youth's lack of connection to work, school, supportive services, and positive relationships as well as juvenile recidivism rates. Youth who were adjudicated delinquent and released from studied group care facilities had high one- and two-year recidivism rates. There was an average 59.1% one-year recidivism rate. Recidivism rate increased from 52.6% in 2015 to 63.3% in 2019. Recidivism rates for Youth of Color exceeded those of White youth in both one- and two-year recidivism. The data is from Iowa justice data warehouse.

In order to find solutions to problems like those described above, Iowa HHS and Chafee funded partners regularly collaborate with Iowa Vocational Rehabilitation (VR) and Iowa Workforce Development. Through a grant from Vocational Rehabilitation, the Iowa Judicial Branch has been able to secure staff with a transition focused role, called Navigators, to help youth transition from the state

training school to their home community. The Navigators (hired in the first quarter of calendar year 2022) assist youth in developing and achieving vocational goals and coordinating services and supports with other stakeholders relevant to each youth's success. Early evidence from the Navigators shows the persistent and individualized approach embedded in the model yields positive outcomes in connecting youth with necessary and meaningful support.

For youth in foster care and transitioning to adulthood, Iowa Workforce is generally used for walk-in help with resumes, computer use, and resumes. Vocational Rehabilitation services are referred when the youth has a diagnosed mental health issue or disability.

The core Iowa Workforce services appealing to aftercare youth are as follows:

- Career services cover a broad range of activities, including skill assessments, staff assisted resume preparation and job development, the development of an individual employment plan, career counseling and career planning, financial literacy, adult basic education, pre-vocational activities, and work experience.
- Training services include occupational skills training, on-the-job training, incumbent worker training, and entrepreneurial training.
- Support services may be provided, when necessary, to enable individual participation in career or training services. Supportive services include dependent care assistance, transportation reimbursement, and required clothing and tools for work.

As good as the Vocational Rehabilitation services can be and in demand, there seems to be a bottleneck to getting these services since there have been recent changes to the application process. It used to be that a youth could self-refer or be directly referred to Vocational Rehabilitation. Now the referrals go to a community group that prioritizes services to the highest need youth, so it seems. The delays create doubt and anxiety.

Chafee Transition Quality Assurance

Specialized Staff

Transition Planning Specialists (TPS) are regional transition experts. One TPS in each HHS service area is responsible to track and record completion of all transition case plan requirements in Iowa Code Section 232.2(4)f and Title IV-E transition plan requirements. These include the date when youth over the age of 14 completed the Casey Life Skills Assessment, documents obtained and provided to the youth, 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. The intent of these emails is to ensure all youth have a viable plan, whether the youth is exiting at age 18 or whenever they leave foster care. It all starts with a checklist of transition responsibilities for a child reaching age 14 or entering care after the age of 14.

Data Tracking and Accountability

A tracking system is an invaluable monitoring tool. HHS maintains an electronic tracking system for transition planning activities to ensure youth get the support they need, and that HHS remains in compliance with all requirements for case planning of transition aged youth. Iowa Code § 232.2(4)(g)

lays out the requirements. HHS uses Iowa's FFY 2020-2024 Child and Family Services Plan (CFSP) to 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.

Service Monitoring

Foster Care Transition Program monitoring includes contract management to ensure proper use of Chafee funding, such as is described here privately contracted and government programs:

- Aftercare is monitored as follows:
    - Contract driven Service (YSS)
    - Quarterly staff meetings and leadership panel meetings
    - Annual reports review
    - Annual audits conducted
    - Monthly claims approved
    - Satisfaction surveys
    - 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, is monitored through an intergovernmental contract as follows:
    - Quarterly reports reviewed by HHS
    - Annual reviews by HHS
    - Performance outcomes (retention)
    - Monthly claims approved by HHS
    - Referring worker feedback (informal)
- Iowa Foster Care Youth Council, for children in foster care, monitored as follows:
    - Contracted service (YSS)
    - Annual reports reviewed
    - Annual audits conducted
    - Satisfaction surveys
    - Monthly claims approved
    - Referring worker feedback (informal)
- Foster Care Transportation for Education Stability Contract with the Iowa Department of Education (DE), monitored as follows:
    - Intergovernmental contract (Department of Education)
    - Quarterly team meetings
    - MOU annual reviews
    - Monthly claims approved-IVE funding provided for eligible transportation
- The Iowa Finance Authority to administer the Iowa Aftercare Rent Subsidy program is monitored through an intergovernmental contract as follows:
    - Periodic reviews by HHS
    - Monthly claims approved by HHS
    - Aftercare feedback (informal)

Local Transition Committee Reviews

Iowa Code 235.7 requires HHS to establish and maintain local transition committees to address the transition needs of those children receiving child welfare services age sixteen or older and have a case

permanency plan as defined in Iowa Code Section 232.2. HHS has rules establishing criteria for transition committee membership, operating policies, and basic functions.

Each Service Area has Local Transition Committees that review every transition plan by the time the youth reach age 17.5. TPS and a team of HHS staff and partners (Aftercare, MCO, VR, etc.) are able to check status of items including, but not limited to vital documents, youth participation, education status and referrals, employment skills and services, health care coverage, housing plan and a backup plan, relationships, and need/referrals for adult services.

In SFY 2022, 381 transition plans were reviewed and approved. Each HHS service area submits a report to central office with total reviews completed, description of the committees including membership, barriers to transition, and possible solutions. A statewide summary is below.

While we don't have data for every service area, it appears about 90% of plans are approved in the first round. When a plan is not initially approved, there is a recommendation for workers to address certain deficits in the plan and is required to return for a final review.

This year the Maximus provider, who handles SSI applications for HHS, has been attending some local transition committee meetings. Her knowledge of the SSI process has been incredibly helpful. Also, she is keen to recognize when there is a child who may have a disability and their needs can be better addressed through Medicaid services and family supports, including but not limited to financial SSI. We want to see if we can include Maximus in more transition meetings in the future.

Challenges identified by Local Transition Committees:

- Assessments and referrals for such things as SSI, IQ testing, Integrated Health Homes (IHH), Habilitative Funding, and waiver programs need to be done much earlier (prior to age 17, when the Transition Committee Reviews the case).
- The HAB Homes accept only clients with relatively few challenges. Many of the HHS population needing HAB homes have a host of difficulties which include aggression and sexualized behaviors. There are also barriers with age limits. Youth cannot be placed in HAB homes prior to age 18 without a variance which makes planning for them problematic as there may not be an opening for the youth right at age 18. Although it is legally permissible for a youth who is eligible for HAB to be in extended foster care, HHS is practicing with the presumption that a youth who can be served in the adult disability system should be served there since they are better equipped to meet their need. HHS plans to watch and see how guidance plays out in practice. The new law does not require a referral for adult services to be made when indicated.
- The amount of funds available to a youth in Aftercare is not enough to secure housing that is safe and affordable.
- Housing or residence obstacles are not just an issue for teens leaving care, but also for teens still in placement. Lack of resource parents willing to accept teens is a problem.
- The Intellectual Disability (ID) Waiver waiting list continues to be approximately two years.
- Case managers sometimes fail to fully understand a youth's mental health diagnoses. Mental health needs should be front and center when working with youth.
- Youth residing in QRTP and shelter aren't consistently offered the opportunity to obtain and maintain employment while residing in placement.

- Iowa Vocational Rehabilitation Services is a valuable service available to our youth, yet very few workers seem to be aware of the service or what they have to offer.
- Youth in foster care placement or QRTP frequently do not have the opportunity to learn to drive. When they have not been able to take Driver's Education, car insurance rates are significantly higher when they do obtain a Driver's License.

Solutions:

- Transition Planning Specialist should continue to provide training to the 99 Iowa counties, including to HHS, JCS, service providers, and the agencies that serve youth in out-of-home placements. Training should be about the transition planning process, resources, and importance of engaging youth in their transition.
- Youth are not always connected to or aware of the academic support that could assist them, such as IEP's and 504's. Case Managers could benefit from more open communication between the education system and the child welfare system, to make sure students are getting their educational needs met and are on track with their credits and graduation requirements.
- Connect youth with Pediatric Integrated Health Homes and MCO Case Managers to get them engaged earlier, so they can assist with transitioning the youth to Adult Services, and make sure there is not a gap in mental/physical health services.
- Consider allowing the case managers more control regarding the SAL program in determining who needs to participate in cluster site verses scattered site or offer more cluster sites throughout the service areas.
- Continue to actively involve the youth in their transition planning and let them drive the decisions and plans for their future. There needs to be frequent youth-centered meetings, to engage youth to work on their goals and develop a plan.
- It is important for HHS, TPS and providers to continue to educate our housing authorities on what FYI-HUD is, how it can assist our young adults with housing stability, and to encourage them to work with HHS to apply for the program.
- Social Workers and JCO's will continue to be reminded to make Maximus referrals early on and to complete the placement payee change form as soon as youth age out.
- SAL providers are encouraged to work on establishing relationships with local landlords who are willing to work with youth in the program before or after they turn 18.
- All youth in out of home placement should be encouraged and supported to participate in AMP to have extra support, learn about life skills and resources available to them, and how to become better advocates.

Support for LGBTQI+s:

There are tailored services in Iowa to meet the needs of youth identifying as LGBTQI+, but none provided directly by HHS. It would be appropriate for a case manager at HHS or our Aftercare advocates to educate youth about programs like these below:

United Action for Youth GLBTQA Youth Group

The GLBTQA Youth Group at United Action for Youth is a casual group for youth ages 12-18 to hang out and to connect to their peers in a setting that affirms their sexual orientation and gender identity.

Transformations Iowa

A support group for transgender and non-binary people with meetings in Des Moines, Urbandale, and Cedar Rapids.

Recent or Impending Changes

The Support of Patients and Communities Act (Support Act) is a federal legislation that mandates that states provide Medicaid to former foster youth ages 18-26, who received Medicaid at the same time they aged out of foster care, regardless of the state they lived in at the time they aged out. Medicaid Director, Liz Matney, approved/signed Iowa Medicaid's strategic plan for implementing the policy in accordance with the Act. As of the writing of this report it has been to the Department of Management for approval and then will be submitted to CMS for review.

The plan updates the Expanded Medicaid for Independent Young Adults (EMIYA) eligibility requirements due to a modification in the Social Security Act. The criteria for youth who aged out of foster care prior to December 31, 2022, has not changed. For youth who aged out of foster care on or after January 1, 2023, they will be eligible for foster care youth Medicaid coverage group if they meet requirements specified in the SPA.

Iowa Aftercare and AMP is effective in supporting and reaching out to youth and young adults in or formerly in foster care to promote wellness and proactively address mental health needs. AMP, in particular, is a supportive environment to be "who I am" and have a right to "mental health care". HHS, AMP, and Aftercare use the Transition Information Packet (TIP) book which provides and creates an opportunity for discussions around mental health, mental health services, and the real-world decisions individuals have to make. For example, one of the several pages on mental health in the TIP book talks about the pros and cons of sharing mental health information at work. Aftercare staff working directly with youth to do all they can to carry on the conversations about living and succeeding with a disability. Among the necessary supports Aftercare checks for is Expanded Medicaid.

This EMIYA update was submitted to local office staff in December 2022 and shared with Aftercare and AMP, among others.:

> *Beginning January 1, 2023, it is mandatory that EMIYA coverage be provided for all former foster care youth regardless of what state they aged out of foster care. This new policy will only apply to youth who turn 18 on or after January 1, 2023. Prior to January 1, 2023, we only provide coverage for those that aged out in Iowa. Another part of this change includes EMIYA coverage as it relates to eligibility for other coverage groups. Prior to January 1, 2023, an individual is only eligible for EMIYA if they are not eligible for another coverage group. Effective January 1, 2023, all former foster care youth who turn 18 on or after January 1, 2023, will be eligible under EMIYA regardless of their eligibility under another coverage group. The process of referring former foster care youth to IV-E Unit to determine EMIYA coverage remains the same.*

The Iowa General Assembly passed HF2252 last year, which created the option to extend licensed family foster care or Supervised Apartment Living (SAL) for a youth to age 21. The bill was drafted by the Iowa Department of Health and Human Services (HHS) to improve outcomes for youth aging out of foster care. It was well supported by youth and was voted in unanimously by the Iowa General Assembly.

New/revised manual, guidance documents, and forms provide information to HHS staff, service providers, youth and others on the requirements, procedures, and opportunities available with extended

foster care. The AMP youth council created a practice document that caseworkers and provider staff may use to help talk through the potential options with youth who are electing to remain in foster care or exit to other services.

Eligible Youth: The potentially eligible youth must meet all of the following:

- Upon reaching age 18, the youth was in court ordered foster care or in an institution listed in section 218.1.
- After reaching eighteen years of age, the person has either:
    - Remained continuously and voluntarily in family foster care or in a supervised apartment living arrangement, in this state, or
    - Voluntarily applied to return to SAL or licensed family foster care.
- Is at imminent risk of becoming homeless or failing to graduate from high school or to obtain a general education development diploma.
- Has demonstrated a willingness to participate in case planning and to complete the responsibilities prescribed in the person's case permanency plan.
- HHS/JCS has made an application for the person for adult services, if it is likely the youth will need or be eligible for services or other support from the adult services system.

Appropriate Program: The service must be appropriate based on all of the following criteria:

- The services are in the child's best interest.
- Funding is available for the services.
- An appropriate alternative service is unavailable.
- The youth, HHS/JCS, and the provider are in agreement the placement is appropriate.
- Is approved by the Service Area Manager or designee.

Activating Youth Engagement (AYE) is a youth-involved/HHS policy group which started meeting in 2021. It is co-led by youth with lived experience and HHS policy staff. Youth were invited to quarterly policy discussions and were promised a seat at the table for policy and practice changes; the first thing they wanted to do was increase clothing allowance. With coaching from HHS and AMP staff, youth got input from other states, estimated clothing costs, developed a budget, and made recommendations in a formal letter. After careful planning and dedicated work, Iowa Administrative Code Chapter 156 has changed (effective July 1) to increase clothing allowance. On July 1, 2023, the clothing allowance for teens will increase from $237.50 a year to $750 a year.

In FY22, forty organizations participated in the Talking Wall, to collect feedback from youth (1,828 post it notes). The Talking Wall was showcased in the second annual Family and Youth Engagement Summit, which was even better attended than in 2021. The third annual Family and Youth Engagement Summit: Moving from Conversation to Action, will be held in September 2023. The state's NYTD Coordinator, IL Coordinator, and Director of Juvenile Justice Services are among leaders currently planning the next summit. That leadership has organized a summit around youth and family engagement should be seen as a statement of our commitment to youth and family voice.

In 2021, the Iowa Department of Human Rights onboarded five NYTD Ambassadors into a NYTD Advisory Council, to partner on the collection, analysis and reporting of NYTD data in Iowa. Ambassadors are youth with lived experience in foster care or juvenile justice, who aspire to improve

the system and/or pursue careers in child welfare or juvenile justice. Iowa benefits from having their perspective and expertise. In 2022, it was decided to better integrate Ambassadors by hiring them as part-time state employees.

Division X Additional Funding from the Supporting Foster Youth and Families Through the Pandemic Act.

- *Provide the final update on how the agency used the additional funding provided by Division X.*
- *Describe accomplishments in using this supplemental funding to assist young people, including available quantitative information on the numbers of youth/ young adults assisted, the amount of funding provided for direct assistance to young people, and available information on the characteristics and demographics of youth assisted.*
- *Describe any challenges or barriers the state has experienced in being able to use the additional Chafee funds.*
- *Describe any lessons learned that may inform future provision of services under the Chafee program.*

Pandemic Response

HHS released the Division X Pandemic Relief for Iowa Foster Youth and Alumni effort May 10, 2021, and it concluded September 30, 2022. Major components included:

- Moratorium on Aging Out and Re-entry into Foster Care: In Iowa, youth in care typically exit the system at age 18. HHS suspended the age restriction through September 30, 2021. Approximately 15 young people were permitted to remain or re-enter care during this time. The fact that some youth chose to remain in care, suggested Iowa needed to expand our foster care to 21 options. We did so in an HHS filed bill, HF2252, previously mentioned.
- Direct Payment to Foster Care Alumni: For young adults ages 18 through 26 who had aged out of foster care were directed to apply for a direct pandemic relief payment of $750 through June 2022 (youth aged 23-26 were not eligible after September 30, 2021). HHS then issued a Summer Pandemic Recovery Payment to qualifying youth who have aged out of foster care, ages 18 through 22. Young adults began applying for the $900 payments on the Fourth of July (July 4), 2022 through Labor Day (September 5), 2022.The Iowa Aftercare Services Network administered the application process and made payments to eligible youth on behalf of HHS. Funds were provided through September 30, 2022, with no eligible youth denied support.

  Phase 1, Initial Payments
  Dates: May 10, 2021 – June 30, 2022 (ages 18 – 26 until Sept 30, 2021; 18 – 23 beginning Oct 1, 2021)
  Amount: $750
  Applications: 1,994 (total received, not including duplicates)
  # Eligible: 1,599 (80%)
  $ Approved: $1,199,250
  Phase 1, Round 2 Payments
  Dates: September – October 2021
  Amount: $500
  # Eligible: 1,130 (approximate; efts and confirmed address)
  $ Approved: $ 565,000
  Phase 2, Summer of 2022 Payments
  Dates: July 4, 2022 – September 5, 2022
  Amount: $900

Applications: 526 (total received through 8/7/2022)
Eligible: 440 (through 8/9/2022)
$ Approved: $ 396,000 (distribution just getting started)
TOTAL AMOUNT APPROVED: $2,160,250
Note: These numbers are approximate and do not account for returned/uncashed checks, etc.

- Extra Support for Teens in Foster Care: HHS provided additional funds to support social, extracurricular, and cultural activities. Fo$ter Fund$ grants (up to $600 per child during the pandemic response) were available to youth ages 14 and older who were in a foster care placement, including family foster care, group care, and supervised apartment living. Up to $300 per year was also available to relative caregivers through a similar program called Kinship Funds.
- Thanks to Children's Bureau and the Capacity Building Center, which provided assistance through experienced program staff from Florida and Washington, Iowa created a "Removing Road Blocks" transportation assistance project, which funded up to $4000 per youth related to a transportation need.
- HHS created forms and fliers and a process by which Transition Planning Specialists received and approved applications. HHS then contracted with a third-party vendor, Central Iowa Juvenile Detention Center, to pay youth and caregivers reimbursement for any transportation costs that meet criteria. As of mid-September 2022, HHS was able to pay $457,605.40, serving a least 190 youth.
- Examples of ways HHS was able to use Division X funds to help youth included payment for public transportation, private driving instruction to complete drive time requirement to obtain a driver's license, Department of Transportation (DOT) fees and registration, driver's ed fees (if they aren't able to be waived), car insurance, car maintenance and repairs, and down payment or matching funds towards the purchase of a vehicle.
- Increased Education and Training Voucher Program (ETV) Funding: ETV contractor Iowa College Aid and HHS offered a maximum $12,000 for the 2021-2022 school year. Part-time students received a pro-rated amount based on enrollment. With the additional money provided through the Consolidated Appropriations Act ETV was able to provide assistance to approximately 145 students in the amount of $661,000. The average additional award per student was $4,562. ETV did also have students who received funding the summer prior in the 220-2021 school year. There were about 32 who received approximately $25,000 total. We have not collected demographic information. There is no process to ask gender, race, ethnicity.
- Rent Subsidy: As mentioned earlier, the Iowa Aftercare Rent Subsidy program, administered by Iowa Finance Authority, provided up to the full cost of rent to eligible youth ages 18 through 22 during the pandemic. Total funding was $233,370.24 and most certainly helped youth avoid homelessness. The funding per youth reverted the max $450 in October 2022.

Other pandemic response activities

While services to youth were never halted due to the pandemic, formal notifications and modifications to contracts were necessary in 2020 through 2022 due to the pandemic. Typically, this meant the providers needed to ensure they were healthy, and their clients were healthy before meeting face-to-face. Public documents are available for review on the HHS website. In June 2022, HHS notified providers, including Aftercare and AMP, that on July 1, 2022, contractors should be returning to pre-pandemic service delivery. The HHS pandemic updates were taken off the website. Since providers were meeting in-person in most circumstances, the guidance was received without much pushback. Aftercare,

in particular, recognizes that in-person work is preferred by youth, for the most part, and believed to be the best way. The lead contractor supported the decision and reinforced it with subcontractors. Among the guidance and contract changes summarized below, these are the ones, which most affect older youth in foster care and alumni.

AMP's annual conference occurred virtually during the pandemic. Many youth, HHS staff, partners, and contractors attended and have been intentional to try to learn from this experience. For example, some have said a shorter, virtual presentation is preferable to a whole day conference (where many have to drive there and stay in a hotel). More information will follow in the AMP section of this report.
In the pre-pandemic times, TPS would visit HHS county offices throughout their Service Area on a periodic basis, some monthly and some less frequently, but always as needed to support the area. The Independent Living Coordinator and TPS have entered a new era where training is done in hybrid fashion; depending on the need, some trainings are in-person, some are virtual, and many are both. We believe virtual options allow for greater efficiency, allow us to reach more people, and reduce the unequal burden of driving to training that those in rural areas have faced in the past.

Aftercare, in cooperation with HHS and Youth Policy Institute of Iowa, continues to support implementation of the Fostering Higher Education (FHE) pilot by Foundation 2 in Cedar Rapids. FHE is a research-informed program model to help older youth in foster care finish high school, make plans for continuing their education in college or career training, and bridge the transition from high school to postsecondary education.

With the assistance of the HHS Cedar Rapids Service Area, Foundation 2 has enrolled nineteen young people in the pilot intervention, which will run for another year. This pilot is designed to be a two-year program. The program was extended for a 3rd year for those enrolled later in the first year of implementation. Thirteen youth from the Des Moines Service Area have agreed to participate as a comparison group for the study. The research is being led by Dr. Amy Salazar and her team at Washington State University. Iowa Aftercare will apply lessons learned from the pilot and research to improve education support for all aftercare participants.

Foster Care Transition-Contracted Programs and Services

About 25% of the annual Chafee appropriation goes to our dedicated TPS staff and the rest goes to contracted direct services for youth. This section describes core contracted services. HHS is proud to have private child welfare agencies joining in this important work.

Achieving Maximum Potential (AMP)

Achieving Maximum Potential (AMP) is a youth engagement program for current and former foster and adoptive youth. Summarized by the motto "Nothing About Us, Without Us", AMP serves as Iowa's Foster Care Youth Council through a contract between YSS (AMP's lead agency) and the HHS. The primary purpose of AMP is to empower young people to become advocates for themselves and for system-level improvements to child welfare policies and practices in Iowa. When supported through productive partnerships with adults, youth can play a pivotal role in making the child welfare system more responsive to youth and families and more effective in achieving desired outcomes.
State Fiscal Year SFY2023 represents the last year of a possible six-year contract between HHS and YSS. HHS put out a public request for proposals in the fall of 2022. An impartial evaluation committee selected YSS to continue the contract. HHS is currently in contract negotiations with YSS and fully

expects a new contract to start July 1, 2023. YSS is very excited about the opportunity, and in fact, is bringing a strong showing for "AMP 2.0" with two new leaders who each possess high educational attainment and lived experience in foster care, among their many credits.

Much of the AMP information in this report comes from the annual AMP report, required by contract. AMP offers leadership opportunities, service-learning projects, speaking opportunities, and educational or vocational assistance to youth ages 13-21 who have experienced foster care, adoption, or other out-of-home placements. AMP also offers opportunities to learn life skills and access to a variety of resources as young people transition from foster care to adulthood.

The agencies involved in the Partnership and the location of the Councils they support are:

- YSS (Ames, Des Moines, Eldora (STS))
    - Des Moines Mobile Council Sites:
        - Ellipsis North
        - Ellipsis South
        - Orchard Place Residential Treatment Center
        - Orchard Place PACE Juvenile Center
        - Polk County Juvenile Detention
            - Wings 400, 500, 600
        - Woodward Academy
        - Woodward Community Based Services (Girls Group Home)
- American Home Finding Association (Ottumwa)
- Children's Square USA (Council Bluffs and Sioux City)
- Foundation 2 (Cedar Rapids)
- Hillcrest Family Services (Dubuque)
- Youth Shelter Care of North Central Iowa (Fort Dodge)
- Young House Family Services (Burlington/Mt. Pleasant)

The Partnership has arrangements with three consulting organizations to supplement and support AMP's activities:

- Common Good Iowa (formerly named the Child and Family Policy Center): Legislative advocacy.
- National Youth in Transition Database: Talking Wall which gathers ideas for the AMP Legislative Agenda

In Fall 2022, AMP experienced significant staff changes. After more than two decades of leading AMP efforts across Iowa, Ruth Eley and Terri Bailey transitioned out of their roles as AMP Program Manager and AMP Program Assistant to pursue new vocational paths and retirement respectively. We continue to carry their legacy as we move AMP forward.

Samanthya Marlatt, MPA was hired in September 2022 as the AMP Program Manager. In addition to lived experience in Iowa's foster care system, she brings extensive knowledge and expertise in program management and authentic youth engagement. Laticia Aossey, MSW was hired in July 2022 as the AMP Council Coordinator and is also the AMP Council Facilitator of the Cedar Rapids Council. In addition to lived experience in Iowa's foster care system, she brings extensive experience in child welfare and social work gained through a variety of roles. Armi Damken-Navarro was hired in March 2023 as the Des

Moines AMP Facilitator following Atalie Ferring's transition from the role. Armi has lived experience in Iowa's foster care and juvenile justice systems. She also serves on the Iowa Department of Human Rights Youth Justice Council.

The Mount Pleasant AMP Council also experienced staffing changes as Danny Slussman transitioned into the role of the Mount Pleasant AMP Council Facilitator following Emmy Rodriguez's transition from the role.

Despite quite the year of transition, AMP Staff have used it as a time to refresh and prepare to lead AMP in innovative and exciting ways as we enter a new contract cycle.

At the height of the pandemic, AMP pivoted from holding mostly community-based meetings to primarily holding meetings in residential and treatment facilities. Due to such a significant change in placement types served, AMP began to evaluate AMP data to ensure and a gain greater understanding of who and where AMP was serving. High-level, preliminary findings are listed below.

- 169 AMP Council Meetings and AMP events have been held across the state (YTD).
- 1,745 youth attended AMP Council Meetings and AMP Events statewide (YTD).
    - 669 Unduplicated Youth
    - 365 Youth indicated it was their first AMP meeting (21%)

Regular meetings could be held in a standard location (often a congregate care facility), in a mobile location in the community, or virtually because of the pandemic. In SFY 2022, 60% of the meetings were held at the primary, standard location for the local Council, while 24% were "mobile" meetings where the Facilitator held a meeting hosted somewhere else in the community, and 16% of the meetings were held virtually.

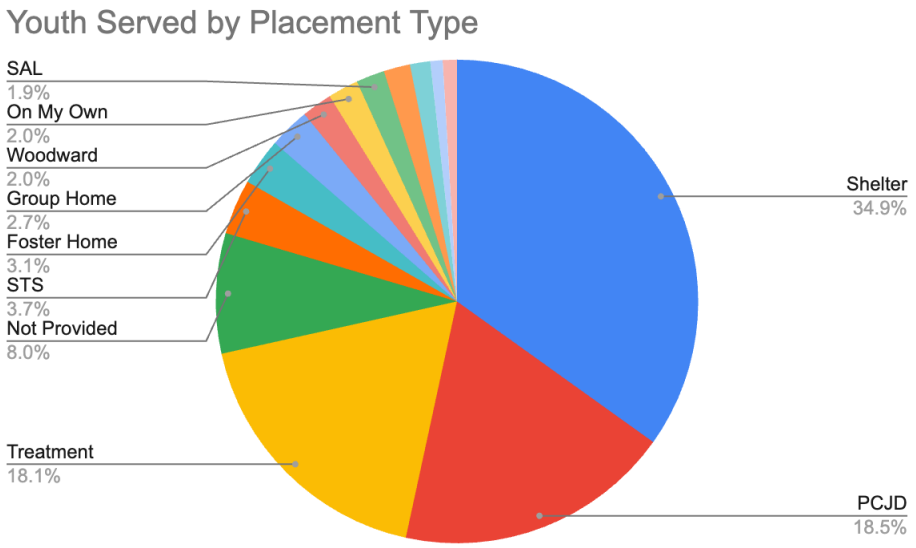
Youth attendance reported in meeting summaries ranged from 1 youth to 24 youth. This size group is conducive to youth development programming, allowing each youth to be engaged in discussion and activities. Often, one or two community members, presenters, or volunteers (in addition to the facilitator) were also present for the meetings.

AMP Facilitators often lead multiple activities during each Council meeting. Meetings included a wide range of guest speakers, including representatives from HHS, Iowa Aftercare, community organizations, law enforcement, health care providers, among others. Several Council meetings involved the "Talking Wall" activity to gather input from foster youth. The Talking Wall activities in which AMP participated generated thousands of comments and reflections from youth across the state about Iowa's child welfare and juvenile justice issues.

Facilitators also categorize the primary topic they address at each Council meeting from a list of options. Categories selected included: AMP Day on the Hill Preparation, Talking Wall, Dream Seed applications, AMP 101, life skills and educational presentations, holiday activities and parties, resilience training, back to school bash, summer games and team building, and AMP minicamp in Bloomfield, IA are just a sample of activities. During the Covid-19 pandemic, AMP facilitators also provided AMP youth with gift baskets full of activities, art supplies, and AMP swag to support connections to youth and reassure them AMP was thinking about them.

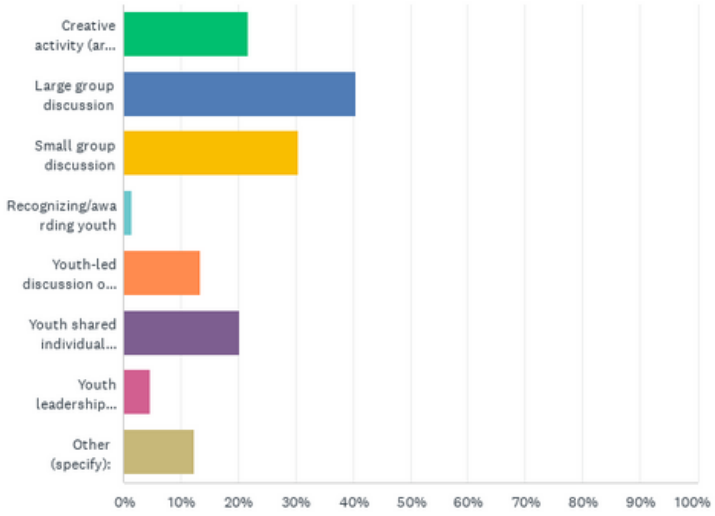
Table 5B3: Youth Served by Placement Type

Shelter	256
PCJD	136
Treatment	133
Not Provided	59
STS	27
Foster Home	23
Group Home	20
Woodward	15
On My Own	15
SAL	14
Adoptive Home	13
Aged Out	10
Aftercare/PAL	6
Bio Home	7



Among the expectations in the AMP contract is that they utilize positive youth development practices. This means youth should have social activities, leadership opportunities and skills building exercises, among other developmental and character-building activities. Below is the breakdown from SFY2022:

Q9 Which Positive Youth Development practices were incorporated during the meeting? Select all that apply.



Lessons Learned as We Move into a New Grant Cycle and New Approaches

- Current data indicates an evaluation of AMP recruitment strategies needs to be conducted to better engage youth in foster and adoptive placements in community settings.
- Current data indicates that current program elements need to be evaluated to ensure we are including youth residing in all placement types and providing equitable opportunities to connect with peers, communities, and programming that supports strengthening of life skills.

Accomplishments in 2022

AMP has received grant funds from the Selfless Love Foundation to support leadership training opportunities for AMP Participants.

Laticia Aossey participated in the FosterClub SPARC Curriculum Facilitator Certification Training and will facilitate leadership training for AMP youth in 2023.

Twenty Youth are positioned to complete Dale Carnegie Leadership Training as the initial requirement of being a Central Council Member. Central Council previously existed in AMP and will be revitalized in the new fiscal year.

AMP has recently been selected as a state-level partner for the Journey to Success Campaign; policy advocacy campaign that seeks to improve opportunities and outcomes for all youth and young adults who experience foster care by promoting their healing, family connections, and economic security. The partnership with the Journey to Success campaign provided 25k in funding that will be used for the AMP Annual Conference in May 2023 and for future advocacy events and activities.

Healing Centered Engagement practices will be implemented throughout AMP. All AMP Staff and Facilitators will attend a Healing Center Engagement training in April 2023. YSS AMP Staff will also be certified in Healing Centered Engagement in the new FY. Healing Centered Engagement (HCE) is a holistic approach. to trauma that involves "culture, spirituality, civic action, and. collective healing."

AMP Legislative Agenda/Day on the Hill

AMP partnered with Iowa's NYTD Coordinator, Kayla Powell, to utilize a "Talking Wall" to solicit input from youth around the state for AMP's legislative recommendations. Kayla Powell facilitated either in-person or virtually the Talking Wall activity with most AMP Councils in the winter of 2022. Input was compiled and used to inform the legislative and advocacy efforts. For the Day on the Hill, AMP prepared the 2023 AMP Legislative Agenda and distributed to legislators via email with an invite to the day's event. Issues prioritized this year included all of the following:

- **Prioritizing Normalcy for Kinship and Group Placements** by reducing programmatic and financial barriers for youth in out-of-home placements.
- **Easing Access to Education** by clarifying enrollment responsibility, easing the transfer across school districts and codifying a grace period for enrollment documents to reduce waiting.
- **Raise the Age** (In partnership with the Iowa Juvenile Justice Council) - establish 12 years old as the age of culpability for children in delinquency proceedings as there is currently no established minimum age and to extend the age of juvenile court jurisdiction from 18 to 21 to provide developmentally appropriate supports and services.

The event was well attended. Students from the Eldora State Training School were also able to join. Iowa Governor Kim Reynolds and AMP Youth and Staff shared remarks before an audience of advocates and interested citizens in the Capitol Rotunda. Youth and other AMP leaders were effective in highlighting the AMP legislative agenda items, and moreover, uplifting the importance of youth voice in advocacy.

Annual Conference

On May 24th 2023, during National Foster Care Month, AMP hosted the Annual AMP Conference. This year's theme was Journey to Success. Nineteen youth from across the state (five councils) joined together at DMACC Community College Southridge to engage with more than 20 service providers and advocates. The goal was to help youth explore their postsecondary opportunities. The Community Connections included:

- Iowa WORKS
- Representatives under the Workforce Innovation and Opportunity Act (WIOA)
- Several state and private colleges and universities
- Aftercare and the Iowa Aftercare Services Network (IASN)
- Opportunity Passport, AmeriCorps
- HHS Transition Planning Specialists
- Other entities that provide specific supports to the population served through AMP

Youth were invited to participate in a feedback session with Iowa ACEs 360 to help build and design a tool to be used by HHS to promote more positive relationships between youth and social workers.

The afternoon session of the conference was called, "Cake and Conversations." HHS staff and leadership, policymakers, and AMP staff and youth interacted with newly released state-level data from

the Fostering Success Youth in Transition report from the Annie E Casey Foundation through a data walk. After the convening, Doug Wolfe, IL Coordinator, offered a debrief with the Transition Planning Specialists, who provided this feedback to help improve the conference next year. The feedback was provided to AMP:

- Strengths: Lots of staff support, good venue, positive energy, good speakers, good food. The youth who were there were engaged and left interested in further exploring career and educational goals. Mentor connections were made or strengthened. Overall, a really great event.
- Challenges: AMP did great. The providers should have sent more kids. It's sad so many don't get the benefit of this. For comparison, the Futurefest event in Cedar Rapids last year drew 60 youth – that is largely due to Foundation 2's involvement.

Iowa Aftercare Services Program

Iowa Administrative Code 441.187 establishes eligibility criteria for Aftercare services, which allows youth to participate if they aged out of foster care (at least age 17.5), regardless of the licensure or payment status of the placement. Participants can start the program at age 17 and may continue until they reach age 23. Youth who aged out of Iowa's detention centers or the State Training School (STS) also are eligible, paid for with state funds.

HHS contracts for the Iowa Aftercare Services Program (Aftercare). Youth & Shelter Services (YSS), a child and family serving non-profit agency from Ames, Iowa, holds the Aftercare contract. In addition to providing direct services through five of its central Iowa locations (Ames, Des Moines, Marshalltown, Mason City, Webster City), YSS subcontracts with seven other youth-serving agencies to provide aftercare services to eligible youth throughout the state. These partner agencies, and the location of the primary aftercare offices, include:

- American Home Finding Association (Ottumwa)
- Children's Square USA (Council Bluffs)
- Family Resources, Inc. (Davenport)
- Foundation 2 (Cedar Rapids)
- Four Oaks (Waterloo)
- Youth Homes of Mid-America (Des Moines)
- Young House Family Services (Burlington)

Further information about these agencies, including the counties they serve as part of Aftercare, is available at www.iowaaftercare.org.

New for the SFY 2023, YSS subcontracts with the Iowa State University (ISU) (this role was formerly held by the Youth Policy Institute of Iowa (YPII), which closed upon the founder's retirement) to provide statewide coordination, policy development, quality assurance, and evaluation services for the program. Dr. Jan Melby and her team at Iowa State are a welcome addition to the team and bring a research orientation that could build on what YPII and YSS started. ISU brought on the full-time Aftercare Coordinator, formerly with YPII, who receives questions from service providers and HHS, creates tools and documents, manages intake and referrals, and side by side assists HHS to audit the entire program. The highly skilled graphic designer from YPII was also hired by HHS and will continue good work to keep documents for staff and the public looking "clear, understandable, and pretty".

Iowa State has already shown to be a great partner, by analyzing some of the Aftercare and HHS data to demonstrate how the program is doing at getting eligible youth to participate in the program. Early lessons from looking at the data is that while the Aftercare network is able to invite and serve youth of color at a participation rate similar to the race breakdown of older youth in foster care, aftercare is not engaging males as well as females. Iowa State University has looked at the number of youth aging out of foster care compared to those participating in Aftercare over a five year period. Of the 2369 males and 1515 females in the full sample, predictive statistics indicated that males were less likely to participate than females. This is something to work on more in outreach efforts.

Much of the written information below is from Iowa Aftercare Annual Reports, written last year by Youth Policy Institute of Iowa. Moving forward, reports will be completed by ISU with approval from YSS and HHS.

The Iowa Aftercare Services website includes very readable annual reports with trend information from intake interviews with youth when they first access aftercare services; participant satisfaction survey reports; demographic and other characteristics of all participants served by aftercare each year; and outcomes of participants who exit services. Program results are in the link: Program Results – Iowa Aftercare Services Network

The Iowa Aftercare Services contract combines funding from federal and state sources. Over the years, legislative changes and increased funding have allowed Aftercare to expand eligibility criteria so that more young Iowans can benefit from the program. As of the writing of this report, there are no additional policy updates as it relates to Aftercare participation and extended foster care. Aftercare is watching enrollment to see if extended foster care is having an impact; it is assumed that the lower enrollment is caused by extended foster care but there has not been a regression analysis that suggests otherwise. Aftercare's participation numbers and age-out numbers have an R value of .44, so Aftercare should not assume ago-out numbers is the only driver of participation. For example, the percentage of who participate and how long youth stay are otherwise variables that they have more control over.

- Since SFY 2002, HHS has designated a portion of Iowa's federal Chafee Foster Care Independence Program funding so the Iowa Aftercare Services Program can serve 18 to 21-year-old youth who age out of foster care. The program has since been extended to permit transition services as the youth's aged 17 and extended services to age 23.
- Since SFY 2006, the Iowa Legislature has appropriated state funding for the Preparation for Adult Living (PAL) program, which provides monthly financial support to youth who a) exit a state-paid foster care placement at age 18 and b) are employed and/or enrolled in postsecondary education or training.
- Since SFY 2015, the Iowa Legislature has provided additional funding so that youth aging out of the State Training School (Eldora, "STS") and other Iowa detention facilities are eligible for Aftercare services as they transition to adulthood.
- Since January 1, 2020, "extended" services became available to 21 and 22-year-olds who had previously received "core" Aftercare services between the ages of 18 and 21. Extended services offer less structured services than core services and designed to be responsive to those young adults who want additional support as they continue on a path towards self-sufficiency.
- In 2020, Iowa Governor Reynolds signed an HHS "pre-filed" bill to allow youth who age out of unlicensed relative foster care to receive the same PAL financial support as those who age out of state paid placements.

- In 2022, Iowa Governor Reynolds signed HF2252, another HHS bill, which extended foster care to 21 and could indirectly impact aftercare participation.

Contracted staff provide case management, life skills training, and financial supports for housing, transportation, clothing, food, and other costs related to the participant's self-sufficiency plan.

Each participant works individually with a Self-Sufficiency Advocate (SSA), assigned to them by their aftercare agency. These SSAs typically meet with participants, ideally at least twice per month, to assess their needs, help them set goals, identify action steps, and persist until they achieve those goals. SSAs offer support, guidance, and provide a range of information and services according to participants' unique needs and interests.

Nearly all Aftercare participants received budget and financial management services and mentoring services. This reflects the emphasis on budgeting and financial issues in the program and the mentoring relationship SSAs work to establish with participants. In addition to assessing and helping youth meet basic needs with financial assistance, SSAs also work with youth on housing, health, postsecondary education, career preparation, and family support issues.

Aftercare participants are either "Aftercare Basic" or "Aftercare Plus" status as determined by program eligibility criteria. Preparation for Adult Living (PAL) essentially means, in addition to case management supports that all participants receive, PAL participants receive up to $600 per month funding for living expenses. Because PAL eligibility requirements are more stringent than Aftercare requirements, some participants are eligible for Aftercare but ineligible for the PAL stipend. These participants have Aftercare Basic status. This status allows those who will never qualify for PAL benefits (i.e., monthly stipend) to receive aftercare case management services and support, as well as limited, short-term financial assistance in the form of vendor payments. Participants that could receive a PAL stipend depending on their education and work status receive designation as Aftercare Plus.

Over recent years we have worked hard to develop "pre-Aftercare" and an "extended" Aftercare service, to bolster the "core" Aftercare case management. Frequency of meetings, plans and budgets are less for pre and extended participants. On the front end, pre-Aftercare helps introduce the program to the youth still in foster care to build trust and get "buy in", so the likelihood of later participation is high. On the "back end" extended Aftercare allows youth to have a less intensive service at age 21 and 22, to meet participants' waning support needs and to "step down" services, as they are older and presumably more skilled.

The number of young people aging out of foster care and other court-ordered placements in Iowa has declined over recent years, which has translated to a decreasing number of new entries into Aftercare services. That said, we may have turned a corner; we saw 212 youth access core Aftercare services for the first time in SFY 2022, compared to 177 in the previous year.

In SFY 2022, HHS/Aftercare convened a work group to strengthen the Aftercare referral process, particularly for Pre-Aftercare services, which can begin when youth (age 17 or older) are still in care and are likely to become eligible for Aftercare services. Many of the work group recommendations will be implemented in SFY 2023, with a goal of increasing the proportion of eligible youth who take advantage

of Aftercare services. Many of the work group recommendations will be implemented in SFY 2023-2024, with a goal of increasing the proportion of eligible youth who take advantage of Aftercare services.

Beginning October 1, 2022, Aftercare, in cooperation with HHS, implemented a formalized Pre-Aftercare referral process with a new Aftercare referral form included in the HHS employee Manual. HHS also changed the provider payment model to better incentivize Pre-Aftercare services. The intent is to reach more youth and inform them about Aftercare services prior to exiting care. This process promotes Aftercare staff meeting with youth more regularly (within the limit of ten contacts allowed per contract) and keeping the transition team and the worker informed. The formalized referral process is for both HHS and Juvenile Court Services (JCS). The increase in monthly average served could be directly related to the formalized Pre-Aftercare referral process.

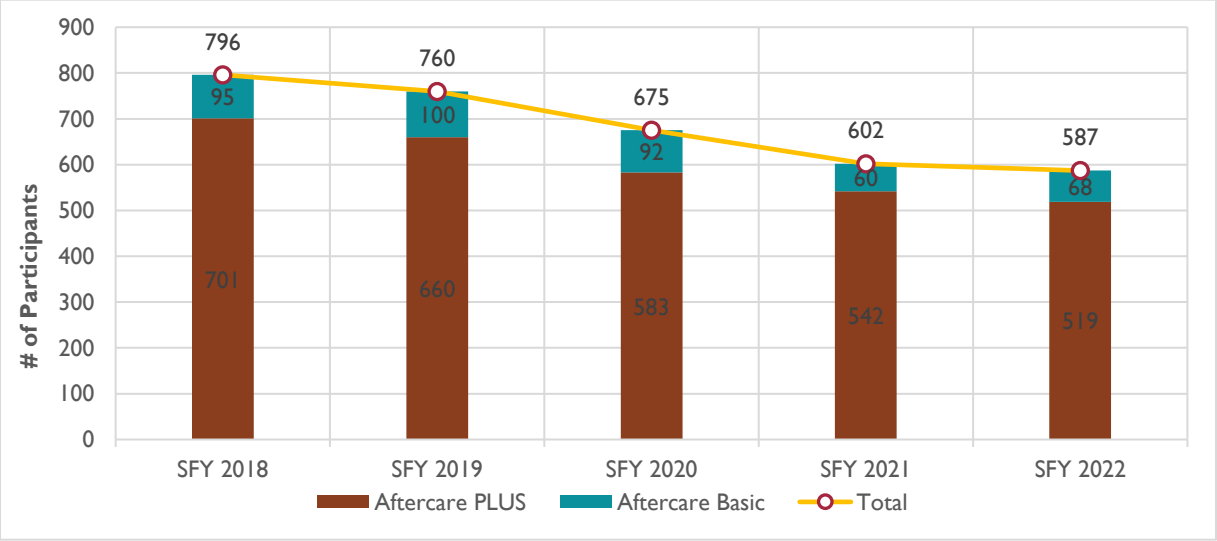
SFY2022 Participation Data - Aftercare

A total of 587 young people ages 18, 19, and 20 received "Core Services" during the SFY 2022, with an average of 353 served per month. STS/detention was the last placement of 66 participants (11.2%) of all those receiving Core Services in SFY 2022.

The median lapse between a youth's discharge from the system and Aftercare intake was just 15 days in 2022. Even though Aftercare is a voluntary program, efforts by HHS caseworkers, Juvenile Court Officers (JCOs) and others is critical to ensuring that young people are aware of and connected to Aftercare services.

The majority of young people access Aftercare within a few months of their 18th birthday. Three in four of SFY 2022 new intakes (75.6%) were under 18½ when first accessing Aftercare; and 90.1% were under the age of 19. The 212 new intakes had mean age of 18.3 and a median age of 18.1. In SFY 2022, 54.3% identify as males and 44.3% as females, while 1.4% identified as transgender or other.
The chart below shows decreasing core services participation over time.

Table 5C3: Youth Core Services Participation



The Aftercare population is quite diverse with the racial/ethnic distribution of new Aftercare participants generally reflecting the population of older youth in placement. According to the annual report, about three-fourths of new intakes identify as "White or Caucasian" each year (75.9% in SFY 2022) and roughly one-fourth identify as "Black or African American" (23.6% in SFY 2022). A small proportion of youth identified as "American Indian or Alaska Native" (3.8%) and about 1.9% as "Asian." Participants can identify with multiple races and separately report their ethnicity; 13.7% identified as Hispanic or Latino. Among all new intakes, 123 (58%) identified as non-Hispanic and selected White as their only race, while the remaining 42% identified with one or more other races, as multiracial, and/or as Hispanic or Latino. A report created by Iowa State University suggests the Iowa Aftercare Services Program participation is statistically similar in race and ethnicity to the population of youth who are potentially eligible. However, men are less likely to participate than women, which has initiated conversations among Aftercare leadership (Aftercare "Panel" meeting April 2023) about how outreach materials and other strategies could be used to better invite males to participate.

While participation in Core services declined again this year as fewer youth have aged out in recent years than in the past, the decrease was offset by the provision of "Extended Services" to those young people ages 21 and 22. A total of 235 distinct young people received "Extended Services" during the year, with an average of 79 participating each month.

Extended Aftercare services for young adults ages 21 and 22 who had previously received Core services (ages 18-21) were provided to 235 young adults in SFY 2022 (an increase from 210 in SFY 2021). An average of 79 young adults participated (i.e., met in person with an SSA at least once) in Extended services each month. Young people accessed Extended services in 41 counties, with 44% of those residing in either Linn County (54 participants) or Polk County (50 participants).

Extended services, which were first available in January 2020, are less structured than Core services and are designed to be responsive to those young adults who want or need additional support as they continue on a path towards self-sufficiency. There are two primary differences between Core and Extended services:

- Expectations for meeting regularly with an Aftercare Advocate are relaxed. There is no pre-determined minimum contact for young people to remain eligible. Participants in Extended services are able to determine the frequency of meetings based on their needs and interest; and
- Participants in Extended services are not eligible for a monthly PAL stipend. Rather, they may receive limited financial support for approved uses in the form of "Extended Aftercare Supportive Payments" on a case-by-case basis. Supportive payments may not exceed $300 per quarter.

Most young people who elected Extended services had Aftercare PLUS status as Core participants (83.4%). Compared to youth exiting Core services, Extended participants were somewhat more likely to be female (59.1% versus 48.4% of Core exits) and to be parenting (39.2% versus 27.2% of Core exits). Twenty-three (23) of those who received Extended services had aged out of the STS or detention. Participants taking advantage of the Extended services met with an Advocate an average of four months in SFY 2022, but that number ranged from one to twelve months.

Aftercare and PAL are voluntary programs, so eligible young adults can initiate and discontinue services as they choose if they meet eligibility requirements. As they move around the state, they may transfer from one Aftercare agency to another. In some cases, services may be discontinued when young people

fail to meet the participant responsibilities established by the program. These young people may re-enter services when they are ready.

For these reasons, young people may have periodic lapses in their participation, and many participants enter and exit services multiple times. Advocates work to keep participants engaged as long as services are needed, but not all young people accept the services or fulfill the requirements of the program. A total of 231 young people exited Aftercare during SFY 2022 and did not return prior to the end of the period. Youth leaving services (with or without an exit interview) had an average duration in the program of two years; median duration was 2.36 years. Because duration is measured as the length between a participant's initial entrance and their most recent exit, the total duration does not necessarily equate to continuous participation in services.

Among all exiting participants, 158 (68.4%) completed an exit interview with an Advocate and 73 (31.6%) did not ("No Interview Exit" or NIX). In the case of NIXs, each participant's reason for exit is reported based on their advocate's understanding of their circumstances, if known. On average, there was a full year age difference between those completing an exit interview (average age of 20.6) compared to the average age of those discontinuing services without an interview of 19.6.

The most prevalent reason for young people being discharged from Core services was turning 21 and therefore becoming ineligible for that phase of services (52.8%). Additionally, 9.5% moved out of their agency's service area, including 3.5% who were expected to transfer to a different Aftercare agency but had not yet done so at the end of the reporting period. Another 13% had their services discontinued for failing to meet "self-responsibility" requirements (e.g., not meeting regularly with an Advocate, not actively working toward self-sufficiency, etc.), 10.4% voluntarily chose to end services, joined the military, or had achieved self-sufficiency, and 3.5% were incarcerated as the reason for exit. One youth died while an active Aftercare participant.

In compliance with reporting requirements for the National Youth in Transition Database (NYTD), Aftercare tracks the provision of specific services to participants and submits monthly reports to Iowa HHS. The table below shows the unduplicated number of youth who received each of the NYTD-defined services at least once during the reporting period. Because NYTD service definitions are very specific, this data is not an exhaustive list of the services provided by Aftercare advocates.

Table 5D3: Youth Receiving NYTD Services

All Participants – NYTD-Defined Services Provided	#	%
Mentoring	571	97.3%
Budget and financial management	547	93.2%
Housing education & home management training	481	81.9%
Independent living needs assessment	468	79.7%
Career preparation	466	79.4%
Health Education and risk prevention	449	76.5%
Other financial assistance	431	73.4%
Family Support and Healthy Marriage Education	388	66.1%
Post-secondary educational support	249	42.4%
Employment programs or vocational training	155	26.4%

All Participants – NYTD-Defined Services Provided	#	%
Academic support	151	25.7%
Room and Board financial assistance	143	24.4%
Education financial assistance	67	11.4%

Among Core participants in SFY 2022, nearly all received "mentoring" services (97.3%) and assistance with "budget and financial management" (93.2%) from their Aftercare advocate. This reflects the mentoring relationship SSAs establish with their clients, as well as the program's emphasis on financial capability (particularly monthly budgeting). Advocates also supported participants in a variety of other areas including housing, assessing needs, career preparation, and health education.

Any participant receiving a PAL stipend or Aftercare vendor payment is recorded as receiving "other financial assistance." The NYTD "Room and board financial assistance" category includes vendor payments used specifically for housing and the Chafee-funded Rent Subsidy program.

Provide an update on the state's plan to strengthen the collection of high-quality data through NYTD and integrate these efforts into the state's quality assurance system. Provide an update to the state's process for sharing the results of NYTD data collection with families 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 the state's quality assurance system, NYTD data and any other available data to improve service delivery and refine program goals.

USE OF DATA, INCLUDING NYTD DATA

The National Youth in Transition Database (NYTD) is a federal requirement that mandates HHS, as a recipient of Chafee funding, collect services and outcome information on youth in foster care or other out-of-home placement.

HHS and JCS case managers are contracted quarterly to survey on the services provided to youth in foster care age 14 and older. The Iowa Aftercare program and Iowa College Aid Commission provides life skills and education services data, respectively.

HHS contracts with the Department of Human Rights (DHR) to collect the outcome information and conduct a survey of youth in foster care or other out-of-home placement at age 17, also referred to as the baseline population. DHR tracks these youth as they age and conducts a follow-up survey with a sample of youth at ages 19 and 21, referred to as the follow-up population. Outcomes derived from the survey includes 24-27 questions that measure youth across six domains - educational attainment, financial self-sufficiency, access to health insurance, experience with homelessness, and positive connections with adults.

Much of the NYTD data is sourced from the NYTD report, created by the Iowa Department of Human Rights (DHR). Please find the full NYTD Annual Report and more information at the NYTD website: NYTD - National Youth in Transition Database | Iowa Department of Human Rights

Iowa NYTD and HHS are using the same survey tool in FFY 2023 as in FFY 2020. In addition to required outcome elements and demographics, Iowa asks questions regarding mental health and barriers to employment and education.

The survey outcomes data is collected directly from youth (and not administrative records). Iowa NYTD offers three methods for completing the survey: phone, mail, or online. All survey responses are voluntary, with youth having the option to decline a question, or the survey itself, at any time. Collected responses are confidential, and no individual youth are identified in this report or in any survey data analysis shared with provider agencies. The majority of participants chose to take the survey via the Internet. Youth were least likely to take the survey via mail.

Youth who complete the Iowa NYTD survey receive an incentive for participating. Survey participants receive incentives to increase the survey participation rate, as well as to show appreciation to NYTD participants for sharing their experiences. Iowa NYTD offers participants multiple options for their incentive. Youth participants receive gift cards from Wal-Mart, Casey's General Store, Amazon, or Hy-Vee. Participants at age 17 and 19 are offered an additional gift card for providing names and contact information for individuals who will know how to contact the youth in two years to take the next survey.

In an effort to maintain contact with youth in the off years, the NYTD Coordinator mails birthday cards to participating youth on their 18th and 20th birthdays. In the exchange, contact information is updated and they are sent a $10 gift card with their birthday card for doing so. This has been a successful strategy to maintain contact with survey participants, as well as keep their contact information as current as possible which has been helpful when surveying them again at age 19 and 21. In FFY 2022, 86% of youth who were successfully contacted on their 18th birthday took the survey when they were 19.

The FFY 2022 outcomes data collection efforts is to survey youth aged 19 who took the survey at age 17. In FFY 2020, 264 youth took the survey near their 17th birthday. A sample of those youth were surveyed again on or near their 19th birthday (102 youth total). Youth who did not take the survey on their 19th birthday are still eligible to take the survey on their 21st birthday. In FFY 2022, there were 170 youth identified to take the survey compared to 203 youth in 2013, a decrease of 17.7%.

All states are federally required to survey at least 60% of eligible youth. 'Eligible' youth include those who are not incarcerated, incapacitated or deceased. In FFY 2022, Iowa surveyed 64% of eligible youth. Of the youth eligible for the survey, 6% were incarcerated which is higher than the national average of 4%.

One key example of how HHS uses transparent and comprehensive youth data to achieve program goals and inform the community is the NYTD Annual Report. The NYTD contractor, with assistance from HHS and with data partners, develops the report. The report not only includes NYTD data, but performance and participation from several other Chafee programs.

On January 25th, 2023, HHS and the NYD Coordinator proudly hosted the annual NYTD report release webinar featuring FFY 2022 National Youth in Transition data and CY 2022 Talking Wall data. These important data sets provide us a glimpse of how older youth are experiencing Iowa's foster care

system. It was attended by nearly 100 individuals, including those from Iowa child welfare, service providers, state officials and even from interested individuals from outside of Iowa. The NYTD data collected for the FFY 2022 reports, including state and national comparisons on select NYTD outcomes was shared. The facilitators engaged the audience in dialogue about the meaning of the data and encouraged collaborations to address shared goals for better youth outcomes.

The TPS and the IL Coordinator use the report to help guide state and local decision-making. TPS have found the data helpful to raise awareness and build local coalitions to improve foster care outcomes. The IL Coordinator uses the data in every new worker training.

In addition to collecting survey results from the NYTD populations of youth, Iowa NYTD has also engaged youth through the several outreach activities:

NYTD Ambassadors are young adults who have previously taken the NYTD survey and are between the ages of 17-26. They play a critical role ensuring the data collected on older youth in foster care is being done so in the most equitable, appropriate, and productive way. This partnership serves as an opportunity for young adults and state agencies to collaborate using survey data to inform, empower, and advance positive youth and community outcomes. In 2021, the Iowa Department of Human Rights onboarded five NYTD Ambassadors into a NYTD Advisory Council, to partner on the collection, analysis and reporting of NYTD data in Iowa. In 2022, it was decided to better integrate Ambassadors by onboarding them as part-time state employees.

The NYTD Creative Expressions Contest is an annual art contest that invites youth and young adults who have experienced foster care and/or juvenile justice to create a work of art that captures the given theme of the contest. In 2022, the 6th Annual Creative Expressions Contest centered the theme "Trust Your Voice and Voice Your Truth," inspired by the Talking Wall project. A total of 118 young people submitted 126 pieces of art into the contest. Artwork was submitted by youth from across the state in a variety of settings including group care, shelter, Psychiatric Mental Institutions for Children, foster homes, detention, and youth who have aged out of the system. To date, 207 youth have participated in this contest.

In 2018, Iowa NYTD began hosting the Talking Wall in partnership with HHS, Achieving Maximum Potential (AMP) and Iowa's Juvenile Justice Advisory Council (JJAC). JJAC provides oversight and guidance to departments and the judicial branch on services and monitoring pertaining to the *Juvenile Justice and Delinquency Prevention Act of* 1974. Through the Talking Wall, youth are empowered to lend their voices to the decision-making process by answered questions, sharing their experiences, and expressing their visions for change. The Talking Wall provides decision-makers an opportunity to align their action to what youth are saying they need. Talking Wall responses are shared with youth advocates, stakeholders, and state leaders. This year's questions included:

- What is one thing you would like to see happen to improve the foster care and/or juvenile justice system in Iowa?
- What is one thing you would like to see happen to improve the foster care and/or juvenile justice system in Iowa, specifically for youth of color and Indigenous youth?
- What is one thing you would like to see happen to improve the foster care and/or juvenile justice system in Iowa, specifically for girls and LGBTQ+ youth?
- What do you and/or other youth need that you don't currently have?

- What are the dos and don'ts of the people who work with you?

In FFY 2023, 48 organizations participated leading to 1,802 post-it notes uplifting the voices of 434 youth. More than 15 state-level stakeholder groups reviewed the Talking Wall data and hosted discussions on how to translate the ideas into actions. In January 2023, Achieving Maximum Potential (AMP) and the Youth Justice Council (YJC) convened together to theme the post-It notes. AMP used the theme to inform their legislative agenda and the YJC used them to create their annual priorities.

During the Talking Wall project, we also administered a survey to youth in out-of-home placement to assess to what extent is authentic engagement and well-being evident in their daily lives. This survey was co-created with the Youth Justice Council and questions were informed by past themes of the Talking Wall. Nearly 250 youth participated in the survey, which also included demographic information (race, disability, gender, sexuality, system type). This survey data coupled with Talking Wall data and recommendations that were co-created with young adults with lived experience and system professionals will be published in the upcoming report, "*A Call for Authentic Engagement and Wellbeing in Iowa's Juvenile Justice and Child Welfare System*" that is set to be released in Fall 2023 by the Division of Criminal and Juvenile Justice Planning.

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.

HHS 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, used by the IL Coordinator and others to evaluate trends in the counts of teens in foster care and those aging out of foster care. The ROM data can be sorted and filtered for gender, race, and court jurisdiction, among other important categories. ROM has extensive historical records about assessments and children in placement. Data include child welfare outcomes and tend to be more up to date than federal sources, which can run two years behind. ROM data is used frequently to monitor the Family First impact on transition aged youth participation.

Iowa Aftercare, AMP, ETV, NYTD and others will continue to be required to submit annual reports, which contribute to federal reports and drive data informed discussions about needed youth services. Contracts will continue to include performance measures and associated payments, including but not limited to a youth's perceived financial stability, housing stability and connection to trusted adults.

CHAFEE IMPROVEMENT PLAN (CFSP REPORT) – PERFORMANCE ASSESSMENT UPDATE TO IMPROVING OUTCOMES

In 2019, HHS submitted the Chafee section of the CFSP, which received approval from the Children's Bureau. This is year four of a five-year plan. This section provides a quick summary of accomplishments in the past year and any next steps.

In order to engage the field staff in the implementation of the CFSP, we identified team leads for each of the goal areas and held at least bi-monthly meetings where we review CFSP status since October of 2019. We have been quite successful this round using "team leads" in the different goal areas. This means each TPS has an area of specialization, and they lead the team activities in the goal area, monitor

results, and provide the report out. It has helped Iowa stay on track with these goals, and as well builds confidence and expertise within the transition team, so we will continue to use team leads moving forward.

TPS continue to collaborate with new and ongoing workers to help them document quality transition plans. TPS offer to meet with case managers individually to help them develop a youth's plan if needed. TPS make themselves available through such things as office hours and Microsoft Teams Meetings. The TPS also provide continuous input about how the transition plan can be improved or revised to ensure a thorough plan is in place.

Transition Planning Specialists continue to attend staff/unit meetings throughout their service areas and provide ongoing training regarding the transition planning process with youth in foster care to case managers and supervisors.

TPS utilize a tracking tool that is updated monthly to identify all youth in out of home placements 14 and older. The TPS use this tool to identify where youth are in the transition planning process and have recently added columns to monitor driver's license status, pre-Aftercare referrals, need for adult services, graduation dates, in addition to the already tracked data of proof of foster care letter, completion of Casey Life Skills Assessment, Transition Committee Reviews, and other transitioning dates. This allows TPS to ensure youth are receiving the transitional planning services necessary.

To better track youth's driver's license status, a column has been added to the TPS tracking tool to document driving status. Choices listed include Learners Permit; School permit; Driver license; Suspended license; Other; and None. Barriers to youth obtaining their License are problem solved with the youth and their team.

Funding available through the Consolidated Appropriations Act allowed TPS to develop a program called "Removing Roadblocks" and although the program was temporary due to time-sensitive funding, many children were able to take advantage of the program. A total of $457,605.40 was distributed to 190 youth across the state for the purpose of transportation related expenses, to address transportation barriers such as the cost of driver's ed, auto repairs, insurance costs, purchasing a vehicle, bus passes, and bicycles. There was a limit of $4000 per youth. This was pivotal in promoting increased social, educational, and occupational opportunities and expanding self-sufficiency. We would like to explore ways to be able to consistently fund a program like this to assist ongoing transition barriers for youth in foster care.

Iowa HHS participated in the Division X Technical Assistance offered by Embrace Families. Nearing completion of the Removing Roadblocks program, Embrace Families provided a report including recommendations to improve future desired outcomes should the opportunity to provide this service once again present itself. Should provisions be made to permanently fund Removing Roadblocks or a similar endeavor, TPS would reference the recommendations for improvement provided by Embrace Families and Paving the Way. These recommendations include goal definition and needs assessment within our served population, marketing efforts, sustainable funding, and data collection among other topics.

Although the pandemic enhancement to Kin$hip Fund$ have been exhausted at the $600 dollar level, Fo$ter Fund$ continue to be available for youth 14-21 years of age in foster care at up to $300/youth/year using Chafee funds.

Although a defined process exists to obtain vital documents, some counties in the state are experiencing continued difficulties in obtaining Social Security Cards. This is due to local and regional SSA offices having inconsistent supporting document requirements. Partnerships with each of these offices will need to continue to be developed to remedy this. HHS has reached out but has been unable to establish a partnership with Social Security Administration to develop and improve a statewide process for obtaining important documents for youth. Frankly, we are experiencing similar systemic barriers in our efforts to connect with the Department of Transportation. TPS will continue to explore way to partner to ensure youth have their social security card and state issued photo ID before exiting care.

To assist in more accurate tracking of vital documents, the IL Coordinator has requested vital documents be added to the new Vision database system (a part of CCWIS) to accurately track and have data on this being obtained for youth.

Annual credit checks continue to occur for every youth in foster care 14 or older. If there is a hit on the youth's credit report the TPS work with the case manager to verify the information. If needed, the three credit reporting agencies are notified, and a request is made to have the information removed from the youth's report. Once this is resolved with the three credit reporting agencies, updated documentation is provided to the youth for their records. At the start FFY 2023, we realized Experian had changed their coding and it resulted in reports not being loaded. This issue was raised by TPS. Our information technology helpdesk quickly reached out to Experian, and we have a solution for file transfers moving forward and to recover files that were missed. Iowa HHS sent 3,867 requests in calendar year 2022 through the three credit reporting agencies combined. No issues were reported for 3,646 and 119 were "blank reports" meaning there was a record, but it had no issue. Two were marked "invalid" due to the issue not being associated with the child. We continue to process 100 where the worker is addressing the potential issue or has resolved it and has not entered the result in the system. We're looking into the data to see what the 100 "in process" really represents. If it is that the worker is not entering the resolution, we'll be developing a process to check in and make entries at the end of the year. The quarterly breakdown of requests is as follows:

Table 5E3: Quarterly Credit Check Requests

Requests	Count
January 2022; HHS submitted a request for a background check to each of the three credit reporting agencies for youth.	1062
April 2022; HHS submitted a request for a background check to each of the three credit reporting agencies for youth.	894
July 2022; HHS submitted a request for a background check to each of the three credit reporting agencies for youth.	921
October 2022; HHS submitted a request for a background check to each of the three credit reporting agencies for youth.	990

The Transition Information Packet (TIP) is a compilation of various transition resources that we have found from many sources and are useful tools for youth who are transitioning to adulthood. TIPs continue to be provided to older youth in out of home placements.

The TPS continue to share and utilize the Transition Planning Training Videos with HHS employees and other professionals, including Iowa College Aid, teachers and education professionals. The videos are readily available on the HHS Transition Planning website. These videos continue to be utilized within the Iowa College & Career Readiness Academy courses as well.

The IL Coordinator and TPS train new and ongoing workers about documenting quality transition plans. The TPS also provide continuous input about how the transition plan can be improved or revised to ensure a thorough plan is in place. TPS also continue to attend staff/unit meetings throughout their service areas and provide ongoing training regarding the transition planning process with youth in foster care to case managers and supervisors.

In a joint effort between the Division of Family Well-Being and Protection (FWBP) and the Division of Public Health (DPH), a new one-step procedure to request an Iowa birth certificate has been developed and implemented in March of 2022. The new procedure is believed to have decreased the processing time and eliminated application payments, that had been a barrier to getting documents for youth.

The Transition Information Packet (TIP) is a compilation of various transition resources that we have found from many sources and are useful tools for youth who are transitioning to adulthood. The TIP was updated in 2021 and is being distributed to youth. The information is also available on various electronic formats for caretakers and providers to access as well.

The IL Coordinator and TPS update and manage tools and resources to assist case managers and providers to assist them with Transition Planning with youth. For example, regularly used documents include the Transition Planning Checklist and a handout of "Resources for Youth in Foster Care". Because of the HHS alignment and new branding, many documents are needing new letterhead. This gives us a chance to refresh all our materials.

Year four CFSP updates 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 aged 14 and older in foster care have an individualized transition plan.

Goal 2: Increase appropriate housing opportunities for Transitioning Youth.
Objective 2.1: Ensure SAL is effectively meeting the needs of transition youth.
Iowa continues to work on rolling out the FYI (Foster Youth Initiative) Youth Housing Voucher Program. Agreements have been made with 9 Public Housing Authorities (PHAs) as of March 31, 2023, for FYI Housing Vouchers. Vouchers are currently available and being issued to youth in those areas. Currently in Iowa, we have approximately 34 youth who are leased up with a FYI Voucher, and 12 youth who are pending/in process of using an FYI Voucher. TPS are helping coordinate the referral process for the PHA's that are participating. Iowa Aftercare is typically the supportive service required to

complement the vouchers. Children's Bureau Regional 7 is hosting Foster Youth to Independence discussions, in which the IL Coordinator and TPS regularly participate. Some of the barriers preventing more use of the FYI Housing Vouchers is needing more PHA to enter agreements to administer FYI to expand coverage area across the state. Also, we need more HUD approved housing options where the owner is willing to accept the FYI Voucher.

We continue to explore other housing options to connect youth to as needed, including Transition Housing Programs throughout the state. Among them is Pillars, United Action for Youth, Lighthouse, YSS, Winding Roads, and Stepping Stones.

Placing youth with kin or fictive kin continues to be a priority with HHS. HHS has continued to advocate the importance of youth establishing and maintaining connections by educating case managers, community members, and youth in their transition meetings. The transition team advocated to support youth in Kinship Placements by creating a project using funds temporarily available through the Division X Funding. This provided the opportunity for youth 14 and older in court-ordered Relative and Kinship Placements to receive payment for extra items that teenagers need as part of social, cultural, and developmental opportunities. We recognized the financial needs of teenagers can exceed the support that is available, therefore HHS provided a one-time payment to help with expenses of supporting a teenager. HHS issued a total of 288 payments of $1000 to Kinship Families.

Currently, the state of Iowa only has 3 provider agencies who provide SAL services including clustered and scattered site. A public procurement process is underway which promises to bring additional providers. The goal of SAL is for a youth to move to Self-Sufficiency while developing interdependence with their community and the systems that supports the youth's completion of education, development of life skills, and preparation to move into adulthood. There continues to be many challenges for youth in SAL, such as finding a place that will rent to the youth in their own community, obtaining effective community supports outside of the SAL program that can help them learn self-sufficiency skills and preparation for adulthood.

Finding housing for foster care youth to rent when they move into their own apartment continues to be a struggle. TPS continue to look for opportunities to build relationships with landlords about the needs of our youth and the benefits of allowing them to rent from them. Caseworkers educate the youth as they get closer to aging out about the importance of saving up income (for deposits and rent) and putting themselves in a good position to be able to secure housing when they need it.

TPS continue to provide housing resources and information to social workers and others providing direct services to youth in foster care. TPS has updated and is sharing a "What You Should Know About SAL Foster Care". This document guides workers to help youth understand the program and encourages youth to save as much money as they can prior to moving out on their own, and to start planning early, knowing it is hard to find housing. Transitioning youth usually do not have a cosigner or credit history, and therefore, need to show that they have more income, or more money saved to be able to rent their first apartment.

Over the next year, HHS is partnering with YSS and other groups to participate in the Youth Homeless Demonstration Program (YHDP) work group to look for state and federal funding to provide more housing and supportive services to youth in the State of Iowa.

We were unable to do a workgroup to address Supervised Apartment Living due to the pending RFP and new contracts. Once new SAL contracts are in place and begin on July 1, 2023, HHS would like to revisit establishing a workgroup.

TPS and local providers will continue to work on ways to improve relationships with Landlords to create more housing opportunities for our youth transitioning into adulthood. One idea being explored is to create a letter to send to landlords seeking those that might be interested in renting to youth aging out and explaining some of the barriers in addition to extra supports they receive that may make them good renters.

Goal 3: Utilize NYTD and other existing data to improve service delivery.
Objective 3.1: Use data to inform caseworkers and providers, thereby creating data-driven practice.

HHS maintains a foster care transition requirements tracking tool, updated monthly, to identify transition needs for all youth in out of home placements 14 and older. The TPS use this tool to identify where youth are in the transition planning process and have recently added columns to monitor driver's license status, pre-Aftercare referrals, need for adult services, graduation dates, in addition to the already tracked data of proof of foster care letter, completion of Casey Life Skills Assessment, Transition Committee Reviews, and other transitioning dates. This allows TPS to ensure youth are receiving the transitional planning services necessary.

All TPS were involved in the NYTD report release. A webinar was provided on January 25, 2023, it is recorded and saved on HHS Training Website & the NYTD Website for ongoing training and access. An infographic highlighting some of the important data was emailed to HHS Supervisors, Case Managers, and Juvenile Court Officers. TPS also continue to work with NYTD Coordinator to continue good communication and response for the youth on their surveys.

TPS connect with youth through AMP meetings and obtain youth opinions. At a recent Future Fest, youth were asked "If you were given $500, what is something you would need and what is something that you would want"? Some of the youth responses about what they need were: transportation, housing, clothing, shoes, cell phones, food and child support payments. Examples of some of the youth's wants were junk food, gaming systems, paying off debt, a dog, jewelry, cosmetics, and other hygiene products such as scented lotions or nail polish. TPS utilizes this information from these type of surveys to create programs that reflect the voices of youth. The most recent program was the $1,000 Kinship Payment to help kinship caretakers be able to address these needs and wants.

In Year four of the CFSP, we utilized the transportation needs and barriers infographic that was previously created from year three with data. The funding provided by the Consolidated Appropriations Act allowed Iowa to create a time limited Removing Road Blocks Program which Provided the opportunity for youth aged 14 and older in foster care to receive payment/reimbursement for fees and expenses associated with transportation (driver's license, insurance, transportation). This program helped 239 youth from May through September of 2022.

NYTD data exposed that 42% of youth reported they were unaware of Aftercare services. This was a shocking realization that we need to vary the approach to telling youth about programs and repeat it with each youth. Also, we need to monitor if referrals are being made prior to the youth's discharge. In

2022, a first ever formal referral process went into effect to refer youth to pre-Aftercare services and ensure all youth are receiving education about the support that is available to them through the Iowa Aftercare network. TPS are collecting a monthly list of referrals completed. This allows TPS to follow up on youth who need a referral and identify any barriers.

Data shows youth in foster care are at higher risk of being sex trafficked[i]. An infographic regarding Human Trafficking Awareness was recently finalized. This infographic explores the connections between trafficking and foster care. It also identified risk factors and resources available. This will be disseminated to all social work staff once finalized.

The Transition Planning Specialists utilized data from NYTD and Aftercare in the development of Transition Planning Training videos for Providers. These videos were originally distributed in April 2020; however, they continue to be available for use by HHS administrators, case managers, providers of residential treatment, SAL, shelter, foster parents, kinship caregivers, and family centered services. New for the spring of 2022, these training videos are a part of a class offered by Iowa College Aid to teachers and education professionals called, "Supporting College & Career Readiness for Systems-Involved Students" to help educate those working directly with the youth in foster care on the transition planning needs of the youth and how to better prepare them.

TPS continue to educate using data in everyday work and contact with youth, case managers, and community members about the needs of youth aging out of foster care by sharing the statistics regarding foster care youth (such as: graduation and employment rates, pregnancy, and homelessness) and why transition planning for youth matters. TPS also utilize Aftercare data as a way of showing case managers the benefits of youth connecting and working with Aftercare when they leave foster care, as their outcomes are more successful when participating in Aftercare. HHS has also started to ask youth who are surveyed for NYTD at 19 and 21 whether they have participated in Aftercare. In the 2022 survey, 42% (43/102) in the 19-year-old group have said they have. HHS collects reasons for not accepting Aftercare, of which 42% say they are not aware and 16% have stated they are not interested. HHS is not at a point where we are reporting the comparison, but we are starting to look at the data. From the data received, we can conclude that Aftercare participants are more likely to have health care coverage (73% of the 19-year-old group and 93% of the 21-year-old group) and are less likely to be disconnected from work and school (7% of the 19-year-old group and 29% of the 21-year-old group). Homelessness in the past two years is almost identical.

In year four, the TPS used data from surveys given to youth in foster care as well as Aftercare data to identify a need in the area of helping youth with transportation barriers. TPS created an Infographic to share this information with others. It identifies the need as well as explains new financial resources that could help youth overcome their barriers towards transportation. This was released by the service helpdesk with a package of materials all about transportation assistance for older youth in foster care.

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.

There are three modules of human trafficking training available to case managers on the HHS training website. In addition, TPS regularly pass on information to supervisors and case managers about human trafficking training that is available in the community.
In the past year, TPS passed on information about the "Human Trafficking: Beyond Awareness Virtual Conference" Training through TSS. CPPCs hosting a variety of community training opportunities, ranging from topics such as Youth Mental Health First Aid, Domestic Violence 101, Healing Centered Engagement, RPI/UIRB Learning Exchanges, Human Trafficking, and Suicide Prevention.

TPS continue to provide 1:1 support to case manager by providing training, resources, and housing program options that are available to youth who have been victims of human trafficking. This helps them know what specific resource(s) to utilize when working with victims of human trafficking. As a result, in the past year Lydia House in Keokuk has continued to be used as well as Family Resources Survivor Services in Davenport.

Case managers continue to be trained of the ongoing need to verify whether youth on their caseload are or have ever been a victim of trafficking and report trafficking to law enforcement and the National Crime Information Center. It is particularly important to screen youth in apartment living and after returning from runaway.

To improve collecting data about youth in foster care and human trafficking, a question was added to the records section of the transition plan. It asks if a youth has been a victim of human trafficking. If identified, the case manager will follow-up and will arrange for services as needed.

The State of Iowa has also implemented requirements for in state lodging providers to complete human trafficking prevention training to receive public funds for state employee lodging or for contracts. State employees and contractors who bill for lodging and conference rooms are only allowed to use lodging providers who have gone through this training.

Social Workers and JCO's continue to attend trainings and work to identify any youth on their caseloads who may have a history of being trafficked or who are at risk. If a youth has a history of being trafficked, social workers or JCO's report that information to the proper authorities and work to provide the youth with the necessary resources to process the trauma and events that have occurred in their lives.

Awareness and education are provided to youth in foster care directly due to their increased risk of being trafficked. Family Resources has a human trafficking program called Braking Traffik that provided education to youth who attended the HHS sponsored Future Fest, a resources fair for transitioning youth in the Eastern Service Area. A volunteer from Chains Interrupted spoke with youth at a local AMP meeting in the Cedar Rapids Service Area.

HHS continues to create Human Trafficking trainings for all staff. Currently, SP 405 Human Trafficking Training is a half day training offered to HHS staff throughout the State of Iowa. Information about this training opportunity was provided to Supervisors, Social Workers, and Child Protection Workers. TPS attended this training opportunity as well.

HHS staff can access other Human Trafficking Trainings through local organizations such as Building Direction for Family or The Coalition for Family and Children's Services in Iowa. These organizations provide trainings that are readily available to HHS Staff. TPS share these opportunities as they arise.

As mentioned in the previous section, a human trafficking infographic was developed in year four to help staff identify and respond to trafficking. This infographic explores the connections between trafficking and foster care. It also identified risk factors and resources available. This infographic will be provided to Supervisors, Social Workers, Child Protection Workers, Juvenile Court Officer's, and Providers to use as a resource.

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.

TPS provide youth with information about Job Corps programing through pamphlet distribution in the TIP binder and help with completing applications. Job Corps campuses have gradually reopened with teens being able to tour in-person upon completion of application. TPS offer opportunities for youth to tour Job Corps in Ottumwa & Denison when the campuses are open. TPS continue to recommend virtual tours that Job Corps has created. Representatives from Job Corps have also attended Future Fest and AMP Conferences to present program information to youth.

TPS invite military personnel to the statewide transition conferences such as Future Fest and the Amp Conference. This is to ensure youth understand the military is a legitimate career opportunity. The western Iowa service area has a Transition Committee member who is in the Army Reserve and can answer questions as they arise.

Similarly, TPS have found it helpful to forward caseworkers information pertaining to trade schools and certificate programs, so they can share with youth in youth centered meetings and on visits to youth on their caseload.

TPS are aware and discuss other funding opportunities for vocational training to youth and their case managers, such as: Gap and Pace Funding which is available at all community colleges across Iowa, Vocational Rehabilitation and/or Iowa Works' Title I programs, and the Last Dollar Scholarship (and discuss examples of careers that are available through this funding source at YTDM's).

In recent years, HHS has increased interaction and coordination with Vocational Rehabilitation (VR). It may be because more youth are eligible, and we are seeing the benefits of having VR services involved prior to the youths aged 18. TPS send reminders at the beginning of the school year to workers to explore this service for all youth on their caseloads. The goal for VR is similar to other programs, that we want to have the conversation with the youth and let them decide what interests them and what they want to pursue. VR is frequently recommended at Transition Committee Review Meetings statewide. TPS are the experts and support case managers to understand eligibility, timelines for application, services provided, and benefits. VR has also benefitted many aftercare youth. We hope to make more formal connections with VR and aftercare in the coming year.

Iowa Works (aka Workforce Development) has been holding various hiring fairs with area employers and monthly Teen/Young Adult Employee Day that allows teens to learn about hiring skills as well as potential employment opportunities available within their communities. TPS informs HHS/JCS staff and area Aftercare about these events for teens in care as well as those that have aged out.

TPS recommend youth placed away from home explore employment opportunities in their local communities. If a youth needs assistance, referrals are made to their home community. Commonly made referrals include Iowa Works, VR, and WIOA.

TPS participate in YTDM's and monthly visits as needed to provide youth and their supports information about the Pell Grant and ETV which can be available up to age 26. TPS receive a weekly list of applicants for FAFSA, ETV, and AIOS from Iowa College Aid and can verify applications have been completed for SWCM's and JCO's. TPS send out annual emails to HHS/JCS staff to inform them of the opening of the FAFSA application, ETV application, and All Iowa Opportunity Scholarships. TPS also send out reminders of approaching deadlines as well as other scholarship opportunities that are distributed to TPS throughout the year. In April of each year, TPS send out graduation reminders and encourage case managers to celebrate the graduation of individuals. Youth also receive assistance completing applications from Aftercare providers, during pre-Aftercare services.

Statewide transition conferences are occurring both in-person and virtually across the state. The Eastern Service area TPS is hosting three Future Fests with the areas Child Partnerships for Protecting Children, Juvenile Court Services, and local schools, which welcomes system involved youth, homeless youth, and undocumented youth. The keynote speakers for these events are Hope City Church, Pastor Q. His presentation has been well received by the youth and professionals. The Northern Service Area and Cedar Rapids Service Area have completed Future Fests Programs in the last year as well. The Western Iowa Service Area and Des Moines Service area is currently in the planning stages for a virtual Future Fest due to the geography that those service areas cover. The virtual even will allow more youth to participate.

Case managers are expected to continue to have youth-centered transition meetings for all teens in foster care. Typically, TPS, Aftercare advocates, and career/educational resource experts are invited. Youth Transition Decision Making (YTDM) is the preferred model for HHS supervised youth. YTDMs have been held in-person with a virtual component to allow more participation of professionals from across the area. This is a lesson from the pandemic. TPS will continue to inform case managers of the contact information for these various resources to better ensure their participation in these meetings. TPS help link the YTDM facilitators with available services/providers and encourage the participation of those providers. TPS have also been making pre-service Aftercare referrals to support the case managers and to increase Aftercare participation, which as shown in the aftercare section of this report, seems to have worked.

Iowa lacks capacity to have a YTDM facilitator, typically from the Family Centered Services Program, whenever one is needed or desired. When YTDM facilitators are unavailable, case managers have to facilitate or get help from TPS. Whether the youth centered meeting is done by a true YTDM facilitator or other person, we want to make sure the meeting involves the youth and those they want to be there and also that it covers the five transition areas. In the coming year, we are exploring options to increase capacity for facilitated meetings, because we recognize having a case manager or TPS facilitate is well-

intended but results in a meeting that is not as in depth and impactful as a professionally administered YTDM.

In Iowa, transportation is basically a pre-requisite for employment. Our public transportation infrastructure is not strong, especially in rural communities. The Consolidated Appropriations Act funded Removing Road Blocks most certainly helped youth on their path to employment as it provided youth aged fourteen and older in foster care payment/reimbursement for fees and expenses associated with transportation (driver's license, insurance, transportation). A service helpdesk release, in April of 2022, described the program. Applications and tip sheets were provided to caseworkers and others working with teens in foster care. While we can't share photos here, due to confidentiality, TPS collected more than a dozen photos of youth with their new bike or gently used car. The photos, each a beaming and hopeful youth, are uplifting and an inspiration for child welfare professionals.

In order to be eligible, youth must have been in court ordered out-of-home placement and been ages of 14-18. Youth who remained in care through a Voluntary Placement Agreement (VPA) between the ages of 18-20 were also eligible. The case manager assisted youth in completing the funding application. The case manager emailed the completed application along with the receipt and/or invoice to the local Transition Planning Specialist for approval. Once approved, the request for funding was submitted to the payment agency (Central Iowa Juvenile Detention Center) and they issued funds directly to the vendor or reimburse the payor.

Funds up to $4,000 were approved per youth related to a transportation need. Examples may include but are not limited to public transportation, private driving instruction to complete the drive time requirement to obtain a driver's license, Department of Transportation (DOT) fees and registration, driver's education fees (if they aren't able to be waived), car insurance, car maintenance and repairs, and down payment or matching funds towards the purchase of a vehicle. Case managers were told they were responsible to ensure these are appropriate purchases for youth - youth should not be buying a vehicle they aren't allowed to have where they live, is "junk", or that youth can't afford to maintain.

This program helped with the purchase of 68 cars and 77 bikes/scooters/mopeds. This program helped 16 youth with city bus passes. It also helped 27 youth complete driver's education to obtain their driver's licenses which will increase their employment options. In total, the program assisted 190 youth from May through September of 2022.

- *Provide an update on how the state involves the public and private sectors in helping youth in foster care achieve independence (section 477(b)(2)(D) of the Act).*
- *Provide an update on coordinating services with "other federal and state programs for youth (especially transitional living programs funded under Part B of Title III of the Juvenile Justice and Delinquency Prevention Act of 1974), abstinence education programs, local housing programs, programs for disabled youth (especially sheltered workshops), and school-to-work programs offered by high schools or local workforce agencies" in accordance with section 477(b)(3)(F) of the Act.*

Coordination with Regional Housing Authority

The Department of Housing and Urban Development (HUD) announced Foster Youth to Independence (FYI) in Notice PIH 2019-20. FYI is an initiative targeting housing assistance and supportive services to young people with a child welfare history who are at-risk-of or experiencing homelessness.

As was mentioned previously in this report, Iowa HHS is trying to increase our current modest utilization of the FYI youth housing vouchers. The Children's Bureau has been particularly responsive to states in Region 7. State representatives have reported challenges with local housing authorities not helping create agreements applying for FYI vouchers. The voucher requests need to come from the local housing authorities, so child welfare agencies depend on them. Amy Hance, Children and Family Program Specialist has invited Iowa's IL Coordinator and other Iowa transition team members to regular meetings with Missouri, Nebraska, and Kansas reps so we can break barriers and get ideas. The meetings leave us feeling heard, but challenges remain and in Iowa the number of vouchers available has been stagnant. Amy Hance is working on pulling in HUD representatives and have even agreed to facilitate getting meetings with local housing authorities in communities where we can have a large impact.

Progress toward FYI grants has slowed and remains unchanged at 26 communities. No new communities have been added since our report last year.

Coordination with State Housing Authority

Through a collaboration of Aftercare, Iowa HHS, and Iowa Finance Authority (IFA), participants can access financial assistance for housing through an Iowa Aftercare Services Rent Subsidy program. The program helps Aftercare participants who are not receiving a PAL stipend meet the cost of housing (see Iowa Administrative Code 265, Chapter 22 for details). The amount is the prevailing cost of housing in the community where the youth resides and a maximum amount of $450 per month.

Annual data from the Iowa Finance Authority shows that an average of 64 Aftercare participants utilized the Rent Subsidy program each month in SFY 2022. A total of $388,119.37 ($32,343 per month on average) was distributed during the year. Young people in 24 counties participated in the Rent Subsidy program during the 12-month period.

Coordination with State Education Agency

On December 10, 2015, President Obama signed into law 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.

Since 2017, HHS maintains a contract with the Department of Education (DE) to ensure transportation funding is available for children in foster care who need transportation from a foster care placement to their school of origin. HHA wrote the contract with a maximum of $300,000 per year since it is expensive to transport children when they are out of their school-bussing zone.

Since the beginning of the pandemic, the already challenging task of getting children to and from school has become nearly impossible. Bus drivers are just not available. It is not uncommon to see hiring bonuses for drivers and $300 per day cost of transportation in provide transportation services. HHS' regional specialists continue to educate staff on the federal requirements. Workers initiate best interest meetings and do what they can to emphasize that it is the role of the school district where the child attended to bus the child from the foster care placement to the provider. Workers are often frustrated

when busing is delaying or simply unavailable. Foster parents, teachers, and family members try to fill the gaps.

We know we need to use data to evaluate performance in this area. Transportation claims over time validate our fears; in SFY 2021 HHS spent $188,886 on transportation for children in foster care. In 2022 it was down to $83,992. SFY 2023 has started to rebound some. HHS has begun to explore what is happening by talking with state and local level managers. We are hearing 1) the problem with getting bus drivers, and 2) the claiming process through the Iowa Department of Education is so onerous that some districts (DSM for one) provide the transportation and don't claim it. It also should be noted, the cost of education here does not include any in-district bussing (from one side of town to the other, for example) and it does not include the cost to the districts, which is undoubtably more than HHS spends). Regardless, the number of children being bussed is usually 20-30 in a quarter statewide. HHS and DE have begun to improve data sharing and the claims process to make it easier to do what is required and to be able to track progress. CCWIS holds the promise of expanded data sharing. We don't yet have the data we need, but we remain committed to doing our part to keep children connected to their homes school, teachers, and classmates.

Collaboration with the Iowa Judicial Branch

The Juvenile Justice Advisory Council (JJAC) is appointed by the Governor pursuant to federal law to oversee Iowa's use of the Juvenile Justice & Delinquency Prevention Act of 1974 (as amended 12/2018) Title II Formula Grant funds and to develop plans for system improvements. The State of Iowa receives annual federal funding for the following areas:

- Juvenile Justice Youth Development Allocation
- Aftercare
- Gender Specific Community Initiative
- Disproportionate Minority Contact
- Mental Health

HHS is a long-time member of the JJAC, with the state's Independent Living Coordinator having sat on the committee for over five years and is welcoming on a new term this summer. The collaboration with other state agencies, judges, service providers and other advocates have been beneficial to transition youth services. For example, staunch advocacy for "deep end services" for females has been a topic of conversation at JJAC and among the formal recommendations for several years. Juvenile Court Services and HHS have partnered to create specialized delinquency QRTP for females, starting with the new contracts July 1, 2023. HHS is also specializing more of the residential services for adjudicated delinquent youth. This approach promises to reduce contagion of delinquent behaviors, makes it more convenient to provide high quality services to address the criminogenic needs of delinquent youth, and could be safer for youth and staff alike. Furthermore, the integration of child welfare and juvenile justice professionals in committees like JJAC benefits all when we share the varied approaches to engage youth in the discussions about how to improve programs. The NYTD description in this report will expand on this work.

Iowa Collaboration for Youth Development (ICYD)

The ICYD is a state youth development advisory council to the Governor's Office and others. Council members are leaders of over 12 public and private 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 for the development of effective policies, practices, programs, and this report. SIYAC consists of youth between 14 to 21 years of age who reside in Iowa. The purpose of SIYAC is to foster 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.

Outreach to Youth Who Have Exited Care

Iowa is increasing our efforts to support and reach out to youth and young adults in or formerly in foster care to promote wellness and proactively address mental health needs. HHS has an all-new website, which holds updated foster care transition information, including information about AMP and Aftercare programs. There is a map with contact information for regional and statewide transition experts. The eligibility information is readily available to anyone who uses the website. The NYTD section describes efforts to connect youth to needed services if they indicate they are struggling with any of the life skills domains and NYTD will connect them with support.

We understand some youth may not go to the website, however, and not all youth who have exited care are going to be surveyed by NYTD. Is it for this reason we seize opportunities to engage providers who will meet Iowa youth who were formerly in foster care.

Representatives from the Iowa Department of Health and Human Services (HHS) Division of Family Well-Being and Protection visited Des Moines' Central Iowa Shelter and Services (CISS) in February 2023 to share program information and tour the facility. CISS is a low barrier adult shelter and service provider that helps hundreds of central Iowans daily, at no charge to those served; CISS target population are those who are unhoused, hungry or in need of services in the Des Moines area. For the Family Well-Being and Protection Division staff, the visit was an intentional opportunity to share foster care/adoption program information and raise awareness with CISS staff and residents in order to familiarize supports and services offered by HHS, Medicaid, SNAP, and Iowa Aftercare Services. The CISS shelter resident count was close to 140 when the team visited. Nancy Swanson, Laura Leise, Kristin Konchalski, Linda Dettmann, and Doug Wolfe served lunch to over 100 people and toured the facility.

If needed, provide an update on the specific training needed in support of the goals and objectives of the states' Chafee plan and to help foster parents, relative guardians, adoptive parents, workers in group homes, and case managers understand their opportunity to promote and assist youth in the transition to adulthood, consistent with section 477(b)(3)(D) of the Act. Please note that such training should be incorporated into the title IV-E/IV-B training plan, but identified as pertaining to Chafee, with costs allocated appropriately. States are encouraged to incorporate principles of Positive Youth Development (PYD) in their Chafee training in support of the program.

CHAFEE TRAINING

Every new case manager receives training through the HHS Bureau of Service Support & Training on how to complete the transition planning process and receive contact information for their local TPS, for support and guidance, and they are provided basic eligibility information on all the key transition programs, including how to make a referral. 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. Youth from AMP are also trainers for all new workers. Youth presenters have a way of talking to new workers that workers remember. When a person with lived experience in foster care says, "You need to call us back" or "I worry about my brother and sister", one doesn't forget it.

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.

Transition Planning Specialists provide service area trainings. No caseworker starts their job without knowing there are certain laws and procedures for all of the following:

- youth-centered planning, including referrals for services, inclusive of the five primary transition domains: 1) housing; 2) positive support system; 3) education; 4) employment; and 5) health care and access to health care coverage;
- how to discuss youth rights and document properly;
- ensuring smooth and timely 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;
- 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;
- requirements to obtain a birth certificate or state ID for every youth prior to aging out of foster care, and assisting them to obtain a social security card;
- discussion and opportunity to identify a health care proxy, for medical care, and
- local transition committee review process; one way Iowa reviews all cases of children planning to age out of foster care;
- Credit checks are completed through credit reporting agencies annually for children in foster care age 14 and older. Caseworkers are alerted when there is a credit issue and they work with the youth, directly. TPS provide support; and
- Reasonable and Prudent Parent responsibility and protections is trained to new workers and is in our employee manual. We have a video on the IFAPA website.
    - Reasonable and Prudent Parent Standard Foster Parent Training_8-3-16 (ifapa.org)

In addition to face-to-face training provided by the HHS training branch and local HHS, online training is available. Transition planning webinars, training videos, and NYTD data are available to those who login at: (http://training.hs.iastate.edu/course/view.php?id=577#section-3). The training is accessible once or multiple times for viewing or download to HHS/JCS, all providers, and the public. HHS periodically reviews the webinar for relevancy.

Below is a list of the "go to" documents TPS use on a frequent basis to educate and inform their communities:

- Samples of transition plans/guidelines that caseworkers may use to supplement the HHS transition plan within the case permanency plan;
- Specifics for caseworkers on how to electronically send a Casey Life Skills Assessment (CLSA) for children in family like foster care settings;
- Monthly transition topic conversations to have with youth;
- Information about what a Power of Attorney for Health Care is and why it is important for youth aging out of foster care to understand this process;
- Resources available to youth aging out of care;
- Transition eligibility scenarios;
- Ways in which the TPS may assist the caseworker with difficult cases regarding transition; and
- A thorough checklist by ages 16, 17, 17 ½, and 18 and what specific required transition processes occur during each of these ages. The checklist is in each youth's case file as a measure to track progress during one-on-one meetings between the caseworker and their supervisor.

To reach foster and relative care families, training is available using various approaches. In addition to the available webinar described above, the recruitment and retention contractor (RRTS) staff provide pre-service and ongoing trainings (currently through video conferencing), including foster family support groups. Training topics include attachment, trauma informed parenting, crisis management, child and youth mental health, self-care, and other localized areas of interest. RRTS caseworkers help families find training that will enhance their skills and that are relevant to children in their home. 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.

Iowa HHS promotes positive youth development programming, particularly in our programs for older youth including Supervised Apartment Living (SAL), AMP, and Iowa Aftercare Services. A couple examples are as follows:

- SAL providers are expected to develop a Service Plan that includes references to the positive youth development and Motivational Interviewing framework utilized with the youth. In SAL, positive youth development means an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.
- Like SAL, Iowa Aftercare makes Motivational Interviewing training available to all staff and the core of the service is about a strength-based, youth-driven approach to case planning. Iowa Aftercare uses the same life skills assessment and budgeting tools that are used in SAL, so the youth are able to transition from one program to the other comfortably. Aftercare promotes and builds on strengths very well, as is observed on case reviews conducted by HHS. Accomplishments of certain youth are held up on the Aftercare website. It may be we need to think about a way to recognize strengths, like a graduation or purchase of a home, on the program level.
- Naturally, the youth council, AMP, provides various opportunities for participants to share their experiences, showcase their abilities, and be engaged to improve the child welfare system. Local

youth councils invite youth to lead discussions and hold up their "highs and lows" for the week, so others can relate to challenges and overcoming them. Youth development is really what AMP I all about. In their annual conference, the contractor selects a venue, invites youth, follows an agenda with skills training and youth development activities, and ensures the experience is safe and meaningful for the youth. AMP uses the same definition of youth development in their contract and in their work as the SAL program to ensure that we are aligning approaches, concepts, and support.

EDUCATION AND TRAINING VOUCHERS (ETV) PROGRAM (SECTION 477(I) OF THE ACT)

In the 2024 APSR, states must:

- *Briefly describe the services provided since the submission of the 2023 APSR, highlighting any changes or additions in services or program design for FY 2024 and how the services assisted or will assist in establishing, expanding, or strengthening program goals (45 CFR 1357.16(a)(4)).*
    - *Provide an update on the state's efforts to engage or re-engage students whose post-secondary education has been disrupted by the COVID-19 pandemic and national public health emergency.*
    - *Describe any collaborative efforts with college campus support programs designed to increase student enrollment, retention and graduation.*
- *Division X Additional Funding from the Supporting Foster Youth and Families Through the Pandemic Act.*
    - *Provide the final update information on how the agency used the additional funding provided by Division X.*
    - *Describe accomplishments to date in using this supplemental funding to assist young people, including available quantitative information on the numbers of youth/young adult assisted and available information on the characteristics and demographics of youth assisted.*
    - *Describe any challenges or barriers the state has experienced in being able to use the additional ETV funds.*
- *If applicable, address any change in how the ETV program is administered, whether by the state child welfare agency in collaboration with another state agency or another contracted ETV provider.*
- *Provide to CB an unduplicated count of the number of ETVs awarded each school year. For this reporting, states may count the combined number of ETVs awarded from both the regular and additional Division X funding. (July 1st to June 30th). (Please see Section F2 and Attachment C).*

Program Service Description

The Iowa Department Health and Human Services (HHS) 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 HHS, ensures that all deliverables specified in the contract shall be provided by Iowa College Aid for an administrative cost that will not exceed the cost for one full-time employee.

Each year Iowa's ETV application is available online beginning in October, to coincide with the Free Application for Federal Student Aid (FAFSA) release. Students must submit both a FAFSA and an Iowa Financial Aid Application annually and awards are made until available funds are depleted. Students are eligible for ETV up to the age of 26. Priority consideration is given to students who received ETV in the previous academic year, then to students who received ETV in any previous academic year, then new applicants, and finally to students who are enrolled in a graduate program and have remaining ETV eligibility. All students who apply on or before July 1 are evaluated and awarded. Applications received

after July 1 are evaluated and awarded based on the priority consideration. Once all funds for a particular academic year are committed, a wait list is started. Students enrolled less than full-time receive a prorated amount. The college/university receives the awards directly, by term, and in most cases by electronic funds transfer. Once tuition, fees, and room and board charges are paid in full, the student then receives any remaining funds to assist in paying for the costs of attendance.

During the 2022-23 academic year, one student was able to utilize ETV as a graduate student. This year there were initially eight students on our waitlist. To fund them, Iowa College Aid ceased paying administrative costs from ETV funding and utilized those funds to cover funding to students. For this, HHS is grateful.

Colleges/universities complete a certification form annually to attest that all recipients will be awarded according to the ETV program guidelines. Colleges/universities also receive annual guidance when the list of eligible ETV applicants is provided. In addition, Iowa College Aid periodically audits colleges/universities to ensure student awards do not exceed the cost of attendance and are following all other eligibility rules, including, but not limited to, Satisfactory Academic Progress (SAP).

Iowa College Aid utilizes a financial aid system called the Iowa College Aid Processing System (ICAPS®) to administer ETV. Iowa College Aid staff use this system to collect applications, determine eligibility, monitor continual eligibility, send notifications to applicants and colleges/universities, monitor commitment levels of spending, and make payments to colleges/universities. Upon receipt of applications, the program administrator uses the child welfare information system to determine if an applicant was in an eligible status. These statuses, flagged in ICAPS, determine the number of eligible applicants in the program. After eligibility is determined, eligible applicants and their college/university receive a system-generated notification. Once colleges/universities determine a student is in attendance, they will notify Iowa College Aid, and a payment is generated.

The ETV Coordinator also reviews and updates ETV promotional materials, website, brochures and pamphlets and distributes materials statewide to numerous audiences. Students in Iowa receive information about ETV's existence in a variety of ways and learn to apply early in the application cycle.

Former foster youth may also qualify for the All-Iowa Opportunity Scholarship (AIOS). The State of Iowa funds this scholarship and it is available to students who have financial need and are attending an eligible Iowa college/university within two years of graduating high school. Students who self-identify as a current or former foster youth are given first priority for the AIOS. This scholarship is renewable for four years as long as the student is continuously enrolled.

Due to the national pandemic, there was more targeted communication with youth and colleges in regard to additional resources available to those youth who have aged out of foster care. Iowa College Aid closely monitored federal regulations in regard to SAP, worked with colleges to ensure housing needs were met for all students living on campuses and ensured students received the maximum amount of ETV possible.

After the passing of the Consolidated Appropriations Act, Iowa College Aid, with the help of HHS and student input, determined all funding would be used to pay ETV funds to students. An additional disbursement of $2,500 funding could be given to ETV recipients in the summer semester of the 2020-

2021 academic year and the maximum ETV amount for the 2021-2022 school year could be $12,000. Iowa College Aid got the word out about additional resources so that the program could connect or reconnect with youth whose education was disrupted by the pandemic. This additional funding allowed 19 students to receive additional funding to attend in the summer semester of 2021. It also allowed every recipient of ETV, 146 students, in the 2021-2022 academic year to receive additional funding.

There was minimal funding remaining for use in the 2022-2023 school year; only seven students received funding in fall 2022. Below is a chart showing the amount of Consolidated Appropriations Act funding spent by fiscal year.

Table 5F3: Consolidated Appropriations Act funding

	Amount	Unduplicated Students
SFY 2021	$25,208	19
SFY 2022	$659,825	146
SFY 2023	$12,328	7
Totals	**$697,415**	**155**

Collaboration

The ETV program continues collaboration efforts with Chafee funded organizations and programs, as well as others who serve youth aging out of foster care. The goal is to ensure all potentially eligible youth are aware of the supports available to them, including financial assistance, grants, and school based or community programs designed to help youth succeed. Among others, ETV collaborates with:

- Iowa Foster Care Youth Council
- College/university financial aid staff
- Other state scholarship and grant program administrators
- Iowa Aftercare Network
- HHS Transition Planning Specialists (TPS)
- Achieving Maximum Potential (AMP)
- Iowa's Tribes

Program support

The ETV Coordinator provides technical assistance, upon request, to college/university staff, Iowa Aftercare Network staff, as well as the TPS and HHS policy staff.

Accomplishments

Goal 1: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.

Objective 1.1: Ensure data is being or will be collected is functional and useful to make data driven decisions on outreach opportunities, assistance through ETV process, and best practices for ETV administration.

Iowa College Aid has standardized a report that will be updated and produced annually. This report can be found here. The data will be useful as decisions are made for best practices in the administration of the ETV program.

Goal 2: Collect data on applicants and recipients to better understand population, assist with ETV process, and track student outcomes.
Objective 2.1: Use standardized data to analyze outreach methods, graduation rates, retention rates, and other student success measures.

Iowa College Aid has begun analyzing the education and employment outcomes for ETV recipients. The report mentioned in Objective 1.1 evaluates persistence and retention rates as well as several other factors. The findings of the report showed the trend line for persistence is decreasing and illustrate the requiring submission of two separate applications may result in some students not being considered for ETV. Due to this, the recommendation is to remove barriers when applying for ETV. Beginning with the 2024-2025 school year, Iowa College Aid will only require the FAFSA and IFAA for new students entering the ETV program. Students who have received ETV in the past will only be required to compete the FAFSA and will be awarded ETV without the need of an additional application.

Provide to CB an unduplicated count of the number of ETVs awarded each school year. For this reporting, states may count the combined number of ETVs awarded from both the regular and additional Division X funding. (July 1st to June 30th). (Please see Section F2 and Attachment C).

HHS offered an additional $7,000 per youth but did not change the ability to pay for items. Funding was almost completed expended in the 2021-2022 school year with the expansion of the maximum award to $12,000. During this year, HHS worked closely with college financial aid offices and students to make any adjustments to the cost of attendance in order to award the maximum ETV amount possible. HHS does not anticipate enough remaining funding to allow any additional students a maximum award of $12,000.

The remaining funds will be used to pay a handful of students the normal maximum in the fall of 2022. With the funding, we were able to assist 145 students increasing their average annual award by $4,562. Every student who received ETV received some of the supplemental funding.

Please see Attachment D.

CONSULTATION WITH TRIBES (SECTION 477(B)(3)(G) OF THE ACT)

Describe the results of the state's consultation with each Indian tribes in the state as it relates to determining eligibility for Chafee/ETV benefits and services and ensuring fair and equitable treatment for Indian youth in care (section 477(b)(3)(G) of the Act). Specifically:

- *Describe how each Indian tribe in the state has been consulted about the programs to be carried out under the Chafee program.*
- *Describe the efforts to coordinate the programs with such tribes.*
- *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.*
- *Report the Chafee benefits and services currently available and provided for Indian children and youth.*

The only federally recognized Tribe in Iowa, the Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) has a settlement in Tama County, Iowa (northeast part of Iowa). Additionally, there is a concentration of Native families in northwest Iowa (primarily Woodbury County). All child welfare agencies, including tribal ones, are continuously in the loop concerning the Chafee purposes and

programs funded under Chafee (including the ETV program). The HHS TPS is the point of contact for Chafee services and transition process questions.

Meskwaki Nation has Meskwaki Family Services (MFS) located within the settlement in Tama County. The TPS for the HHS service area in which Tama County is located meets with the MFS staff to train on transition practices. The MFS staff is in the loop concerning Iowa's transition planning protocol, practices, and resources for youth still in care and aftercare resources, including the ETV program, for youth who age out of care.

The TPS in the Cedar Rapids Service area 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.

HHS includes MFS in distribution of information about resources for older youth in Foster Care and youth transitioning to adulthood. HHS' TPS in the Cedar Rapids Area notifies the MFS case manager when they have a youth who is on our list needing to do their Casey Life Skills Assessment within 90 days of turning 18 and needs to review their transition plan with the youth, and when they have a youth who needs to be reviewed by the Transition Committee.

Contact with MFS has continued to be limited this past year, due to staff turnover at MFS, by not being able to offer in-person training and because of lower numbers of youth in care. MFS only had a few youth who showed up on the HHS tracking as being 14 and older in out of home placement. HHS has offered and requested to meet with MFS again to provide information/resources/training regarding transition planning.

Native Youth Standing Strong (NYSS) - Native youth in Woodbury County receive encouragement to participate in cultural and recreational activities. NYSS is a collaborative effort between the Native communities, Sioux City School District, Four Directions Community Center, Juvenile Court Services, HHS, Goodwill Industries, Big Brothers Big Sisters and counseling and support services.

HHS works with tribal partners to ensure tribal youth have similar opportunities for engagement in transition planning (including assessments and planning activities) and the same array of services provided for non-native teens in foster care/alumni. Tribal children in Iowa foster care typically have a state caseworker (through either HHS or JCS) due to no tribe requesting to develop an agreement to administer, supervise, or oversee the Chafee program with respect to Indian children. HHS has had talks with the other tribes that reside in Nebraska but do have children in the Iowa foster care system. The tribes have shown interest after seeing the agreement that HHS has with Meskwaki Nation. HHS also has quarterly meetings with those tribes to see if there are any open cases, what the status is of those cases, any concerns the tribe or HHS has, and what the team can do moving forward.

Native youth eligible for Chafee benefits and supports have their transition plan reviewed beyond court and agency review by a local transition committee prior to turning 17 ½ years of age (or if entering foster care after the age of 17 ½, within 30 days of completion of the transition plan).

The Tribal/State Agreement with Meskwaki Nation states HHS is responsible for contracting and payment for foster care and Chafee transition services accessed by Meskwaki children. MFS has all case

management responsibilities, which includes activities such as life skills assessments and youth centered meetings. Aftercare services and AMP are available through HHS contracted services.

During this last reporting period, none of the Nebraskan tribes requested to develop an agreement to administer, supervise, or oversee the Chafee or an ETV program with respect to eligible Indian children and to receive an appropriate portion of the state's allotment for such administration or supervision. The Omaha Tribe has been in contact with the HHS Program Manager to create an agreement that would primarily allow for information sharing between HHS and the Omaha Tribe Family Services unit.

Please see *Section VI: Consultation and Coordination between States and Tribes* for more information.

Section VI: Consultation and Coordination between States and Tribes

In the 2024 APSR, states must update the following:

- *Describe the process used to gather input from Tribes since the submission of the 2023 APSR, 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)).*
- *Provide a description of the state's plan for ongoing coordination and collaboration with Tribes in the implementation and assessment of the CFSP/APSR. Describe any barriers to this coordination and the state's plans to address these barriers. (See 45 CFR 1357.15(l) and 45 CFR 1357.16(a)).*
- *Provide an update, since the submission of the 2023 APSR, 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).)*
- *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.)*
- *Describe the results of the state's consultation with each Indian Tribe in the state as it relates to determining eligibility for Chafee/ETV benefits and services and ensuring fair and equitable treatment for Indian youth in care (section 477(b)(3)(G) of the Act). Specifically:*
    - *Describe how each Indian Tribe in the state has been consulted about the programs to be carried out under the Chafee program.*
    - *Describe the efforts to coordinate the programs with such Tribes.*
    - *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.*
    - *Describe the Chafee benefits and services currently available and provided for Indian children and youth.*
    - *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.*

States may provide this information either in this section or in the Chafee Section of the 2024 APSR but are requested to indicate clearly where the information is provided.

- *State agencies and Tribes must also exchange copies of their APSRs (45 CFR 1357.15(v) and 1357.16(d)). Describe how the state will meet this requirement for the 2024 APSRs.*

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 Nebraska Tribes who have a presence in Iowa.

Discussions with Meskwaki Nation

As previously stated, Meskwaki Nation is the only federally recognized Tribe located in Iowa. Meskwaki Family Services (MFS) provides services and supports to tribal families located on and off the Settlement. HHS and MFS developed a strong working relationship for Meskwaki families involved in state court proceedings and tribal court proceedings. Mylene Wanatee, Director of MFS and Oceana Papakee, MFS Social Worker; leadership for Linn and Tama Counties; and central office staff discussed ongoing case specific and systemic issues, as needed, either through scheduled meetings or through email correspondence.

HHS' Indian Child Welfare Act (ICWA)/Tribal Relations Program Manager (Federal Programs Program Manager) scheduled meetings with MFS for June 21, 2022, September 27, 2022, February 16, 2023, and March 28, 2023. The meetings scheduled for September and February did not occur due to cancelation. The purpose of these meetings was to discuss the ICWA Training and Technical Assistance contract HHS holds with MFS, discuss any concerns regarding services, and follow up on continued issues.

HHS held a site visit with Meskwaki Nation on November 1, 2022. During this site visit, leadership staff from HHS met with leadership from Meskwaki Nation to tour the museum and Settlement, discuss equity, and build relationships now that IDPH and DHS are merged into one Department. Following this site visit, it was agreed that holding a site visit on an annual basis will be beneficial as relationships are continuing to grow and strengthen. The next site visit has yet to be scheduled.

Email discussions over the last year between the HHS Federal Programs Program Manager and MFS staff, Mylene Wanatee, included but were not limited to the following:

- Continued discussion of Tama County's refusal to pay its share of shelter costs for MFS children in shelter care.
- Revision and execution of the intergovernmental agreement between HHS and Meskwaki Nation.
- Usage of Promoting Safe and Stable Family (PSSF) funding under HHS' contract with MFS.
- Contract and agreement updates.
- Questions surrounding adoption subsidy.
- Background check process for HHS.

HHS and MFS renewed the ICWA Training and Technical Assistance Intergovernmental Agreement (IGA) contract for the next fiscal year. Minor changes were made to the contract, including removal of information related to Emergency PSSF, change in Agency name from DHS to HHS, and future change in Agency location. The new contract will take effect on July 1, 2023.

Discussions with Nebraska Tribes

Iowa HHS local, service area, and central office staff actively participates in monthly meetings in Sioux City involving Tribes domiciled in other states but who have a significant presence in the area. The Community Initiative for Native Children and Families (CINCF) includes representatives 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 of Iowa (LSI), health, and education and other local native community members. The group collaboratively works monthly 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 Liaisons regularly attends the meeting and update representatives on new Iowa HHS initiatives, data regarding Native children, and concerns related to practice or ICWA compliance. Iowa HHS Program Manager attends these meetings, provides policy information, and receives information regarding ICWA compliance concerns and makes policy or practice changes, in concert with field staff, as needed.

Examples of topics discussed during CINCF meetings included but were not limited to the following:

- Licensing, recruitment and retention of Native foster parents in the area.
    - Lutheran Services in Iowa (LSI)'s efforts to market and work with area Tribes to increase Native foster homes, e.g., marketing and reaching out to the Winnebago Tribes creating an advisory committee to help move those efforts forward.
- Urban Indian Center
    - Kenny Provost is the new Cultural Coordinator with the center. Kenny Provost, Urban Indian Connections Cultural Coordinator along with Hannah Helseth, USD student instructs a Youth Night every Tuesday. The first meeting starting with 10-15 youths. To date they have 6o participants and about 15 parents attending.
    - Kenny's outreach includes working with the Sioux City School District and the Native American Childcare Center with cultural curriculum and language programs.
    - Urban Native Center held its 2022 Halloween Bash in South Sioux City and was a huge success with 300 in attendance and several sponsors.
- SHIP was awarded the Strengthen Urban Natives grant (SUNS) in September 2022. This 3-year grant will receive $300,000 per year to support a social worker, therapist and additional outreach positions.
    - SHIP received 3 additional grants for BOOST and Sky Ranch Behavioral Services. BOOST serves 18–24-year-olds involved with the system. With this new grant they will also serve students with an IEP-Individual Education Plan.
- Native Youth Standing Strong (NYSS).
    - Will Meier with NYSS reports they have been fundraising for sweat lodge tarps for area prisons. They have purchased 1 so far to be delivered to Ft. Dodge. He has been working with the state advisory on other needs. The Cultural representative position in the prison system will be open this year. It has been suggested that someone from the Woodbury County area would be a best fit. The prisons need more cultural representation.
- The Native Resilient Grant will begin its 3rd year on July 1, 2023, with the goal of building awareness and resources. The 4 areas of focus are: Youth Centered-Family Focus, Poverty, Resource Access, and Education.
    - The media coverage will kick off with billboards in the Siouxland area. The group will present data and future plans at the Memorial March educational event in November and plan to present at the 2024 NICWA conference.
    - Val Uken, Heidi Kammer-Hodge, and Erin Binneboese presented updates on the Native Resilient Communities Grant. Year 2 of the grant just wrapped up; they continue to

measure their work through strategic planning documents and action plans. There are 3 more years of the grant left. They are making strides in data collection and youth engagement. There is a big focus on education for youth.
    - Val and Heidi presented at the Equity conference noting the process and progress for future opportunities in their community. Diane Murphy-Smith, Assistant Attorney General for HHS, noted our community as the 3 C's – Creativity, Collaboration, and Courage.
- A site visit with the state PCAI (Prevent Child Abuse Iowa) will be the week of June 8. Meeting is set at the Ho-Chunk Center with a site visit to the Urban Native Center to follow. SHIP holds an ICAPP contract with PCAI and they are connected to native issues in the Siouxland community.
- Terry Medina is now the new Community Based Native Advocate for the Siouxland area. He is based at the Frances Building in Sioux City. Terry is able to provide native specific classes to families in the Siouxland Area as well as an advocate.
- Neal Lawhead is currently a Tribal Child and Family Program specialist in the Children's Bureau. Neil is working towards uniting Nebraska and Iowa state departments and tribes along with state and federal offices concerning our child welfare system.
- Memorial March to Honor Lost Children
    - 2022 was the 20th Anniversary of the Memorial March to Honor Lost Children. The schedule of events from the March is provided below:
        - Saturday, November 19th dinner at the Urban Native Center.
        - Sunday, November 20th showing of the documentary "Women of White Buffalo" at the Orpheum.
        - Monday, November 21st Race: Power of An Illusion was in-person at Briar Cliff St. Francis Center.
        - Tuesday, November 22nd educational event will also be at Briar Cliff with a family dinner and youth forum held at the SC Convention Center.
        - Wednesday, November 23rd the March started at War Eagle Monument 7:30 am ending with lunch at the Sioux City Convention Center.
    - There were over 300 relatives at the final dinner on Wednesday after the March.
- Iowa Child Abuse Prevention Program (ICAPP), Native Resilient Communities Grant updates- Woodbury County was one of four counties who received the grant. Nola Aalberts expressed her interest to collaborate with the Native Resilient Grant in offering an AmeriCorps position to help with the grant in any way needed. SHIP did not move ahead with an Ameri Composition under the Native Resilient Community Grant. For more information on these grants, please see Section V. Updated Services Descriptions, Prevention, Iowa Child Abuse Prevention Program.
- Monthly updates of Native children served by the HHS Native unit who meet or do not meet ICWA requirements and their placements, i.e., relative's home, Native foster family home, non-Native foster home, etc. are shared with the group. This also includes tracking the number of families and number of self-identified Native American children.
- Full Circle Recovery-The Recovery Community Center is an independent nonprofit organization led by representatives of local communities in recovery that provide peer-based recovery support services, public education, and policy advocacy. Full Circle is not a treatment center. It offers emotional, informational, and practical support for individuals and families affected by substance use.
- Lutheran Social Services of Iowa continue to provide Native Family Information Sessions on becoming a foster or adoptive parent in Iowa through Lutheran Services in Iowa RRTS program.

- The Kinship Caregiver program began in July 2021. Since April 2022 there have been 73 Kinship Referrals in Service Area 1.
    - In the Western Service Area there have been 10 Kinship Referrals for Licensing involving Native American children who are place in the home since April 2022.
    - LSI RRTS holds a monthly Orientation/information Session to promote the importance of maintaining Native American culture, assisting families with the paperwork if they chose to meet in person. Virtual orientation opportunities are also made available.
    - There have been 3 Resource Families who have been licensed through the Kinship Caregiver Process with Native American children placed in the home. One home study has been submitted and was approved in March to increase that to 4 Resource families being licensed as foster parents for Native American kin placed in their homes. Kinship Licensing has impacted a total of 10 Native American children who were placed in these homes.
    - 4 Kinship licensing referrals for Native American children were cancelled as the children were moved from the home. Two withdrew from licensing but are proceeding with an adoption only home study.

Iowa HHS' Native unit in Woodbury County includes five caseworkers and two Native Liaisons. The liaisons' role is to exchange cultural and case information between tribes, HHS and the Native families. Iowa HHS also has considerations for creating a Native Unit in the Des Moines Service Area (DMSA), as it was the 2nd largest Native populated area. This option will be explored over the next year.

Iowa HHS SAM, SWA, Native Unit supervisor, Iowa HHS Program Manager, and the Assistant Attorney General (AG) assigned to the WISA meet with the four Nebraska Tribes on a semi-annually or quarterly basis, 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 Tribal Customary Adoptions (TCA), relative placements, transfer proceedings, and improving communication. Meetings occur by video in lieu of in-person meetings.

- Quarterly Meetings held:
    - Winnebago Tribe of Nebraska:
        - These meetings include Roz Koob, the Tribe's attorney, and Elexa Mollett, the Social Service Tribal and ICWA Specialist.
        - During the meetings, participants discuss upcoming training events and services available to families as well as discuss and work through practice and policy concerns. If there are policy concerns, participants educate each other on how their respective systems operate to develop a solution. Additionally, participants may contact the Iowa HHS 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.
        - Additional focus occurred around the permanency option of TCA with the Winnebago Tribe. This has been a topic of discussion with local Tribes and is now a permanency option that is being utilized by the Winnebago Tribe.
    - Omaha Tribe of Nebraska:

        - These meetings previously included the Alexis Zendaja, the Tribe's attorney, Mosiah Harlan, the Social Service Director, and Kash Echtenkamp, the ICWA Specialist. However, since the departure of Mosiah Harlan and Kash Echtenkamp and the addition of Alexis Zendejas as Omaha Tribe's ICWA Director and Attorney, meetings now include Alexis and DeAnna Parker, Social Service Director.
        - 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 Iowa HHS program manager to address statewide policy concerns.
        - The outcomes established by these meetings are similar to that of the Winnebago Tribe, i.e., improved communication and a better understanding of how each other's programs operate to increase efficiency of services for children and families.
        - Discussions around TCA continue as a process has been put in place to implement these permanency recommendations.
    - Santee Sioux Tribe of Nebraska:
        - Attendance from the meeting's vary between representatives of the Santee Sioux Tribe, i.e., Social Services Director, Danielle LaPointe, Supervisor Clarissa LaPlante, and ICWA Specialist Renae John.
        - Similar to the other Tribes, the topics of discussion included strengthening relationships, improved communication, and improved understanding of how each other's programs operate to increase efficiency of services for children and families.
        - At this time, TCA is not a permanency option within the Santee Sioux tribal law. Through conversations, it is an option the Tribe is now using utilizing the Ponca Tribal Court, as a service court. There is currently one family going through the customary adoption process through the Ponca court, from the Santee Sioux Tribe.
- Semi-annual meetings:
    - Ponca Tribe of Nebraska:
        - Meetings occur with Social Services Director for the Ponca Tribe, Stephanie Pospisil. The purpose of the meetings is to build relationships and communication with the Ponca Tribe. During meetings, participants discuss policy, services provided by the Ponca Tribe, and the Tribe's position on termination of parental rights hearings.
        - Iowa HHS discussed TCA with the Ponca Tribe as well. The Ponca Tribe does have TCA available as part of their tribal law and they are able to utilize their court as a service court for other Tribes that do not have TCA in their tribal law.

As briefly mentioned above, HHS has had an AG assigned to the WISA. The AG works with Iowa HHS WISA and central office leadership and Iowa HHS WISA social workers to improve ICWA practice in the WISA, e.g.:

- utilizing the four questions to prevent removal:
    - What can we do to remove the danger instead of the child?
    - Can someone that the child or family knows move into the home to remove the danger?
    - Can the caregiver and child go live with relative or fictive kin?
    - Could the child temporarily live with relative or fictive kin?

- utilizing Iowa HHS' Employee Manual 18-C(5): Indian Child Welfare Act (ICWA) and providing feedback of what does and does not work and anything that might be missing in the manual;
- discussing relative notices;
- leading efforts to utilize permanency options, other than termination of parental rights (TPR), when appropriate; and
- utilizing a plan, do, study, act (PDSA) to focus on TCA.

Due to having an AG assigned for the WISA, the AG participates in Native Unit meetings, meetings with the Tribes, as noted above, and the tribal case specific staffings HHS has with the Tribes. Due to this new position, HHS had not previously had an attorney present with them during these meetings. TCA and the involvement of the AG has been the primary focus of recent discussions.

The PDSA for TCA has a workgroup comprising a variety of stakeholders, e.g., HHS central office and WISA field staff, Iowa AGs, Tribes, Tribal AGs, Iowa Children's Justice, Court Appointed Special Advocate (CASA) Coordinator for WISA, etc. The workgroup continues to meet monthly or as needed, and a sub-workgroup formed to draft documents for further review by the bigger workgroup. Prior to the implementation of TCA, the HHS program manager had reached out to the California ICWA Specialists to learn more about how TCA works, including what happens to parental rights since there is no TPR, what happens to the birth certificate, social security number, etc. Information that was received from the California ICWA Specialists was used to help implement TCA. HHS staffs cases that are approaching permanency with the Attorney General assigned to the WISA, along with the tribes and other court parties, to exhaust all tribally appropriate family preservation alternatives. To date, HHS has assisted in completing 3 TCAs to avoid TPR, with several more in the process of completing. HHS is also finalizing TCA steps for publishing in Employee Manual 18-C(2): Case Management, Employee Manual 18-F(1): Permanent Placement Procedures, and Employee Manual 18-C(5): Indian Child Welfare Act. Since each tribal court uses different language in effectuating TCA or TCA is not written into the Tribe's tribal laws, creating a single statewide document with steps for TCA effectuation has shown to be difficult; this is something the workgroup continues to work through with input from the Tribes in Iowa.

WISA HHS has also been sending letters to Tribes notifying them that we are involved with a family on a voluntary basis. Per ICWA requirements, Tribes receive Notice when there is court involvement. However, when our assessment worker first meets with a family, the worker is not only asking if the family identifies as Native, but also asking about tribal affiliation or enrollment. When HHS learns the identity of the Tribe, and with the family's permission through a Release of Information, we send them a letter, letting them know of our voluntary involvement with the family. This allows direct communication on our voluntary cases with tribes. This has been a direct result of suggestions from Tribes during our meetings. The benefits of early engagement include determining membership or eligibility for membership early in the case, which supports ICWA compliance, and conducting active efforts, e.g., including the Tribe in case planning activities, identifying appropriate tribal services, etc. The practice continues after the parents sign a Release of Information for HHS to share information with identified tribes. This has been going well and there haven't been any challenges.

State level meetings, between HHS central office staff, IA AGs, Tribes, Tribes' Attorneys, CB, and Nebraska ICWA Specialist, IV-E Unit, and AGs, when applicable, included but were not limited to the following:

- Discussions regarding tribal placements into Iowa and Iowa transferring cases to the Tribes where dropping Medicaid occurs and there is a dispute between Iowa and Nebraska regarding residency, with meetings held in July, August, September, and October 2020. After meetings with the Tribes noted above, the HHS Program Manager sent out a draft email that the Tribes could send to HHS' Interstate Compact on the Placement of Children (ICPC) office with documentation to determine IV-E eligibility. Later, all parties agreed that the Tribes would add the NE ICWA Specialist and the NE Department of Health and Human Services (DHHS) IV-E Unit to the email. The issues regarding who (IA or NE) pays for Medicaid is yet to be resolved.
- HHS, Iowa Court Improvement Project (CIP), the Tribes, and CB saying "hello" to the Tribes individually and discussing issues related to HHS and IA Juvenile Court ICWA practice in Iowa, e.g., engagement of Tribe in case planning activities, ability of Tribe's ICWA Specialist to testify in Juvenile Court, court ordering hair stats, etc.
- Collaboration between Iowa Courts and Tribal Courts
- State-Tribal Agreements

The State of Iowa continues to meet with Tribes as described above. The Tribes and HHS are all willing to continue this process and all report the meetings are beneficial. At this time, meetings continue to be virtual.

Update on Next Steps

The following are updates to the next steps in Iowa's FFY 2024 Annual Progress and Services Report (APSR).

- The State of Iowa and The Sac and Fox Tribe of the Mississippi in Iowa (Meskwaki Nation) Intergovernmental Agreement: The Agreement was executed in November 2022 and will have a revision to include HHS' new name, logo, and website.
- HHS' Federal Programs Program Manager, as mentioned under Discussions with Meskwaki Nation, continues to hear concerns regarding FCS' provision of services to Native families. State level program discussions regarding these issues will hopefully address them within the next year.
    - FCS contracts will be renewed by July 1, 2023. A plan to improve and monitor this so contractors and HHS have a clear understanding of expectations and what the contractors are being held accountable to with active efforts will be developed.
    - HHS plans to hold an in-person meeting with MFS, Four Oaks and Families First contractors, and HHS representatives to have a discussion regarding barriers to FCS services and plan on moving forward. This meeting is set to take place in fall of 2023, with a date yet to be determined.
- HHS Federal Programs Program Manager previously explored with MFS staff the possibility of providing Positive Indian Parenting to their families. However, at this time, MFS did not believe the services was needed.
- Work will continue on the following:
    - HHS staff holding themselves accountable for activities in the State/Tribe Agreement with Meskwaki Nation;
    - Improve HHS accountability through enhanced communication with Tribes;
    - Address the 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.; and

- Work with the Tribes to implement agreements.

Provide a description of the state's plan for ongoing coordination and collaboration with tribes in the implementation and assessment of the CFSP/APSR. Describe any barriers to this coordination and the state's plans to address these barriers (See 45 CFR 1357.15(l) and 45 CFR 1357.16(a)).

HHS will include tribal representatives in the ongoing Service Area meetings, which continue throughout the year to address local interests.

- Meskwaki Nation – quarterly meetings with HHS staff
- Winnebago, Omaha, and Santee Tribes of Nebraska – quarterly meetings with HHS
- Ponca Tribes of Nebraska –quarterly meetings with HHS
- Monthly CINCF meetings attended by the various tribes.

Provide an update, since the submission of the 2022 APSR, 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).)

A noted above, Meskwaki Nation is the only federally recognized tribe domiciled in Iowa. They established their tribal court in 2005. HHS and Meskwaki Nation finalized a State/Tribal Agreement initially in 2006 and revised in 2018, which outlined Tribal and HHS responsibilities for service provision, payment for services, federal reporting and assessing child abuse. HHS and MFS finalized a protocol in June 2011, with revision in 2018. The protocol further defines the roles and responsibilities of HHS 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 latest revision to the agreement took place in 2022. This revision reflects the *McGirt* U.S. Supreme Court decision, written in a format that aligns with HHS' MOUs that are held with other entities, Title IV-E State Plan requirements, and language that is more respectful for Meskwaki Nation.

The State/Tribal Agreement states HHS will be responsible for payment for foster care or other child welfare services accessed by Meskwaki Nation children under tribal court jurisdiction. MFS has all case management responsibilities. Children under tribal court jurisdiction may access any service available to a child under state court jurisdiction as long as the child is eligible for HHS services.

The Agreement also states the cases of children under tribal court jurisdiction, but for whom HHS pays for services, may be subject to federal review through a Title IV-E Eligibility Review or through a Child and Family Services Review. MFS provides all required Title IV-E documentation including court orders and family household composition, income and resources, and ongoing documentation to HHS in order to determine initial and continued eligibility for Title IV-E claiming.

MFS has responsibility for the management of cases under tribal court jurisdiction and meeting the law of their nation regarding case requirements and a case review system. Tribal law explains case planning requirements including required federal language in case plans. Tribal law also includes periodic review and reporting requirements by MFS. Tribal law addresses case requirements to prevent children's removal from their home, to achieve reunification, and to achieve permanency.

HHS performs all case review requirements for Meskwaki Nation children under state court jurisdiction, which includes providing credit reports to children aged 14 or older in foster care.

There are several tribes domiciled in Nebraska and South Dakota who have a presence in the northwest part of Iowa. At this time, HHS does not have agreements to pay for services for children under the jurisdiction of the tribal courts of these tribes. HHS, in consultation with the federal Children's Bureau and the Tribes, plans to establish agreements with as many of these tribes as possible. The Omaha Tribe, from Nebraska, has started conversations with the HHS Program Manager in creating an agreement between the Omaha Tribe and HHS. The primary focus of the agreement would include information sharing between the Tribe and HHS. Discussions continue as of the date of this report.

Children under state court jurisdiction are eligible for all child welfare services. HHS pays for these services and manages these cases in collaboration with the child's Tribe. Children under the jurisdiction of a tribal court in another state 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.)

HHS does not have a specific process to determine ICWA compliance nor an automated mechanism to collect data to determine ICWA compliance. Due to the COVID-19 pandemic staff turnover, HHS and MFS had to halt case readings that required travelling to HHS offices, reviewing files, and conducting case interviews with HHS social workers. Therefore, no compliance reviews occurred from July 2022 through June 2023. There is no timeframe to resume the reviews.

However, below are several initiatives occurring in Iowa to address ICWA compliance.

- The HHS Federal Programs Program Manager re-recorded, due to poor audio quality of the previous recording, a training webinar on ICWA, that also covered the employee's ICWA manual, entitled *"ICWA: Social Work Practice with First Nations"*. This training webinar is still in use.
- HHS is in the process of developing our comprehensive child welfare information system (CCWIS). The HHS Federal Programs Program Manager met with CCWIS and IT staff to include several adoption and foster care analysis and reporting system (AFCARS) data elements and possibly additional elements related to ICWA compliance. HHS Federal Programs Program Manager continues to answer questions on reporting system data elements and compliance.
- As part of Iowa's Child and Family Services Review (CFSR), program improvement plan (PIP), Iowa's Joint CQI workgroup decided its first project would be to apply the joint CQI process to ICWA. Clear gaps were identified, including not having enough data needed to measure performance on virtually any ICWA-related areas. Without documentation, we are unable to determine how we are currently performing. ICWA-related performance tracking is a significant gap for both agencies; the plan is to begin laying the foundation by focusing on the starting point of the process: exploration of

tribal eligibility when a family intersects with the child welfare system, with a concurrent measure of a data gathering process that supports monitoring.

For information about the CFSR PIP and information about the joint CQI process, please see *Attachment 3A: Iowa's Child and Family Services Review (CFSR) Round 3, Program Improvement Plan (PIP), Final Progress Report, as of June 30, 2022*

Describe the results of the state's consultation with each Indian tribe in the state as it relates to determining eligibility for Chafee/ETV benefits and services and ensuring fair and equitable treatment for Indian youth in care (section 477(b)(3)(G) of the Act). Specifically:

- *Describe how each Indian tribe in the state has been consulted about the programs to be carried out under the Chafee program.*
- *Describe the efforts to coordinate the programs with such tribes.*
- *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.*
- *Describe the Chafee benefits and services currently available and provided for Indian children and youth.*
- *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.*

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 APSRs (45 CFR 1357.15(v) and 1357.16(d)). Describe how the state will meet this requirement for the 2023 APSRs.

The HHS Program Manager will provide electronically the approved FFY 2024 APSR to the Director of Meskwaki Family Services and to the individuals identified by each of the Nebraska Tribes. During a CINCF meeting, the HHS Program Manager also will provide a link to the CINCF members where they can view and/or download the report from the HHS website.

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Section VII: CAPTA State Plan Requirements and Updates

Please see FFY 2024 CAPTA Report.

Section VIII: Targeted Plans

Please see the following attachments for the targeted plans:

- Attachment 8A: Foster and Adoptive Parent Diligent Recruitment Plan
- Attachment 8B: Health Care Oversight and Coordination Plan
- Attachment 8C: Disaster Plan
- Attachment 8C1: 2023 COOP COG Plan
- Attachment 8C2: Appendix – COOP At a Glance – Attachment A
- Attachment 8C3: Appendix – Recovery Members Teams – Attachment B
- Attachments 8D: Training Plan, with Attachments 8D1 through 8D9

Section IX: Statistical and Supporting Information

CAPTA ANNUAL STATE DATA REPORT ITEMS

Please see FFY 2024 CAPTA Report.

EDUCATION AND TRAINING VOUCHERS

Please see Attachment D to this report.

INTER-COUNTRY ADOPTIONS

Report the number of children who were adopted from other countries and who entered into state custody in FY 2022 as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or the adoption, the plans for the child, and the reasons for the disruption or dissolution. (See section 422(b)(12) of the Act.)

Iowa's automated information system tracks:

- The number of children adopted from other countries or who enter into State custody because of the disruption of a placement for adoption or the dissolution of an adoption;
- The agencies that handled the placement or the adoption;
- The plans for the child; and
- The reasons for the disruption or dissolution.

In the past year, no children adopted from another country experienced disruption or dissolution through HHS.

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Section X: 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 2024. 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 2024.

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 Centered 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.

Table 10A below shows financial information comparing FY 2021 state and local share spending for subpart 2 programs against the 1992 base year amount as required to meet the non-supplantation requirements in section 432(a)(7)(A) of the Act.

Table 10A: Comparison of FY 2021 State/Local Spending and 1992 Base Year Spending		
Category	**FY 2021**	**FY 1992**
Family Preservation	75,000	-
Family Support	517,888	581,841
Family Reunification	705,487	-
Adoption Promotion	502,629	-
Other Service-Related Activities	523,943	-
Total Administration	187,382	-
Total	**2,512,330**	**581,841**
Source: HHS		

In FY 2007, Iowa began targeting the adoption promotion portion of PSSF funds to provide adoption support services to adoptive families via the statewide Resource and Recruitment contract, which became the Resource, Recruitment, Training and Support of Resource Families (RRTS) contract effective July 1, 2017. Iowa updated the FY 1992 baseline to reflect that change in the use of these funds.

[i] Responding to Human Trafficking among Children and Youth in Foster Care and Missing from Foster Care | The Administration for Children and Families (hhs.gov)

Attachment D

Annual Reporting of Education and Training Vouchers Awarded

Name of State/Tribe: Iowa

	Total ETVs Awarded	**Number of New ETVs**
Final Number: **2021-2022 School Year** (July 1, 2021 to June 30, 2022)	146	72
2022-2023 School Year* (July 1, 2022 to June 30, 2023)	137	73

Comments: 2022-2023 School Year is an estimate.

*in some cases this might be an estimated number since the APSR is due on June 30, the last day of the school year.