THE CHILD WELFARE POLICY & PRACTICE GROUP

Iowa Department of Human Services

Provider Forums Report

Conducted by:

The Child Welfare Policy and Practice Group

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Consultant Biographies

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Freida Baker is the Executive Director of the Child Welfare Policy and Practice Group (CWG) in Montgomery, Alabama. Freida was previously Deputy Director of Family Services with the Alabama State Department of Human Resources (DHR). She has 36 years of child welfare experience, and her areas of expertise include best practices in child safety, permanency, and well-being, as well as system performance. Freida has supported child welfare systems assessments, CFSR reviews, and Quality Services Reviews since 2000. She participated closely in the implementation of Alabama's landmark R.C. Consent Decree and has significant expertise in systems and change management. She is also LAMM certified through the National Child Welfare Workforce Institute. She has trained social workers, the judiciary, educators, foster parents, physicians, and other partners across the nation.

Jennice Floyd, MSW, LCSW

Jennice has experience in all areas of child welfare, including front line practice, supervision, and directing a county welfare agency. As Director, she managed all areas of child welfare and led the county's reform efforts in reaching compliance with Alabama's sweeping R.C. Consent Decree. As a state consultant during the reform effort, she helped developed the case practice model, family teaming, and quality service review protocol. Since joining CWG she has frequently provided technical assistance and consultation to child welfare systems throughout the nation. She has developed and provided training, coached supervisors in management practices, coached staff to facilitate Family Team Meetings, and conducted Quality Service Reviews (QSR) across the country.

Iowa Department of Human Services

Provider Forums – Voice and Vision

I. Purpose and Focus of the Forums

Leadership at the Iowa Department of Human Services (DHS) made a specific commitment in late 2018 to elicit input from the provider community relative to current processes and practices. This included recommendations for improved outcomes for children and families; greater fiscal efficiency and, as Iowa approaches implementation of Family First Prevention Services Act (Family First), a particular sense of provider questions and concerns about the state's vision for practice as well as technical implementation of the law.

Agency leaders agreed that it would be helpful for providers to have a neutral opportunity to discuss their questions and concerns about the issues that impact them now and will so in the future. These leaders charged The Child Welfare Policy and Practice Group (CWG) with presenting and managing the forums similar to an agency Request for Information (RFI) opportunity. Toward this end, in February and March, 2019, CWG facilitated 10 Provider forums throughout the state. Invited were stakeholders, provider directors and administrators, Family Safety Risk and Permanency (FSRP) Care Coordinators and supervisors and other child welfare service providers. CASA representatives were present at most of the meetings as well. While the venues, invitations, and scheduling were managed at DHS central office, there were no DHS employees present at any of the Forums.

II. Methodology

The Child Welfare Policy and Practice Group assisted the Department of Human Services by facilitating statewide provider forums. Questions for discussion, featured below, were created by DHS with input from select providers and CWG. These questions were submitted to invitees in advance of the forums, and served as the foundation for the agenda. The three-hour forums also presented opportunities for global discussions in addition to capturing specific responses to the aforementioned questions. Participants were assured of confidentiality and anonymity, and were encouraged to speak freely about policies and practices. Nearly 110 persons participated in the forums. CWG agreed to prepare a report to capture themes, obtain responses to questions, and offer recommendations to DHS relative to the agency's partnership with the provider community.

A team of two facilitators supported the first three forums, then that team divided facilitation of the other seven meetings. These forums occurred in the following Iowa cities: Bettendorf, Council Bluffs, Des Moines, Iowa City, Johnston, Mason City, Osceola, Sioux City, Washington, and Waterloo. The logistics were well-planned and managed by the DHS Central Office.

As a substantial number of individuals participated in the forums across the state, responses to the questions were understandably varied. The **summary answers** appear below, and briefly capture the responses most representative of the majority of participants. It is crucial that

those reading the report understand that vivid and earnest discussions unfolded at every site, above and beyond any specific answers to the questions. Providers had a larger message for DHS, and repeatedly asked that facilitators from CWG include thematic narrative and specific examples of their input in the report to Central Office. That narrative follows the summary responses.

III. Provider Responses to Questions by Major Topics

A. Financing

The current contract provides FSRP providers with a flat rate for services and provides this payment up to 18 months. The monthly payment rate is automatically reduced to 70% of the initial rate after the case is open by DHS for 18 consecutive full months of services with the same contractor. Payment remains at this reduced rate until the case is closed. Challenges with funding services this way include: no incentive for front-loading intensity of services and no stable funding stream for contractors. The Crisis Intervention, Stabilization and Reunification contract moved payment to a "Firehouse" model meaning that DHS can anticipate the volume of service needed per historical usage and pay accordingly. Purchasing these services per number of families served allows providers to build staffing based on guaranteed funding streams and encourages greater intensity of services to move towards closing with shorter lengths of service.

1. **How would a "Firehouse model" of payments impact services? (for instance: a contractor is serving 500 families at $6,500/family = $3.25M, instead of being paid a monthly rate).**

Providers largely said that they were not comfortable with this model, particularly with the way contracts are currently bundled. Some said they could see positives about the model, but would be more confident if services were unbundled. Many perceived Firehouse as a "high risk", even "volatile" model. One provider framed a response this way, and similar thoughts and concerns were shared across sites: "If we were allowed to use evidence-based practices (EBP) as they're designed and not stray away from them, I don't think families would be impacted" by Firehouse". However, the consensus was that EBP's are changed by DHS and then become "unrecognizable as the EBP we submitted". Participants were concerned that one serious impact on families has been that cases remained open for longer periods of time since the EBP had been significantly changed from original submission. Providers also noted that, if they "are bankrupt", the impact on families is severe because the service is no longer available. Others were concerned that Firehouse would inhibit individualization of planning and services. Some suspected that the Firehouse model would not cover all expenses. A concern across Forum sites was the fear that realistic deliverables would not be designed from the beginning in partnership with providers. A cap on caseloads was appealing to some, but concerns were raised about the possibility of "bankrupting" an organization if policy changed mid-stream to require more services that are unfunded.

Providers were concerned that the model does not effectively weigh cases or capture case trends with families. Providers stressed that caseload size is rarely an indicator of actual work with families, and noted that one family can require services "all day every day". A recurring theme

throughout the Forums was the disparity of available resources, and how unfortunate this was for families who need services to achieve their case goals. Finally, some were concerned that a Firehouse model would be designed for ease of DHS oversight and not so much focused on improved services/efficiency.

2. **If a "Firehouse model" of payment is used, what variables should be considered in arriving at a payment AND what should that payment be? Why?**

Variables should include:

- Family case status – e.g. Intact
- Court status of case
- Caseload size
- Geography – rural vs. urban
- Full cost of EBP
- Intensity of care required, e.g. low, moderate, intensive.
- Scope of work
- Identify which blended funding streams are allowable/disallowable

In terms of payments, providers reasoned that the amounts will be different for all organizations based on which EBPs are offered. There was "no one answer" because the EBPs all have different costs.

3. **How long would it take to serve an "average" family?**

The collective average offered by providers was 16 weeks. They stressed that, in the future, the EBP will dictate this. Therefore, for some families, service delivery would be 10 weeks, some 24, etc.

4. **From your point of view, provide the pros and cons of each financing model?**

a. Fee for service (pay per unit of direct service)

Clear definition of all deliverables remained a theme and was mentioned frequently. One group spent several minutes asserting that this model should stimulate DHS funding and the use of informal supports.

Under the monthly unit, FSRP services contractors receive a monthly payment amount for each full calendar month in which a case is opened/approved for services and the Contractor meets the minimum monthly service delivery requirements. Generally, providers agreed that "fee for service" is their preferred payment option. Some noted, however, that the preference for "fee for service" was more because of a lack of confidence in DHS vis-à-vis EBP's than a loyalty to the model.

Pros

- Participants asserted that they could provide needed services for a longer duration with fee for service, and that they would be paid for what they "actually do".
- Enables them to individualize the service to the family, including control relative to case closure (with DHS oversight)
- Some thought this would be helpful relative to supervised visitation.

Cons

- Must take ancillary costs into account and make that part of the true cost.
- More paperwork involved than, e.g. Firehouse model.
- Concerned that figures submitted might not match up with state data
- Concern about potential for organizations to "raise money through more visits" even if not needed by the family.

b. Capitation (pay per month/per client)

This was described as how the current structure operates. FSRP providers thought they should be able to count cases the same way that DHS does, and that data should be current, shared, and consistent.

Pros

- A more predictable cash flow and a reduced wait time for reimbursement.
- A greater incentive for encouraging and providing preventative care.
- "We continue to get paid if we're serving the family."

Cons

- Puts increased financial risk on the providers for those children and families with significant needs
- Several providers indicated that prompt and accurate data entry has not historically been a strength of the system's workforce, and speculated that this might become another "burnout risk" as all staff must strictly adhere to reporting requirements.
- Less incentive to "push services" if capitated. For example, if payment structure is fee-for-service, a provider might recommend eight hours for a family, then provide only two hours but still "be paid as if we provided eight". Capitation may lessen incentives to take the longer time.

c. “Firehouse” model of payment.

Pros

- Providers agreed that this is an easier way to track and predict payment as soon as a family begins receiving services, with the important caveat that this would require that they be allowed to provide the EBP as designed.
- Easier for state to track.
- Great predictor over the course of a year, which would be helpful to legislators and others.

Cons

- Despite the promising positives listed above and discussed at each site, no more than 10% of the attendees thought this model should be adopted at this time. Concerns about the EBP’s resonated with most in attendance: they were collectively not confident that EBP’s will unfold as designed.
- Some said that it would cost them more to provide EBPs alone, without other services, and that transportation would have to be managed differently.
- Could inhibit individualization.

5. What incentive-based contracting models could help financially reward contractors who achieve better outcomes? What would incentives look like? What outcomes would you consider important to driving the incentive decision?

This question provoked a wider range of responses than others, and it proved challenging as discussions unfolded. Overarching that challenge was the assertion that incentives would not be clear enough unless the provider had more control and autonomy in cases. Some providers were not necessarily opposed to the current incentive structure, and all were interested in exploring additional or different options in partnership with DHS. Most recommended that incentive dollars be increased, whatever model(s) may be used. Participants asserted that incentives should allow the agency to reinvest in future programming, describing incentives as simply “a way to make the budget work”. Regardless of how future incentive models evolve, providers believed DHS should begin to review incentives “within contracts to make them true incentives”. For example, one participant challenged DHS to help providers “figure out what to do with special incentives regarding sexual offenders.” Some attendees stressed that many of the current performance outcomes are not controlled by the provider and many are not achievable, e.g. occurrence of Family Team Decision Meetings. They reminded facilitators that providers have no control over team members’ schedules or their willingness to participate”.

The liveliest discussions occurred when providers wondered if “achievement of case goals” would be fair/possible as an incentive. Some thought this was logical and more representative of individualization of goals and outcomes. Others countered with concerns that goals are not consistently identified and are established and documented with “vague statements/language” that would make it difficult to measure when or if goals had been met. One provider summed it

up thusly: "If families are getting better, that's the right thing, so why not tie incentives to the family truly getting better?"

Current information indicates that the statewide base monthly payment amount for all contractors is **$708.00** per month and they may be eligible to receive performance-based incentive payments in addition to this base rate. Per information discussed in the forums and included in Iowa's 2019 Child and Family Service Review (CFSR), the following performance measures currently determine eligibility for performance pay:

a. Children are safe from abuse during episode of services and for 12 consecutive months following the conclusion of their episode of services. ($105 per case). ***This figure represents a $5.00 increase from $100.00 in 2007.***

b. Children are safely maintained in their own homes during episodes of services and for six consecutive months following the conclusion of their episode of services ($263 per case). ***This figure represents a $13.00 increase from $250.00 in 2007.***

c. Children are reunified within 12 months and remain at home without experiencing reentry into care within 12 consecutive months of their reunification date. ($525 for each child). ***This figure represents a $25.00 increase from $500.00 in 2007.***

d. Children achieve permanency through guardianship placement within 18 months of removal or through adoption within 24 months of removal ($525 for each child). ***This figure represents a $25.00 increase from $500.00 in 2007.***

6. **How should transportation be handled, both as it pertains to funding and as it pertains to who should be responsible for delivering these activities? For example, should the Care Coordinator be responsible for all, some or none of the transportation?**

Currently, the majority of transportation is provided by the Care Coordinator. Services contractors have the ability to utilize the Support Worker (SW) but not all providers do this. Relative to the first question, the short answer from every forum was "differently". The primary message was that some transportation by Care Coordinators (and others) is necessary for bonding, trust, opportunities for teaching/learning, and other components of their work with families, but that it had become unmanageable and prevented them from accomplishing other case goals or providing other services.

Some suggested that transportation be a separate service with reimbursement that is separate from the FSRP service, but still provided by the same person or contract agency. One participant said "let me hire and pay for travelers". There were those who did not think that transportation should be handled differently, and wondered if transportation might be divided by 1. Visitation and 2. Family Needs. Many calculated that it was less expensive and more efficient for transportation to remain in-house. All noted that transportation is a major expense for providers, with some indicating that they "lose money" providing the service.

This question led many participants to assert that, throughout the state, informal and/or free supports and services, including transportation by family or friends, are largely underutilized. Questions were posed about intact families, as providers wondered why parent(s) were not being given transportation opportunities and responsibilities. Providers wondered if foster parents were being asked if they could help with even minimal travel. Some said that everyone should be able to transport, and that the state needs to identify who will and won't provide certain transportation as opposed to the broad interpretation some have now.

7. What is the impact on families if staff members, besides Care Coordinators, are responsible for transportation responsibilities?

The primary concern lifted at each site was the potential impact of introducing additional people into the family's case. Providers did not want children and families to be overwhelmed with a myriad of transportation providers, and spoke to the value of the quiet opportunity for conversation and bonding during travel. Some proposed that, if designed carefully, a core group of transportation support staff could have "caseloads" similar to others so that children and families would have a more cohesive experience.

8. What is a reasonable caseload? Clarify in-home vs. out-of-home. How is this number reached?

In-home numbers averaged 10-12; Out-of-home (especially EBP), 6-7; rural families 6-7. Reaching a number was challenging for participants, as the variables of intensity of family needs and whether services were provided in rural or more urban areas continued to be debated, as well as uncertainty about caseload requirements in upcoming EBP.

9. If transportation issues were managed by another staff person, how would a caseload change?

The possibility of transportation being managed by another staff person was met with hopeful but guarded conversation. Many participants stated that this would give them greater opportunities to provide what they believe are the professional services families deserve. However, some feared that this would cause their caseloads to become inordinately high if leadership added too many cases to compensate for the reduction in transportation time. The majority of participants thought that assistance with transportation would give them time to serve a caseload similar to the ones they have now –but with more frequency and intensity.

10. As it pertains to determining appropriate caseload sizes, what would weighting cases look like? What types of cases would be given greater weight?

Weighting was consistently rejected as a way to determine caseload sizes. Participants presented that case dynamics of complexity and fluidity make it difficult to weigh cases fairly.

Participants noted, however, that if discussions continue regarding weighted cases, suggested factors to be taken into consideration included whether cases are in urban or rural areas, visitation – volume and distance, intensity, length of time a case is open, intact family or other, and whether a case was voluntary or supervised. Ultimately, most providers did not believe weighting cases was feasible and recommended that this not be pursued as a way to determine caseload size.

11. What are the primary causes of staff turnover?

Providers believed that if salaries could be remotely competitive with DHS, turnover would decrease dramatically.

Participants prioritized the following:

- Stress over unrealistic expectations from DHS.
- Real or perceived lack of respect and regard from DHS.
- Work-life balance out of equilibrium.
- Providing excessive transportation.
- Poor hiring decisions by provider administrators, i.e. staff have been selected who do not understand the strengths and needs of families in a clinical way
- Morale impacted as provider staff leave agency to work for DHS
- Lack of communication from upper management within the provider agency.

12. What should the salary range be for a Care Coordinator with a Bachelor's degree? A Care Coordinator with a Master's Degree? A Supervisor?

Average of responses below:

- Care Coordinator Bachelor's: $43,000.00
- Care Coordinator Master's: $52,000.00
- Supervisor: $62,000.00

13. What strategies are contractors using to retain staff?

Relationship-building within agencies was stressed, and many described an internal culture of encouragement and self-care as a priority. Good peer support was noted by most attendees. Some agencies/leaders provide opportunities for team-building outside of the office. A "sign-on" bonus was mentioned as appreciated by new employees. Many agreed with one administrator who responded to this question by saying "begging and brownies." Strategies have been inconsistently successful as participants continued to highlight turnover and the emotional, physical, and professional toll the work has had on CC's and other staff.

14. **What would be the impact of contracting for in-home and out-of-home services separately?**

Providers were open to separate contracts, but most felt that these should be under one contract with separate expectations. It was suggested that if separating the contracts is to be seriously considered, a different referral process would be necessary since the expectations of service delivery would be different. For example, if in-home, then transportation or supervision of interactions would likely be reduced, thus a case would be short-term and closed more quickly. Some participants thought this would be difficult due to the fluid nature of work with families.

15. **What part of safety planning is most effective? Would there be an impact to providing it longer than 30 days? What would be the impact of providing Safety Planning Services (SPS) for 14 days, but allowing SPS to be reinitiated after the beginning of the case? What would be the impact to integrating SPS into the ongoing caseworker role?**

A number of participants voiced that they see safety planning as working very well, but added that there should be more flexibility in the provision of services. They also agreed that this is where the most important work is done to prevent entry. One provider said "we are the eyes and ears of DHS". However, they raised this as another area where they did not feel there was partnership around decision-making at critical points in the case. They noted that, frequently, compliance steps are in the plans, rather than actions that would address the areas of risks. They said that generally 14 days is adequate to assess and prevent entry into care. Often, however, the safety plan is continued for another 14 days, typically because the investigation report has not been completed, rather than due to any continued true safety concerns. In the providers' experience, SPS cases are not usually closed at the end of safety planning and go on to receive longer term services. They speculated that there may be some fear of "what could go wrong" if the case is not kept open.

Sometimes there is a tendency to focus case planning around only one issue or caregiver as when casework is concentrated on the mother but father is excluded. Some providers were open to initiating another safety plan after the case is open as long as safety threats and risks could be adequately managed by the plan. Participants believed that providers and case managers need a better understanding of safety and risks, and their differences. They discussed this as another training opportunity.

B. Evidence-Based Practices (EBP)

The Family First Act will require front-end services to be evidence-based. Some contractors already have experience with delivering EBPs. Concerns have emerged that DHS may create case plans that do not align with the intended outcome of a model or are closing cases before the family is able to complete the model.

1. **How can roles, responsibilities and contract requirements be aligned with implementing EBPs?**

Providers emphasized that EBPs are expensive, and that start-up costs should be included in new contracts. These costs include dollars for training, monitoring/maintenance of fidelity, retention, and oversight. Some suggested that the state focus upon EBPs for intervention, as opposed to the "life of the case". Some participants argued that provider caseloads should be aligned with the requirements of the EBP. Providers wanted DHS staff to be trained in at least foundational understanding of each EBP curriculum.

2. What are the biggest challenges to taking on and sustaining EBPs?

Providers consistently reported that caseloads, placement of children, and lack of available resources will be challenging. Others mentioned higher educational requirements for those delivering EBP's as a barrier in terms of potential employees. Others were concerned that the time invested in training staff in EBPs would be lost if staff turnover remains at the rate it is today, and noted that start-up costs for EBP's are expensive and aren't currently supported through DHS contracts. Further, most described EBPs as being "very prescriptive" at identifying a specific population, which limits a provider's flexibility when serving multiple populations, ages, and families with a variety of needs. Providers suggested that it would be helpful for them to see data about the EBPs in other states, locations, and Iowa communities, and were hopeful that DHS could assist with this.

Many of the EBP's listed under the California Clearinghouse require a master's degree and are clinically focused, for example, Family Functional Therapy, Parent Child Interactive Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multi-systemic Therapy, and others. Care Coordinators noted a shortage of mental health providers across the state, and stressed that it will be difficult to hire individuals with a master's degree in some areas. As noted above, participants recommended that the master's and other requirements be amended as possible. Some voiced concern that the current EBP (The North Carolina Family Assessment Scale) is required to be completed monthly, yet it does not seem to be used to guide the case planning and casework process.

Others thought that utilization of family, informal supports, or even volunteers was already too low, and that more stringent EBP requirements could exacerbate this problem. Providers emphasized that local DHS staff must know enough about EBPs to inform decisions or make recommendations about models. They also suspected that it will be challenging to help families know what services will be offered and to understand what will be expected of them to complete the model.

3. Biggest benefit of implementing more evidence-based practices into Iowa preventive services?

The majority of providers believed that children would be safer and fewer would require removal.

4. Should safety plan services, FSRP, and FTDMs stand alone or be combined into one contract with braided requirements?

Some felt that safety services should not be managed differently from others and that keeping them together makes collaboration better. Others said that FTDMs are part of their existing contract and budgeting, and should be stand-alone items. They voiced that being bundled into the existing contracts allows for some providers to conduct one FTDM while others provide as many as needed, yet both providers would be paid the same. Some participants suggested that a formal and diverse committee of providers should be formed to have a more focused discussion about the braided requirements as opposed to the fairly brief time available in the forum setting for this particular question.

The providers asked for clear steps relative to selection, design, and agreement around deliverables for contracts to be in alignment with Family First and develop capacity-building for EBPs. One provider who believed FTDM's should be under one contract said "We need to be able to understand and support deep underlying needs of families", and that this not happening now.

5. **What percent of your budget for a family centered services program, ideally, would go to the following: Salary, benefits (including health care), tangible goods, training, transportation, administrative costs, buildings and infrastructure (including IT), other?**

The discussion yielded fairly consistent suggestions and ideas, and recommendations were made with particular focus on how to establish and manage a budget with funds remaining to re-invest as start-up costs for development of EBP's that will soon be required. This was a recurring theme in the discussion of EBP's, i.e. how expensive it will be to implement them. Below are two sample and fairly representative estimated budgets, as shared by actual providers. The provider on the right recommended retaining 1% for EBP start-up costs; others cautioned that more would be needed. One provider encouraged the state to utilize information from Healthy Blueprints for Families, for example, and stated that this would give the state a better idea of true costs for services.

EXAMPLE 1		EXAMPLE 2	
Salary, Taxes, and Benefits	72%	Salary, Taxes and Benefits	75%
Occupancy	04%	Administrative	14%
Supplies/Tangibles	03%	Tangible Goods	03%
Mileage/Fuel	07%	Training	02%
Communications	01%	Transportation	01%
Administrative	13%	Buildings and Infrastructure	04%
Total	100%		99%

6. **What should minimum education and training requirements be for staff providing direct services? What should minimum human service experience requirements be, if applicable?**

The majority of participants thought that a bachelor's in some area of human services should be required for a Care Coordinator. Recommendations were consistent throughout the sites that DHS should broaden qualifications to increase the number of people eligible to be Care Coordinators. The requirements were described as too rigid, even "crazy", impacting an already "shrinking pool" of potential employees, particularly in rural areas. More flexibility in requirements/hiring was requested at every forum.

Providers believed that support staff should reasonably have an associate's degree or high school diploma plus training and/or experience. A concern was that, even though support workers currently have a high school diploma or GED, they cannot teach an EBP. Others noted that "paid experience" is the only eligible "hiring experience", and saw this as an unnecessary caveat. They suggested that internships should be considered as "experience", as those placements often give potential employees great experience that would strengthen their workforce.

Numerous participants asserted that Central Office should work on exceptions for approval of Care Coordinators because of the educational requirements which do not meet current EBP standards for hiring. One provider's voice summed up what many said: "If group care shrinks, 40-60% of our staff may not make it into transition because of educational requirements – they will become a 'lost resource'".

7. **Families have varying needs, including some that may require clinically-oriented interventions that call for Master's level training. What would be the opportunities and challenges of having both Master's level and Bachelor's level staff?**

Some providers noted that they already have both in their organizations. Others predicted that the salary gap and salary spread would be low. They argued that the requirements for the job would be very similar, so nothing warrants creating these differing levels of staff. Many expected this to be problematic in rural areas, saying that it is difficult to find Master's level staff in rural areas. They discussed the very challenging family issues that are presented by most families. They cited drug use, domestic violence and mental illness as issues their staff face regardless of Bachelor or Master's level. Some offered that they worry that this would contribute to "jealousy" about differing pay scales and reduced morale, although they acknowledge that when putting EBPs in place this will continue to be a challenging discussion. They continued to discuss the need for DHS to "lift" certain EBP educational requirements and, like other groups, were concerned that this would contribute to a lack of success with the EBP's.

8. What services are you currently providing that you think should be considered a promising practice and with evaluation, could be an evidence-based practice?

Forum participants offered the following models and services:

- Bridges Out of Poverty was named as a community-based program in southeast Iowa that has shown promising outcomes for families and children struggling to meet their most basic needs. This program also utilizes an evidence-based curriculum known as "Paths" that is again utilized but not listed on the California Clearinghouse.
- Parent Partners
- In-Home Visitation - designed for preschool aged children. This program utilizes an evidence-based curriculum, includes parent development skills, and promotes healthy parent child interactions. The curriculum is called "Raising a Thinking Child," and although it has been identified as an EBP, it is not currently listed on the California Clearinghouse.
- Skill building, individualized counseling services and group skill services to youth were mentioned. These youth are currently an under-served population receiving no behavioral health services as they await placement or results of their charges. These skill building services can prevent future incidents and shorten out-of-home placements.

9. What services do you think could be replaced with evidence-based programs?

Providers disclosed that much of the general counseling, parenting, and intensive in-home services they are now providing would benefit from transitioning to one of the evidence-based models. For example, if they are now offering intensive in-home services using a model other than Homebuilders, they would transition to it. Likewise, if they are offering family therapy focused on managing the behavior problems of older youth, that would call for consideration of FFT, MST, Parenting with Love and Limits (PLL), or perhaps another EBP designed for that population.
A review of parent education models should occur, and providers were interested in what they could do to support this work, but remained wary based on their concerns about exclusion from conversations in which these decisions will be made.

10. What evidence-based programs are you currently using that you find very effective? Do you think they should be expanded?

The following were described by participants as effective programs or tools although not all are actually evidence-based. Not all participants were familiar with each program, but each program was recommended for expansion by one or more participants.

- Kinship Navigator Pilot – includes neighbors being paid
- Safe Care
- Brief Intensive Services. This program is available to all families regardless of income level who are not currently involved with DHS or JCS. This service has proven to be very successful

and provides safety planning and services to keep children in their homes safely. This is a short-term program, is flexible and serves a variety of ages. The Homebuilders model is used in some places, in addition to In-Home Family Services through Boys Town and possibly others.

- Family Team Meetings
- North Carolina Family Assessment Scales
    - Parent-Child Interaction Therapy is evidence based and described as successful
    - Boys Town In-home family services model – based off of the teaching family model.
    - Common Sense Parenting
    - "On the way home" aftercare model (Boys Town) as of July 1 with new contract. Has been researched as an aftercare model for EBP

11. What are the top three reasons you see children entering out-of-home care when not able to successfully remain at home with preventive services (in-home) in place? *

- Lack of continuum of services for parental substance use disorder – severe lack in rural areas
- Domestic violence not impacted by services or services not readily available
- Untreated behavioral health needs of parents

12. What are the top 3 challenges for families that aren't able to meet their preventive services (in-home) goals within 12 months?

- Unsuccessful substance use disorder treatment
- Transportation
- Lack of natural supports, including respite assistance

13. Are you aware of any services that could better meet the needs of in-home or out-of-home families that are not currently available?

While available, accessibility to substance use treatment is extremely varied depending on factors like population, geography, employment opportunities, etc. This was lifted as the primary service that would positively impact children and families if more accessible.

Several providers indicated that DHS needs to develop residential after care programs for parents and/or parents with children,, which should be part of contracting for services. Currently there is little to no aftercare to monitor or support the family upon the child's return to home or case closure. According to those providers, the lack of aftercare services has resulted in failed return home placements.

C. Provider Manual

Role confusion and responsibilities of FSRP contractors have been a frequent challenge between contactors and DHS. Different service areas have interpreted contract requirements differently and some have been left to ask "What is the difference between a DHS case manager and an FSRP contractor?"

1. Please describe strategies for clarifying role delineation with DHS?

The provider community clearly longed for opportunities to strengthen and build relationships, and varied suggestions for ways to accomplish this included:

- Shared learning and training venues
- "Meet and greet" opportunities
- Increased joint visits and other work with families
- Joint preparation for FTDM's
- Quarterly meetings to set and assess relationship and practice goals
- Contract information distributed/discussed among providers and DHS
- Clear DHS and provider policy and procedures to support a collaborative model.

Providers were hopeful that in-person opportunities to develop trust and strengthen the partnership model with DHS would be planned very soon.

2. Would there be a positive impact for having an FSRP Contactor Manual to help standardize practice – both roles and responsibilities – around the state?

Providers agreed that this would be helpful and also acknowledged this as an appreciated goodwill gesture. They thought the manual could clarify roles and ensure consistency, and largely approved of the more focused guidance that it should bring. Participants were consistently quick to indicate that a manual alone would likely not accomplish the hoped-for changes, so suggestions to ensure success included meetings between Care Coordinators and DHS local staff and a formal "manual launch meeting" to support a "fresh start". Participants wanted clarity about what led to development of the manual and the policies and procedures relative to standardization. Care Coordinators wanted to be familiar in general with the Contractor Manual and, more specifically, that it be presented as a "Partnership Manual", with joint DHS and CC training provided.

3. How should FSRP work in coordination with collateral services needed by the family? (For example, if a parent needs a therapist, whose responsibility is it to establish the service, make the referral and have ongoing communication with the therapist?).

FSRP staff and supervisors were quick to contend that they are largely coordinating collateral services already, as well as providing transportation. They also advised that they routinely and frequently refer to collateral services "so that it will get done", even though most CC's thought "Case Managers are supposed to be doing this." The broader takeaway was that the FSRP staff

wished for a more collaborative relationship and maintained that, if partnership were demonstrated as it's supposed to be "by policy", these questions would be answered based on how the CM/CC "team" divided responsibilities.

D. Case Management for non-court involved families

Role confusion is a common result of having multiple workers in a home. Additionally, families who are engaged in services and working closely with FSRP are frequently receiving the services needed to keep their children safe. Allowing FSRP contractors the ability to case manage services and determine when a case is ready to close would also align with efforts to implement evidence-based practices.

1. **What would be the impact of moving case management to FSRP for families not involved with the court?**

There was a noteworthy continuum of responses to this question. Some believed this would be empowering and that communication, decision-making, and case closure would be more efficient. Many felt they already perform as case manager and, if compensated fairly, would accept the role. There was a sense that voluntary case families had been served successfully by the providers. Most believed it would benefit families and result in greater utilization of community resources as opposed to court-ordered services. Providers indicated that they would want to have a strong voice in case decisions, assuming that DHS would have little to no contact with the family during this time. They understood that new risks and other safety-related issues would have to be brought to the attention of DHS, but thought that would be manageable.

Some FSRP staff indicated that the responsibilities inherent in case management are precisely why they do not work for DHS. They expressed concerns about liability and suggested that families would experience even more potential confusion than they may now based on the number of providers working with any given case. Some participants said they couldn't understand why this question was being asked, citing the "sensitivity of the question" and alleged rumors of judicial concerns about Family First.

2. **What would contractors need in order to take on this role/responsibility?**

Clear protocol and mutual understanding of the responsibilities. Autonomy and respect were named as frequently as increased salary in response to this question. One group reminded everyone that someone would "have to tell the judges".

E. Discussion

Each forum began with CWG facilitator asking providers to describe their community's perception of the families they serve in partnership with DHS, and to share an overall assessment of their community's service continuum. Most spoke to strides having been made over the past 10 years in terms of greater community awareness and advocacy for families. Participants were also informed

that discussion was welcome and a helpful way to hear the perspective of many during our three-hour meeting opportunity. As forum agenda questions were posed to the groups, it became clear that, in addition to offering responses to the questions, attendees were eager to participate in discussions that built upon each question, and to make suggestions for improvements. Despite recent conversations between DHS and providers relative to Iowa's Child and Family Services Review (CFSR) and the development of the evolving Program Improvement Plan, most attendees explained that this was their first opportunity to discuss the questions at hand or proffer concerns or suggestions, and their engagement and lively dialogue were striking. The following narrative was created to convey what emerged as **the ten most frequent areas of concern (in alphabetical order)** and a synopsis of the thoughts and recommendations of the majority of participants.

1. Communication and Role Clarification

Participants were vocal about the need for role delineation specifically and improved relationships with DHS in general. **More than any other question or prompter on the agenda, including funding, the issues of role clarification, relationships, and communication were discussed with exceeding frustration.** An essential message from providers was that families were not well-served because too many "don't know who's driving". Iowa's 2018 Annual Progress and Services Report (APSR) echoes many of the issues raised in the Forums, as evidenced by this narrative: "A lack of clarity on roles and responsibilities was noted, as some stakeholders indicated that contract child welfare workers handle case management whereas the statewide assessment identifies DHS staff only as having case management responsibility. Turnover is high, particularly among contract providers, especially in urban areas of the state, leading to inconsistency for children and families that negatively affects their access to services." The discussions held at each forum affirmed these as significant issues that too often prevent families from being well-served or achieving outcomes and case goals.

At each site, most if not all providers shared a similar conviction that communication and role clarity are areas where serious improvements are needed. Likewise, at each site there were participants who described strong and successful relationships. Care Coordinators in those areas spoke to creative and sound practices, e.g. the success they had in their counties with "joint visits", wherein the CM and the CC make some visits together. The Care Coordinators pointed out that this was a "helpful, realistic and fair experience for all". In addition, they noted that families appreciate and enjoy the visits when CC and DHS case manager visit together. Most of these individuals offered the caveats of "personality" or "work ethics" or "county management style" as leading to success, as opposed to a level of consistent expectations and protocol within DHS. One provider said "It's not right that personality – more than policy – impacts teaming with DHS. It works so well in some places, but is adversarial in others. Why?" This observation was consistent across all forums. At one forum, a Care Coordinator said she and others wanted to pose this question to Case Managers: "Why do you hate us?"

Others believed there are organizational reasons for poor communication, citing challenges faced by DHS Case Managers, including "large caseloads" and what was called a "culture of caution" that has

allegedly led to more children entering care and to a keener sense of liability among DHS employees. Some explained that DHS staff work in fear of child safety and "what might go wrong". Others described local offices where tensions were high, internal relationships poor, and where case managers did not feel they were receiving the support they needed to succeed. Several impassioned providers said that, if DHS would allow, they would "gladly stand in partnership with DHS" on high-risk cases, sharing responsibilities and demonstrating a united presence to support families. Many providers said that they understand the competing priorities that exist for Case Managers, and how these challenges may contribute to the communication and partnership issues they described. One participant said "all we really share right now is mutual turmoil", which was met with agreement by others.

A consistent theme in terms of role clarity was that most Care Coordinators believed that they are involved in a "power struggle" with DHS, and that too often DHS has "no intention" of using their expertise or feedback to make decisions around practice, policy, or funding. Several claimed that, during the most recent DHS hiring freeze, Care Coordinators absorbed much of their work. In every location, there were participants who spoke to being treated with disrespect and disdain by DHS case managers, citing this as widespread and a contributor to provider stress and turnover. At least twice, forum participants were asked what, if the tables were turned, might case managers say about their relationships and what they needed. Surprisingly, most of them said they doubted that CM's would identify relationships or communication as an issue.

Others described DHS case managers behaving as if they were the provider's supervisor, instructing them rather than working together toward solutions. Some believed that they are perceived as "administrative assistants". They felt further disrespected when case managers would not answer or return calls from their state-issued phones nor respond to emails. This was presented as the norm rather than the exception. FSRP staff were particularly incensed because Iowa DHS policy does not clearly require case managers to provide the number of their state-issued phones to the families in their caseloads.

Providers suggested that frequent and ongoing communication with DHS would benefit families, and urged leadership to support this. Care Coordinators and others said that disrespect from DHS is not infrequently noticed and commented upon by community representatives in, for example, FTDM's or multi-agency meetings. One supervisor, when asked about any need for clarity, said "I just tell my staff to be the case manager". Another supervisor added "We are colliding with each other and creating an *us vs. them* environment." Providers wanted more opportunities to staff cases with DHS and create an environment amenable to joint discussion, listening, and case planning.

In order to further facilitate clarity, providers felt that DHS Case Managers and others need a better understanding of the actual contracts between their agencies and DHS, i.e. what each contract does and doesn't require of providers. They suggested that DHS staff receive specific training on provider/program understanding of the contracts available for referral, as some Case Managers' expectations remain for programs that have changed and/or are no longer parts of some contracts. Issues of role clarity and positive communication have been identified as recently as in the 2018

APSR, which includes the following: “A lack of clarity on roles and responsibilities was noted, as some stakeholders indicated that contract child welfare workers handle case management whereas the statewide assessment identifies DHS staff only as having case management responsibility. Turnover is high, particularly among contract providers, especially in urban areas of the state, leading to inconsistency for children and families that negatively affects their access to services.”

2. Court/Legal

The Care Coordinators were especially concerned about how their poor relationships with DHS impact court proceedings. They shared a range of concerns, but the primary one was their interest in an improved and mutually respectful court/legal experience with DHS. Relative to court preparation and actual hearings, many indicated that their recommendations are rarely considered, especially relative to case closure if different from the DHS plan. They thought that case goals should be shared with them initially, as at times they had been working steadily with a family toward what they believed was reunification, when DHS was instead working toward TPR.

They described challenging judicial dynamics in terms of variations in court expectations and experiences across their service areas, as well as varying levels of what some called “specific casework directives” from the judge which contradicted what DHS, the family, providers and the FTDM team recommended. Others regretted that some families experience child removal “due to where they reside” as opposed to any merits of the case. (The CWG facilitator noted that these were areas of discussion across the country and that these challenges were not isolated to the provider community or to Iowa). Perceived “lack of harmony between DHS and judges” was noted as having seriously impacted outcomes in some areas. Many maintained that DHS decisions are too often reached outside the FTDM before court. Some did not understand why they were asked to make recommendations, as they had “never been followed”. It was clear that it **is extremely important to the CC’s that DHS respect and consider their casework and legal recommendations.** Some examples of their concerns and suggestions include:

- At the very first hearing, provider was told that DHS would be “terminating parental rights” in six months, so regardless of what the family accomplished through services, she had already been informed that TPR would occur. She asserted that this was unfair to everyone involved and was a demonstration of DHS struggling to meet TPR standards as opposed to assessing family progress.
- Another participant mentioned that a DHS Case Manager came to the removal hearing of an infant and immediately stated “we are going for TPR in six months”.
- Providers perceived an underutilization of kinship care; one noted that a particular supervisor in one service area “didn’t like it and didn’t know how to do it, so she didn’t”. Others suggested that there should be a greater level of expectations relative to kinship guardianship as a permanency resource. According to data presented in the “Casey Family Programs Foster Care Statistics Report” of November, 2017, of children exiting care, 57% were reunified with family; 25% were adopted; 7% exited to live with relatives or guardians, and 11% exited due to their age.

- They reported that monthly DHS contacts occur too frequently at court as opposed to teamwork/planning/visitation prior to court date. One provider described court in the service area as "chaotic and not the best environment to assess a family or make a plan".
- Providers were unsure of frequency or intensity of Central Office relationships and communication with judges in the state, but said "more is needed".
- Providers stressed the importance of assessing family progress, not just whether the parent is in treatment at the time DHS considers filing a petition.
- Providers wondered why DHS did not more frequently present legal compelling reasons/requests for extensions of timeframes for families that had made progress.
- The CC's expressed a need for the courts to grant discretion regarding visitation and its levels of supervision. They believed they should be able to establish lesser restrictive visits when appropriate. As it is now, the CC must wait for the court to make the ruling at each phase of the step-down process of visits along the way.

3. Data

Providers consistently mentioned data sharing as an area needing improvement in the system, and believed that understanding data would be helpful and would support consistency. Many of them described DHS as "not transparent" or reciprocal with data. One attendee said "we give data all the time that nobody looks at." This was met with agreement and heard in other forums throughout the state. Further, providers wanted to see data and tracking information in order to assess and monitor the expected outcomes that are tied to incentives. Additional data examples included:

- FTDM – frequency, fidelity, outcomes, monitoring
- Youth TDM – frequency, fidelity, outcomes, monitoring
- EBP – outcomes data about the EBP's in other states, locations, and Iowa communities
- "No eject" critical history

4. Drug Testing

Care Coordinators said the drug testing policy and processes currently in place should be re-visited with the lens of "what's not working". Current contract language reads: "The Contractor shall provide transportation assistance to ensure that a parent completes required drug testing." The participants questioned the utility of the testing and the efficiency of the transportation. The majority of them thought there should be less testing than occurs presently. Several asserted that too many parents are "punished by removals" more for doing something illegal than for presenting true risk to the children, citing that positive drug screens are frequently reason for removals or barriers to reunification, even if no safety concerns are noted. "Drug Testing Collection" information on the Iowa Department of Human Services website speaks to the issue, and includes the following language: "*Due to its limitations, drug testing results should not be relied on as the sole measure in determining issues of safety and risk. Drug testing results should be viewed as one component of the accumulated information that needs to be considered during a child abuse*

assessment and an ongoing child welfare service case." Further, important "bench note" guidelines for judges and adopted by the Iowa Children's Justice State Council in 2011 point out that *"inappropriate uses for drug and alcohol testing include: when used as the sole indicator of a parent's progress, when the parent admits to a relapse, when a parent is already an active participant in a substance abuse treatment program in which frequent, random testing is a required component of the program, or when used as punishment to a parent"*. Providers consistently maintained that "too much weight" is given to positive drug screens as plans for permanency are established and monitored. The point was also made that families with long-term sobriety or other wellness issues typically need more than six months to demonstrate progress. They also emphasized that they work more closely and more frequently with families than Case Managers do, and therefore have helpful firsthand knowledge of progress toward sobriety that is not being utilized by DHS. Some wondered if drug testing could be changed to "in-home testing". Some urged the development of more drug screening options in rural areas, e.g., DHS pursue contracts with local hospitals. Providers described one area where drug testing occurs in a hotel lobby, and they were concerned about confidentiality for the family.

5. Family Team Decision Meetings

CCs emphasized how helpful the FTDM is for families. They indicated that, when the meetings were well-planned and well-attended, clear goals and steps were identified and that this proved to be beneficial to everyone. Participants consistently communicated a belief in family-focused practice, and some were optimistic that the FTDM process was a good foundation for fulfilling the requirements of Family First. It was apparent that most of the CCs had participated in productive FTDMs, and they recognized the value of the team model. On the other hand, many stated that they were concerned about the inconsistency of the process statewide, and how this has impacted the fidelity of the FTDM model. They maintained that, in some places, FTDMs were not individualized, were held "because they had to be", and that families were often confused because they had multiple plans that might not complement one another in terms of goals and timeframes. One participant suggested, with agreement from others, that, "if workers don't like FTDM's, they don't happen". Another frequent observation was that the strengths of families are not consistently recognized as the foundation of the family's FTDM. Current Iowa DHS policy has some qualifiers in terms of FTDM requirements: "Subject to the availability of funds and within the capacity of the Service Area, every family shall be offered the opportunity to participate in a family team meeting that is structured within the approved family team decision-making standard". An additional and separate case plan is required by DHS with no qualifiers. *

Examples of their concerns and suggestions include:

- Frequent observation that DHS staff do not give families or other team members a copy of the FTDM case plans

- FTDM's now occur in the family's case later than they should – providers suggested that the team should meet immediately after the case is open, not at three months, six months or later as they claimed is happening now
- Clarity is needed for family and team members relative to the difference in case planning and the FTDM process. Some providers suggested that the "written plan" is not a working road map for the family but, rather, a required process to put services in place
- Case Managers and supervisors reportedly create FTDM goals separate and apart from the meeting.
- Providers wondered if policy could be changed to include FTDM's in preventive cases
- It appeared to many participants that legal partners have "taken over the process" in many locations, making the FTDM "no longer the family's meeting".
- Some FTDM's are occurring immediately before or after court hearings, and CC's suggested that, while likely convenient for the attorneys or CM, families had a heightened sense of anxiety and did not experience this venue as helpful.
- Some suggested that FTDM's would be more efficient if existing information from all case plans was shared with the teams.
- The CC's were concerned about the lack of input or joint planning with DHS. They reasoned that they are the ones in the home building relationships "and know more about what services the family needs".
- Providers asked for more flexibility around who can facilitate an FTDM.
- Payment for completion of FTDM's is included in the overall rate of pay, not as a separate item. This leads to inconsistency of teaming. Providers explained, for example, that they might be getting payment to complete one FTDM, while in reality they are "completing many more on one case, or, only doing one while many more are needed".

** "Law: Public Law 113-183; 42 USCA 671(a)(15)(A), 671(a)22, 675(1), and 675(15); Iowa Code Supplement section 232.2(4) Rule 441 Iowa Administrative Code 130.7(234) and 202.15(234) Policy Statement: The Department shall develop a case plan for each child and family receiving services that meets federal and state requirements. A case plan shall be developed in partnership with the child and family.*

6. Financial

Providers expressed frustration with what was called a "too-cautious" DHS fiscal message to the Iowa legislature. Some noted that agencies are often urged not to request additional funds, which presents a legitimate challenge for administrators. There was a uniform sense that DHS is aware of what is needed to improve outcomes for families, but has not, for whatever reasons, asked for the dollars to support these improvements. Some recommended that the agency ask for what is needed and no less, understanding that the legislature would make the final decisions.

Providers shared a universal interest in supporting the development of future contract opportunities and decision-making. Most suggested that opportunities should be available to all providers, without restricting state-wide or service-area-wide contracts. They added that this becomes problematic due to juvenile services areas not matching DHS service areas. Many said that, in rural areas, it is "impossible for smaller organizations to serve an entire service area cost effectively." At every forum, the message from providers was that current pay structures do not cover the costs of the services provided. Examples of their concerns and suggestions include:

- Allow flexible access to specialized funding to promote a well-trained, qualified and diverse workforce. Providers had similar ideas about what has prevented this, including lack of clear expectations by local leadership relative to free/low-cost resources; lack of understanding by case managers relative to what those resources are; and the convenience of what are seen as "automatic" referrals.
- Providers are submitting actual cost reports but there is no return communication from the Department. Some were frank with speculation that provider costs reports may not be reviewed as closely as would be more helpful.
- Caseload and workload issues for contract child welfare providers can be attributed, according to stakeholders, to the lack of a limit on cases or caseload size, as well as restrictions on DHS staff in terms of availability and work hour limits that result in transition of the workload to contract child welfare providers.
- To spotlight an area where clarification is needed, some stakeholders indicated that certain contract child welfare workers handle case management, whereas the statewide assessment identifies DHS staff only as having case management responsibility.
- Participants noted that the most recent increase in funds to providers was in 2015, but they reasoned that not enough consideration had been given to the fact that FTDM's were launched at the same time.
- Some recommended that DHS provide trainings to CM's, in conjunction with the Provider Manual being launched, to reduce start-up costs and establish consistency. They alleged that providers are currently delivering services that are not needed often because it is too convenient for some CM's to hurriedly refer to the most standard services.
- Some indicated that the state does not actually know how much they are paying for services because some providers are currently billing Medicaid for services which are already paid for through a child welfare contract.
- Most administrators expressed concerns that "non-negotiables" have consistently not been proven to get the best outcomes for families.
- Some administrators did not believe that their cost reports were consistently read or understood.
- Administrators recommended that DHS should examine a full continuum of services for DHS and JCS to ensure that both agencies have the necessary funds for equal programs and services for the entire continuum from prevention to out-of-home placement.

7. Informal Supports

It is appropriate to refer to this issue as a “theme” throughout the forums. Participants emphasized across the sites that informal supports are not being cultivated or utilized. Their conclusion was that CM’s “automatically refer” because of time constraints or inability or unwillingness to explore more deeply for informal supports. Suggestions were made that DHS make it a priority to “recruit and license or approve natural supports” in order to reduce costs and drive time, but more importantly, to increase those interactions better offered by a natural network and to build an enduring safety network. At one site, providers wondered if DHS had data or even anecdotal information about reunification rates for families with and without informal supports. Interestingly, current contract activities language includes the following: “and to connect the children and family to community resources and informal supports as identified in the Safety Plan and Referral Face Sheet.” This appears to clearly outline identification of informal supports as being at least partially a responsibility of the contract staff. This is an excellent example of the need for greater clarity.

8. No Reject- No Eject

The “No Reject – No Eject” policy was described as a concern across all sites. Ultimately, providers contend that they are forced to deal with children they are not prepared to serve. They mentioned safety concerns for the focus child and other children in their programs. Providers are paying more in overtime costs to bring in additional staff for increased safety and supervision. This is not reimbursed by Medicaid or DHS. The consensus among participants was that the policy was unethical, dangerous, and not congruent with forthcoming EBPs. The EBPs are prescriptive about inclusionary and exclusionary criteria, and the rigidity of an EBP will be the reason certain referrals can’t be taken. Providers stressed that immediate conversations with Central Office are needed in order to consider options relative to this policy.

9. Transportation

As noted earlier, providers were consistently vocal about what was commonly called “windshield time”, describing up to seven hours of transportation a day. It was not uncommon to hear that a CC had provided 30 hours of transportation in a week. Some explained that they purchased “monthly oil changes” because of excessive miles traveled to provide transportation. Transportation assignments were noted as a crucial reason that turnover is “rampant”. The overwhelming majority of participants described the excessive driving responsibilities as keenly problematic and a barrier to families achieving case outcomes. However, they were equally concerned about inserting yet another person or persons into the family’s case. They said that bonding opportunities during, for example, long drives to visits, were important and helpful. As above, several providers were opposed to transportation being delivered by another agency; more were open to changing transportation contract design and assignments internally. In general, participants agreed that “something different must be done” in order for families to receive the level of professional services that they deserve in their homes, and that this remains challenging to impossible when so much of their time is spent transporting.

10. Turnover

Providers talked recurrently about turnover at each forum. Every forum included an animated discussion about how staff have experienced their jobs, the families they serve, their partners (DHS and others), and their co-workers, and how those things have impacted their professional and personal lives. Contributors to turnover were included in the issues previously introduced in responses to Question 11, e.g. transportation, morale, etc. They emphasized that their salaries are low and often inadequate for their family's needs, and suggested they should be more competitive with DHS. Still, many "love the work" despite these struggles. Every participant thought that salary/pay increases were needed. What is noteworthy, however, is that the vast majority of forum attendees said that if DHS introduced communication and respectful collaboration into their work together, they believed turnover would decrease. **CWG facilitators cannot over-emphasize how the lack of respect and communication, real or perceived, was reported to have impacted morale and turnover.**

F. Summary and Recommendations

Providers in Iowa want to serve children and families well in partnership with DHS. The provider forums were consistently described by participants as helpful, thought-provoking, and appreciated. The specific and the global questions designed by DHS yielded information that will support solutions and inform future collaboration. The DHS appears committed to identifying and understanding what providers need. Recently, varied assessments of provider concerns, both global and specific, were completed with all yielding similar results. Assessments are ongoing within DHS, and include strong partnerships with The Coalition for Family and Children's Services. The CFSR, APSR, and Program Improvement Plan process all held provider assessments. In February and March, 2019, CWG facilitated provider forums across the state. The global issues have been discussed. Specific areas of great concern have been discussed with vivid and heartfelt conversations as seen above.

CWG is peripherally aware that work has been completed on the required Program Improvement Plan (PIP). Some of the issues lifted here have likely been addressed already, with plans and measurable steps in place to ensure that goals are met. However, the large number of forum participants and their observations and suggestions are significant, and their input can only strengthen any work that is occurring, as well as provide specificity that will inform future solutions for the state.

Recommendations:

The suggested steps listed below are intended to be responsive to the key issues identified in the provider forums.

1. The creation of the new Provider Manual is an excellent and timely segue into the work-at-hand relative to role clarity and communication. We recommend that DHS immediately include select

Care Coordinators in the development of a Provider Manual or increase the number if they are already assisting. Their voice was clear and broad relative to communication and role clarification. They can strengthen the manual and its message, regardless of whether it has been finalized or not.

2. Determine how to quickly get information from Case Managers relative to how they experience their work with CCs. Focus on report's discussion issues of: communication, FTDM's, transportation, court, and drug testing. Current assessments including those from DHS, CWG, Annie E. Casey, the CFSR and others may contain valuable information about CM perspective. It is clear that more assessment will be needed, however. Their input should be considered before recommendations are made. It is as important to value their perspective as the CCs.

3. Upon receipt and analysis of CM information, host joint DHS/provider in-person opportunities – preferably within counties but no larger than Service Areas – to "launch" the manual and reiterate the need for strong relationships. Present the manual as a logical first step toward addressing issues identified by both the CC's *and* the CM's. In addition, use the day for team-building, review of Iowa child welfare data, etc. Care Coordinators advocated for "neutral facilitation" similar to the Forum's design, but with DHS Central Office staff included. They envisioned a positive and interactive day.

4. Administrators indicated that there have been hints that "true negotiations" will occur in the next contracting process. Recommend that DHS define "negotiations" now and decide whether they can occur or not. That decision should be shared with providers immediately.

5. Design transportation as a separate service with reimbursement that is separate from the FSRP service but still provided by the same person or contract agency. Identify which county/service area has the greatest number of informal supports providing transportation. Find out how they have made this a successful priority and work to replicate. Although beyond the scope of its work in facilitating and compiling the input received in the provider forums, CWG consultants believe that we would be remiss if we did not point out and address the larger systemic issues suggested by the information contained in this report particularly as it is viewed in light of the issues raised in our 2017 review. The secondary recommendations offered below speak to factors that directly affect the quality of services to children and families.

6. There is a need to determine and clearly define in both policy and in the anticipated Provider Manual the role of the DHS CM in relation to the FSRP CC. Doing so should contribute substantially to improving the relationship between DHS and providers. It may also be an exercise that enables DHS to consider whether the current system provides the greatest efficiency and is most effective in engaging families and meeting their needs. While case management models are widely used in child welfare agencies in the United States, many represent more of a composite in which agency service personnel provide some direct casework to families and involve contracted or other public agency service providers based on specific child or family needs. Iowa's approach, which appears to call for

referral of all cases to a contracted provider understandably raises questions about role clarity for both professionals and, undoubtedly, for families.

7. The family teaming model and implementation used in DHS should be assessed to determine if it is functioning as intended. CWG consultants also have questions about the need for two family case plans as reflected in the forum comments and by DHS policy. Do families understand the purpose of these? Are families involved in the development of each one and invested in their fulfillment? In the family teaming models with which consultants are familiar and endorse, there is one plan and it is crafted with the family at the team meeting.

8. Transportation is a significant and troubling issue in most child welfare systems. However, the degree to which it appears to be burdening providers suggests the need for DHS to explore ways to minimize the amount of transportation called for. Questions to inform that exploration follow: Is there an opportunity to keep more children in their communities through increased kinship placements? Are foster parents involved as full members of the child and family team and thus understanding of their role in accompanying children to visits, court hearings, therapy sessions, and medical appointments? Are foster parents prepared to interact with children's bio parents including hosting visits in the foster home when this is appropriate? How can informal resources be involved or parents helped to develop their own transportation resources? Are there locales where bus tokens would enable parents to use public transit?

9. . There is a need to determine the education and skill level truly needed by direct service personnel both in DHS and in provider agencies. Currently, providers call for qualifications to be set based on the extant labor pool, not what is actually needed to provide high quality services to families. The qualifications of FSRP staff in particular were an issue of concern in the child welfare system review conducted by CWG in 2017 and this will likely be exacerbated by the requirements of Family First. It is important that DHS act now to define its actual labor force needs and costs and work to engage universities and clinical professional groups as partners in defining and developing an effective workforce.

G. Conclusion

There was a tangible sense of encouragement in the provider meetings, but this was met with a somber level of skepticism as well. Some providers "didn't want the discussion to end – it's exciting". On the other hand, one provider summed it up this way: "been there done that". She and others said that, although they appreciated the opportunity, they had given input before and did not think it had been valued or utilized in planning for funding, service development, or relationship-building, and they left the forums with the palpable air of "we'll see". The participants were open to conversation, but cautious about recommendations or possible retribution. Many if not most were receptive to dialogue but skeptical that the information would be utilized to inform improvements. One attendee said she believed she was speaking for the provider community as a whole when she expressed great disappointment that "nothing has changed" with funding or requests to the

legislature, in spite of recommendations made in the recent past by The Coalition for Family and Children's Services in Iowa, Alliance, and CWG. Consistent pleas were heard across sites relative to the need for DHS to utilize the information from the Forums and to allow more provider participation in model design and decision-making. One provider summed up what many said: "Please don't let these meetings be the end." It will thus be important for DHS to move decisively in the immediate future to follow up on provider input and the recommendations of this report.