Iowa Department of Human Services
Child and Family Services Review (CFSR) Round 3
Program Improvement Plan

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Program Improvement Plan

State/Territory: Iowa

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Section 1: Introduction to Iowa

The child welfare system in Iowa is in the midst of significant and inter-related initiatives, each focused on improving the child welfare system. In addition to this Child and Family Services Review (CFSR) Program Improvement Plan (PIP), each of these concurrent initiatives touches most if not all aspects of the child welfare system in Iowa.

- Family First Prevention Services Act (FFPSA): Iowa is doing a gap analysis and preparing to take important steps to improve prevention and front-end intervention services through improved case management services, evidence-based interventions, robust teaming and collaboration, and changes in how federal funds support the child welfare system.
    - Staff with the Annie E. Casey Foundation (AECF) conducted focus groups in 2018 and early 2019. The feedback from those groups has been incorporated in the AECF Needs Assessment, which Iowa will use to help inform decisions about what services are needed to keep children out of foster care.
    - The Department is pursuing an expedited kin license process, to provide a mechanism to provide financial support to unlicensed relatives and keep more children with relatives.
    - The Child Welfare Policy & Practice Group conducted interviews with Family Safety, Risk and Permanency (FSRP) services providers to help assess strengths and gaps in the Child Welfare System and inform future choices.
- Comprehensive Child Welfare Information System (CCWIS): Iowa is completing its analysis and seeking state funding from the legislature to move toward a CCWIS that will be modular, have well-defined business processes to support case management for those working in the system, including support of mobile technology, support registration and monitoring of evidence based interventions, stakeholders working with the child and family will have a role based permission to information, and the system will integrate with other systems to make coordination more effective.
- Workforce loss: Iowa has experienced large workforce exits impacting both child welfare and eligibility staff. Iowa had 342 Social Work Case Manager Staff in 2016 and at time of PIP submission was at 296 Year to Date (YTD) in 2019. That amounts to a 13% decline in staffing since 2016 and the staff has seen a corresponding 19% increase in the number of cases served (all case types), from 30.6 average caseload in 2016 to 36.5 in 2019. Initiatives to address workforce issues include actively working on rigorous hiring processes in order to address the workforce issues, focusing on recognition and celebration to support retention of staff, and rollout of a new voluntary peer mentorship program. Workforce issues will also be addressed by Strategy 3.3 with the new supervision model.

Section 2: Iowa CFSR Background

Iowa participated in the Children's Bureau (CB) onsite review from April 1, 2018 through September 30, 2018. As part of this review, the CB conducted 31 focus groups with stakeholders, and the state conducted 65 case reviews which were finalized following federal secondary oversight. Iowa's onsite process used two-person teams of paired reviewers for each case. The teams consisted of one Social Work Supervisor and one Quality Improvement Coordinator for each of the state's five Service Areas.

The two-person team was intended to provide an arm's length independent perspective through the Quality Improvement Coordinators, all under the coordination and supervision of the statewide Quality Improvement Unit, and to help identify and share opportunities for local practice improvement through involvement of one of the local Service Area Supervisors serving as the second reviewer. This paired-reviewer process had been trained and tested prior to the state self-assessment year and used throughout the state self-assessment. In addition to training reviewers before performing the case reviews, reviewers also participated in periodic inter-rater exercises to help assure all reviewers were as consistent as possible in application of scoring criteria and in the documentation of rationale for scores.

Following the onsite period, staff from the Iowa Department of Human Services (DHS) along with a variety of stakeholders received the CFSR round three Final Results on February 5, 2019.

Ongoing opportunities have been available for stakeholders to provide input in Iowa's Child Welfare System for many years, both leading up to the onsite review and following the review. Whether from a systemic view or a specific case review, stakeholders in Iowa's Child Welfare System have provided their perspectives on their experience with the Child Welfare System, including what is working well and what is not. Most relevant to the PIP, information developed over a 5-year period of time starting with the CFSP in 2014 and its annual updates through development of the CFSR performance improvement plan was utilized. Prior to conducting the onsite review in 2018, the state of Iowa completed a statewide assessment of current functioning of the Iowa Child Welfare System through engagement of stakeholders and review of data regarding current agency performance. All of these activities generated diverse opinions and perspectives and the state aggregated the feedback. The stakeholder groups below have been key in providing input on Iowa's child welfare system and developing an informed performance improvement plan consistent with and focused on stakeholder-identified needs:

- Child Welfare Provider and DHS PIP workgroup (December 2018)
- CIP and DHS PIP workgroup (December 2018)
- Final Report Out and Root Cause workgroup (February 2019)
- Strategy Workgroup (March 2019)
- Oversight group final strategy deselection (April 2019)
- Stakeholder Root Cause Feedback Workgroups (August 2019)

In addition, the following documents provided input into the development of the program improvement plan:

- Child and Family Services Plan (CFSP) (FFY 2014-2019)
- Annual Progress and Services Report (APSR) (Annual updates to the CFSP)

- CFSR Statewide Assessment (February 2018)
- Feedback from Federally-led focus groups (July - September 2018)
- Case review results (for cases read April - September 2018)

DHS sought guidance from the Capacity Building Center for Courts (CBCC) in planning for convening the final stakeholder workgroups in August 2019. We had worked with the CBCC and our Court Improvement Project (CIP) to develop some specific court-related PIP strategies and wanted to replicate some of that work with these focus groups. We brought the 7 groups together in August 2019 with the goal of conducting additional root cause analysis in 9 areas, developing theories of change and identifying strategies to address those. The focus groups were comprised of a variety of stakeholders dependent upon the specific PIP item the group was being asked to address. Stakeholders included DHS social workers (Child Protection Workers (CPW) and SWCMs), DHS supervisors, youth, parents, foster parents, Parent Partners, and court representatives. The specific PIP items the groups were asked to address were those that we believe would have the most cross cutting impact and those areas are as follows:

1. Item 1: Timeliness of Initiating Investigations
2. Item 2: Did the agency make concerted efforts to provide services to the family to prevent children's entry into foster care or re-entry after reunification?
3. Item 3: Did the agency make concerted efforts to assess and address the risk and safety concerns relating to the children in their own homes or while in foster care?
4. Item 12: Did the agency (1) make concerted efforts to assess the needs of children, parents, and foster parents to identify services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family and (2) provide the appropriate services?
5. Item 13: Did the agency make concerted efforts to involve parents and children (as developmentally appropriate) in the case planning process on an ongoing basis?
6. Item 14: Were the frequency and quality of visits between caseworkers and child(ren) in the case sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?
7. Item 15: Were the frequency and quality of visits between caseworkers and the mothers and fathers of the child(ren) sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?
8. Recurrence of Maltreatment: For children who were victims of abuse or neglect during a 12-month period, how successful was the agency in preventing another occurrence of abuse or neglect within 12 months?
9. Maltreatment in Foster Care: For children who were in foster care during a 12-month period, how successful was the agency in keeping the children in foster care safe, regardless of who the perpetrator was?

Each group had two facilitators and approximately ten participants. Each group was provided an explanation of a specific CFSR measure, data from various sources including but not limited to CFSR case review data and ROM data. Facilitators lead their groups through root cause analysis using the 5 Why's approach. Groups developed a list of root causes and then selected what they believed to be the most impactful. They then brainstormed strategies to address those root causes, selected strategies, developed theories of change and identified key activities for the

selected strategies. The results of the focus group work both supported many of the current PIP strategies and offered new information that has been incorporated into this PIP.

Groups that met December 2018 through August 2019 received information prior to the meetings in order to allow for thoughtful feedback and discourse during each meeting. Among all groups, the information gathered was consistent regarding the three goal areas identified in Iowa's CFSP:

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

In addition to the goals above, stakeholder groups identified and prioritized a fourth area focusing on support to supervisors and workers. Discussion around this centered on the need for consistent supervisory consultation, feedback, and clarity of expectations for workers and the need to adequately equip supervisors to fill that need.

Below is a brief overview of additional stakeholder engagement opportunities, which usually occurred at a local area and were rolled-up to state level. These opportunities will also be referenced later in this document in our strategies to address the Quality Assurance systemic factor.

Stakeholder Engagement

- Service Area All Contractor Meeting: Held in each Service Area, these meetings are attended by leadership of agencies that hold contracts with DHS. This group comes together quarterly to share agency updates, performance data, as well as the current focus of the state as a result of upcoming policy or contract changes. This allows everyone to have a voice and provide feedback regarding upcoming changes. Often, this is a time for stakeholders to communicate regarding any barriers that they are experiencing and begin problem-solving issues. Attendees include leadership from providers of group care, shelters, FSRP agencies, psychiatric medical institute for children (PMIC), Parent Partner program, Foster care recruitment contract holder, as well as Decategorization (Decat) project coordinators, and Juvenile Court Services (JCS) Chiefs.
- Foster and Adoptive Parents: Service Area Adoption and Licensing Supervisors, along with Service Area Managers (SAM) and Social Work Administrators (SWA), periodically attend regularly scheduled foster parent support groups within the service area to gather any feedback from them, to ensure that their needs are being meet and brought back to DHS.
- Joint Supervisor Meetings: These occur quarterly between DHS, FSRP, and foster care supervisors. This is time to partner and problem solve regarding service-related issues that staff are experiencing. Any messages from the quarterly All Contractor Meeting are also shared with supervisors here. Supervisors often jointly develop topics for cluster PALS meeting that are warranted as a need for field staff.
- Preparation for Adult Living (PAL) Meetings: These occur quarterly between front line staff from DHS, FSRP, and some foster care case managers. Various topics that are directly related to services and upcoming policy and practice changes are discussed. Local speakers will share information related to the resource available to DHS staff and clients.

- Joint QA Meetings: Occur in some Service Areas quarterly between DHS QA staff and QA staff from the contracted agencies in the Service Areas. This is an opportunity for QA staff to share what they have been focusing on and offer any assistance. This is a partner and learner opportunity to share across agencies for continuous improvement.
- Community Outreach: Social work supervisors have each developed a plan that outlines what community members they are committed to contacting and how frequently to ensure that the lines of communication are open. For example, local schools, substance abuse providers, judges, juvenile court officers (JCOs), Decat boards, mental health providers, and clinical case consultation teams.

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

CFSR Oversight Team

This team is the core working and oversight group responsible for leading the PIP change effort. This is the internal team, which used data and stakeholder feedback to select which items best fit into the PIP and those which will be addressed in the CFSP. The team is also responsible for the communication plan to facilitate the engagement and involvement of all other partners and stakeholders in the development of the PIP and communication thereafter. Group members use existing channels of communication with other partners, courts, providers and other to share information and to seek feedback. Team members include:

1. Jana Rhoads, Division Administrator, Adult Children and Family Service
2. Vern Armstrong, Division Administrator, Field Operations
3. Janee Harvey, Bureau Chief, Bureau of Child Welfare & Community Services
4. Kara Lynn Regula, Social Worker 6, Bureau of Child Welfare & Community Services
5. Matt Majeski, Service Area Manager, Services Area 04
6. Lori Frick, Service Area Manager, Service Area 03
7. Paige Casteel, Social Work Administrator, Service Area 04
8. Carol Gutchewsky, Social Work Administrator, Service Area 01
9. Lori Lipscomb, Service Area Manager, Service Area 06; Interim Division Administrator, Adult Children and Family Service (eff 1/2/20)
10. Dawn Turner, Service Area Manager, Service Area 02
11. Matt Haynes, Bureau Chief, Service Support and Training
12. Steve Campagna, Bureau Chief, Bureau of Enterprise Systems
13. Bob Norris, Information Technology Specialist 5 (ITS5), Bureau of Enterprise Systems
14. Susan Godwin, Bureau Chief, Bureau of Quality Assurance and Improvement

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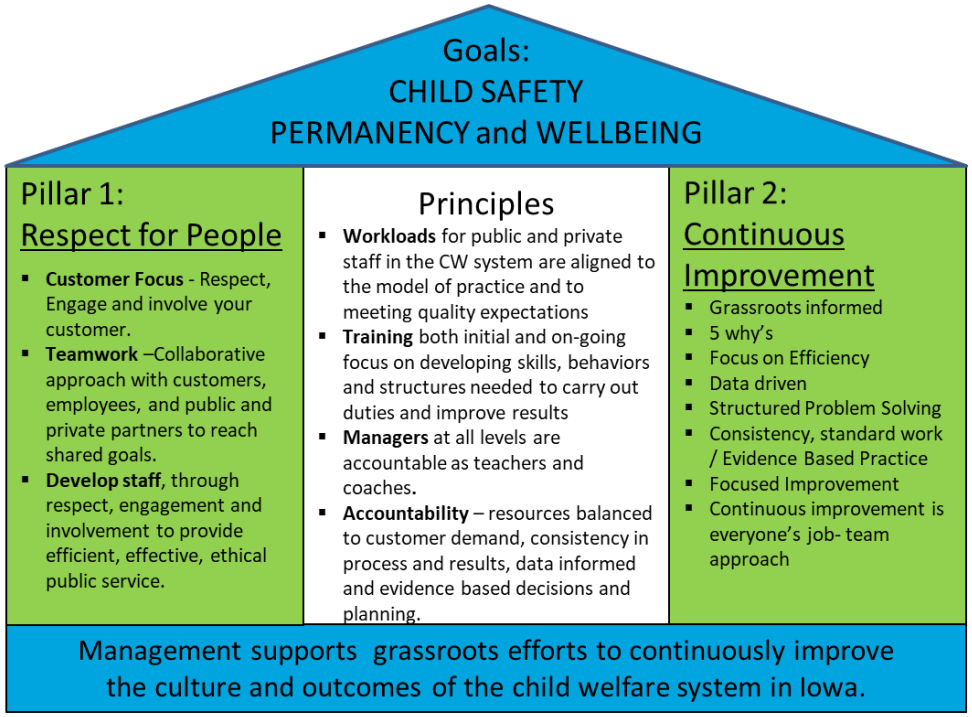
The Iowa Approach for Change:

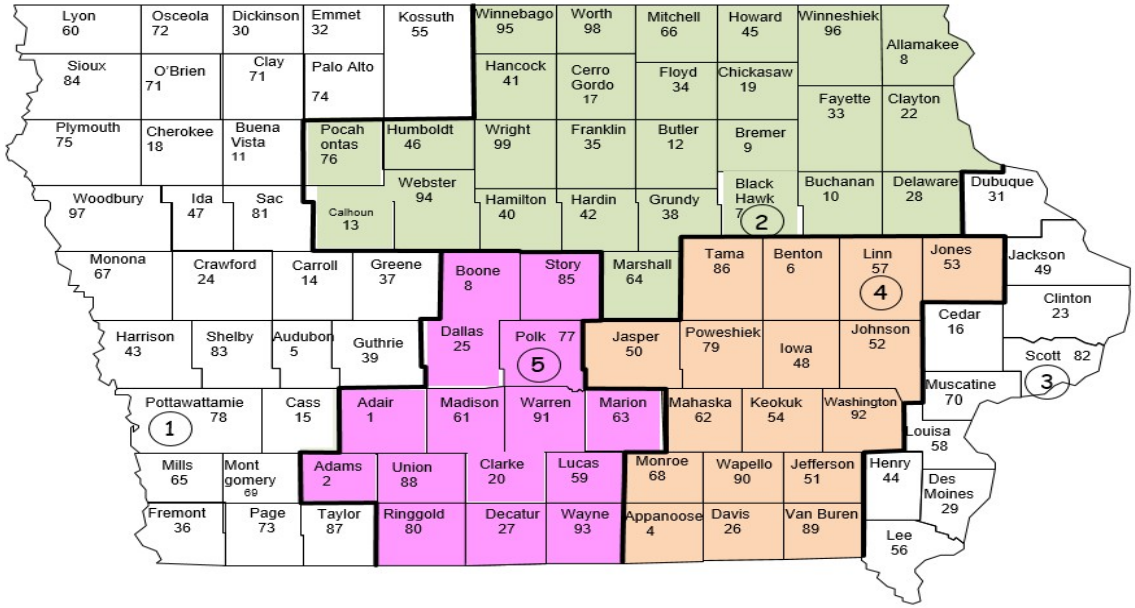


One of the many ways this approach for change is lived out is through the processes Iowa will use to help drive our CFSR improvement. Most of the strategies employ action steps involving small group work. The work of those groups is part of the State of Iowa Performance Monitoring and Improvement Business Process. This approach is important because it uses frontline staff to find practical solutions that work in real life. The groups are chartered and given clear guidance about their work, bilateral communication with related work groups, have diverse membership, and are supported by the Oversight Team.

As an illustration of the team process, in preparation for the PIP, Iowa tested the State of Iowa Performance Monitoring and Improvement Business Process in 2018, chartering a group to address a problem, to test the group process, the implementation process, and the monitoring and measurement of performance. The problem was that child visit documentation was missing for some children for consecutive months. The stretch goal was set for a 50% improvement (reduction) of the children with no documentation for 90 days, to be completed within 30 days. Iowa had addressed the same issue numerous times in the past each with a 2% to 15% improvement, only to see gains disappear once the "focus" was over. The group was called together and shared pre-work they had been assigned before meeting, which showed the problem was not that children were not seen, it was one of documentation. This was complicated by the way the state's dated case management system (the legacy SACWIS system, called FACS) works, which did not help staff to see a caseload list or visit data. The frontline staff in the group all agreed there is no reason they could not get visits done and identified some best practice supports they use to get visits done. The group designed a tool they needed to better

manage the work to do, and the completion of documentation, and asked the SBT for resources to create it. The “client visit tool” was designed, reviewed, tested, and finalized by the group the next day. The group also came up with strategies for scheduling visits, documentation, and monitoring with included supervisor and SWA roles. The new strategies and tools were put into practice statewide within 30 days, and by the end of the month, they had an amazing improvement of 80%. The tool, the structure for monitoring, and management support and attention recognizing higher performers, continues so the practice and performance do not revert.

The DHS leadership identifies key performance areas for the state. These areas represent a subset of all CFSR measures that are prioritized for state focus and are determined by review and analysis of performance reports. The DHS is moving toward an organized system of prioritizing items in sequence so, as quality improvement efforts are completed, the next focus area is initiated. By identifying statewide priority areas, Iowa creates focus, alignment, and consistency in efforts to change/improve practice. Staff review priority data monthly at the service area level and statewide at all levels throughout the DHS. Staff analyze the data identifying trends, which helps to determine where strategies are effective and where strategies need enhancement. The process also identifies those service areas that are achieving the established target, which leads to sharing of information on effective strategies that may be implemented across service areas. Iowa DHS has 5 geographic Service Areas and one Centralized Service Area which performs statewide activity including child welfare Intake, shown below:



Section 3: Data to Inform the Problem

CFSR Case Reading Final Performance; [Item] Performance Ratings

[Item	Performance Item	S	ANI	NA	App Cases
1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	71.43%	28.57%	n=30	n=35
2	Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care	85.71%	14.29%	n=51	n=14
3	Risk and Safety Assessment and Management	50.77%	49.23%	n=0	n=65
4	Stability of Foster Care Placement	80%	20%	n=0	n=40
5	Permanency Goal for Child	85%	15%	n=0	n=40
6	Achieving Reunification, Guardianship, Adoption, or OPPLA	60%	40%	n=0	n=40
7	Placement with Siblings	88%	12%	n=15	n=25
8	Visiting with Parents and Siblings in Foster Care	74.19%	25.81%	n=9	n=31
9	Preserving Connections	62.5%	37.5%	n=0	n=40
10	Relative Placement	77.78%	22.22	n=4	n=36
11	Relationship of Child in Care with Parents	65.52%	34.48%	n=11	n=29
12	Needs and Services of Child, Parents, and Foster Parents	44.62%	55.38%	n=0	n=65
12A	Needs Assessment and Services to Children	66.15%	33.85%	n=0	n=65
12B	Needs Assessment and Services to Parents	44.07%	55.93%	n=6	n=59
12C	Needs Assessment and Services to Foster Parents	84.85%	15.15%	n=32	n=33
13	Child and Family Involvement in Case Planning	49.21%	50.79%	n=2	n=63
14	Caseworker Visits with Child	50.77%	49.23%	n=0	n=65
15	Caseworker Visits with Parents	25.42%	74.58%	n=6	n=59
16	Educational Needs of the Child	83.72%	16.28%	n=22	n=43
17	Physical Health of the Child	59.09	40.91%	n=21	n=44
18	Mental/Behavioral Health of the Child	55.81%	44.19%	n=22	n=43

CFSR Case Reading Final Performance ; Outcome Ratings

[#]	Outcome	SA	PA	NACH	NA	App Cases
SO 1	Children are, first and foremost, protected from abuse and neglect.	71.43%	0%	28.57%	n=30	n=35
SO 2	Children are safely maintained in their homes whenever possible and appropriate.	50.77%	13.85%	35.38%	n=0	n=65
PO 1	Children have permanency and stability in their living situations.	45%	50%	5%	n=0	n=40
PO 2	The continuity of family relationships and connections is preserved for children.	67.5%	27.5%	5%	n=0	n=40
WB 1	Families have enhanced capacity to provide for their children's needs.	38.46%	24.6%	36.92%	n=0	n=65
WB 2	Children receive appropriate services to meet their educational needs.	83.72%	2.33%	13.95%	n=22	n=43
WB 3	Children receive adequate services to meet their physical and mental health needs.	47.54%	16.39%	36.07%	n=4	n=61

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Statewide Systemic Factors	Source of Data and Information	State Performance
Statewide Information System	**Statewide Assessment (SWA) and Stakeholder Interviews**	**Not in Substantial Conformity**
Item 19: Statewide Information System	SWA and Stakeholder Interviews	Area Needing Improvement
Case Review System	**SWA and Stakeholder Interviews**	**Not in Substantial Conformity**
Item 20: Written Case Plan	SWA and Stakeholder Interviews	Area Needing Improvement
Item 21: Periodic Reviews	SWA and Stakeholder Interviews	Area Needing Improvement
Item 22: Permanency Hearings	SWA and Stakeholder Interviews	Area Needing Improvement
Item 23: Termination of Parental Rights	SWA and Stakeholder Interviews	Area Needing Improvement
Item 24: Notice of Hearings and Reviews to Caregivers	SWA and Stakeholder Interviews	Area Needing Improvement
Quality Assurance System	**SWA and Stakeholder Interviews**	**Not in Substantial Conformity**
Item 25: Quality Assurance System	SWA and Stakeholder Interviews	Area Needing Improvement
Staff and Provider Training	**SWA and Stakeholder Interviews**	**Not in Substantial Conformity**
Item 26: Initial Staff Training	SWA and Stakeholder Interviews	Area Needing Improvement
Item 27: Ongoing Staff Training	SWA and Stakeholder Interviews	Area Needing Improvement
Item 28: Foster and Adoptive Parent Training	SWA and Stakeholder Interviews	Area Needing Improvement
Service Array and Resource Development	**SWA and Stakeholder Interviews**	**Not in Substantial Conformity**
Item 29: Array of Services	SWA and Stakeholder Interviews	Area Needing Improvement
Item 30: Individualizing Services	SWA and Stakeholder Interviews	Area Needing Improvement
Agency Responsiveness to the Community	**SWA and Stakeholder Interviews**	**Substantial Conformity**
Item 31: State Engagement and Consultation With Stakeholders	SWA and Stakeholder Interviews	Strength
Item 32: Coordination of CFSP Services With Other Federal	SWA and Stakeholder Interviews	Strength
Foster and Adoptive Parent Licensing, Recruitment, and	**SWA and Stakeholder Interviews**	**Substantial Conformity**
Item 33: Standards Applied Equally	SWA and Stakeholder Interviews	Strength
Item 34: Requirements for Criminal Background Checks	SWA and Stakeholder Interviews	Strength
Item 35: Diligent Recruitment of Foster and Adoptive Homes	SWA and Stakeholder Interviews	Strength
Item 36: State Use of Cross-Jurisdictional Resources for Permanent	SWA	Area Needing Improvement

Root Cause Themes

The first root cause brainstorming group met on February 6, 2019 following the Final CFSR Report Out. To better understand the root causes of Iowa's current performance, about 100 individuals including internal and external stakeholders, received both quantitative and qualitative data in to assist them in identifying root causes. This allowed Iowa to focus on the crosscutting strategies, which would best help us drive necessary improvements. The stakeholders identified the root causes/problems listed below, capturing their own words to maintain integrity of the stakeholder work. The stakeholders then grouped root causes into categories and associated each category to the three goal areas.

Category	Safety	Permanency	Well-being
Workforce-related: lack of time, high turnover • High caseloads, resulting in lack of time for quality visits, concurrent planning, training of staff • High turn-over (DHS and Providers) relates to adequate service provision to family • Resources/Training-FSRP	X	X	X
Lack of access or gaps to needed services • Lack of services for mental health and substance abuse • Lack of foster/adopt homes, older children/teen especially • Lack of wraparound services	X	X	X
Lack of collaboration across agencies, court, providers • Working in silos, lack of communication with providers • Lack of partnering between DSH and Court regarding family recommendations/decisions • Inefficient use of resources-FTDMs, Parent Partners, Foster Parents, Social Histories	X	X	X
Lack of understanding of safety versus risk • Lack of common understanding/definition across the system of the difference between safety and risk • Inconsistent application of safety vs risk concerns related to removal of children and when to reunify	X	X	X
Lack of identifying and engaging relatives and informal supports • Parents are overwhelmed with what they are told they need to do (visits, SA treatment, counseling, UA's, in- home services, etc.) • Need to ID supports formal and informal	X	X	
Lack of comprehensive assessment and service provision for children and families • During assessment, underlying causes of abuse are not addressed; focus only on surface symptoms • Services are narrowly focused-addressing safety issues but not getting at underlying factors • Child abuse-shifted policy, practice, break out allegations, focus on singular not all parts	X		X
Policy/procedure • New founded reports based on past or substance use when child may be there (dangerous) • THV-length of 6 months affects data and definition	X		X

Category	Safety	Permanency	Well-being
Lack of concurrent planning • Lack of concurrent planning • Lack of diligent concurrent planning; not starting until too late		X	
Court-related delays/inconsistencies/procedures • Court delays, late reports, attorney schedule, not enough time scheduled • Judicial oversight/expectations of appropriate relatives • Inconsistency among state courts		X	
Lack of quality safety plans and effective use of safety plan services • Unclear criteria for a "good" safety plan • Not fully utilizing safety services (i.e. THV, open services, first 30 days)	X		

Based on the root cause work above, a smaller group of approximately 30 stakeholders met to identify strategies which would be cross-cutting and best drive improvements. The stakeholders identified the strategies listed below, again in their own words to maintain integrity of their work. The stakeholders divided into two groups and the top strategies from both groups are shown below.

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

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

Following the work of these groups, Iowa brought together seven focus groups in August 2019 and tasked them with additional root cause analysis as previously outlined in this document.

Based on the above information, considering resource needs, other long-range initiatives, and the timeframes to demonstrate improvement for the PIP, the following goals, strategies and key activities were selected for inclusion in the PIP. The remaining will be addressed in the CFSP. The following table summarizes the PIP goals and strategies. All strategies are cross-cutting and affect multiple outcomes and systemic factors, but only one or two were chosen for each goal as the main or most impacted areas.

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Goal 1: Keep Children Safe at Home with Their Families Whenever Possible

Targeted Outcome or Systemic Factor	Strategy	TOC	Intended Practice Change
Safety 1, Safety 2	Strategy 1.1: Ensure child safety during each stage of the case and improve safety and risk assessment and management	We will clearly outline staff practice expectations for safety assessment and safety planning **so that** social workers understand how to effectively develop safety assessments and safety plans **so that** they are used consistently in communication and decision making **so that** parents' legal rights are supported **so that** family units can be preserved when possible and **so that** children can remain safe. We will clearly outline staff practice expectations for safety assessment and safety planning **so that** social workers understand how to effectively develop those **so that** they are used consistently in communication and decision making **so that** parents' legal rights are supported **so that** family units can be preserved when possible and so that children can remain safe.	• Improved ongoing assessments, including identifying individual safety and risk issues for all children in the home, not just the child with the needs that led to agency involvement • Using safety plans to address safety issues rather than to outline necessary behavior changes • Clear definitions of danger and risk in making removal decisions, and improved practice on using them correctly (including decision-making, initial and ongoing safety assessment, removal, and writing an actionable plan) • Ensuring knowledge to support decision-making on when a child is safe to go home • Improved monitoring and revision of safety plans • Clarification of the components of Family Preservation services, including contract language with providers • Distinguishing between safety plans and action plans • New Safety Assessment and Safety Plan • Child Safety Conferences to allow opportunities for non-traditional safety decision-making

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Targeted Outcome or Systemic Factor	Strategy	TOC	Intended Practice Change
Safety 1, Safety 2	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 the face to face contact occurs.	Provide clear policy and practice direction regarding actions and documentation required when encountering barriers to meeting assigned timeframes to see the child(ren) **so that** staff will consult with their supervisor prior to the timeframe expiring **so that** worker and supervisor can thoroughly discuss and work through: 1. efforts that have been made to see a child victim(s); and 2. additional actions that must be taken to locate/see the child within the assigned timeframe **so that** appropriate decisions can be made as to whether it is reasonable to delay a timeframe **so that** the department philosophy and expectation of meeting the assigned timeframe without delay is fully integrated into the practice culture **so that** children can be seen timely whenever possible or, if a delay is appropriate, consultation can occur on potential safety issues and mitigation needed to assure the child's safety at home **so that** a revised timeframe to see the child can be established **so that** child victim(s) are seen as soon as possible **so that** children are first and foremost safe.	• Increased performance regarding face to face contact with child victim(s) within assigned timeframes through proactive consultation and problem-solving between CPW and Supervisor. • Correct identification of when a delay is appropriate. • Activities to ensure safety of the child during a delay are completed and documented. • Accurate documentation of the delay and the additional activities during the delay so safety and performance can be monitored. • Clear establishment of reasonable case-specific revised timeframes assigned when contact delay is approved.

Targeted Outcome or Systemic Factor	Strategy	TOC	Intended Practice Change
Safety 1, Safety 2	Strategy 1.3: Implement the Safe 4 Home Initiative (4 questions) statewide	We will expand the 4 questions pilot (aka Safe 4 Home Initiative) statewide **so that** judges, DHS staff, and legal representatives are similarly oriented in identifying the actual danger **so that** mitigation efforts are fully explored **so that** appropriate safety measures are implemented **so that** family units can be preserved when possible and **so that** children can remain safe.	• Standardize practice to continually ask the 4 questions. • Common language and decision-making framework between the Courts and DHS. • Standardize practice to ensure kids stay home when it is safe to stay home. • Systemic approach to addressing danger • Prevent unnecessary removals.

Goal 2: Improve Time to Permanency and Time to Safe Reunification

Targeted Outcome or Systemic Factor	Strategy	TOC	• Intended Practice Change
• Permanency 1 • Permanency 2 • Statewide Information Systemic Factor	Strategy 2.1: Develop resources, strategies, and training to address issues related to identifying, locating, and engaging all fathers	We will identify and utilize additional sources to locate fathers and will develop tools to support improved father engagement practices **so that** we ensure a comprehensive understanding of all available and appropriate methods to locate and engage fathers **so that** fathers are incorporated into case planning **so that** additional resources and options are available for the child **so that** permanency can be achieved more timely.	• Social Workers will be equipped with guidance on how to engage fathers in difficult family situations (Mom doesn't want non-resident parent involved, there is an NCO due to domestic violence, etc.) • Improved identification, location, and engagement of fathers • Father experiences with the Department will be incorporated into training so that workers will be exposed to the father perspective so that they have a personal understanding of what a father may be able offer a child • Unconscious biases will begin to break down so that workers will be more apt to prioritize the identification, location, and engagement of fathers so that these additional resources are available for the child so that permanency can be achieved timely

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Targeted Outcome or Systemic Factor	**Strategy**	**TOC**	• **Intended Practice Change**
• Permanency 1 • Permanency 2 Statewide Information Systemic Factor	Strategy 2.2: Increase timely successful permanency through improved quality legal representation	Elevate the visibility and importance of quality legal representation by getting IV-E training funds for NACC Redbook training **so that** the attorneys are better informed **so that** the quality of representation will increase **so that** the parties are more focused on timely permanency **so that** parents receive timely appropriate services to meet their underlying needs **so that** parents can safely take care of their children **so that** children may safely remain in their own homes or achieve timely permanency if removed.	• Attorneys and judges have increased knowledge about child welfare law and the importance of timely permanency • Attorneys and judges more focused on utilizing the court process to improve time to permanency • Children achieve permanency sooner • Legal representation will be available for parents and children at all stages of a case including the pre-filing of a CINA petition
• Permanency 1 • Permanency 2 Statewide Information Systemic Factor	2.3 DHS workers enter information regarding a child's initial placement or change in placement within 3 business days of the placement/placement change.	Set a clear practice expectation in policy **so that** the standard for timely data entry is known by all **so that** supports (training, IT solutions) for the field can be identified to assist with meeting the expectation **so that** the information is entered timely **so that** we are able to accurately and readily identify the location for children who are, or within the immediately preceding 12 months have been, in foster care.	• Entry of children's physical location within three business days of a change in placement

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Goal 3: Children experience optimal well-being because of an increased focus on improving the parent's capacity to provide for their children's needs

• **Targeted Outcome or Systemic Factor**	**Strategy**	**TOC**	• **Intended Practice Change**
• Well-Being Outcomes 1, 2, 3 • Systemic Factors: Case Review System; Service Array; Staff and Provider Training	Strategy 3.1: Early engagement of the family in assessment and identification of the needs of the family and services to address those needs	Preservation Service Array will be implemented **so that** resources are available **so that** field staff understand our collective commitment to preserving and strengthening family connections **so that** field staff will effectively engage the family at the onset of an assessment **so that** the worker and family can identify ways to preserve the family while mitigating danger when possible **so that** the family is better positioned to actively participate in identifying what they need to enhance their parenting capabilities **so that** they are actively engaged in building their case plan **so that** workers support the family's self-determined service needs.	• Early identification of family and child needs • Enhance the family's capacity to care for their children • Increase the family centered approach in field staff's work with families • Increase the joint development of written case plans through more effective collaboration with families • Increase availability of evidence-based services for families and children
• Well-Being Outcomes 1, 2, 3 • Systemic Factors: Case Review System; Service Array; Staff and Provider Training	Strategy 3.2: Effectively engage with substance using parents	The agency and courts will collaborate to identify where there are current Family Drug Courts and Infusion Project Pilots and plan to add 2 Infusion Project sites **so that** there is a coordinated statewide system effort to improve engagement for substance using parents **so that** the parents get the support and services they need **so that** their children can be safely returned to the home or safely remain in the home.	• Early identification of family and child needs with substance using parents • Early access to substance abuse evaluations and treatment services • Increase collaboration between social workers, substance abuse treatment professionals and the court for families and children with substance using parents • Increase the family centered approach in field staff's work with substance using parents • Find ways to keep children at home or get them home quicker when there is substance using parents

• **Targeted Outcome or Systemic Factor**	**Strategy**	**TOC**	• **Intended Practice Change**
• Well-Being Outcomes 1, 2, 3 • Systemic Factors: Case Review System; Service Array; Staff and Provider Training	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	In order to improve worker practice, we will improve our supervision model to integrate practice expectations into practice **so that** practice changes can be sustained **so that** family centered services are embedded in practice **so that** supervisors can guide and support workers while monitoring change in behavior and culture **so that** workers feel supported **so that** turnover is reduced.	• Build supervisor capacity to manage staff in ways that use data to inform and help them with developing staff and understanding measures. • Provide additional support to staff to reduce turnover. • Support workers with time management to ensure required casework is being completed. • Support supervisors as they mentor workers and monitor performance

Goal 4: Improve and increase collaborative joint CQI system and Interventions

Targeted Outcome or Systemic Factor	**Strategy**	**TOC**	• **Intended Practice Change**
Quality Assurance Systemic Factor	Strategy 4.1: Implement a joint CQI process between DHS 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.	A joint CQI process will be developed **so that** shared priorities are identified and a structured communication process is established **so that** child welfare system stakeholders receive robust, integrated information **so that** a unified consistent statewide message is communicated regarding the child welfare system performance **so that** stakeholders have the opportunity to provide feedback on the functioning of the child welfare system **so that** the child welfare system is continuously making improvements.	• Ongoing partnership between DHS and CIP • Inclusion of stakeholders in the CQI process • Collaborative identification of shared priorities • Robust statewide data reflecting system performance • Increased coordination with practice initiatives

Section 4: Goals, Strategies, and Key Activities

Goal 1: Keep Children Safe at Home with Their Families Whenever Possible

Targeted Outcome or Systemic Factor: Safety 1 and Safety 2

Strategy 1.1: Ensure child safety during each stage of the case and improve safety and risk assessment and management
Strategy 1.2: Increase face to face contact with child victim(s) within the assigned timeframes and, if delays must occur, Supervisors and CPWs collaborate to implement actions to assure the child's safety at home until the face to face contact occurs.
Strategy 1.3: Implement the Safe 4 Home Initiative (4 questions) statewide

Goal Rationale: In order to safely keep children at home whenever possible, focus will be placed on identifying danger, developing appropriate safety plans to mitigate the danger, ensuring the following areas:

- Accurate ongoing assessment of safety and risk throughout the life of a case with safety issues identified and mitigated early through safety plans and services so children remain safely in their homes rather than entering foster care;
- Improving timeliness of investigations seeing child victims in new assessments of maltreatment so that any safety issues can be promptly addressed through safety plans, as needed, so children remain safely in their homes rather than entering foster care; and
- Establishing safety of the child in situations in which we cannot see them within the assigned timeframe despite all efforts to do so.

With regard to ensuring safety, the data show that the completion of ongoing assessments is by far the primary concern. In 29 of the 32 (91%) applicable cases for item 3B (the agency conducted ongoing assessments that accurately assessed all risk and safety concerns), assessments were not sufficiently in-depth.

In addition to a lack of quality assessment, case reviews also identified that all children in the home were not clearly assessed for individual safety and risk issues. Similar to the assessment of needs and services, safety and risk assessments tended to focus only on the child(ren) with the greatest presenting needs based on the reason for agency involvement.

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

1. Safety plans used as "promissory notes" with parents agreeing to abstain from identified behavior
    a. Discussions between Iowa reviewers determined that "safety" plans were not consistently used to address safety issues, but to clarify expectations of behavior or actions a caretaker is to demonstrate. Feedback from reviewers based on interviews conducted indicated that Iowa's Safety Plan form is the one document the workers have with them on home visits that provides the ability for a worker to leave a copy with the family and have a copy for the file. This could be one reason for safety plans appearing to address non-safety issues and for a lack of meaningful intervention. Safety plans were often used to establish "next steps" for families, rather than to address issues of imminent danger.
    b. Related to this, there also appear to be different interpretations of danger versus risk and when/how safety plans may be used to keep a child in their home rather than utilizing foster care.
2. Safety services

a. "Safety services" were often contracted to monitor the safety plan through daily drop-in visits. It was difficult to describe any specific intervention aimed at mitigation of safety issues but consisted primarily as a checkup on the family to assure compliance. Monitoring and revision of safety plans was also identified as an issue, primarily resulting from the promissory nature of the plans as there was no progress to monitor, but documented compliance.

b. Lack of a common understanding of what qualifies as "safety services" between DHS and contracted providers of these services may contribute to this issue. Notably, the Department has embraced the Family First philosophy and, in SFY20, overhauled contracts for these services to prevent the need for removal through evidence-based family preservation services.

3. Safety plans misnamed
   a. At times there appeared to be a safety plan in place, but upon review of the content it was not a plan for maintaining ongoing safety for the child but rather a crisis plan for handling a hypothetical future situation to mitigate risk.

   b. This also relates to Item 1 above regarding an attempt to document clear expectations of the family using the Safety Plan form as it most closely and conveniently meets the logistical need of the worker when interacting with the family. Of note, having recognized this pattern, a workgroup developed, and DHS has implemented, an action plan to be used in cases where next steps are needed but no imminent danger is present.

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

Identified Need: Case review data from Iowa's 2018 onsite review indicated that Risk and Safety Assessment and Management was rated a strength 51% of the time (33/65 cases). Analysis of the data and corresponding narrative explanations found two primary areas of concern regarding Item 3:

- Ongoing accurate assessment 9% (3/32 cases) were rated as a strength
- Safety planning 36% (4/11 applicable cases) were rated as a strength

The case review narratives indicated the following trends in cases not meeting the standards for ongoing assessment and management:

- N=8 No/inadequate assessment due to a lack of probing questions
- N=8 Did not assess all children
- N=8 Lack of visits to primary home
- N=6 Lack of consistent visits

In case reviews, 7 of the 11 applicable cases for item 3C ("Develop an appropriate safety plan with the family and continually monitor and update the safety plan as needed") were rated as needing improvement. The Children's Bureau noted that many of the safety plans being described in case review narratives:

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

Multiple stakeholder workgroups looked at case review data, drew upon their individual experiences, and provided information about the issues of assessment of safety and risk and safety plans.

On August 13, 2019, a stakeholder feedback group evaluated the case review information outlined above. This was a facilitated workgroup brought together to focus on CFSR Items 2 and 3 involving safety and risk assessment and management and services to prevent entry/re-entry into care. The content of the meeting involved the participants completing the same 7 steps discussed in Section 2 of this document.

Regarding cases where there was a lack of visits to the child's primary home, the reviewers noted that 4 of the 8 cases concerned children of divorced parents and blended families where there was more than one primary household. Reviewers explored this with case managers during interviews and found the definition of "household" members was not clear and led the staff to focus service provision on one home to the exclusion of another resulting in:

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

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

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

Social workers have noted that agency policy does not address safety and risk assessments in both households; rather staff are instructed to complete safety and risk assessments on the household of the parent with primary physical care. In situations where the child spends equal time with each parent, the household where the alleged abuse occurred is evaluated. Due to this focus on one residence, the primary trends identified above are interwoven as an entire household has not been thoroughly considered, therefore not comprehensively assessed.

The use of periodic safety planning with families is directly tied to the determination of danger versus risk; a clear issue of danger must be identified in order to develop, implement, and monitor an effective safety plan. During the secondary oversight portion of the onsite review, Children's Bureau

(CB) and Iowa representatives had discussions regarding the philosophy and purpose of safety plans as well as elements that must be addressed in order to develop a quality safety plan.

Currently, CPWs are held to strict safety and risk guidelines, and supervisors are required to uphold the policy language when making safety decisions. If caseworkers and supervisors had the ability to think creatively about safety decision making and safety planning, they would be better able to create tailored safety plans and services for families as needed. Both caseworkers and supervisors need to have the opportunity to broaden their scope of thinking around safety decision making and planning. One option they have for this is through Child Safety Conferences, which would allow this creativity and allow for the use of innovative approaches with families.

An Iowa Courts stakeholder group, including court and DHS personnel, and Children's Bureau (CB) personnel in collaboration with the Capacity Building Center for Courts (CBCC), met in December 2018 to discuss ways that Iowa child welfare partners can work together to positively affect timely permanence, in particular, reunification. Through structured discussion, this group identified the lack of accurate safety assessments and thorough understanding of safety planning as root causes impacting timely permanency, specifically reunification.

Decisions regarding when it is safe to reunify are intricately associated with not only accurate assessments but also a common understanding of danger versus risk. This group concluded that there is not a common understanding which hampers effective communication, collaboration and informed decision making among all child welfare partners. While this group was focusing on successful reunification it should also be noted that reaching a common understanding of danger versus risk is essential when making decisions regarding whether removal of a child is warranted and what an effective safety plan might entail.

This same issue was identified in stakeholder groups that met in February and March of 2019. Based on practical experience, these groups described the difficulty of determining when an issue rises to the level of danger which impacts decisions regarding removal, use of safety planning, and reunification. One of the cross-cutting themes identified by a diverse group of more than 100 stakeholders present was "lack of understanding of danger versus risk." (See Section 3 – Root Cause Themes)

The case review data and stakeholder workgroup results are consistent in the conclusion that Iowa does not have a common understanding of danger versus risk and that this has a direct impact on removal rates and the content and monitoring of safety plans. When looking at these issues, it is clear that one issue easily leads to another – the safety plan must identify a specific safety issue, be actionable and thorough in order to measure, monitor, and revise when needed to mitigate a dangerous situation. Stakeholder workgroups confirmed this finding and added that there are not consistent expectations for the content of a safety plan and no consistent supervisory follow up or mentoring to provide feedback.

Root causes:

- Lack of sufficient training with clear definitions of danger versus risk, leading to difficulty in making informed case planning decisions.
- Lack of common understanding and terminology between all child welfare partners, negatively impacting communication, collaboration, and decision-making.
- Lack of sufficient training on the development of meaningful safety plans that are actionable and clearly address safety issues and include clear direction on content of safety plans.

- Lack of follow up to assure quality assessments and safety plans are being developed. There is the belief that once the training has been completed, staff are trained and we move on to the next "focus".
- Lack of collaboration with families to determine the right services at the right time because we tend to use a cookie-cutter approach to common issues as this is the perceived outcome the court wants so we don't actively collaborate with families to identify their unique needs.
- Lack of shared vision of the purpose of a safety plan and how it should be used to keep a child safe at home.
- Lack of a common belief that safety plans are important, not seeing a direct impact of safety planning with a family and positive results (timely permanence, keeping a child safe at home rather than removal, etc.)

Theory of Change: We will clearly outline staff practice expectations for safety assessment and safety planning **so that** social workers understand how to effectively develop safety assessments and safety plans **so that** they are used consistently in communication and decision making **so that** parents' legal rights are supported **so that** family units can be preserved when possible and **so that** children can remain safe.

Strategy Rationale: Having standardized policy and practice expectations, along with a new safety assessment and safety plan, associated training and supervisory tools, will allow CPWs and supervisors to make consistent safety decisions for families statewide. CPWs will have an opportunity to practice drafting safety assessments and making safety decisions in a training environment that allows them to obtain feedback in a learning environment. Supervisors will also have opportunities to strengthen their role in supporting their workers. The agency will include courts and other partners in this effort, leading to collaborative safety decision making for families throughout the child welfare system.

Intended Practice Change:

- Improved ongoing assessments, including identifying individual safety and risk issues for all children in the home, not just the child with the needs that led to agency involvement
- Using safety plans to address safety issues rather than to outline necessary behavior changes
- Clear definitions of danger and risk in making removal decisions, and improved practice on using them correctly (including decision-making, initial and ongoing safety assessment, removal, and writing an actionable plan)
- Ensuring knowledge to support decision-making on when a child is safe to go home
- Improved monitoring and revision of safety plans
- Clarification of the components of Family Preservation services, including contract language with providers
- Distinguishing between safety plans and action plans
- New Safety Assessment and Safety Plan
- Child Safety Conferences to allow opportunities for non-traditional safety decision-making

Key Activity	Who	Start Date	End Date
1. Review policy and practice to identify any gaps or challenges related to assuring our safety plans are not coercive and provide parents with their legal protections and utilize this information to inform subsequent key activities.	Safety Plans and Parent Legal Rights group	March 2020	May 2020
2. Contract with National Council on Crime and Delinquency (NCCD) to assist Iowa in developing a new and validated structured decision-making tool for safety assessment and safety planning. At the close of the project, Iowa will have a validated tool.	SBT	April 2020	April 2020
3. Begin work with the NCCD regarding development of a new safety assessment tool and safety plan that will be validated for Iowa.	Safety Assessment and Safety Plan Workgroup (an internal DHS workgroup to manage NCCD contract) and NCCD	May 2020	November 2020
4. Define supervisor role in implementing and monitoring worker use of the safety assessment and safety plan, including supervisory attention to key safety decision points. The supervisor holds a supportive and leading role to allow for mentoring as well as compliance with policy, and provides the opportunity for non-traditional safety decision-making.	Safety Assessment and Safety Plan Workgroup and NCCD	November 2020	January 2021
5. Test draft structured decision-making tool (workers, supervisors, judges, parents, etc.)	Safety Assessment and Safety Plan Workgroup, Safety Assessment and Planning Practice Champions, and NCCD	November 2020	December 2020
6. Collect feedback from users/stakeholders, adjust as needed	Safety Assessment and Safety Plan Workgroup, Safety Assessment and Planning Practice Champions, and NCCD	January 2021	February 2021

Key Activity	Who	Start Date	End Date
7. Clearly outline staff practice expectations for safety assessment and safety plans and for consistent use of danger vs. risk in practice, in communication, and in decision making and incorporate into training.	Safety Assessment, Safety Assessment and Planning Practice Champions, and Safety Plan Workgroup and NCCD	January 2021	February 2021
8. Draft new administrative rules for publication	Safety Assessment and Safety Plan Workgroup	January 2021	February 2021
9. Develop concrete safety plan examples that include a variety of different safety threats (such as domestic violence, mental health, substance abuse, and physical abuse) in collaboration with FCS contractors, DV advocates, substance abuse and mental health partners etc. and incorporate into training.	Safety Assessment and Safety Plan Workgroup	January 2021	February 2021
10. Develop SDM training (both initial and refresher) that outlines elements such as: • Clear definition of “danger” vs “risk” • Application of danger vs. risk in completion of ongoing assessment • Including families in completing the safety assessment and developing the safety plan as needed • Writing a quality safety plan – required elements • Effective monitoring of safety plans • Which household to focus the assessment on. • Self-examination of how a worker’s values and experiences influence their safety decision making	Safety Assessment and Safety Plan Workgroup, Safety Assessment and Planning Practice Champions, Bureau of Service Support and Training ,and NCCD	January 2021	March 2021
11. Train DHS staff (and child welfare partners, such as the legal community, service providers, and JCS) using existing structures, such as CIP trainings, quarterly DHS-service provider meetings, and quarterly DHS-JCS meetings on the new practice expectations and tools, rooted in evidence-based resources, including how they inform decision making, initial and ongoing safety assessment, removal and writing actionable plans consistent with safety expectations.	Safety Assessment and Safety Plan Workgroup, Safety Assessment and Planning Practice Champions, Bureau of Service Support & Training, and NCCD	April 2021	May 2021

Key Activity	Who	Start Date	End Date
12. Create an evaluation plan that will incorporate the CFSR case review data and NCCD data, and will include the manner in which gaps will be addressed and necessary practice changes will be implemented.	Safety Assessment and Safety Plan Workgroup and NCCD	May 2021	June 2021
13. Quarterly, review the prior quarter's data: • CFSR case review • Founded substantiation while case is open (children safe during in-home services, maltreatment rate during in-home services) (ROM) • Re-entry (ROM)	CFSR PIP Oversight	July 2021	Ongoing

In addition to monitoring data, the NCCD will be evaluating the effectiveness of our implementation and we expect that information to help identify any needed adjustments.

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 the face to face contact occurs.

Identified Need: A stakeholder group evaluated case review data, as well as data from the Results-Oriented Management (ROM) system for January – June 2019, which indicated that 65% of the cases met the timely initiation requirement. This workgroup was brought together to identify root causes of Iowa's performance regarding timeliness of seeing alleged victims face-to-face. The meeting participants completed the following:

1. Analysis of the data, including brainstorming factors impacting performance
2. Determination of factors they believe were primary influencers
3. Creation of a problem statement around the primary influencer(s)
4. Utilization of the "5 WHYs" process to help the group dissect the problem and determine the root cause(s)
5. Development of a strategy to solve the problem by addressing the identified root cause(s)
6. Identification of key activities that would need to take place in order to achieve the strategy goal
7. Application of the Theory of Change model to test the logical progression of their developed approach

While the data indicated that the one-hour timeframe was missed more often than the other timeframes, as the group worked through the root causes and strategies, they determined that the key activities developed would impact timeliness across all timeframes.

Root Causes Identified: In terms of timeliness of initiating investigations, Iowa child protection intake prioritizes assessments based on the type of abuse, access of the abuser, and child vulnerability. Based on assessment of these factors, a timeframe of 1 hour, 24 hours, 72 or 96 hours is

assigned within which face-to-face contact between the DHS worker and alleged child victim(s) must occur. In Iowa's onsite review, 71% (25 of 35) of cases reviewed met the criteria for Item 1: Timeliness of Initiating Investigations of Reports of Child Maltreatment. Based on case review narratives, the primary reasons that the remaining 10 cases did not meet the assigned timeframe include often a combination of:

- The child protective worker did not meet the assigned timeframe and also did not follow department policy to consult their supervisor for approval.
- Documentation did not include the reason for the delay or how safety was assured
- Reasons for delay were not beyond the control of the agency
- A new timeframe was not established to see the child victim(s) and efforts to follow up were significantly delayed.

Missing from each of the above issues is the supervisory direction of practice actions at the point of attempted contact with a family. Supervisory guidance is essential to guide CPW efforts to keep children safe, as well as ensure consistent policy application. In addition, if unable to make initial contact with the child victim within the assigned timeframe, the practice of establishing and documenting a new timeframe in which to see the child victim was not specified in policy; this may have contributed to a lack of documentation of actions taken or planned and/or an additional delay in seeing the child victim(s). CFSR case review data also indicate there were times when timeframes were delayed for reasons that were not beyond the Department's control, therefore not meeting policy criteria. Reasons for this are partially due to workload issues so potentially not being able to meet all requirements; this may result in workers prioritizing their workload, using the report information and local knowledge of a family to determine urgency to make contact. Workforce issues were noted in the stakeholder feedback groups that met in February, March, and August 2019. The Division of Field Operations has recognized the need and set out a four-year plan to increase front line staffing levels as budgets allow. Front line staff include social work case managers, abuse investigators and eligibility workers. The chart below demonstrates the significant increase in child welfare staff since the CFSR on-site review was commenced in SFY2018.

Position Title	SFY 18	SFY 20	Growth	% Growth
Case Managers (SW2)	312	336	24 staff	8%
Abuse Investigators (SW3)	205	248	43 Staff	20%

Theory of Change: Provide clear policy and practice direction regarding actions and documentation required when encountering barriers to meeting assigned timeframes to see the child(ren) **so that** staff will consult with their supervisor prior to the timeframe expiring **so that** worker and supervisor can thoroughly discuss and work through: 1. efforts that have been made to see a child victim(s); and 2. additional actions that must be taken to locate/see the child within the assigned timeframe **so that** appropriate decisions can be made as to whether it is reasonable to delay a timeframe **so that** the department philosophy and expectation of meeting the assigned timeframe without delay is fully integrated into the practice culture **so that** children can be seen timely whenever possible or, if a delay is appropriate, consultation can occur on potential safety issues and mitigation needed to assure the child's safety at home **so that** a revised timeframe to see the child can be established **so that** child victim(s) are seen as soon as possible **so that** children are first and foremost safe.

Strategy Rationale: The creation of a field guide for staff and supervisors will provide clear and consistent direction regarding timeliness of initial investigations and establishing safety of the child(ren) if unable to meet the assigned timeframe. These guides will also reinforce the practice of supervisor and worker consultation when facing barriers to seeing a child timely; this allows for the integration of clear direction with the nuances of specific case circumstances. Iowa's Supervisory Model of Practice has been developed to affirm, guide, reinforce, and support supervisors in promoting strength-based, solution focused, and family centered practice at all levels. We believe these essential conversations will reinforce not only the policy requirements surrounding seeing children and establishing safety, but also reinforce the Department's mission and values through supervisory practice guidance.

Throughout strategies in this document and practice generally, supervisor and worker consultation is essential as an ongoing method of guiding, supporting, and reinforcing family centered practice; this contact is one of the primary conduits to implementing and sustaining change. It allows the supervisor to support the worker in application of practice skills to specific family circumstances and dynamics; this serves to bridge a gap identified by workers between classroom training and application of skills. In conjunction with PIP strategy 3.3 and initiatives described within Goal 3 regarding the mentor program, we believe these guides will provide the needed additional foundational information upon which to base decisions.

Intended Practice Change:

- Increased performance regarding face to face contact with child victim(s) within assigned timeframes through proactive consultation and problem-solving between CPW and Supervisor.
- Correct identification of when a delay is appropriate.
- Activities to ensure safety of the child during a delay are completed and documented.
- Accurate documentation of the delay and the additional activities during the delay so safety and performance can be monitored.
- Clear establishment of reasonable case-specific revised timeframes assigned when contact delay is approved.

Key Activity	Who	Activity Start	Implementation
1. Develop one-page field guides for reference that clearly outlines policy and practice expectations as well as system inputs required. The field guides will include: • Reinforce that timeframes may be delayed but they are never waived • The definition of concerted efforts • How to establish a child's safety when not able to see child within timeframes • Guidelines for acceptable reasons to delay assigned timeframes • How and where to document delays and reasons for the delay	Child Protection Workgroup	October 2020	February 2021

Key Activity	Who	Activity Start	Implementation
2. Revise policy to specify the documentation required when a delay in seeing a child victim is approved. This will include, but is not limited to: • Barriers encountered to meeting the timeframe • Steps taken to establish the child's safety • The revised timeframe in which to see the child	Policy	September 2020	December 2020
3. Supervisory responsibilities in consultation and guidance: • Reinforce Department philosophy and expectations that children are seen timely whenever possible; • Assure all reasonable efforts have been made to see the child within the assigned timeframe; • Problem-solve additional strategies that could result in seeing the child timely; • Assure child safety in those cases where a delay is approved; • Establish a revised timeline to see the child in situations where a delay is approved; • Assure accurate documentation in the Child Protection/Family Assessment Reports	SAMs / SWAs	November 2020	February 2021

Key Activity	Who	Activity Start	Implementation
4. Develop a clear and detailed implementation plan that outlines such things as: • Communication about the guide with staff and stakeholders • Training on the guide, which will include allowing CPWs to use the field guide to practice establishing safety when they are not able to see a child, and to also practice determining acceptable reasons for delays in seeing a child in an environment that allows them to obtain feedback. • Additional training for supervisors will include details on how they can support and guide their workers through case specific consultation regarding attempts to make contact, additional strategies to attempt, rationale of a delay, safety considerations, etc. • Assessment of training effectiveness and staff competency • Monthly method to measure if supervisor and staff practice has been impacted • When and how to revisit the guidance if improvement is not seen • How to incorporate into new worker training Statewide rollout plan, including any pilot sites • Evaluation and monitoring plan • Definition of success • Communication plan to share outcomes data with staff and stakeholders	Child Protection Workgroup	October 2020	February 2021
5. Explore any desired JARVIS changes and submit service request if applicable. Also consider what data reports will reflect the system change and be used to accurately monitor performance. **Approval of the SR and then priority of that work will have to be determined according to available resources and weighed against competing projects.*	Child Protection Workgroup	October 2020	February 2021
6. Implement field guide in accordance with the implementation plan	Child Protection Workgroup	March 2021	March 2021
7. Review monthly ROM data and CFSR case review report submitted to the CB in order to monitor effectiveness of change theory/strategy, identify trends, and make adjustments as needed to ensure positive change.	Child Protection Workgroup and CFSR Oversight	March 2021	Ongoing
8. Communicate any challenges to Oversight so that needed adjustments can be made in accordance with the evaluation plan	Child Protection Workgroup and CFSR Oversight	April 2021	Ongoing as needed

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

Identified Need: The first root cause group met after the CFSR report out in February 2019 and identified that Iowa struggles with:

- lack of partnering between DHS and court regarding family recommendations/decisions
- lack of common understanding of safety versus risk and inconsistent application of safety versus risk related to removal of children and when to reunify
- lack of quality safety plans and effective use of safety plan services

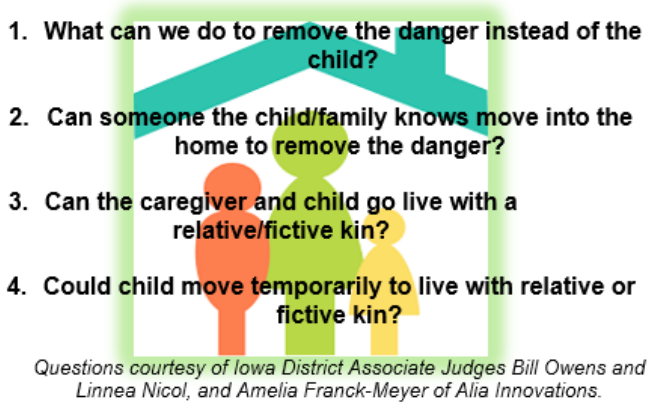
A subsequent group came together to take the identified challenges and brainstorm potential solutions. This group placed a strong emphasis on the need for a standardized tool that effectively defines and assists in assessing for danger opposite of safety to help with collective understanding of danger versus risk. They also identified the importance of developing shared principles with DHS and the legal system aligning with Family First.

As outlined in strategy 1.1, Iowa will be working with the NCCD in implementing a new structured decision making tool in order to better assess danger. The Safe 4 Home Initiative takes that concept of danger identification and utilizes that to frame conversations between judges, social workers, GALs, and attorneys as it relates to removals. This effort also dovetails with our Family First Child Safety Conference model that will also reframe how we work with families in keeping their children safe at home whenever possible. Identification of the actual danger will lead to more effective safety plans. Reframing of these conversations around danger can be utilized not only during assessment but throughout the life of a case which should lead to timelier reunification when a removal was necessary.

Root Causes Identified: Iowa does not have definitions of danger and risk that are used consistently statewide, nor is there a standard of practice to consistently ask why a child cannot remain safely in the home or if a child can safely be returned home throughout the life of a case. These inconsistencies lead to variations in safety decision making around the state.

Theory of Change: We will expand the 4 questions pilot (aka Safe 4 Home Initiative) statewide **so that** judges, DHS staff, and legal representatives are similarly oriented in identifying the actual danger **so that** mitigation efforts are fully explored **so that** appropriate safety measures are implemented **so that** family units can be preserved when possible and **so that** children can remain safe.

Strategy Rationale: Implementation of the Safe 4 Home initiative will support consistent definition of danger and risk, consistent conversation about whether a child can stay safely in the home as well as continual assessment of whether a child is safe to return home at multiple points throughout the life of a case. The 4 questions were developed by Iowa District Associate Judges Bill Owens and Linnea Nichol in collaboration with Amelia Franck-Meyer of Alia Innovations as part of Iowa's work with Alia. The 4 questions are:



The pilot, which involved 7 judges, indicate notable positive changes. For December 2019 through March 2020 there were 83 requests for removal and only 44 (53%) were granted. Of those granted, 24 kids were placed with family, 5 with fictive kin and 15 in stranger foster care.

Time Frame	Relative Placement	Suitable Other	Foster	Shelter
Dec 19 – Mar 20	55%	11%	34%	0%

In comparison, data from these same judges from August through November 2019 indicated 99 removals granted. Of those, 42 were placed with family, 9 with fictive kin, 34 in stranger foster care and 9 in shelter.

Time Frame	Relative Placement	Suitable Other	Foster	Shelter
Aug 19 – Nov 19	42%	9%	34%	13%

The 4 questions pilot was highlighted at a national conference in March and the Capacity Building Center for Courts is interested in exploring use in other states.

Intended Practice Change:

- Standardize practice to continually ask the 4 questions.
- Common language and decision-making framework between the Courts and DHS.
- Standardize practice to ensure kids stay home when it is safe to stay home.
- Systemic approach to addressing danger
- Prevent unnecessary removals.

Key Activity	Who	Activity Start	Implementation
1. Introduce the Safe 4 Home Initiative to Judges in their September 2020 training. Training will include: • Pilot information presented by a participating judge • Connecting the name of the initiative to the initial questions • Overview of the pilot • Goal of the 4 questions • Data from the pilot (7 judges) ▪ Items and data monitored include: # of removal requested, # denied, # approved, of the removals approved - a description of the reason the removal was necessary	CIP	September 2020	September 2020
2. Create an implementation plan that will include • Outcome targets • Data collection process • Monitoring and evaluation process • Training and ongoing support (Judges and SWs)	CIP/DHS Alia Team	September 2020	October 2020
3. Implement Safe 4 Home statewide	CIP	November 2020	Ongoing

Goal 2: Improve Time to Permanency and Time to Safe Reunification

Targeted Outcome or Systemic Factor: Permanency 1 and Permanency 2; Statewide Information System (item 19)

Strategy 2.1: Develop resources, strategies, and training to address issues related to identifying, locating, and engaging all fathers
Strategy 2.2: Increase timely successful permanency through improved quality legal representation

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

Goal Rationale: Permanency Outcome 1 was rated as Not in Substantial Conformity with 45% Substantially Achieved, and the three items (Stability of Foster Care Placement, Permanency Goal for the Child, and Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement) were all rated as Areas Needing Improvement (ANI) based on the 40 applicable cases chosen:

Item	Rating
Item 4: Stability of Foster Care Placement	80% of 40 cases rated as a Strength
Item 5: Permanency Goal for the Child	85% of 40 cases rated as a Strength
Item 6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	60% of 40 cases rated as a Strength

By creating a goal focused on improving time to permanency and time to safe reunification, Iowa will be able to improve these outcomes for children and families and better engage families in their involvement in the child welfare system.

Impact of Strategies: The strategies identified in Goal 2 will improve timelines to permanence and safe reunification for families by:

- Continually and consistently engaging fathers in order to provide additional connections and potential permanent resources for children and youth in foster care.
- Creating a structure by which CPWs and supervisors will practice under consistent definitions of danger and risk, and will continually prompt the CPWs to ask if a child can be returned safely home at multiple times throughout a case.
- Improving quality legal representation for families and engaging them more actively in their case process.

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

Identified Need: Research indicates that active involvement of fathers contributes to timely permanency for children in foster care. Anecdotal evidence suggests that positive permanency outcomes are more likely for children in the foster care system if fathers are actively involved in services. (The Urban Institute, November 2003). When fathers were identified during the child welfare process, their child spent less time in foster care and were significantly more likely to be reunified and/or receive permanent placement with a parent, than in cases where the child's father was not identified (Burrus et al., 2012).

Involving fathers in a child welfare case will impact permanency by:

- Preventing the child's entry into foster care through:
  - Actively supporting efforts to maintain the child safely in the primary home
  - Providing an alternative living environment for the child if the child cannot remain in the primary home safely (concurrent planning)
- Identifying extended relative resources in order to:
  - Actively support efforts to maintain the child safely in the primary home
  - Explore in the event the child must be placed in foster care (concurrent planning)

- Increasing positive permanency outcomes for the child by increasing the number of relatives identified

For non-resident fathers, this means an added emphasis on identifying, locating, and engaging. To this end and in the spirit of preserving and strengthening family connections, DHS recently entered into a contract with the Department of Human Rights to use social media and other resources to find the address, phone number, email address and/or other contact information for the father and paternal relatives of children of color who are at risk of entering the foster care system. Though they may not be able to find information on every case, they will make every attempt to do so, forwarding any information they find to the worker no later than 15 business days after the referral.

For fathers residing with their children, this means a focus on actively involving them as well as their own extended family in all aspects of the child's life. Through active involvement of all parents, the child is able to strengthen connections and a more robust network of resources is available to support the parents.

The Iowa case review data below was collected between April and September 2018, and illustrates agency interaction with mothers and fathers:

--	Item 12	Item 12	Item 13	Item 15	Item 15	Item 8	Item 8
--	Comprehensive Assessment	Provision of Services	Active Involvement in Case Planning	Worker Visits Frequency	Worker Visits Quality	Parent Visits with Child Frequency	Parent Visits with Child Quality
Mother	74%	58%	63.8%	89%	85.7%	89.3%	85.7%
Father	61%	40%	50%	68.8%	73.3%	68.8%	73.3%

Root Causes Identified: When reviewing data and discussing personal experience, workers identify they are more successful in their efforts to engage mothers than fathers. Stakeholder groups identified the engagement of non-resident fathers as the primary barrier to parental participation in the lives of their child(ren). This group identified barriers such as current resources to assist in locating non-custodial parents and social worker's lack of confidence in their rights and legal parameters pertaining to confidentiality, including who they can contact and what information they can share.

While the stakeholder group focused on non-resident fathers, Iowa's data indicates a broader definition of the issue – specifically that fathers as a group are significantly marginalized as key participants in the child welfare system regardless of whether a non-resident father or part of a two-parent family. The data above also support that even when efforts are made with fathers, the quality and follow up with them is still significantly less than that performance with mothers (for instance, comprehensive assessment is completed but needed services not provided; worker/father visit occurs but quality is deficient). Research indicates there is an unconscious cultural bias against fathers regarding their role in the life of the child and successful outcomes. Iowa's data is consistent with this research and supports an underlying perception that involvement of a father is not as vital to a child as that of the mother. This will be a focus in the key activities.

Some of the issues around engaging fathers, both in the child's home and non-resident, that were identified in case reviews include:

- Worker did not make efforts to meet with the father(s) during the PUR, specifically with
  - Incarcerated parent(s)
  - Homeless parents or those who frequently moved

  - Non-resident parent/ parent with whom we were not working toward reunification
  - Fathers in two-parent families
- When interactions did occur, there was a lack of substantive discussion
- Reliance on father's presence at FTMs instead of establishing a regular pattern of contact and meaningfully involving the father in the services and case work
- Minimizing the importance of in-person visits and/or regular telephone contact, resulting in reliance on written case plans as primary communication
- Lack of prioritization and resource time to coordinate visits with two parents rather than the one parent viewed as primary

Pairing these factors with the culturally ingrained perception of the mother as the primary caregiver, the vital role of a father (both resident and non-resident) may be overlooked.

Theory of Change: We will identify and utilize additional sources to locate fathers and will develop tools to support improved father engagement practices **so that** we ensure a comprehensive understanding of all available and appropriate methods to locate and engage fathers **so that** fathers are incorporated into case planning **so that** additional resources and options are available for the child **so that** permanency can be achieved more timely.

Strategy Rationale: Through focus on fathers, additional supports and resources will be identified and integrated into the family's case plan, resulting in greater options for the child and more support when the child returns home, increasing timely reunification and decreasing the risk of re-entry into care.

Intended Practice Change:

- Social Workers will be equipped with guidance on how to engage fathers in difficult family situations (Mom doesn't want non-resident parent involved, there is an NCO due to domestic violence, etc.)
- Improved identification, location, and engagement of fathers
- Father experiences with the Department will be incorporated into training so that workers will be exposed to the father perspective so that they have a personal understanding of what a father may be able offer a child
- Unconscious biases will begin to break down so that workers will be more apt to prioritize the identification, location, and engagement of fathers so that these additional resources are available for the child so that permanency can be achieved timely

Iowa Department of Human Services
Child and Family Services Review (CFSR) Round 3
Program Improvement Plan

Key Activities	Who	Activity Start	Implementation
1. Explore and expand access to options to locate non-resident parents, including Department protocols for use, such as: • Board of Vital Records (birth certificate info) • Social media • Other	SBT	September 2020	November 2020
2. Develop desk aid of resources for locating non-resident parents: • DOT • Departmental records • Federal Parent Locator • Any new resources identified	Bureau of Service Support and Training	December 2020	January 2021
3. Establish clear practice expectations around timeframes for workers to meet/talk with fathers, repeat attempts to locate and concrete documentation expectations.	SBT	December 2020	January 2021
4. Develop training for new and ongoing workers that addresses: • Expectations for identification, location, and engagement of non-resident parents throughout the LOC • Practice expectations about methods in which to engage fathers • Resources to utilize • Confidentiality considerations • Impact statements from fathers	Bureau of Service Support and Training	February 2021	April 2021
5. In collaboration with a small group of fathers, develop impact statements/ stories that illustrate their experience with the Department and resulting outcome.	Parent Partner Advisory Council	August 2020	September 2020
6. Incorporate fathers and their statements/ stories into new and ongoing worker training in order to: • Share the father experience with DHS • Identify any barriers experienced • Identify what and how DHS could do differently and what we did well • Emphasize the benefits of a father's involvement • Identify the importance and impact of father's involvement • Impact beliefs, values, thoughts, and actions regarding the engagement of fathers throughout the agency	Bureau of Service Support and Training	February 2021	April 2021

Key Activities	Who	Activity Start	Implementation
7. Task the Child Welfare Partner Committee (CWPC) with determining how to embed the father stories into their various existing meetings/trainings for the legal community and contractors so the legal and judicial partners have training to reinforce the importance of engaging fathers.	CWPC	February 2021	May 2021
8. Develop a training and implementation plan, including expectation for supervisory monitoring of staff practice change, an evaluation plan, which will include data collection, reporting, adaptation of the initiative and communication of data to agency staff and stakeholders.	Bureau of Service Support and Training	February 2021	April 2021
9. Develop and implement a training evaluation that utilizes pre-test and post-test	Bureau of Service Support and Training	February 2021	May 2021
10. Outline and communicate expectations for Supervisor consultation on and monitoring of the clearly defined worker practice expectations.	Bureau of Service Support and Training	February 2021	April 2021
11. Provide training	Bureau of Service Support and Training	May 2021	July 2021
12. Develop proactive tracking and monitoring tools focusing on parent and worker visits broken out by gender	Bureau of Quality Assurance & Improvement	July 2020	July 2020
13. Monitor data (State Visit Report) quarterly and share data with agency staff and stakeholders.	CFSR Oversight	July 2021 and ongoing	Ongoing
14. Monitor pre and post-test data in order to monitor progress and identify ways in which to strengthen the curriculum to reinforce the importance of engaging fathers.	CFSR Oversight	July 2021 and ongoing	Ongoing

The monthly and quarterly monitoring and oversight will be used as short-term indicators of change theory success.

Strategy 2.2: Increase timely successful permanency through improved quality legal representation

Identified Need: The federal Children's Bureau identified quality legal representation at all stages of child welfare proceedings as a way to integrate child and parental voices in child welfare processes:

"…Attorneys that directly represent the expressed interest of their families and children have the ability to file petitions to access court processes at any point where a parent or youth has a concern or need that is unaddressed… High quality legal representation requires that attorneys spend time with the individuals they represent outside of court to understand their strengths, needs and resources. It requires attorneys to work with parents and youth to identify and advocate for services and supports and to ensure that parents and youth understand their rights and the complicated processes that directly affect their lives and well-being… Attorneys can also provide legal services to remove obstacles for families and youth that may leave them more vulnerable of entering the child welfare system, such as housing, educational advocacy, employment, paternity and other civil legal issues." (ACYF-CB-IM-19-03, dated August 1, 2019, Engaging, empowering, and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement. Pages 7 and 8)."

Several studies also show quality legal representation for parents positively "…contributes to or is associated with:

- Increases in…perceptions of fairness
- Increases in…engagement in case planning, services and court hearings
- More personally tailored and specific case plans and services
- Increases in visitation and parenting time
- Expedited permanency
- …Reductions of time children and youth spend in care." (ACYF-CB-IM-17-02, dated January 17, 2017, Legal Representation and Child Welfare, Page 2, available at https://www.acf.hhs.gov/sites/default/files/cb/im1702.pdf)

Furthermore, "…attorneys can contest removals, identify fit and willing relatives to serve as respite care providers, advocate for safety plans and identify resources, all of which may help prevent unnecessary removal and placement." (Ibid, page 6), including re-entry into foster care.

Root Causes Identified: Iowa identified inconsistent quality of representation in the first study of the court process at the initiation of Iowa's court improvement project (CIP), also known in Iowa as Iowa Children's Justice (ICJ). Court assessments since then continue to raise it as an issue to the ICJ Advisory Committee. According to recent ICJ assessment reports, court observations, and feedback, inconsistency in representation remains an issue that leaves some families without adequate advocacy and representation. For example, some attorneys meet with their clients in between court hearings, represent their interest during the hearing, and explain the court results to the parents at its conclusion. In contrast, some attorneys do not meet with their clients between hearings in order understand the clients' interests nor do they check in with their clients after hearings, and some also request continuances that delay permanency.

Theory of Change: Elevate the visibility and importance of quality legal representation by getting IV-E training funds for NACC Redbook training **so that** the attorneys are better informed **so that** the quality of representation will increase **so that** the parties are more focused on timely permanency **so that** parents receive timely appropriate services to meet their underlying needs **so that** parents can safely take care of their children **so that** children may safely remain in their own homes or achieve timely permanency if removed.

Strategy Rationale: Iowa has taken steps to improve quality legal representation in recent years, as reflected in the CIP Strategic Plan. One of the key activities was to establish a task force on improving quality of legal representation. This task force has two sub groups, one on continuous quality improvement of legal representation and the other is focused on assuring quality educational opportunities are available for attorneys. Task force members comprise judges, attorneys, DHS representatives and child welfare provider agencies. To develop a CQI plan, the task force chose to do an in-depth study that included a review of what other states have done to assure quality, gathered information from developed or adapted surveys for many constituents, including judges, attorneys, state agency, foster parents, parents and contract providers. Additional information on this effort is contained within Attachment 3B of the Iowa CFSP for this CQI Plan.

The task force has also been exploring ways to continue to elevate legal representation by offering first-class educational opportunities in the specialty of child welfare law. The task force has identified the Child Welfare Law and Practice, also known as the "Red Book", training offered by the National Association of Counsel for Children (NACC) as the most comprehensive and respected curriculum in this practice area. A variety of topics are covered in this resource. Indian Child Welfare Act, counseling legal clients that are children, child safety, representing parents, federal due process and educational goals for children in foster care are just a few examples. A judge from Iowa's Court of Appeals and a judge from the

juvenile bench have taken the Red Book training and feel the broad array of topics would provide a foundation of knowledge that would raise the standard of practice of legal representation for parties in Iowa's child welfare system. This curriculum is available as an in-person training and also online.

In addition to the task force activities, Iowa Supreme Court Justice Christensen, State Public Defender's office, Jeff Wright, DHS' Director, Jerry Foxhoven, and ICJ Executive Director, Kathy Thompson met in spring 2019 to discuss the new opportunity to receive Title IV E funding for parent and children's legal representation. Also discussed was the possibility to provide legal representation prior to any involvement with the court. Currently an attorney cannot be assigned until the court has jurisdiction which is initiated when a CINA petition is filed. Results of the discussion identified a need for the DHS, as the Title IV E agency for the state, and the SPD's office to enter into a memorandum of understanding (MOU) and to identify next steps needed to integrate attorneys as early as possible and to secure funding.

Intended Practice Change:

- Attorneys and judges have increased knowledge about child welfare law and the importance of timely permanency
- Attorneys and judges more focused on utilizing the court process to improve time to permanency
- Children achieve permanency sooner
- Legal representation will be available for parents and children at all stages of a case including the pre-filing of a CINA petition

Key Activity	Who	Activity start	Implementation
1. Determine requirements needed to draw down title IV-E funding.	DHS	March 2020	April 2020
2. Develop required processes/documents to draw down title IV-E funding, such as the cost allocation plan and the DHS MOU with SPD.	DHS, CIP, and SPD, as required	May 2020	June 2020
3. Work with the Quality Legal Representation Task Force to plan for Redbook Training with NACC State Coordinator.	CIP, DHS, Children's Justice Advisory Committee	July 2020	July 2020
4. Develop a training plan for regional Redbook training for attorneys and judges, including highlighting the importance of permanency and time to permanence.	CIP, SPD, Iowa County Attorney Association	August 2020	October 2020
5. Develop a staged implementation plan, which will include an evaluation plan that will outline data collection, data monitoring plan, outcome measures, and a process by which to adapt the framework as needed. The evaluation plan will also include identification of baseline data from currently tracked court time to permanency data.	DHS, CIP, SPD, and others, as needed	November 2020	December 2020
6. Implement training in accordance with training plan.	CIP, SPD	January 2021	July 2021
7. Encourage trained attorneys to apply and take the test to become CWLS certified.	CIP, SPD	August 2021	March 2022
8. CIP will provide funds for attorneys to support partial or all of the application fee.	CIP	September 2021	March 2022

Key Activity	Who	Activity start	Implementation
9. SPD to explore a higher rate of pay for attorneys who are certified as CWLS using indigent support funds.	CIP, SPD	September 2021	March 2022
10. Track changes in practice and focus on time to permanence, using the CQI subcommittee of the Children's Justice Quality Representation Task Force, including DHS staff on the CQI subcommittee to track progress and evaluate the efforts.	CIP, DHS, Children's Justice Quality Representation Task Force	October 2021	December 2021

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

Identified Need: Iowa was not in substantial conformity with Item 19 due to the inability to accurately and readily identify the location of the children placed into foster care; this included the lack of a policy expectation regarding the timely documentation of an initial placement or changes in placement for children in foster care. Additionally, Iowa's child welfare information system is an antiquated legacy system. Iowa is in the process of replacing the legacy system with a comprehensive child welfare information system (CCWIS).

Strategy Rationale: By setting an expectation in Policy Iowa will have a standard expectation for Field to enter data timely, which we have not had to this point. A reliable monitoring system will allow for measurement of performance and follow up when needed as this new expectation is integrated into practice.

Theory of Change: Set a clear practice expectation in policy **so that** the standard for timely data entry is known by all **so that** supports (training, IT solutions) for the field can be identified to assist with meeting the expectation **so that** the information is entered timely **so that** we are able to accurately and readily identify the location for children who are, or within the immediately preceding 12 months have been, in foster care.

Intended Practice Change:
Entry of children's physical location within three business days of a change in placement

Key Activity	Who	Activity Start	Implementation
1 Develop policy, applicable training, and IT solutions for field staff to enter required data elements within 3 business days of a child's placement and/or placement change	DHS (Policy, Bureau of Service Support and Training, DoIT)	May 2020	August 2020
2. Coordinate with IT staff to develop the report that allows for monitoring of timely entry.	Bureau of Service Support and Training	May 2020	July 2020
3. Begin generating the report to establish baseline data	IT	August 2020	Ongoing
4. Communicate the policy expectations in the bi-monthly service CIDS and notification from the Service Help Desk	Policy, Bureau of Service Support and Training	September 2020	September 2020
5. Expectation begins for Field staff to enter required data within 3 business days of a child's placement and/or placement change	DHS Field Staff	October 2020	Ongoing
6. System data will be compiled to monitor timeliness of data entry monthly upon implementation and quarterly when in the maintenance phase.	DHS (Field, Bureau of QA&I, DoIT)	November 2020	Ongoing
7 Disseminate monthly/quarterly statewide for service area follow up.	SBT	November 2020	Ongoing
8. Quarterly SBT will review the data and make adjustments in practice, reporting, policy as needed	SBT	January 2021	Quarterly Ongoing

Goal 3: Children Experience Optimal Well-Being Because of an Increased Focus on Improving the Parent's Capacity to Provide for Their Children's Needs

Targeted Outcome or Systemic Factor: Well-Being 1, Well-Being 2, and Well-Being 3; Staff and Provider Training Systemic Factor; Service Array Systemic Factor; Case Review Systemic Factor

Strategy 3.1: Early engagement of the family in assessment and identification of the needs of the family and services to address those needs
Strategy 3.2: Effectively engage with substance using parents
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

Identified Need: One of the most significant ways to successfully enhance parental capacity to care for their children is to engage families in the case process, identifying strengths and goals, and supporting them in meeting the needs of their family. This begins with active involvement in an accurate and comprehensive assessment of needs including social, educational, mental/behavioral health, and physical/dental health, and the provision of services, such as skill building, to address the identified needs for families for keeping their family safe. Following assessment, the family and DHS jointly will create a case permanency plan that reflects the family's goals, builds on family strengths, and clearly maps how parental capacity will be enhanced in order for the family to be successful.

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

Impact of Strategy: Iowa was found to be Not in Substantial Conformity with Well-Being Outcome 1, with 38% of the cases Substantially Achieving the standard. The strategies outlined below will impact the Well-Being 1 items as well as Well-Being 2 and Well-Being 3, all of which were found be Areas Needing Improvement:

CFSR Item	Overall Determination	State Performance
Item 12: Needs and services of child, parents, and foster parents	Area Needing Improvement	45% Strength
Sub-Item 12A: Needs assessment and services to children	Area Needing Improvement	66% Strength
Sub-Item 12B: Needs assessment and services to parents	Area Needing Improvement	44% Strength
Sub-Item 12C: Needs assessment and services to foster parents	Area Needing Improvement	85% Strength

CFSR Item	Overall Determination	State Performance
Item 13: Child and family involvement in case planning	Area Needing Improvement	49% Strength
Item 14: Caseworker visits with child	Area Needing Improvement	51% Strength
Item 15: Caseworker visits with parents	Area Needing Improvement	25% Strength
Item 16: Educational needs assessment and services	Area Needing Improvement	84% Strength
Item 17: Physical and dental needs assessment and services	Area Needing Improvement	59% Strength
Item 18: Mental and behavioral health needs assessment and services	Area Needing Improvement	56% Strength

The key activities contained within Strategy 3.1 and 3.2 will address Item 12 (and the sub-items) by improving assessment of needs for children and parents, as well as Item 13, by involving the family in the case planning process, and Strategy 3.3 will also address Item 12 by meeting the needs of families through improved case practice.

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

Identified Need: DHS has embraced the Family First Act (FFPSA) and is committed to evolving our system in ways that better preserve and strengthen family connections. Our focus is to keep children safely at home. If removal is warranted, children will be placed with kin or fictive kin. Institutional care will be used only when absolutely necessary for treatment purposes.

Root Causes Identified: The implementation of FFPSA in Iowa has pointed out a need to reframe practice in order to engage families earlier on and utilize prevention services when appropriate. The practice changes will allow Iowa to create a focus around the vital importance of including and engaging the family at each step of the case process.

Theory of Change: A Family First (FFPSA) framework and new Family Preservation Service Array will be implemented **so that** resources are available **so that** field staff understand our collective commitment to preserving and strengthening family connections **so that** field staff will effectively engage the family at the onset of an assessment **so that** the worker and family can identify ways to preserve the family while mitigating danger when possible **so that** the family is better positioned to actively participate in identifying what they need to enhance their parenting capabilities **so that** they are actively engaged in building their case plan **so that** workers support the family's self-determined service needs.

Strategy Rationale: As a first step in implementing the FFPSA in Iowa, a group of DHS field and central office representatives developed a Blueprint for Iowa's Future Child Welfare System that outlines a set of foundational principles and the commitment to designing our system around the importance of the family. Our Blueprint contains practice commitments and builds upon our Child Welfare Guiding Principles by more clearly defining the linkage between philosophy, strategy and commitments needed to evolve our system.

The Blueprint then informed Iowa's development of our new service array, which will be implemented in October 2020. Iowa will utilize Family Preservation services to address the family's immediate safety needs. We will be adding Safe Care and Solution Based Casework (SBC). When a family comes to our attention, our CPWs will assess for danger and, when appropriate, will initiate a Child Safety Conference (CSC) with the goal of answering the Safe 4 Home (4 questions). Family Preservation services will be utilized as needed. If a case progresses, the CPW will be responsible for developing consensus with the family around what their identified needs are as well as building the basic focused case plan objectives. Those initial objectives will then prepare the family for transitioning into ongoing services and interventions where full case planning would take place with the SWCM and SBC service provider. Safe Care will be utilized in families where it is appropriate and there is a child(ren) 5 years of age and younger. SBC will facilitate a partnership approach with families, identification of family patterns, a more focused approach to identification of family needs and identification of specific prevention skills the family needs to develop in order to keep their family safe.

Intended Practice Change:

- Early identification of family and child needs
- Enhance the family's capacity to care for their children
- Increase the family centered approach in field staff's work with families
- Increase the joint development of written case plans through more effective collaboration with families
- Increase availability of evidence-based services for families and children

Key Activity	Who	Activity Start	Implementation
1. Each DHS service area will identify at least one pilot site for Child Safety Conferences (CSC) and will implement CSCs	Service Area Managers	January 2020	March 2020
2. Incremental implementation of CSCs statewide, beyond pilot counties.	Family First Oversight and Service Area Managers	March 2020	Ongoing
3. Monitor removal and placement data to determine effectiveness of CSCs • Starting with pilot counties • Following with each county as they roll out	Family First Oversight and Service Area Managers	April 2020	Ongoing
4. Train social work supervisors on Safe Care and SBC	Family First Oversight with model developer	January through April 2020	January 2020
5. Train social work staff on Safe Care and SBC	Family First Oversight with model developer	May 2020	May 2020

Key Activity	Who	Activity Start	Implementation
6. Utilize survey to determine training Safe Care and SBC comprehension	Janee Harvey and Matt Haynes	May 2020	June 2020
7. Evaluate survey data and determine what additional training and practice support is needed.	Family First Oversight	July 2020	August 2020
8. Conduct Parent Partner mentee survey	Parent Partner Policy and Practice Recommendation Team	Nov 2019	December 2019
9. Analyze survey results and current practice approaches with DHS	Parent Partner Advisory Council	March 2020	April 2020
10. Draft formal recommendations for systems change and present to DHS (Recommendations will be based on survey results and any identified issues surrounding Iowa's roll out of Family First).	Parent Partner Policy and Practice Recommendation Team	March 2021	March 2021
11. Utilize Parent Partner mentee survey results/recommendations to determine what practice supports are needed to continue to evolve practice aligned with Family First. (Implementation of needed practice supports will depend on what those look like.)	Family First Oversight	March 2021	May 2021

Strategy 3.2: Effectively engage with substance using parents

Identified Need: One aspect of successfully working with families is the ability to successfully engage parents who struggle with substance abuse issues. Parents dealing with substance use face a unique set of obstacles and treatment needs, and need to be engaged and supported in ways that not only improve their parental capacities but also allow them to address their own treatment goals.

Root Causes Identified: Iowa's CFSR data showed that only 44% of the applicable 59 cases reviewed in Sub-Item 12B, Needs Assessment and Services to Parents, were rated as a Strength, leading to a designation that this item was an Area in Need of Improvement. With regard to meeting the needs of parents, in 59% of the 58 applicable cases, the agency made concerted efforts both to assess and address the needs of mothers, and in 45% of the 51 applicable cases, the agency made concerted efforts both to assess and address the needs of fathers.

Theory of Change: The agency and courts will collaborate to identify where there are current Family Drug Courts and Infusion Project Pilots and plan to add 2 Infusion Project sites **so that** there is a coordinated statewide system effort to improve engagement for substance using parents **so that** the parents get the support and services they need **so that** their children can be safely returned to the home or safely remain in the home.

Strategy Rationale: The results from the nearly 13 year effort have demonstrated that the collaborative family treatment court model is an effective way to assist and support parents in their recovery to receive early substance abuse assessments and treatment and have their children returned to their or remain in their home. As of March 2019, the twelve Family Treatment Courts have served 1, 385 families, including 2,630 children and 1,523 adults. In those Family Treatment Court cases where children were at risk of removal, they have been able to remain in their homes through case closure 74% of the time. In FTC cases involving removal, the reunification rate is 73%. The average length of stay for those FTC children is

334 days or 11.1 months, which is lower than the state average of 13.2 months for cases that involve parental substance use. Seventy four percent of Family Treatment Court children have been reunified in fewer than 12 months. Lastly, 96% of FTC cases have no recurrence of maltreatment within six months. Ninety Five percent of the parents participating in Family Treatment Courts accessed substance abuse treatment with a median length of stay in treatment of 204 days.

Recognizing that every county in Iowa may not have the need or ability to implement a Family Treatment Court, we identified an alternative model to serve families with substance abuse issues who do not need the intensity of a family treatment court but would benefit from something in addition to traditional services. The structure and idea behind this model is to take key elements that have the largest impact on family treatment court families and infuse these principles into Child in Need of Assistance cases. This model focuses on key factors such as more frequent judicial oversight, early intervention and access to treatment in a team structured approach. These key standards have contributed to the success of families in family treatment court and are proving to be beneficial in Child in Need of Assistance where the family may not need the intensive family treatment court process. Families assessed as high risk and have a high level of need would benefit from family treatment court whereas families assessed as moderate risk and a moderate level of need may benefit from the infusion model.

While the infusion model has been implemented in a few locations and the numbers are small, this approach has shown promise. The lesson that stands out the most is the importance of identification of the appropriate program for the family and meeting the individual where they are at. While some families need the more intensive FTC route, others may better succeed in a setting where they have more judicial oversight than a typical Child in Need of Assistance case without the additional requirements of a FTC. It's been shown that when an individual who is of low risk is placed in a situation with others at high risk, many times that individual's risk level may increase. By assessing the level of need and matching them with the most appropriate services they are able to get the most out of the program and see better results. In the infusion model, families who have an open Child in Need of Assistance case along with an underlying issue of substance abuse are identified and offered a chance to participate in a less intense version of FTC. The family reports to the court once a month to check in with the judge and support team (which includes designated Social Workers, Recovery Coach, County Attorney, parent's attorneys, GAL and any additional supports they have or need). The more frequent judicial oversight allows the judge and all involved to observe the family's progress towards reunification or the case plan goals to achieve the appropriate permanency at a more rapid pace. Alternatively, if the family has a setback or is in need of additional support and/or services the court has the ability to intervene faster and attempt to prevent the situation from escalating any further and offered additional resources if needed. As reported by parents in our CQI surveys, more frequent CINA reviews and contact with the judge kept them apprised of their progress on the requirements of the case plan and added an additional layer of support.

Intended Practice Change:

- Early identification of family and child needs with substance using parents
- Early access to substance abuse evaluations and treatment services
- Increase collaboration between social workers, substance abuse treatment professionals and the court for families and children with substance using parents
- Increase the family centered approach in field staff's work with substance using parents
- Find ways to keep children at home or get them home quicker when there is substance using parents

Key Activity	Who	Activity Start	Implementation
1. Request TA from the NCSACW regarding evidence-based practice regarding effectively engaging with substance using parents	Policy	July 2020	July 2020
2. Identify two new Infusion Project Sites	DHS, CIP	July 2020	August 2020
3. Disseminate information and resources about Family Treatment Courts and Infusion Project Sites and services	DHS, CIP, SAMs	August 2020	September 2020
4. Initial outreach to local stakeholders for identified sites for initial interest	DHS, CIP	September 2020	October 2020
5. Gather local data on parents with substance abuse issues	DHS, CIP, SAMs	September 2020	October 2020
6. Bring courts, providers, and DHS together to learn about key components of Infusion Projects and treatment courts; review data; determine local needs; gain commitment from stakeholders	DHS, CIP	October 2020	November 2020
7. Identify who will benefit the most from the Infusion Model (moderate needs, extended outpatient services, moderate risk); share this identification process with local stakeholders	DHS, CIP	October 2020	November 2020
8. Gain commitment from local stakeholders to move forward with the model	DHS, CIP, SAMs	November 2020	December 2020
9. Prepare for implementation including practice changes to each stakeholder and what the new model looks like, time commitment, and services available to families locally	DHS, CIP, SAMs	December 2020	February 2021
10. Implement two new sites	DHS, CIP	February 2021	May 2021
11. Evaluate two new sites on eight child indicators (safety in home, repeat maltreatment, out of home placement, placement stability, permanency timeliness, and other indicators)	DHS, CIP	May 2021	June 2021

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

CFSR on-site review results indicated that Staff and Provider Training was not in conformity. While initial and ongoing worker training feedback during the review indicated effectiveness and timeliness were not consistently meeting the needs of the staff, Iowa chose to focus the PIP strategy for this systemic factor on enhancement of training for supervisors. The reason for this is that Iowa has been aware of concerns with worker training and implemented many initiatives; these are in various stages of monitoring and DHS is making adjustments as needed. In contrast, supervisory skills and professional development have not been a primary area of focus; the idea came up during work groups and quality curricula are available. New workers are provided a lot of information upon hire which is sometimes overwhelming; this can be easily forgotten when it comes to applying it to case work. A strong supervisor is key in helping the worker recall what they learned and apply it to cases. Supervisors continue to guide worker practice ongoing through individual and group supervision.

Below are highlights of efforts recently implemented for staff training:

- Mentoring program: DHS developed a mentoring program for new child protection workers and social work case managers in the DHS. This was implemented in October, 2019 and is currently functioning statewide. Field mentoring aids new workers in applying classroom learning to practice in real life situations, bridging an existing gap. This framework formalizes an informal system that has been in place in pockets around the state as it was identified as a promising practice, both in these pockets and also in national research. Mentoring does not take the place of supervision, but does provide additional guidance from someone with acknowledged skills regarding social work practice at DHS.

  Some expected benefits of this program include:
  - Bridge the gap between the classroom and Field practice
  - Develop a supportive network for new workers so they are comfortable reaching out with questions and consultation.
  - Support team development
  - Enhance social work skills
  - Provide an opportunity for experienced staff to add to their professional skills
  - Standardize training, guidance, and forms statewide

  Other active initiatives include:

- The facilitator model that DHS implemented in fiscal year 2020 consists of pairing an internal DHS trainer with a carefully selected subject matter expert (SME) co-facilitator. In the past, ISU facilitators who lacked direct DHS field experience trained DHS staff. Under the new model, DHS employs two full-time internal trainers with significant DHS background in the field. Direct line experience is critical for establishing facilitator credibility to the audience. A second component of this model is that DHS will be more selective in finding qualified subject matter experts, seeking to partner with leaders across disciplines to keep training relevant and fresh.
- Analysis of Training Effectiveness: Starting in fiscal year 2020, DHS began partnering with ISU to conduct an in-depth analysis to evaluate the effectiveness of the trainings. An ISU graduate student is conducting the in-depth evaluations.
- Enhanced Reporting: Starting fiscal year 2020, the Department developed quarterly reporting that tracks the average length of time between new worker hire dates and the start of new worker training (SW 020/CP 200), enabling the Department to better assess the length of time it takes to initiate core training for new workers in their first three months of employment; in addition, there will be a quarterly report specific to the Social Work Administrators and Service Area Managers on all staff – both new and veteran – to monitor progress on annual training requirements so as to proactively follow up as needed

Identified Need: In order to support a developing work force, Iowa recognizes the need to provide supervisors with opportunities to become skilled leading and guiding people through implementing change, fostering collaborations, implementing results-oriented decisions, and promoting best practice case work. Skilled supervisors have the ability to strengthen child welfare practice effectiveness and to support the success of staff and families.

Root Causes Identified: The workgroups that met in summer 2019 to identify root causes consistently identified that they need more supervisory support in order to effectively do their jobs. Feedback indicated they were looking for increased involvement, consistency, and creative problem-solving, such as how to write a quality safety plan so children can remain in the home; understanding best practice and CFSR outcomes; how to engage families; and practice guidance for challenging families. The feedback gathered indicated that the lack of these supports has a significant impact on staff turnover, which compounds existing workforce issues.

Theory of Change: In order to improve worker practice, we will improve our supervision model to integrate practice expectations into practice **so that** practice changes can be sustained **so that** family centered services are embedded in practice **so that** supervisors can guide and support workers while monitoring change in behavior and culture **so that** workers feel supported **so that** turnover is reduced.

Strategy Rationale: In an effort to support supervisors in their professional growth, DHS will consult with the National Child Welfare Workforce Institute (NCWWI) regarding their Leadership Academy Series (LAS). The LAS is a free online leadership academy for child welfare supervisors with one or more years of experience. There are 6 self-directed web-based modules that vary in length and involve two methods to enhance learning transfer - a personal learning plan to develop leadership skills and a change initiative to contribute to a systems change within the agency. The NCWWI website indicates that evaluation results show that LAS participants increased application of leadership behaviors, including setting priorities and managing resources, encouraging collaborative and inclusive units, utilizing more collaborative and consensus-building efforts, and adapting to changes implemented. There is some indication that the LAS and another series, Leadership Academy for Middle Managers (LAMM) are being combined into a new curriculum in the spring of 2020. DHS will pursue additional information regarding LAS/LAMM training.

In addition to the implementation of the LAS and LAMM, Iowa has provided supervisors with “The Essential Handbook for Highly Effective Human Service Managers”. New supervisors will also receive these books as they participate in the Supervisory Model of Practice training. “The Essential Handbook for Highly Effective Human Service Managers” emphasizes an innovative approach to equip managers at all levels with the strategies and tools necessary to maximize employee commitment, performance and client care. Chapters that are 3-5 pages in length cover 30 vital skills, which makes for easy reading and immediate skill building and implementation. Each chapter provides an opportunity for growth and development with critical thinking questions designed to challenge your insight and perspective. The SWAs in each Service Area will be required to develop a plan based on guidelines provided by Oversight of how to deploy and implement the use of the book with his or her supervisors. All SWA's agreed to use this book and guidelines. They were behind the decision to adopt the Essential Handbook as a practice tool, and are working together to roll it out and share best practices statewide.

When using these resources in conjunction with Iowa’s Supervisory Model of Practice, supervisors will be equipped to drive practice improvement and sustain changes that promote the achievement of child welfare outcomes. This model of practice has been developed to affirm, guide, reinforce, and support supervisors in promoting strength-based, solution focused, and family centered practice at all levels. This model includes three variations of supervisory consultation with workers: a 1:1 consultation between supervisor and worker a minimum of monthly to review case practice on all cases; case consultations as needed to address more immediate concerns on a case; and group supervision within the unit for creative problem-solving around complex case issues. In coordination with the initiatives focusing on new workers described above, we believe this will strengthen our workforce through increased support, knowledge, oversight, and consultation, as well as potentially impacting the high rate of turnover in the direct worker positions across the state.

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Intended Practice Change:

- Build supervisor capacity to manage staff in ways that use data to inform and help them with developing staff and understanding measures.
- Provide additional support to staff to reduce turnover.
- Support workers with time management to ensure required casework is being completed.
- Support supervisors as they mentor workers and monitor performance

Key Activity	Who	Activity Start	Implementation
1. Distribute "Essential Handbook…." to all supervisors	Social Work Administrators	March 2020	April 2020
2. SWAs will meet in order to discuss the action plans they have developed to use the "Essential Handbook…" with their supervisors. Each action plan shall include an evaluation plan regarding impact on supervisory capacities	Social Work Administrators	April 2020	July 2020, Ongoing
3. Develop and implement a service area-level action plan based on required elements provided by Oversight that provides supervisors with opportunities to utilize the 30 vital skills from the handbook.	Social Work Administrators	July 2020	August 2020, Ongoing
4. Contact NCWWI to explore supervisor training • When will combined curriculum be available? • Will implementation guide be updated? • How many total hours are required to complete the course?	Members of CFSR Oversight	June 2020	June 2020
5. Pursue NCWWI training, develop Iowa's framework for implementation to include things such as: • Pilot or statewide? • How do we define how the training affects the outcomes? • Blending of online curriculum and application • Opportunities for supervisors to process what they learned and plan for how to use it after the online training • Measurement and monitoring of effectiveness • Evaluation plan, including monitoring improvement of supervisory capacities	Bureau of Service Support and Training	July 2020	September 2020 (Dependent on information about the timing of the combination of the LAS/LAMM curriculum.)
6. Implement the LAS/LAMM training according to framework	Bureau of Service Support and Training	October 2020	January 2021
7. Facilitate group sessions with supervisors after the online training, in each service area, to process the training, talk about how to use it, and how it changes supervision practice and support for case workers	SWA's and Supervisors	January 2021	March 2021
8. Using the evaluation plan, monitor the efficacy of the supervisory support initiatives.	Bureau of Quality Assurance & Improvement	April 2021	Ongoing

Goal 4: Improve and Increase Collaborative Joint CQI System and Interventions

Targeted Outcome or Systemic Factor: Quality Assurance Systemic Factor

Strategy 4.1: Implement a joint CQI process between DHS 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.

Identified Need: Iowa received ratings of Area Needing Improvement for Item 25, Quality Assurance System, in part due to lack of a functional feedback loop that allows for regular communication both from the state to stakeholders, and stakeholders to the state regarding strengths and needs; this includes frontline staff and providers, but also the multitude of stakeholders interested in the success of the child welfare system.

The Court Improvement Project and DHS share stakeholders; both are key components of the child welfare system and have common stakeholders interested in outcomes being achieved in both. Currently, there are two isolated CQI systems that assess how each is performing; there is nothing that brings together organized data from both programs to provide a more robust, integrated view of the broader child welfare system. By identifying the overlapping priority goals for each system and melding the data reflecting those goals, Iowa will be able to provide a broader perspective on how child welfare system outcomes are operating. The goal will be to capitalize on both the work DHS and the Courts are already doing independently to combine this into an integrated report that provides comprehensive information for our stakeholders. Additionally, there will be a shared process to disseminate the data to stakeholders, provide opportunity for stakeholder feedback, and make adjustments based on that stakeholder feedback.

Root Causes Identified: Regarding Item 25, Quality Assurance System, Iowa received an overall rating of Area Needing Improvement based on information from the statewide assessment and stakeholder interviews. Elements of a quality assurance system exist throughout the state, but are not operating consistently across geographic areas. There is not currently a standard set of metrics used, shared, and discussed statewide that provide a structure for each geographic area to build upon. Iowa values flexibility within the service areas so they can be responsive to the local needs; however, there is an absence of a statewide foundation for continuous improvement and quality assurance, leading to a disjointed efforts. . There is no functional feedback loop to allow frontline staff and providers to identify strengths and needs, and there are no data demonstrating how program improvement measures are assessed statewide. Some frontline staff have access to data reports, but how staff are to use these reports is not well-defined.

Theory of Change: A joint CQI process will be developed so that shared priorities are identified and a structured communication process is established so that child welfare system stakeholders receive robust, integrated information so that a unified consistent statewide message is communicated regarding the child welfare system performance so that stakeholders have the opportunity to provide feedback on the functioning of the child welfare system so that the child welfare system is continuously making improvements.

Strategy Rationale: By working jointly to identify mutual priorities, the child welfare system will send a consistent message statewide regarding systemic performance to all stakeholders; this will be foundational information to open up a process by which to routinely share information, discuss, and receive feedback. This will include common talking points for all geographic areas to promote the consistency, while allowing for local priorities to be incorporated as well.

The creation of a joint, comprehensive CQI process will set statewide consistent priorities and establish a process by which to communicate to and with stakeholders of the child welfare system. This will allow for a more inclusive quality assurance process. A joint workgroup and a shared self-assessment will provide an opportunity for Iowa to examine current practice and identify opportunities for improvement.

Intended Practice Change:

- Ongoing partnership between DHS and CIP
- Inclusion of stakeholders in the CQI process
- Collaborative identification of shared priorities
- Robust statewide data reflecting system performance
- Increased coordination with practice initiatives

Key Activity	**Who**	**Activity Start**	**Implementation**
1. Establish joint workgroup to examine current processes and establish a collaborative CQI process.	DHS, CIP	June 2020	July 2020
2. Complete the CQI Self-Assessment in order to evaluate current CQI processes within both the agency and court system.	Joint workgroup	September 2020	November 2020
3. Determine overlapping priorities between CIP and DHS	Joint workgroup	December 2020	March 2021
4. Determine which priorities are currently being measured in each CQI process in order to identify gaps, consistencies across the two systems, and opportunities for alignment.	Joint workgroup	December 2020	March 2021
5. Develop the joint CQI system including: • Finalize shared measures • Determination of any changes in monitoring/ gathering of information needed in order to accurately measure • Consistent format for streamlined compilation • Logistics of communication – how, who, what, when • Methodology to promote, collect, and utilize stakeholder input	Joint workgroup	April 2021	May 2021

Key Activity	Who	Activity Start	Implementation
6. Identify changes that will need to be made on both the agency and court sides in order to improve the joint CQI process.	Joint workgroup	April 2021	June 2021
7. Create an implementation plan for the joint CQI process, including: • A rollout plan for communicating the purpose and desired outcome of the joint CQI process • Data points that will be gathered and analyzed in order to monitor efficacy and success • Dissemination of information –format, timeframe, process for providing information/receiving and acting on feedback. • Evaluation plan for the implementation of the joint process	Joint workgroup	July 2021	July 2021
8. Implement the plan	Joint workgroup	August 2021	October 2021
9. Begin sharing data as determined by the group (quarterly/six months/annual)	Joint workgroup	December 2021	Ongoing
10. Monitor and evaluate implementation of joint CQI process.	Joint workgroup	December 2021	Ongoing

Conclusion

Iowa's child welfare system is dedicated to practice improvements outlined in this plan, which will positively impact the children and families served by the system in Iowa. Upon final approval of the PIP, the plan will be posted on the DHS website for public viewing. The strategies and key activities within the document will be shared broadly with staff and stakeholders. Progress throughout the PIP period including the group work, implementation and monitoring processes will also be shared.

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