Testimony before the Health and Human Services Appropriation Subcommittee

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By

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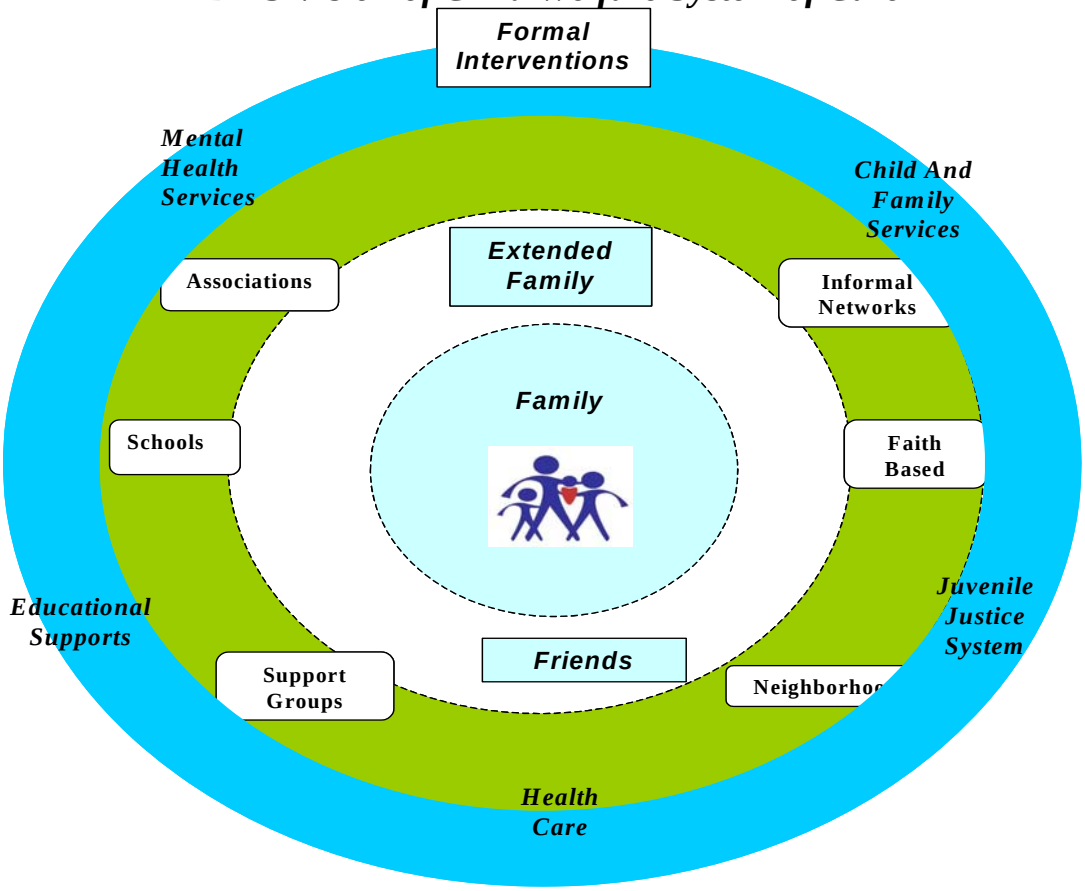
"Headline" Issues Impacting Iowa's Child Welfare System

Following are major factors impacting Iowa's child welfare system.

- ***Federal Child and Family Service Reviews (CFSR)*** -- The CFSR sets high standards for state child welfare systems, both in terms of safety, permanency and well-being outcomes for the children and families served and in terms of system "infrastructure" (e.g., training). Iowa's first review was in May 2003, and our second review will be sometime between **April and July 2009**.
- ***Iowa's Better Results for Kids (BR4K) Child Welfare Redesign*** – The General Assembly directed DHS to redesign the child welfare system in 2003. BR4K emphasizes improved safety, permanency and well-being for children and families served in the child welfare system through implementation of best practices such as family team meetings, community partnerships, and the use of performance based contracting[1].
- ***Accountable Government Act (AGA)*** -- The AGA mandates competitive procurement, and the assessment of performance under the terms of a contract and payment upon achievement of that performance.
- ***Casey Family Programs 2020 Agenda to Safety Reduce Foster Care by 50%*** – Casey Family Programs, in collaboration with the National Governors Association (NGA) and the National Conference on State Legislatures (NCSL), has launched an initiative to safely reduce the nation's foster care population by 50% by the year 2020.

DHS Vision of Child Welfare System of Care



[1] The authorizing legislation also reduced the state funding for child and family services by $10 million.

DHS Key Strategies to Improve Safety, Permanency and Well-Being

DHS has focused on 2 primary strategies to improve safety, permanency and well-being outcomes for children and families.

- Strengthening the array of services for children and families – both community based alternatives and formal child welfare services.
- Focusing and strengthening DHS' practice with children most at risk of harm from child maltreatment, including increasing the voice of youth, birth families and tribes in child welfare policy and practice.

Key Strategy #1. Strengthening Array of Services for Children and Families

Community Based Alternatives to Formal Child Welfare Services. Since 2005, DHS has implemented several community-based supports for families to prevent the need for involvement in the formal child welfare system. In addition, the General Assembly passed legislation enabling families to voluntarily place a child in a psychiatric medical institution for children (PMIC), rather than going through child in need of assistance (CINA) adjudication.

Program	Population Served	Number of Children/Families Served	FY 2007 Actual Expenditures/FY 2008 Projected Expenditures
Community Care	Families that have been identified by DHS as having a lower risk of abuse	Average of 625 to 650 families/month	FY 2007 - over $2.3 M FY 2008 - almost $2.5 M
HCBS Children's Mental Health Waiver (CMH)	Children that have behavioral health needs that would otherwise require placement	FY 2007 - Average of 287 children/month FY 2008 – Average of 438 children/month	FY 2007 -- over $2 M FY 2008 - almost $4.7 M
Medicaid Remedial Services Program (RSP)	Medicaid eligible children with behavioral health needs	FY 2008 - Average of over 7,000 children/month that are <u>not</u> involved in the formal child welfare system[2], including children participating in the adoption subsidy program.	FY 2007 -- almost $15 M FY 2008 –almost $42 M

[2] In addition, an average of over 2,600 children/month that are involved in the child welfare system also received remedial services during FY 2008. Prior to November 2006, families had to be involved in the formal child welfare system to access these services.

Key Strategy #1. Strengthening Array of Services for Children and Families

Changes in Formal Child Welfare Services

Over the last two years, DHS has also implemented several new services within the formal child welfare system, and we've made changes in how we contract for services. These are summarized in the table below.

Service	Summary
Performance Based Contracts ***Evidence Based/Informed Practice***	DHS has implemented performance-based contracts with monetary incentives for improved outcomes. Contracts focus on the outcomes we want to achieve, require use of evidence based/informed practice, and allow greater flexibility for providers to deliver services based on child and family needs in exchange for greater provider accountability for positive outcomes. · Single statewide foster and adoptive family recruitment, training, matching and support. · Multiple regional contracts with private child welfare agencies that provide safety and permanency services to abused children and their families.
Drug Testing	In FY 2008, DHS allocated funding for drug testing of parents in open child welfare cases. Prior to this, funding was only available for drug testing during a child abuse assessment, through Court Ordered Services on a limited basis for families involved in Juvenile Court, and through locally funded decat projects.
Legal Fees	In FY 2008, DHS also allocated funding to reimburse legal fees associated with achieving permanency for a child through guardianship or transfer of custody in district court. Previously, funding was only available for legal fees associated with adoption.
Shelter Care	Between January 2004 and September 2005, the number of youth in shelter care decreased by 26%, reflecting primarily a significant (60%) reduction in median length of stay for both DHS and JCS placements. In October 2005, DHS implemented new contracts with shelter care facilities that provided for guaranteed payment of 273 beds, regardless of usage, in order to stabilize funding for shelter care facilities.
Subsidized Guardianship	In February 2007, DHS implemented our IV-E Subsidized Guardianship waiver. To date, 6 children have achieved permanency through guardianship as a result of this program.
Transition Services	Over the last 2 years, DHS has also implemented several changes to improve outcomes for youth that transition from foster care to young adulthood. · Preparation for Adult Living (PAL) – provides ongoing support for youth that have left foster care at age 18, and are working or in post-secondary education. As of December 2007, there were 198 youth participating in PAL. · Medicaid for Young Adults (MIYA) – provides Medicaid coverage for youth have left foster care at age 18. As of

	December 2007, there were 224 youth participating in MIYA. The College Aid Commission has also implemented a new program expanding post-secondary educational support. · All Iowa Opportunity Foster Care Youth Grants – provides financial assistance for youth that have left foster care at age 18 (or were adopted at age 16 or older) that are attending post-secondary education. For the 2007 – 2008 academic year, there were 171 youth participating in the federally funded Education and Training Voucher program, and an additional 80 participating in the All Iowa Opportunity Foster Care Youth Grant program.

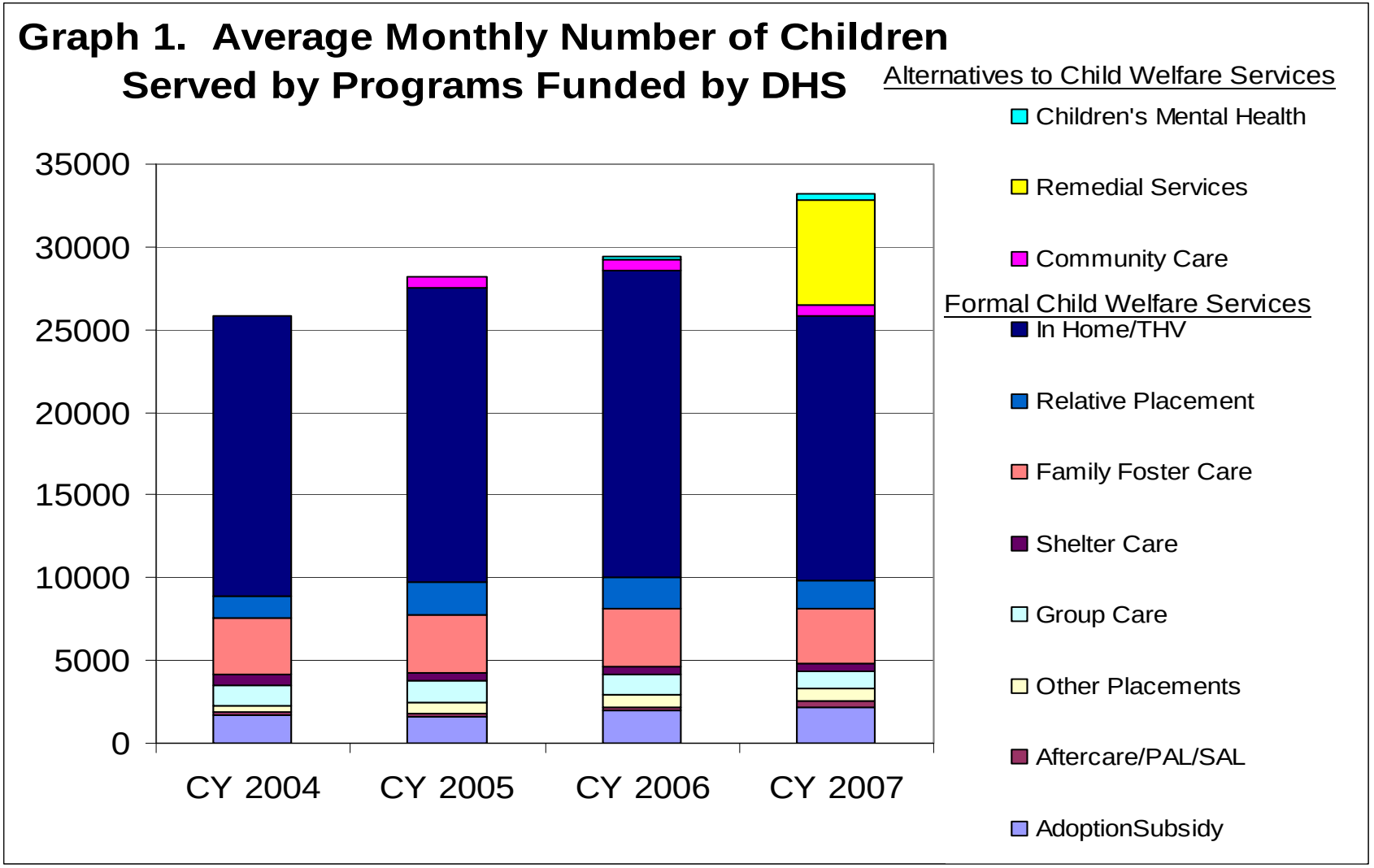
As a result of these changes, we are investing more funding in services to children and families, and we are serving more children and families, but their experience with services is changing . . .

- More children and families are receiving services funded by DHS that are outside the formal child welfare system – especially families with low risk of child maltreatment and families needing behavioral health services for their child. As more children and families receive services outside the formal child welfare system, fewer children are entering the formal child welfare system – including fewer children entering all levels of out-of-home placement, except relative care. There are also fewer Juvenile Court Services (JCS) cases entering out-of-home care, including group care, shelter care and detention. This reflects efforts by JCS to improve practice – including implementation of a standardized risk assessment tool, as well as use of evidence-based practices such as Functional Family Therapy.
- Children and families that are involved in the formal child welfare system are experiencing shorter lengths of stay at all levels of care. This is also true for youth served by JCS.

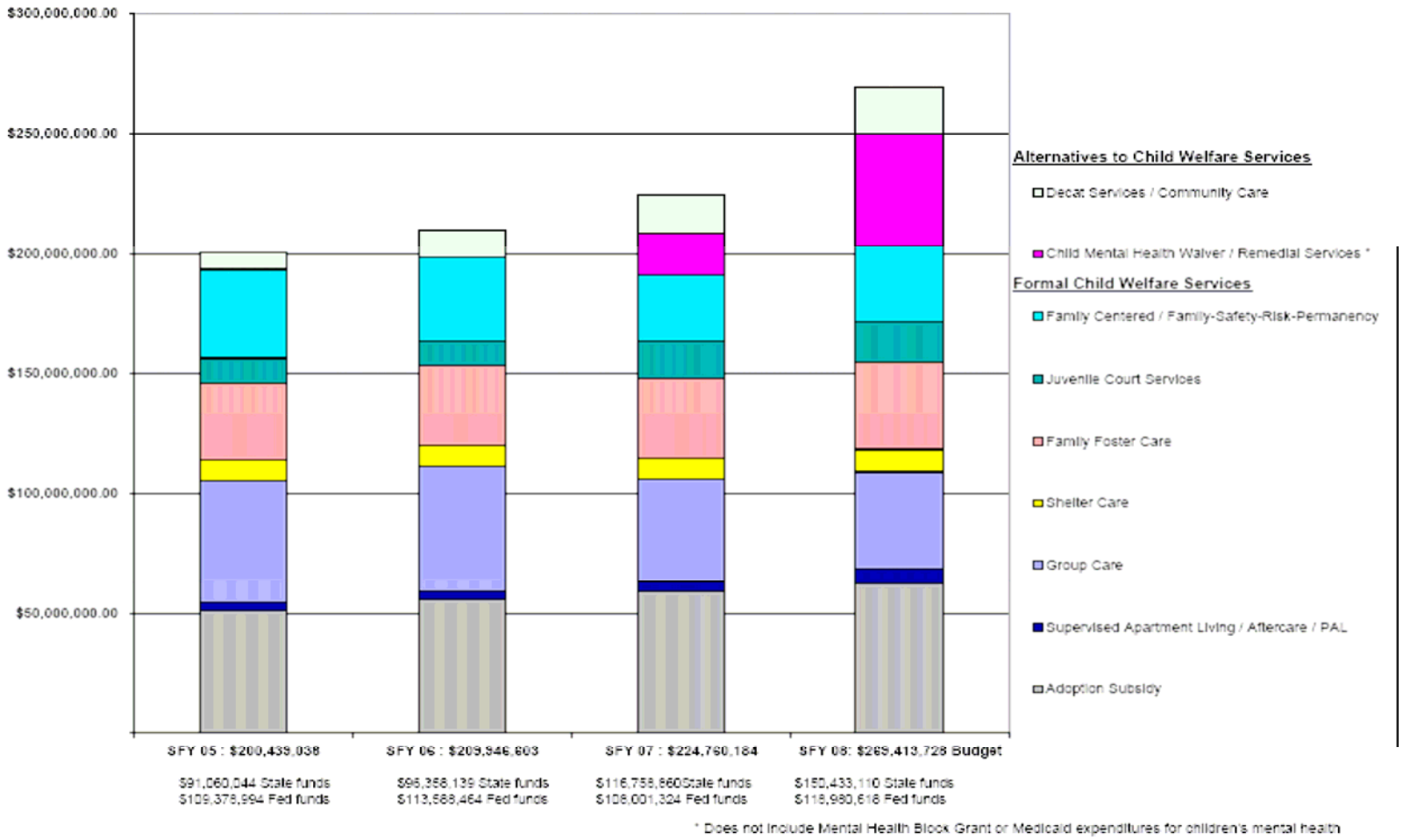
Graphs 1 and 2 show how these changes have impacted both children and families, and expenditures.

- **Graph 1 shows the average monthly number of children served by programs funded by DHS for the time periods calendar 2004 through calendar 2007**. For the most part, the numbers reflect an unduplicated count across services. This chart excludes expenditures for mental health services for children funded by the federal Community Mental Health Block Grant and Medicaid (other than the Children's Mental Health waiver and remedial services [RSP]). Note that this chart also excludes the number of children receiving decategorization services and juvenile justice services, as case counts were not readily available; as well as the number of youth participating in MIYA (Medicaid for Young Adults), as these counts would be largely duplicative of PAL and Aftercare.
- **Graph 2 shows total DHS expenditures for services to children for the time periods SFY 2005 through SFY 2007**. This chart also excludes expenditures for mental health services for children funded by the federal Community Mental Health Block Grant and Medicaid (other than the Children's Mental Health waiver and remedial services [RSP]).

Graph 1. Average Monthly Number of Children Served by Programs Funded by DHS



Graph 2. Total DHS Expenditures for Children's Services SFY 2005 - SFY 2008

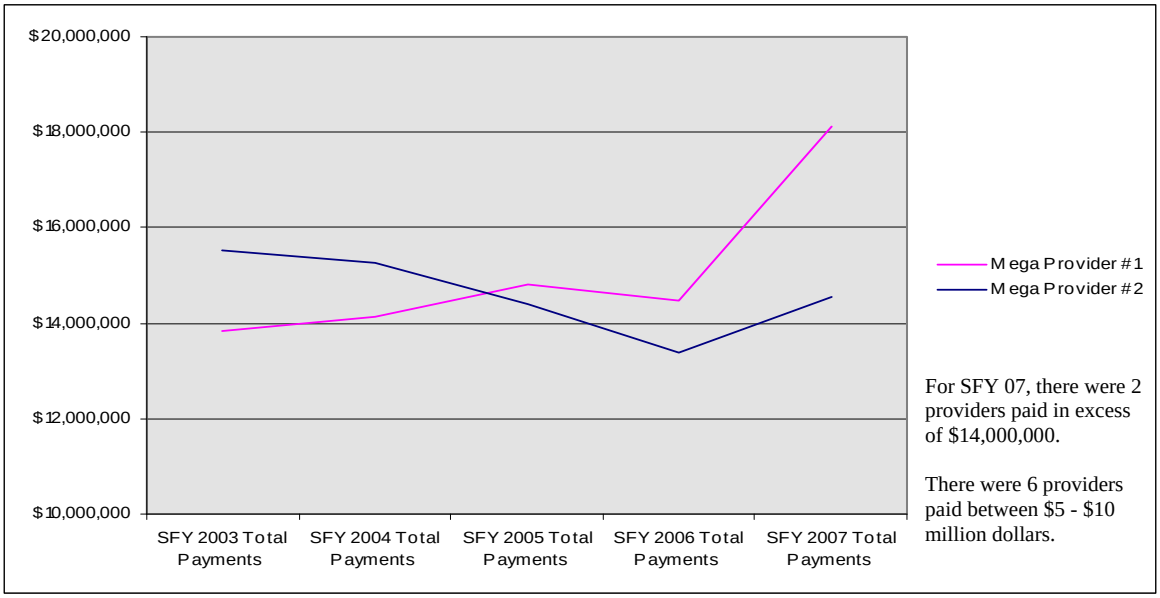


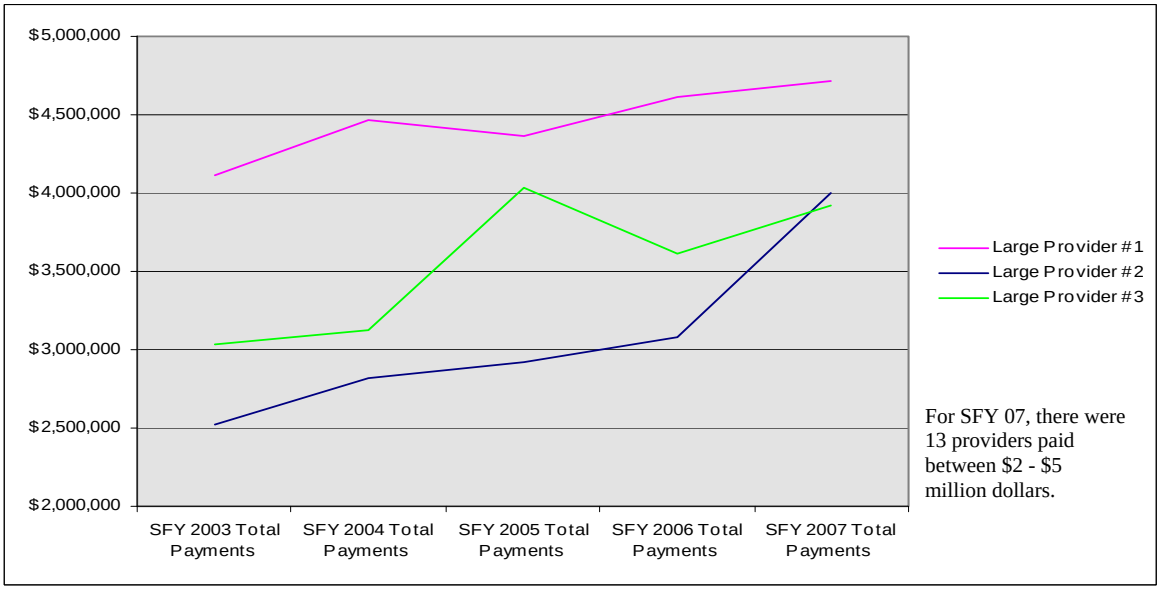
* Does not include Mental Health Block Grant or Medicaid expenditures for children's mental health

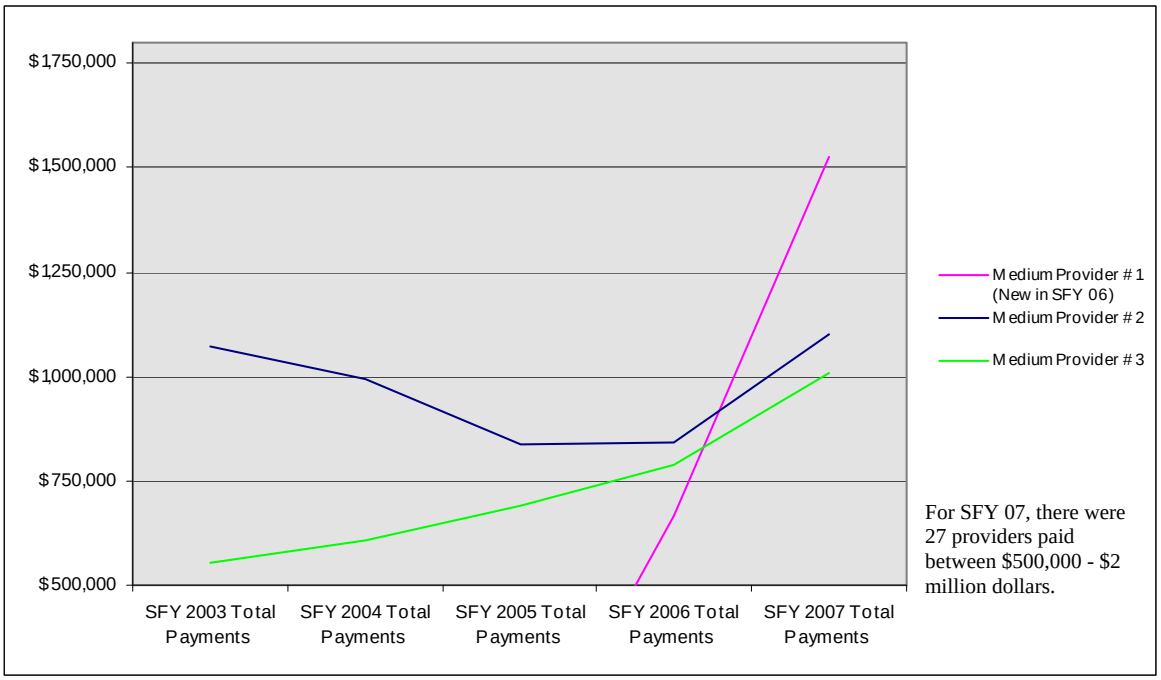
Financial Impact on Individual Providers. The changes that are shown in graphs 1 and 2 have had varying impacts on individual providers. Graph 3 shows how these changes have impacted a sample of 11 providers between SFY 2003 and SFY 2007. In SFY 2007, these providers had income from DHS for services to children ranging from $270,000 to $18.1 M. Providers are grouped into four categories, based on the size of their income from DHS for services to children. These charts show that many providers have seen an increase in income, while others have seen a decrease.

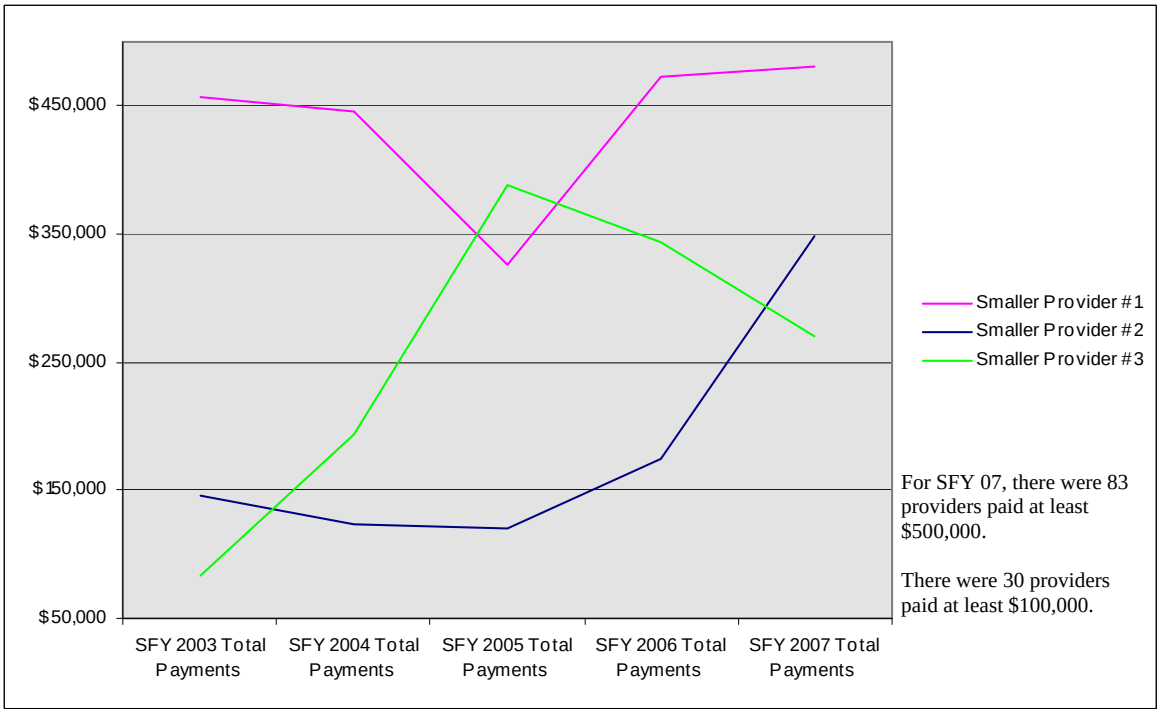
In SFY 07, there were a total of 131 Child Welfare service providers

Graph 3. Changes in Provider Income from DHS Programs for Children SFY 2003 to SFY 2007









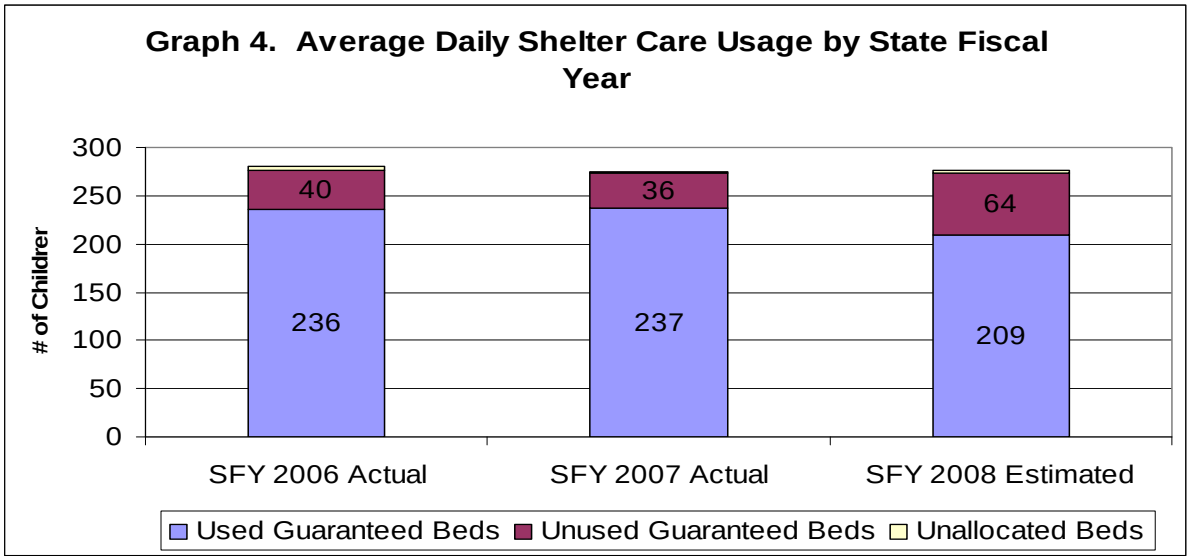
Provider Income includes: RTSS programs: family centered services, family preservation services, foster care services, group care services; POSS programs: adoption services, shelter care services, supervised apartment living services; Child Mental Health waiver services; Remedial services; PMIC services; Decat contracts; and other services contracts - including but not limited to: Aftercare, Community Care, Family Safety Risk Permanency, and Recruitment & Retention

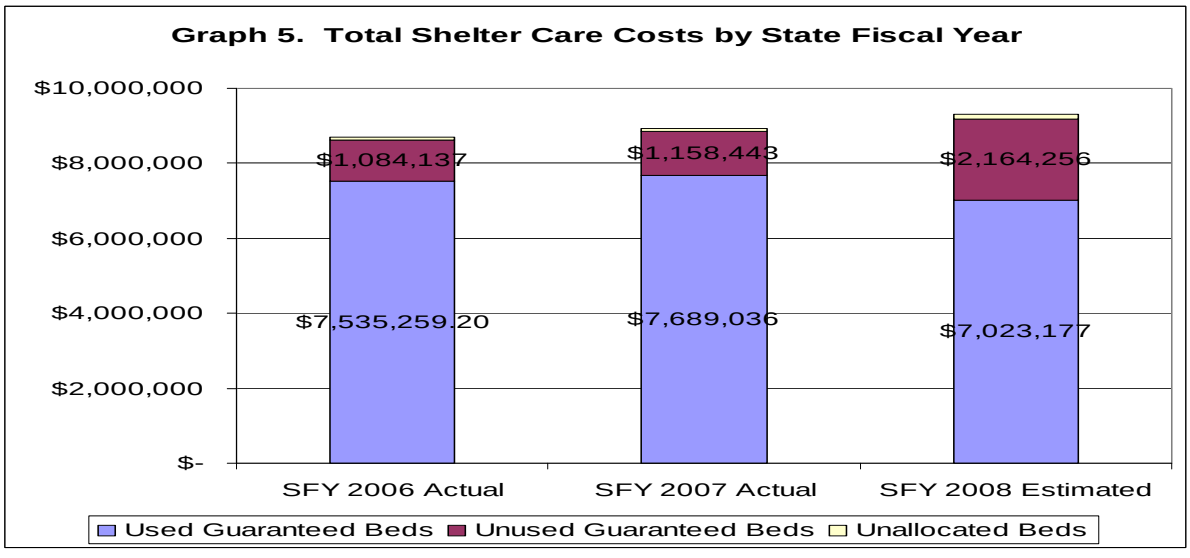
Key Strategy #1. Strengthening Array of Services for Children and Families

Changes in Shelter Care Utilization

As noted in the chart above, between January 2004 and September 2005, the number of youth in shelter care decreased by 26%, reflecting primarily a significant (60%) reduction in median length of stay for both DHS and JCS placements. In October 2005, DHS implemented new contracts with shelter care facilities that provided for guaranteed payment of 273 beds, regardless of usage, in order to stabilize funding for shelter care facilities.

Graphs 4 and 5 show that shelter care utilization has continued to decline since October 2005, reflecting both a decrease in DHS and JCS admissions (21%) and continued decrease in median length of stay (44%). As a result, the amount of funding spent on "unused" guaranteed beds is projected to increase from $1.1M in SFY 2007 to over $2M in SFY 2008.





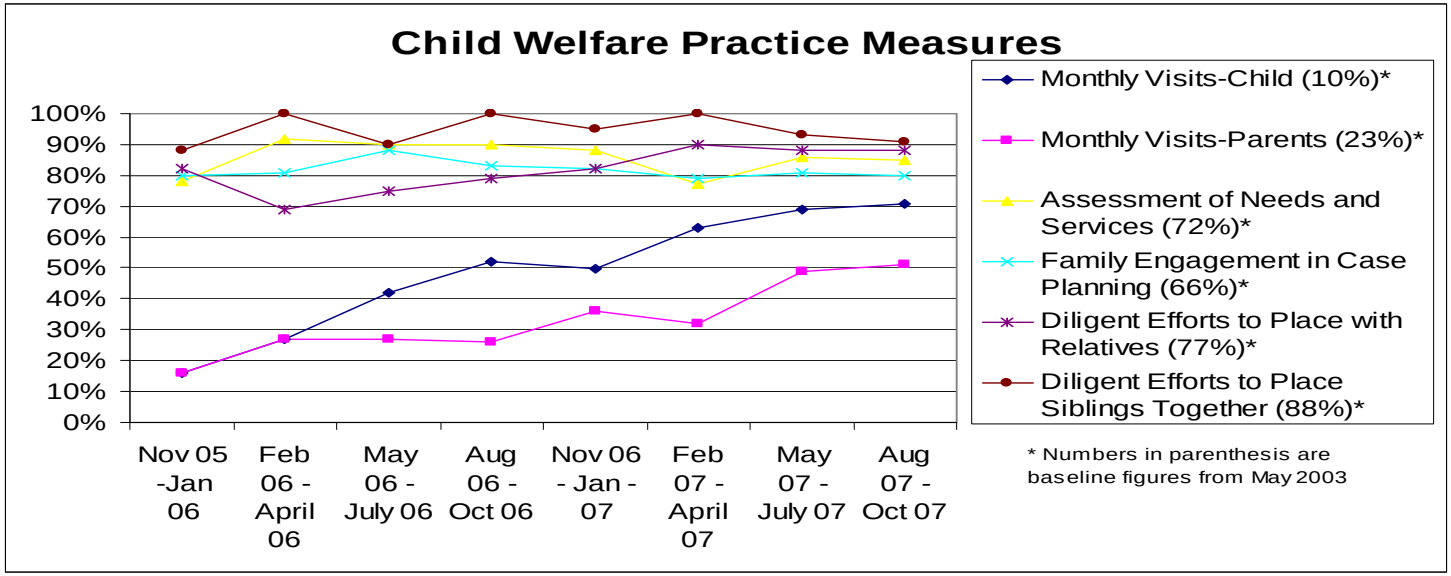
Key Strategy #2. Focusing DHS caseworkers on children most at risk of harm from child maltreatment and strengthening frontline practice

DHS has also made a number of changes to strengthen our own child welfare practice as part of the Better Results for Kids (BR4K) Child Welfare Redesign, and in response to findings from our first federal Child and Family Service Review. These have also impacted lengths of stay at various levels of care. These changes are summarized below.

Practice	Summary
Standardizing risk assessment and criteria for formal child welfare services	As part of Better Results for Kids (BR4K) Child Welfare Redesign, DHS established criteria for opening a formal child welfare case based on presence of abuse/neglect, risk of future abuse/neglect and age. We have also continued to standardize intake practice across the state and implemented a common framework for assessing child safety based on materials developed by the National Child Welfare Resource Center on Child Maltreatment and the National Association of Public Child Welfare Administrators.
Child welfare caseloads	Since 2006, DHS has reassigned 33 social work staff from other services (elderly waiver and state cases) to child welfare, and added 20 child welfare caseworkers as the result of additional funding provided by the General Assembly. This has enabled us to reduce child welfare caseloads from 51to 30 per worker, so that staff can spend more time working with children and families. DHS SFY 2009 budget request would fund 25 additional caseworkers to further increase monthly visits with children and families, consistent with federal requirements and best practice.
Access to clinical consultation	Since 2005, funding provided by the General Assembly has enabled DHS to add 23 clinical consultant/supervisors, thereby reducing supervisory ratios from 11:1 to 9:1. DHS SFY 2009 budget request would fund 5 additional clinical consultant/supervisors to maintain supervisory ratios at 9:1.
Professional development	Thanks to funding from the General Assembly in 2007, DHS was able to support 36 staff in pursuing MSW coursework this last year.
Evidence based/informed practice	Since December 2007, DHS has been publishing monthly *Practice Bulletins* that provide best practice tips focused on improving safety, permanency and well-being. Supervisors use these to support casework practice. They are also posted on DHS website. DHS has also implemented several evidenced based/informed and promising practices, such as family team meetings and Parent Partners.
Monthly visits with children and parents	This was Iowa's weakest measure in the federal Child and Family Service Review (CFSR). With modest decreases in caseloads and increased emphasis on visits, DHS caseworkers have significantly increased monthly visits. As a result, children and families feel more informed about what is happening, and Judges have commented that DHS workers are

	better prepared in court.
Family engagement in case planning	As part of BR4K redesign, DHS instituted the use of Family Team Meetings (FTM) to engage parents and youth in identifying family strengths and needs, as well as service plans. Between July 2006 and December 2006, DHS staff almost tripled the number of FTM's used to engage families in case planning -- from 284 per month to 819 per month.
Minority Youth and Family Initiative	In March 2004, DHS began demonstration projects in Sioux City and Des Moines focused on reducing disproportionality for Native American and African American children and families. Disparities persist, but the project to reduce disparities among Native Americans has been particularly successful in establishing bridges between the DHS and tribal officials in northwest Iowa and in increasing the use of relative placements. The separate project addressing African American families in Des Moines is also helping to build bridges between DHS and the community.
Youth, family and tribal voice in policy and practice	Increasingly, DHS has engaged the voice of youth, families and Native American tribes in guiding child welfare policy and practice – primarily through consultation with the Elevate youth group, Parent Partners participants, and tribal representatives. All three groups have also been active participants in the Child Welfare Stakeholder Panel co-chaired by DHS and the Director of the Children's Justice Initiative.

Graph 6 shows how these changes have impacted performance on several child welfare practice measures over the last 2 years.



Key Lessons Learned Related to Performance Contracting

Following are key lessons we've learned related to performance contracting.

- ***Communication***. Gathering input from and communication with providers and stakeholders during the development process is invaluable, but also challenging at times in light of competitive procurement requirements in statute and administrative rules. Open and ongoing communication with contractors through the implementation process, including joint training, has also been important. Monthly or more frequent meetings with contractors in the early stages have helped to work through questions and issues that have arisen.

- ***Changing Roles and Expectations***. Changing how we buy services and increasing flexibility for providers has meant changes in how DHS and providers do business. It takes time for staff in both DHS and providers to get comfortable in their new roles and learn how to do things differently. We are also still learning how to balance our new relationship with providers in a performance environment. On the one hand, we are "partners" in improving outcomes for children and families. On the other, we have a contractual relationship and have an obligation to ensure quality and accountability in the services delivered under the contract.

- ***Contract Modifications***. Openness to modifying the contract has also been critical. New issues have arisen as we began implementation, and it's been important to be able to approach issues that arise and "bumps" in the road from a problem-solving perspective and to make changes in contract language as we learn new things.

- ***Pacing Transition***. We need to "pace" the number of changes, so that public and private agency staff have adequate time and opportunity to work through each change before taking on another change. We also need to build in transition time as we move from the "old system" to the "new system". And, we need to focus on how each change is part of a larger picture towards improving safety, permanency and well-being.

- ***Data***. Access to timely and accurate data is critical for both DHS and providers. At times, this has been a challenge for DHS due to limited resources and issues related to confidentiality (e.g., HIPAA, SSA restrictions, etc.).

Key Challenges Facing the Child Welfare System

Despite progress made over the last few years, a number of key challenges still face Iowa's child welfare system.

- ***High caseloads for DHS child welfare caseworkers***. While funding from the General Assembly has enabled DHS to reduce child welfare caseloads over the last few years, they remain above national standards. Without further reductions, DHS will not be able to meet federal expectations for monthly visits with children and parents and improved outcomes.
- ***Substance Abuse Treatment for Parents***. Parental substance abuse is one of the leading factors bringing children to the attention of the child welfare system. Parents must have access to timely and quality substance abuse treatment in order to have an opportunity to safely parent their children. Adequate funding for drug testing is also needed -- frequent and on-going drug testing is critical to ensuring child safety and to supporting the parental substance abuse treatment.
- ***Mental Health Services for non-Medicaid eligible parents and children***. Children that are victims of abuse/neglect are at high risk for mental health issues. We have a responsibility to assess and address those needs when children are involved in the formal child welfare system. Although children in foster care have access to mental health services through Medicaid, many of the children and parents that we serve at home are not eligible for Medicaid and lack comprehensive health insurance coverage for behavioral health services.
- ***Declining IV-E federal funding.*** Iowa, like other states, has experienced a decrease in federal IV-E dollars due to several factors – including the "AFDC look-back" that results in fewer children meeting IV-E eligibility requirements and the fact that IV-E funding is limited to out-of-home placement. In addition, as DHS and JCS focus on serving children and families at home, we have less access to federal IV-E dollars and have to rely more on state funding. **This impacts funding for both programs and for DHS caseworkers.**
- ***CFSR Part 2.*** Iowa's second Child and Family Service Review (CFSR) is scheduled for sometime between April and July 2009. We are working closely with stakeholders to prepare for our review – focusing on conducting our self-assessment and on stabilizing and strengthening our practice. Three areas where we know we need to improve are:
  - Reducing repeat maltreatment - Our safety rate is 90.8%, which is an improvement over 88.2% at the time of our initial federal, but short of the federal target of 93.9%.
  - Timely reunification within 12 months of removal – 61.6% of our reunification cases meet this goal, which is short of the federal target of 76.2%.
  - Reducing re-entry into care – 10.4% of reunified children re-enter foster care, which is short of the federal target of 8.6%.

Collaborative Opportunities in Child Welfare

Following are some of the key opportunities for collaboration within child welfare over the next several years.

Children's Justice Initiative (CJI). DHS is an active participant in the CJI teams at the Judicial District level and on the CJI State Council.

Community Partnerships for Protecting Children (CPPC). DHS is partnering with CPPC sites to implement 2 demonstration projects that we hope to ultimately roll-out statewide.

- *Parent Partners* – which trains parents that have successfully had their children returned home from foster care to provide support and mentoring to parents that have an open child welfare case.
- *Jim Casey Youth Opportunity Initiative* – which engages the community in supporting the successful transition of youth from foster care to young adulthood.

Child Welfare and Substance Abuse. DHS, the Judicial Department and the Department of Public Health are participating in 2 exciting opportunities designed to improve outcomes for children that come to the attention of the child welfare system due to parental substance abuse.

- 5-year federal grant to establish Family Drug Courts and Community Based Treatment in 5 sites across Iowa.
- 15-month technical assistance from the National Resource Center on Substance Abuse and Child Welfare to establish a common approach to substance involved families involved with the child welfare system and protocols across DHS, the Juvenile Court and public health/substance abuse treatment providers.

Education and Foster Care. Through the auspices of the Chief Justice's Children's Justice Initiative, DHS and Department of Education are working together to improve opportunities for children in foster care to remain in the same school and to smooth transitions when they have to change schools.

Child Welfare Advisory Committee. On January 30, 2008, Governor Culver appointed members to the Child Welfare Advisory Committee established by the General Assembly last year. This Committee will advise DHS on programmatic and budgetary matters related to the provision or purchase of child welfare services.