Iowa Department of Human Services

Differential Response System Overview

Calendar Year 2017

Executive Summary

The Iowa Department of Human Services (DHS) began its Differential Response (DR) System in January 2014. The system consists of two pathways - Family Assessment (FA) and Child Abuse Assessment (CAA) - to respond to allegations of neglect and abuse. DR was instituted by the DHS based on child welfare research and best practices demonstrating that intakes involving the most serious allegations of abuse require shorter timeframes to ensure initial safety of children, need more involved family support services at the conclusion of a DHS assessment, and may also require legal action to ensure caregivers meet the needs of their children. Allegations found to involve families at lower risk for committing child abuse are separated from allegations that involve the most serious allegations of abuse.

DR created the framework by which allegations of varying severity prompt an appropriately differentiated response. Changes made in the Iowa Administrative Code, which created the regulatory framework for the implementation of DR, impacted worker response times, the labeling of perpetrators and victims, and eligibility for contracted child welfare services. In addition, Code changes established a firm path for case reassignment from the FA pathway to CAA pathway in the event children are unsafe or only conditionally safe. These decisions were based on the premise that safety of a child is first and foremost in both a FA and CAA.

The DHS and stakeholders developed process and outcome measures to monitor implementation. Process and outcome measures were developed to indicate how the system is working and to track caregivers' increased ability to protect and parent their children.

DR findings following several years of implementation remain promising. Process and outcome measures continue to indicate that the system is working as designed, and the outcomes for children and families are positive. Children who receive a FA are as safe as children who receive a CAA.

Highlights of report findings include:

- 93% of children who received a FA did not have a substantiated abuse report within 12 months.
- 98.21% of families referred to Community Care did not experience a Child in Need of Assistance (CINA) adjudication within six months of service.
- 89.10% of families referred to Community Care did not experience a substantiated abuse report within 12 months of service.
- 3,458 families were referred to Community Care.
- 1,554 of 8,722 families originally assigned to the FA path were re-assigned to the CAA pathway. Reassigned families constitute 4% of all accepted intakes for CY17 of those reassigned; 42% resulted in a confirmed or founded outcomes.

Introduction

Data included in this report represents historical information for purposes of comparison. In addition, data for this report was generated in late February 2018 and not all CY2017 cases were closed by this time. Hence, cases reassigned subsequent to CY2017 are not reflected in reported numbers. Case numbers generated before or after February 2018 will reflect slight variation as a result.

I. Intake Decisions

A. Background (Figure 1.1)

DR did not impact the criteria for accepting a report for assessment. At intake, a family is assigned to either the CAA or the FA. Both pathways result in families receiving a formal assessment conducted by Child Protection Workers (CPW) employed by DHS.

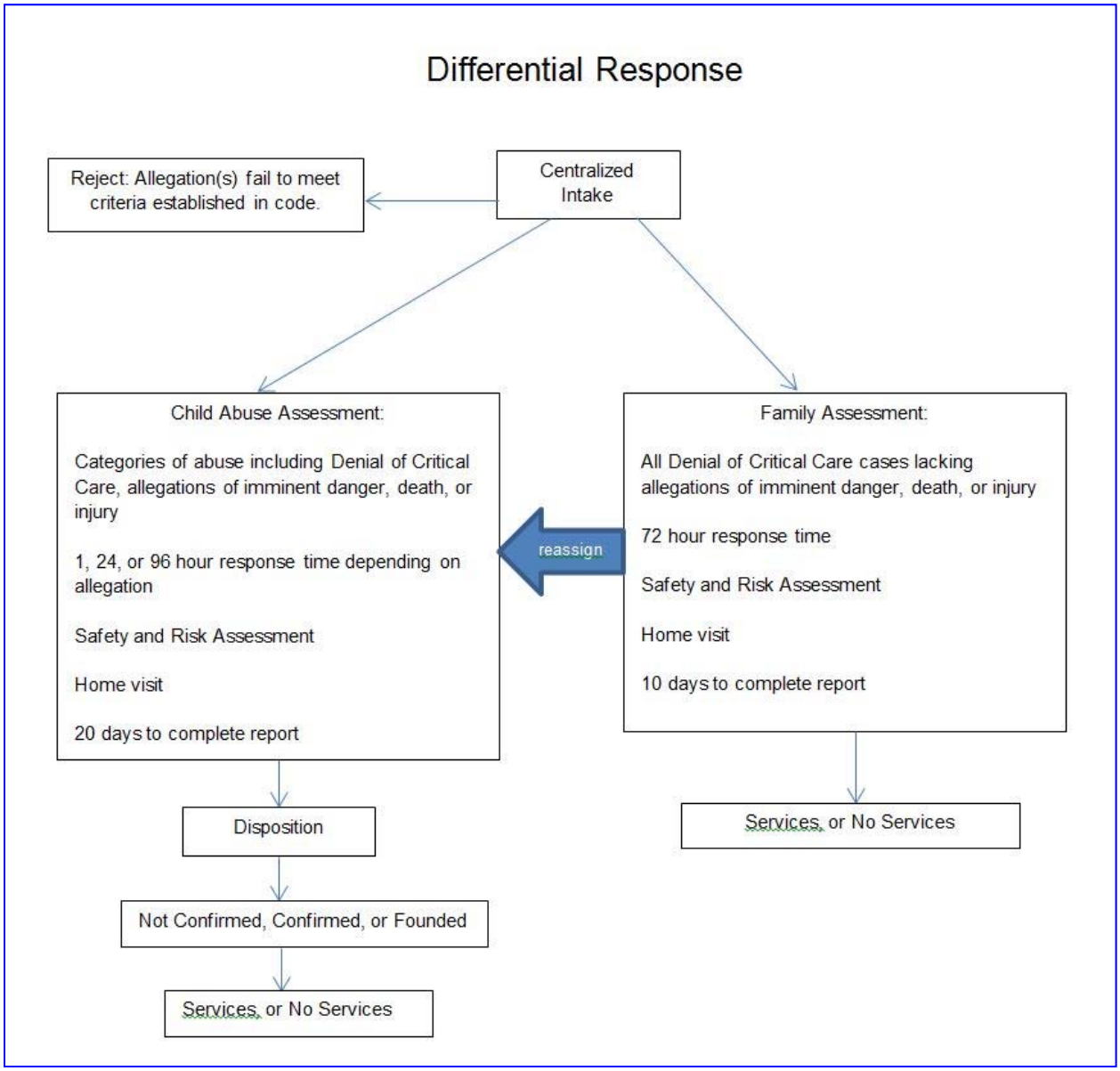

Figure 1.1 Differential Response Pathways

B. Analysis of Intake Decisions (Figure 1.2)

The process of assigning families to either a CAA or to a FA begins at intake, where allegations are either accepted and the DHS opens an assessment, or rejected, and the DHS does not open a case. Implementation of DR did not impact the criteria for accepting a report for assessment.

In CY2017, the DHS accepted 63% of its requests to open an assessment, which was higher than the 52% acceptance rate in CY2016. The overall volume of cases reported to the DHS also increased from 50,086 in CY2016 to 54,653 in CY2017, an increase of 11% from CY2016. The number of accepted intakes is up 33% from 2016, compared to a 6% increase between 2014 and 2015.

The DHS implemented the Centralized Statewide Intake Unit (CSIU) in 2010 as a means of increasing consistency at the point an intake is made to the DHS. The DHS' CSIU uses standardized tools to promote uniform decision-making focused on child safety. At intake, time frames are assigned according to the seriousness of the allegations. Reports of serious abuse have time frames as short as one hour in which the DHS must assess a child's safety and assure caregivers are not able to expose children to harm. The Intake Screening Tool is used for each report in order to maintain a strict application of rules to each case.

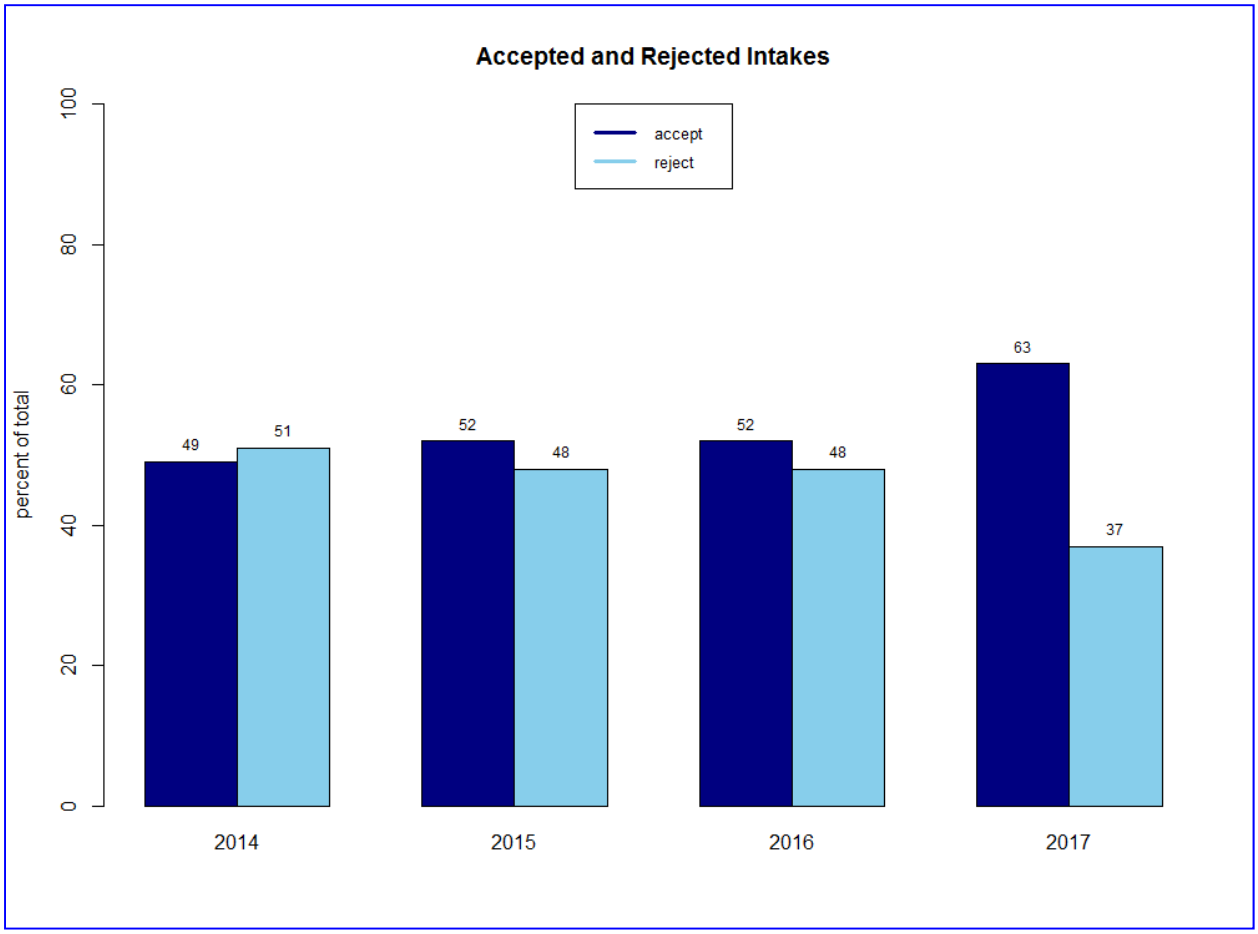

Figure 1.2 Percent of Accepted and Rejected Intakes

II. Initial Pathway Assignment

A. Background

There was no change in criteria to accept or reject a report of suspected abuse. However, since January 1, 2014, accepted intakes are assigned to one of two possible assessment pathways, the CAA or the FA pathway.

B. Analysis of Pathway Assignment (Figure 2.1)

During the planning phase of DR, the DHS forecast that 37% of accepted intakes would be assigned to the FA pathway. This projection included cases assigned to FA at intake as well as cases re-assigned from the FA pathway to the CAA pathway. During the fourth year of DR implementation, the FA pathway assignment rate was 40%.

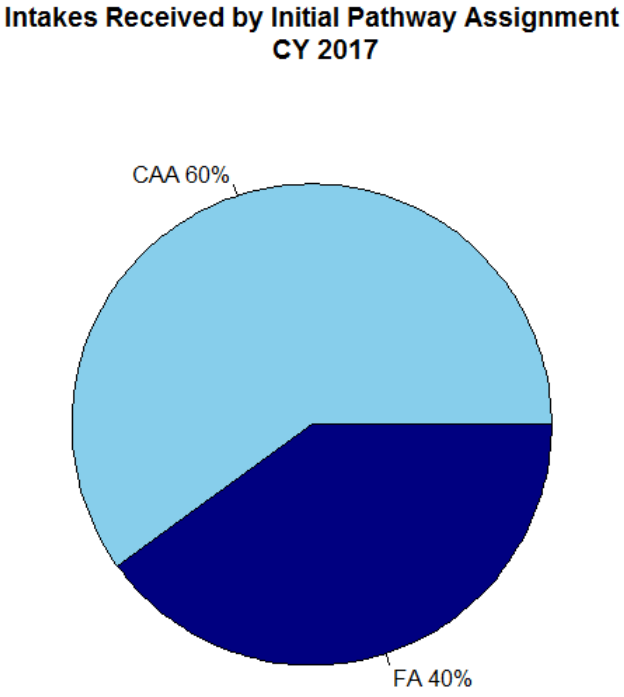

Figure 2.1 Initial Pathway Assignments

III. Initial Pathway Assignment Criteria

A. Background

Iowa law defines a set of criteria for pathway assignment. Each report may have met one or more criteria for assignment to the CAA pathway. Consequently, the total reason count exceeds the total unique assessments (25,878) for the period.

B. Analysis of Initial Pathway Assignment Criteria (Table 3.1 and Figure 3.2)

At the point an intake is accepted for an assessment, the CISU assigns the case to the CAA or FA. Among the many reasons allegations automatically merit a CAA in lieu of a FA during screening at intake include:

- allegations of abuse other than Denial of Critical Care
- allegations of imminent danger, death, or injury to a child

- prior Confirmed or Founded abuse within six months
- manufacture or sale of drugs in the family home
- alleged perpetrator has had parental rights terminated in the past
- alleged perpetrator uses, possesses, manufactures, cultivates "dangerous substances"[1] in the presence of a child

Screening Criteria	Reason Count	Distribution
Alleges imminent danger, death, or injury to a child.	7,373	17.95 %
It is alleged a caregiver uses OR knowingly allows another person to use, possess, or manufacture methamphetamines, amphetamines, or chemicals used in drug manufacturing in a child's home, on the premises, or in a motor vehicle located on the premises even if the child is not present.	1,031	2.51 %
It is alleged a caregiver uses or possess cocaine, heroin, opiates, or meth/amphetamines in the presence of a child OR knowingly allows such activity by another person in the presence of a child.	1,965	4.78 %
It is alleged illegal drugs are being manufactured, cultivated, or distributed in the presence of a child.	438	1.07 %
It is alleged that illegal drugs are being manufactured or sold from the family home.	692	1.68 %
The allegation involves an incident for which the caretaker has been charged with a felony under chapter 726 of the Iowa Code (including neglect or abandonment of a dependent person; child endangerment resulting in the death, serious injury, or bodily injury of a child or minor; multiple acts of child endangerment; or wanton neglect of a resident of a health care facility resulting in serious injury).	69	0.17 %
The allegation is failure to thrive or that the caregiver has failed to respond to an infant's life-threatening condition.	25	0.06 %
The allegation is meth and at least one child victim is under six years old.	368	0.90 %
The allegation requires a 1-hour response or alleges imminent danger, death, or injury to a child.	1,197	2.91 %
The allegation requires a 1-hour response.	1,497	3.64 %
The alleged abuse type includes a category other than Denial of Critical Care	15,261	37.16 %
The alleged person responsible is not a parent (birth or adoptive), legal guardian, or a member of the child's household.	2,073	5.05 %
The child does not live in the home with a parent (birth or adoptive) or legal guardian.	0	0.00 %
The child has been taken into protective custody as a result of the allegation	212	0.52 %
The report of suspected abuse was originally assigned as a family assessment and imminent danger, death, or injury to a child is identified through the course of the family assessment.	0	0.00 %
There has been prior Confirmed or Founded abuse within the past 6 months which lists any caretaker who resides in the home as the person responsible.	1,161	2.83 %
There has been TPR (in juvenile court) on the alleged person responsible or any caretaker who resides in the home.	347	0.84 %
There is a separate incident open on the household that requires a child abuse assessment.	3,901	9.50 %
There is an open DHS service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the non-custodial parent if they are the alleged person responsible.	3,463	8.43 %
Total	41,073	

Table 3.1 Screening Criteria

The DHS has used DR in order to prompt quicker responses for allegations describing more imminent risk to children. DR exists to help states provide aid to families who need DHS assessments, interventions and services necessary for keeping children safe. The data confirms that assignment to the CAA pathway is for the more serious cases.

[1] Effective July 1, 2017, Dangerous Substances include: amphetamine, methamphetamine, cocaine, heroin, opium, and opiates

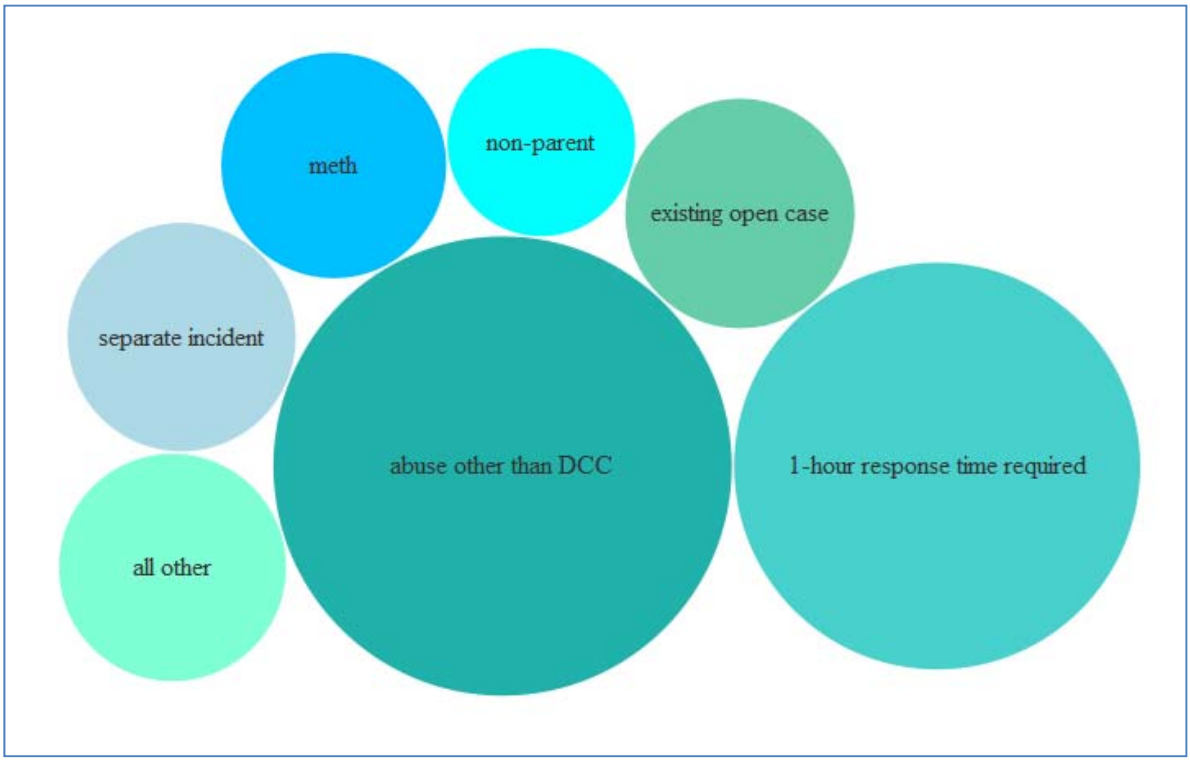

Figure 3.2 CY 2017 Proportion of Reasons for CAA Pathway Assignment

IV. Pathway Re-assignment

A. Background

In the design of the DR system it has been critically important to ensure the safety of the alleged victim(s) through the entire assessment process. Consequently, Iowa law established a firm path for cases to be reassigned from the FA pathway to the CAA pathway at any point if the case meets one or more of the established criteria related to child safety. There are times when CPWs initiate assessments, and new information is uncovered increasing concerns pertaining to the safety and risk to a child. In such instances, the case is reassigned to ensure more serious allegations are addressed as a CAA. It should be noted that Iowa law does not allow the ability for a cases to move from the CAA to the FA pathway.

B. Analysis of Pathway Re-assignment (Figure 4.1)

As stated earlier, the DHS forecast the total percentage of FA pathway assignment which was inclusive of re-assignment.

In 2017, 4% of the total volume of cases was subsequently reassigned to the CAA pathway[2].

During the fourth year of DR implementation, 8,722 cases were originally assigned to the FA pathway during intake. After initiating an FA, 1,554 of the original 8,722 were then reassigned to the CAA pathway. After reassignments, 7,168 of cases were assessed on the FA pathway. A 4% reassignment rate demonstrates two successful functions of the DR system: Cases are being appropriately assigned at the time of intake and the CPWs are reassigning cases when the assessments' point to more serious concerns of safety and risk.

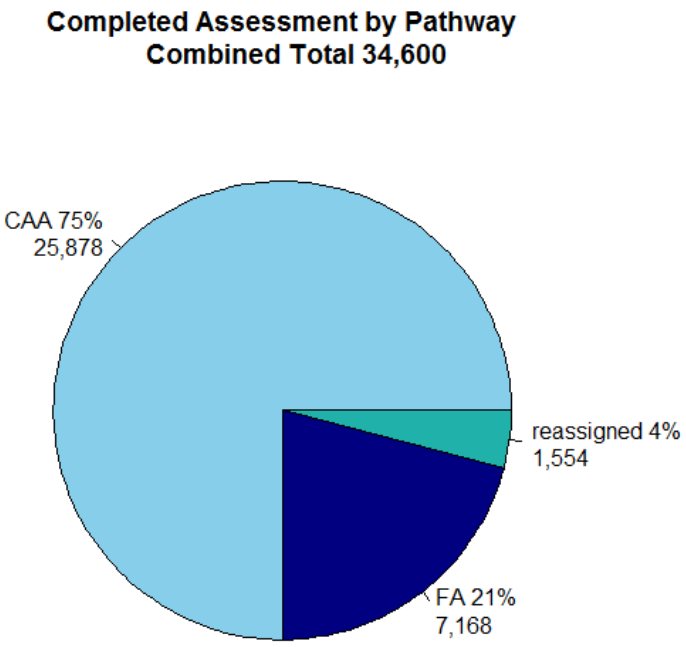

Figure 4.1 Assessments by Pathway

V. Pathway Re-assignment Criteria

A. Background

As stated earlier, Iowa law established a firm path for cases to be re-assigned from the FA pathway to the CAA pathway at any point in the FA if the case was determined to fit the appropriate criteria.

B. Analysis of Pathway Re-assignment Criteria (Table 5.1)

The data confirms that re-assignment to the CAA pathway is for the more serious cases and is a cautious approach used by the department to assist in assessing high risk safety concerns. There are a variety of reasons why a CPW, in consultation with his/her supervisor, would reassign pathways due to a child safety concern. Of 8,722 family assessments, 1,554 cases were reassigned for a child safety concern. Of 1,554 cases reassigned for a safety concern, a total of 646 (42%) cases resulted in a substantiated finding, which indicates pathway reassignment is being utilized as designed; specifically, a reassignment pathway is being utilized for cases in which the CPW discovers additional information while performing a comprehensive assessment. Safety of children continues to be first and foremost.

[2] Counts may contain duplicates as multiple reasons may be selected for a single intake. Data as of 26 Feb 2018

Re-Assignment Criteria	Reason Count	Distribution
Alleges imminent danger, death, or injury to a child.	157	9.57 %
Child unsafe	792	48.26 %
Family Chose CAA	156	9.51 %
It is alleged a caregiver uses OR knowingly allows another person to use, possess, or manufacture methamphetamines, amphetamines, or chemicals used in drug manufacturing in a child's home, on the premises, or in a motor vehicle located on the premises even if the child is not present.	6	0.37 %
It is alleged a caregiver uses or possess cocaine, heroin, opiates, or meth/amphetamines in the presence of a child OR knowingly allows such activity by another person in the presence of a child.	27	1.65 %
It is alleged illegal drugs are being manufactured, cultivated, or distributed in the presence of a child.	4	0.24 %
It is alleged that illegal drugs are being manufactured or sold from the family home.	7	0.43 %
The allegation involves an incident for which the caretaker has been charged with a felony under chapter 726 of the Iowa Code (including neglect or abandonment of a dependent person; child endangerment resulting in the death, serious injury, or bodily injury of a child or minor; multiple acts of child endangerment; or wanton neglect of a resident of a health care facility resulting in serious injury).	13	0.79 %
The allegation is failure to thrive or that the caregiver has failed to respond to an infant's life-threatening condition.	4	0.24 %
The allegation is meth and at least one child victim is under six years old.	10	0.61 %
The allegation requires a 1-hour response or alleges imminent danger, death, or injury to a child.	32	1.95 %
The allegation requires a 1-hour response.	2	0.12 %
The alleged abuse type includes a category other than Denial of Critical Care	23	1.40 %
The alleged abuse type includes a category other than Denial of Critical Care.	75	4.57 %
The alleged person responsible is not a parent (birth or adoptive), legal guardian, or a member of the child's household.	36	2.19 %
The child has been taken into protective custody as a result of the allegation	8	0.49 %
The child has been taken into protective custody as a result of the allegation.	19	1.16 %
There has been prior Confirmed or Founded abuse within the past 6 months which lists any caretaker who resides in the home as the person responsible.	7	0.43 %
There has been TPR (in juvenile court) on the alleged person responsible or any caretaker who resides in the home.	52	3.17 %
There is a separate incident open on the household that requires a child abuse assessment.	152	9.26 %
There is an open DHS service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the non-custodial parent if they are the alleged person responsible.	59	3.60 %

Table 5.1 Pathway Reassignment Criteria

VI. Analysis (Figures 6.1, 6.2, 6.3, and 6.4)

Reassignment rates are not in and of themselves an indication of the success or failure of DR. *Outcomes* that result in ensured safety or minimize future risk of harm for youth over the long term are more indicative of a successful and efficient child welfare system. The DHS' strategy to ensure the child welfare system is efficient and effective focuses on providing the appropriate assessment to families with the appropriate interventions

and services caregivers need in order to keep their children safe. The primary means of analyzing whether Iowa's DR system is working as designed is to compare outcomes of families that went on both paths, and compare their re-abuse rates.

One would anticipate that the DHS' differentiated response to families is working as designed if increased risk for future DHS involvement is correlated with families on the CAA pathway and lower risk is correlated with families who went the FA path. Families are stratified into different risk pools according to assessment levels at the point of pathway assignment. The FA pool is constructed to include less risk for future involvement with DHS and is less likely to have negative outcomes. The different treatments and service-eligibility at the conclusion of assessments for each risk pool makes an evaluation of outcomes complicated. Hence, comparing outcomes for families on each of the pathways are fraught due to the risk pools, service-eligibility, and anticipated rates of future DHS involvement being quite different. Nevertheless, comparison does indicate that risk pools are constructed appropriately when higher risk incidents are sent down the CAA path and turn out to be high risk, while lower risk incidents are sent down the FA path and turn out to be lower risk.

The CY17 risk pool below (Figure 6.1) shows paths and outcomes. For the sake of simplicity, the numbers below reflect percentages. Of 100 youth involved in a DHS open case, 75 were assigned to the CAA pathway, and 25 to the FA pathway. Of those 25 cases assigned to the FA path, four were reassigned to a CAA. After reassignment, the result is 33 of the original 100 youth have a confirmed or founded case of child abuse. Subsequently, four of the original 25 youth assigned to the FA pathway returned to the system and had a confirmed or founded case within 2017.

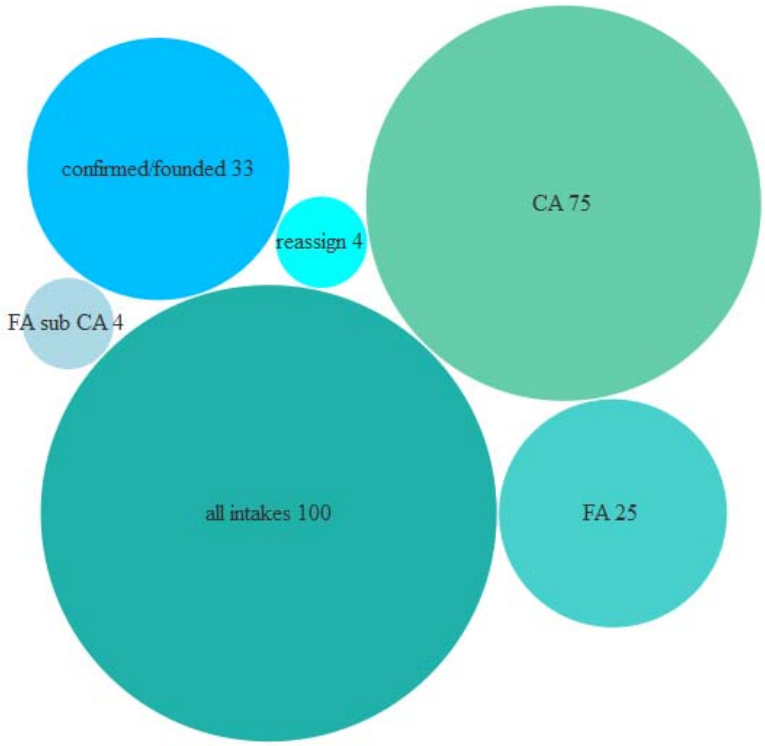

Figure 6.1 2017 Risk pool

Data for all youth assigned to the FA pathway since the implementation of DR, which is more than a 4 year period of time, show that 9%[3] have subsequently experienced a confirmed or founded child abuse report. A family that had a Family Assessment in January of 2014 has had a significantly longer period of time to commit subsequent abuse than a family assessed in December of 2017, who would have had less than a one-month opportunity.

When time is disaggregated into individual years, families have between a one- and 12-month window in which to commit substantiated abuse subsequent to a Family Assessment. In Figure 6.2, we can see that the percent of abuse after a Family Assessment has remained low and steady since the beginning of DR.

[3] The 2016 report stated an 11.2% abuse rate subsequent to a Family Assessment. However, this number erroneously reported the percent of youth who had a Family Assessment and had ever – either before or after – had a substantiated claim. The 9% rate reported above measures the percent of the FA population with a *subsequent* substantiated case.

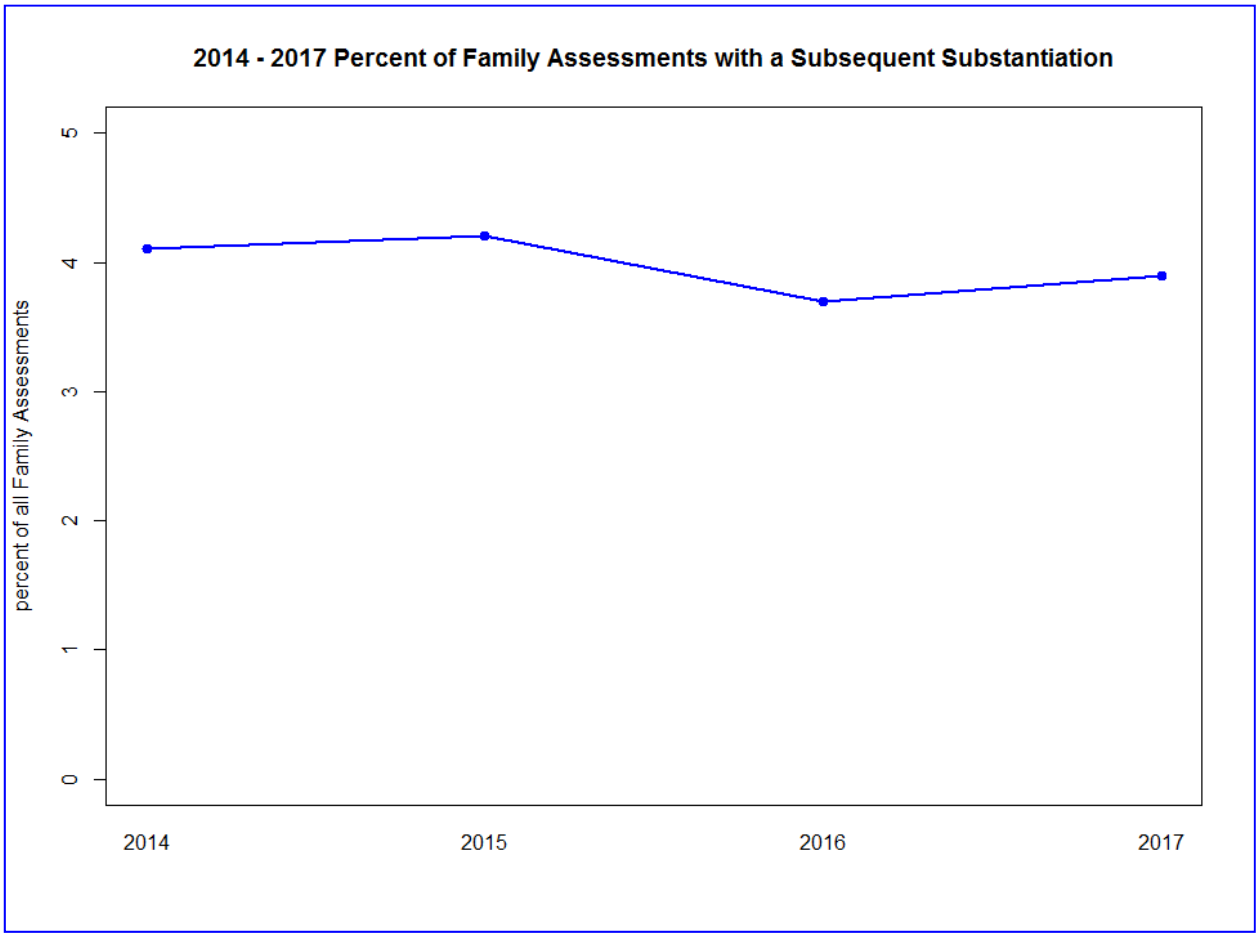

Figure 6.2 Families with a Substantiated Abuse Report Subsequent to a Family Assessment by CY

Interestingly, as both the rate and count of FAs has gone down, subsequent abuse rates remain consistent. In CY 2014, an average of 739 cases a month was assigned to the FA path (see Figure 6.3). By CY 2017, that monthly average dropped to 651 per month, which is a significant change. Likewise, as a percentage of all cases, the portion of FA cases also dropped significantly by CY 2017 to 40% from a high in CY 2014 of 65%[4] (see Figure 6.4).

[4] Both the counts and percentages references here are by child, not by incident. A single incident may involve multiple children, and hence this count will be higher than by incident. However, as both CAAs and FAs can involve multiple children at a time, both paths have an equal likelihood of having higher children-counts than incident-counts.

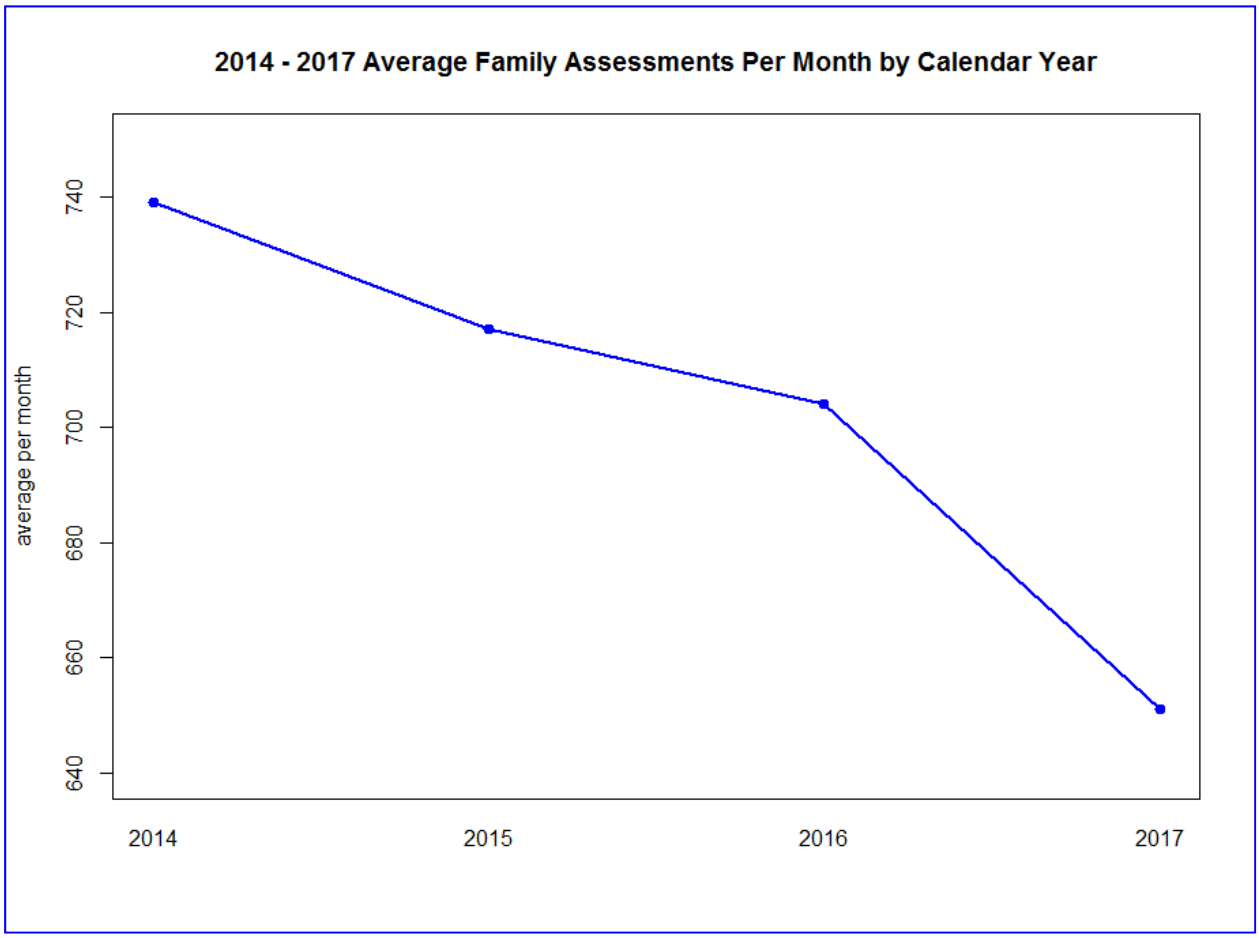

Figure 6.3 Average Number of Cases per Month Assigned to the FA Path by CY

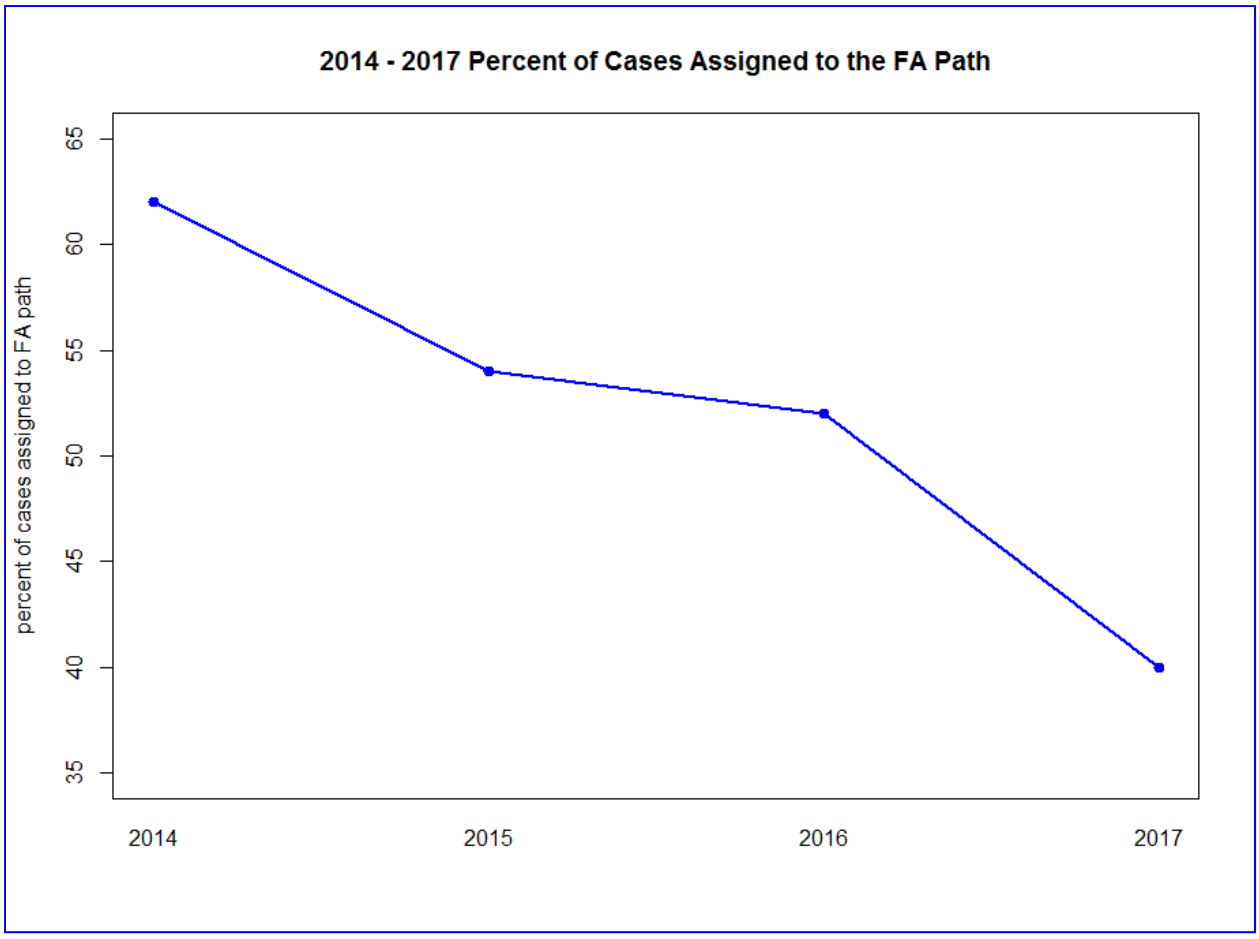

Figure 6.4 Percent of Cases Assigned to the FA Path by CY

As both the number and portion of FA cases adjusts yearly, the subsequent abuse rate remains stable, an indication that fluctuation in child welfare needs can be accommodated by DR, keep children safe, and minimize risk.

Neglect remains the largest category of abuse in Iowa. Of those with confirmed or founded CAA cases, 13% were for physical abuse; 68% for neglect; 6% for sexual abuse; 1% for psychological abuse; and 13% for PIDS, possession, or manufacture of drugs in the family home (see Figure 6.5).

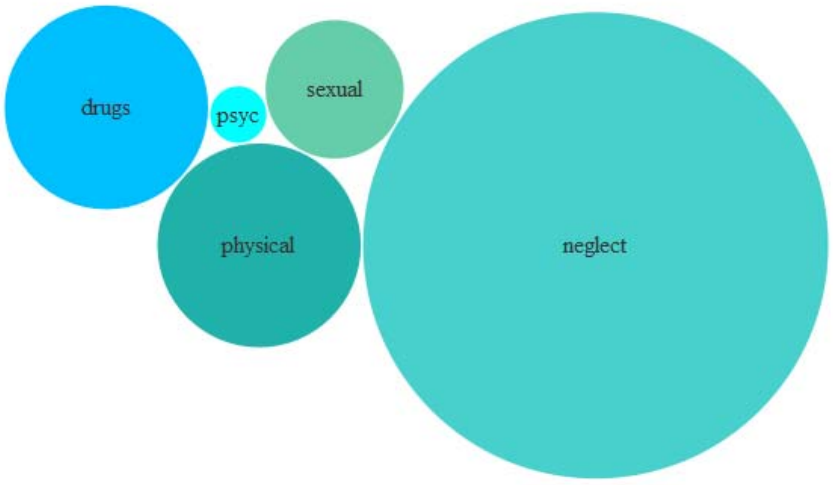

Figure 6.5 Percent of total Reasons for confirmed/founded abuse cases CY2017

The overwhelming reason for confirming or founding an abuse case was for neglect. At intake, most accepted cases are for Denial of Critical Care (DCC) and most substantiated outcomes are due to DCC.

VII. Founding Rates

A. Background

Throughout the design of DR it was anticipated that the “founding rate” - the percentage of accepted CAA pathway intakes that result in a founded case - would increase. This projection was based on the notion that, as lower risk cases were assigned to the FA pathway, the remaining cases on the CAA pathway would be more serious cases.

B. Analysis of Founding Rates (Figure 7.1)

Based on the first four years of Differential Response, the child abuse founding rate demonstrates that the more serious cases are being assigned to the CAA pathway. The smaller total number of cases on the CAA pathway, and the fact that they are, by design, the more serious cases, has resulted in a higher percentage of those cases being founded. Consequently, while the percentage of CAA founded reports has increased, the smaller total number of cases resulting in a founded report means fewer names on the Central Abuse Registry.

Iowa's focus on a comprehensive assessment, use of research and validated tools to assess risk and safety, ongoing training, and clinical oversight, will continue to evolve. It is anticipated that over time fewer children and families over time will enter the formal child welfare system.

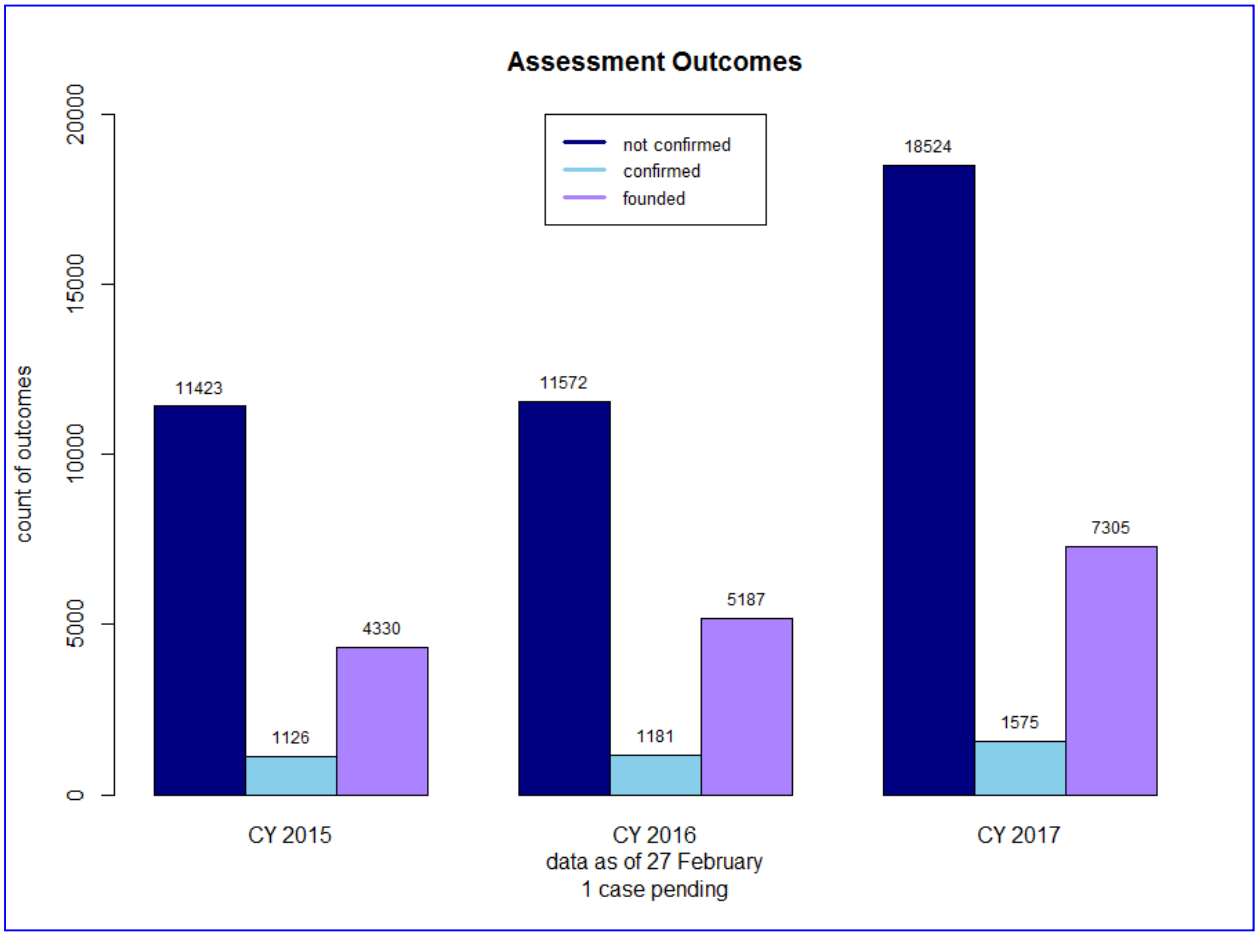

Figure 7.1 Assessment Outcomes

In CY 2017, Iowa experienced a substantial increase in the number of child protective assessments compared to previous year, as seen in Figure 7.1. Beginning on July 1, 2017, Iowa changed the abuse definition for "Manufacture and Possession of a Dangerous Substance" from previously only referring to methamphetamine and its precursors, to include cocaine, heroin, and opium/opiates. This expansion of the substances category to include more types of drugs represents one reason for this increase in the total number of child protective assessments. An additional reason stems from a practice change that restructured the way the DHS addresses additional allegations that arise during an open child protective assessment. Previously, if a CPW learned of new abuse allegations during the course of his/her child protective assessment, those allegations were added to the open assessment. In 2017, a change in practice resulted in workers being required to open a new child protective

assessment for subsequent allegations resulting in a sharp increase in the number of child protective assessments for the year. Updates to the child welfare information system, which houses all child protective assessment information, are being implemented which will allow additional allegations to be formally linked to the open child protective assessment without requiring a separate child protective assessment. This system update is expected to lead to a decrease in the total number of child protective assessments in future years.

III. Ongoing Service Provision

A. Background

By design, it was anticipated that the DR system would increase the number of families voluntarily engaging in protective services. Iowa Administrative Code (IAC) defines what type of state purchased services a family may receive at conclusion of an assessment. IAC 441 – 172.22(1) defines service eligibility for Family Safety, Risk, and Permanency (FSRP) Services and IAC 441 – 186.2(1) defines service eligibility for Community Care.

- Community Care is available to families at the conclusion of a CAA when the assessment is not confirmed (moderate and high risk), confirmed (moderate risk), and at the conclusion of a FA when there is moderate or high risk.
- FSRP Services are available to families when a child is adjudicated CINA, and/or when there is a founded child abuse assessment (low, moderate and high risk) and a confirmed child abuse assessment (high risk). The service can be opened at any point during the life of a DHS service case as long as eligibility criteria are met.

Community Care	**FSRP Services**
Available to families at the conclusion of a CAA when the assessment is not confirmed (moderate to high risk), confirmed (moderate risk), or after a FA (moderate to high risk).	Available to families for adjudicated CINA, for founded child abuse of all risk levels, or confirmed child abuse at a high risk level.

The data is organized based on the service referral date and may or may not be related to the presence or date of a child protective intake. Because of the time needed to conduct an assessment and to complete initial case management activities that result in a service referral and service case opening some of the November and December intakes (CY16) that eventually were opened for FSRP Services would be counted in CY17 and November and December intakes (CY17) would be potentially opened in January or February 2018.

B. Analysis of Ongoing Service Provision (Figure 8.1)

There were 8,451 families referred for state purchased services in CY17, compared with 8,614 families referred in CY16. In CY13, the most recent year without DR, 5,619 families were referred. DHS anticipated an increase in referrals following the implementation of DR.

There was an increase in the number of FSRP Services referrals, and a decrease in the number of Community Care referrals, when comparing CY16 to CY17. Both FSRP Services and Community Care are contracted services available to families who have been involved in a DHS assessment. The services are designed to build a family's ability to protect and parent their children, therefore reducing the likelihood they would enter more deeply into the formal child welfare system.

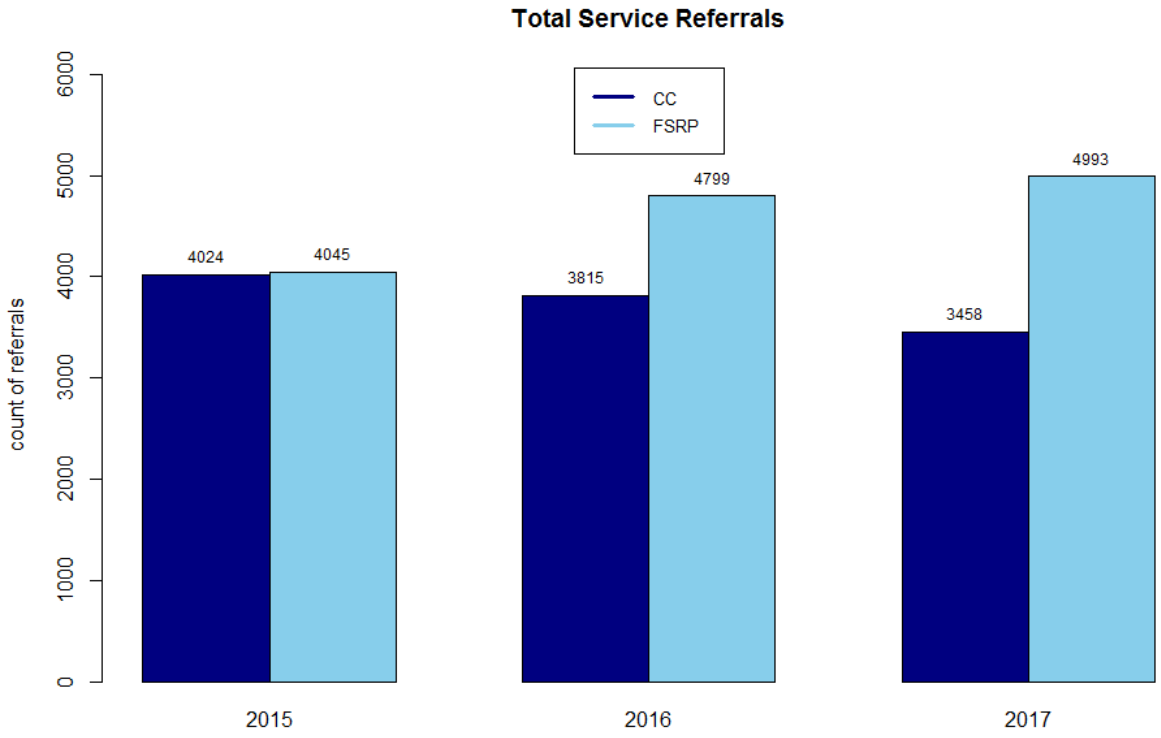

Figure 8.1 Total Service Referrals for Community Care and FSRP Services

IX. Community Care Outcomes

A. Background

Community Care is provided through a single statewide performance-based contract. Referrals to Community Care are made at the completion of both CAA and FA. The intent of this service is for families to learn new skills, or establish supportive

relationships in order to better protect their children. The outcome measures in Figure 9.1 and 10.1 were established to measure the service success.

B. Analysis of Community Care Outcomes (Figure 9.1)

The percent of families who do not experience a CINA adjudication within six months of being referred to Community Care increased from CY16 (98.09%) to CY17 (98.21%). The percent of families who do not experience a substantiated child abuse report within 12 months of a referral to Community Care had a small decrease from CY16 (92.9%) to CY17 (89.10%). The number of statewide referrals to Community Care more than tripled after implementation of DR. Community Care is voluntary with no open DHS service case so families referred are more open to addressing the needs and issues identified during the assessment through family-focused services, supports and linkages to community-based resources.

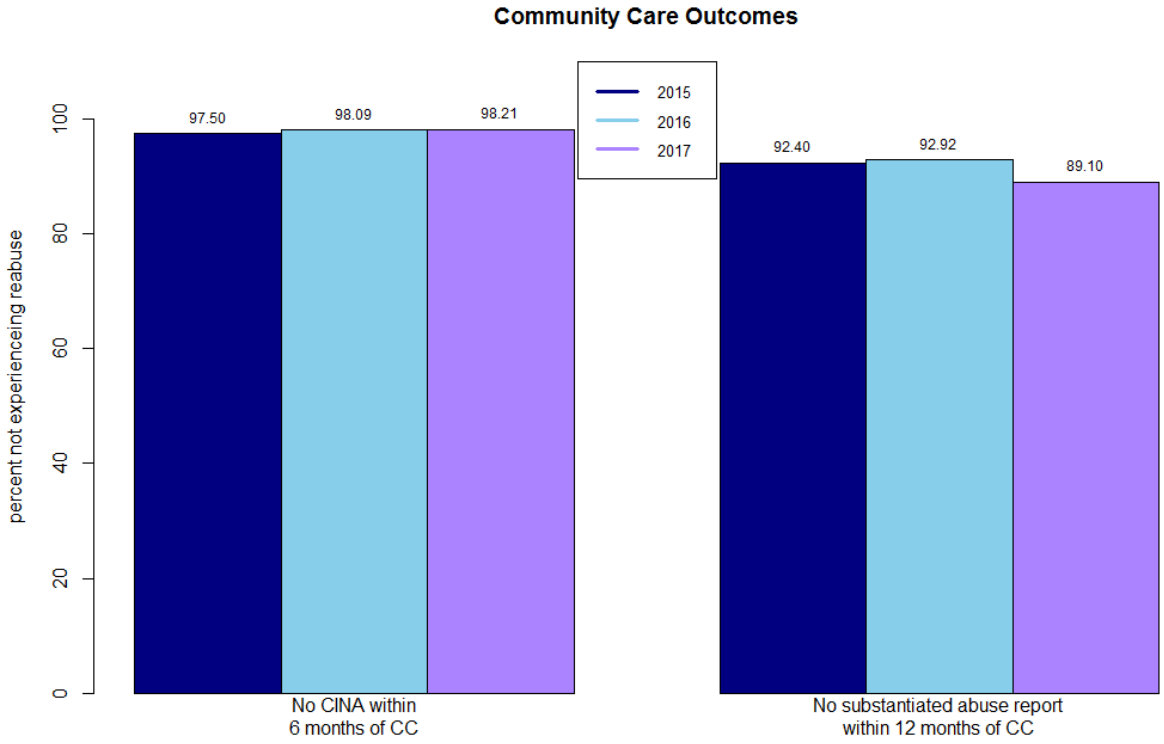

Figure 9.1 Community Care Outcomes

X. Safe from Abuse or Neglect

A. Background

The child protection system places the safety and well-being of children at the forefront of all decision making. Once the child protection system intervenes in the life a family, the goal is to improve the caregiver's ability to protect their children and prevent re-entry

into the system through a substantiated child abuse report or the adjudication of a CINA petition in Juvenile Court.

DR established an FA pathway to respond to less serious allegations of child neglect. The CAA pathway remained unchanged in the DR system. This system was built on the premise that children would be as safe or safer because the response to allegations of neglect would be tailored (differentiated) to the seriousness of the situation and to the families' particular needs.

B. Analysis of Safe from Abuse and Neglect (Figures 10.1, 10.2, 10.3)

The data confirms that children who receive an FA are as safe as those who receive a CAA. 97% of children who receive an FA did not experience a substantiated report within six months, 97%[5] of children who had an unsubstantiated CAA did not experience a substantiated report within six months and 95% of children who had a substantiated abuse CAA did not experience a subsequent substantiated report within six months.

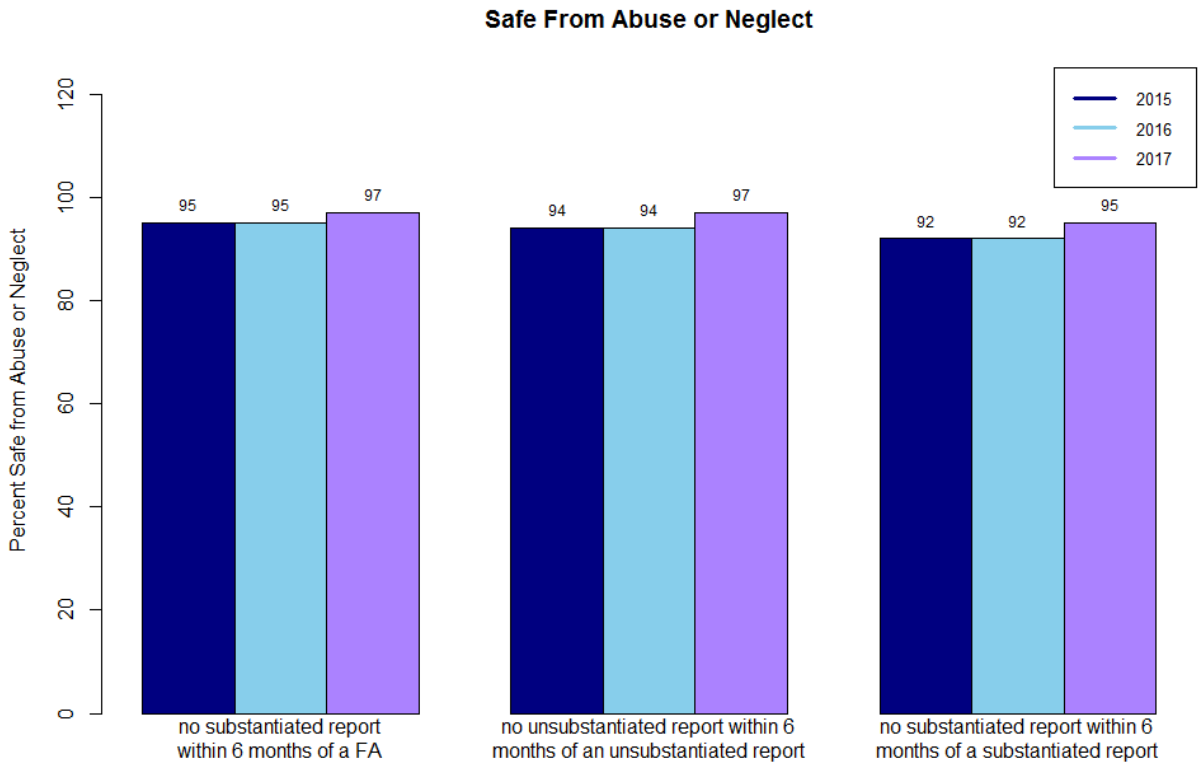

Figure 10.1 Safety after Assessments for six months

Differential Response has not had an adverse impact on child safety in Iowa. Data for the program demonstrates a significantly lower rate of a substantiated case after the

[5] 69 cases pending at time of writing

completion of a FA compared with families at the completion of a CAA, which highlights the DHS' ability to correctly place families on an appropriate path. Additionally, DR has not had a negative or unanticipated impact on the findings at the conclusion of an assessment. Abuse allegations assigned for an assessment to the CAA pathway are still confirmed and founded at the same rate under DR. Percentages of abuse allegations that are founded, confirmed and not confirmed have remained largely consistent since 2012 (see Figure 10.3).

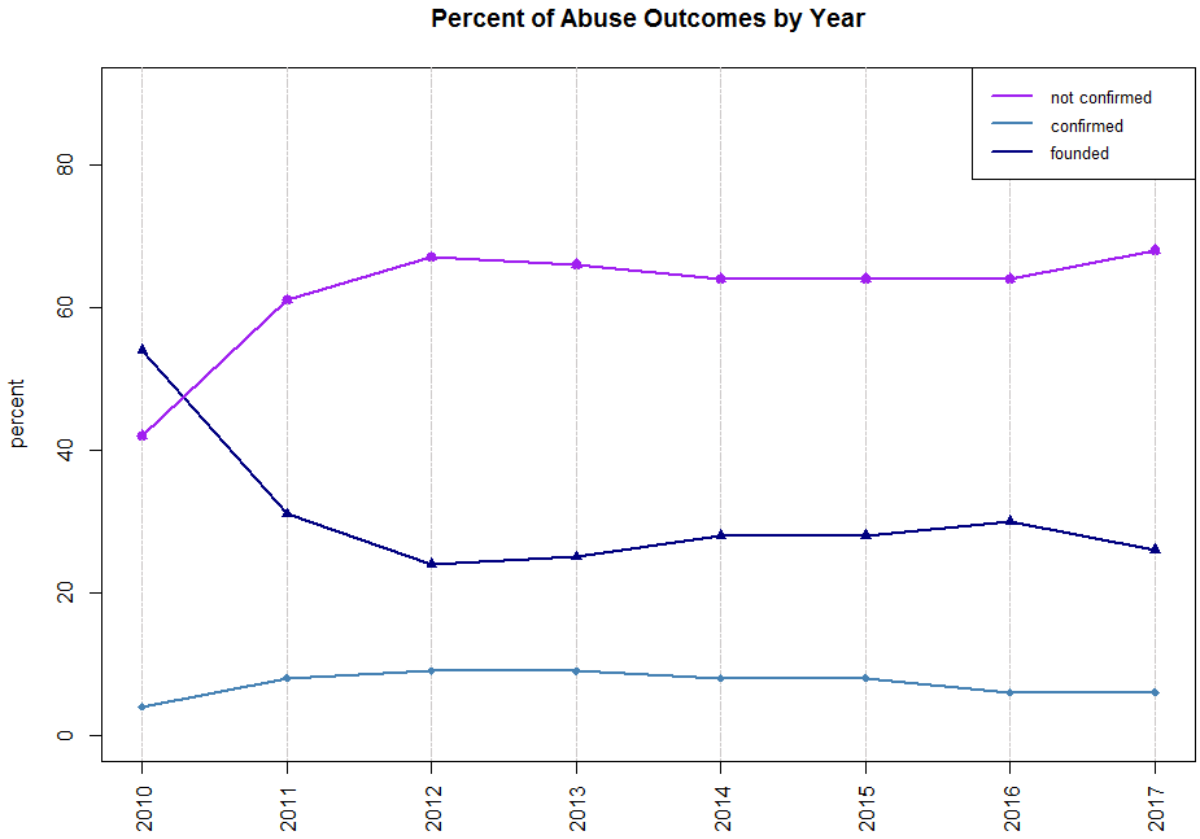

Figure 10.3 Percent of Abuse Outcomes 2010-2017

XI. Conclusion

Child safety remains the primary goal of the State's child protection system. The DR system, by design, supports child protection by assessing safety throughout the life of a case, during both CAA and FA, and by increasing the numbers of families who voluntarily access protective services. The ultimate goal of a child welfare agency is to build on a family's resources and develop support with the family in their community while reducing the need for higher service intervention. National research indicates that families who engage with services are more apt to sustain change and reduce the potential risk of abuse or neglect.

DR results across the country have demonstrated that children are no less safe in a judiciously vetted DR system, and engagement/shared partnership with families increases their interest and involvement in services. Following three years of implementation, the data confirms that children are as safe in Iowa's DR system as under the prior child assessment system, which only allowed for one possible pathway for families.

The first step in assessing DR implementation was to compare the projected forecast of process measures with actual performance. Iowa's DR system was designed in order that low risk cases receive a FA. Criteria for pathway assignment were carefully chosen with the assistance of national experts, representative from diverse disciplines and lawmakers.

The next step in assessing DR implementation was to measure outcomes for the families after the assessment and service case has concluded. Outcome measures focus on child safety and future involvement with the formal child welfare system. Performance after four years indicates that children are as safe in a DR system and are not experiencing re-entry into the formal child welfare system at a deeper level.

In addition to assessing process and outcome measures, the DHS has and will continue quality assurance activities to monitor implementation.

Quality assurance activities include:

- Case reading
- Structured state and local community meetings
- External and internal communication feedback structure

It is by using these valuable tools that the system will continue to evolve and become even stronger in its protection of the children of Iowa.