

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State DUNS Number

Number

137348624

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name

Iowa Department of Human Services

Organizational Unit

Division of Mental Health and Disability Services

Mailing Address

1305 E. Walnut St.

City

Des Moines, IA

Zip Code

50319

II. Contact Person for the Grantee of the Block Grant

First Name

Charles M.

Last Name

Palmer

Agency Name

Iowa Department of Human Services

Mailing Address

1305 E. Walnut St.

City

Des Moines

Zip Code

50319

Telephone

515-281-5452

Fax

Email Address

cpalmer1@dhs.state.ia.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

9/3/2013 6:38:31 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Laura

Last Name

Larkin

Telephone

515-242-5880

Fax

515-242-6036

Email Address

llarkin@dhs.state.ia.us

Footnotes:

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Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

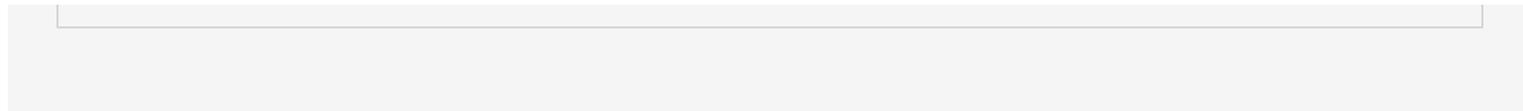
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	<input type="text" value="Charles M. Palmer"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Iowa Department of Human Services"/>

Signature: _____ Date: _____

Footnotes:



I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee

Charles M. Palmer

Title

Director

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Charles M. Palmer"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Iowa Department of Human Services"/>

Signature: _____ Date: _____

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

Step 1-Address the strengths and needs of the service system to address the specific populations

Overview of the State Mental Health System

Mental Health and Disability Service System Redesign Legislation.

For the last three years, the SMHA, along with other public and private partners and stakeholders has been engaged in a major redesign of Iowa's Mental Health and Disability system. The redesign of Iowa's system began in 2011 when the Iowa General Assembly enacted, and Governor Branstad signed, Senate File 525, which directed the Department of Human Services to develop a workgroup process with stakeholders, consumers, family members, providers, and other community members. The purpose of the workgroup process was to develop recommendations to be submitted to a legislative interim committee regarding redesign of the publicly funded mental health and disability system in Iowa. The legislative committee developed recommendations, incorporating the recommendations of the workgroups that required redesign of the county-based system of adult mental health and disability services into a regionally managed, locally delivered system.

The legislation for adult mental health and disability system redesign was enacted in Senate File 2315 in 2012. The Mental Health and Disability Redesign legislation can be found at this link:

http://www.dhs.state.ia.us/Partners/Partners_Providers/MentalHealthRedesign/2012Legislative.html

Senate File 2315 identified the expectations for the redesigned mental health and disability services (MHDS) system, incorporating recommendations from the workgroups, individuals served by the disability services system, family members and other concerned persons. The purpose of this legislation was to move toward statewide access to consistent services and to reduce the disparity that currently exists among counties regarding what type and quantity of mental health and disability services are available. Major changes in this new law include mandates that counties must form into regions of three or more unless granted a waiver, regions must provide access to specified core services, and that individuals shall have access to services for co-occurring conditions, evidence-based services, and trauma-informed care. Efforts are also underway to work toward equalization of funding to the counties and regions.

Another mental health-related bill passed in 2012 was Senate File 2312 which made changes to the involuntary commitment laws for mental health and substance use. These changes were designed to align the processes involved for these procedures and reduce duplication of processes that individuals engage in to receive assistance. This bill also mandated that law enforcement officers receive mental health training every four years. The SMHA has worked with the Iowa Law Enforcement Academy to implement this requirement through the Mental Health First Aid training.

A two-year workgroup process for redesign of the children's disability service system was also mandated in SF 525. The workgroup recommended that a children's system of

care be implemented through development of Integrated Health Homes that would provide care coordination and integrated services for children with serious emotional disturbance and other co-occurring conditions. The workgroup also recommended creation of a Children's Cabinet comprised of stakeholders, family members, and state agency leaders to serve in an advisory and oversight capacity for the children's service system. The final Children's Disability Workgroup Report filed in December 2012 can be accessed at this link:

http://www.dhs.state.ia.us/Partners/Partners_Providers/MentalHealthRedesign/Redesign-Reports.html.

In 2013, the Iowa General Assembly did not implement these provisions of the final recommendations of the children's disability workgroup and instead requested that the workgroup meet again in 2013 and submit further recommendations regarding the children's disability system. Through a Medicaid state plan amendment, Iowa has chosen to move forward with implementing Integrated Health Homes for Medicaid-eligible children with a serious emotional disturbance while recommendations for the statewide children's disability service system are being finalized. Integrated Health Homes are described in greater detail in the Services Section.

The redesign legislation has identified timelines that the state is required to meet in order to move the state from a county-based to a regionally managed, locally delivered system. All counties must meet the regional formation requirements in law by July 1, 2014. As part of this process, Iowa's 99 counties have formed into 14 mental health and disability service regions and are in the process of developing their service delivery systems and management plans. Three counties requested exemption from joining a region. One county was granted an exemption from forming a region and remains a single-county MHDS administrative entity. Two other counties requesting exemption were denied an exemption; one has joined a MHDS region and the other is appealing the decision.

The target population for the regional service system remains adults with a diagnosis of mental illness or intellectual disability whose incomes are at or below 150% of poverty level and do not have other insurance coverage for mental health and disability services. As Iowa develops a new health plan for individuals at or below 133% of poverty level, as part of the Affordable Care Act requirements, numbers of individuals whose services are funded by the regional service system may be impacted. The proposed plan, the Iowa Health and Wellness Plan, is summarized in a later section.

The State Mental Health Authority

The Iowa Department of Human Services (DHS), Division of Mental Health and Disability Services (MHDS) Administrator is the designated State Mental Health Authority (SMHA) for Iowa. Rick Shults is the Division Administrator for the Division of Mental Health and Disability Services.

MHDS includes:

- The two State Resource Centers for individuals with developmental and intellectual disabilities.

- Woodward State Resource Center
 - Glenwood State Resource Center
- The four state Mental Health Institutes provide inpatient mental health services to adults. Children's inpatient mental health services are provided at the MHIs located at Cherokee and Independence.
 - Cherokee Mental Health Institute
 - Clarinda Mental Health Institute
 - Independence Mental Health Institute
 - Mount Pleasant Mental Health Institute
- The Civil Commitment Unit for Sexual Offenders (violent sexual predators)
- The two Juvenile Programs
 - Eldora State Training School-for juvenile males adjudicated delinquent
 - Iowa Juvenile Home at Toledo-for females adjudicated delinquent, and court-ordered males and females adjudicated as children in need of assistance
- The Office of Facility Support
- The Bureau of Targeted Case Management
- The Bureau of Community Services and Planning

The Current Iowa Mental Health System

The Iowa system of community based services for adults and children with mental illness is managed and funded in various ways depending on an individual's income and whether the individual is Medicaid eligible and the services needed are eligible for Medicaid funding. Services specifically for children will be identified throughout this section.

Adults and children who are eligible for Medicaid receive mental health service funding and management through the Iowa Plan for Behavioral Health Services. The Iowa Plan is the state's managed care program for mental health and substance abuse services funded by Medicaid under the authority of the Department of Human Services, and for substance abuse services funded by the Substance Abuse Prevention and Treatment Block Grant and associated State appropriations under the authority of the Iowa Department of Public Health SSA. The contractor for the Iowa Plan is Magellan Health Services.

Mental health services through the Iowa Plan include a broad range of inpatient and outpatient mental health services and supports. Medicaid -eligible adults needing residential and/or vocational services are funded through 100% county funding, dependent on which specific services a county or region elects to fund. Some of those costs may be offset by the individual's ability to access Habilitation Services through Medicaid. Habilitation services are available to Medicaid-eligible individuals who meet the criteria for chronic mental illness and have income at or below 150% of poverty level. As of July 1, 2013, management of Habilitation services has been transferred to Magellan as part of Iowa's efforts to develop an integrated mental health service system. A more detailed description of Habilitation services and the integration of Habilitation into the Integrated Health Home program is included in the services section.

Adults without Medicaid or other insurance coverage may access mental health services through the county-based system if eligible by residence and financial eligibility.

County /Regional Services and Funding

County governments have historically managed many of the adult mental health and disability services available in the state. Iowa is currently transitioning from a county based system to a regional system with new expectations for provision of standardized core services, eligibility based on residency rather than legal settlement, and increased usage of functional assessments to determine need for services. Under the existing system, adults who are not eligible for Medicaid, but meet the statewide financial guidelines may receive the same services as Medicaid enrollees but the services are funded in part by county governments and managed by county governments.

The counties also previously managed some Medicaid-funded services due to the county being responsible for the non-federal share of certain Medicaid mental health and disability services. As part of Mental Health and Disability Services redesign, the state removed the obligation to fund the non-federal share of Medicaid services from the counties effective July 1, 2012. All Medicaid non-federal share obligations are now the responsibility of the state. The county is only responsible for funding of non-Medicaid eligible individuals and for services not covered by Medicaid and included in the county management plan while the state is fully responsible for management and oversight of Medicaid-funded services.

Iowa counties fund outpatient mental health services, mental health hospitalizations (and those services associated with involuntary hospitalizations), community support services, facility based residential services, work and/or day activity services, when no other funding is available through Medicaid or private insurance. Counties are not required to fund services for children but some fund outpatient mental health services and sometimes coordinate the involuntary commitment process for juveniles. Some counties also choose to use county funds to support System of Care and wraparound services for children and youth in their counties.

Previously each county was required to employ a Central Point of Coordination (CPC) Administrator who managed the funding and eligibility processes for individuals, primarily adults, seeking publicly-funded mental health and disability services. Counties are in the process of developing new regional management entities. CPC's are still in place, but will be phased out by July 1, 2014. Under the new regional MHDS system, regions comprised of three or more counties provide services under a regional administrative entity with local access points available to individuals within the region.

State payment program funds and property tax equalization payments from the State to the counties, are combined with property tax dollars raised by the counties to fund disability services. Counties continue to be financial partners in the provision of mental health and other disability services in the state.

Changes in state funding formulas and uncertainty about the change to regionalization have led some counties to initiate waiting lists for some mental health and disability services. Seven counties have waiting lists as of September 1, 2013. Commitment services for psychiatric hospitalization services and outpatient commitment services cannot be reduced or eliminated by counties.

Integrated Health Homes for Individuals with an SMI or SED

As of July 1, 2013, Iowa has begun implementation of integrated health homes for Medicaid-eligible adults with a serious mental illness and children with a serious emotional disturbance. The health home program was created through Section 2703 of the Patient Protection and Affordable Care Act. Magellan Health Services, the contractor for the Iowa Plan, is managing integrated health home development and implementation in close collaboration with Iowa Medicaid Enterprise and the SMHA.

This new program's goal is to provide care coordination and integrated services to populations at high risk of poor health outcomes. Development of health homes is part of Iowa's overall goal to increase availability of supports for individuals with serious mental health conditions that allow them to remain in their homes and communities and have improved health and wellness outcomes. Integrated health homes are currently operational in five of Iowa's ninety-nine counties with a plan for residents in the entire state to have access to integrated health homes by July 1, 2014. The role of Integrated Health Homes in delivery of services to individuals with an SMI or SED will be further explained in the sections on Children's Mental Health Services, Habilitation, and Case Management. A map of the phased implementation of the integrated health home program is included in attachment 1. An overview of the program can be found at this link: <http://www.magellanofiowa.com/for-providers-ia/integrated-health-home.aspx>

The Iowa Health and Wellness Plan

Beginning January 1, 2014, the Patient Protection and Affordable Care Act mandates a new eligibility group for individuals with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. Iowa has chosen to develop a new program, the Iowa Health and Wellness Plan, to meet the federal requirements. Iowa has submitted the plan for federal approval. The goals of the new plan are focused on improvements in health and outcomes, incentives for healthy behavior, an emphasis on care coordination, and local access to care. The plan has two types of coverage, dependent on income. For individuals at 100% of FPL or below, they will be eligible for the Wellness Plan, a Medicaid-administered plan that offers coverage equal to that provided to state employees. For individuals identified as having a chronic mental illness, home and community based services (HCBS) equivalent to those offered by Medicaid will be available. Coordination of care will occur through the individual's primary health care provider. Incentives for using preventative services will be built into the program.

For individuals with incomes of 101-133% of FPL, the state will offer premium assistance for individuals to purchase a commercial health plan on the Health Insurance Marketplace. The Marketplace Choice plan will offer coverage at least equivalent to that offered to state employees.

Covered services that are not provided by a commercial health plan will be provided by Medicaid. Using private health plans to extend coverage to this population allows individuals to remain in the same plan if their income changes. Individuals considered “medically frail” which includes individuals with disabling mental disorders, chronic substance use disorders, and other serious medical conditions may choose between the Marketplace Plan or the Wellness Plan. The SMHA has worked with Iowa Medicaid to address how coverage under these plans will meet the needs of Iowans with mental health and disability needs who may need services not normally available under commercial health insurance.

These plans will replace the current limited benefit medical plan, Iowa Care, offered to low-income individuals between the ages of 19-64. The Iowa Care plan does not cover mental health services. These individuals have been served by the county-based system and have received services based on what was mandated through the county management plan, income, and other eligibility requirements. It is anticipated that the county/regional service system will experience a decrease in demand for services due to previously uninsured or underinsured individuals having coverage for mental health and disability services.

STRENGTHS AND NEEDS OF IOWA’S MENTAL HEALTH SYSTEM

The strengths and needs of the mental health system will be described under the four primary headings of prevention, early intervention, treatment service, and recovery supports. Some organizations or services may be included in more than one category.

1. BEHAVIORAL HEALTH PREVENTION

Education for the general public and providers

The Iowa Mental Health Conference is held annually in October. This conference is planned by consumer groups including NAMI and Iowa Advocates for Mental Health Recovery; state agencies including Iowa Department of Human Services-MHDS, Iowa Department of Public Health-SSA, and Iowa Department of Education; and private providers and individuals. This is an opportunity for professionals and experts to share the most recent trends and issues, treatment programs and research relating to mental health and mental illness. This conference traditionally brings mental health professionals, substance use disorder professionals and stakeholders, consumers, families, program funders, policy makers, and community partners together to learn and work toward establishing and improving the mental health system of Iowa. MHBG funds are used to support consumer stipends which promote conference participation by individuals served by the mental health system. In October 2012, 33 consumers of mental health services attended the conference with support from the Mental Health Block Grant. A similar amount is expected to attend the 2013 conference. Presentations at the 2013 conference will include an overview of Integrated Health Homes for children and adults with serious mental health conditions, the redesign of the mental health and disability service system, trauma-informed care, and mental health care in the correctional system.

The Iowa Empowerment Conference began in 1999 to provide an opportunity for mental health consumers to join with each other and share ideas, talents, and experiences. The goal of the annual conference is to provide individuals, families, and youth dealing with mental health issues to learn coping skills and to strive for recovery through education. This consumer-led conference includes state and nationally recognized keynote speakers, peer support, social functions and more. The most recent conference was held in August 2013 which had over 100 consumers, providers, and other members of the public in attendance. Many of the workshops each year are presented by consumers. MHBG funds are used to promote mental health consumer participation in the conference through providing stipends for consumers with insufficient financial means to attend.

The Iowa Advocates for Mental Health Recovery, a consumer run organization which also operates the Iowa Office of Consumer Affairs, in the past has hosted an annual conference to educate mental health consumers and providers. In 2013, instead of hosting a traditional training conference, a statewide peer support summit was held in Des Moines. Attendance was open to the public. The event was a collaboration of the Iowa Chapter of the United States Psychiatric Rehabilitation Association, Magellan Health Services, the Office of Consumer Affairs, and the Iowa Advocates for Mental Health Recovery. Over 150 people attended, including peer support specialists, mental health providers, consumers, advocates, and state officials. Consumer attendance at the summit was also supported with MHBG funds.

System of Care-Child and Family Focused Training-The Community Circle of Care (CCC) System of Care for Northeast Iowa provides a wide variety of trainings at free or reduced cost to families and stakeholders across the state. CCC has also collaborated with many community partners to co-sponsor training events that attract participants from across Iowa and neighboring states. Trainings offered include the CCC Annual Children's Mental Health Conference, Trauma-Informed Care, Cultural Competency, Nurtured Heart Parenting Approach, Circles of Security, Mental Health First Aid (for youth and adults), Psychological First Aid, Mindfulness, 1,2,3 Magic for Parents and Professionals, training regarding Gay, Lesbian, Bisexual, Transgendered, and Questioning (GLBTQ) youth and mental health issues, and training specific to children diagnosed with Reactive Attachment Disorder (RAD).

Staff that have worked in the Community Circle of Care System of Care are now providing coaching and training to the children's Integrated Health Home staff, in order to infuse System of Care principles and practices into the Integrated Health Homes.

Trauma-Informed Care Training-Orchard Place Child Guidance Center, a MHBG contractor in the Des Moines area, has organized multi-day trainings to improve understanding and knowledge of trauma-informed care, provides targeted trainings and technical assistance to providers and community stakeholders, and facilitates a local stakeholders group to promote trauma-informed awareness and practices.

NAMI training-Other educational opportunities (most are free to participants) available to the public in Iowa include, but are not limited to, various classes provided by NAMI including:

- NAMI Basics (*for parents and caregivers of children and adolescents with an SED*)
- NAMI Family to Family (*for family members and friends of adults with SMI*)
- NAMI Peer to Peer (*for persons with mental illness*)
- NAMI Provider (*for agencies and organizations who work with persons with MI*)
- NAMI In Our Own Voice (*a speaker's bureau for persons with MI*)
- 30 Pearls of Wisdom in Treating a Person with Mental Illness (*an hour in-service*)
- Hearing Voices That Are Distressing (*a training and simulation experience*)
- NAMI Parents and Teachers as Allies (*2 ½ hr in-service training*)
- Wellness Recovery Action Planning (*WRAP*)
- NAMI Hearts and Minds (*on-line*) – *wellness education*
- Mental Health First Aid
- Crisis Intervention Team training (*NAMI is part of a community effort to present this training*)

Each NAMI affiliate may offer all or part of the classes listed above and may have additional classes advertised on their website. Classes can be through webinars, on-line trainings, and in-person training.

Iowa offers a wide variety of training opportunities related to mental health. The focus on professional growth and development is a strength of the Iowa mental health and disability system. Consumers of mental health services are integral participants of many of the training opportunities offered, either as attendees, planners, or presenters.

Mental Health First Aid

Mental Health First Aid is an eight hour certification course available to the general public. Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. The main goals are:

- Preserve life when a person may be a danger to self or others
- Provide help to prevent the problem from becoming more serious
- Promote and enhance recovery
- Provide comfort and support

In Iowa there are 90 Mental Health First Aid instructors certified to train the adult Mental Health First Aid course and 6 instructors to train people who work with youth. There are additional designations awarded to the 90 instructors; 16 have a rural classification and 1 has a Spanish classification. The instructors are located across the state in a variety of settings which include state staff from the Department of Human Services, Division of Mental Health and Disability Services, Department of Public Health, Division of

Behavioral Health Services, Iowa Law Enforcement Academy and the Iowa National Guard.

Currently there are six community mental health centers using Mental Health Block Grant funds to support their provision of Mental Health First Aid training.

Disaster Behavioral Health Response Training and Team Deployment

The State Mental Health Authority is responsible for administering the disaster behavioral health plan for Iowa. The State Mental Health Authority Administrator assigns a position to serve as the liaison between the federal government disaster programs and the state of Iowa. In addition to this function, the position provides oversight and management of the Iowa Disaster Behavioral Health Response Team.

In Iowa, the team responds when local resources have been depleted or are insufficient to respond to the mental health needs of Iowans during all phases of disaster including preparedness through long term recovery. The team is also trained to assist with crisis and critical incident efforts. The team is comprised of trained volunteers who can be deployed within the United States through the Emergency Management Assistance Compact.

Disaster Behavioral Health Response Team members are trained in a wide range of response skills including but not limited to: Psychological First Aid, Critical Incident Stress Management, Mental Health First Aid and Basic Disaster Training.

2, EARLY INTERVENTION

Early ACCESS

Early ACCESS is a partnership between families with young children, birth to age three, and providers from the Departments of Education, Public Health, Human Services, and the University of Iowa Child Health Specialty Clinics. The purpose of this program is for families and staff to work together in identifying, coordinating and providing needed services and resources that will help the family assist their infant or toddler to grow and develop.

Services: The family and providers work together to identify and address specific family concerns and priorities as they relate to the child's overall growth and development. In addition, broader family needs and concerns can be addressed by locating other supportive resources and services in the local community for the family and/or child. All services to the child are provided in the child's natural environment including the home and other community settings where children of the same age without disabilities participate.

Services required to be provided to children and families include:

- Service Coordination

- Screenings, evaluation and assessments
- "Individualized Family Service Plan" (IFSP)
- Assistive Technology
- Audiology
- Family Training/Counseling
- Health Services
- Medical evaluations to determine eligibility
- Nursing
- Nutrition
- Occupational Therapy
- Physical Therapy
- Psychology
- Social Work
- Special Instruction
- Speech Language Therapy
- Vision
- Transportation

Age Requirements and Eligibility:

An infant or toddler under the age of three (birth to age three) who,

- Has a condition or disability that is known to have a high probability of later delays if early intervention services were not provided, OR
- Is already experiencing a 25% delay in one or more areas of growth or development.

Costs: There are no costs to families for service coordination activities; evaluation and assessment activities to determine eligibility or identify the concerns, priorities and resources of the family; and development and reviews of the Individualized Family Service Plan. The service coordinator works with the family to determine costs and payment arrangements of other needed services. Some services may have charges or sliding fee scales or may be provided at no cost to families. Costs are determined by a variety of factors that are individualized to each child and family.

Adverse Childhood Experiences (ACEs)

The Central Iowa Adverse Childhood Experience (ACEs) Steering Committee has provided training regarding the impact of adverse childhood experiences and trauma on children’s current and future development, behaviors, and long-term health outcomes. Iowa is planning an ACEs summit in October 2013 to present the results of a study of ACEs using Iowa data and identify systemic responses to the data.

1st Five Healthy Mental Development

A program that will be expanded in SFY 14 is the 1st Five Healthy Mental Development Initiative. Iowa’s 1st Five Initiative builds partnerships between physician practices and public service providers to enhance high quality well-child care. 1st Five promotes the use of standardized developmental tools that support healthy mental development for young

children in the first five years. The tools include questions on social/emotional development and family risk factors, such as depression and stress. When a medical provider discovers a concern, the provider makes a referral to a 1st Five coordinator. Shortly after receiving the referral, the coordinator then contacts the family to discuss available resources that will meet the family's needs. For every one medical referral to 1st Five, there are an additional 2-3 referrals identified when the care coordinator contacts the family. Often these intervention services are related to the behavioral health needs of the child and/or family. In this respect, 1st Five supports a community-based systems approach to building a bridge between primary care and mental health professionals. From 2007-2012, services were provided in 13 counties and 83 health practices with an estimated 77,000 children aged birth to 5 reached. 4,985 families were referred by their health providers to the program.

Project LAUNCH-

Project LAUNCH is a SAMHSA-funded program operated by the Iowa Department of Public Health (IDPH). SMHA and SSA staff participate in, and support Project LAUNCH activities. This grant, funded in 2009, has provided funding to implement direct services for families as well as technical assistance for service providers within a targeted residential area in Des Moines, Polk County, Iowa. Project LAUNCH seeks to develop the necessary infrastructure and system integration to ensure that Iowa children are thriving in safe, supportive environments and entering school ready to learn and able to succeed.

The project targets children ages 0–8 and their families who reside in a seven zip-code area in inner-city Des Moines, Polk County, Iowa, with a focus on low-income and minority families who are traditionally underserved. Outreach, recruitment, and retention efforts specifically target African American, Hispanic, Asian, and limited/non-English-Speaking immigrant and refugee populations.

The goals at the state level are to:

- Build state infrastructure to increase the capacity of the children's mental health system and to integrate it into a comprehensive early childhood system of care to promote positive development for Iowa children ages 0–8 and their families
- Promote sustainability and statewide spread of best practices for system development

The goals at the local level are to:

- Build local infrastructure to increase the capacity of the children's mental health system and to integrate it into a comprehensive early childhood system of care to promote positive development for Polk County children ages 0–8 and their families
- Deliver family-centered, fully integrated evidence-based services for children living in the target community who are at risk for poor social-emotional outcomes

To achieve these goals, Iowa Project LAUNCH has established both a State and Local Council on Young Child Wellness. Membership on these councils includes the major public and private stakeholders from the areas of health, mental health, child care, and early childhood advocacy in order to ensure collaboration and coordination.

Implementation has included several evidence-based programs and practices, including standardized developmental screening in primary care and other settings (utilizing ASQ and ASQ-SE), Nurse Family Partnership, Positive Behavior Interventions and Supports (PBIS), and mental health consultation in schools and child care settings.

An expected outcome at both the state and local levels is a coordinated and comprehensive mental health care system for all Iowa children ages 0–8 and their families. At the state level, expected outcomes include more efficient and effective population-based policies and processes related to wellness for children ages 0–8 and their families; increased public understanding of the social and emotional health care system; and improved resources for detection of and intervention regarding mental illness. At the local level, an expected outcome is that each year a minimum of 410 children ages 0–8 will show improvement in health, school performance, and family functioning.

Initial evaluation data for the first six months of direct services, April 1-September 30, 2010, identified 53 children receiving direct services, 45 collaborating agencies at the state and local levels, 178 individuals receiving training on evidence based practices for young children and 20 individuals receiving training regarding media advocacy and infant/child physical health. Participating families expressed a high level of satisfaction with the services provided.

Parent Child Interaction Therapy (PCIT)

Iowa is continuing the focus on increasing provider’s abilities to provide evidence based practices with young children. Provider trainings on the EBP of Parent-Child Interaction Therapy (PCIT) have occurred across the state. This is an evidenced based practice for parents of children ages 2 to 7, consisting of 40 hours of intensive training followed by 16 hours of advanced training in the small group setting. Currently trained providers are located in over 35 Iowa counties. MHBG funding has helped support provider training and implementation of this practice and will continue to be used to assist mental health providers increase their knowledge and skills in delivering this EBP.

Early Childhood Iowa Professional Development Workgroup

Early Childhood Iowa (ECI) is composed of six component groups, including one focused exclusively on professional development. The Professional Development workgroup’s membership includes state agency representatives, service providers and other stakeholders that are responsible for guiding Iowa’s early childhood education, health, mental health, and special education system. This group has developed a goal of increasing competencies for professionals who work with young children and their families, including child care providers, preschool staff, medical professionals, and mental health clinicians.

Iowa Association for Infant and Early Childhood Mental Health

In 2013, a group of public and private stakeholders formed the Iowa Association for Infant and Early Childhood Mental Health. This association is a collaboration among

many public and private partners, including Early Childhood Iowa, Project LAUNCH, and the Iowa Chapter of the American Academy of Pediatrics. The association has filed incorporation documents, and has held an introductory event to develop interest and membership in the organization. A focus of this organization is to develop professional competency standards for providers of early childhood services and supports. This organization is also interested in integrating promotion of children's mental health through the early childhood care and education system with redesign of the wider children's mental health system. Organization leaders have participated in the Children's Disability Services workgroups as part of the larger system redesign and will continue to advocate for inclusion of promotion and prevention activities focused on young children and their families as part of the statewide mental health and disability services system.

IDPH Suicide Prevention Efforts

Iowa is no longer utilizing Teen Screen through the Iowa Department of Public Health. The Department of Public Health is currently funding, in partnership with Boys Town, the State of Iowa Youth Advisory Committee and the Iowa Department of Education, a bullying prevention, intervention and reporting initiative named Your Life. Your Life is a web-based resource for all Iowans to obtain help and information about bullying and youth suicide. There is a hotline available 24 hours a day, seven days a week where people can talk or text with a trained counselor.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR):

Since 2011, Iowa has implemented a multitude of positive changes with regard to the PASRR process. PASRR in Iowa is now a fully federally compliant process as a result of a commitment by the Iowa Medicaid Authority (IME) and the SMHA to move forward together in the implementation of the process. PASRR is required for all applicants to any Medicaid-certified nursing facility in the state. An RFP was released in 2011 and an award for a PASRR contract was made to Ascend Management Innovations of Nashville, TN. A full-time program manager for PASRR has been designated within MHDS to represent the SMHA in PASRR and to manage the contract with Ascend and a staff person in IME has also been designated to collaborate around the new PASRR process. The new procedures for the Level II part of PASRR screening went into effect Sept. 1, 2011. Many training opportunities were undertaken in person, by webinar, and by phone, with hospitals and nursing facility staff, during 2011, and were well attended by the provider community. In January of 2012, the next phase of implementation began, when Ascend launched "WebSTARS," a web-based data entry and application system which can accept and process Level I referrals for PASRR on a 24/7/365 basis. This quick, efficient, and effective system has been well embraced by the provider community. LI PASRR screens are now completed within one business day and LII evaluations, which require face to face contact with the individual by an Iowa based independent assessor and a detailed review of records as well as interviews with caregivers and family members are completed within five business days.

Iowa's PASRR process helps assure that individuals with an identified mental health, intellectual disability, or related condition are not inappropriately placed in nursing

facilities unless necessary and appropriate. It also addresses evaluation for necessary services and care planning needs.

3. TREATMENT SERVICES

The Iowa Plan for Behavioral Health Care

The State's managed care organization for the Iowa Plan is Magellan Health Services. The Iowa Plan managed mental health and substance abuse services for approximately 504,953 eligible enrollees. In SFY 13, Magellan provided mental health services to 45,964 children ages 0-17, and 39,199 adult clients 18 or older. This equates to approximately 17% of the Medicaid-eligible population receiving some type of mental health service during the fiscal year. Magellan maintains a network of appropriately credentialed mental health service/substance abuse providers to assure availability of the following services to meet the behavioral needs of eligible enrollees. Covered services are those included in the Iowa Medicaid Program and are reimbursed for all non-*Iowa Plan* beneficiaries through the Iowa Medicaid Enterprise (IME). The Contractor maintains a network of appropriately credentialed mental health service providers to assure availability of the following services to meet the mental health needs of eligible enrollees.

The *Iowa Plan* continues to be jointly administered by the Department of Human Services and the Department of Public Health to best coordinate services and funding so Iowans with mental health and/or substance abuse concerns can live, recreate, and work in the communities of their choice with minimum disruption. The *Iowa Plan* is designed to focus services toward system of care ideals by offering:

- Easy and prompt access to needed services and supports
- Improved outcomes for consumers which span multiple programs and funding streams
- A seamless service delivery system which spans health, mental health, substance abuse, education and special education
- Strong consumer and community investment in the local service delivery system contoured to community strengths and needs
- Interagency planning and coordination of services
- Prevention and early intervention with those at risk
- Communication in the primary language of the consumer and family
- Freedom to purchase service elements based on consumer choice and needs
- Recovery and resiliency-based services

The *Iowa Plan* promotes and implements an integrated managed care program for both mental health and substance abuse services through a single contractor.

The *Iowa Plan* contractor, Magellan Health Services is at full risk for all Medicaid-funded services and provides specified administrative support for the IDPH-funded substance abuse treatment service system. The contractor is required to:

- Implement a quality assurance process to monitor consistency of access and quality of care

- Focus on best practices within and across the systems
- Support local planning and decision-making through existing de-categorization boards, county and regional administrative entities, and provider consortiums
- Allow flexible and cost-effective use of resources by blending various funding streams
- Individualize services by requiring the consideration of environmental factors in the authorization of services and supports
- Promote an on-going dialogue between the state agencies, consumers, and providers through roundtables for a variety of constituencies
- Eliminate duplication and gaps through a coordinated, consumer-centered treatment planning and administration of services
- Improve consistency through centralized utilization management, quality assurance, provider profiling, statistical reporting, and analysis

The *Iowa Plan* covers both categorically and medically needy individuals eligible through the Iowa Medicaid program. Enrollment in the *Iowa Plan* is mandatory and automatic for all Medicaid beneficiaries. The state Medicaid agency oversees this contract.

Mental health services available through the *Iowa Plan* to Medicaid-eligible Iowans-children and adult unless designated otherwise

Medicaid Mental Health

Services are provided by appropriately credentialed mental health service providers to assure availability of the following services to address the mental health and substance abuse needs of both adults and children:

- Ambulance services for psychiatric conditions
- Emergency services for psychiatric conditions, available 24 hours per day, 365 days per year
- Community support services
- Home health services
- Inpatient hospital care for psychiatric conditions
- Intensive psychiatric rehabilitation services
- Mobile crisis and counseling services
- Outpatient services
- Peer Support Services
- Programs of Assertive Community Treatment
- Psychiatric nursing services by a home health agency
- Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes
- Services of a licensed psychologist for testing/evaluation and treatment of mental illness

- Targeted Case Management services to Enrollees with chronic mental illness

Additional Required Services in the *Iowa Plan*

Although not covered in the fee-for-service Iowa Medicaid Program, the following services are required of the *Iowa Plan* Contractor as appropriate ways to address the mental health needs of enrollees. The Contractor must expand availability of all required services assuring system capacity to meet the needs of *Iowa Plan* enrollees. These additional required services are:

- Services for those diagnosed with both chronic substance abuse and chronic mental illness (services for the dually diagnosed)
- Level I Sub-acute Facilities delivering 24-hour stabilization services;
- 23-hour observation in a 24-hour treatment facility;
- Case consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Focused case management;
- Peer support services for persons with chronic mental illness;
- Community support services; Community support services include:
 - monitoring of mental health symptoms and functioning/reality orientation
 - transportation
 - supportive relationship
 - communication with other providers
 - ensuring Enrollee attends appointments and obtains medications
 - crisis intervention and developing of a crisis plan
 - coordination and development of natural support systems for mental health support;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family;
- Respite services
- Family therapy to family members of a child in order to address the mental health needs of that child;
- Reimbursement to appropriately credentialed/trained clinicians for administration of an appropriate level of functioning assessment to each *Iowa Plan* Enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness; the scale shall be repeated at intervals recommended by the selected scale; the final determination of the scales shall be made by DHS following negotiation with the selected Contractor and the *Iowa Plan* Clinical Advisory Committee;
- Specified services to adults admitted to a state mental health institute
- Court-ordered mental health services if clinically appropriate or up to 5 days for a mental health assessment
- Services to address the mental health needs of children in the adoption subsidy program

Children’s Health Insurance Program (CHIP)- Healthy and Well Kids in Iowa (hawk-I)

The Children's Health Insurance Program (CHIP) was created by Title XXI of the Social Security Act. The purpose of the Children’s Health Insurance Program (CHIP) program is to increase the number of children with health and dental coverage, thereby improving their health outcomes. The CHIP program includes both a Medicaid expansion and a separate program called the Healthy and Well Kids in Iowa (*hawk-i*) program.

Children covered by *hawk-i* receive a comprehensive package of health and dental benefits that includes coverage for physician services, hospitalization, prescription drugs, immunizations, dental, chiropractic, vision care and mental health services. The *hawk-i* program provides health and dental coverage to eligible children whose families have too much income to qualify for Medicaid but who do not have health care coverage.

Eligibility requirements:

- Under age 19.
- Uninsured and do not qualify for Medicaid.
- U.S. citizens or lawfully residing children
- Live in a family whose countable income is between 133 - 300% of the Federal poverty guidelines. For a family of four, the maximum annual income is \$70,650.

Inpatient Psychiatric Care and Residential Care

Mental Health Institutes (MHI)

The Iowa Department of Human Services oversees four MHIs, located in Cherokee, Clarinda, Independence and Mount Pleasant. The MHIs provide critical access to quality acute psychiatric care for Iowa’s adults and children needing mental health treatment, and provide specialized mental health-related services, including substance abuse treatment, dual diagnosis treatment for persons with mental illness and substance addiction, psychiatric medical institution for children (PMIC), and long-term psychiatric care for the elderly (geriatric-psychiatric).

All four MHIs are licensed as hospitals and provide inpatient mental health services via a total of:

- 88 beds of inpatient psychiatric services to adults;
- 32 beds of inpatient psychiatric services to children and adolescents;
- 20 beds of geriatric psychiatric services;
- 19 beds of dual diagnosis services;
- 15 beds of PMIC services; and
- 50 beds of residential-level substance abuse services.

Specialized Psychiatric Units in General Hospitals

There are twenty –five general hospitals in Iowa which have licensed psychiatric units with a total capacity of 656 beds. While inpatient psychiatric care is concentrated in metropolitan areas, Iowans can generally access inpatient care within a two-hour drive of their residence. As part of the formation of mental health and disability service regions,

inpatient psychiatric care available is required to be available within the region or within reasonably close proximity (defined in administrative rule as 100 miles or a drive of two hours or less from the county or region). Iowa is also considering the need for an inpatient psychiatric bed tracking system to help ensure that individuals in need of inpatient care receive care as close to their homes and families as possible. Additionally, the courts and law enforcement systems often expend large amounts of resources locating available beds and then transporting individuals long distances due to difficulty coordinating the existing inpatient resources.

Residential Care Facilities for Persons with a Mental Illness

The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for Persons with a Mental Illness (RCF/PMI). Fourteen programs with 321 beds are currently licensed. These programs provide care in residential facilities to persons with severe psychiatric disabilities who require specialized psychiatric care. While they are scattered around the state, these programs are not readily available in every locale. Iowa is moving toward less dependency on institutional care, leading to some RCF-PMI providers reviewing their business models and seeking ways to provide care in more community-based settings.

Intermediate Care Facilities for Person with Mental Illness:

The Department of Inspections and Appeals also licenses Intermediate Care Facilities for person with mental illness (ICF/PMI). These programs provide care at the intermediate nursing level to persons who also have specialized psychiatric care needs. They may participate in Medicaid, if they wish, as a Nursing Facility for Persons with Mental Illness (NF/PMI). Medicaid will only fund persons 65 and over in this setting. Currently there are three Iowa facilities that hold this licensure with a capacity of 102. County governments pay for the level of care for those individuals who are not eligible for Medicaid funding.

Psychiatric Medical Institutions for Children (PMIC)

These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are 10 private facilities with 430 Medicaid-funded beds and one public facility with 15 beds that deliver these services to children in Iowa. 45 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs. Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa.

In July 2012, Iowa moved management of PMIC services to the Iowa Plan contractor, Magellan as part of the effort to improve coordination of mental health services for Medicaid-eligible individuals. Magellan was tasked with providing intensive review and oversight of children in, or at risk of, out of state placements. Magellan has provided additional funding and training to providers willing to work with high-needs children and youth, and has facilitated conference calls among the PMIC providers to identify providers willing to serve high-needs children who otherwise might be referred out of state. Magellan has regular meetings with the PMIC provider community. Topics

include improvement of coordination between the educational system and the PMIC providers and improvement of family involvement in their child's care in the PMIC to help ensure that children placed out of the home have a successful transition back to their home, school, and community.

Services provided in PMICs include diagnostic, psychiatric, nursing care, behavioral health, and services to families, including family therapy and other services aimed toward reunification or aftercare. Children served are those with psychiatric disorders that need 24-hour services and supervision. Children may be admitted voluntarily by parental consent or through a court order if the child is under the custody of the Department of Human Services. 1,153 children received PMIC services in SFY 13.

Iowa Plan Substance Abuse Services-

Since 1995, Iowa has had a statewide managed care plan for mental health and substance abuse services funded by Medicaid, under the authority of the Iowa Department of Human Services, and for substance abuse treatment funded by State appropriations and the federal Substance Abuse Prevention and Treatment Block Grant, under the authority of the Iowa Department of Public Health. Since 1999, the managed care plan has been called the Iowa Plan for Behavioral Health. Magellan Health Services is the State's contractor for management of the Iowa Plan.

A full continuum of Iowa Plan substance abuse assessment and treatment services is available to residents of all 99 Iowa counties including:

- Ambulance services for substance abuse conditions
- Ambulatory Detoxification
- Emergency services for substance abuse conditions available 24 hours a day, seven days a week
- Evaluation, treatment planning, and service coordination;
- Inpatient
- Intake, assessment and diagnosis services
- Intensive Outpatient
- Outpatient Treatment
- Partial Hospitalization
- PMIC substance abuse services
- Residential Treatment

Iowa residents without insurance, Medicaid enrollment or other resources to pay for substance abuse services can receive IDPH-funded assessment and treatment by going directly to one of the twenty-three (23) IDPH-funded and licensed providers. *The provider will review income and family size to determine eligibility for funding and any co-pay.*

The *Iowa Plan* uses the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R) as the clinical criteria for all levels of substance abuse services. The *Iowa Plan* also uses PMIC Admission and Continued Stay Criteria for PMIC services.

For *Iowa Plan* Medicaid Enrollees, authorization by Magellan is required for ASAM Level IV Inpatient and Level III Residential and for PMIC services. Authorization may be required by the Contractor for other services or levels of care for quality improvement or contract compliance purposes, as approved by the Departments.

For IDPH-funded services, Magellan provides certain administrative services and contracts with providers for at-risk, provider-managed services, with providers required to serve a minimum number of IDPH Participants. Authorization is not required at any level of service for the IDPH population.

Co-Occurring System Initiatives and Services

For the past several years, the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) have led state efforts to understand and develop services for Iowans with co-occurring mental health and substance abuse problems. These efforts have involved consumers, clients, family members, providers, consultants, Departments staff, and other stakeholders in forums, planning groups, and trainings. As a result, Iowa has a strong base of educated and committed individuals who are contributing in ways specific to their individual advocacy organization, or agency mission, to a statewide comprehensive system of care that supports people working toward personal recovery. Information on available resources and known activities and events statewide are posted on DHS and IDPH websites including: DHS and IDPH activities, meetings, resources and training opportunities.

In January 2009, in collaboration with previous Co-Occurring Academy participants and with other stakeholders, including consumers, DHS and IDPH developed a joint statement on the Recovery Care System: "Over time, all Iowa mental health and substance abuse treatment services and all State processes that support such services will become recovery-oriented and capable of meeting the complex needs of individuals and families."

IDPH has implemented a transition to a comprehensive and integrated resiliency- and recovery-oriented system of care (ROSC) for addictive disorders, built on coordination and collaboration across problem gambling and substance abuse prevention, treatment, and recovery support services. IDPH-funded treatment provider contracts include financial incentives for documented co-occurring capability.

DHS and IDPH continue to develop services for co-occurring disorders with the goal of assuring a strong base of educated and committed individuals who contribute in ways specific to their individual, advocacy organization, or agency mission to a statewide comprehensive system of care that supports people working toward personal recovery.

The State has contracted with ZIA Partners (Dr. Ken Minkoff and Dr. Chris Kline) to provide training for mental health, substance abuse, disability service and brain injury service providers as well as community stakeholders and administrative level personnel to understand, develop and integrate multi-occurring capabilities throughout the general systems of service in Iowa. ZIA Partners also provides technical assistance in addressing some of the barriers for individuals with multi-occurring service needs to receive effective treatment. Mental Health providers have worked to certify some of their therapists in both substance abuse and mental health issues. Training has been conducted in recovery principles related to other complex needs including individuals who have co-occurring mental illness, substance abuse, intellectual or developmental disability, brain injury or other health conditions.

Services for individuals with co-occurring issues

IDPH administers Access to Recovery (ATR), a four year grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment. ATR is a presidential initiative which provides vouchers to clients for purchase of ATR covered services including mental health services. The goals of the program are to support client choice and increase the array of faith-based and community based providers. ATR - Iowa focuses on serving individuals in recovery from substance abuse.

The state Mental Health Institute at Mount Pleasant operates a 19 bed dual diagnosis unit for individuals with co-occurring mental health and substance abuse. Two other adult residential programs in Iowa are also identified as co-occurring capable by Magellan.

There are two PMIC's licensed to provide substance abuse treatment and mental health services to individuals up to age 21. Both are in western Iowa, with a combined capacity of 56 beds. Other providers of mental health services are increasing their co-occurring capability through training in motivational interviewing, the co-occurring capability training referenced above, and cross-training between mental health and substance abuse providers. Substance abuse providers in Iowa have also become part of the Mental Health First Aid initiative with five mental health professionals certified as Mental Health First Aid instructors.

Case Management Services

Targeted Case Management is a Medicaid service that assists adult persons with Chronic Mental Illness, Intellectual Disabilities, Developmental Disabilities, or Brain Injury in gaining access to appropriate living environments, needed medical services, and interrelated social, vocational, and educational services. In addition, children with an SED who receive the Children's Mental Health Waiver are eligible for Targeted Case Management. In Iowa, case management services are used to link consumers to service agencies and community supports, and to coordinate and monitor those services. Case managers are not responsible for providing direct care. Each county is responsible for accepting the responsibility of TCM by either providing the service or contracting with an accredited agency or the Target Case Management Unit affiliated with the Department of Human Services. As of SFY 13, counties are no longer responsible for funding the

non-federal share of case management for Medicaid-eligible individuals but are still responsible for making targeted case management available through county and regional management plans. Persons who are not eligible for Medicaid but would benefit from case management services are funded by the county.

Clients are linked with appropriate resources to receive direct services and supports and participate in developing an individualized plan. Clients are encouraged to exercise choice, make decisions, and take risks that are a typical part of life, and to fully participate as members of the community. Family members and significant others may be involved in the planning and provision of services as appropriate and as desired by the client.

Through the Integrated Health Home program that started operation in five counties as of July 1, 2013, Medicaid-eligible individuals who qualify for TCM due to a chronic mental illness or a serious emotional disturbance will receive care coordination through an Integrated Health Home (IHH) in place of traditional TCM. Individuals in the Phase 1 counties are currently in a six-month transition from TCM to IHH services. The goal is for the individual to receive coordination of services through a team that includes a care coordinator, nurse care manager, and family or peer support specialist. This will allow greater integration of the coordination/case management functions with the actual services and supports provided to the individual.

The Case Management program for the Frail Elderly is designed to assist persons who are frail elders to gain access to a variety of services through the assistance of a case manager. A comprehensive assessment of the individual's medical, social, emotional, and personal needs is completed. A team of professionals works with the individual to develop a plan of care that will allow the client to live safely and independently in his or her own home. Case management services for the elderly are provided through the Area Agencies on Aging (AAA's).

Behavioral Health Intervention Services-

Behavioral health intervention services –BHIS- (formerly remedial services) are available to children who are Medicaid eligible. BHIS are supportive, directive, and teach interventions provided in a community-based or residential group care environment designed to improve the individual's level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control. This service is managed through the Iowa Plan, allowing for coordination between the clinical services managed by the *Iowa Plan* and the primarily community-based skill building and crisis intervention service provided through BHIS.

BHIS enables Medicaid eligible children and their families to access in-home or community-based services in addition to traditional outpatient mental health care without having to enter the child welfare and/or juvenile justice system. BHIS services are also available to children in the custody of the Department of Human Services due to their eligibility for Medicaid. Through eligibility for the *Iowa Plan* as part of the Children's Mental Health Waiver, BHIS services are also available to children with an SED served

by the waiver.

Specific services available through the BHIS include individual, group, and family skill building services, crisis intervention services, and services to children in residential settings. BHIS services are typically provided in the home, school, and community, as well as foster family and group care settings.

Children's Mental Health Waiver

When the Children's Mental Health (CMH) waiver program began in October 1, 2005, it had a capacity of serving 300 children. The current capacity of the waiver is 1,144. As of July 2013, 968 individuals are currently receiving services with 251 applications pending. The waiver has a waiting list of 1,411 with the next child to be served having an application date of February 24, 2012. This effectively means that the time from application to an open funding slot remains at approximately 18 months even though slot capacity has greatly increased since the implementation of the waiver. These numbers vary over time and are not stagnant.

Services included in the CMH waiver are respite, community supports, in-home family therapy, environmental modifications and adaptive devices, and targeted case management. In addition, every child receiving services through the CMH waiver is also enrolled in the Iowa Plan; thus, services are combined through the two programs to meet the child's and family's needs. Children approved for the CMH waiver will also begin to receive their care coordination through Integrated Health Homes as previously described in this document. The goal is to better coordinate the services children with an SED and their families receive and to ensure that children with an SED are accessing all appropriate services that will enable them to remain in their homes and communities.

Iowa continues to annually in July make available 10 reserved slots on the CMH waiver for children being discharged from MHI's, PMIC's, or out-of-state placements. These reserved slots are usually used within the first few months of release. This fact, as well as the large waiting list for the CMH waiver demonstrates the need for coordinated, supportive services in order to divert children from more intensive services, and aftercare services for children returning to their communities from PMIC and out of state treatment and placements. Children leaving high-end, restrictive types of treatments and placements need immediate access to services to support a successful transition back to their homes and communities.

Habilitation Services

Habilitation Services is a Medicaid program operated through a 1915-I waiver. The Habilitation program provides services similar to HCBS waiver services to individuals meeting the criteria of chronic mental illness. The goal is to separate rehabilitative and non-rehabilitative services into distinct programs in order to continue the services needed by Iowans, while at the same time assuring that the state remains in compliance with federal regulations. Individuals receiving Habilitation also qualify to receive targeted case management.

As part of the new Integrated Health Home program, individuals receiving Habilitation services will start receiving care coordination through an Integrated Health Home as the program is phased in statewide in lieu of targeted case management. This will align the community supports offered through Habilitation with the mental health and physical health care needs of the individual and provide additional coordination services to those with intensive health needs.

Habilitation services include the following:

- Home-based Habilitation which is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision.
- Day Habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the participant's service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.
- Vocational (pre-employment) Habilitation includes services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are directed to habilitative rather than explicit employment objectives.
- Supported Employment Habilitation are services that consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.

Educational System Services and Supports

For children in primary and secondary schools, Area Education Agencies are significant providers of services to children under IDEA. Iowa Area Education Agencies are

regional service agencies which provide school improvement services for students, families, teachers, administrators and their communities.

Area Education Agencies (AEAs) work as educational partners with public and accredited, private schools to help students, school staff, parents and communities meet these challenges. AEAs provide special education support services, media and technology services, a variety of instructional services, professional development and leadership to help improve student achievement.

AEAs were established by the 1974 Iowa Legislature to provide equitable, efficient and economical educational opportunities for all Iowa children. AEAs serve as intermediate units that provide educational services to local schools and are widely regarded as one of the foremost regional service systems in the country.

AEA budgets include a combination of direct state aid, local property taxes and federal funds. AEAs have no taxing authority. Funding appears in each local school district's budget and "flows through" the school budgets

Local School Systems also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Plans and 504 plans for children identified as eligible individuals.

The Iowa Department of Education, in collaboration with area and local education agencies, is implementing the Learning Supports Initiative.

Learning Supports are the wide range of strategies, programs, services, and practices that are implemented to create conditions that enhance student learning. Learning supports:

- promote core learning and healthy development for all students,
- are proactive to prevent problems for students at-risk and serve as early interventions and supplemental support for students that have barriers to learning, and
- address the complex, intensive needs of some students.

Department of Education Suicide Prevention Taskforce

The Iowa General Assembly passed legislation in 2013 that directed the Iowa Department of Education to study development of training in suicide prevention and trauma-informed care for licensed educators. The Department of Education has convened a taskforce of stakeholders, including mental health providers, educators, and representatives from other state agencies, including representatives from the SMHA and SSA, and will submit a report to the General Assembly by Dec.15, 2013 with finding and recommendations regarding such training.

SERVICES TO VETERANS

Iowa has two Veterans Administration (VA) health centers located in Iowa City and Des Moines that provide comprehensive mental health care for veterans. The VA facilities work to connect with community providers to ensure that veterans, service personnel and

their families have access to appropriate care and services. In August 2013, the Central Iowa VA Health System held a veterans mental health summit with a wide range of community providers. The purpose of the Mental Health Summit was to enhance the mental health and well-being of Veterans and their family members through increased collaboration between the VA and the community. The goal was to engage in active dialogue on how the community can address the mental healthcare needs of Veterans and their families.

The objectives/topics of discussion of the Mental Health Summit were:

- 1.) Increase awareness in the community regarding the unique mental health needs of Veterans and the services provided by the VA to meet those needs.
- 2.) Increase Veteran utilization of VA services.
- 3.) Identify community-based programs and services to support the mental health needs of Veterans and their families.
- 4.) Educate and train community-based providers and future providers about the mental health care needs of Veterans and their families.
- 5.) Strengthen VA and community relationships.

The SMHA was represented at the summit. Interest was expressed in offering Mental Health First Aid training to veterans and their families to increase awareness of mental health issues and help individuals gain confidence in addressing those issues. The SMHA will continue to work with the VA and other partners on serving this population.

Veterans are also represented on the Mental Health Planning Council and the Mental Health and Disability Services Commission. The veterans' representatives offer information and insight into the unique mental health needs of veterans.

SERVICES TO HOMELESS INDIVIDUALS

DHS's Mental Health and Disability Services Division (the State Mental Health Authority) directly assists homeless individuals with mental health issues by administering the Projects for Assistance in Transition from Homeless (PATH) program. It is a formula grant program administered by SAMHSA. Iowa will receive a \$316,000 grant for state fiscal year 7/1/2013- 6/30/2014.

Federal PATH funds are used for outreach, screening and diagnostic treatment, staff training, short-term case management, some housing services, and referrals for primary health care, job training, educational services, and housing. DHS-MHDS administers contracts with six provider agencies located in Des Moines, Waterloo, Cedar Rapids, Davenport, Iowa City, and Dubuque. Provider allocations vary from \$35,779 to \$63,144 for SFY 2014. In recent years each provider agency exceeded goals for numbers of individuals contacted, engaged and enrolled in the program; percent of individuals enrolled that are literally homeless; and percent of enrollees that receive community mental health services. The agencies predict that this state fiscal year they will contact and engage 1308 individuals, enrolling 966 of them in PATH services.

The Iowa Council on Homelessness staffed by the Iowa Finance coordinates homelessness services statewide. The SMHA has a voting member on the council. The state mental health authority does not directly fund or manage any programs providing services to individuals in emergency shelter, temporary housing, or permanent supportive housing, but it does work closely with and collaborate with the Iowa Finance Authority, the Iowa Council on Homelessness, the three Iowa housing continuums of care, and local public housing authorities in providing services to homeless Iowans with mental illness.

DHS-MHDS does not directly fund or manage services targeted specifically to homeless youth, but it does collaborate with the Department of Human Services, - Division of Adult, Children, and Family Services, the Iowa Department of Education, and with the organizations listed in the above paragraph to assure that homeless or at-risk youth with behavioral illnesses have access to all the mainstream services that other youth have.

S.O.A.R- SSI/SSDI Outreach, Access, and Recovery

SSI/SSDI Outreach, Access, and Recovery (S.O.A.R.) is a national project to provide intensive assistance in applying for Social Security disability benefits for adults that are (a) homeless or at risk of homelessness and (b) meet Social Security criteria for “unable to work because of disability. SMHA staff provide leadership in training providers across the state to assist individuals to apply for disability benefits. These benefits help individuals with serious mental illness and other disabilities obtain access to stable housing and health care.

The national SSI/SSDI approval rate for homeless individuals with serious mental illness without S.O.A.R. assistance is less than 15%. National S.O.A.R.-assisted averages are 70% of applications approved and an average of 90 days to approval . In FY 12, 79% of Iowa’s S.O.A.R assisted applications were approved with an average length of 140 days to approval. FY 13 data is expected to show improvement in these statistics.

Housing Supports

Many adults with serious mental illness utilize take advantage of the “HUD Section 8 Rental Voucher Program”. This program increases affordable housing choices for very low-income households by allowing families to choose privately owned rental housing. The public housing authority (PHA) generally pays the landlord the difference between 30 percent of household income and the PHA-determined payment standard, - about 80 to 100 percent of the fair market rent (FMR). The rent must be reasonable. The household may choose a unit with a higher rent than the FMR and pay the landlord the difference or choose a lower cost unit and keep the difference.

Certain IDPH-funded substance abuse treatment providers, including Women and Children programs, offer HUD Section 8 housing. Specific housing supports are also covered under the Access to Recovery program.

Home and Community Based Services Waiver Rent Subsidy Program

Rental subsidies are available to various disability populations in the state through the home and community-based waiver programs including: Ill and Handicapped; Elderly; AIDS/HIV; MR; Brain Injury and, Physical Disabilities Waivers. The overall purpose of this program is to encourage and assist persons who currently reside in a medical institution to move to and live in community housing. Iowa like most other states, does not have a waiver specifically targeted to individuals with mental illness; consequently, it is difficult if not impossible for individuals with mental illness to take advantage of this potentially important opportunity.

SUPPORTED EMPLOYMENT/EMPLOYMENT SERVICES

Since 2010, Iowa has been working with Community Mental Health Centers on improving employment outcomes and supported employment participation. Technical Assistance was provided to these centers through monthly conference calls where connections were made to local and state resources. In 2012 a project on self-employment options concentrated on CMHC consumers and staff through seminars and webcasts. Several staff members of these centers participated in the webcast, seminars, and certificate trainings on Supported Employment for Mental Illness provided by Virginia Commonwealth University and Griffin-Hammis and Associates. Seven community mental health centers have implemented supported employment programs with the assistance of MHBG funding.

The MHDS system redesign legislation and stakeholder input process has had an important impact on our work to improve employment services and supports. The core services required in Iowa's new regional structure has a strong emphasis on community inclusion and employment grounded in Olmstead principles.

DHS has engaged employment service stakeholders in the process of rebalancing Iowa's disability employment services. The goal is to expand the array of employment services available, so more Iowans with disabilities are employed in integrated community jobs at prevailing wage. One hundred fifty two (152) people attended public forums held throughout Iowa to solicit input from diverse stakeholders. Out of that process an intensive workgroup of providers, family members, case managers, county representatives, and funders was formed to delve into employment service definitions, capacity building, and funding methodology. This workgroup has technical assistance provided by national subject matter experts affiliated with the U.S. Department of Labor Office of Disability Employment Policy (ODEP) and the State Employment Leadership Network (SELN). This work will continue with ongoing collaboration among Iowa Vocational Rehabilitation Services, Iowa Department for the Blind, Iowa Department on Aging, Iowa Department of Education, Iowa Workforce Development, and the Medicaid and the Mental Health and Disability Services divisions of DHS. The outcome goal for this work is "A service and funding system that is individualized and flexible over the person's employment lifecycle and that coordinates the use of all available resources toward individual jobs."

The State of Iowa has developed an effective, collaborative working relationship with eight state partner agencies to identify and resolve barriers related to employment services for individuals with disabilities. These State partners, who meet on a quarterly basis, include the Department of Education, Iowa Vocational Rehabilitation Services (IVRS), Department of Human Rights, Department for the Blind, Department of Human Services, Iowa Department of Workforce Development, Iowa Department of Aging, and the Iowa Developmental Disabilities Council. A Memorandum of Agreement (MOA) further strengthens this partnership and demonstrates a commitment to enhancing employment services for Iowans with disabilities through the ongoing activities of the Governance Group and through the commitment of staff and resources to a statewide Operations Team to maintain communication and feedback from the field offices.

Iowa Vocational Rehabilitation Services (IVRS) works closely with students and their families to help the students develop career goals and a plan of action to assist the student in achieving their employment goal. Students can begin working with a trained Vocational Counselor during their sophomore year of high school. Services provided are specific to the students needs to achieve their employment goal, but may include: assessments activities, career exploration, work experiences, college preparation, support services, financial assistance and job placement.

PROVIDERS OF MENTAL HEALTH SERVICES

Community Mental Health Centers and other Mental Health Service Providers

Community mental health centers and other mental health service providers who act in lieu of a community mental health center are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 30 CMHC's in Iowa which provide mental health services to adults and children, with the exception of two CMHC's in Polk County, one of which serves only children and one which serves adults. Approximately 45 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHC's receiving MHBG funding, Iowa law mandates that CMHCs receiving MHBG funds use them for the development and implementation of evidence based practices and direct services to individuals. The CMHC identifies through their contract with the state how the organization will serve adults with an SMI and children with an SED.

EBP's and best practices supported in SFY13 through the MHBG include:

- Peer support services
- Trauma-informed care
- Co-occurring/multi-occurring capability
- Mental Health First Aid (MHFA)
- Parent Child Interaction Therapy (PCIT)
- WRAP services
- Motivational Interviewing
- Cognitive Behavioral Therapy (CBT)
- School-Based Mental Health

- Eye Movement Desensitization and Reprocessing (EMDR)
- Suicide Prevention
- Supported Employment
- Dialectical Behavior Therapy (DBT)
- Illness Management and Recovery (IMR)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

CMHCs serve a defined catchment area, ranging from one county to seven counties. Other Mental Health Service Providers generally serve a specific geographic area. These agencies may be accredited to provide any of the following services: partial hospitalization, day treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient, emergency, and evaluation. Rules for the accreditations are found in Iowa Administrative Code 441--Chapter 24. Community mental health centers, targeted case managers, and certain mental health providers are accredited by the SMHA.

Federally Qualified Health Centers

Iowa presently has 14 Federally Qualified Health Centers (FQHC's). These FQHC's are present in 24 counties. There are also enrolled providers in three of the neighboring states (Nebraska, South Dakota, and Illinois) which benefit individuals needing health care in the most western and most eastern portions of Iowa. FQHC's receive an actual cost reimbursement for Medicaid patients rather than the established rate of reimbursement. To qualify to be an FQHC, the clinic agrees to treat all that present, regardless of insurance or method to pay for services. This has become a valuable resource for adults and families that may not have any insurance coverage and do not qualify for any of the Medicaid programs. FQHC's also provide screening and referral to behavioral health services and in some instances, provide direct behavioral health services. Iowa has one agency that is qualified as both an FQHC and a CMHC, encouraging coordinated care for individuals with co-occurring health and mental health needs.

Mental Health Professionals Statewide

There are approximately 243 psychiatrists, in the State of Iowa, with 39 identified as child psychiatrists, according to the University of Iowa Carver College of Medicine as of January 2013. The majority of psychiatrists practice in metropolitan or urban counties. A secondary concentration is found in or near those counties with a psychiatric institution, an MHI or a VA Hospital. There are, according to the professional licensing boards' website: 603 licensed psychologists; approximately 60 Nurse Practitioners and Physicians Assistants with a Mental Health Specialty; 4,162 social workers which includes those at the independent (requires a master's in social work and additional experience), bachelor, and master's levels. There are 234 licensed marital and family therapists and 995 licensed mental health counselors, including temporary and fully licensed counselors and therapists.

The Iowa Department of Public Health /Board of Medical Examiners is responsible for regulating medical and osteopathic doctors. The Iowa Department of Public Health,

Bureau of Professional Licensure licenses mental health professionals such as social workers, mental health counselors, and psychologists.

Mental Health Shortage Area Designation

As of August 2013 the Health Resources and Services Administration listed 89 Iowa counties as having a Health Professional Shortage Area designation for Mental Health. Only 10 Iowa counties were not designated. These counties are in or near the larger urban areas.

Lack of access to qualified mental health professionals at all levels is an identified gap in the service system.

CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

The Iowa Department of Human Services is designated by Iowa Code 225C.52 as the lead agency responsible for the development, implementation, oversight, and management of the mental health services system for children and youth with those responsibilities to be carried out by the Division of Mental Health and Disability Services, the State Mental Health Authority. The SMHA also oversees three Systems of Care in Iowa which serve 14 of Iowa's 99 counties. Other regions and counties in Iowa are at differing stages of development regarding Systems of Care for children. Several counties and mental health centers are attempting to build community support and blend available funds in order to support System of Care development.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of the Department of Human Services, each with their own eligibility, funding, and limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as some areas may have a larger service array and more financial investment in children's mental health services.

The Iowa Department of Human Services includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:

- The State Mental Health Authority (the Division of Mental Health and Disability Services)
- The State Child Welfare Authority (the Division of Adult, Children, and Family Services)
- The Division of Field Operations which oversees local service areas and De-categorization boards, and
- The State Medicaid authority (Iowa Medicaid Enterprise).

Additional state and local agencies which have funding, service, or regulatory responsibility within the children's mental health system include:

- The Juvenile Court System,
- Department of Education which includes Area Education Agencies and public and private Local Education Agencies,

- Department of Public Health which includes Title V agencies such as the Child Health Specialty Clinics, and Iowa’s Project LAUNCH program for children ages 0-8 who lives in a statistically high poverty area in Polk County.
- Department of Human Rights,
- Department of Inspections and Appeals,

Children in need of mental health services have multiple access points by which they may enter the service system. While this is a strength of the system, it can also make it difficult for families to navigate the system. Families are not always aware of the array of services and may choose higher-end, more restrictive types of care because that is what they are aware of, or that is what is most readily available. Private mental health providers of psychiatric and clinical services are available to individuals with Medicaid, as well as those with private insurance. Behavioral health intervention services –BHIS- are available to children who are Medicaid eligible. BHIS provides skill building services to children with a mental health diagnosis who are in need of additional services beyond traditional clinic-based therapy and/or medication management.

Iowa has a shortage of child psychiatrists with only 39 child psychiatrists in the state. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs. The Community Circle of Care System of Care operated by University of Iowa Child Health Specialty Clinics operates a program to offer psychiatric consultation to primary care doctors who treat children with mental health issues, in order to support the medical home model and allow children to receive needed health and mental health services from their primary health care provider.

Private clinics and individual providers are not required to be accredited by the SMHA. There is no Central Point of Coordination for children at the local level to provide coordination of children’s services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children’s system.

Iowa has moved to consolidate management of Medicaid mental health services under the managed mental health care organization. Previously certain children’s mental health services including PMIC, the Children’s Mental Health Waiver, and BHIS were managed directly by Medicaid, while other outpatient and inpatient mental health services were managed through Magellan. The goal for this change is to improve quality of services, coordination of clinical and other services, and to improve outcomes for those clients who receive this service.

SYSTEMS OF CARE

Central Iowa System of Care, Community Circle of Care, Four Oaks System of Care
The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), and Four Oaks System of Care serve children and youth ages 0-21 who are diagnosed with a

mental health disorder and meet the criteria for Serious Emotional Disturbance. CCC was a SAMHSA and state funded program until Sept. 30, 2012 when the SAMHSA grant ended. The program has continued with state funding. CISOC and Four Oaks are both funded by state appropriations. The children and youth served by these programs are assessed to be at high risk of involvement with more intensive and restrictive levels of treatment due to their serious behavioral and mental health challenges. All programs provide the following services:

- Care Coordination
- Parent Support Services
- Wraparound Family Team Meeting
- Flexible Funding

The purpose of the SOC program is to help the identified child remain successfully in, or return to, their home, school, and community unless safety or clinical reasons require more intensive services. Families referred to an SOC are often at the point of requesting assistance from the court or child welfare system or are seeking PMIC placement. SOC services offer a community-based alternative to children who are at risk of out of home treatment and their families. If out of home services are recommended, the program can remain involved with the family to support the child's return to the family home by providing ongoing coordination and parent support. In some cases, this ongoing support can help shorten the length of stay in out of home treatment. Services provided include care coordination, access to clinical mental health services, wraparound and family team facilitation, family peer support, and funding for flexible services that strengthen the child's ability to function in the home, school, and community.

Referral sources for SOC programs include parents, DHS Child Welfare, Juvenile Court Services, PMIC's, therapists, and other mental health service providers.

CCC directly served 1,353 children and youth in SFY 13 in a ten county area. CISOC directly served 136 children and youth in a two county area. Four Oaks served 63 children in SFY 13. Outcomes for the Systems of Care programs demonstrate improved stability of living situation, improved school attendance and performance, and diversion from involuntary mental health commitment.

The SOC programs are in a state of transition as Iowa develops Integrated Health Homes for children with an SED. All three programs have enrolled with Magellan Health Services as Integrated Health Homes in four of the initial five counties of the phased implementation. The IHH program allows children with Medicaid whose care coordination was previously not a billable Medicaid service to be served through the IHH program. The SOC programs are using their expertise in providing flexible, family driven care to be the first IHH sites for children in Iowa. All three programs continue to provide care coordination services for non-Medicaid children in their geographical areas using state dollars in addition to providing IHH services for Medicaid-eligible children.

Other areas of the state are at varying stages of Systems of Care development. A statewide System of Care Resource Team comprised of stakeholders of planned and existing Systems of Care and wraparound projects meets on a regular basis to work on system development issues, training of providers, consistency among programs, legislative issues related to children's mental health and networking and information sharing among providers.

In SFY 14, Iowa was awarded a SAMHSA System of Care Expansion Planning Grant. The purpose of the grant is to support Iowa in developing a plan for expansion of the System of Care through the IHH framework. Iowa will form a planning team made up of SOC leaders, family and youth, community stakeholders and other state partners to develop the statewide plan. A focus of the grant is also on developing cultural competency in Iowa's mental health system as well as increasing wraparound skills through implementation of a statewide training program. Iowa is just beginning this planning process but is excited about the opportunities to develop a long-term plan for development of a statewide system of children's mental health services and supports.

SERVICES TO YOUTH AGING OUT OF FOSTER CARE/TRANSITION AGE YOUTH

Independent Living/Aftercare/PALS

On or before the date a child in foster care reaches the age of sixteen, the Iowa Department of Human Services engages the Independent Living Program, which is intended to help the child transition successfully from the foster care system to adulthood. Children in foster care often do not have sufficient support from parental figures and frequent change impedes the development of skills to live successfully in adulthood. Compounding their challenges, over 50% of children who "age out" of foster care have a diagnosed mental health condition.

Aftercare is a statewide program which includes pre-exit planning (up to 6 months prior to youth "aging out" of foster care) and case management services for youth ages 18 through 20 who have "aged out" of foster care or a PMIC. Aftercare also includes an assessment for independent living skills, life skills training, and referrals to appropriate community resources. Financial Assistance may be available to assist with one time or crisis needs for help purchasing housing, clothing, transportation, medical needs, food, day care, etc. Regular payments are provided to aftercare participants who attend work or school and meet certain program requirements. These funds are referred to as Preparation for Adult Living, or PAL, and help with rent, transportation, or other needs determined by the youth to move them closer to self sufficiency. Aftercare program eligibility requires that the young adult meet regularly with a case manager, participate in a self-sufficiency plan, develop goals, and participate in an education or training program or employment. The program is voluntary.

Iowa's county and regional mental health and disability services systems are also becoming more involved in ensuring smooth transitions from child to adult services systems. In the new regional system currently being formed, individuals can receive

services in the adult system three months before the age of 18 to allow them to move into the adult system in a planned manner. Several statewide summits and trainings have been held in the last two years addressing youth with disabilities and their transition needs. More training is planned to ensure that children and youth with mental health needs and other disabilities do not fall into gaps but rather have full access to available services and supports. The Integrated Health Home program is also expected to improve transitions as more individuals will have access to care coordination than have had before, and will have more opportunity to be provided appropriate transition services.

4. RECOVERY SUPPORT SERVICES

Peer Support Services have grown tremendously in Iowa and across the nation. Peer Support is an evidence-based practice which has been widely recognized by the Substance Abuse and Mental Health Services Agency (SAMHSA) and the Centers for Medicaid and Medicare Services (CMS). Peer Support Services are Medicaid billable in Iowa. In Iowa, Peer Support services are authorized through the managed care entity, Magellan Health Services. In SFY13, 525 individuals received Medicaid or state payment program funded peer support. This was an increase of almost 100 individuals from SFY 12 and it is expected that the demand for this service will continue to increase as Integrated Health Homes offer increased awareness and access to family and adult peer support services

This year, the Division of MHDS plans to contract for an entity to provide technical assistance, oversight, and build on the work already done toward development of a certification process for family peer support and adult peer support. As peer support specialists are required members of care coordination teams through the Integrated Health Homes which will be available statewide, Iowa is experiencing increased demand for trained peer support specialist and has identified as a need the importance of statewide consistent standards of training and certification.

In the substance use disorders system, Recovery Peer Coaching is a key service in IDPH's Access to Recovery program. IDPH has conducted several trainings based on the Connecticut Community of Addiction Recovery model, conducted by CCAR staff. SSA staff have been approved by SAMHSA and CCAR to become trainers of the CCAR Recovery Coaching Academy and Trainer of Trainers curriculum, one of only two states to be granted this honor.

Supported Community Living Programs

Supported Community Living Programs are accredited by the Mental Health/Disabilities Division of MHDS, the Department of Human Services, to provide supervised supported living to persons with disabilities. There are 90 accredited programs which currently provide services to persons with various disabilities.

These programs may be provided in residential institutions but most provide in-home services and supports to persons with a mental illness and other disabilities living in their own homes. Supported Community Living programs operate in every county of Iowa.

Illness Management Recovery (IMR)

Another program targeted at reducing hospitalization is Illness Management Recovery (IMR). This program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personalized strategies for managing mental illness and achieving personal goals. The program can be provided in an individual or group format, and generally lasts between three to six months. It is designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression. Some of the components of IMR are:

- Recovery strategies
- Practical facts about schizophrenia, bipolar disorder and major depression
- The stress-vulnerability model and treatment strategies
- Building social support
- Using medication effectively
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

As part of Iowa's redesign of the mental health and disability service system, IMR was identified as an EBP that must be available in each MHDS region or county approved to operate as a region.

Intensive Psychiatric Rehabilitation

Intensive Psychiatric Rehabilitation program incorporates recovery-oriented principles as part of a public sector managed care carve-out. IPR is guided by the values of consumer involvement, empowerment, and self-determination. Its mission is to provide enhanced role functioning accomplished through strategies for readiness, skill, and support development.

IPR provides services to adults with a serious and persistent mental illness who are interested in making a community 'role recovery' within the next six months to two years. The concept of role recovery is to engage or re-engage individuals in personally meaningful community roles. The purpose of intensive psychiatric rehabilitation services is to assist the person to choose, obtain get and keep valued roles and environments. The four specific environments and roles in which psychiatric rehabilitation will assist the individual are living, working, learning, and social interpersonal relationships.

Respite

Children and adults who access respite services typically do this through one of the HCBS waiver programs, including the Children's Mental Health Waiver for children identified with an SED. Respite providers must be approved to be a Medicaid provider. For children served by Systems of Care, respite is also a key service requested by families. The Systems of Care have provided funding for families of children with SED in need of this service who are not receiving waiver services.

Wellness Recovery Action Plan

The Wellness Recovery Action Plan (WRAP) model is a person-driven program, which educates clients to manage illness and become active partners in their recovery. Three community mental health centers are utilizing MHBG funds to develop WRAP capability for adults, and one CMHC is utilizing MHBG funds to develop capability for WRAP for children/youth.

Consumer Organizations

The **Office of Consumer Affairs** is supported by the Mental Health Block Grant and offers a variety of services and supports to persons and families with behavioral health recovery and disabilities challenges, other state agencies, providers. The Office of Consumer Affairs:

- Serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving, and system navigation.
- Provides input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa.
- Provides an advocacy voice to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons and families with behavioral health recovery and disabilities challenges.
- Assists DHS staff and contractors with disseminating information and gathering feedback from end users of behavioral health services and systems in Iowa.

Each of the five DHS service areas is served by a Regional Coordinator with further support offered by regional Advisory Committees comprised of persons and families with behavioral health recovery and/or disability experience. The Office Director and a statewide Advisory Committee function to consolidate the activities of regional committees and coordinators.

Iowa Advocates for Mental Health Recovery (IAMHR) is a statewide consumer advocacy network founded by and for adults with serious mental illness and other life challenges. Iowa Advocates for Mental Health Recovery is also the contractor for the Office of Consumer Affairs through the SMHA. IAMHR is a member of the National Coalition for Mental Health Recovery, committed to working for all persons “seeking to regain something lost” and/or “working toward a positive future.” It is the mission of IAMHR to “create opportunities for advancing hope and recovery for all by transforming our community, and the mental health system it reflects, to one of respect and trust by educating, advocating and empowering.” IAMHR was founded in April of 2007. Currently IAMHR serves people in recovery through direct membership and through indirect service such as education, advocacy and social inclusion efforts.

The **Depression and Bipolar Support Alliance (DBSA)** is the leading patient directed national organization focusing on the most prevalent mental illnesses. Since 1985, DBSA has worked to provide hope, help, and support to improve the lives of people living with depression, bipolar disorder, and other mental illnesses with common symptoms. DBSA pursues and accomplishes this mission through peer-based, recovery oriented, empowering services and resources when people want them, where they want them, and how they want them.

DBSA in Iowa has six local chapters and an incorporated statewide organization. There is no such thing as official membership, although each chapter has elected officers and facilitators to run the group. Each chapter chooses how it would like to operate within the DBSA guidelines, but each chapter does have a mental health professional advisor who may or may not attend meetings. There is no charge to attend meetings, and attendance is completely voluntary. Meetings vary in size, from as few as three to as many as forty. Most of the people who attend on a regular basis show improvement in their ability to cope with their illness.

National Alliance on Mental Illness (NAMI) is a 501c3 non-profit organization offering support, education, and advocacy to persons, families, and communities affected by mental illness. The NAMI organization operates at the local, state and national levels and is the largest grassroots organization of its kind working on mental illness issues.

Local and state affiliates work with the following centers at the National Office:

- Policy and Research Institute,
- Crisis Intervention Team (CIT) Technical Assistance Resource Center,
- Child and Adolescent Action Center,
- Multi-Cultural Action Center, and the
- Education, Training and Peer Support Center - NAMI offers 8 educational and support programs and offers these programs at no cost to families, consumers, and mental health and school professionals.

Besides the state office, Iowa has 12 local affiliates and 6 support group organizations. Each local affiliate offers a variety of educational activities and support groups for consumers, family members, and parents/caregivers of children and adolescents with severe emotional disorder. Local affiliates and the state organization identify and work on issues most important to their community and state. The goal is to free people with mental illnesses and their families from stigma and discrimination, and to assure their access to a world-class mental health treatment system to speed their recovery.

The NAMI Basics class is a six-week class for parents and caregivers of children and adolescents with severe emotional disorders. Caregivers may be parents, extended family, or foster parents. Teachers of the program are trained family members who have experienced firsthand the rewards and challenges of raising children with brain disorders.

The Iowa Federation of Families for Children's Mental Health (IFFCMH) is a statewide network of families of children and youth who have serious emotional

disturbances and behavioral disorders. The mission of IFFCMH is to ensure families have access to a comprehensive, coordinated, individualized, strength-based system of care in which they are seen as partners in determining the nature and volume of care provided, and that communities are supportive of families with children who have emotional/behavioral challenges. The IFFCMH Director is a member of several statewide boards, councils, and committees addressing state system level change.

Access for Special Kids (ASK) Family Resource Center is a "one-stop-shop" for children and adults with disabilities and their families. Through its partner organizations, ASK Resource Center provides a broad range of information, advocacy, support, training, and direct services. These services are all accessible in one building or from one phone call. A single contact can direct individuals or families to the most appropriate services and supports to meet their needs. Access for Special Kids identifies its primary focus as offering information and resources for the benefit of children with disabilities and their families throughout the state of Iowa.

Parent Training and Information Center of Iowa (PTI) is a federally funded grant project from the U.S. Department of Education that focuses on the educational needs of children with disabilities in Iowa, particularly those who are underserved or may be inappropriately identified.

In addition to technical assistance to families, PTI also provides training on the Individuals with Disabilities Education Act (IDEA). The goal is to help parents better understand the Individual Education Program (IEP) and Individual Family Support Program (IFSP) process and become better advocates for their children.

There is no cost for information and training provided to families. Shared costs may be requested for services to professionals and others. Services provided include information and training on IDEA, skills to effectively participate in the IEP process, communication strategies to help improve family/ school relationships, information on family support, disability types and rights.

The **Iowa Coalition on Mental Health and Aging** is an initiative that was originally funded and given a great deal of support by the Division of MHDS. The Coalition was formed in 2005 and was funded with varying amounts of mental health block grant dollars from 2005 - 2011. The ICMHA continues to exist, but has scaled back activities dramatically in the absence of ongoing funding. ICMHA exists to expand and improve mental health care for older Iowans so that they can live, learn, recreate, engage in meaningful activities and access appropriate services in the communities of their choice. The three primary goals of the Coalition are as follows:

1. Make mental wellness for older adults a priority for public policy makers.
2. Promote mental wellness among aging Iowans with emphasis on prevention, early intervention, evidence based treatment and recovery.
3. Increase the number of qualified providers of evidence based mental health services to older adults.

The Division of MHDS had a contract with the University of Iowa, Center on Aging, to support the work, the tools, and the website of the Coalition, www.icmha.org. The leadership team for the ICMHA has recently resumed having frequent meetings in hopes of re-energizing the education and training efforts of the Coalition. Participants include: the Division of MHDS, the University of Iowa, the Department on Aging, Iowa's aging services network, and Magellan Health Services. During 2010, the Coalition joined the National Coalition on Mental Health and Aging, which has a membership of over thirty organizations, all collaborating to address this most rapidly growing segment of our population. Iowa remains an active member in this national organization. The membership of the ICMHA includes over 500 individuals across Iowa.

Access to mental health services by persons over the age of 60 remains the lowest among all population groups, despite the fact that Iowa's aging population is growing more rapidly than any other segment of the population. As of July 1, 2010, Iowa's managed behavioral health care provider, Magellan Health Services, was contracted by the state Medicaid authority, to manage mental health and substance abuse services to Medicaid members over the age of 64. This population has previously been carved out of the managed care system, but now many more individuals over age 60 can access the wider array of appropriate services that are available under Medicaid managed care, including ACT, Peer Support, and mobile counseling services.

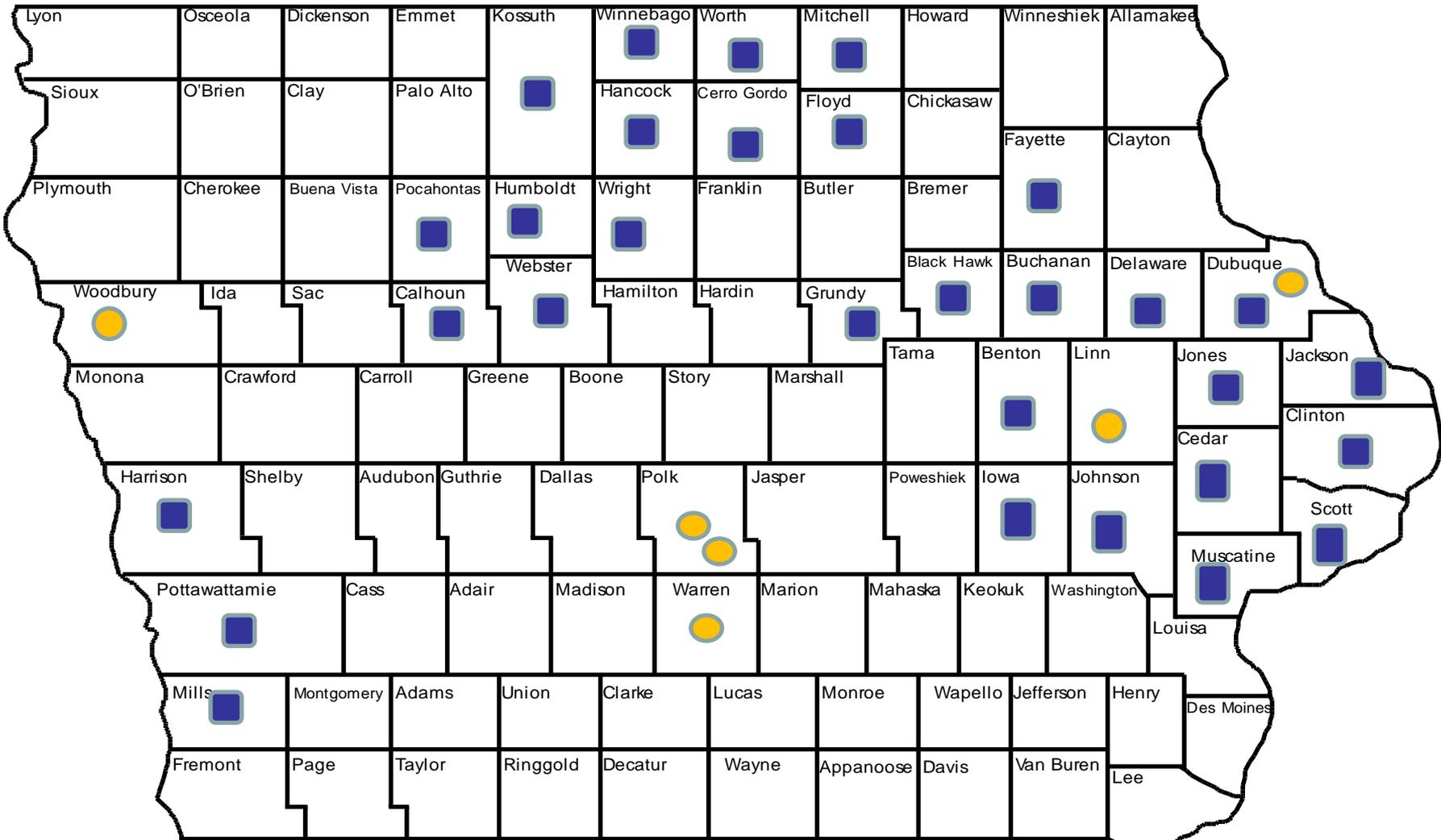
During SFY11, the ICMHA was contracted to develop and implement a statewide survey regarding training needs in the area of aging and mental health, targeting direct care workers, long-term care and aging services providers, as well as traditional mental health and substance abuse providers. Results indicated that 317 responses were received: 42% of respondents were direct care providers and 58% were administrators, program managers, or other non-direct care providers. A full report on the results was disseminated in March of 2012. "Older Iowans with Behavioral Health Needs: Survey of Current Context and Training Activities, Executive Summary and Recommendations," can be found on the website. Please visit: www.icmha.org to see the full report.

The ICMHA has hoped to respond to the needs identified within the report by delivering training throughout the state around the identified areas. No training has been launched at this time. However, through other efforts in collaboration with the Department on Aging, and around Iowa's implementation of PASRR, many training opportunities that may enhance the capacity of Iowa's long term care providers to understand older adult mental health issues and needs have moved forward.

The Iowa Department on Aging (IDA) has a significant collaborative and policy relationship with Iowa's Area Agencies on Aging (AAA), covering all 99 counties. The AAA's have a strong statewide membership organization, the Iowa Association of Area Agencies on Aging (IAA). In 2012, new legislative requirements caused the restructuring of Iowa's AAA's into a new regional structure, with six regions as opposed to the prior thirteen service areas. This restructuring of the AAA's coincides with the many MHDS

redesign efforts taking place within the State. The leadership of the IDA has been solid and active participants in the MHDS redesign efforts and as a result of these many new changes, new and stronger partnerships have been formed between the DHS and the IDA. IDA is partnering with DHS and AAA's in the development of the Aging and Disability Resource Centers, which will be housed within the newly reconfigured AAA regions.

Beginning in 2009, the largest AAA in Iowa, Aging Resources in Des Moines, began piloting two evidence-based models for improved mental health of older adults that they serve. Healthy IDEAS and PEARLS programs have both been implemented and trainings have taken place with staff of AAA's in all areas of the State. It appears there will be an increased focus and availability of these mental health services through the aging services network and improvements in the ability to meet older adult mental health needs as the ADRC efforts move toward full implementation in 2013 and 2014.



Magellan Iowa IHH SPA Phases

- Phase 1
July 1, 2013
- Phase 2
- Phase 3 (all other counties)
July 1, 2014

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2-Identify the unmet service needs and critical gaps within the current system

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

Identified needs and gaps within the current system

Through meetings with the Mental Health Planning Council among other information-gathering activities, the following concerns and system gaps were identified.

- Development of integrated health homes for children with an SED and adults with a SMI- implementation, training needs for required family and peer support staff
- Evidence-based practices- how to implement with fidelity, concerns about implementation costs
- Implementation of the Affordable Care Act in Iowa and changes to existing Iowa Care program
- Lack of mental health services in correctional facilities and jails due to funding cuts
- Lack of options after individuals leave inpatient psychiatric care
- Legislative requirements for new regions to meet co-occurring, trauma-informed care, and evidence-based practice standards
- Limited numbers of mental health courts in Iowa
- Mental health training for law enforcement, judicial staff, educators, medical professionals
- Need for crisis intervention training for community-based service providers
- Need for more youth suicide prevention and anti-bullying programs
- Need for more assistance for homeless veterans
- Ongoing need for peer support training and standards
- Provider access to information and health technology improvements
- Underserved populations/cultural competency of the system
- Workforce issues-lack of access to mental health professionals and psychiatric care

From this list, Iowa identified three priorities that align with state goals for redesign of the mental health system, current state initiatives, and priorities of the MHBG.

Children with Serious Emotional Disturbance-Identified Needs

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2011, it is estimated that approximately 40,018 children in Iowa meet the criteria of serious emotional disturbance. The following table illustrates numbers of children receiving services targeted toward children identified with an SED. The table demonstrates that the services specifically identified for the SED population are serving a small portion of the estimated SED population.

Service targeted toward children with an SED	Number of children who received the service in SFY 13	Percent of the prevalence estimate of children with an SED who received the service
Children's Mental Health Waiver	1,159 (ages 0-up to age 18)	2.8%
Systems of Care	1,552 (ages 0-21)	3.8%
PMIC	975-MH PMIC (ages 5-21)	2.4 %

Increasing numbers of families are on the waiting list for the Children's Mental Health Waiver. The waiting list is currently over 1,411. (Iowa Medicaid Slot Waiting List July 2013). Because of a combination of factors including limited waiver slots, lack of coordinated care, limited access to community-based services if not Medicaid-eligible, lack of providers able to manage behaviors of children with SED, children with serious emotional disturbance are at risk of higher-intensity, out of home treatment and placement.

Iowa is in the beginning stages of implementing Integrated Health Homes for Medicaid-eligible children with a Serious Emotional Disturbance. Iowa Medicaid has identified approximately 16,000 children with an SED across the state who are eligible for Integrated Health Home Services based on mental health diagnosis and evidence of functional impairment. A total of 45,964 children received at least one mental health service through the Iowa Plan (managed mental health care for Medicaid-eligible individuals) in SFY 13.

Iowa is developing Integrated Health Homes for children with an SED based on System of Care (SOC) principles and practices to address the need for coordinated services and supports for Iowa's children with serious mental health issues. Iowa is using the former SAMHSA-funded SOC program through the University of Iowa Child Health Specialty Clinics to provide technical assistance and coaching of the new Integrated Health Homes. It is a priority for Iowa that the new Integrated Health Homes operate using the principles of family driven, youth guided care with the goal of helping children remain in their homes, schools, and communities, and families remain together. Iowa has also received a SAMHSA System of Care Planning Expansion Grant to help create a plan for the development of a statewide SOC using Integrated Health Homes and System of Care principles and practices as the basis for a statewide system.

It was the recommendation of the legislatively mandated Children's Disability Workgroup that Iowa develop these Integrated Health Homes for all children in need of coordinated services. Iowa is starting this process with Medicaid eligible children and a small number of non-Medicaid eligible children funded through State SOC funds to receive IHH care coordination services.

Iowa identifies continued development of a statewide children's mental health system based on System of Care principles as a priority activity.

**Adults /Older Adults with Serious Mental Illness/Children with an SED
Co-occurring/complex needs training and technical assistance**

Major depressive episodes in lifetime or past year were assessed in SAMHSA's National Survey on Drug Use and Health among adults aged 18 or older. Combined data from SAMHSA's 2004

and 2005 National Surveys on Drug Use and Health were used to examine co-occurring alcohol use and depression as well as treatment for these disorders in adults aged 18 or older.

The following prevalences were found:

An estimated 7.6% of adults aged 18 or older (approximately 16.4 million adults) had experienced at least one major depressive episode during the past year.

An estimated 8% (17.3 million adults) met criteria for alcohol use disorder in the past year. An estimated 1.2% (2.7 million adults) had co-occurring major depressive episode and alcohol use disorder in the past year.

- Among adults with past year co-occurring major depressive episode and alcohol use disorder, 48.6% received treatment only for major depressive episode, 1.9% received treatment at a specialty facility only for alcohol use disorder, and 8.8% received treatment for both problems. About 40% received no treatment.
- The rate of past year alcohol use disorder was over twice as high among adults who had experienced a major depressive episode (16.2%) compared with adults who had not experienced a major depressive episode in the past year (7.3%).

Data from the Iowa Department Public Health data system identifies that individuals in substance abuse treatment who self-identify having a mental illness have less successful treatment outcomes than those who do not identify a mental health need. This indicates that providers in the current behavioral health system may need further training and technical assistance in order to understand the unique needs of individuals with co-occurring disorders.

Co-occurring/multi-occurring conditions continue to be of concern to Iowa's providers as evidenced by the continued demand for training and technical assistance in this area. Iowa's providers are working diligently to change their organizations to be more welcoming and inclusive of individuals with complex needs. As part of Iowa's mental health and disability services redesign, regions are required to include co-occurring services in their regional management plans. Iowa has an existing technical assistance initiative through ZIA Partners that has trained numerous stakeholders across Iowa through large group trainings and targeted technical assistance. Iowa proposes to use this technical assistance to assist the new regional authorities in developing co-occurring/multi-occurring capability and competency in the state-mandated plans for their new service systems.

Adults/Older Adults with Serious Mental Illness, Children with an SED and their families Adult Peer Support Services, Family Peer Support Services

Iowa is increasing the availability of peer support through the inclusion of peer support specialists in the care coordination teams offered through Integrated Health Homes. Peer support is also a required service to be offered through the new Mental Health and Disability Regional Service systems. Use of peer support services has increased by nearly 100 individuals from SFY 12 to SFY 13. However, as the need for trained family and adult peer support specialists continues to increase in SFY 14 and ongoing due to the new programs and requirements, a gap has been identified in the consistency and types of certification offered for peer support

specialists. Training has been offered in the past through the Iowa Peer Support Training Academy. Other training programs have been developed to meet the need but there is confusion among providers regarding monitoring of training, certification, and standards.

The SMHA plans to contract for a technical assistance provider that will develop consistent training standards, certifications, and quality measures for family and adult peer support specialists. This technical assistance will help ensure that Iowa is providing effective peer support services based on consistent statewide and national standards regardless of funding source.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Increase availability and quality of services provided by peer support and family peer support specialists
Priority Type:	MHS
Population (s):	SMI, SED
Goal of the priority area:	<p>Provide a consistent system of oversight and training for peer support services. Increase the number of trained peer support and family peer support specialists available to lowans with a serious mental illness or serious emotional disturbance.</p>
Strategies to attain the goal:	<p>Iowa is in the process of implementing two major system changes that will increase access to peer support for individuals and their families. The creation of Integrated Health Homes across the state will provide access to peer support and family peer support on a statewide basis for Medicaid-eligible individuals and their families. Peer support and family peer support specialists are mandated members of the Medicaid-funded care coordination teams available through Integrated Health Homes. As part of the Mental Health and Disability Services (MHDS) Redesign, peer support and family peer support have been identified in law as core services that will be available in each MHDS region for adults not eligible for Medicaid. Iowa's managed care contractor is funding peer support training but there is recognition that oversight and technical assistance is needed on a statewide basis to improve quality and consistency of the peer support services available to lowans. Iowa proposes to release an RFP for a contract to provide the technical assistance, training, and oversight of peer support services in Iowa.</p>
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	In SFY 14, Iowa will release an RFP for technical assistance and oversight of the peer support training system
Baseline Measurement:	Iowa does not currently have standardized training expectations nor have a designated entity to identify or monitor training standards for peer support specialists.
First-year target/outcome	A contract will be executed for technical assistance and oversight of the peer support

measurement: training system.

Second-year target/outcome measurement: The contracted entity will provide technical assistance and oversight of the peer support training system.

Data Source:

Iowa Department of Human Services, Division of Mental Health and Disability Services

Description of Data:

RFP and contractual documents

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: To develop a service system that includes the capability of serving individuals with co-occurring or complex needs.

Priority Type: MHS

Population SMI, SED

(s):

Goal of the priority area:

Iowa, through the Mental Health Block Grant, will increase the mental health and disability system's capability to provide services to populations that experience co-occurring and multi-occurring conditions.

Strategies to attain the goal:

Iowa provides four opportunities annually for large -group training regarding multi-occurring and complex needs. Iowa will provide no less than two opportunities per fiscal year for each mental health and disability regional administrative authority to receive intensive technical assistance regarding development and implementation of regional management plans that include evidence of co-occurring/multi-occurring capability.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of regional management plans that include requirements for evidence of co-occurring capability in the regional mental health and disability system

Baseline Measurement: 0
First-year target/outcome measurement: 100%
Second-year target/outcome measurement: 100%

Data Source:

Iowa Department of Human Services, Division of Mental Health and Disability Services

Description of Data:

Regional Management Plans required by law to be submitted to Iowa Department of Human Services by April 1, 2014

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: 70 or more individuals representing service providers, stakeholders, and regional administrative entities will participate in technical assistance with ZIA Partners regarding co-occurring system development.

Baseline Measurement: 0

First-year target/outcome measurement: 70

Second-year target/outcome measurement: 70

Data Source:

Contractor reports of participants in technical assistance activities, SMHA contract monitoring activities which includes coordinaton and oversight of the technical assistance activities provided by ZIA Partners.

Description of Data:

Written reports from the technical assistance contractor, including a detailed list of participants and content and results of technical assistance.

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: To develop a coordinated system of care for children and youth identified with or at risk of serious emotional disturbance and their families.

Priority Type: MHS

Population SED

(s):

Goal of the priority area:

Develop a plan for development of a statewide System of Care in year 1. Begin implementation of the plan in year 2

Strategies to attain the goal:

Creation of a state planning team, engagement with families, children and youth served by the system, development of cultural competency in the children's mental health system through training and technical assistance, training and technical assistance on the use of high fidelity wraparound.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Iowa will develop a comprehensive plan for a statewide system of care for children and youth identified with, or at risk of a serious emotional disturbance and their families.

Baseline Measurement:

Iowa does not have such a plan currently. Recommendations for system development have been made to the Iowa Legislature but more input has been requested from stakeholders.

First-year target/outcome measurement:

Iowa will engage in a formal planning process for development of a plan for a statewide SOC as evidenced by production of a written system of care expansion plan.

Second-year target/outcome measurement:

Based on the recommendations included in the SOC expansion plan, Iowa will develop infrastructure necessary to support development of a statewide system. This may include increased training or technical assistance to children's mental health providers, educators, families, and other interested parties.

Data Source:

Department of Human Services, Division of Mental Health and Disability Services

Description of Data:

Written System of Care Plan for statewide expansion, documentation of activities undertaken in development of the plan including consumer and family outreach and provider training.

Data issues/caveats that affect outcome measures::

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non -24 Hour Care		\$ 1,349,744	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8. Mental Health Primary Prevention		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 1,200,000	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
10. Administration (Excluding Program and Provider Level)		\$ 337,436	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
11. Total	\$	\$2,887,180	\$	\$	\$	\$	\$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$
Specialized Outpatient Medical Services			\$
Acute Primary Care			\$
General Health Screens, Tests and Immunizations			\$
Comprehensive Care Management			\$
Care coordination and Health Promotion			\$
Comprehensive Transitional Care			\$
Individual and Family Support			\$
Referral to Community Services Dissemination			\$
Prevention (Including Promotion)			\$
Screening, Brief Intervention and Referral to Treatment			\$

Brief Motivational Interviews			\$
Screening and Brief Intervention for Tobacco Cessation			\$
Parent Training			\$
Facilitated Referrals			\$
Relapse Prevention/Wellness Recovery Support			\$
Warm Line			\$
Substance Abuse (Primary Prevention)			\$
Classroom and/or small group sessions (Education)			\$
Media campaigns (Information Dissemination)			\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$
Parenting and family management (Education)			\$
Education programs for youth groups (Education)			\$
Community Service Activities (Alternatives)			\$
Student Assistance Programs (Problem Identification and Referral)			\$
Employee Assistance programs (Problem Identification and Referral)			\$

Community Team Building (Community Based Process)				\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)				\$
Engagement Services				\$
Assessment				\$
Specialized Evaluations (Psychological and Neurological)				\$
Service Planning (including crisis planning)				\$
Consumer/Family Education				\$
Outreach				\$
Outpatient Services				\$
Evidenced-based Therapies				\$
Group Therapy				\$
Family Therapy				\$
Multi-family Therapy				\$
Consultation to Caregivers				\$
Medication Services				\$

Medication Management				\$
Pharmacotherapy (including MAT)				\$
Laboratory services				\$
Community Support (Rehabilitative)				\$
Parent/Caregiver Support				\$
Skill Building (social, daily living, cognitive)				\$
Case Management				\$
Behavior Management				\$
Supported Employment				\$
Permanent Supported Housing				\$
Recovery Housing				\$
Therapeutic Mentoring				\$
Traditional Healing Services				\$
Recovery Supports				\$
Peer Support				\$
Recovery Support Coaching				\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$
Personal Care			\$
Homemaker			\$
Respite			\$
Supported Education			\$
Transportation			\$
Assisted Living Services			\$
Recreational Services			\$
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$
Intensive Support Services			\$
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$

Assertive Community Treatment				\$
Intensive Home-based Services				\$
Multi-systemic Therapy				\$
Intensive Case Management				\$
Out-of-Home Residential Services				\$
Children's Mental Health Residential Services				\$
Crisis Residential/Stabilization				\$
Clinically Managed 24 Hour Care (SA)				\$
Clinically Managed Medium Intensity Care (SA)				\$
Adult Mental Health Residential				\$
Youth Substance Abuse Residential Services				\$
Therapeutic Foster Care				\$
Acute Intensive Services				\$
Mobile Crisis				\$
Peer-based Crisis Services				\$

Urgent Care			\$
23-hour Observation Bed			\$
Medically Monitored Intensive Inpatient (SA)			\$
24/7 Crisis Hotline Services			\$
Other (please list)			\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ 707,000
MHA Planning Council Activities	\$ 12,000
MHA Administration	\$ 168,718
MHA Data Collection/Reporting	\$ 210,000
Enrollment and Provider Business Practices (3 percent of total award)	\$ 30,000
MHA Activities Other Than Those Above	\$
Total Non-Direct Services	\$1127718
Comments on Data: <input type="text"/>	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman,2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

Iowa Suicide Prevention Plan: 2011 to 2014

The Iowa Department of Public Health (IDPH) has guided the development of the Iowa Plan for Suicide Prevention: 2011 to 2014. IDPH reviewed the most recent Iowa Plan for Suicide Prevention 2005-2009 and the *Surgeon General's Call to Action to Prevent Suicide* and the *National Strategy for Suicide Prevention*, which highlights the need to increase awareness of suicide as a public health issue and calls for a public health approach toward suicide prevention. This approach calls for five basic steps: clearly define the problem; identify risk and protective factors; develop and test interventions; implement interventions; and evaluate effectiveness.

Problem: IDPH reports that from 2002-2007, a total of 1,998 suicide attempts resulted in death and 332 of these completions were children and young adults from 10 to 24 years of age. In Iowa, suicide is the second leading cause of death for all Iowans 15-40 years of age.

Suicide affects Iowa's families, friends, schools, businesses and communities. Although the number of Iowans impacted by suicide is difficult to calculate, conservative estimates indicate that there are at least six family members and friends intimately affected for every person who has attempted or completed suicide. This equates to about 12,000 Iowans affected by a person's death from suicide from 2002-2007. The IDPH reports that over this same time period, 2,656 Iowa youth were hospitalized for attempted suicide, tragically impacting an estimated 15,936 family members and friends.¹ A successful reduction in the number of people who attempt or complete suicide will require a reduction in the number of people who are at risk.

Risk and Protective Factors: Risk factors are conditions or circumstances that increase a person's vulnerability or potential for suicidal behavior. Protective factors reduce one's potential for suicidal behavior or reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental, or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.² The following risk and protective factors were developed as part of the national strategy.

RISK FACTORS

Biopsychosocial

- Mental disorders
- Alcohol and substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Suicide contagion

¹ Calculated using data provided by the American Association of Suicidology – www.suicidology.org - 1,998 and 2,656 multiplied by 6 respectively.

² National Strategy for Suicide Prevention: Goals and Objectives for Action, United States Department of Health and Human Services, 2001.

Social Cultural

- Lack of social support and perceived sense of isolation
- Stigma associated with help-seeking behavior and mental illness
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs regarding suicide, mental illness, seeking professional help
- Exposure to, including through the media, and influence of others who have died by suicide

PROTECTIVE FACTORS

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

Interventions and Evaluation: This plan is designed to increase awareness of suicide as a public health issue in Iowa and calls for a public health approach focused on suicide prevention across the life span. The purpose is to build on the foundation of prior suicide prevention efforts in order to develop and implement statewide suicide prevention and early intervention strategies, grounded in public/private collaboration. The plan seeks to specify a targeted number of goals and objectives, focused on implementing initiatives with a focus on evidence-based programs. The goals and objectives are flexible with specific objectives or dates changing based on emerging opportunities and available financial resources.

The committee acknowledges the need to develop the plan over a long time period, but agreed on a draft plan that includes broad goals and objectives. As more stakeholders are identified, workgroups will be established to focus on each goal to ensure it is being addressed. Each workgroup will reassess objectives within the goal, and determine the activities, timelines and specific agencies or individuals responsible for carrying out the activities.

Goal 1: Develop and implement a public education and information campaign focused on recognition of suicide as a public health problem that is preventable.

Objective 1.1: IDPH and partners will select data-driven, promising practices focused on promoting suicide prevention services.

Objective 1.2: IDPH and partners will include the promotion of the importance of positive mental health and its impact on the whole person.

Objective 1.3: IDPH and partners will expand collaborative partnerships to develop an implementation plan for a social marketing campaign.

Objective 1.4: IDPH and collaborative stakeholders will utilize a logic model to develop an implementation plan for a social marketing campaign, to include identification of measurable outcomes.

Objective 1.5: IDPH and partners will promote the Suicide Prevention Lifeline number and website through their networks.

Objective 1.6: IDPH and partners will implement the planned social marketing campaign.

Objective 1.7: On an annual basis, IDPH and partners will review, update and distribute media guidelines for reporting about suicide to schools as well as all media.

Goal 2: Implement training across multiple disciplines for the recognition of at-risk behavior and referral to appropriate service providers.

Objective 2.1 IDPH and partners will identify specific populations (substance abuse treatment centers, mental health providers, LGBT, etc.) needing training.

Objective 2.2: IDPH and partners will identify promising practices in suicide prevention training focused for each of the identified populations.

Objective 2.3: IDPH and partners will develop plans to train volunteers who work with at-risk older adults, and those who work with families facing mental health challenges.

Objective 2.4 IDPH and partners will work with aging networks, youth workers (such as counselors, coaches, child care providers, and college resident hall advisors), and with Family-to-Family education programs of the Iowa Alliance for the Mentally Ill.

Objective 2.5: IDPH and partners will identify and promote suicide awareness and prevention training programs for a variety of professions.

Goal 3: Expand evidence based, community screening, early identification and intervention programs.

Objective 3.1: The Department of Education, through its Learning Supports Initiative will encourage Area Education Agencies and local schools to collaborate with community service providers to implement research-based early identification and intervention programs (e.g. Columbia University Depression TeenScreen® Program, Signs of Suicide, etc.).

Objective 3.2: IDPH and partners will promote mental health screening programs to primary care providers, pediatricians, and other healthcare providers.

Objective 3.3: IDPH and partners will collaborate with the Iowa Department of Elder Affairs and its Area Agencies on Aging to enhance its screening and suicide prevention efforts.

Objective 3.4: IDPH and partners will collaborate with the Iowa National Guard, the Veteran's Administration Central Iowa Healthcare System and Vet Center Programs to enhance screening and suicide prevention efforts for Iowa veterans.

Objective 3.5: IDPH and partners will promote development of statewide suicide survivor programs and a statewide survivor network to address the needs of relatives and friends of those who have died by suicide.

Goal 4: Promote evidence-based gatekeeper training programs in schools, colleges, and in the general population.

Objective 4.1: IDPH and partners will identify current suicide prevention gatekeeper programs conducted in schools and colleges and determine the most effective method to promote them.

Objective 4.2: IDPH and partners will identify gatekeeper programs for other populations (elderly, veterans, etc.) and assist appropriate agencies in implementing them.

Goal 5: Improve and expand surveillance and evaluation systems and develop methods for systematically disseminating knowledge obtained about effective practices and programs for suicide prevention.

Objective 5.1: The IDPH epidemiologist will collect suicide death and injury data and provide a summary report, using hospital data and tracking demographic data and rates at the county, state, and regional levels.

Objective 5.2: The IDPH, in consultation with the partners, will complete the development of a database to track statewide suicide prevention activities and evaluation results and will begin distribution of a quarterly e-mail newsletter about suicide prevention research, potential funding sources, and updates on the state suicide plan to identified stakeholders.

Objective 5.3: IDPH and partners will identify additional data sources and indicators to expand understanding of those at risk for suicide.

Goal 6: Develop a policy agenda for suicide prevention.

Objective 6.1: IDPH and partners will develop a policy agenda to educate legislators and policy makers on the importance of mental health, and affordable/accessible substance abuse and mental illness treatment for all Iowans.

Objective 6.2: IDPH and partners will develop a policy agenda to educate legislators and policy makers on the importance of expanding and replicating the concept and principles of mobile crisis response teams.

Objective 6.3: IDPH and partners will distribute its policy agenda to legislators and policy makers.

Partners:

The following organizations participated in the development of the Iowa Suicide Prevention Plan:

Community School Representatives
Foundation 2 Crisis Center
Iowa Department of Education
Iowa Department of Human Services
Iowa Department of Public Health
Bureau of Substance Abuse Treatment and Prevention
Bureau of Family Health
Iowa School Nurse Organization

Veteran's Administration Medical Center – Des Moines
Iowa National Guard
Employee and Family Resources
NAMI of Greater Des Moines
Iowa Pride Network
NASW – Iowa Chapter
Orchard Place – Child Guidance Center
University of Iowa Carver College of Medicine

Polk County Health Services
Juvenile Court Services – Sioux City

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

From: Larkin, Laura L

Sent: Tuesday, December 11, 2012 10:35 AM

To: Fanselow, Connie B; Donna Richard-Langer (drldkl@msn.com); Jim

Rixner; Julie Kalambokidis (jkalambokidis@EmbracelowaInc.com);

Kenneth Briggs Jr. (kebriggs@earthlink.net); Kimberly Wilson; Teresa

Bomhoff; Virgil Gooding (virgil.gooding@gmail.com)

Cc: Armstrong, Theresa

Subject:RE: Today's Block Grant Committee Meeting

Attachments: Federal Register BG overview.pdf

This is the link Connie is referring to that was shared at the last meeting. (Oct. 26, 2012)

Proposed FY 2014-15 Block Grant Application.

<http://www.samhsa.gov/grants/blockgrant/>

FY 12 Block Grant Application

<http://www.dhs.state.ia.us/mhdd/docs/MHBG-FY-12-Submitted-Application.09.0.11.pdf>

From the last meeting, the Council members were asked to look at the State Assessment sections completed in the FY 12 application and identify any areas of interest for assisting with the updates for the FY 14-15 application.

At the meeting , we discussed actions that the MHPC is taking to encourage integration of Mental Health and Substance Abuse, which will be detailed in the new assessment, and also what other activities regarding co-occurring/multi-occurring capability do we want to assure are highlighted in the new assessment section.

Please let me know if you need further information or documents.

Thanks, Laura Larkin

Present:

- Connie Fanselow
- Laura Larkin
- Kim Wilson (phone)
- Julie Kalambokidis (phone)
- Jim Rixner (phone)
- Teresa Bomhoff (phone)

Discussion:

- Go over and update the behavioral health assessment plan that was completed in August of 2011 for FY 12-13 application-link to this document is:
<http://www.dhs.state.ia.us/mhdd/docs/MHBG-FY-12-Submitted-Application.09.0.11.pdf>
- Discussed specific planning steps in the SAMHSA FY 14-15 application and guidance document-link to this document
<http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf>

Reviewed Application guidance for 2014-15 – page 46 planning steps –

- MHPC members are encouraged to consider if information should be added that is not in the FY 12-13 plan as well as revision and updates to existing information.

Review of behavioral health assessment section in SFY 12-13 plan-tasks identified are for MHDS to complete with MHPC input unless marked otherwise:

- Add redesign information
 - 2nd year of workgroups and their recommendations
 - Overview of 3 major pieces of legislation passed
 - Can update with any new legislative developments before filing April 2013
 - Liked timeline re deadlines for system changes – could go as attachment
 - Could share link for website reports
- Will update state mental health authority info
- Page 15 - Current Iowa mental health system/treatment services
 - Lots of changes – references to county based system and old funding structure
 - Before and after graphic of funding
- Anything missing?
- Reduce size of paragraphs
- Use bulleting where possible

- References to CPC and other changes in terminology
- Provide links to lists of service providers or other large documents.
- Pg. 16 Affordable Health Care section and New Initiatives
 - Original guidance written before Supreme Court decision re expansion
 - Important to show what decisions Iowa has made about participation and any decisions that are not yet made
 - Show effect of expansion or not
 - Status of Iowa Care coverage
 - Percentage of people in state on Medicaid now – from DHS budget
 - State plan amendment for health home services – goal that it will be in place by next year – can speak to that
 - Integrated health homes project
 - Access to information/health information technology
 - System improvements – new data systems – MIDAS, ELIAS
 - County CSN – opportunities for portals to merge/integrate systems
 - Balancing Incentives Payment Program
 - Movement of PMIC services to Iowa plan management
 - Efforts to bring out of state placements back and prevent OOS placements
- Pg. 17 Behavioral health prevention and education
 - Updates
 - ACES conference
 - Minkoff and Cline – section later?
 - Conference on Autism with Temple Grandin
 - Law enforcement training for mental health
 - Trauma informed care update
 - NAMI – now “Basics” instead of visions for tomorrow; also have “In Our Own Voice” – TB will submit a paragraph on NAMI training
 - Update MHFA training
 - Gaps/Needs:
 - Youth mental health first aid
 - Special effort to target schools
 - TB will send a chart of training she prepared
 - MHFA Training for judges, attorneys, educators, students, medical students, primary care doctors
 - Crisis service training for direct care staff in habilitation homes, etc. – will share flyer (Julie?) – for emotional intensity
 - Teen Screen – Columbia University pulled its sponsorship abruptly – can no longer use those tools
 - Need for suicide prevention services in the State
 - Bullying efforts
- PASRR
 - Update from Lila

- p. 26 Treatment Services -
 - Iowa Plan, Medicaid
 - Physical and mental health care integration – need to strive to integrate substance abuse treatment as well
 - Legislative requirements in redesign – co-occurring capable, trauma informed care, evidence based practices
 - Judicial workgroup – integrated screening process for commitment; treatment resources available for inpatient care – see workgroup report
 - SA commitments released after 48 to 72 hours – not committed to programs – few commitment options except Mt. Pleasant
 - When people do present they need to have a friendly, standardized process to get their needs met

- Page 31 – inpatient psych care
 - Types of facilities – update numbers

- P. 34 Co-occurring-make sure we are discussing this throughout the application as well as describing the Minkoff/Cline training.

- P. 35 Case management services
 - May be some changes as health homes become more wide spread
 - Change county information

- P. 37 Waivers/Medicaid Services
 - BHIS changes – move to Magellan, provider qualifications
 - Habilitation

- p. 38 Educational System
 - Learning supports initiative
 - Reorganization in dept. of education – integrate special education
 - Gaps between achievement of students with/without disabilities

- p.39 Services to homeless individuals
 - homeless
 - homeless veterans
 - Veterans Policy Academy
 - housing supports

Next meetings:

- **Tues, Jan. 15 – 3 to 430 pm**
- Plan for this meeting is to complete the review of the behavioral health assessment. We will start at page 42. If updates to the above sections are ready for review, we will also review them at this meeting or via email. We will also move into Step 2 of the planning process-Identify unmet needs and critical gaps within the current system.

- **Mon, Feb. 18 - 3 to 430 pm**
- Plan for this meeting is to complete Step 2, and review section drafts that have been completed. Further meetings will be scheduled as needed, but the plan is to continue collaboration and review via email review of documents.

Meeting minutes-MHPC and Iowa DHS staff

Present-Laura Larkin, Robyn Wilson, Connie Fanselow- DHS staff

MHPC members-Kim Wilson, Julie Kalambokidis, Jim Rlxner

Continued review of existing behavioral health assessment.

Ideas of priority areas were proposed by council members.

Kim suggested that co-occurring/multi-occurring capability for providers to children and youth be considered. She also expressed concerns about the needs of transition age youth. There is proposed language in the redesign bill that addresses transition from child to adult systems.

Jim suggested school-based services as an area of focus. Educators are struggling with how to deal with mental health or behavior issues.

Veterans services were also mentioned as needing more attention in the document.

Consumer run organizations should also be highlighted.

Concerns were raised about Iowa's unwillingness to expand Medicaid and what would happen to low income people if they lose the Iowa Care program and nothing is created to replace it.

There is a need for crisis stabilization and subacute care which is supposed to be addressed through the regions but the block grant could assist with those services.

Funding of Mental Health First Aid and other Mental health education for the public, education system, law enforcement, and primary care providers is seen as essential also.

Transportation for individuals in rural areas is also seen as a gap.

MH Block Grant Committee Meeting
March 4, 2013
3:00 pm – 4:20 pm
Hoover 5 NE 1
Notes by Connie F.

Participating:

- Jim Rixner – on phone
- Kim Wilson – on phone
- Theresa Bomhoff – on phone
- Virgil Gooding – on phone
- Ken Briggs
- Donna Richard-Langer
- Robyn Wilson
- Connie Fanselow
- Laura Larkin

Work up to now:

- Went through services and supports available in the State
- Talked about what has changed in the two years since the plan was last written
- Went over gaps and needs part of plan

Today - finish up any new thoughts on gaps and needs:

- Have talked about transportation issue becoming a bigger gap with budget constraints
- How do we address needs we recognize for things that should be added to core services?
- Can still speak to it as a gap and look at whether it is something that is appropriate for the block grant to address
- Mental health and corrections – how do we deal with that?
- Counties are losing jail MH services, MH court, jail diversion services to budget cuts; possibility there will be money restored to put them back in place - identify that as a gap
- Only a few court jail diversion programs in the State
- Only two MH courts in Woodbury and Black Hawk Counties
- Legislation stills says 70% of funds go to CMHCs
- Funding needed for peer support and opportunities for PSS to be employed
- Health homes will create opportunities for peer support and family support people who will be needed as part of teams
- Workforce issues; accessibility to MH professionals/psychiatric care
- Telehealth
- Intersection between federal and state funding
- Deep concerns about Governor's proposal for new Iowa Cares plan and lack of MH coverage
- State funds only account for about 8% of Iowa Cares funding

- For the last 2 years the focus has been on how we can use the block grant to cover those who won't be covered under ACA
- Teresa B. wants a statement from the Planning Council that they support Medicaid expansion and reject expansion of an Iowa Cares-like program
- Implementation plan report – page 7 footnotes – where talked about what we did
- Went with goals that fit what we were doing
- Suggestions for new goals or priorities?
- Can identify state priorities to be addressed by BG funds or by other means
- Peer and family support should probably remain a priority – shift to health homes; redesign core services
- Discussion about research based vs. evidence based?
- Using practice with fidelity to the model
- A lot of BG money has been spent for training to do EBPs
- How do we keep moving on goals we previously had and integrate new goals?
- Want to be consistent, but keep making and showing progress
- Dual diagnosis – multi-occurring issues – complex needs
- Prioritize MH and corrections
- Address underserved and minority groups
- Look at infusing cultural relevancy/minority issues throughout the narrative

Submission is April 1.

Laura will send out documents for the committee to review and provide feedback to her on, and will plan to update the Council at their March 20 meeting.

Section IV-W Behavioral Health Advisory Council narrative:

States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?

Answer-The SSA, which is in a separate department of Iowa state government has responsibility for planning and implementation of substance abuse services. The SMHA and SSA work together on issues of joint concern, and representatives of each agency participate on the other department's planning boards for grants and projects as appropriate.

- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?

Answer-The SMHA does not have an advisory body for substance abuse prevention and treatment services. The SMHA has two advisory bodies, the Mental Health Planning Council and the Mental Health and Disability Services Commission. The MHPC has included the director of the Iowa Department of Public Health, Division of Behavioral Health (SSA) as a member of the Planning Council to enhance collaboration between mental health and substance abuse prevention and treatment services.

- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.

Answer-The Mental Health Planning Council met with SMHA staff on four separate occasions to review the previous Block Grant application and discuss priorities for the new application. Planning Council members provided information for the Behavioral Health Assessment and reviewed the application prior to submission. Notes from joint meetings are attached.

- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?

Answer- The Council has begun the process of integration but there is still work to be done in this area. The addition of the representative from the Iowa Department of Public Health, who has expertise in and responsibility for overseeing the management of substance prevention and treatment services in Iowa, to the Council has enhanced the group's ability to share information about mental health concerns, learn more about substance abuse issues, and have meaningful discussion toward integrating SA activities into the work of the Council.

- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- **Answer-**The Council has a mix of rural, suburban, and urban representatives. The council does not have representation of families with young children, but does have a strong contingent of parents of children with an SED who are teens and are sensitive to issues children with mental health needs of all ages face. The Council is actively seeking applications for one or two new members who are the parent of a young child with SED. Recruitment from this group has been challenging because parents often express that the time commitment for Council participation is difficult with young children at home. Several individuals on the MHPC are older adults and the MHPC does address the mental health needs of older persons. A representative from the Iowa Department on Aging is an active Council member. According to US Census information, Iowa's racial composition is 92.8% white, 3.2% Black, .5% American Indian/Alaska Native, Native Hawaiian and other Pacific Islander .1%, and two or more races 1.6%. 88% of Iowans are identified as white alone, not Hispanic or Latino, and 5.3% Hispanic or Latino. The Planning Council's current composition is 97% white and 3% Black. The Planning Council is always seeking culturally diverse membership and is open to increasing diversity in all aspects of membership.
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Answer- People in recovery and families are well represented in the membership of the Council. Many of the members are active in groups and programs in their local communities that bring them into contact with other people in recovery and other family members who share issues and concerns with them to bring back to the Council. Various Council members are involved with community advocacy organizations such as the Iowa Advocates for Mental Health Recovery, Veterans groups, parent groups, and peer support groups, which help them connect with and gather input from others in their communities. Several members of the Council gather input through their experiences as Peer Support Specialists, and several also work, or have worked, with the Office of Consumer Affairs (OCA). One of the key functions of the OCA regional coordinators is to provide an advocacy voice to and families with behavioral health recovery and disabilities challenges and to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons. Policymakers are also regularly invited to Council meetings to provide information about current issues and initiatives, and to both provide input to and gather input from Council members.

These are the duties of the Planning Council as identified in the By-Laws

Section 1. Duties

- A. To participate in the development of and subsequently review mental health plans for Iowa provided to the Council pursuant to 42 USC 300X-4 (a) and to submit to the State of Iowa any recommendations of the Council for modifications to the plans;
- B. To serve as an advocate for adults with serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems;
- C. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Iowa; and
- D. To affiliate, join, and collaborate with groups, organizations, and professional associations that the Council may designate or choose to advance its stated purposes under these bylaws and federal law; and, specifically, to join the National Association of Mental Health Planning and Advisory Councils.

Section 2. Activities

- A. To organize as a proactive and effectively working Council;
- B. To actively participate in the development of the State's Center for Mental Health Services (CMHS) Community Mental Health Block Grant Application;
- C. To provide recommendations on State goals according to the criteria of the CMHS Community Mental Health Block Grant;
- D. To advise on the allocation of monies received by the State Mental Health Authority through CMHS Community Mental Health Block Grant funding;
- E. To advise the State Mental Health Authority on matters that may affect the stated purposes of this Council;
- F. To review the annual submission of the CMHS Community Mental Health Block Grant Application and comment on it to the Director of the Center for Mental Health Services;
- G. To review the annual submission of a copy of the CMHS Community Mental Health Block Grant Application and comment on it to the Governor of the State of Iowa; and
- H. To perform other duties as required by federal regulations.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Teresa Bomhoff	Family Members of Individuals in Recovery (to include family members of adults with SMI)		200 S.W. 42nd Street Des Moines, IA 50312 PH: 515-274-6876	tbomhoff@mchsi.com
Kenneth Briggs, Jr.	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1701 Campus Drive, Apt. 3430 Clive, IA 50324 PH: 515-221-4560	kebriggs@earthlink.net
Jim Chesnik	State Employees		Hoover State Office Bldg., 5th Floor, 1305 E. Walnut Des Moines, IA 50319 PH: 515-281-9368	jchesni@dhs.state.ia.us
Ron Clayman	Others (Not State employees or providers)	Depression and Bipolar Support Alliance	3800 Rollins Des Moines, IA 50312 PH: 515-279-5710	bacomentalhealth@aol.com
Jackie Dieckmann	Family Members of Individuals in Recovery (to include family members of adults with SMI)		620 Grace Street Council Bluffs, IA 51503 PH: 712-343-1647	jackiead@cox.net
Jim Donoghue	State Employees		Grimes Bldg, 400 E. 14th Street Des Moines, IA 50319 PH: 515-281-8505	Jim.donoghue@iowa.gov
Virgil Gooding	Providers	Keys to Awareness	1073 Rockford Road SW Cedar Rapids, IA 52404 PH: 319-363-5001	Virgil.gooding@gmail.com
Julie Kalambokidis	Parents of children with SED		6 North Hazel Glenwood, IA 51534 PH: 712-527-4188	Embracellc@yahoo.com
Sharon Lambert	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Box 362 Buffalo, IA 52728 PH: 563-499-3502	Lambertsha@gmail.com
Todd Lange	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		225 West 6th Street Dubuque, IA 52001 PH: 563-564-2933	tjlange1@yahoo.com
Amber Lewis	State Employees		Iowa Finance Authority, 2015 Grand Ave. Des Moines, IA 50312 PH: 515-725-4900	Amber.lewis@iowa.gov
Sally Nadolsky	State Employees		Iowa Medicaid Enterprise, 100 Army Post Road Des Moines, IA 50315 PH: 515-725-1142 FAX: 515-725-1010	snadols@dhs.state.ia.us
Lori Reynolds	Parents of children with SED		106 South Booth Anamosa, IA 52205 PH: 319-462-2187	lori@iffcmh.org
Donna Richard-Langer	Others (Not State employees or providers)		4105 Bel Air Drive Urbandale, IA 50323 PH: 515-278-7010	drldkl@msn.com

Brad Richardson	Others (Not State employees or providers)	School of Social Work, University of Iowa, Research Park, W206 Oakdale Hall Iowa City, IA 52242 PH: 515-953-1990	Brad-richardson@uiowa.edu
James W. Rixner	Family Members of Individuals in Recovery (to include family members of adults with SMI)	114 Midvale Avenue Sioux City, IA 51104 PH: 712-258-7855	jwrx@aol.com
Rhonda Shouse	Parents of children with SED	4861 First Avenue SW, Apt. 2A Cedar Rapids, IA 52405 PH: 319-310-9350	Rhonda_Shouse@yahoo.com
Kris Graves	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2631 Lakeside Drive #1 Iowa City, IA 52404 PH: 319-354-3155	kgraves@live.com
Diane Johnson	Others (Not State employees or providers)	2600 Westown Parkway, Suite 200 West Des Moines, IA 50266 PH: 515-273-5054	dljohnson@magellanhealth.com
Dr. Gary Keller	State Employees	Iowa Medical and Classification Center, Highway 965 Oakdale, IA 52319 PH: 319-626-4278	Gary.j.keller@iowa.gov
Joe Sample	Others (Not State employees or providers)	23919 Hayes Street Pleasantville, IA 50225 PH: 515-848-5013	Joseph.sample@iowa.gov
Kimberly Uhl	Parents of children with SED	418 W. Main Smithland, IA 51056 PH: 712-889-2415	Kimuhl43@yahoo.com
Kimberly Wilson	Others (Not State employees or providers)	2510 320th Street Spencer, IA 51301 PH: 712-262-9438	kwilson@co.clay.ia.us
John Eveleth	Parents of children with SED	29232 Jones St. Sioux City, IA 51104 PH: 712-389-6518	john@lawnspondsmore.com
Doug Keast	Others (Not State employees or providers)	Iowa Workforce Development	
Todd Noack	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1303 14th Street DeWitt, IA 52742 PH: 563-726-3244	toddnoack@yahoo.com
Lee Ann Russo	State Employees	Iowa Vocational Rehabilitation Services	Leeann.russo@iowa.gov
Dennis Sharp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1106 4th Street, Apt. 416 Sioux City, IA 51101 PH: 712-899-2809	Dennissharp2007@yahoo.com
Kathy Stone	Others (Not State employees or providers)	Iowa Department of Public Health, Division of Behavioral Health PH: 515-281-4417	kathy.stone@idph.iowa.gov
Ann Wood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	1506 E. Avenue NW, Apt. 2A Cedar Rapids, IA 52405 PH: 319-396-6591	Annwood1313@yahoo.com

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	33	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	5	
Vacancies (Individuals and Family Members)	<input type="text" value="1"/>	
Others (Not State employees or providers)	8	
Total Individuals in Recovery, Family Members & Others	24	72.73%
State Employees	6	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="2"/>	
Total State Employees & Providers	9	27.27%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Planning Council members were provided a copy of the application on August 30, 2013 and given until Sept. 3, 2013 to provide comment. The Planning Council chairperson provided the only written comment which included suggestions on formatting of information, inclusion of additional information about system gaps identified by the Planning Council, and additional information regarding state juvenile homes' ability to meet the needs of children with serious mental health needs and how this related to usage of out of state treatment for children and youth.

Footnotes:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Planning Council members were provided a copy of the application on August 30, 2013 and given until Sept. 3, 2013 to provide comment. The Planning Council chairperson provided the only written comment which included suggestions on formatting of information, inclusion of additional information about system gaps identified by the Planning Council, and additional information regarding state juvenile homes' ability to meet the needs of children with serious mental health needs and how this related to usage of out of state treatment for children and youth.

The FY14-15 MHBG submitted application will be sent to the Mental Health Planning Council and posted on the Iowa Department of Human Services website for public comment.