**I: State Information**

**State Information**

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<td><strong>End Year:</strong></td>
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<td><strong>Extension</strong></td>
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<table>
<thead>
<tr>
<th><strong>I. State Agency to be the Grantee for the Block Grant</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Agency Name</strong></td>
</tr>
<tr>
<td>Iowa Department of Human Services</td>
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<tr>
<td><strong>Organizational Unit</strong></td>
</tr>
<tr>
<td>Division of Mental Health and Disability Services</td>
</tr>
<tr>
<td><strong>Mailing Address</strong></td>
</tr>
<tr>
<td>1305 E. Walnut St.</td>
</tr>
<tr>
<td><strong>City</strong></td>
</tr>
<tr>
<td>Des Moines, IA</td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
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<tr>
<td>50319</td>
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<thead>
<tr>
<th><strong>II. Contact Person for the Grantee of the Block Grant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td>Charles</td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td>Palmer</td>
</tr>
<tr>
<td><strong>Agency Name</strong></td>
</tr>
<tr>
<td>Iowa Department of Human Services</td>
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<tr>
<td><strong>Mailing Address</strong></td>
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<tr>
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<tr>
<td>Des Moines,</td>
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<tr>
<td><strong>Zip Code</strong></td>
</tr>
<tr>
<td>50319</td>
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<tr>
<td><strong>Telephone</strong></td>
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<tr>
<td>515-281-5452</td>
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<tr>
<td><strong>Fax</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Email Address</strong></td>
</tr>
<tr>
<td><a href="mailto:cpalmer1@dhs.state">cpalmer1@dhs.state</a> ia.us</td>
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<th><strong>III. State Expenditure Period (Most recent State expenditure period that is closed out)</strong></th>
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### V. Contact Person Responsible for Application Submission

<table>
<thead>
<tr>
<th>Field</th>
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</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Laura</td>
</tr>
<tr>
<td>Last Name</td>
<td>Larkin</td>
</tr>
<tr>
<td>Telephone</td>
<td>515-242-5880</td>
</tr>
<tr>
<td>Fax</td>
<td>515-242-6036</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:llarkin@dhs.state.ia.us">llarkin@dhs.state.ia.us</a></td>
</tr>
</tbody>
</table>

**Footnotes:**
I: State Information

Assurances - 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 (29 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.


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 Environmental Enforcement 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 Clean 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. 93-205); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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: Charles Palmer
Title: Director
Organization: Iowa Department of Human Services

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 workplace 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), (?), (d), (?), 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 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: Charles Palmer
Title: Director
Organization: Iowa Department of Human Services

______________________________
Signature: Date:

Footnotes:
I: State Information

Chief Executive Officer’s Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Iowa agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”) and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.
(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
   (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
   (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:
   (1) to provide inpatient services;
   (2) to make cash payments to intended recipients of health services;
   (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
   (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
   (5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:
   (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
   (2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
   (1) make copies of the reports and audits described in this section available for public inspection within the State; and
   (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section.

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.
Notice: Should the President’s FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name: Charles Palmer
Title: Director
Organization: Iowa Department of Human Services

Signature: ___________________________ Date: ___________________________

Footnotes:
I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

Standard Form LLL (click here)

Footnotes:
II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations
Page 22 of the Application Guidance

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, intermediate 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, 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 as well as youth who are often underserved.

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.

In 2011, the Iowa General Assembly enacted, and Governor Branstad signed, Senate File 525, (See Appendix 1 for the complete legislation) 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 is 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 is to develop legislation that will propose a redesign of the current county-based system of mental health and disability services into a regional system. The workgroup meetings are open to the public and are designed to encourage public comment and involvement.

The workgroup goals are to identify a wide variety of system issues including best practices, eligibility criteria for individuals served, the array and definition of core services, quality assurance and outcome measures, work-force cultural competency issues, mental health workforce shortages, funding of the system, sub-acute level of care, mental health crisis response services, and provider accreditation, certification, and licensure. The workgroups are also to consider co-occurring disorders across all of the workgroups as well as include Olmstead principles in their recommendations. Workgroup members also include representation from Iowa Substance Abuse Prevention and Treatment Block Grant stakeholders. The Iowa Department of Public Health, Director of the Division of Behavioral Health, is the State Substance Abuse Authority, (SSA), and is a member of the Adult Mental Health Workgroup. Other IDPH SSA staff and providers are also key participants in the workgroup process.

The purpose of the redesign is to provide greater consistency of services across the state, more equitable funding for such services, and to accommodate the expected influx of individuals into the Medicaid system due to potential PPACA enactment in 2014. Adults with serious mental illness, especially those who currently are not Medicaid eligible, are primary consumers of the current county-based system and will benefit from a redesigned mental health system.

The five workgroups created from the legislation are:

- Adult Mental Health
- Adult Intellectual/Developmental Disability
- Children’s Disability (includes mental health and other disabilities)
- Brain Injury
- Regional System
The workgroups began their work in August 2011 and are expected to provide final recommendations to the legislative committee in December 2011. The committee is to propose legislation as a result of these recommendations during the 2012 Iowa legislative session. An incentive for the workgroups and the legislature to develop concrete proposals is the repeal of the funding and structure of the current county-based system built into the legislation. The repeals are effective July 1, 2013 and the progress that the workgroups and the legislative committee make during the coming months will determine how soon the system will be changed. This bipartisan legislation will move Iowa toward the goal of achieving a good and modern mental health and disability services system.

The workgroup process will also be performing many of the functions identified in the MHBG planning section regarding assessing the strengths and needs of the system, unmet service needs and gaps, and developing state priorities. For this reason, Iowa is requesting the opportunity to revise this MHBG application when this workgroup process and legislative actions have been completed in 2012. It is expected that through this process the foundations and assumptions that have informed the system to this point will be shifted, and a new paradigm will be created for delivery of publicly funded mental health and disability services. This process is an exciting and challenging one for Iowa. The Mental Health Block Grant must be consistent with the goals and expectations created from this stakeholder-driven process and therefore may need to be amended in order for MHBG priorities to be aligned with priorities identified in the redesign process.

While the system redesign workgroup process is occurring, there will also be a Court and Department of Human Services Mental Health workgroup convened. This group is focusing specifically on the issues surrounding individuals who are involuntarily committed for mental health evaluation and treatment, or chronic substance abuse. Workgroup topics include, but are not limited to, consideration of implementation of jail diversion programs, mental health crisis intervention training for law enforcement personnel, funding and supervision issues related to mental health and substance abuse advocates, civil commitment prescreening procedures, and other proposals related to ensuring that those who are involved with the judicial system due to mental health needs are provided appropriate assessment and diverted to the mental health system when appropriate.

In addition, the bill required formation of a work group for developing implementation provisions for an integrated data and statistical information system for mental health, disability services, and substance abuse services. The SMHA, the SSA, and county representatives will participate in this workgroup.

**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. Karalyn Kuhns, an administrator in MHDS, Office of Facility Support, is currently the Interim Division Administrator for MHDS due to the
retirement of Jeanne Nesbit in May 2011. The new MHDS Administrator is Richard Shults, and he will begin his work in Iowa on September 19, 2011.

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 states 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 SAPTBG and associated State appropriations under the authority of the IDPH SSA.

Mental health services through the Iowa Plan include a broad range of inpatient and outpatient mental health services. Medicaid eligible adults needing residential and/or vocational services are funded through 100% county funding. 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. A more detailed description is included in the services section on page 23.
County governments have historically paid for many of the adult mental health and disability services available in the state. The State of Iowa began a property tax relief program, in 1996, to provide financial relief to the property tax payer of Iowa for the increasing costs of the disability services that counties were funding. This partnership between the state and the counties included some basic changes to the county based system. Each county was mandated to hire a person to serve as the Central Point of Coordination (CPC) Administrator of the Mental Health, Intellectual, and Developmental Disability funding system. Counties were required to develop a county management plan describing the criteria for eligibility (financial and disability) and what services the county will fund. The state legislature set a minimum financial requirement of 150% of poverty and $2000/$3000 in resources (individual/family). 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. Some counties have chosen to serve persons above the 150% percent income level for some services.

Property tax relief and growth 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. Even though the current legislation places the responsibility for development and implementation of County Management Plans on Iowa’s counties, each county controls their service system infrastructure that is not funded by Medicaid. Through local control each county prioritizes needs, develops plans, establishes system goals and indicators, identifies consumer outcomes, and allocates resources.

The county system provides funding for services to persons with Mental Health, Intellectual, and Developmental Disabilities who may or may not be eligible for Medicaid. Iowa counties fund 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. For children, counties 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, although they are not legally required to do so.

Changes in the state and local economies have caused some (5 in SFY2012, year to date) counties to initiate waiting lists. However, most counties with waiting lists are not including outpatient services on the waiting list. Commitment services for psychiatric hospitalization services and outpatient commitment services cannot be reduced or eliminated by counties.

**AFFORDABLE HEALTH CARE**

Beginning January 1, 2014, the Affordable Health Care Act creates a mandatory new eligibility group for individuals with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. New eligibles include all non-elderly, non-pregnant individuals who are not entitled to Medicaid today.
In Iowa, many persons with serious mental illness are not entitled to Medicaid because they do not meet the eligibility requirements. They have been forced to forego care, resulting in acute and expensive health and mental health emergencies. One population that may be positively affected are those individuals who are released from correctional facilities. Individuals served in the correctional system exhibit a high prevalence of mental illness. In 2000, the American Psychiatric Association reported estimates that one in five prisoners was seriously mentally ill. The figures in Iowa are higher than this estimate where over one-third (33.8%) of offenders are identified as mentally ill. Most inmates do not currently qualify for Medicaid services because they do not meet the traditional Medicaid eligibility categories. In 2005, approximately 732 offenders with mental illness-only were released across the state. Offenders leaving prison with mental health conditions are at risk for becoming dependent upon income assistance programs. Early mental health screenings, assessments and referrals using intensive mental health care management programs in coordination with new reentry preparation programs and employment maintenance efforts will provide the likelihood of a successful transition back into the community.

Iowa is in the process of submitting a State Plan Amendment (SPA) for Health Home Services. The goals are to: lower the rates of emergency room use, reduce hospital admission/readmissions reduce health care costs, reduce admissions/stays in long term care facilities, improve experience of care and improve quality of care outcomes.

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 abuse professionals and stakeholders, program funders, policy makers, community partners, consumers and families 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. A keynote and breakout presentation at the October 2011 conference will be presented by national experts Larry Fricks and Tom Lane on new developments regarding peer support including integrating peer support services into integrated health and mental health systems, also known as peer support whole health. A national expert in self-help/peer support for veterans, Moe Armstrong, will also present a workshop at the conference.
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 objectives of the conference are for participants to become better informed and to gain skills to assist them along their path toward empowerment and recovery. This consumer-led conference includes state and nationally recognized keynote speakers, entertainment, peer support, social functions and more. The most recent conference was held in August 2011 under the theme, “Reaching for Recovery”. 180 consumers, providers, and other members of the public attended the conference. 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. A high percentage of the workshops each year are presented by consumers. MHBG funds are used to promote mental health consumer participation in the conference.

The Iowa Advocates for Mental Health Recovery, a consumer run organization which also operates the Iowa Office of Consumer Affairs, hosts an annual conference to educate mental health consumers and providers. The focus of the conference held in May 2011 was “Building a Wellness Community.” National and local speakers provided workshops on self-direction, wellness, peer support, parent support, trauma, and Iowa’s Olmstead plan, among other topics. 220 people attended this conference. Consumer attendance at this conference is also supported with MHBG funds.

In SFY 11, Community Circle of Care (CCC) System of Care for Northeast Iowa provided 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 provided in SFY 11 included the CCC Annual Children’s Mental Health Conference (Wraparound Approach-presented by Karl and Kathy Dennis), Cultural Competency, Parent Management (Train the Trainer), Nurtured Heart Parenting Approach, Circles of Support, Mental Health First Aid (for youth and adults) , 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).

The Central Iowa System of Care in Iowa, based in Des Moines, also offered wraparound training presented by Karl and Kathy Dennis, national experts in building community-based systems of care. Central Iowa System of Care also offers weekly parent training classes, Mental Health First Aid, and other trainings that encompass a variety of topics related to children’s mental health prevention, promotion, and treatment. Both Systems of Care programs view community education regarding mental health promotion and treatment as central to their mission of providing community-based services and supports to children with serious emotional disturbance and their families.

A two day training was held in Des Moines in June 2011 on the topic of Trauma Informed Care. This training was partially sponsored with MHBG funds. Over 250 individuals attended in order to gain knowledge on the topic "Psychological Trauma:
Impact On Mind, Body, Behavior And Community - Current Research And Practice Trends", with more unable to attend due to limited space. The level of interest in this training is evidence that professionals in Iowa are aware of the need for education on trauma-informed care, and wish to increase their skills on this topic. This has been identified as a priority for the Iowa system and will be addressed in Section II, Table 2, Step 3.

Other educational opportunities available to the public in Iowa include but are not limited to various classes and workshops provided by NAMI including Visions for Tomorrow, Peer to Peer, Family to Family, and Provider Training; and webinars, on-line trainings, and in-person training on various topics of interest to consumers of mental health services and their families.

The variety and availability of training related to mental health is 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. Needs for additional training expressed by stakeholders include, but are not limited to, additional training on trauma informed care, working with individuals with co-occurring conditions, wraparound facilitation, and basic mental health education/literacy training.

Mental Health First Aid
Iowa continues to develop statewide capacity for Mental Health First Aid training and has increased the numbers of individuals trained in Iowa every year. Iowa currently has 60 instructors located across the state in a variety of settings. Instructors include SMHA and SSA staff members. Five community mental health centers are currently using MHBG funds to support their provision of Mental Health First Aid training. In SFY 11, 27 new instructors were added in targeted areas including National Guard staff to train active military/veteran/stakeholder audiences, Iowa Law Enforcement Academy staff who are working on integrating Mental Health First Aid into basic law enforcement training, and state university and community college personnel. The SMHA is sponsoring an instructor training for 24 additional individuals in September 2011. Those proposed to be trained this year include National Guard personnel, school district counselors, substance abuse counselors, community members, homeless outreach workers, and other human services/mental health professionals. The MHFA training course can be taken by any member of the public. It is emphasized that the course is not therapy and that it is not a substitute for getting professional help. The training also emphasizes to participants that the course does not qualify them to be a counselor, just as a conventional first aid course does not qualify someone to be a doctor or a nurse. Its role is to promote first aid, the initial help that is given before professional help is sought, and early identification and intervention for mental health and substance abuse problem. In SFY 11, 1,230 people attended 77 trainings surpassing the goal set in 2010 that 1,200 individuals would be trained in Mental Health First Aid in SFY 11.

The Veterans Mental Health Task Force, as part of recommendations made in July 2010, identified Mental Health First Aid as a priority activity. Mental Health First Aid training
for veterans’ stakeholders will be offered in September 2011 in two locations by the Task Force.

**Disaster Behavioral Health Response Training and Team Deployment**
The Division of Mental Health and Disability Services administers the Disaster Behavioral Health Response Team, utilizing volunteers to respond to the mental health needs of Iowans following disasters and critical incidents. The state is divided into six regions and the Disaster Behavioral Health Response Team, consisting of over 450 trained members, can be deployed anywhere in Iowa. SSA staff participate in, and support disaster behavioral health efforts. The teams respond when local resources have been depleted or are insufficient. The goal of the team is to provide an organized response to victims, families, volunteers, first responders, survivors and others affected in order to lessen the mental health effects of trauma. Disaster Behavioral Health Response Team members are trained in 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. The Division continues to train individuals to enhance the state’s capability to respond to traumatic events and long term recovery needs from the disasters of 2008.

The team has been deployed for numerous natural disaster events and other critical incidents across the state. Over 6,000 people were served by the Disaster Behavioral Health Response Team in SFY11.

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.

Early Childhood Mental Health/Healthy Mental Development
Assuring Better Child Health and Development (ABCD II) was a project funded by the Commonwealth Foundation. The grant focused on the identification and implementation of policy and system changes to support the provision of preventive care by Medicaid providers to children birth through age three and early identification of risk for social/emotional issues. As a result of this grant, Iowa continues to facilitate community-planning, linkages between public and private practitioners to create a system of services, identification of service resources and gaps, and identification of provider training needs. The ABCDII website: www.iowaepsdt.org continues to demonstrate high utilization by the community.

A proposal that was developed from the ABCD II initiative is the 1st Five Healthy Mental Development Initiative. Currently, Iowa is addressing sustainability and spread. 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. The 1st Five program is currently in 16 counties and works with 61 medical practices, serving over 75,000 children birth to five years in their medical clinics.

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. From September 2007 through February 2011, 67 mental health providers from 21 agencies completed the training. In a follow up survey the practitioners reported seeing an average of 32 families/children per provider for a total of 1091 families/children. Currently trained providers are located in over 35 Iowa counties. Initial training began on the west side of the state as there due to fewer resources for young children in that part of the state but training is now completed in all areas of the state. This training will continue in the next year to continue to expand practitioner resources able to provide this EBP in Iowa.

Iowa is also focusing on increasing provider’s abilities to provide standardized developmental screening. Ages and Stages trainings and train the trainer trainings have taken place in the last year. This will increase the ability of the early childhood work force to identify developmental concerns earlier. Iowa now has thirty-four trainers on Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE). These trainers have delivered 38 ASQ and ASQ:SE trainings to a variety of early childhood professionals that include Child Health Specialty Clinic nurses, public health employees, home visiting staff, social workers, preschool staff, child care and Area Education Agency personnel. These trainings build cross system support for developmental screening.

**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.

A recent partnership has been formed between the Professional Development workgroup and the Iowa Chapter of the American Academy of Pediatrics (IAAP). The IAAP has agreed to serve as an “umbrella organization” for an Early Childhood Mental Health Association. This Association will serve as a catalyst for building infrastructure in the area of early childhood social, emotional and behavioral health competencies. The Association will take a tiered approach for inclusion of professionals at all levels of service to ensure a competent, connected and informed workforce.

One strategy of this workgroup includes coordination of an Early Childhood Mental Health Retreat scheduled for September 7th, 2011. The intent of this retreat is to assess existing initiatives in the area of children’s mental health, to identify gaps and barriers to ongoing professional development, and to develop recommendations for next steps. A white paper will be produced that will summarize the group’s discussion and include recommendations for future professional development. This white paper will also be shared with the Mental Health and Disability Services Redesign -Children’s Disability Workgroup as they address the overall children’s service system. The SMHA views the development of a comprehensive early childhood mental health system as essential to promotion of positive mental health and prevention of mental illness.

Following the submission of the white paper to the Children’s Disability Services workgroup and subsequent recommendations, the SMHA will consult with the Early Childhood workgroup regarding additional strategies which may be added to the Mental Health Block Grant Plan for SFY 12 and 13 regarding early childhood mental health.

**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.

**Early Childhood Positive Behavior Interventions and Supports**
Positive Behavioral Interventions and Supports describes a process for addressing children’s challenging behavior that is based on an understanding of the purpose of the behavior and a focus on teaching new skills to replace challenging behavior.

In school wide and early childhood PBIS, all of the staff work together to ensure that children:

- understand behavior expectations
receive instruction in social skills
– with persistent problem behavior receive individualized assistance.

The Iowa Department of Education is currently implementing a training and coaching model based on the CSEFEL Pyramid Model to train child care and preschool providers to implement EC-PBIS in their programs and also be able to coach other teachers and providers as they implement the model. The early childhood mental health system is also involved with this initiative through consultation and direct services to children identified in need of indicated interventions, however many areas of the state do not have trained mental health practitioners to work with young children.

**Teen Screen**

The Iowa Department of Public Health (IDPH) Youth Suicide Prevention program has provided a variety of suicide prevention services. IDPH’s “flagship” initiative has been the promotion and funding of TeenScreen programs in Iowa schools.

TeenScreen is a voluntary mental health screening program that requires parent consent and student assent. It provides families with the opportunity to get a “mental health check-up” that can help identify mental health problems. The program has had the following components:

- Support of school administration and community involvement,
- Parent information and active consent,
- Youth assent,
- Administration of the screening questionnaire,
- Debriefing of youth,
- A brief clinical interview when indicated,
- And parent notification and case management if further evaluation is recommended.

TeenScreen has been offered to families with students in junior or senior high schools. Most programs offered screening to families of 9th grade students, but some sites offered screening to a range of 7th to 11th grade youth. Along with the local TeenScreen program coordinator, each school selected the group to be offered screening services. Each program had 2-16 schools in which the TeenScreen® program was offered. IDPH funded seven (7) TeenScreen programs with 46 screening sites in Iowa. In the 2009-10 school year, over 2,600 youth were screened at TeenScreen sites funded by IDPH.

IDPH is seeking grant funding to support program continuation and is looking at opportunities to incorporate suicide risk indicators and protective factors into ongoing substance abuse prevention and general health promotion efforts.

**PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASSR):**

Iowa is in the process of implementing the PASSR pre-admission screening process for all applicants prior to admission to a Medicaid-certified nursing facility. The new
procedures for this screening will be effective Sept. 1, 2011. The MHBG has helped support Iowa’s development of a clinically sound and responsive Level I and II PASRR evaluation process. A PASRR level 1 screening identifies all potential nursing facility residents with a possible mental illness or mental retardation diagnosis. All residents with a possible MI or MR diagnosis will have a level 2 screening completed which identifies special service needs for the individual and evaluates if these specialized service needs can be met in the nursing facility. A level 2 screening will also be completed when a nursing facility resident experiences a significant change in the resident’s physical or mental condition.

This process will help assure that individuals with an identified mental health or intellectual disability receive necessary services and are not placed in nursing facilities that cannot appropriately meet their needs. The development of this process is part of Iowa’s Olmstead Plan to encourage individual choice and community inclusion for individuals with disabilities.

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 manages mental health and substance abuse services for approximately 455,864 eligible enrollees ages 0 to 64. Effective July 1, 2010, Magellan also began managing services to approximately 27,000 enrollees aged 65 and older, coordinating and improving access for older persons to mental health and substance abuse services. In SFY 11, Magellan provided mental health services to 41,430 children ages 0-17, which is 15.2% of the Medicaid eligible child population and 35,213 adult clients 18 or older, 17.2% of the Medicaid eligible adults. 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 and county Central Point of Coordination, and provider consortium
• 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**

Services are provided by appropriately credentialed mental health service providers to assure availability of the following services to address the mental health 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 – for adults only
- 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 – for adults only
- 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

Bi-Directional Integration of Behavioral Health and Primary Care Services
Magellan is piloting Integrated Health Homes in Iowa and Maricopa County, Arizona for Medicaid members who have a serious mental illness or who have a serious mental illness with co-occurring substance dependency. Primary care services and behavioral health services are provided within the integrated health home which, unlike other health home initiatives, begins with the behavioral health provider. While the models vary by state and location, these integrated health homes ensure quality management of both physical and behavioral health care needs through a partnership of behavioral and physical health care providers, coordination of a broad set of services and supports, and measurable improvement in health outcomes. These partnerships focus on:

- Aiding the journey to recovery.
- Improving health and wellness through coordinated care.
- Managing chronic illness.
- Realizing fiscal savings.

Why Integrate Behavioral Health and Physical Health Care?
- Physical and behavioral health problems often occur at the same time.
- People with common medical disorders have high rates of behavioral health issues.
- People with serious mental illness often have chronic physical health conditions.
- Many people with serious mental illness often do not receive the preventive or physical health care services they need.
- Integrating services to treat both can provide the best outcomes for individuals being served.
- Health care reform encourages integrated care.

Key Elements of Magellan’s Integrated Health Home Model
- Co-location of medical services with behavioral health providers. The behavioral health care site is the point of entry for care – the health home. Individuals with serious mental illness have strong relationships with their behavioral health provider,
who is often their major point of intersection with the health care system and where they feel the most comfortable accessing care.

- **Comprehensive care coordination and health promotion.** Behavioral health provider’s partner with physical health providers to offer preventive, routine and maintenance health care. This includes:
  - Outreach to people with serious mental illness to evaluate their health status and need for additional services.
  - Personalized health, wellness and treatment plans.
  - Enhanced coordination across all providers—behavioral, primary and specialty care—as well as outpatient, emergency room, inpatient, and other types of care settings.
  - Comprehensive transitional care from inpatient to other settings, including follow-up and aftercare.
  - Treatment guidelines and tools that address the unique needs of individuals with both serious mental illness and chronic medical conditions.

- **Member engagement, peer support and family support.** The “whole-person” approach includes a person-centered recovery plan and self-management tools. Peer support services encourage a commitment to recovery and wellness.

- **Referral to community resources and social support.** Access to a wide range of community resources maximizes coordination with community-based services. Examples include support groups, transportation and other social services. Support services can address problems that compromise total health, such as a reluctance to use public transportation or the inability to articulate needs or symptoms to health care providers.

- **Health information technology to link services, provide feedback and facilitate communication among team members.** Electronic sharing of health data among behavioral and physical health providers in a HIPPA-compliant manner enables tight coordination with the broader physical health delivery system. Online profiles are able to include medical, behavioral and pharmacy history, as well as:
  - Tracking for referrals to specialists and the results of consultations.
  - Medication management to reduce drug interactions and duplications.
  - Shared treatment plans.
  - Aftercare coordination for those with hospital admissions.

- **Increased access to care, including use of telemedicine.** Care is available 24 hours a day in settings familiar to the individual.

**Anticipated Outcomes**

- Improved quality of care.
- Improved health status.
- Increased community tenure and reduction in hospital readmissions.
- Increased access to primary care, with a reduction in inappropriate use of emergency room and urgent care.
- Reduction in preventable hospitalizations.
- Improved functional status as indicated on the Consumer Health Inventory (CHI) and Consumer Health Inventory-Child (CHI-C) or other outcome tools.
- Improved evidence-based prescribing and medication adherence.
- Improvement in identifying substance use/abuse and engagement in treatment.
- Reduction in lifestyle-related risk factors.
- Improved experience of care (member satisfaction).

Managing Total Health for Individuals with Serious Mental Illness and Helping to Control Associated Costs
While individuals with serious mental illness usually comprise a small percentage of the Medicaid population, they account for a large share of Medicaid expenditures. The prevention efforts and coordinated services offered through integrated health homes will provide better total health and quality care for individuals with serious mental illness – and will help reduce unnecessary costs for states and their taxpayers.

Also, a community mental health center is planning to expend MHBG funds in the coming year to partner with an FQHC to integrate health and behavioral health services. The CMHC will send a mental health therapist to the FQHC to provide services on-site, and the FQHC will send a health professional to the CMHC to provide health-related services at the mental health center.

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 about $67,050.

Inpatient Psychiatric 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-seven general hospitals in Iowa which have licensed psychiatric units with a total capacity of 609 beds (463 Adult, 90 children/adolescents beds with 20 of those beds for patients above the age of 16 with substance abuse issues, and 56 geriatric beds). While more concentrated in metropolitan and urban areas, psychiatric inpatient services are available within a 60-90 minute drive anywhere in the state. The past decade has seen the closing of seven inpatient psychiatric service facilities.

• **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). Thirteen programs with 284 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.

• **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 two Iowa facilities that hold this licensure with a capacity of 82. 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 SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are twelve private facilities with 430 Medicaid-funded beds and one public facility with 15 beds that deliver these services to children in Iowa. Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa. During the last three years, approximately 4% of the PMIC placements have been to out of state facilities. Iowa is concerned about this statistic and would like to address reasons that children are served in these out of state facilities, and develop services and supports that would allow them to remain in their homes and communities if possible, and to be served in the closest treatment setting to their homes if needed. Services 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. 1,074 children received PMIC services in SFY 11. The average length of stay for this service was 249 days. Both average length of stay and numbers served in this type of care decreased from SFY 10 to SFY 11.

**Iowa Plan Substance Abuse Services**

Substance abuse treatment services are provided by programs licensed by the Iowa Department of Health, Division of Behavioral Health.

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.

**Iowa Plan substance abuse covered services:**

Medicaid Substance Abuse Services
- 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 for individuals up to age 21
• Residential Treatment

IDPH-funded Substance Abuse Services
• Residential treatment
• Intensive outpatient
• Outpatient treatment
• Halfway House
• Assessment (except related to drinking and driving)

21 local hospitals provide inpatient substance abuse treatment. The MHI at Mt. Pleasant also has 50 residential substance abuse treatment beds, as well as 19 dual diagnosis treatment beds. General hospitals may also provide inpatient medical detoxification services.

Co-Occurring Mental Health and Substance Abuse Services

System Change Efforts
Beginning in late 2004, IDPH participated in SAMHSA’s Co-Occurring Academy. The SSA led those efforts, starting with Iowa substance abuse providers and later including DHS mental health representatives and Department of Correction’s staff. Trainings were conducted with all IDPH SSA-funded treatment providers and were opened to other interested providers and parties. Through the Iowa Plan, a motivational interviewing training and implementation project was conducted with IDPH SSA-funded providers. IDPH also participated in several rounds of NIATx substance abuse program improvement projects, which were expanded through the Iowa Plan to include community mental health centers. In January 2009, in collaboration with previous Co-Occurring Academy participants and with other stakeholders, including consumers, DHS and IDPH developed a joint statement that said “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 was granted a SAMHSA Access to Recovery grant in 2008. Care coordination, mental health services, and recovery peer coaching are among the covered benefits that recovering persons can select. In December of 2009, IDPH implemented a transition to a more 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. Effective July 2011, IDPH-funded treatment provider contracts include financial incentives for documented co-occurring capability.

Since 2009, DHS and IDPH have continued development of 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 SMHA, in collaboration with the SSA, has contracted with Dr. Ken Minkoff and Dr. Chris Kline to provide co-occurring disorders training for mental health and substance abuse providers and provide technical assistance in addressing some of the barriers for individuals with co-occurring mental health and substance abuse to receive effective treatment. Mental Health providers have worked to certify some of their therapists in both Substance Abuse and Mental Health issues. In FFY 12, MHDS will contract for specialized training in co-occurring recovery principles related to other complex needs including individuals who have co-occurring mental health, substance abuse, intellectual or developmental disability, brain injury or other health conditions.

These agencies have formed an official organization, Iowa Co-occurring Recovery Network or ICORN. The purpose of ICORN is to be a resource for agencies and communities in the implementation of the co-occurring model. ICORN has leadership group consisting of 13 members. The goal for Iowa is to continue to expand the number of agencies in Iowa who actively participate in the Co-occurring training and process.

Co-occurring Services
As identified previously, 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 (mental retardation), 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 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. In SFY11, 77 counties provided case management services or contracted with another accredited agency and 20 counties are contracted with DHS Targeted Case Management services for adults. The Iowa Plan managed care provider pays for the non-federal share (FMAP) of TCM for most clients with Chronic Mental Illness. County governments and the State of Iowa are responsible for FMAP for clients with Intellectual Disabilities or Developmental Disabilities. 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.

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 teaching 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 illness, 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 was moved to the Iowa Plan as of July 1, 2011 from Iowa Medicaid. This move will allow for more 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 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 730. 685 individuals are currently receiving services with 50 applications pending. The waiver has a waiting list of 1,104 with the next child to be served having an application date of March 25, 2010. This effectively means that the time from application to an open funding slot is approximately 18 months. The Iowa Legislature authorized additional funds in SFY12 to reduce the size of the waiver waiting list but it is not clear yet how many additional children will be served.

Services included in the CMH waiver are respite, community supports, in-home family therapy 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. The State will be considering adding the Consumer Choices Option to the CMH waiver at a future date. CCO will allow members and their families to self direct some of the services in the CMH waiver. Additional services may be added in the future but will be contingent on need and funding.

A new program that started July 1, 2010 reserved 10 slots on the CMH waiver for children being discharged from MHI’s, PMIC’s, or out-of-state placements. Ten slots were awarded and seven accessed during SFY 11. In SFY 12, all 10 slots have already been awarded. This statistic, 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 which provides waiver like services to individuals meeting the criteria of chronic mental illnesses. 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. These general 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.

The Learning Supports Initiative has provided several trainings to the public that address mental health and behavior issues of children in the school setting. For the 2011-12 school year, the Department of Education will provide training and technical assistance from Dr. Lucille Eber and other consultants to 12 schools who are currently implementing school-based mental health wraparound and 9 new schools that will join the program. During the three years that the program has been in existence, 119 students and their families have participated in the school-based wraparound process and 47 are current participants in the program. These wraparound programs promote mental health and educational systems working together to wrap the appropriate services around the child and family in order to promote improved functioning in the school as well as home setting.

**Services to Homeless Individuals**

The most recent Iowa Council on Homelessness report on numbers of Iowa homeless was published in 2009. Nearly 24,000 homeless persons received some sort of publicly funded service, up 39% from the prior year. The increase is attributed to economic conditions. Forty-one per cent of the adult homeless individuals receiving services reported long-term disabilities, mostly mental health issues.
DHS’s Mental Health and Disability Services Division (the State Mental Health Authority) directly assists homeless individuals with mental health issues by administering the PATH program. It is a formula grant program administered by the federal Substance Abuse and Mental Health Administration (SAMHSA). Iowa will receive a $337,000 grant for state fiscal year 7/1/2011-6/30/12. The amount of federal funding has been nearly level for several years.

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 $38,014 to $67,150 this fiscal year. 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 1,474 homeless individuals, enrolling 829 of them in PATH services. This is a very cost effective program in that clients are contacted and engaged, provided short term case management, housed, and begin mental health and substance abuse services for an average cost of $406 per person.

DHS-MHDS, as part of its 18-month action plan to implement DHS’s Olmstead State Plan, also assists clients with mental illness in obtaining permanent supportive housing in these ways:

- It is working with the Iowa Finance Authority to ensure availability of Home and Community Based Waiver rent subsidies to support Money Follows the Person participants and other individuals on Waivers.
- It is working with local public housing authorities to ensure that individuals with disabilities have the same access to federal Housing Choice Vouchers (Section 8) as individuals without disabilities.

The Iowa Council on Homelessness staffed by the Iowa Finance Authority and chaired by an IDPH-SSA staff person, coordinates homelessness services statewide. Theresa Armstrong, Bureau Chief, DHS-MHDS, is an active voting member. 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 youth with behavioral illnesses have access to all the mainstream services that other youth have.
Mental Health Planning Council members, as part of the behavioral health assessment process, surveyed providers of homeless services regarding strengths and needs of the service system for individuals who are homeless and mentally ill, as well as those who have involvement with the justice system and are mentally ill. These providers identified that the system has many strengths including availability of peer-led support groups, opportunities for education and treatment courses, more awareness and education of community corrections staff on mental health and substance abuse issues, more benefit from medications, and more focus on the family system in therapy as opposed to focusing on just the client and his/her symptoms. Unmet needs include lack of mental health professionals, a need for mental health professionals to meet homeless individuals in shelters as opposed to expecting the struggling person to get to an appointment, increased access to career development/pre-employment training, gender specific interventions, specialized services and advocacy for those individuals who have difficulty maintaining treatment relationships and need long-term case management.

**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). Consistent with the spirit of Olmstead, 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. This is an area MHDS is reviewing in the context of implementing the Department’s Olmstead plan.

**Supported Employment/Employment Services**

Beginning in the summer of 2010 several Community Mental Health Centers made a commitment to improving or developing supported employment programs and services.
Technical Assistance was provided to these centers through monthly conference calls where connections were made to local and state resources, Employment Networks for Ticket to work, and Social Security and Medicaid work incentives. Several staff members of these centers participated in Certificate trainings on Supported Employment for Mental Illness provided by Virginia Commonwealth University. Seven community mental health centers have implemented supported employment programs with the assistance of MHBG funding.

Improved employment outcomes are a major focus of Iowa’s Olmstead Plan. Within this framework, Iowa has developed specific goals relating to community based employment and services for Iowans with all types of disability. Through MHDS membership in the State Employment Leadership Network (SELN), as well as local surveys, Iowa has identified funding and rate structures for employment services and outcome measurement as areas of focus for SFY2012. Iowa will be using Medicaid Infrastructure Grant (MIG) funding to complete projects in these areas which will impact statewide service systems for all Iowans with disabilities, including mental illness. In addition, the areas of Interagency collaboration and youth transition are being addressed within the state. The related agencies of Iowa Vocational Rehabilitation, Department of Education, Iowa Workforce Development, and the Medicaid and the Mental Health and Disability Services divisions of DHS are working together on projects to improve employment outcomes with a focus on community based employment.

IDPH SSA staff is currently considering how employment services such as those in the Connecticut Community for Addiction Recovery (CCAR) Recovery Oriented Employment Services model might fit with Access to Recovery services.

The Governance Group and the Memorandum of Agreement:
Methods to Strengthen Employment Services for Iowans with Disabilities: The State of Iowa has developed an effective, collaborative working relationship with seven 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 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 Support Team to maintain communication and feedback form the field offices.

Iowa Vocational Rehabilitation Services (IVRS) works closely with students and their families to help the student 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 also 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 31 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 36 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. It is up to each individual CMHC to determine the array of such services and the level at which the center serves children. For CMHC’s receiving MHBG funding, the development and implementation of evidence based intervention practices are required. As of SFY11, these interventions included but were not limited to: Trauma Informed Care; Incredible Years; Parent Child Interaction Therapy (PCIT); School-Based outreach, consultation, and therapy services; Cognitive Behavioral Therapy; Supported Employment; Peer Support Services; Wellness Recovery Action Plan; Co-Occurring/Complex Needs programs and Crisis/Emergency Service Expansion.

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 a 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 are 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 238 psychiatrists (203 Adult, 35 Child) in the State of Iowa, according to the University of Iowa Carver College of Medicine as of February 2011. 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: 564 licensed psychologists; approximately 60 Nurse Practitioners and Physicians Assistants with a Mental Health Specialty; 4,114 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 180 licensed marital and family therapists and 822 licensed mental health counselors.

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 June 3, 2011 the federal Mental Health Care Designations listed 3 areas covering sixteen counties as a geographic high need area, 1 area covering 4 counties designated as low income and another 12 areas covering 70 counties as having a mental health care shortage. Only 9 counties were determined to have enough mental health care services to not be eligible for a Mental Health Care Designation. Not surprisingly, these 9 counties are in 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 the two Systems of Care in Iowa which serve 12 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 Decategorization 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,
• County governments—limited in most areas by funding and Iowa code which defines the responsibility of counties to funding of outpatient services for children if financial eligibility criteria are met.

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—(formerly remedial services) 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. This service was moved to the Iowa Plan as of July 1, 2011 from Iowa Medicaid. This will allow for more coordination between the clinical services managed by the Iowa Plan and the primarily community-based skill building and crisis intervention service provided through BHIS. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children’s system. 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.

Iowa has a shortage of child psychiatrists with only 35 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 Systems of Care operated by University of Iowa Child Health Specialty Clinics has begun 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 are fragmented. These systems may include Systems of Care, Child Welfare, Children’s Mental Health Waiver, Juvenile Justice, Education, and Medicaid Managed Care (Magellan Behavioral Health).

SYSTEMS OF CARE
Central Iowa System of Care and Community Circle of Care

The Central Iowa System of Care (CISOC) and the Community Circle of Care (CCC) serve children and youth ages 0-21 who are diagnosed with a mental health disorder and meet the criteria for Serious Emotional Disturbance. CCC is a SAMHSA and state funded program while CISOC is funded by state and other federal funds. The children and youth served by both 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. Both programs provide the following services:

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

The overall goal of both programs is to help the identified child remain in their home, school, and community unless safety or clinical reasons require more intensive services. If such services are recommended, the program can remain involved with the family to support the child’s return to the family home more quickly by providing ongoing coordination and parent support. Families referred to the Systems of Care are often at the point of requesting assistance from the court or child welfare system or are seeking PMIC placement. Families have exhausted available resources and need an organized system of services and supports to avert placement or treatment of their child out of the home. Referral sources for both programs include parents, Department of Human Services (DHS) Child Welfare, Juvenile Court Services, PMIC’s, therapists, and other mental health service providers. CCC directly served 1,567 children and youth in SFY 11 in a ten county area. CISOC directly served 120 children and youth in a two county area.

Outcomes for the two Systems of Care programs demonstrate improved stability of living situation, improved school attendance and performance, and diversion from involuntary mental health commitment.
Additionally, Scott County has aligned with the Community Circle of Care to develop a System of Care and anticipates beginning direct services to children and families in October 2011. Other areas of the state are at varying stages of Systems of Care development. A statewide System of Care Workgroup comprised of stakeholders of planned and existing Systems of Care and wraparound projects meet on a regular basis to work on system development issues, consistency among programs, outcomes, and priorities.

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. This grant is instrumental in addressing these challenges by partially funding the Iowa Aftercare Services Program (aftercare).

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 of up to $574 per month 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.

Assisting these young people with housing and other forms of assistance during their transition from foster care is important because data from the report titled Medicaid Access for Youth Aging Out of Foster Care, published by the American Public Human Services Association states that 80% of youth in foster care have received services for mental health issues during placement, 54% have a mental health diagnosis after leaving care, and 12% and 10% had a lifetime diagnosis of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder, respectively. Iowa statistics for youth served by the Iowa Aftercare Network in SFY10 identify that 54% of participants are identified as SED. The services provided by this program are designed to help these youth receive housing and other supportive services needed to be successful, including community mental health 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, and at least 26 States around the country. In Iowa, Peer Support services are authorized through the managed care entity, Magellan Health Services. At present, there are 15-16 mental health providers billing Medicaid for Peer Support services. Graduates of the Iowa Peer Support Training Academy are working as Peer Support Specialists within each of those programs. In SFY 11, 330 individuals received peer support services, a slight increase in numbers served from SFY 10 when 269 individuals received peer support services. Less than 1% of the estimated individuals with Serious Mental Illness in Iowa currently receive Peer Support.

This year, the Division of MHDS hopes to release another call for proposals, to fund the Iowa Peer Support Training Academy for the next several years. The Advisory Committee of the IPSTA is also working with the Division of MHDS and the Iowa Board of Certification, around the development of criteria for certification for peer support specialists in Iowa.

The Iowa Peer Support Training Academy was developed in 2006, based upon the Georgia model, and is supported by Mental Health Block Grant dollars. Since 2006, when Iowa developed a training program for Peer Support Specialists, a total of 112 people have graduated from the Academy.

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. The next trainings in Iowa are scheduled for October.

Supported Community Living Programs
Supported Community Living Programs are accredited by the Mental Health/Disabilities Division of the Department of Human Services to provide supervised supported living to persons with disabilities. There are 103 accredited programs which currently provide services to persons with various disabilities. Approximately 20 of the programs can be identified as serving primarily persons with mental illnesses. It is accepted that the majority of the accredited programs serve individuals with mental health issues as a co-occurring disorder with other 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

IMR is a recognized EBP and there are currently approximately 4 providers serving approximately 8 counties in Iowa. IMR is also one of the EBPs identified to be more fully implemented within the next two years.

Intensive Psychiatric Rehabilitation
The 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 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 will be 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 will function to consolidate the activities of regional committees and coordinators.

The **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. 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 over 400 people in recovery through direct membership and several thousand people 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 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.

The 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.

NAMI Family Education course consists of a series of workshops for caregivers of children with brain disorders. Caregivers may be parents, extended family, or foster parents. Visions for Tomorrow is a family member-to-family member course. 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 has been very active in working as a community partner with the Iowa Juvenile Home and the Dare to Dream youth organization. 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 the mental health and aging initiative supported by the Division of MHDS. The Coalition was formed in 2005 and has been funded with mental health MHBG dollars since that time. The 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 has 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 meets weekly. 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 now has a membership of thirty organizations, all addressing the rapidly growing mental health needs of aging Americans. Iowa remains an active member in this national organization. The membership of the ICMHA includes over 600 individuals across Iowa.

Access to mental health services by persons over the age of 65 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. Preliminary results indicate 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 is expected by the end of September and will be made widely available. The Division of MHDS hopes to use these survey results to target training needs and inform the process of meeting the mental health needs of Iowans over the age of 60 in the years to come. The ICMHA has been delivering information and training throughout the state for the past several years.

The primary state agency serving older adults is the Department on Aging. The Department on Aging is a relatively small agency within state government and has a primary role in policy making. Among its’ many functions, the Department on Aging is home to the Office of the Long Term Care Ombudsman.

The Department on Aging has a significant collaborative and policy relationship with Iowa’s thirteen 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 (I4a).

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 plans are underway in SFY 12 to train staff in several additional areas of the State. It appears
there will be an increased focus and availability of these mental health services through the aging services network.

An important change in Iowa’s aging network is underway due to a legislative change mandated by the Iowa General Assembly during the 2011 session under House File 45.

In July and August of 2011, the Director of the Department on Aging, Donna Harvey hosted community conversations across the state to give Iowans an opportunity to understand the aging network and to provide the agency an opportunity to understand the concerns of Iowans about aging. This was also an opportunity to discuss HF 45, the legislative mandate to reduce the number of Area Agencies on Aging. A primary focus at each of the meetings has been on mental health, and the agency heard repeatedly from service providers and members of the public that mental health is a very large area of concern with a lot of unmet need.

The Aging and Disability Resource Center (ADRC) is supported by the Administration on Aging (AoA), the Centers for Medicare and Medicaid (CMS), and the State of Iowa. The Iowa Commission on Aging is the policy-making body that oversees the work of the project, which started with grant funding in 2008 in two counties and has since expanded.

The project is designed to

- Empower individuals to make informed choices
- Streamline access to long-term care supports and services
- Minimize consumer confusion
- Enhance individual choice
- Enable policy makers and program administrators to effectively respond to individual needs, address system problems, and limit the unnecessary use of high-cost services

The project hosts the Lifelong Links Web site, which provides information about long-term planning and access to services and resources. All Iowans, especially older adults, caregivers, people with disabilities and parents of children with disabilities, now have easier access to local, state, and national resources through one this Web portal, www.LifeLongLinks.org.
II: Planning Steps

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

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**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**

**Children with Serious Emotional Disturbance - Identified Needs**

Children served in out of state residential settings due to lack of local access points and treatment options available statewide for families to receive information, referral, and services for children with serious emotional disturbance and other mental health needs.

Iowa estimates that approximately 38,943 children meet the criteria of serious emotional disturbance. Of that amount, approximately 2% annually are served by the Children’s Mental Health Waiver, 1.5% are served by Systems of Care, 2.7% are served in Psychiatric Medical Institutions for Children, and 4% are the subject of involuntary mental health commitment filings. Increasing numbers of families are on the waiting list for the Children’s Mental Health Waiver. The waiting list is currently over 1,100. (Iowa Medicaid Slot Waiting List August 2011). Because of a combination of factors including limited waiver slots, 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.

The Iowa Legislature has directed the Children’s Disability Workgroup to address the issue of children placed out of state as a priority. An initial goal for this population is to address the reasons that children are placed out of state in order to receive mental health treatment and other types of residential care. From that process recommendations will be made to the Legislature regarding system changes needed to avoid out of state placement. The MHBG may be used to develop additional community based services to support these children upon return to their home communities and to prevent out of state placements for children at risk. Additional training and technical assistance of providers, stakeholders, and family members will be required to improve the system. This training may include wraparound facilitation training, mental health literacy, and specific children’s mental health issues. It is the opinion of the SMHA that addressing the needs of this population with creative, community-based treatment options will benefit all children with mental health needs as research on the Iowa population shows they have had multiple placement and treatment episodes prior to being placed in out of state facilities. These children have touched multiple systems prior to out of state placement and are in need of coordinated services before their symptoms exacerbate to the point of requiring out of home and eventually out of state placement.

**Adults with Serious Mental Illness**

**Co-occurring/complex needs training and technical assistance**

National data regarding adults with co-occurring disorders states that co-occurring mental health and substance abuse disorders are common. More than half (52 percent) of the people surveyed who had ever been diagnosed with alcohol abuse or dependence had also experienced a mental disorder at some time in their lives. An even larger proportion (59 percent) of people with a
history of other drug abuse or dependence also had experienced a mental disorder. Mental health problems often predate substance abuse problems by 4-6 years; alcohol or other drugs may be used as a form of self-medication to alleviate the symptoms of the mental disorder. In some cases, substance abuse precedes the development of mental health problems. Data Source (National Household Survey on Drug Abuse, 1999)

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.

Adults with Serious Mental Illness/Children with Serious Emotional Disturbance

Trauma-informed Care Training and Technical Assistance

The SMHA and Iowa mental health providers have identified development of trauma-informed systems of care as a priority for the mental health system. The experience of the providers in serving individuals with significant trauma histories, as well as national data regarding the prevalence of trauma, informs the system that trauma is a factor that must be addressed in order to improve service outcomes in the mental health system. An additional factor for Iowa is the high number of Iowa National Guard personnel who have served on active duty during the recent military mobilizations. These service personnel are at risk for trauma-related mental health issues, and it is important for the mental health system to be capable of identifying and addressing veterans’ trauma-related mental health needs.

Data Source: 51 – 98% of public mental health clients with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma (Goodman et al., 1999, Mueser et al., 1998; Cusack et al., 2003).

Data Source: 93% of psychiatrically hospitalized adolescents had histories of physical and/or sexual and emotional trauma; 32% met criteria for PTSD (Lipschitz et al., 1999).

Data Source: A national study reported that 14% of individuals who served in Iraq and Afghanistan screened positively for PTSD and 14% screened positively for Major Depression. (Iowa Veterans Mental Health Task Force Report, July 2010)

Adults with Serious Mental Illness

Peer Support Services

There is limited availability of peer support services in Iowa. Less than 1% of estimated individuals with SMI receive Peer Support Services. The SMHA would like to support training and retention of peer support services through use of the MHBG to provide new and ongoing training and technical assistance for Peer Support Specialists and the agencies that employ them. (Data Source: Iowa DHS Data Warehouse)
### Table 2 Step 3: Prioritize State Planning Activities

<table>
<thead>
<tr>
<th>Number</th>
<th>State Priority Title</th>
<th>State Priority Detailed Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To develop a coordinated system of care for children and youth identified with, or at risk of, serious emotional disturbance and their families.</td>
<td>The state is in the process of a legislatively mandated redesign of the adult and children's mental health and disability systems, enacted in July 2011. As a result of this process, it is expected that changes will be recommended by the Children's Disability Services work group regarding how the mental health system identifies, assesses and treats children and youth with mental health needs. An initial goal the workgroup is tasked with is identifying the needs of children and youth placed in out of state treatment and placement settings due to lack of treatment resources in this state.</td>
</tr>
<tr>
<td>2</td>
<td>To develop a service system that includes the capability of serving individuals with co-occurring or complex needs, those suffering from trauma, in crisis, etc.</td>
<td>The state is in the process of a legislatively mandated redesign of the adult and children's mental health and disability systems, enacted in July 2011. One of the tasks identified by the Iowa Legislature is to develop a proposal for service providers addressing co-occurring mental health, intellectual disability, brain injury, and substance abuse disorders. These recommendations are due to the Legislative interim committee by October 2011 with final recommendations to be made by December 9, 2011. The SMHA, in partnership with the SSA, has been engaged in developing co-occurring capability in the mental health, substance abuse, and other human service agencies for the last three years through provision of training to providers by national experts. Providers have also developed an advocacy group, Iowa Co-Occurring Recovery Network, in order to raise awareness of the needs of individuals with co-occurring issues and increase provider competency in this area. The SMHA plans to expand the knowledge base regarding trauma informed care, crisis intervention/stabilization, complex needs to other conditions that may co-occur with mental illness, including intellectual disability, brain injury, or other health conditions.</td>
</tr>
<tr>
<td>3</td>
<td>To further develop and sustain peer support services as a provider of mental health services.</td>
<td>The SMHA has used the Block Grant to support both the training of Peer Support Specialists at the statewide level and Community Mental Health Centers that receive Block Grant funds to implement peer support programs within their centers. The SMHA proposes to continue those initiatives as well as pursuing development of a standardized certification process for Iowa Peer Support Specialists and provision of continuing</td>
</tr>
</tbody>
</table>
education for Peer Support Specialists.

**Footnotes:**

Iowa may be amending any or all of the priorities and/or goals. The state is currently under a legislatively mandated Mental Health/Disability Services Redesign project.
## Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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

<table>
<thead>
<tr>
<th>Priority</th>
<th>Goal</th>
<th>Strategy</th>
<th>Performance Indicator</th>
<th>Description of Collecting and Measuring Changes in Performance Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. The Department of Human Services is engaged in a multi-division review of every child placed in an out of state facility for treatment of mental health or other disability conditions. This information will be provided to the Children's Disability Workgroup for development of recommendations to the Iowa Legislature in 2012.</td>
<td>There will be no net increase in numbers of children placed outside the state of Iowa for purposes of mental health treatment in SFY 13.</td>
<td>DHS will review placement data through the database identified in the strategy section, and report trends in placement of children out of state for mental health treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. DHS will create an internal monitoring and review process of each child currently out of state, or at risk of out of state placement, in order</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To reduce utilization of out of state placement and allow children to remain in their home communities whenever clinically appropriate.

To develop a service system that includes the capability of serving individuals with co-occurring or complex needs, those suffering from trauma, in crisis, etc.

Iowa, through the Mental Health Block Grant, will increase provider knowledge and skills in addressing trauma, crisis and conditions that co-occur with mental illness.

Iowa will provide 4 trainings in FFY 12 to service providers regarding development of a service system that is capable of successfully serving individuals with complex needs including trauma, crisis, and co-occurring issues. A component of the trainings is the opportunity for agencies to participate in a self-assessment and receive technical assistance.

The number of agencies/providers participating in technical assistance.

In FFY 12, at least 25 service providers will engage in the formal technical assistance process.

1. The SMHA will continue to provide support for agencies that implement peer support programs.
2. The SMHA will fund training of new peer support specialists in order to increase the available workforce. 3. The SMHA will fund continuing
To further develop and sustain peer support services as a provider of mental health services.

Iowa will increase the numbers of individuals who receive Medicaid-funded peer support services.

education and training of existing peer support specialists in order to support retention and professional development of peer support specialists.

4. The SMHA will work with the Advisory Committee of the Iowa Peer Support Training Academy and the Iowa Board of Certification toward the development of criteria for certification for peer support specialists in Iowa.

5. The SMHA will allow use of Block Grant funds to pay for peer support services for individuals without any other source of funding.

To increase the number of individuals receiving peer support services in SFY12 and SFY13, through Medicaid or block grant funding, using SFY 11 as our base year.

The SMHA will analyze and report utilization of peer support services from Medicaid data and agencies receiving the Block Grant to fund peer support services. A report of unduplicated number of persons receiving peer support services will be provided.

Footnotes:

Iowa may be amending any or all of the priorities and/or goals. The state is currently under a legislatively mandated Mental Health/Disability Services Redesign project.
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 4 Services Purchased Using Reimbursement Strategy

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Start Year: 

End Year: 

<table>
<thead>
<tr>
<th>Reimbursement Strategy</th>
<th>Services Purchased Using the Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Data Available</td>
</tr>
</tbody>
</table>

**Footnotes:**
### III: Use of Block Grant Dollars for Block Grant Activities

#### Table 5 Projected Expenditures for Treatment and Recovery Supports

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<table>
<thead>
<tr>
<th>Category</th>
<th>Service/Activity Example</th>
<th>Estimated Percent of Funds Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Home/Physical Health</td>
<td>• General and specialized outpatient medical services</td>
<td>&lt;10%</td>
</tr>
<tr>
<td></td>
<td>• Acute Primary Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• General Health Screens, Tests and Immunization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Comprehensive Care Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Care coordination and health promotion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Comprehensive transitional care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individual and Family Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Referral to Community Services</td>
<td></td>
</tr>
<tr>
<td>Engagement Services</td>
<td>• Assessment</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• Specialized Evaluation (Psychological and neurological)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services planning (includes crisis planning)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consumer/Family Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outreach</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>• Individual evidence-based therapies</td>
<td>&lt;10%</td>
</tr>
<tr>
<td></td>
<td>• Group therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multi-family therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consultation to Caregivers</td>
<td></td>
</tr>
<tr>
<td>Medication Services</td>
<td>• Medication management</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• Pharmacotherapy (including MAT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Laboratory services</td>
<td></td>
</tr>
<tr>
<td>Community Support (Rehabilitative)</td>
<td>• Parent/Caregiver Support</td>
<td>10-25%</td>
</tr>
<tr>
<td></td>
<td>• Skill building (social, daily living, cognitive)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case management</td>
<td></td>
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<tr>
<td></td>
<td>• Behavior management</td>
<td></td>
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<tr>
<td></td>
<td>• Supported employment</td>
<td></td>
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<tr>
<td></td>
<td>• Permanent supported housing</td>
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<td></td>
<td>• Recovery housing</td>
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<tr>
<td></td>
<td>• Therapeutic mentoring</td>
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<tr>
<td></td>
<td>• Traditional healing services</td>
<td></td>
</tr>
<tr>
<td>Recovery Supports</td>
<td>• Peer Support</td>
<td>&lt;10%</td>
</tr>
<tr>
<td></td>
<td>• Recovery Support Coaching</td>
<td></td>
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<tr>
<td></td>
<td>• Recovery Support Center Services</td>
<td></td>
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<tr>
<td></td>
<td>• Supports for Self Directed Care</td>
<td></td>
</tr>
<tr>
<td>Other Supports (Habilitative)</td>
<td>• Personal care</td>
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<tr>
<td></td>
<td>• Homemaker</td>
<td></td>
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<tr>
<td></td>
<td>• Respite</td>
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<tr>
<td></td>
<td>• Supported Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transportation</td>
<td></td>
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<tr>
<td></td>
<td>• Assisted living services</td>
<td></td>
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<tr>
<td><strong>Recreational services</strong></td>
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<tr>
<td>--------------------------</td>
<td></td>
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<tr>
<td>Interactive Communication Technology Devices</td>
<td></td>
<td></td>
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<tr>
<td>Trained behavioral health interpreters</td>
<td></td>
<td></td>
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<tr>
<td><strong>Intensive Support Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse intensive outpatient services</td>
<td></td>
<td></td>
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<tr>
<td>Partial hospitalization</td>
<td></td>
<td></td>
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<tr>
<td>Assertive community treatment</td>
<td></td>
<td></td>
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<tr>
<td>Intensive home based treatment</td>
<td></td>
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<tr>
<td>Multi-systemic therapy</td>
<td></td>
<td></td>
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<tr>
<td>Intensive case management</td>
<td></td>
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<tr>
<td><strong>Out-of-Home Residential Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis residential/stabilization</td>
<td></td>
<td></td>
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<tr>
<td>Clinically Managed 24-Hour Care</td>
<td></td>
<td></td>
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<tr>
<td>Clinically Managed Medium Intensity Care</td>
<td></td>
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<tr>
<td>Adult Mental Health Residential</td>
<td></td>
<td></td>
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<tr>
<td>Adult Substance Abuse Residential</td>
<td></td>
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<tr>
<td>Children's Mental Health Residential Services</td>
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<tr>
<td>Youth Substance Abuse Residential Services</td>
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<td>Therapeutic Foster Care</td>
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<td><strong>Acute Intensive Services</strong></td>
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<tr>
<td>Mobile crisis services</td>
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<tr>
<td>Medically Monitored Intensive Inpatient</td>
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<tr>
<td>Peer based crisis services</td>
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<tr>
<td>Urgent care services</td>
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<tr>
<td>23 hour crisis stabilization services</td>
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<tr>
<td>24/7 crisis hotline services</td>
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</tr>
<tr>
<td><strong>Prevention (Including Promotion)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment</td>
<td></td>
<td></td>
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<tr>
<td>Brief Motivational Interviews</td>
<td></td>
<td></td>
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<tr>
<td>Screening and Brief Intervention for Tobacco Cessation</td>
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<tr>
<td>Parent Training</td>
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<tr>
<td>Facilitated Referrals</td>
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<tr>
<td>Relapse Prevention /Wellness Recovery Support</td>
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<td></td>
</tr>
<tr>
<td>Warm line</td>
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<td></td>
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<tr>
<td><strong>System improvement activities</strong></td>
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</tr>
<tr>
<td>26-50%</td>
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</tr>
<tr>
<td><strong>Other</strong></td>
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<tr>
<td>&lt;10%</td>
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</tbody>
</table>

**Footnotes:**

System Improvement Activities: Iowa MHA uses the majority of the Mental Health Block Grant to provide training and consultation in evidenced base practices, including but not limited to: Co-Occurring Disorders, Trauma Informed Care, Family Psycho Education, Illness Management and Recover, etc.

Other: The Mental Health Block Grant supports the Office of Consumer Affairs. This is a statewide organization of persons with lived experience and family members of persons with lived experience.
### Table 6 Primary Prevention Planned Expenditures Checklist

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<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>Block Grant FY 2012</th>
<th>Other Federal</th>
<th>State</th>
<th>Local</th>
<th>Other</th>
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<tbody>
<tr>
<td>Information Dissemination</td>
<td>Universal</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Information Dissemination</td>
<td>Selective</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Information Dissemination</td>
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</tr>
<tr>
<td>Information Dissemination</td>
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<td>Information Dissemination</td>
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<td>$</td>
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<tr>
<td>Education</td>
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<td>$</td>
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<td>$</td>
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<tr>
<td>Education</td>
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<tr>
<td>Education</td>
<td>Total</td>
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<td>Alternatives</td>
<td>Selective</td>
<td>$</td>
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<tr>
<td>Alternatives</td>
<td>Indicated</td>
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<tr>
<td>Alternatives</td>
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<tr>
<td>Alternatives</td>
<td>Total</td>
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<tr>
<td>Problem Identification</td>
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<td>Problem Identification</td>
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<td>Problem Identification</td>
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<td>Problem Identification</td>
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<td>$</td>
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<td>Problem Identification</td>
<td>Total</td>
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<table>
<thead>
<tr>
<th>Community-Based Process</th>
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<td>Section 1926 Tobacco</td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

**Footnotes:**
### Table 7 Projected State Agency Expenditure Report

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Start Year: __________________________

End Year: __________________________

Date of State Expenditure Period From: 10/01/2011  Date of State Expenditure Period To: 09/30/2013

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Block Grant</th>
<th>B. Medicaid (Federal, State, and Local)</th>
<th>C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>D. State Funds</th>
<th>E. Local Funds (excluding local Medicaid)</th>
<th>F. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4. HIV Early Intervention Services</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5. State Hospital</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6. Other 24 Hour Care</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>7. Ambulatory/Community Non-24 Hour Care</td>
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<td>8. Administration (Excluding Program and Provider Level)</td>
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<td>9. Subtotal (Rows 1, 2, 3, 4, and 8)</td>
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<td>10. Subtotal (Rows 5, 6, 7, and 8)</td>
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**Footnotes:**
## III: Use of Block Grant Dollars for Block Grant Activities

### Table 8 Resource Development Planned Expenditures Checklist

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<tr>
<td>1. Planning, Coordination and Needs Assessment</td>
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<td>2. Quality Assurance</td>
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<td>4. Education (Pre-Employment)</td>
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<td>5. Program Development</td>
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<td>6. Research and Evaluation</td>
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<td>7. Information Systems</td>
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**Footnotes:**
IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
  - As applicable, please answer the following:
    - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
    - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
    - Does your State’s IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
    - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
    - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State’s current efforts to assist providers with developing and using Electronic Health Records.
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
Narrative Question:
SAMHSA expects 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 that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their 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 critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to 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 opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, 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 include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description 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.

Footnotes:
The State Mental Health Authority is currently working to set up meetings with the Tribes. This section will be amended by April 15, 2012.
H. Service Management Strategies

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
IV: Narrative Plan

I. State Dashboards (Table 10)
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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

<table>
<thead>
<tr>
<th>Plan Year:</th>
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<tr>
<th>Priority</th>
<th>Performance Indicator</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of a coordinated system of care children and youth identified with, or at risk of, serious emotional disturbance and their families</td>
<td>There will be no net increase in numbers of children placed outside the state of Iowa for purposes of mental health treatment in SFY 13.</td>
<td>€</td>
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<tr>
<td>Development of a service system that is capable of serving individuals with co-occurring or complex needs</td>
<td>Number of agencies/providers that participate in technical assistance with the consultants providing the training</td>
<td>€</td>
</tr>
<tr>
<td>Development of a trauma-informed system of care</td>
<td>Four trauma-informed care trainings will be held by June 30, 2013. Attendees will complete satisfaction surveys and demonstrate increased knowledge regarding the effect of trauma on individuals served within their systems.</td>
<td>€</td>
</tr>
<tr>
<td>Development and support of peer support services</td>
<td>Increased number of individuals receiving peer support services, through Medicaid or block grant funding, from SFY 11 to SFY 13.</td>
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</table>

Footnotes:
We request the ability to not select our Dashboard Priorities now. The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section will be amended and we will select our Dashboard Priorities.
In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America’s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:
The Iowa Department of Public Health (IDPH) and Iowa’s Suicide Prevention Strategy Steering
Committee, hereinafter referred to as the Committee, has guided the development of the Iowa
Plan for Suicide Prevention: 2011 to 2014. The committee 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](http://www.suicidology.org) - 1,998 and
2,656 multiplied by 6 respectively.

Draft - Iowa Plan for Suicide Prevention: 2011 to 2014

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: The Committee and the IDPH will select data-driven, promising practices focused on promoting suicide prevention services.

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

Objective 1.3: The Committee will expand collaborative partnerships to develop an implementation plan for a social marketing campaign.

Objective 1.4: The Committee, the 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: The committee will promote the Suicide Prevention Lifeline number and website through their networks.
Draft - Iowa Plan for Suicide Prevention: 2011 to 2014

Objective 1.6: The Committee, the IDPH and collaborative stakeholders will implement the planned social marketing campaign.

Objective 1.7: On an annual basis, the Committee 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 The Committee and the IDPH will identify specific populations (substance abuse treatment centers, mental health providers, LGBT, etc.) needing training.

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

Objective 2.3: The Committee and IDPH 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 The Committee and IDPH 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: The Committee and the IDPH 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: The Committee and the IDPH will promote mental health screening programs to primary care providers, pediatricians, and other healthcare providers.

Objective 3.3: The Committee 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: The Committee 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: The Committee 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: The committee will identify current suicide prevention gatekeeper programs conducted in schools and colleges and determine the most effective method to promote them.

Objective 4.2: The committee 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 Committee, 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: The Committee 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: The Committee 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: The Committee 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: The Committee will distribute its policy agenda to legislators and policy makers.

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

- 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

K. Technical Assistance Needs

Narrative Question:
Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. 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.

Footnotes:
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
L. Involvement of Individuals and Families
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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State 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:

• How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
• Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
• Does the State sponsor meetings that specifically identify individual and family members’ issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
• How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
• How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
Section L-Involvement of Individuals and Families

Iowa is actively engaging individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system through the following activities.

- Iowa has contracted with a consumer-operated organization, Iowa Advocates for Mental Health Recovery to operate the Office of Consumer Affairs (OCA). The OCA is developing regional advisory councils to provide input to the SMHA about consumer and family mental health needs.

- As part of the development of the FY2012 MHBG Application, SMHA staff met with the Mental Health Planning Council Block Grant application workgroup four times, with the entire Mental Health Planning Council once, and with a joint meeting of the Iowa Mental Health and Disability Services Commission and Mental Health Planning Council. The purpose of the meetings was to provide an overview of the new guidance from SAMHSA regarding the Mental Health Block Grant to all council and commission members and to work with a smaller group of Planning Council members regarding identification of strengths and needs of the Iowa mental health system. Planning Council members include consumers, family members, and other community stakeholders.

- The SMHA’s support of peer support specialists is documented in the needs assessment section, as well as identified as a priority for further development.

- The SMHA provides Block Grant funds that enables consumers to attend statewide mental health conferences, two of which are consumer-organized and include training presented by mental health consumers.

- Magellan Health Services, the Iowa Plan for Behavioral Health provider, provides on-line recovery and resiliency training free of charge to the public. Topics include peer support services, self-determination, self-directed planning, and other recovery and resiliency subjects.

- The Consumer and Family Experience Teams (CFET) Project is a statewide effort to obtain information from Iowa Plan for Behavioral Health members and their families about their experiences with accessing and utilizing mental health and substance abuse services. The results will be used to enhance communication of Iowa Plan information and support recovery and resiliency efforts across the state—and will be the driving force behind many of the focused changes and improvements to the behavioral health service delivery system. The Visiting Nurse Services (VNS) of Iowa and the Iowa Advocates for Mental Health Recovery (IAMHR), a consumer-operated organization, were selected to conduct focus groups and surveys. The information will be gathered by individuals who have the “lived experience” of a mental illness or substance abuse problem, or who have been a parent to someone who has experienced mental illness or substance abuse. The information will be shared with Magellan through peer-to-peer discussions in communities across Iowa.

- As part of the Mental Health and Disability Service System Redesign, the Department of Human Services will conduct regional meetings with multiple consumer advocacy organizations on a monthly basis during the redesign process to ensure consumer involvement and input into the redesign process.
Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICTs include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan 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?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
N. Support of State Partners

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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, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. 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; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State 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. 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 Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into 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.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local 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 child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.
The State of Iowa is currently undergoing a legislatively mandated Mental Health/Disability Services Redesign project. When the legislature provides direction of the future system this section may be amended.
Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:
## IV: Narrative Plan

**Table 11 List of Advisory Council Members**  
Pages 51 and 52 of the Application Guidance

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Belstene</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>714 Woodland Drive Carroll, IA 51401  PH: 712-792-9806</td>
<td><a href="mailto:jbelstene@hotmail.com">jbelstene@hotmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Teresa Bomhoff</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>200 S.W. 42nd Street Des Moines, IA 50312 PH: 515-274-6876</td>
<td><a href="mailto:tbomhoff@mchsi.com">tbomhoff@mchsi.com</a></td>
<td></td>
</tr>
<tr>
<td>Carol Braaksma</td>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>208 7th Street N.W. Orange City, IA 51041 PH: 712-707-9563</td>
<td><a href="mailto:Esllady03@yahoo.com">Esllady03@yahoo.com</a></td>
<td></td>
</tr>
<tr>
<td>Kenneth Briggs, Jr.</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>1701 Campus Drive, Apt. 3430 Clive, IA 50324 PH: 515-221-4560</td>
<td><a href="mailto:kebriggs@earthlink.net">kebriggs@earthlink.net</a></td>
<td></td>
</tr>
<tr>
<td>Jim Chesnik</td>
<td>State Employees</td>
<td>Hoover State Office Bldg., 5th Floor, 1305 E. Walnut Des Moines, IA 50319 PH: 515-281-9368</td>
<td><a href="mailto:jchesni@dhs.state.ia.us">jchesni@dhs.state.ia.us</a></td>
<td></td>
</tr>
<tr>
<td>Ron Clayman</td>
<td>Others (Not State employees or providers)</td>
<td>Depression and Bipolar Support Alliance</td>
<td>3800 Rollins Des Moines, IA 50312 PH: 515-279-5710</td>
<td><a href="mailto:bacomentalhealth@aol.com">bacomentalhealth@aol.com</a></td>
</tr>
<tr>
<td>Dr. Harbans S. Deol</td>
<td>State Employees</td>
<td>Iowa Medical and Classification Center, HWY 965 Oakdale, IA 52319 PH: 319-626-2391</td>
<td><a href="mailto:harbans.deol@iowa.gov">harbans.deol@iowa.gov</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Organization/Address</td>
<td>Phone</td>
<td>Email</td>
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</tr>
<tr>
<td>Jackie Dieckmann</td>
<td>Family Members of Individuals in</td>
<td>620 Grace Street Council Bluffs, IA 51503</td>
<td>PH: 712-343-1647</td>
<td><a href="mailto:jackiead@cox.net">jackiead@cox.net</a></td>
</tr>
<tr>
<td></td>
<td>Recovery (from Mental Illness and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addictions)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Tom Eachus</td>
<td>Providers</td>
<td>Black Hawk-Grundy Mental Health Center</td>
<td>PH: 319-234-2893</td>
<td><a href="mailto:teachus@bhgmhc.com">teachus@bhgmhc.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3251 West 9th Street Waterloo, IA 50702</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Flansburg</td>
<td>State Employees</td>
<td>Grimes Bldg, 400 E. 14th Street Des Moines, IA 50319</td>
<td>PH: 515-281-5795</td>
<td><a href="mailto:jim.flansburg@iowa.gov">jim.flansburg@iowa.gov</a></td>
</tr>
<tr>
<td>Patricia Gilbaugh</td>
<td>Family Members of Individuals in</td>
<td>202 7th Street, Box 266 Van Horne, IA 52346</td>
<td>PH: 319-361-6529</td>
<td><a href="mailto:Patti.gilbaugh@gmail.com">Patti.gilbaugh@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Recovery (from Mental Illness and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addictions)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Virgil Gooding</td>
<td>Providers</td>
<td>Keys to Awareness</td>
<td>PH: 319-363-5001</td>
<td><a href="mailto:Virgil.gooding@gmail.com">Virgil.gooding@gmail.com</a></td>
</tr>
<tr>
<td>Julie Kalambokidis</td>
<td>Providers</td>
<td>6 North Hazel Glenwood, IA 51534</td>
<td>PH: 712-527-4188</td>
<td><a href="mailto:Embracellc@yahoo.com">Embracellc@yahoo.com</a></td>
</tr>
<tr>
<td>Dr. Gregory Keller</td>
<td>State Employees</td>
<td>Clarinda Treatment Complex-MHI, 2000 N. 16th Street Clarinda, IA 51632</td>
<td>PH: 712-542-2161</td>
<td><a href="mailto:Gregory.keller@iowa.gov">Gregory.keller@iowa.gov</a></td>
</tr>
<tr>
<td>Sharon Lambert</td>
<td>Individuals in Recovery (from</td>
<td>Box 362 Buffalo, IA 52728</td>
<td>PH: 563-499-3502</td>
<td><a href="mailto:Lambertsha@gmail.com">Lambertsha@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>Mental Illness and Addictions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Todd Lange</td>
<td>Individuals in Recovery (from</td>
<td>225 West 6th Street Dubuque, IA 52001</td>
<td>PH: 563-564-2933</td>
<td><a href="mailto:tjange1@yahoo.com">tjange1@yahoo.com</a></td>
</tr>
<tr>
<td></td>
<td>Mental Illness and Addictions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amber Lewis</td>
<td>State Employees</td>
<td>Iowa Finance Authority, 2015 Grand Ave. Des Moines, IA 50312</td>
<td>PH: 515-725-4900</td>
<td><a href="mailto:Amber.lewis@iowa.gov">Amber.lewis@iowa.gov</a></td>
</tr>
<tr>
<td>Carol Logan</td>
<td>Providers</td>
<td>595 Crestview Avenue Ottumwa, IA 52501</td>
<td>PH: 641-799-4811</td>
<td><a href="mailto:clogan2011@gmail.com">clogan2011@gmail.com</a></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Name</td>
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</tr>
<tr>
<td>--------------------</td>
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<td>--------------------------------------------------</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>Sally Nadolsky</td>
<td>State Employees</td>
<td>Army Post Road Des Moines, IA 50315</td>
<td>515-725-1142</td>
<td><a href="mailto:snadols@dhs.state.ia.us">snadols@dhs.state.ia.us</a></td>
</tr>
<tr>
<td>Patrick Neal</td>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>Iowa Veteran's Home, 1301 Summit Street Marshalltown, IA 50158</td>
<td>641-752-2804</td>
<td><a href="mailto:prneal1944@yahoo.com">prneal1944@yahoo.com</a></td>
</tr>
<tr>
<td>Lori Reynolds</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>106 South Booth Anamosa, IA 52205</td>
<td>319-462-2187</td>
<td><a href="mailto:lori@iffcmh.org">lori@iffcmh.org</a></td>
</tr>
<tr>
<td>Donna Richard-Langer</td>
<td>Others (Not State employees or providers)</td>
<td>4105 Bel Air Drive Urbandale, IA 50323</td>
<td>515-278-7010</td>
<td><a href="mailto:drldkl@msn.com">drldkl@msn.com</a></td>
</tr>
<tr>
<td>Brad Richardson</td>
<td>State Employees</td>
<td>School of Social Work, University of Iowa, Research Park, W206 Oakdale Hall Iowa City, IA 52242</td>
<td>515-953-1990</td>
<td><a href="mailto:Brad-richardson@uiowa.edu">Brad-richardson@uiowa.edu</a></td>
</tr>
<tr>
<td>James W. Rixner</td>
<td>Providers</td>
<td>114 Midvale Avenue Sioux City, IA 51104</td>
<td>712-258-7855</td>
<td><a href="mailto:jwrx@aol.com">jwrx@aol.com</a></td>
</tr>
<tr>
<td>Rhonda Shouse</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>4861 First Avenue SW, Apt. 2A Cedar Rapids, IA 52405</td>
<td>319-310-9350</td>
<td><a href="mailto:Rhonda_Shouse@yahoo.com">Rhonda_Shouse@yahoo.com</a></td>
</tr>
<tr>
<td>Gennette Simmerman</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>1666 330th Avenue Randolph, IA 51649</td>
<td>712-310-6113</td>
<td><a href="mailto:gsimmer66@iowatelecom.net">gsimmer66@iowatelecom.net</a></td>
</tr>
<tr>
<td>Robin Stone</td>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>109 Grayson Court Manchester, IA 52057</td>
<td>563-927-5067</td>
<td><a href="mailto:rstone71256@yahoo.com">rstone71256@yahoo.com</a></td>
</tr>
<tr>
<td>Karen Van Ginkel</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>1319 11th Avenue Rock Valley, IA 51247</td>
<td>712-476-2436</td>
<td><a href="mailto:karengv51247@yahoo.com">karengv51247@yahoo.com</a></td>
</tr>
<tr>
<td>Michael Wood</td>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>2005 Geneva Street Sioux City, IA 51103</td>
<td>712-234-1040</td>
<td><a href="mailto:mhasiouxland@aol.com">mhasiouxland@aol.com</a></td>
</tr>
<tr>
<td>Nancy Sayres</td>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>18358 490th Street Mystic, IA 52574</td>
<td>PH: 641-647-2968</td>
<td><a href="mailto:nancy.sayres@gmail.com">nancy.sayres@gmail.com</a></td>
</tr>
</tbody>
</table>

**Footnotes:**
### Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
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<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>30</td>
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<tr>
<td>Individuals in Recovery (from Mental Illness and Addictions)</td>
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<tr>
<td>Family Members of Individuals in Recovery (from Mental Illness and Addictions)</td>
<td>10</td>
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<tr>
<td>Vacancies (Individuals and Family Members)</td>
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</tr>
<tr>
<td>Others (Not State employees or providers)</td>
<td>2</td>
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</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>18</td>
<td>60%</td>
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<tr>
<td>State Employees</td>
<td>7</td>
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<tr>
<td>Providers</td>
<td>5</td>
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<tr>
<td>Leading State Experts</td>
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<tr>
<td>Federally Recognized Tribe Representatives</td>
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</tr>
<tr>
<td>Vacancies</td>
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</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>12</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Footnotes:**
IV: Narrative Plan

P. Comment On The State Plan
Page 50 of the Application Guidance

Narrative Question:
SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:
Mental Health Planning Council participated in meetings with the SMHA in the creation of the Mental Health Block Grant. These meetings took place from April through July, 2011. The draft plan was disseminated in August, 2011 and feedback was incorporated.
AN ACT
RELATING TO REFORMING STATE AND COUNTY RESPONSIBILITIES FOR
ADULT DISABILITY SERVICES, MAKING APPROPRIATIONS, AND
INCLUDING EFFECTIVE DATE PROVISIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I
SERVICE SYSTEM REDESIGN

Section 1. ADULT DISABILITY SERVICES SYSTEM REDESIGN.

1. For the purposes of this section, "disability services" means services and other support available to a person with mental illness or an intellectual disability or other developmental disability.

2. It is the intent of the general assembly to redesign the system for adult disability services to implement all of the following:

   a. Shifting the funding responsibility for the nonfederal share of adult disability services paid for by the Medicaid program, including but not limited to all costs for the state resource centers, from the counties to the state.

   b. Reorganizing adult disability services not paid for by the Medicaid program into a system administered on a regional basis in a manner that provides multiple local points of access to adult disability services both paid for by the Medicaid...
program and not paid for by the Medicaid program.

c. Replacing legal settlement as the basis for determining financial responsibility for publicly funded disability services by determining such responsibility based upon residency.

d. Meeting the needs of consumers for disability services in a responsive and cost-effective manner.

3.  
a. The legislative council is requested to authorize an interim committee on mental health and disability services for the 2011 legislative interim to commence as soon as practicable. The purpose of the interim committee is to closely engage with, monitor, and propose legislation concerning the recommendations and proposals developed by the workgroups and other bodies addressed by this Act, particularly with regard to the identification of core services.

b. (1) It is intended that the interim committee members consist of equal numbers of legislators from both chambers and from both political parties. It is also requested that legislators serving on the interim committee and other interested legislators be authorized to participate in the meetings of the workgroups and subcommittees addressed in this Act.

(2) In addition to addressing workgroup recommendations, it is intended that the interim committee address property tax issues, devise a means of ensuring the state maintains its funding commitments for the redesigned services system, recommend revisions in the requirements for mental health professionals who are engaged in the involuntary commitment and examination processes under chapter 229, recommend revisions to the chapter 230A amendments contained in this Act as necessary to conform with the system redesign proposed by the interim committee, develop proposed legislation for amending Code references to mental retardation to instead refer to intellectual disabilities, and consider issues posed by the July 1, 2013, repeals of county disability services administration and funding provisions in 2011 Iowa Acts, Senate File 209. In addressing the repeal provisions, the interim committee shall consider all funding sources for replacing the county authority to levy for adult disability services.

(3) It is intended that the interim committee shall receive and make recommendations concerning the detailed and final proposals submitted by workgroups during the 2011 legislative interim for consideration by the general assembly in the 2012
legislative session.

c. (1) The department of human services shall design the workgroup process to facilitate effective decision making while allowing for a broad array of input. The workgroup process shall begin as soon after the effective date of this Act as is practicable. The membership of workgroups and subcommittees involved with the process shall include consumers, service providers, county representatives, and advocates and provide for adequate representation by both rural and urban interests. The department of public health shall be represented on those workgroups and subcommittees with a focus relevant to the department.

(2) The detailed and final proposals developed by the workgroups during the 2011 interim shall be submitted to the interim committee on or before December 9, 2011.

d. At least one workgroup shall address redesign of the adult mental health system and at least one workgroup shall address redesign of the adult intellectual and other developmental disability system. The workgroup process shall engage separate workgroups and subcommittees enumerated in this Act and may involve additional bodies in the process as determined by the department.

e. It is intended that interim committee members be engaged, to the extent possible, in workgroup deliberations and begin formal discussions of preliminary proposals developed by the workgroups beginning in October.

4. The workgroup process implemented by the department of human services pursuant to subsection 3 shall result in the submission of proposals for redesign of adult disability services that include but are not limited to all of the following:

a. Identifying clear definitions and requirements for the following:

   (1) Eligibility criteria for the individuals to be served.

   (2) The array of core services and other support to be included in regional adult disability services plans and to be delivered by providers based on individual needs and medical necessity and in a manner that promotes cost-effectiveness, uniformity, accessibility, and best practice approaches. The array shall encompass and integrate services and other support paid for by both the Medicaid program and other sources.

   (3) Outcome measures that focus on consumer needs, including but not limited to measures addressing individual
choice, empowerment, and community.

(4) Quality assurance measures.

(5) Provider accreditation, certification, or licensure requirements to ensure high quality services while avoiding unreasonable expectations and duplicative surveys.

(6) Input in regional service plans and delivery provisions by consumer and provider representatives. The input process shall engage local consumers, providers, and counties in developing the regional provisions.

(7) Provisions for representatives of the regional system and the department to regularly engage in discussions to resolve Medicaid and non-Medicaid issues involving documentation requirements, electronic records, reimbursement methodologies, cost projections, and other measures to improve the services and other support available to consumers.

b. Incorporating strategies to allow individuals to receive services in accordance with the principles established in Olmstead v. L.C., 527 U.S. 581 (1999), in order for services to be provided in the most community-based, least restrictive, and integrated setting appropriate to an individual’s needs.

c. Continuing the department’s leadership role in the Medicaid program in defining services covered, establishing reimbursement methodologies, providing other administrative functions, and engaging in federal options for program enhancements that are beneficial to consumers and the state such as medical or behavioral health homes.

d. Implementing mental health crisis response services statewide in a manner determined to be most appropriate by each region.

e. Implementing a subacute level of care to provide short-term mental health services in a structured residential setting that supplies a less intensive level of care than is supplied by acute psychiatric services.

f. Reviewing best practices and programs utilized by other states in identifying new approaches for addressing the needs for publicly funded services for persons with brain injury. The proposals regarding these approaches may be submitted after the workgroup submission date set out in subsection 3.

g. Developing a proposal for addressing service provider and other workforce shortages. The development of the proposal shall incorporate an examination of scope of practice limitations and barriers to recruiting providers and maintaining the workforce, including recruitment of minorities
and addressing cultural competency considerations for the workforce in general and for accrediting professional level providers, evaluating the impact of inadequate reimbursement, identifying the appropriate state role in providing the resources to ensure an appropriately trained workforce is available, and an examination of the variation in health insurance payment provisions for the services provided by different types of providers.

h. Developing a proposal for service providers addressing co-occurring mental health, intellectual disability, brain injury, and substance abuse disorders. Each workgroup or subcommittee shall address co-occurring disorders as appropriate to the focus of the workgroup or subcommittee. The overall proposal may be developed by a body consisting of members from other workgroups or subcommittees. The proposal shall also provide options, developed in coordination with the judicial branch and department of human services workgroup, for implementation of the provision of advocates to patients with substance-related disorders.

i. Developing a proposal for redesign of publicly funded children’s disability services, including but not limited to the needs of children who are placed out-of-state due to the lack of treatment services in this state. The proposal shall be developed by a separate workgroup or subcommittee led by the department of human services, in consultation with the department of public health, and in addition to the other interests and representation required by this section, the membership shall include the department of human services staff involved with child welfare, children’s mental health, and Medicaid services, and education system and juvenile court representatives. The preliminary findings and recommendations, and the initial proposal shall be submitted by the October and December 2011 dates required for other workgroups and subcommittees. The initial proposal developed during the 2011 legislative interim shall include an analysis of gaps in the children’s system and other planning provisions necessary to complete the final proposal for submission on or before December 10, 2012.

j. Developing a proposal for adult disability services not paid for by the Medicaid program to be administered on a regional basis in a manner that provides multiple local points of access for consumers needing adult disability services, regardless of the funding sources for the services.
The proposal shall be integrated with the other proposals under this subsection and shall be developed by a separate workgroup or subcommittee engaging both urban and rural county supervisors and central-point-of-coordination administrators and other experts. The considerations for inclusion in the proposal for forming regional entities shall include but are not limited to all of the following:

1. Modifying the relevant provisions of chapter 28E for use by counties in forming regional entities and addressing other necessary contracting measures.

2. Providing for performance-based contracting between the department of human services and regional entities to ensure the existence of multiple, local points of access for adult disability services eligibility, intake, and authorization, service navigation support, and case coordination or case management, regardless of the funding sources for the services.

3. Developing a three-year service plan and annual update to meet the needs of consumers.

4. Providing for the regional entities to implement performance-based contracts, uniform cost reports, and consistent reimbursement practices and payment methodologies with local providers of services not paid for by the Medicaid program.

5. Providing for the regional entities to determine the Medicaid program targeted case managers to serve the regions.

6. Providing for the regional entities and the department of human services to regularly coordinate and communicate with one another concerning the adult disability services paid for by the Medicaid program so that services paid for by the program and the regional entities are integrated and coordinated.

7. Identifying sufficient population size to attain economy of scale, adequate financial resources, and appropriate service delivery.

8. Addressing full participation in regional entities by counties.

9. Including dispute resolution provisions for county-to-county relationships, county-to-region relationships, and region-to-state relationships.

10. Providing for a consumer appeal process that is clear, impartial, and consistent, with consideration of an option that appeals beyond the regional level should be to a state administrative law judge.
(11) Addressing financial management provisions, including appropriate financial reserve levels.

(12) Proposing other criteria for forming regional entities. The other criteria considered shall include but are not limited to all of the following:
(a) Requiring a region to consist of contiguous counties.
(b) Evaluating a proposed region’s capacity for providing core services and performing required functions.
(c) Requiring a region to encompass at least one community mental health center or federally qualified health center with providers qualified to provide psychiatric services, either directly or with assistance from psychiatric consultants, that has the capacity to provide outpatient services for the region and has provided evidence of a commitment to provide outpatient services for the region.
(d) Requiring a region to encompass or have reasonably close proximity to a hospital with an inpatient psychiatric unit or to a state mental health institute, that has the capacity to provide inpatient services for the region and has provided evidence of a commitment to provide inpatient services for the region.
(e) Requiring an administrative structure utilized by a region to have clear lines of accountability and to serve as a lead agency with shared county staff or other means of limiting administrative costs to not more than five percent of expenditures.

k. Incorporating into proposals any necessary changes to the chapter 230A amendments contained in this Act.

1. Providing cost estimates for the proposals.

5. The target date for full implementation of the plan and implementation provisions described in subsections 3 and 4 shall be July 1, 2013, provided, however, that any expansion of services is subject to available funding.

Sec. 2. CONTINUATION OF WORKGROUP BY JUDICIAL BRANCH AND DEPARTMENT OF HUMAN SERVICES. The judicial branch and department of human services shall continue the workgroup implemented pursuant to 2010 Iowa Acts, chapter 1192, section 24, subsection 2, to improve the processes for involuntary commitment for chronic substance abuse under chapter 125 and for serious mental illness under chapter 229, and shall coordinate its efforts with the legislative interim committee and other workgroups initiated pursuant to this Act. The recommendations issued by the workgroup shall address options
to the current provision of transportation by the county sheriff; to the role, supervision, and funding of mental health patient advocates and substance-related disorder patient advocates, along with options for implementation of the provision of advocates to patients with such disorders; for revising requirements for mental health professionals who are engaged in the involuntary commitment and examination processes under chapter 229; for authorizing the court to order an involuntary hold of a patient under section 229.10 for not more than twenty-three hours who was not initially taken into custody but declined to be examined pursuant to a previous court order; for implementing jail diversion programs, comprehensive training of law enforcement in dealing with individuals who are experiencing a mental health crisis, mental health courts, and other promising reforms involving mental health and the criminal justice system; and for civil commitment prescreening. Preliminary recommendations shall be submitted to the legislative interim committee in October 2011, as specified by the interim committee. Additional stakeholders shall be added as necessary to facilitate the workgroup efforts. The workgroup shall complete deliberations and submit a final report to the legislative interim committee providing findings and recommendations on or before December 9, 2011.

Sec. 3. SERVICE SYSTEM DATA AND STATISTICAL INFORMATION INTEGRATION. In coordination with the legislative interim committee and workgroups initiated pursuant to this Act, representatives of the department of human services, department of public health, and the community services network hosted by the Iowa state association of counties shall develop implementation provisions for an integrated data and statistical information system for mental health, disability services, and substance abuse services. The implementation provisions shall incorporate federal data and statistical information requirements. When completed, the departments and affiliate shall report on the integrated system to the governor, the joint appropriations subcommittee on health and human services, and the legislative services agency, providing their findings and recommendations.

Sec. 4. DEPARTMENT OF HUMAN SERVICES. There is appropriated from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2010, and ending June 30, 2011, the following amount, or so much thereof as is necessary, to be used for the purposes designated:
For the costs of planning and other processes associated with implementation of this Act: $250,000

Notwithstanding section 8.47 or any other provision of law to the contrary, the department may utilize a sole source approach to contract to support planning and other processes associated with implementation of this Act. Notwithstanding section 8.33, moneys appropriated in this section that remain unencumbered or unobligated at the close of the fiscal year shall not revert but shall remain available for expenditure for the purposes designated until the close of the succeeding fiscal year.

Sec. 5. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION II
CONFORMING PROVISIONS

Sec. 6. CONFORMING PROVISIONS. The legislative services agency shall prepare a study bill for consideration by the committees on human resources of the senate and house of representatives for the 2012 legislative session, providing any necessary conforming Code changes for implementation of the system redesign provisions contained in this Act.

DIVISION III
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

Sec. 7. Section 135H.3, subsection 1, Code 2011, is amended to read as follows:
1. A psychiatric medical institution for children shall utilize a team of professionals to direct an organized program of diagnostic services, psychiatric services, nursing care, and rehabilitative services to meet the needs of residents in accordance with a medical care plan developed for each resident. The membership of the team of professionals may include but is not limited to an advanced registered nurse practitioner or a physician assistant. Social and rehabilitative services shall be provided under the direction of a qualified mental health professional.

Sec. 8. Section 135H.6, subsection 8, Code 2011, is amended to read as follows:
8. The department of human services may give approval to conversion of beds approved under subsection 6, to beds which are specialized to provide substance abuse treatment. However, the total number of beds approved under subsection 6 and this
subsection shall not exceed four hundred thirty. Conversion of beds under this subsection shall not require a revision of the certificate of need issued for the psychiatric institution making the conversion. Beds for children who do not reside in this state and whose service costs are not paid by public funds in this state are not subject to the limitations on the number of beds and certificate of need requirements otherwise applicable under this section.

Sec. 9. PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN AND RELATED SERVICES — TRANSITION COMMITTEE.

1. For the purposes of this section, unless the context otherwise requires:
   a. "Iowa plan" means the contract to administer the behavioral health managed care plan under the state’s Medicaid program.
   b. "PMIC" means a psychiatric medical institution for children.

2. It is the intent of the general assembly to do the following under this section:
   a. Improve the reimbursement, expected outcomes, and integration of PMIC services to serve the best interests of children within the context of a redesign of the delivery of publicly funded children’s mental health services in this state.
   b. Support the development of specialized programs for children with high acuity requirements whose needs are not met by Iowa’s current system and must be served in out-of-state placements.
   c. Transition PMIC services while providing services in a manner that applies best practices and is cost-effective.

3. The department of human services, in collaboration with PMIC providers, shall develop a plan for transitioning the administration of PMIC services to the Iowa plan. The transition plan shall address specific strategies for appropriately addressing PMIC lengths of stay by increasing the availability of less intensive levels of care, establishing vendor performance standards, identifying levels of PMIC care, providing for performance and quality improvement technical assistance to providers, identifying methods and standards for credentialing providers of specialized programs, using innovative reimbursement incentives to improve access while building the capacity of less intensive levels of care, and providing implementation guidelines.
4. a. The transition plan shall address the development of specialized programs to address the needs of children in need of more intensive treatment who are currently underserved. All of the following criteria shall be used for such programs:
   (1) Geographic accessibility.
   (2) Expertise needed to assure appropriate and effective treatment.
   (3) Capability to define and provide the appropriate array of services and report on standardized outcome measures.
   (4) Best interests of the child.

b. The transition plan shall also address all of the following:
   (1) Providing navigation, access, and care coordination for children and families in need of services from the children’s mental health system.
   (2) Integrating the children’s mental health waiver services under the Medicaid program with other services addressed by the transition plan as a means for supporting the transition plan and ensuring availability of choices for community placements.
   (3) Identifying admission and continued stay criteria for PMIC providers.
   (4) Evaluating changes in licensing standards for PMICs as necessary to ensure that the standards are aligned with overall system goals.
   (5) Evaluating alternative reimbursement and service models that are innovative and could support overall system goals. The models may include but are not limited to accountable care organizations, medical or other health homes, and performance-based payment methods.
   (6) Evaluating the adequacy of reimbursement at all levels of the children’s mental health system.
   (7) Developing profiles of the conditions and behaviors that result in a child’s involuntary discharge or out-of-state placement. The plan shall incorporate provisions for developing specialized programs that are designed to appropriately meet the needs identified in the profiles.
   (8) Evaluating and defining the appropriate array of less intensive services for a child leaving a hospital or PMIC placement.
   (9) Evaluating and defining the standards for existing and new PMIC and other treatment levels.

5. a. The department shall establish a transition committee
that includes departmental staff representatives for Medicaid, child welfare, field, and mental health services, the director of the Iowa plan, the department of inspections and appeals, a representative of each licensed PMIC, the executive director of the coalition of family and children’s services in Iowa, a person with knowledge and expertise in care coordination and integration of PMIC and community-based services, two persons representing families affected by the children’s mental health system, and a representative of juvenile court officers.

b. The transition committee shall develop the plan and manage the transition if the plan is implemented. A preliminary plan shall be provided to the legislative interim committee authorized pursuant to division I of this Act for consideration by the committee in October 2011. The completed plan shall be provided to the interim committee by December 9, 2011, and any revisions to address concerns identified by the interim committee shall be incorporated into a final plan developed by December 31, 2011, which shall be submitted to the general assembly by January 16, 2012. The submitted plan shall include an independent finding by the director of human services, in consultation with the office of the governor and the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, that the plan meets the intent of the general assembly under this section. Unless otherwise directed by enactment of the general assembly the department and the transition committee may proceed with implementation of the submitted plan on or before July 1, 2012.

c. The transition committee shall continue to meet through December 31, 2013, to oversee transition of PMIC services to the Iowa plan.

6. The director of the Medicaid enterprise of the department of human services shall annually report on or before December 15 to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services through December 15, 2016, regarding the implementation of this section. The content of the report shall include but is not limited to information on children served by PMIC providers, the types of locations to which children are discharged following a hospital or PMIC placement and the community-based services available to such children, and the incidence of readmission to a PMIC within 12 months of discharge. The report shall also recommend whether or not to continue
administration of PMIC services under the Iowa plan based upon the quality of service delivery, the value of utilizing the Iowa plan administration rather than the previous approach through the Medicaid enterprise, and analysis of the cost and benefits of utilizing the Iowa plan approach.

DIVISION IV

COMMUNITY MENTAL HEALTH CENTERS

COMMUNITY MENTAL HEALTH CENTERS — CATCHMENT AREAS

Sec. 10. IMPLEMENTATION OF DIVISION — LEGISLATIVE INTENT. It is the intent of the general assembly that the statutory amendments contained in this division shall receive further consideration in the disability services system redesign process implemented pursuant to division I of this Act and by the general assembly during the 2012 legislative session. The purpose of the further consideration is to ensure that the statutory amendments are integrated with the system redesign provisions, including but not limited to the provisions involving meeting the needs of consumers, connecting the regional administration of the overall system with the catchment areas for community mental health services, involvement of counties, terminology utilized, matching core services for centers with the core services for the overall system redesign, and matching accreditation standards, financing provisions, and accountability measures.

Sec. 11. NEW SECTION. 230A.101 Services system roles.

1. The role of the department of human services, through the division of the department designated as the state mental health authority with responsibility for state policy concerning mental health and disability services, is to develop and maintain policies for the mental health and disability services system. The policies shall address the service needs of individuals of all ages with disabilities in this state, regardless of the individuals’ places of residence or economic circumstances, and shall be consistent with the requirements of chapter 225C and other applicable law.

2. The role of community mental health centers in the mental health and disability services system is to provide an organized set of services in order to adequately meet the mental health needs of this state’s citizens based on organized catchment areas.

Sec. 12. NEW SECTION. 230A.102 Definitions.

As used in this chapter, unless the context otherwise requires:
1. "Administrator", "commission", "department", "disability services", and "division" mean the same as defined in section 225C.2.

2. "Catchment area" means a community mental health center catchment area identified in accordance with this chapter.

3. "Community mental health center" or "center" means a community mental health center designated in accordance with this chapter.

Sec. 13. NEW SECTION. 230A.103 Designation of community mental health centers.

1. The division, subject to agreement by any community mental health center that would provide services for the catchment area and approval by the commission, shall designate at least one community mental health center under this chapter for addressing the mental health needs of the county or counties comprising the catchment area. The designation process shall provide for the input of potential service providers regarding designation of the initial catchment area or a change in the designation.

2. The division shall utilize objective criteria for designating a community mental health center to serve a catchment area and for withdrawing such designation. The commission shall adopt rules outlining the criteria. The criteria shall include but are not limited to provisions for meeting all of the following requirements:

   a. An appropriate means shall be used for determining which prospective designee is best able to serve all ages of the targeted population within the catchment area with minimal or no service denials.

   b. An effective means shall be used for determining the relative ability of a prospective designee to appropriately provide mental health services and other support to consumers residing within a catchment area as well as consumers residing outside the catchment area. The criteria shall address the duty for a prospective designee to arrange placements outside the catchment area when such placements best meet consumer needs and to provide services within the catchment area to consumers who reside outside the catchment area when the services are necessary and appropriate.

3. The board of directors for a designated community mental health center shall enter into an agreement with the division. The terms of the agreement shall include but are not limited to all of the following:
a. The period of time the agreement will be in force.

b. The services and other support the center will offer or provide for the residents of the catchment area.

c. The standards to be followed by the center in determining whether and to what extent the persons seeking services from the center shall be considered to be able to pay the costs of the services.

d. The policies regarding availability of the services offered by the center to the residents of the catchment area as well as consumers residing outside the catchment area.

e. The requirements for preparation and submission to the division of annual audits, cost reports, program reports, performance measures, and other financial and service accountability information.

4. This section does not limit the authority of the board or the boards of supervisors of any county or group of counties to continue to expend money to support operation of a center.

Sec. 14. NEW SECTION. 230A.104 Catchment areas.

1. The division shall collaborate with affected counties in identifying community mental health center catchment areas in accordance with this section.

2. a. Unless the division has determined that exceptional circumstances exist, a catchment area shall be served by one community mental health center. The purpose of this general limitation is to clearly designate the center responsible and accountable for providing core mental health services to the target population in the catchment area and to protect the financial viability of the centers comprising the mental health services system in the state.

b. A formal review process shall be used in determining whether exceptional circumstances exist that justify designating more than one center to serve a catchment area. The criteria for the review process shall include but are not limited to a means of determining whether the catchment area can support more than one center.

c. Criteria shall be provided that would allow the designation of more than one center for all or a portion of a catchment area if designation or approval for more than one center was provided by the division as of October 1, 2010. The criteria shall require a determination that all such centers would be financially viable if designation is provided for all.

Sec. 15. NEW SECTION. 230A.105 Target population — eligibility.
1. The target population residing in a catchment area to be served by a community mental health center shall include but is not limited to all of the following:
   a. Individuals of any age who are experiencing a mental health crisis.
   b. Individuals of any age who have a mental health disorder.
   c. Adults who have a serious mental illness or chronic mental illness.
   d. Children and youth who are experiencing a serious emotional disturbance.
   e. Individuals described in paragraph "a", "b", "c", or "d" who have a co-occurring disorder, including but not limited to substance abuse, mental retardation, a developmental disability, brain injury, autism spectrum disorder, or another disability or special health care need.

2. Specific eligibility criteria for members of the target population shall be identified in administrative rules adopted by the commission. The eligibility criteria shall address both clinical and financial eligibility.

Sec. 16. NEW SECTION. 230A.106 Services offered.

1. A community mental health center designated in accordance with this chapter shall offer core services and support addressing the basic mental health and safety needs of the target population and other residents of the catchment area served by the center and may offer other services and support. The core services shall be identified in administrative rules adopted by the commission for this purpose.

2. The initial core services identified shall include all of the following:
   a. Outpatient services. Outpatient services shall consist of evaluation and treatment services provided on an ambulatory basis for the target population. Outpatient services include psychiatric evaluations, medication management, and individual, family, and group therapy. In addition, outpatient services shall include specialized outpatient services directed to the following segments of the target population: children, elderly, individuals who have serious and persistent mental illness, and residents of the service area who have been discharged from inpatient treatment at a mental health facility. Outpatient services shall provide elements of diagnosis, treatment, and appropriate follow-up. The provision of only screening and referral services does not constitute outpatient services.
b. Twenty-four-hour emergency services. Twenty-four-hour emergency services shall be provided through a system that provides access to a clinician and appropriate disposition with follow-up documentation of the emergency service provided. A patient shall have access to evaluation and stabilization services after normal business hours. The range of emergency services that shall be available to a patient may include but are not limited to direct contact with a clinician, medication evaluation, and hospitalization. The emergency services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

c. Day treatment, partial hospitalization, or psychosocial rehabilitation services. Such services shall be provided as structured day programs in segments of less than twenty-four hours using a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services based on the needs of the patient. These services may be provided directly by the center or in collaboration or affiliation with other appropriately accredited providers.

d. Admission screening for voluntary patients. Admission screening services shall be available for patients considered for voluntary admission to a state mental health institute to determine the patient’s appropriateness for admission.

e. Community support services. Community support services shall consist of support and treatment services focused on enhancing independent functioning and assisting persons in the target population who have a serious and persistent mental illness to live and work in their community setting, by reducing or managing mental illness symptoms and the associated functional disabilities that negatively impact such persons’ community integration and stability.

f. Consultation services. Consultation services may include provision of professional assistance and information about mental health and mental illness to individuals, service providers, or groups to increase such persons’ effectiveness in carrying out their responsibilities for providing services. Consultations may be case-specific or program-specific.

g. Education services. Education services may include information and referral services regarding available resources and information and training concerning mental
health, mental illness, availability of services and other support, the promotion of mental health, and the prevention of mental illness. Education services may be made available to individuals, groups, organizations, and the community in general.

3. A community mental health center shall be responsible for coordinating with associated services provided by other unaffiliated agencies to members of the target population in the catchment area and to integrate services in the community with services provided to the target population in residential or inpatient settings.

Sec. 17. NEW SECTION. 230A.107 Form of organization.
1. Except as authorized in subsection 2, a community mental health center designated in accordance with this chapter shall be organized and administered as a nonprofit corporation.

2. A for-profit corporation, nonprofit corporation, or county hospital providing mental health services to county residents pursuant to a waiver approved under section 225C.7, subsection 3, Code 2011, as of October 1, 2010, may also be designated as a community mental health center.

Sec. 18. NEW SECTION. 230A.108 Administrative, diagnostic, and demographic information.
Release of administrative and diagnostic information, as defined in section 228.1, and demographic information necessary for aggregated reporting to meet the data requirements established by the division, relating to an individual who receives services from a community mental health center, may be made a condition of support of that center by the division.

Sec. 19. NEW SECTION. 230A.109 Funding — legislative intent.
1. It is the intent of the general assembly that public funding for community mental health centers designated in accordance with this chapter shall be provided as a combination of all funding sources.

2. It is the intent of the general assembly that the state funding provided to centers be a sufficient amount for the core services and support addressing the basic mental health and safety needs of the residents of the catchment area served by each center to be provided regardless of individual ability to pay for the services and support.

3. While a community mental health center must comply with the core services requirements and other standards associated with designation, provision of services is subject to the
availability of a payment source for the services.

Sec. 20. NEW SECTION. 230A.110 Standards.

1. The division shall recommend and the commission shall adopt standards for designated community mental health centers and comprehensive community mental health programs, with the overall objective of ensuring that each center and each affiliate providing services under contract with a center furnishes high-quality mental health services within a framework of accountability to the community it serves. The standards adopted shall conform with federal standards applicable to community mental health centers and shall be in substantial conformity with the applicable behavioral health standards adopted by the joint commission, formerly known as the joint commission on accreditation of health care organizations, and other recognized national standards for evaluation of psychiatric facilities unless in the judgment of the division, with approval of the commission, there are sound reasons for departing from the standards.

2. When recommending standards under this section, the division shall designate an advisory committee representing boards of directors and professional staff of designated community mental health centers to assist in the formulation or revision of standards. The membership of the advisory committee shall include representatives of professional and nonprofessional staff and other appropriate individuals.

3. The standards recommended under this section shall include requirements that each community mental health center designated under this chapter do all of the following:
   a. Maintain and make available to the public a written statement of the services the center offers to residents of the catchment area being served. The center shall employ or contract for services with affiliates to employ staff who are appropriately credentialed or meet other qualifications in order to provide services.
   b. If organized as a nonprofit corporation, be governed by a board of directors which adequately represents interested professions, consumers of the center’s services, socioeconomic, cultural, and age groups, and various geographical areas in the catchment area served by the center. If organized as a for-profit corporation, the corporation’s policy structure shall incorporate such representation.
   c. Arrange for the financial condition and transactions of the community mental health center to be audited once each year.
by the auditor of state. However, in lieu of an audit by state accountants, the local governing body of a community mental health center organized under this chapter may contract with or employ certified public accountants to conduct the audit, pursuant to the applicable terms and conditions prescribed by sections 11.6 and 11.19 and audit format prescribed by the auditor of state. Copies of each audit shall be furnished by the accountant to the administrator of the division of mental health and disability services.

d. Comply with the accreditation standards applicable to the center.

Sec. 21. NEW SECTION. 230A.111 Review and evaluation.

1. The review and evaluation of designated centers shall be performed through a formal accreditation review process as recommended by the division and approved by the commission. The accreditation process shall include all of the following:
   a. Specific time intervals for full accreditation reviews based upon levels of accreditation.
   b. Use of random or complaint-specific, on-site limited accreditation reviews in the interim between full accreditation reviews, as a quality review approach. The results of such reviews shall be presented to the commission.
   c. Use of center accreditation self-assessment tools to gather data regarding quality of care and outcomes, whether used during full or limited reviews or at other times.

2. The accreditation process shall include but is not limited to addressing all of the following:
   a. Measures to address centers that do not meet standards, including authority to revoke accreditation.
   b. Measures to address noncompliant centers that do not develop a corrective action plan or fail to implement steps included in a corrective action plan accepted by the division.
   c. Measures to appropriately recognize centers that successfully complete a corrective action plan.
   d. Criteria to determine when a center’s accreditation should be denied, revoked, suspended, or made provisional.

Sec. 22. REPEAL. Sections 230A.1 through 230A.18, Code 2011, are repealed.

Sec. 23. IMPLEMENTATION — EFFECTIVE DATE.

1. Community mental health centers operating under the provisions of chapter 230A, Code 2011, and associated standards, rules, and other requirements as of June 30, 2012, may continue to operate under such requirements until the
department of human services, division of mental health and disability services, and the mental health and disability services commission have completed the rules adoption process to implement the amendments to chapter 230A enacted by this Act, identified catchment areas, and completed designations of centers.

2. The division and the commission shall complete the rules adoption process and other requirements addressed in subsection 1 on or before June 30, 2012.

3. Except for this section, which shall take effect July 1, 2011, this division of this Act takes effect July 1, 2012.

DIVISION V
PERSONS WITH SUBSTANCE-RELATED DISORDERS
AND PERSONS WITH MENTAL ILLNESS

Sec. 24. Section 125.1, subsection 1, Code 2011, is amended to read as follows:

1. That persons with substance-related disorders be afforded the opportunity to receive quality treatment and directed into rehabilitation services which will help them resume a socially acceptable and productive role in society.

Sec. 25. Section 125.2, subsection 2, Code 2011, is amended by striking the subsection.

Sec. 26. Section 125.2, subsection 5, Code 2011, is amended by striking the subsection and inserting in lieu thereof the following:

5. “Substance-related disorder” means a diagnosable substance abuse disorder of sufficient duration to meet diagnostic criteria specified within the most current diagnostic and statistical manual of mental disorders published by the American psychiatric association that results in a functional impairment.

Sec. 27. Section 125.2, subsection 9, Code 2011, is amended to read as follows:

9. “Facility” means an institution, a detoxification center, or an installation providing care, maintenance and treatment for persons with substance-related disorders licensed by the department under section 125.13, hospitals licensed under chapter 135B, or the state mental health institutes designated by chapter 226.

Sec. 28. Section 125.2, subsections 13, 17, and 18, Code 2011, are amended by striking the subsections.

Sec. 29. Section 125.9, subsections 2 and 4, Code 2011, are
amended to read as follows:

2. Make contracts necessary or incidental to the performance of the duties and the execution of the powers of the director, including contracts with public and private agencies, organizations and individuals to pay them for services rendered or furnished to substance abusers, chronic substance abusers, or intoxicated persons with substance-related disorders.

4. Coordinate the activities of the department and cooperate with substance abuse programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local or private agencies in this and other states for the treatment of substance abusers, chronic substance abusers, and intoxicated persons with substance-related disorders and for the common advancement of substance abuse programs.

Sec. 30. Section 125.10, subsections 2, 3, 4, 5, 7, 8, 9, 11, 13, 15, and 17, Code 2011, are amended to read as follows:

2. Develop, encourage, and foster statewide, regional and local plans and programs for the prevention of substance abuse misuse and the treatment of substance abusers, chronic substance abusers, and intoxicated persons with substance-related disorders in cooperation with public and private agencies, organizations and individuals, and provide technical assistance and consultation services for these purposes.

3. Coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in the prevention of substance abuse and the treatment of substance abusers, chronic substance abusers, and intoxicated persons with substance-related disorders.

4. Cooperate with the department of human services and the Iowa department of public health in establishing and conducting programs to provide treatment for substance abusers, chronic substance abusers, and intoxicated persons with substance-related disorders.

5. Cooperate with the department of education, boards of education, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of substance abuse and the treatment of substance abusers, chronic substance abusers, and intoxicated persons with substance-related disorders, and in preparing relevant curriculum materials for
use at all levels of school education.

7. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders, which program shall include the dissemination of information concerning the nature and effects of chemical substances.

8. Organize and implement, in cooperation with local treatment programs, training programs for all persons engaged in treatment of substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders.

9. Sponsor and implement research in cooperation with local treatment programs into the causes and nature of substance abuse misuse and treatment of substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders, and serve as a clearing house for information relating to substance abuse.

11. Develop and implement, with the counsel and approval of the board, the comprehensive plan for treatment of substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders in accordance with this chapter.

13. Utilize the support and assistance of interested persons in the community, particularly recovered substance abusers and chronic substance abusers, persons who are recovering from substance-related disorders to encourage substance abusers and chronic substance abusers persons with substance-related disorders to voluntarily undergo treatment.

15. Encourage general hospitals and other appropriate health facilities to admit without discrimination substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders and to provide them with adequate and appropriate treatment. The director may negotiate and implement contracts with hospitals and other appropriate health facilities with adequate detoxification facilities.

17. Review all state health, welfare, education and treatment proposals to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to substance abuse, substance abusers, chronic substance abusers, and intoxicated persons persons with substance-related disorders.
Sec. 31. Section 125.12, subsections 1 and 3, Code 2011, are amended to read as follows:

1. The board shall review the comprehensive substance abuse program implemented by the department for the treatment of substance abusers, chronic substance abusers, intoxicated persons persons with substance-related disorders, and concerned family members. Subject to the review of the board, the director shall divide the state into appropriate regions for the conduct of the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to city and county lines, population concentrations, and existing substance abuse treatment services.

3. The director shall provide for adequate and appropriate treatment for substance abusers, chronic substance abusers, intoxicated persons persons with substance-related disorders, and concerned family members admitted under sections 125.33 and 125.34, or under section 125.75, 125.81, or 125.91. Treatment shall not be provided at a correctional institution except for inmates.

Sec. 32. Section 125.13, subsection 1, paragraph a, Code 2011, is amended to read as follows:

a. Except as provided in subsection 2, a person shall not maintain or conduct any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program, the primary purpose of which is the treatment and rehabilitation of substance abusers or chronic substance abusers persons with substance-related disorders without having first obtained a written license for the program from the department.

Sec. 33. Section 125.13, subsection 2, paragraphs a and c, Code 2011, are amended to read as follows:

a. A hospital providing care or treatment to substance abusers or chronic substance abusers persons with substance-related disorders licensed under chapter 135B which is accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized organization approved by the board. All survey reports from the accrediting or licensing body must be sent to the department.

c. Private institutions conducted by and for persons who adhere to the faith of any well recognized church or religious
denomination for the purpose of providing care, treatment, counseling, or rehabilitation to substance abusers or chronic substance abusers persons with substance-related disorders and who rely solely on prayer or other spiritual means for healing in the practice of religion of such church or denomination.

Sec. 34. Section 125.15, Code 2011, is amended to read as follows:

125.15 Inspections.

The department may inspect the facilities and review the procedures utilized by any chemical substitutes or antagonists program, residential program, or nonresidential outpatient program that has as a primary purpose the treatment and rehabilitation of substance abusers or chronic substance abusers persons with substance-related disorders, for the purpose of ensuring compliance with this chapter and the rules adopted pursuant to this chapter. The examination and review may include case record audits and interviews with staff and patients, consistent with the confidentiality safeguards of state and federal law.

Sec. 35. Section 125.32, unnumbered paragraph 1, Code 2011, is amended to read as follows:

The department shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, subject to chapter 17A, considering available treatment resources and facilities, for the purpose of early and effective treatment of substance abusers, chronic substance abusers, intoxicated persons, persons with substance-related disorders and concerned family members. In establishing the rules the department shall be guided by the following standards:

Sec. 36. Section 125.33, subsections 1, 3, and 4, Code 2011, are amended to read as follows:

1. A substance abuser or chronic substance abuser person with a substance-related disorder may apply for voluntary treatment or rehabilitation services directly to a facility or to a licensed physician and surgeon or osteopathic physician and surgeon. If the proposed patient is a minor or an incompetent person, a parent, a legal guardian or other legal representative may make the application. The licensed physician and surgeon or osteopathic physician and surgeon or any employee or person acting under the direction or supervision of the physician and surgeon or osteopathic physician and surgeon, or the facility shall not report or disclose the name of the person or the fact that treatment
was requested or has been undertaken to any law enforcement officer or law enforcement agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. If the person seeking such treatment or rehabilitation is a minor who has personally made application for treatment, the fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without the minor’s consent, and the minor may give legal consent to receive such treatment and rehabilitation.

3. A substance abuser or chronic substance abuser person with a substance-related disorder seeking treatment or rehabilitation and who is either addicted or dependent on a chemical substance may first be examined and evaluated by a licensed physician and surgeon or osteopathic physician and surgeon who may prescribe a proper course of treatment and medication, if needed. The licensed physician and surgeon or osteopathic physician and surgeon may further prescribe a course of treatment or rehabilitation and authorize another licensed physician and surgeon or osteopathic physician and surgeon or facility to provide the prescribed treatment or rehabilitation services. Treatment or rehabilitation services may be provided to a person individually or in a group. A facility providing or engaging in treatment or rehabilitation shall not report or disclose to a law enforcement officer or law enforcement agency the name of any person receiving or engaged in the treatment or rehabilitation; nor shall a person receiving or participating in treatment or rehabilitation report or disclose the name of any other person engaged in or receiving treatment or rehabilitation or that the program is in existence, to a law enforcement officer or law enforcement agency. Such information shall not be admitted in evidence in any court, grand jury, or administrative proceeding. However, a person engaged in or receiving treatment or rehabilitation may authorize the disclosure of the person’s name and individual participation.

4. If a patient receiving inpatient or residential care leaves a facility, the patient shall be encouraged to consent to appropriate outpatient or halfway house treatment. If it appears to the administrator in charge of the facility that the patient is a substance abuser or chronic substance abuser
person with a substance-related disorder who requires help, the director may arrange for assistance in obtaining supportive services.

Sec. 37. Section 125.34, Code 2011, is amended to read as follows:

125.34 Treatment and services for intoxicated persons and persons incapacitated by alcohol. Persons with substance-related disorders due to intoxication and substance-induced incapacitation.

1. An intoxicated person with a substance-related disorder due to intoxication or substance-induced incapacitation may come voluntarily to a facility for emergency treatment. A person who appears to be intoxicated or incapacitated by a chemical substance in a public place and in need of help may be taken to a facility by a peace officer under section 125.91. If the person refuses the proffered help, the person may be arrested and charged with intoxication under section 123.46, if applicable.

2. If no facility is readily available the person may be taken to an emergency medical service customarily used for incapacitated persons. The peace officer in detaining the person and in taking the person to a facility shall make every reasonable effort to protect the person’s health and safety. In detaining the person the detaining officer may take reasonable steps for self-protection. Detaining a person under section 125.91 is not an arrest and no entry or other record shall be made to indicate that the person who is detained has been arrested or charged with a crime.

3. A person who arrives at a facility and voluntarily submits to examination shall be examined by a licensed physician as soon as possible after the person arrives at the facility. The person may then be admitted as a patient or referred to another health facility. The referring facility shall arrange for transportation.

4. If a person is voluntarily admitted to a facility, the person’s family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, the request shall be respected.

5. A peace officer who acts in compliance with this section is acting in the course of the officer’s official duty and is not criminally or civilly liable therefor, unless such acts constitute willful malice or abuse.
6. If the physician in charge of the facility determines it is for the patient’s benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

7. A licensed physician and surgeon or osteopathic physician and surgeon, facility administrator, or an employee or a person acting as or on behalf of the facility administrator, is not criminally or civilly liable for acts in conformity with this chapter, unless the acts constitute willful malice or abuse.

Sec. 38. Section 125.43, Code 2011, is amended to read as follows:

125.43 Funding at mental health institutes.

Chapter 230 governs the determination of the costs and payment for treatment provided to substance abusers or chronic substance abusers persons with substance-related disorders in a mental health institute under the department of human services, except that the charges are not a lien on real estate owned by persons legally liable for support of the substance abuser or chronic substance abuser person with a substance-related disorder and the daily per diem shall be billed at twenty-five percent. The superintendent of a state hospital shall total only those expenditures which can be attributed to the cost of providing inpatient treatment to substance abusers or chronic substance abusers persons with substance-related disorders for purposes of determining the daily per diem. Section 125.44 governs the determination of who is legally liable for the cost of care, maintenance, and treatment of a substance abuser or chronic substance abuser person with a substance-related disorder and of the amount for which the person is liable.

Sec. 39. Section 125.43A, Code 2011, is amended to read as follows:

125.43A Prescreening — exception.

Except in cases of medical emergency or court-ordered admissions, a person shall be admitted to a state mental health institute for substance abuse treatment only after a preliminary intake and assessment by a department-licensed treatment facility or a hospital providing care or treatment for substance abusers persons with substance-related disorders licensed under chapter 135B and accredited by the joint commission on the accreditation of health care organizations, the commission on accreditation of rehabilitation facilities, the American osteopathic association, or another recognized
organization approved by the board, or by a designee of a department-licensed treatment facility or a hospital other than a state mental health institute, which confirms that the admission is appropriate to the person's substance abuse service needs. A county board of supervisors may seek an admission of a patient to a state mental health institute who has not been confirmed for appropriate admission and the county shall be responsible for one hundred percent of the cost of treatment and services of the patient.

Sec. 40. Section 125.44, Code 2011, is amended to read as follows:

125.44 Agreements with facilities — liability for costs.

The director may, consistent with the comprehensive substance abuse program, enter into written agreements with a facility as defined in section 125.2 to pay for one hundred percent of the cost of the care, maintenance, and treatment of substance abusers and chronic substance abusers persons with substance-related disorders, except when section 125.43A applies. All payments for state patients shall be made in accordance with the limitations of this section. Such contracts shall be for a period of no more than one year.

The contract may be in the form and contain provisions as agreed upon by the parties. The contract shall provide that the facility shall admit and treat substance abusers and chronic substance abusers persons with substance-related disorders regardless of where they have residence. If one payment for care, maintenance, and treatment is not made by the patient or those legally liable for the patient, the payment shall be made by the department directly to the facility. Payments shall be made each month and shall be based upon the rate of payment for services negotiated between the department and the contracting facility. If a facility projects a temporary cash flow deficit, the department may make cash advances at the beginning of each fiscal year to the facility. The repayment schedule for advances shall be part of the contract between the department and the facility. This section does not pertain to patients treated at the mental health institutes.

If the appropriation to the department is insufficient to meet the requirements of this section, the department shall request a transfer of funds and section 8.39 shall apply.

The substance abuser or chronic substance abuser person with a substance-related disorder is legally liable to the
facility for the total amount of the cost of providing care, maintenance, and treatment for the substance abuser or chronic substance abuser person with a substance-related disorder while a voluntary or committed patient in a facility. This section does not prohibit any individual from paying any portion of the cost of treatment.

The department is liable for the cost of care, treatment, and maintenance of substance abusers and chronic substance abuser persons with substance-related disorders admitted to the facility voluntarily or pursuant to section 125.75, 125.81, or 125.91 or section 321J.3 or 124.409 only to those facilities that have a contract with the department under this section, only for the amount computed according to and within the limits of liability prescribed by this section, and only when the substance abuser or chronic substance abuser person with a substance-related disorder is unable to pay the costs and there is no other person, firm, corporation, or insurance company bound to pay the costs.

The department’s maximum liability for the costs of care, treatment, and maintenance of substance abusers and chronic substance abuser persons with substance-related disorders in a contracting facility is limited to the total amount agreed upon by the parties and specified in the contract under this section.

Sec. 41. Section 125.46, Code 2011, is amended to read as follows:

125.46 County of residence determined.

The facility shall, when a substance abuser or chronic substance abuser person with a substance-related disorder is admitted, or as soon thereafter as it receives the proper information, determine and enter upon its records the Iowa county of residence of the substance abuser or chronic substance abuser person with a substance-related disorder, or that the person resides in some other state or country, or that the person is unclassified with respect to residence.

Sec. 42. Section 125.75, unnumbered paragraph 1, Code 2011, is amended to read as follows:

Proceedings for the involuntary commitment or treatment of a chronic substance abuser person with a substance-related disorder to a facility may be commenced by the county attorney or an interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located or which is the respondent’s
place of residence. The clerk or the clerk’s designee shall assist the applicant in completing the application. The application shall:

Sec. 43. Section 125.75, subsection 1, Code 2011, is amended to read as follows:

1. State the applicant’s belief that the respondent is a chronic substance abuser person with a substance-related disorder.

Sec. 44. Section 125.80, subsections 3 and 4, Code 2011, are amended to read as follows:

3. If the report of a court-designated physician is to the effect that the respondent is not a chronic substance abuser person with a substance-related disorder, the court, without taking further action, may terminate the proceeding and dismiss the application on its own motion and without notice.

4. If the report of a court-designated physician is to the effect that the respondent is a chronic substance abuser person with a substance-related disorder, the court shall schedule a commitment hearing as soon as possible. The hearing shall be held not more than forty-eight hours after the report is filed, excluding Saturdays, Sundays, and holidays, unless an extension for good cause is requested by the respondent, or as soon thereafter as possible if the court considers that sufficient grounds exist for delaying the hearing.

Sec. 45. Section 125.81, subsection 1, Code 2011, is amended to read as follows:

1. If a person filing an application requests that a respondent be taken into immediate custody, and the court upon reviewing the application and accompanying documentation, finds probable cause to believe that the respondent is a chronic substance abuser person with a substance-related disorder who is likely to injure the person or other persons if allowed to remain at liberty, the court may enter a written order directing that the respondent be taken into immediate custody by the sheriff, and be detained until the commitment hearing, which shall be held no more than five days after the date of the order, except that if the fifth day after the date of the order is a Saturday, Sunday, or a holiday, the hearing may be held on the next business day. The court may order the respondent detained for the period of time until the hearing is held, and no longer except as provided in section 125.88, in accordance with subsection 2, paragraph "a", if possible, and if not, then in accordance with subsection 2, paragraph "b", or, only if
neither of these alternatives is available in accordance with subsection 2, paragraph "c".

Sec. 46. Section 125.82, subsection 4, Code 2011, is amended to read as follows:

4. The respondent’s welfare is paramount, and the hearing shall be tried as a civil matter and conducted in as informal a manner as is consistent with orderly procedure. Discovery as permitted under the Iowa rules of civil procedure is available to the respondent. The court shall receive all relevant and material evidence, but the court is not bound by the rules of evidence. A presumption in favor of the respondent exists, and the burden of evidence and support of the contentions made in the application shall be upon the person who filed the application. If upon completion of the hearing the court finds that the contention that the respondent is a chronic substance abuser person with a substance-related disorder has not been sustained by clear and convincing evidence, the court shall deny the application and terminate the proceeding.

Sec. 47. Section 125.83, Code 2011, is amended to read as follows:

125.83 Placement for evaluation.

If upon completion of the commitment hearing, the court finds that the contention that the respondent is a chronic substance abuser person with a substance-related disorder has been sustained by clear and convincing evidence, the court shall order the respondent placed at a facility or under the care of a suitable facility on an outpatient basis as expeditiously as possible for a complete evaluation and appropriate treatment. The court shall furnish to the facility at the time of admission or outpatient placement, a written statement of facts setting forth the evidence on which the finding is based. The administrator of the facility shall report to the court no more than fifteen days after the individual is admitted to or placed under the care of the facility, which shall include the chief medical officer’s recommendation concerning substance abuse treatment. An extension of time may be granted for a period not to exceed seven days upon a showing of good cause. A copy of the report shall be sent to the respondent’s attorney who may contest the need for an extension of time if one is requested. If the request is contested, the court shall make an inquiry as it deems appropriate and may either order the respondent released from the facility or grant extension of time for
further evaluation. If the administrator fails to report to the court within fifteen days after the individual is admitted to the facility, and no extension of time has been requested, the administrator is guilty of contempt and shall be punished under chapter 665. The court shall order a rehearing on the application to determine whether the respondent should continue to be held at the facility.

Sec. 48. Section 125.83A, subsection 1, Code 2011, is amended to read as follows:

1. If upon completion of the commitment hearing, the court finds that the contention that the respondent is a chronic substance abuser person with a substance-related disorder has been sustained by clear and convincing evidence, and the court is furnished evidence that the respondent is eligible for care and treatment in a facility operated by the United States department of veterans affairs or another agency of the United States government and that the facility is willing to receive the respondent, the court may so order. The respondent, when so placed in a facility operated by the United States department of veterans affairs or another agency of the United States government within or outside of this state, shall be subject to the rules of the United States department of veterans affairs or other agency, but shall not lose any procedural rights afforded the respondent by this chapter. The chief officer of the facility shall have, with respect to the respondent so placed, the same powers and duties as the chief medical officer of a hospital in this state would have in regard to submission of reports to the court, retention of custody, transfer, convalescent leave, or discharge. Jurisdiction is retained in the court to maintain surveillance of the respondent’s treatment and care, and at any time to inquire into the respondent’s condition and the need for continued care and custody.

Sec. 49. Section 125.84, subsections 2, 3, and 4, Code 2011, are amended to read as follows:

2. That the respondent is a chronic substance abuser person with a substance-related disorder who is in need of full-time custody, care, and treatment in a facility, and is considered likely to benefit from treatment. If the report so states, the court shall enter an order which may require the respondent’s continued placement and commitment to a facility for appropriate treatment.

3. That the respondent is a chronic substance abuser person
with a substance-related disorder who is in need of treatment, but does not require full-time placement in a facility. If the report so states, the report shall include the chief medical officer’s recommendation for treatment of the respondent on an outpatient or other appropriate basis, and the court shall enter an order which may direct the respondent to submit to the recommended treatment. The order shall provide that if the respondent fails or refuses to submit to treatment, as directed by the court’s order, the court may order that the respondent be taken into immediate custody as provided by section 125.81 and, following notice and hearing held in accordance with the procedures of sections 125.77 and 125.82, may order the respondent treated as a patient requiring full-time custody, care, and treatment as provided in subsection 2, and may order the respondent involuntarily committed to a facility.

4. That the respondent is a chronic substance abuser person with a substance-related disorder who is in need of treatment, but in the opinion of the chief medical officer is not responding to the treatment provided. If the report so states, the report shall include the facility administrator’s recommendation for alternative placement, and the court shall enter an order which may direct the respondent’s transfer to the recommended placement or to another placement after consultation with respondent’s attorney and the facility administrator who made the report under this subsection.

Sec. 50. Section 125.91, subsections 1, 2, and 3, Code 2011, are amended to read as follows:

1. The procedure prescribed by this section shall only be used for an intoxicated person with a substance-related disorder due to intoxication or substance-induced incapacitation who has threatened, attempted, or inflicted physical self-harm or harm on another, and is likely to inflict physical self-harm or harm on another unless immediately detained, or who is incapacitated by a chemical substance, if that person cannot be taken into immediate custody under sections 125.75 and 125.81 because immediate access to the court is not possible.

2. a. A peace officer who has reasonable grounds to believe that the circumstances described in subsection 1 are applicable may, without a warrant, take or cause that person to be taken to the nearest available facility referred to in section 125.81, subsection 2, paragraph "b" or "c". Such an intoxicated or incapacitated person with a substance-related disorder due
to intoxication or substance-induced incapacitation who also
demonstrates a significant degree of distress or dysfunction
may also be delivered to a facility by someone other than a
peace officer upon a showing of reasonable grounds. Upon
delivery of the person to a facility under this section, the
examining physician may order treatment of the person, but only
to the extent necessary to preserve the person’s life or to
appropriately control the person’s behavior if the behavior is
likely to result in physical injury to the person or others
if allowed to continue. The peace officer or other person
who delivered the person to the facility shall describe the
circumstances of the matter to the examining physician. If the
person is a peace officer, the peace officer may do so either
in person or by written report. If the examining physician
has reasonable grounds to believe that the circumstances in
subsection 1 are applicable, the examining physician shall
at once communicate with the nearest available magistrate
as defined in section 801.4, subsection 10. The magistrate
shall, based upon the circumstances described by the examining
physician, give the examining physician oral instructions
either directing that the person be released forthwith, or
authorizing the person’s detention in an appropriate facility.
The magistrate may also give oral instructions and order that
the detained person be transported to an appropriate facility.

b. If the magistrate orders that the person be detained,
the magistrate shall, by the close of business on the next
working day, file a written order with the clerk in the county
where it is anticipated that an application may be filed
under section 125.75. The order may be filed by facsimile if
necessary. The order shall state the circumstances under which
the person was taken into custody or otherwise brought to a
facility and the grounds supporting the finding of probable
cause to believe that the person is a chronic substance abuser
person with a substance-related disorder likely to result in
physical injury to the person or others if not detained. The
order shall confirm the oral order authorizing the person’s
detention including any order given to transport the person
to an appropriate facility. The clerk shall provide a copy
of that order to the chief medical officer of the facility
attending physician, to which the person was originally taken,
any subsequent facility to which the person was transported,
and to any law enforcement department or ambulance service that
transported the person pursuant to the magistrate’s order.
3. The chief medical officer of the facility attending physician shall examine and may detain the person pursuant to the magistrate’s order for a period not to exceed forty-eight hours from the time the order is dated, excluding Saturdays, Sundays, and holidays, unless the order is dismissed by a magistrate. The facility may provide treatment which is necessary to preserve the person’s life or to appropriately control the person’s behavior if the behavior is likely to result in physical injury to the person or others if allowed to continue or is otherwise deemed medically necessary by the chief medical officer attending physician, but shall not otherwise provide treatment to the person without the person’s consent. The person shall be discharged from the facility and released from detention no later than the expiration of the forty-eight-hour period, unless an application for involuntary commitment is filed with the clerk pursuant to section 125.75. The detention of a person by the procedure in this section, and not in excess of the period of time prescribed by this section, shall not render the peace officer, attending physician, or facility detaining the person liable in a criminal or civil action for false arrest or false imprisonment if the peace officer, physician, or facility had reasonable grounds to believe that the circumstances described in subsection 1 were applicable.

Sec. 51. Section 226.9C, subsection 2, paragraph c, Code 2011, is amended to read as follows:

   c. (1) Prior to an individual’s admission for dual diagnosis treatment, the individual shall have been prescreened. The person performing the prescreening shall be either the mental health professional, as defined in section 228.1, who is contracting with the county central-point-of-coordination process to provide the prescreening or a mental health professional with the requisite qualifications. A mental health professional with the requisite qualifications shall meet all of the following qualifications: is a mental health professional as defined in section 228.1, is a certified alcohol and drug counselor certified by the nongovernmental Iowa board of substance abuse certification, and is employed by or providing services for a facility, as defined in section 125.2.

   (2) Prior to an individual’s admission for dual diagnosis treatment, the individual shall have been screened through a county’s central point of coordination process implemented
pursuant to section 331.440 to determine the appropriateness of the treatment.

Sec. 52. Section 229.1, subsection 12, Code 2011, is amended to read as follows:

12. "Psychiatric advanced registered nurse practitioner" means an individual currently licensed as a registered nurse under chapter 152 or 152E who holds a national certification in psychiatric mental health care and who is registered with the board of nursing as an advanced registered nurse practitioner.

Sec. 53. Section 229.15, subsection 3, paragraph a, Code 2011, is amended to read as follows:

a. A psychiatric advanced registered nurse practitioner treating a patient previously hospitalized under this chapter may complete periodic reports pursuant to this section on the patient if the patient has been recommended for treatment on an outpatient or other appropriate basis pursuant to section 229.14, subsection 1, paragraph "c", and if a psychiatrist licensed pursuant to chapter 148 personally evaluates the patient on at least an annual basis.

Sec. 54. Section 229.21, subsection 2, Code 2011, is amended to read as follows:

2. When an application for involuntary hospitalization under this chapter or an application for involuntary commitment or treatment of chronic substance abusers persons with substance-related disorders under sections 125.75 to 125.94 is filed with the clerk of the district court in any county for which a judicial hospitalization referee has been appointed, and no district judge, district associate judge, or magistrate who is admitted to the practice of law in this state is accessible, the clerk shall immediately notify the referee in the manner required by section 229.7 or section 125.77. The referee shall discharge all of the duties imposed upon the court by sections 229.7 to 229.22 or sections 125.75 to 125.94 in the proceeding so initiated. Subject to the provisions of subsection 4, orders issued by a referee, in discharge of duties imposed under this section, shall have the same force and effect as if ordered by a district judge. However, any commitment to a facility regulated and operated under chapter 135C, shall be in accordance with section 135C.23.

Sec. 55. Section 229.21, subsection 3, paragraphs a and b, Code 2011, are amended to read as follows:

a. Any respondent with respect to whom the magistrate or judicial hospitalization referee has found the contention that
the respondent is seriously mentally impaired or a chronic substance abuser 
sustained by clear and convincing evidence presented at a hearing held under section 229.12 or section 125.82, may appeal 
from the magistrate’s or referee’s finding to a judge of the district court by giving the clerk notice in writing, within 
ten days after the magistrate’s or referee’s finding is made, that an appeal is taken. The appeal may be signed by the 
respondent or by the respondent’s next friend, guardian, or attorney.

b. An order of a magistrate or judicial hospitalization 
referee with a finding that the respondent is seriously 
mentally impaired or a chronic substance abuser 
shall include the following notice, located conspicuously on the face of the order:

NOTE: The respondent may appeal from this order to a judge of 
the district court by giving written notice of the appeal to 
the clerk of the district court within ten days after the date 
of this order. The appeal may be signed by the respondent or 
by the respondent’s next friend, guardian, or attorney. For a 
more complete description of the respondent’s appeal rights, 
consult section 229.21 of the Code of Iowa or an attorney.

Sec. 56. Section 229.21, subsection 4, Code 2011, is amended 
to read as follows:

4. If the appellant is in custody under the jurisdiction 
of the district court at the time of service of the notice of appeal, the appellant shall be discharged from custody unless 
an order that the appellant be taken into immediate custody has 
previously been issued under section 229.11 or section 125.81, 
in which case the appellant shall be detained as provided in 
that section until the hospitalization or commitment hearing 
before the district judge. If the appellant is in the custody 
of a hospital or facility at the time of service of the notice of appeal, the appellant shall be discharged from custody 
pending disposition of the appeal unless the chief medical 
officer, not later than the end of the next secular day on 
which the office of the clerk is open and which follows service 
of the notice of appeal, files with the clerk a certification 
that in the chief medical officer’s opinion the appellant 
is seriously mentally ill or a chronic substance abuser 
with a substance-related disorder. In that case, the appellant 
shall remain in custody of the hospital or facility until the 
hospitalization or commitment hearing before the district
court.

Sec. 57. Section 230.15, unnumbered paragraph 2, Code 2011, is amended to read as follows:

A substance abuser or chronic substance abuser person with a substance-related disorder is legally liable for the total amount of the cost of providing care, maintenance, and treatment for the substance abuser or chronic substance abuser person with a substance-related disorder while a voluntary or committed patient. When a portion of the cost is paid by a county, the substance abuser or chronic substance abuser person with a substance-related disorder is legally liable to the county for the amount paid. The substance abuser or chronic substance abuser person with a substance-related disorder shall assign any claim for reimbursement under any contract of indemnity, by insurance or otherwise, providing for the abuser’s care, maintenance, and treatment in a state hospital to the state. Any payments received by the state from or on behalf of a substance abuser or chronic substance abuser person with a substance-related disorder shall be in part credited to the county in proportion to the share of the costs paid by the county. Nothing in this section shall be construed to prevent a relative or other person from voluntarily paying the full actual cost or any portion of the care and treatment of any person with mental illness, substance abuser, or chronic substance abuser or a substance-related disorder as established by the department of human services.

Sec. 58. Section 232.116, subsection 1, paragraph 1, subparagraph (2), Code 2011, is amended to read as follows:

(2) The parent has a severe, chronic substance abuse problem, substance-related disorder and presents a danger to self or others as evidenced by prior acts.

Sec. 59. Section 600A.8, subsection 8, paragraph a, Code 2011, is amended to read as follows:

a. The parent has been determined to be a chronic substance abuser person with a substance-related disorder as defined in section 125.2 and the parent has committed a second or subsequent domestic abuse assault pursuant to section 708.2A.

Sec. 60. Section 602.4201, subsection 3, paragraph h, Code 2011, is amended to read as follows:

h. Involuntary commitment or treatment of substance abuser persons with a substance-related disorders.

Sec. 61. IMPLEMENTATION OF ACT. Section 25B.2, subsection 3, shall not apply to this division of this Act.
Sec. 62. EFFECTIVE DATE. This division of this Act takes effect July 1, 2012.

______________________________
JOHN P. KIBBIE
President of the Senate

______________________________
KRAIG PAULSEN
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 525, Eighty-fourth General Assembly.

______________________________
MICHAEL E. MARSHALL
Secretary of the Senate

Approved ___________, 2011

______________________________
TERRY E. BRANSTAD
Governor
## Vision: A Life in the Community For Everyone

### Principles Guiding a Transformed System

1. **Public awareness and inclusion**...Iowans increasingly recognize, value, and respect individuals with mental illness or disabilities as active members of their communities.

2. **Access to services and supports**...Each adult and child has timely access to the full spectrum of supports and services needed.

3. **Individualized and person-centered**...Communities offer a comprehensive, integrated, and consistent array of services and supports that are individualized and flexible.

4. **Collaboration and partnership in building community capacity**...State and local policies and programs align to support the legislative vision of resiliency and recovery for Iowans with mental illness, and the ability of Iowans with disabilities to live, learn, work, and recreate in communities of their choice.

5. **Workforce and Organizational Effectiveness**...Investing in people through appropriate training, salary and benefits improves workforce and organizational effectiveness.

6. **Empowerment**...Communities recognize and respect the ability of people (1) to make informed choices about their personal goals, about the activities that will make their lives meaningful, and about the amounts and types of services to be received; and (2) to understand the consequences and accept responsibility for those choices.

7. **Active Participation**...Individuals and families actively participate in service planning; in evaluating effectiveness of providers, supports and services; and in policy development.

8. **Accountability and results for providers**...Innovative thinking, progressive strategies and ongoing measurement of outcomes lead to better results for people.

9. **Responsibility and accountability for government**...Adequate funding and effective management of supports and services promote positive outcomes for Iowans.

### Definitions

**Goals** are the broad long term results towards which efforts and resources are to be directed in order to transform Iowa’s mental health and disability service system. The five goals of this plan are over arching themes emerging from years of public dialogue with stakeholders. **Objectives** are more specific, shorter term end results that help us refine our thinking about what it takes to achieve our goals. Many objectives listed serve more than one goal. **Action steps** are initiatives to achieve specific measurable outcomes that help us progress towards the objectives under which they are listed. They too can serve more than one. **Strategic priorities** are the sets of initiatives that will be the primary focus of the Department’s energy and resources (budget) over the duration of the Plan (2011-2015), because of the importance of the need addressed, the opportunities currently available to make significant progress, or other factors such as new statutory mandates. Resources will not be focused solely on strategic priorities, since there are on-going responsibilities on a wide range of initiatives. The Department’s Action Agenda (action steps to be emphasized over the next 18 months (1/1/11-6/30/12) is highlighted in this document. See the Framework Key on the top of page 3.
## Principle Driven Goals

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## Strategic Priorities

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Goal 1 – Communities

Welcoming communities that promote the full participation of Iowans with mental illness or disabilities. (Principle 1)

Obj. 1.1 Improve public awareness of positive contributions of people with mental illness and disabilities, and public understanding of the dignity of independence.

a. Identify existing web-based resources and develop a reference library in collaboration with state and other partners to assist community groups in promoting public awareness of positive contributions of people with mental illness, brain injury or other disabilities, celebrating the anniversary of the Americans with Disabilities Act and other observances, and outreach to other organizations committed to changing public attitudes. (SP 1)

b. Create a statewide speakers bureau and video lending library that can make individuals with lived experience in mental health, brain injury or other disabilities and/or expertise available to present information and raise awareness. (SP1)

c. **Think Beyond the Label – Build on the national media campaign by customizing the message within the State, to promote public awareness and to make the business case for hiring people with disabilities.** (SP 1)

d. Conduct targeted outreach to families and guardians of individuals with mental illness, brain injury and other disabilities to raise awareness of opportunities for community living, including competitive employment, by accessing available supports and services. (SP 1)

e. Integrate public awareness initiatives undertaken under this Plan objective with awareness initiatives pursuant to the Governor’s Task Force on Dependent Adults Final Report (Recommendations II.C –D), balancing the focus on abilities and contributions of people with disabilities with their fundamental right to live and work in environments that are safe and free from neglect, abuse, discrimination or exploitation. (SP 1)

Obj.1.2 Improve public understanding of the causes and effects of mental illness, brain injury and other disabilities for all ages and of effective supports and services, through public awareness and education initiatives.

a. **Collaborate with the Iowa Departments of Public Health, Education, and Public Safety and other stakeholders in providing continuing support for the**
Obj. 1.3 Expand involvement of young people and adults with mental illness, brain injury or other disabilities in workforce and volunteer projects

a. **Support opportunities for involvement of young people and adults with disabilities in Americorps or other national service programs, as well as locally developed initiatives.** *(SP 2)*

b. **Analyze current policies and practice regarding transition, and determine, with the engagement of the Department of Education, how these can be strengthened to support integrated employment as a preferred outcome for students moving into the adult service system. This should include clarity of post secondary and national service options to further prepare students for adult life.** *(SP 2, SP 5 - See also Obj. 3.1.b)*

Obj. 1.4 Promote active participation of people with mental illness, brain injury or other disabilities on State and local boards, councils and commissions and provide tools and financial assistance to support active participation.

a. **Partner with the Mental Health and Disability Services Commission, the Mental Health Planning Council, the Iowa Developmental Disabilities Council, the Advisory Council on Brain Injuries, the Prevention of Disabilities Policy Council, the Olmstead Consumer Task Force, and other statewide advocacy groups to identify strategies to support opportunities for meaningful participation by people with disabilities on State, regional and local boards, councils and commissions dealing with any topic of interest to them, not just disability-related matters. Strategies could include expansion of peer support and leadership and advocacy training, and creative approaches to removal of barriers such as transportation.** *(SP 2)*

b. Create new opportunities for involvement of people with mental illness, brain injury or other disabilities in DHS policy planning and program development and monitoring, in such areas as the DHS response to the federal Affordable Care Act, community based services, and Health Information Technology. *(SP 2)*

c. **Re-establish and strengthen the Office of Consumer Affairs and its role in securing regional and statewide consumer and family input.**

Obj. 1.5 Support and provide educational and training opportunities in cultural awareness and sensitivity for organizations and people working with individuals with mental illness, brain injuries and other disabilities, to ensure that consumers receive

effective, understandable, and respectful services provided in a manner compatible with their cultural beliefs, practices and preferred language.

a. Collaborate with the Iowa Civil Rights Commission in the identification and dissemination of resources to support cultural competency in the mental health, brain injury and disability services delivery systems. (See also Obj. 4.7.b)

Obj. 1.6 Promote adoption of a common, people first language about mental illness, disability, and all aspects of the service system that reflects the dignity and potential of the individual and the values of consumer and family driven planning and service delivery.

a. Develop a common language and definitions for community and facility based providers to improve communications and to reflect a commitment to empowerment of individuals and a focus on strengths and functional needs rather than a diagnosis. (SP 2, SP 7 - See also Obj. 3.3.b)

b. Extend use of the common language to policies and administrative rules.

Goal 2 – Access

*Increased access to information, services, and supports that individuals need to optimally live, learn, work, and recreate in communities of their choice. (Principle 2)*

Obj. 2.1 Improve awareness and access to appropriate community based services, including prevention services, for individuals in crisis and their families.

a. Promote alternatives and complements to hospital-based emergency and inpatient services for urgent behavioral health care needs of adults and children through the development and expansion of community-based access centers and crisis stabilization beds (SP 3)

b. Expand provider capacity to address behaviors related to co-occurring mental illness and intellectual disabilities through deployment of the Iowa Program Assistance Response Team (I-PART). (SP 3, SP 7 - See also Obj. 3.3.a)

c. Expand the capacity of the state mental health facilities as resource centers for the community provider network, in helping individuals to stay in the community. (SP 3 – See also Obj. 3.3)

d. Build provider capacity to ensure access to community based crisis intervention, behavioral programming and mental health outreach services. (SP 3, - SP 7 See also Obj. 3.4.c)
Olmstead Plan for Mental Health and Disability Services:  

e. Maintain and promote availability of 24/7 telephone access to Medicaid-funded case management services.  (SP 3)

f. Develop emergency mental health services in pilot areas.  (SP 3)

g. Expand access to training for community based providers (including primary care providers as well as non-prescribing mental health professionals) in behavioral health medication management.  (SP 3 - See also Obj. 3.7.c)

h. Expand access to training and education for consumers, families and other natural supports in behavioral health medication management.  (SP 3 – See also Obj. 3.7.d)

Obj. 2.2 Increase awareness in schools of mental health issues and promote screenings to identify and refer children and youth at risk.

a. Improve access to school-based mental health services, including teacher access to consultations with mental health professionals, and awareness of and access to available resources to promote acceptance of children with mental health disorders and/or disabilities.  (SP 3)

b. Partner with the Department of Education and institutions of higher education in Iowa to expand access to teacher training in mental health issues, crisis prevention and intervention, and access to the mental health service system.

c. Collaborate with the Iowa Department of Public Health and other state agencies to address methods to reduce suicide risks among teens and young adults.  (SP 3)

d. Promote and provide Mental Health First Aid training and support for school systems, child welfare providers, and members of the public to create awareness of mental health and disability issues and improve the capability for individuals to recognize and appropriately respond to individuals experiencing mental health issues and crises.  (SP 3, SP 1 – See also Obj. 1.2.a)

e. Continue to collaborate with the Iowa Department of Education, the area education agencies, and local school districts in the development of a response to school crisis situations, including use of the Disaster Behavioral Health Response Team and other MHDS services.  (SP 3)

Obj. 2.3 Strengthen the State’s ability to support informed choice by people with mental illness, brain injuries or other disabilities who need services.
Olmstead Plan for Mental Health and Disability Services:  

a. Continue to work towards a “No Wrong Door” concept in access to services. No Wrong Door refers to a system that welcomes people in need wherever they try to gain access to services.

b. Maintain and continue to enhance Iowa’s web based Information & Referral services for people with disabilities and older Iowans and make cross-training available on information regarding services and supports for all disabilities. (SP 3)

c. Develop a network of trained parent navigators and educators for parents of children with disabilities, including Serious Emotional Disturbance. (SP 3 - See also Obj. 3.2.d)

d. Develop outreach strategies for more proactive dissemination of information about available services and supports, including training opportunities for individuals, their families, and providers of natural supports.

e. Continue outreach and education for people with mental illness, brain injury and disabilities to optimize understanding of the impact of employment on their current benefits and awareness of available Medicaid and Social Security Administration work incentives and other asset development opportunities (e.g., Earned Income Tax Credit, Individual Development Accounts, self employment or microenterprise, etc.). (SP 5 – See also Obj. 3.1.e)

f. Provide education and training opportunities to youth with serious emotional disturbance or other disabilities and their families to establish an early understanding of asset development options and to prepare for competitive employment. Work with Parent-Educator Connection staff, Special Education Directors, ADA and 504 Coordinators and disability support groups to invite students with IEPs and 504 plans and their parents to the trainings. (See also Obj. 3.1.f)

Obj. 2.4 Improve awareness of mental health, brain injury and disability issues in the judicial branch, law enforcement, and among community emergency responders, to promote access to appropriate treatment settings. (SP 3)

a. Expand educational programs for law enforcement and the judicial branch on the symptoms of and supports for mental illness and other disabilities. (SP 3)

b. Continue the work of the Court Mental Health Work Group. (SP 3)

c. Establish vehicles for communication among law enforcement, the judicial branch and MHDS about options available for diversion, and alternatives to arrest, detention, incarceration and commitment. (SP 3)
d. Establish vehicles for communication and education about alternatives to full guardianship and conservatorship.

Obj. 2.5 Continue collaboration with State partners in the work of the Ex-Offender Reentry Coordinating Council recommendations to strengthen and improve ex-offender re-entry programs and processes to ensure access to mental health services and other supports essential to successful community living.

a. Continue to improve access to Medicaid mental health and substance abuse services, including psychotropic medications. (SP 3)

b. Improve access to housing and employment supports.

Obj. 2.6 Maintain the capacity to provide timely, effective mental health support in response to natural and human-caused disasters.

a. Expand Disaster Behavioral Health Response Team services statewide. (SP 3)

b. Expand Mental Health First Aid training statewide. (SP 3 – See also Obj. 1.2.a)

Obj. 2.7 Work with the Division of Homeland Security & Emergency Management, the Departments of Human Rights and Public Health, and the Prevention of Disabilities Policy Council to build awareness and capacity of communities to serve people with disabilities during and after a disaster event, and of people with disabilities to plan and prepare for emergencies.

a. Coordinate with other agencies in the design and implementation of regional and state trainings and dissemination of information for community emergency planners to increase awareness and understanding of the needs of individuals with disabilities during emergencies.

b. Work with the Iowa Department of Public Health and the Prevention of Disabilities Policy Council to evaluate the Community Access Project as a vehicle to build community capacity for emergency response to people with disabilities and to educate individuals about personal preparedness issues.

Obj. 2.8 Improve system capacity to conduct consistent assessments to best determine service and support needs. (SP 4)

a. Strengthen implementation of Pre Admission Screening and Resident Review (PASRR) for Iowans prior to admission to nursing homes to insure that placement is appropriate and needed services are available,
b. Develop and implement policies and procedures for implementation of new federal requirements to ensure the rights of nursing home residents to choose where they receive their long term supports and services, including referral to local contact agencies for options counseling, referral to disability-specific services such as neuro-resource facilitation, and transition services as appropriate. (MDS 3.0, Section Q) (SP 4, SP 7 – See also Obj.3.4.e)

c. **Explore use of a standardized functional assessment tool (the Supports Intensity Scale) in determining service and support needs for people with intellectual disabilities.** (SP 4)

d. **Explore use of a standardized functional assessment tool to determine service and support needs for people with mental illness and implement upon agreement.**

e. Explore use of a functional assessment tool for people with brain injury who do not have a diagnosis of intellectual disabilities.

f. Explore use of a functional assessment screening tool to identify mental health and disability issues for all children and youth.

g. **Identify opportunities to improve discharge planning to meet the needs of individuals for services in the communities of their choice.** (SP 3, SP 7 – See also Obj. 3.3.c)

Obj. 2.9 Improve access to services and supports by creating or expanding affordable transportation options for Medicaid members.

a. **Incorporate a Medicaid transportation brokerage as a Medicaid State Plan service, providing more efficient use of resources and enhanced access to transportation.**

b. Explore with the broker possible expansion of transportation brokerage services beyond Medicaid population services, using alternative funding and financial reporting.

Obj. 2.10 Improve access to mental health services for underserved populations.

a. **Explore with Iowa Medicaid Enterprise (IME) opportunities to integrate behavioral, mental and physical health services for older adults to maximize their ability to remain independent in the community.**
b. Expand access to mental health services to adults over age 65 under the Iowa Plan for Behavioral Health’s Senior Connect, a program that will provide this age group with access to appropriate Iowa Health Plan Services and continuity of care across the lifespan.

c. Partner with the Iowa Departments of Public Health and Aging and other stakeholders to explore options to address training needs related to mental health assessment and the service delivery continuum across the lifespan. (See also Obj. 3.6)

d. Improve access for individuals with all multi-occurring disorders (SP 8 - See also Objective 4.1)

e. Explore strategies to enhance access to services in underserved areas, including rural communities, through tele-health and other technologies.

f. Improve access to services for homeless individuals with mental illness through (1) participation in Projects for Assistance in Transition from Homelessness (PATH) and SSI/SSDI Outreach, Assistance and Recovery (SOAR) Technical Assistance Initiative; and (2) partnering with the Iowa Finance Authority in the utilization of homelessness assistance funding. (See Obj. 3.4.c)

g. Work with the Veterans Administration, the Iowa Department of Veterans Affairs and veterans’ organizations to develop collaborative approaches to meeting the needs of veterans with mental health issues and/or brain injuries, and their families. (SP 3)

Obj. 2.11 Continue to address barriers to access that are created by county of legal settlement and related funding issues.

Obj. 2.12 Promote early, accurate diagnoses and referrals for individuals with or at risk of mental illness, brain injury or other disabilities.

a. Provide parents, schools and health professionals with tools to learn the signs of autism and other developmental disabilities as early as possible.

b. Support the efforts of Iowa Medicaid Enterprise to implement the Iowa ABCD II (Assuring Better Child Health Development) recommendations for promotion, prevention and treatment services for the healthy mental development of young children, including maternal screening for depression.

c. Collaborate with IDPH and the Brain Injury Resource Network in improving information on and access to available community resources for individuals identified with brain injury.
d. Promote awareness by professionals and parents of Iowa’s system of early intervention for children at risk of developmental delays (Early Access program).

Goal 3 – Capacity
A full array of community based services and supports that is practically available to all Iowans (Principles 3 and 4)

Obj. 3.1 Support strategies for asset development to create opportunities for independence and self reliance for people with mental illness, brain injury or other disabilities, including promotion of competitive employment as the preferred outcome of services, personal savings, home ownership, and entrepreneurship.

a. Continue current work in collaboration with the State Employment Leadership Network (SELN) and other State agency partners, including Department of Education, Voc Rehab, Workforce Development, Department for the Blind, Iowa DD Council, Department of Human Rights and others to develop and implement a statewide competitive employment plan for people with disabilities, mental illness, or brain injuries. (SP 5)

b. Analyze current policies and practice regarding transition, and determine, with the engagement of the Department of Education, how these can be strengthened to support integrated employment as a preferred outcome for students moving into the adult service system. This should include clarity of post secondary and national service options to further prepare students for adult life. (SP 5, SP 2 – See also Obj. 1.3.b)

c. Work in collaboration with the Board of Regents and community colleges to educate and encourage people with mental illness, brain injury or other disabilities and their families to pursue higher education.

d. Engage people with mental illness and other disabilities, family members, and community providers in the design of employment service models and supports that meet the labor market needs of the region, to drive successful high school and adult transitions to competitive employment. (SP 5)

e. Continue outreach and education for people with mental illness, brain injury and disabilities on the impact of employment on their benefits, and awareness of, available Medicaid and Social Security Administration work incentives and other asset development opportunities (e.g., Earned Income Tax Credit, Individual Development Accounts, self employment or microenterprise, etc.). (SP 5 – See also Obj. 2.3.e)
f. Provide education and training opportunities to youth with serious emotional disturbance or other disabilities and their families to establish an early understanding of asset development options and to prepare for competitive employment. Work with Parent-Educator Connection staff, Special Education Directors, ADA and 504 Coordinators and disability support groups to invite students with IEPs and 504 plans and their parents to the trainings. (See also Obj. 2.3.f)

g. Continue to promote self-employment as a viable asset development strategy through workshops and technical assistance targeted to individuals with disabilities and their families. (SP 5)

h. Collaborate with Iowa Workforce Development, Iowa Vocational Rehabilitation Services, Department for the Blind, CPCs, the Iowa Association of Community Providers, and other partners, to establish common data sets regarding desired outcomes of employment and day services. (SP 5 – See also Obj. 5.2.f)

i. Continue regional trainings on the Ticket to Work program, the Employment Network, work incentives and the Medicaid-Buy-In (MEPD) program to community disability providers, case managers, CPC Directors, and individuals with mental illness, brain injury or other disabilities and their families. (SP 5)

Obj. 3.2 As the State develops its implementation plan for the federal Affordable Care Act, take steps to ensure coordination of primary care, mental health, substance abuse, disability and other services.

a. Develop and maintain a mental health delivery system that meets the needs of children with SED in the community by extending children’s mental health systems of care: (1) Continue to build the sustainability of the Northeast Iowa Community Circle of Care; (2) Support state-funded systems of care for children in Polk/Warren Counties; (3) Seek support for the East Central Iowa Children’s Mental Health Initiative; (4) Promote expansion to additional regions in Iowa, with emphasis on the western region of the State. (SP 6)

b. In collaboration with the IDPH Medical Home Advisory Council and other relevant stakeholders, explore opportunities presented by the federal affordable care act to promote health home service delivery models centered in appropriate providers characterized by person-centeredness; care continuity; coordination and integration across settings and providers; chronic disease management; prevention and wellness care; evidence-informed medicine; and health information management. (SP 6)

c. **Develop service definitions and expectations regarding the use of remedial services and integration of remedial services with other services. Improve coordination and quality of mental health services by transferring remedial services administration to the Iowa Behavioral Health Plan.** *(SP 6)*

d. **Continue to develop and support a statewide network of trained family navigators and educators, that help families of children with developmental disabilities and other special health care needs make informed healthcare decisions and navigate the service system, and offer web-based resources (DHS Family 360/Family to Family Health Information Center initiative).** *(SP 6, SP 3 - See also Obj. 2.3.c)*

e. **Continue to support and explore expansion of the Program of All-Inclusive Care for the Elderly (PACE) for older Iowans who require a nursing home level of care, to enable them to remain living at home.**

f. **Improve integration and coordination of child welfare and mental health services.** *(See Obj. 3.7.e.)*

**Obj. 3.3 Redefine the role of the State Resource Centers and Mental Health Institutes in order to reduce reliance on institutionally based services.** *(SP 7)*

a. **Expand provider capacity to address behaviors related to co-occurring mental illness and intellectual disabilities through deployment of the Iowa Program Assistance Response Team (I-PART).** *(SP 7, SP 3 – See also Obj. 2.1.b)*

b. **Develop a common language and definitions for community and facility based providers to improve communications, that reflects a commitment to empowerment of individuals, and a focus on strengths and functional needs rather than a diagnosis.** *(SP 7, SP 2 – See also Obj. 1.6.a)*

c. **Continue to strengthen discharge planning at Resource Centers and orient internal operations to reductions in length of stay.** *(SP 7, SP 3 – See also Obj. 2.8.g)*

d. **Continue to diversify programs and services at the State Resource Centers and Mental Health Institutes to expand the capacity of Iowa’s home and community based service network.** *(SP 7)*

**Obj. 3.4 Ensure that individuals receiving facility based residential services retain community living options.**

a. **Explore extension of Iowa’s Money Follows the Person demonstration to 2016 (with continuation of operations to 2019) to assist individuals**
b. Explore expansion of Money Follows the Person transition services and supports to additional populations receiving facility based care. (SP 7)

c. Build provider capacity to ensure access to community based crisis intervention, behavioral programming and mental health outreach services. (SP 7, SP 3 - See also Obj. 2.1.d)

d. Build community provider capacity for Supported Employment services. (SP 5 – See Obj. 3.1)

e. Develop policies and procedures for implementation of new federal requirements to ensure the rights of nursing home residents to choose where they receive their long term supports and services, including referral to local contact agencies for options counseling, disability-specific services such as neuro-resource facilitation, and transition services as appropriate (MDS 3.0 Section Q). (SP 7, SP 4 – See also Obj. 2.8.b)

Obj. 3.5 Improve access to safe, affordable and accessible housing.

a. Work with the Iowa Finance Authority to ensure availability of Home and Community Based Services Waiver Rent Subsidies to support Money Follows the Person participants and other individuals on Waivers. (SP 7)

b. Advocate for system changes or accommodations for people with disabilities at local public housing authorities in the federal Housing Choice Voucher (Section 8) application process to enable the same access as individuals without disabilities. (SP 7)

c. Reduce homelessness for persons with mental illness by (1) leveraging federal funds to expand case management and benefits counseling services (Projects for Assistance in Transition from Homelessness (PATH) and SSI/SSDI Outreach, Assistance and Recovery (SOAR) Technical Assistance Initiative; and (2) partner with the Iowa Finance Authority in the utilization of homelessness assistance funding. (See also Obj. 2.10.f)

d. Support the efforts of the Iowa Finance Authority to expand availability of affordable and accessible housing in Iowa.

Obj. 3.6 Build the capacity at all levels of service to serve individuals with intensive needs.

a. Develop and/or enhance Iowa-based capacity, through provider training and program development, to serve individuals in need of high intensity services,
especially those who currently require or are at risk of placement in out of state facilities or the State Resource Centers.

b. Expand access to the Waivers and explore opportunities for expansion of State Plan Home and Community Based Services under the federal Affordable Care Act, such as the Community First Choice option for State Medicaid Plans.

c. **Expand wraparound services for youth with serious emotional disturbance (SED) and challenging behaviors and their families** *(SP 6 - See also Obj. 3.2, and SP 8 – See also Obj. 4.2.b)*

d. **Expand access to peer support.**

Obj. 3.7 Implement pre-service and in-service training to improve healthcare, social services and education for people with mental illness, brain injury or other disabilities.

a. **Expand pre-service and in-service training of medical and dental students and other health professionals, including education on:**
   - Current and emerging trends in service delivery, including evidence-based practice and recovery-based services
   - Effective communication with patients who have mental health or other disabilities
   - Providing primary care to patients who have mental health or other disabilities
   - Early identification, diagnosis and treatment of young children with or at risk of disabilities, including social-emotional disabilities.
   - Impact of mental health disorders on other health conditions.

b. **Expand initiatives to train pediatricians, family practice physicians and physician extenders in diagnosis and treatment (including best practices) of children with Serious Emotional Disturbance, autism or other developmental disabilities, and brain injury.** *(See also Obj. 2.12)*

c. **Expand access to training and education for community based providers (including primary care providers as well as non-prescribing mental health professionals) in behavioral health medication management.** *(SP 3 - See also Obj. 2.1.g)*

d. Expand access to training and education for consumers, families and other natural supports in behavioral health medication management. *(SP 3 – See also Obj. 2.1.h)*

e. **Expand access to training for DHS child welfare workers on the identification of mental health issues and referral of children and families for appropriate treatment.** *(See also Obj. 3.2.f)*
f. Work with Iowa Medicaid Enterprise to expand in-service training of mental health service providers in the provision of proven early childhood treatment therapies.

g. Develop and make available training for case managers on mental health screening for older adults. (See also Obj. 2.10)

h. Address systemic issues resulting in the shortage of certified behavioral analysts in Iowa, including curriculum development and delivery and reimbursement.

Goal 4 – Quality

High quality services and supports. (Principles 5, 6 and 7)

Obj. 4.1 Integrate and improve services to individuals with multi-occurring conditions including mental health, substance abuse, cognitive and intellectual disabilities, and other medical conditions.

a. Provide training and technical support for providers to build their capabilities to address multi-occurring conditions and promote holistic approaches to meet individuals’ service needs in a recovery-oriented system of care. (SP 8 – See also Obj. 2.10.d)

b. Develop a curriculum on best practices for individuals with multi-occurring diagnoses, and their families. (SP 8)

c. Continue to collaborate with the Iowa Department of Public Health (IDPH) to review accreditation standards and policies used for both mental health and substance abuse services and develop protocol to cross-accept accreditation determinations made by each agency, similar to deemed status applied to national accreditation by IDPH and DHS. (SP 8)

Obj. 4.2 Promote the use of practices based on best available scientific knowledge

a. Expand Assertive Community Treatment services in Iowa. (SP 8)

b. Promote utilization of the Wraparound concept to provide integrated and flexible supports to individuals and families. (SP 8, SP 6 - See also Obj. 3.2.a and Obj. 3.6.c)

c. Improve competitive employment outcomes by expanding Supported Employment services in partnership with the State Employment Leadership Network (SELN). (SP 8, SP 5 - See also Obj. 3.1.a)
d. Work with parent navigator/educator networks to promote improved outcomes for individuals with mental illness, through information and supports to their families, and family involvement in planning and treatment delivery (consistent with the evidence-based practice of family psychoeducation).

Obj. 4.3 Develop a statewide retention and recruitment plan for the direct care workforce in all settings and programs.

a. **Partner with the Iowa Department of Public Health (IDPH) and other agencies and organizations to identify and define direct support professional competencies and the curricula needed to provide effective services to individuals with mental illness, brain injury and other disabilities, including, as appropriate, training supporting the expansion of evidence-based practices in Iowa. (SP 9)**

b. **Expand access to the web-based trainings such as the DHS/IDPH/BIA/IACP collaborative brain injury training initiative for providers, and the College of Direct Support that offers a wide range of on-line training and education programs targeted for direct support professionals and their supervisors, to assist them in their pursuit of a career path and to facilitate mobility from one provider setting to another. (SP 9)**

c. Explore the establishment of a single statewide learning management system to address the training needs of providers, State employees, family members and providers of natural supports to build capacity to address the needs of individuals with mental illness, brain injury or other disabilities.

d. **Explore developing an incentive strategy to assist providers that improve retention and performance of direct support professionals, including strategies linking reimbursement to competency-based skill development training and on site supports. (SP 9)**

e. **Continue to explore options to reimburse HCBS providers for staff training costs. (SP 9)**

f. Provide education and training opportunities to individuals who self-direct their services, on recruitment, hiring and firing, training, and supervision of their support staff.

Obj. 4.4 Increase quality of services through enhanced accreditation standards and processes (1) For community mental health centers as providers of an array or core services; and (2) For individual services offered by other providers.

a. **Develop proposed revisions to Iowa Administrative Code 441-24.1 (225C) governing provider and service accreditation.**
Obj. 4.5 Expand participation of individuals and their families in determining their service plans and increase their ability to make informed choices, including the use of self direction.

   a. Promote use of the Consumer Choice Option for HCBS Waiver participants, giving them control over an individualized budget for a portion of their supports.

   b. Align quality oversight and standards for CCO with other HCBS quality standards in conformance with federal requirements.

   c. Expand use of self direction to individuals with mental illness.

Obj. 4.6 Ensure that user-friendly processes are in place for consumers, families and the general public to seek effective remedies for issues related to service quality, fairness, and the right of individuals to live and work in environments that are safe and free from neglect, abuse, discrimination or exploitation.

   a. Provide materials and training to individuals, families and service providers, regarding enforcement options available to address discrimination based on disability.

   b. Use standardized incident reporting to collect and report system-wide data.  (SP 10 – See also Obj. 5.3)

   c. Clarify the consumer complaint processes and provide consumers, families and providers with access to complaint information.

Obj. 4.7 Support and provide educational and training opportunities in cultural awareness and sensitivity for organizations and people working with individuals with mental illness, brain injury and other disabilities, to ensure that consumers receive effective, understandable, and respectful services provided in a manner compatible with their cultural beliefs, practices and preferred language.

   a. Work with Iowa’s higher education system to coordinate an effort to recruit a culturally diverse (in terms of ethnicity, age, income, rural versus urban, etc.) and appropriately trained mental health and disability workforce.

   b. Collaborate with the Iowa Civil Rights Commission in the identification and dissemination of resources to support cultural competency in the mental health, brain injury and disability services delivery systems.  (See also Goal 1, Obj. 5)
Goal 5 – Accountability
Administrative accountability for service delivery, and results: supporting individuals to live, learn, work and recreate in communities of their choice. (Principles 8 and 9)

Obj. 5.1 Secure and maintain an inter-agency collaboration and focus on removal of barriers to community living, in coordination with the Olmstead Consumer Task Force, the MHDS Commission, and the Mental Health Planning Council.

  a. In collaboration with relevant stakeholders, pursue opportunities presented by national healthcare reform legislation to expand home and community based services.

  b. Provide for annual stakeholder review of this Plan and recommendations for updating. (SP 10)

Obj. 5.2 Expand outcomes measurement and reporting systems, with standardized processes to monitor consumer outcomes.

  a. Strengthen Iowa’s compliance with National Outcome Measures (NOMs) reporting through continued implementation of outcomes reporting. (SP 10)

  b. Begin work to incorporate National Core Indicators in outcomes reporting for the developmental disabilities service system. (SP 10)

  c. Build IME’s capacity to implement core quality measures recommended by the U.S. Department of Health and Human Services for children’s healthcare under the Children’s Health Insurance Program Reauthorization Act (CHIPRA; Public Law 111-3). (SP 10)

  d. Build IME’s capacity to implement quality standards for adult healthcare services upon promulgation of guidelines by the U.S. DHHS. (SP 10)

  e. Continue to strengthen compliance with CMS quality assurance requirements. (SP 10)

  f. Collaborate with Iowa Workforce Development, Iowa Vocational Rehabilitation Services, Department for the Blind, CPCs, the Iowa Association of Community Providers, and other partners, to establish common data sets regarding desired outcomes of employment and day services. (SP 5 – See also Obj. 3.1.g)

Obj. 5.3 Strengthen accountability for service system outcomes through a data management strategy that informs policy and measures program impact.

a. Expand capacity and utilization of DHS stored data to provide detailed reporting on target populations (demographics, diagnoses, service utilization, outcomes, etc.). (SP 10)

b. Create a mental health and disability service system data dashboard (or standardized reports) to promote awareness of system and provider results and to promote continuous improvement. (SP 10)

c. Collaborate with the Iowa Department of Public Health in development of the Health Information Technology (HIT) infrastructure required for implementation of national healthcare reform. (SP 10)

d. Use standardized incident reporting to collect and report system-wide data. (SP 10 - See also Obj.4.6.b)

e. Explore with counties and other partners issuance of an annual individual consumer report on services and costs.

f. Acknowledge programs that are achieving excellent outcomes.

Obj. 5.4 Collaborate with internal and external partners in reviewing and aligning policies towards community inclusion through redirection of resources for more effective outcomes.

   a. Identify initial targets as priorities for analysis of reimbursement rates and possible alignment of reimbursement with expected outcomes, such as supported employment services leading to competitive employment. (SP 11)

Obj. 5.5 Collaborate with counties and key stakeholders in the development of recommendations for long term system funding, to include an assessment of the options available under the Affordable Care Act, including mental health parity, health home and the benchmark plan. (SP 11)