CCBHC Stakeholder Committee
River Place Euclid Ave, Des Moines
January 26′ 2016
10AM-3PM
MINUTES

Stakeholder Committee Members:; Teresa Bomhoff; Kelsey Clark; Nancy Hale (phone); Gayla Harken; Jessica Leonard; Vickie Lewis; Bob Lincoln (phone); Kristie Oliver; Jason Orent (phone); Aaron Todd

General Public: Ashley Adams; Anne Armknecht; Kevin Dalin; Cindy Kaestner; Kim Scorza

CCBHC Grant Governance Team: Theresa Armstrong; Lori Hancock-Muck; Laura Larkin; Julie Maas; Michele Tilotta; Deanna Triplett

Staff: CDD: Caitlin Owens; Ann Riley; IDPH: Eric Preuss (phone) Consortium: Stephan Arndt (phone); Deshauna Jones (phone)

Theresa Armstrong opened the meeting by welcoming the committee members and reporting that Iowa is honored to be one of 24 states selected to receive a Certified Community Behavior Health Clinics planning grant. During the planning period, the grant team will work on planning the infrastructure needed to build the CCBHC system to serve Iowans with behavioral health needs. Theresa commented there is a lot of work to accomplish in the short nine months remaining in the planning grant and thanked members for joining the stakeholder committee to provide input to DHS and IDPH through the planning process.

Laura Larkin reviewed the agenda and provided an overview of the CCBHC Planning grant. Planning grant activities offer the opportunity for stakeholders to provide input on how Iowa will transform and enhance our existing mental health and substance use disorder services to create a system coordinated with person centered services and quality outcomes that meet SAMSHA expectations. A power point providing an overview of the planning grant activities was presented.

I. CCHBC Planning Grant Overview

Larkin encouraged input from the stakeholder advisory committee throughout the planning grant. This input will help DHS and IDPH identify current service gaps, recommend ways to address those gaps, and finalize the selection of the proposed Evidence Based Practices (EPBs) selected CCBHCs will be expected to provide. Over the next nine months Iowa will determine the certification process for clinics, develop a prospective payment system, and apply for a two-year demonstration grant. SAMHSA is expected to award demonstration grants to successful

applicants in January 2017. The grant governance team provides the opportunity for DHS and IDPH to work together to build a cohesive behavioral health system.

During the planning year SAMSHA provides technical assistance and monthly phone calls with the 24 participating states. The TA calls focus on the development of certification requirements for CCBHCs, the prospective payment system (PPS), statewide coordination, and data collection and evaluation.

The state must certify two to four CCBHC providers before the implementation of the demonstration grant, and there must be at least one urban and one rural site. Providers not selected to become certified CCBHCs during the demonstration years may participate in TA and training on the evidence based practices (EBPs) selected by Iowa. CCBHC requirements are complex and SAMHSA has provided a readiness tool that will help providers become familiar with all the requirements. For example, a CCBHC must demonstrate how it will reach diverse populations in their community. For example if there are a large number of individuals with Spanish as their primary language in their community what are they doing to reach and serve that population? The clinics must demonstrate accessibility methods used to serve their community such as scheduling options for evenings and weekends hours, and reasonable travel time to access the services if they serve a rural community. CCBHCs must also be a non-profit organization and have a governance body membership which includes 51% people with lived experience or their families.

Stakeholder Questions

1. If a provider is accredited by a national group such as CARF and it meets the standards of Chapter 24 will the provider still have to complete Chapter 24 accreditation?
2. Do other states already have CCBHC programs in place?

Response

1. At this time providers would have to apply for Chapter 24 accreditation.
   DHS will have to review deemed status for CARF within Chapter 24 to determine the alignment with CCBHC requirements. Michele Tilotta reminded stakeholders CCBHCs must provide life span services not just children or adult services and CCBHCs must serve everyone including individuals who do not receive Medicaid. Michele also reviewed that to provide Substance Abuse Outpatient Services, providers must be licensed under Chapter 155- Licensure Standards for Substance Use Disorder and Problem Gambling Treatment Programs.
2. At this time no state has an existing CCBHC and all 24 states selected for the planning grant are at different levels in the planning process. Some states have already selected the programs that will become CCBHCs while many are just in the process of doing the readiness assessments.

Stakeholder Feedback

- Providers of children's services would not be interested in becoming a CCBHC if additional accreditation was required and deemed status was not recognized.
- CCBHC is a new concept but it clearly aligns with the behavioral health system Iowa is developing.

A. CCBHC Required Services

Larkin reviewed the services which must be directly provided by the CCBHC and the services which may be provided through an agreement with a designated collaborating organization (DCO). She noted the payment must be made to the CCBHC by Medicaid, and they pay their designated collaborating organizations for their service. Outpatient substance use disorder services must be provided by the CCBHC directly and cannot be through a DCO.

Larkin reported DHS is seeking guidance from SAMHSA on the definition of state sanctioned crisis services. These definitions should align with Iowa's definitions as regions develop their crisis service network. Iowa is also asking for clarification on the type of detox service the clinic would have to provide since detox could be defined as an inpatient service but the CCBHC site is reimbursed only for community based services.

CCHBC **Must Provide** These Services Directly	CCBHC **May Use** a Designated Collaborating Organization (DCO)
• Crisis Behavioral Health	• Primary Care Screening an Monitoring
• Screening, Assessment, Diagnosis	• Targeted Case management
• Person and Family Centered Treatment Planning	• Psychiatric Rehabilitation Services
• Outpatient MH and SUD Services	• Peer Support, Peer Counseling, Family/Caregiver Support
	• Services for Members of the armed forces or veterans

B. **Prospective Payment System**

Larkin shared that a prospective payment system (PPS) will be developed for the CCBHCs. There will be a cost-based, daily rate for all services provided by the CCBHC on a day of service. SAMHSA is providing guidance through their technical assistance network. Monthly calls and state specific assistance is available. Since PPS is new to many providers Larkin asked Aaron Todd to provide a brief over view of how it is currently working in federally qualified health centers (FQHC). Todd shared the FQHC system is based on the level of care an individual needs. FQHCs have a 1) mandated list of required services; 2) can choose to offer a higher level of service; and 3) establish an "encounter rate" and bill for every patient in a specified time period. Some services are inexpensive and some are high cost but both are part of the

encounter rate. Yearly adjustments are made to the base encounter rate based on the addition of or changes in services. Quarterly wrap adjustments are based on number of clients seen versus the number projected to be seen.

Stakeholder Questions

1. Will the reimbursement be outside of the service reimbursement from MCOs?
2. Is this initiative about transforming our existing system rather than creating a new structure?
3. Will TA and training funds be available to help all providers develop capacity?

Response

1. The CCBHC rate will be set using the PPS methodology provided by SAMHSA and the rates established will be included in the MCO reimbursement structure. FQHCs currently use a PPS methodology and receive their reimbursement through IME, but will be reimbursed through the Medicaid MCOs when that system begins operating.
2. The initiative is both an opportunity to enhance and transform our existing system and create a new category of provider. The concept for CCBHCs was created by the Excellence in Mental Health Act to ensure high quality care, a no wrong door approach, and provide services in a cost effective manner.
3. TA and training funds are available only during the planning grant timeframe, not during the demonstration period. Once the state identifies the programs that will become CCBHCs in the planning grant a state cannot add additional certified clinics as part of the demonstration grant.

Stakeholder Feedback

- It feels like Iowa will be creating an ACO within the MCO system.
- This collaborative model is similar to the system used by VA now. VA centers recognize veterans need services closer to where they live and encourage providers to contract with the VA to offer local supports.
- It seems like an opportunity for all providers to collaborate and build partnerships.

B. Evidence Based Practices (EBP)

EBPs that CCBHCs must provide were identified following SAMHSA guidance. SAMHSA did not mandate specific EBPs, but they did provide a list of possible EBPs for states to consider. Iowa chose six EBP's for consideration: three for mental health services and three for substance use disorder treatment services. Assertive Community Treatment (ACT), Intensive Psychiatric Rehabilitation (IPR), and Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) are the suggested EBPs for mental health services. Tilotta reviewed the EBP's for Substance Use Disorders which includes Motivational Interviewing, Medication Assisted Treatment and

Feedback Informed Treatment. Larkin explained DHS needs stakeholder input to consider which EBPs are available in Iowa and to identify challenges and opportunities for enhancing the use of these practices statewide. For example, for years many providers have said that Iowa needs more ACT teams. The planning grant could provide the opportunity for technical assistance and training to build more ACT Teams. Currently TA and training through the grant are funded only through the end of September 2016 but SAMSHA might consider a no cost extension if all funds have not been utilized. Larkin noted providers not chosen to be certified clinics may still participate in trainings and TA during the planning grant period.

Stakeholder Questions

1. How will workforce issues be addressed by this grant opportunity?
2. Are there requirements on the wait time for services from CCBHCs?

Response

1. SAMHSA is open to the use of telehealth services to enhance access in shortage areas. Capacity enhancement is a grant requirement.
2. DHS will be looking at capacity of clinics applying to be a CCBHC because they should be prepared to serve a population within a reasonable timeframe. This is a good opportunity to identify gaps.

Stakeholder Feedback

- Workforce shortages are statewide and should not be overlooked since they clearly impact timely access to services.
- Telehealth is not the only answer for improved access to services and workforce shortages. Providers trying to offer child psych services are experiencing lots of barriers even with telehealth services.
- This grant could provide opportunities to improve access.

C. Demonstration Program

Larkin reported the original guidance required states selected for a demonstration grant to be prepared to start January 1, 2017 which is a short timeline since states submit the demonstration grant application in mid-October 2016. SAMHSA has already issued a modified timeline clarifying demonstration grants will have up to July 1st to begin their two-year implementation activities. Clinics must commit to collecting specific data to demonstrate outcomes. States will be part of a national evaluation.

Stakeholder Questions

1. What happens if the state does not get a demonstration grant?
2. Are CCBHCs required to provide services to veterans?

3. Can a FQHC access the future CCBHC PPS rate if they become a certified clinic during the demonstration years?
4. Could the enhanced payment rates be directly connected to elevating staff salaries since many providers are currently working at very low hourly rates considering their experience and education level?
5. What is the enhanced FMAP rate was during the demonstration years?

Response

1. The states could choose to implement on their own without the enhanced FMAP. There is advocacy support for developing future opportunities so all states could eventually have CCBHCs. States not selected would be more prepared for future SAMHSA demonstration grants. There has been some discussion at the federal level about increasing demonstration round funding to allow all 24 states with planning grants to receive a demonstration grant.
2. SAMHSA does require CCBHCs to serve veterans because the distance to a VA service is often too far and transportation is difficult. Laurie Raymond explained the VA system has tried to address this issue with their Veterans Choice Program, for veterans more than 40 miles from a VA service or if there is more than one month wait for an appointment. Unfortunately, no community providers have applied to become a contracted service provider.
3. Clinics not selected to be CCBHCs in the planning year will not receive the PPS rate during the demonstration years.. However, non-CCBHC providers can receive TA and training during the planning year.
4. The PPS could include enhanced salaries for staff offering EBPs because it encompasses all the costs for provider to implement the required services. At this time it is not known if the PPS will or will not be higher than current service rates today.
5. The enhanced FMAP rate is the same as the FMAP for the state Hawk-I program which is 69.72%.

Stakeholder Feedback

- Staff is inadequately reimbursed in many settings**.**

D. Public Comment

Kim Scorza from Seasons Center asked for clarification on the intersection between the state innovation model (SIM), integrated health home (IHH) program, and the new CCBHC services. Larkin replied care coordination and case management happen to be a holistic component in Iowa's service system and many organizations provide it through IHH programs. In the application to SAMHSA, DHS clearly outlined that they expect CCHBCs to collaborate with

existing services, providers, and initiatives already happening in the state including the SIM initiative and the IHH model of care coordination. Iowa will orient SAMHSA on how Iowa's IHH and SIMS network during this planning year and in our Demonstration grant application.

II. Discussion of Stakeholder Roles

The afternoon discussion began with Michele Tilotta asking the stakeholders to share what they see their role as on the stakeholder group. She also asked them to identify what makes sense to them about this planning grant, what challenges they see, what may be missing, what needs to be considered, and any concerns they have.

Stakeholder Comments on Roles

- Associations can help keep their constituency informed about the initiative, and help bring together groups of people, both their membership base and groups and individuals with whom they work.
- Sharing information on lessons learned about what works well from both the individual and provider perspective, what community needs are, and what is needed at a system level.
- Federal law for FQHCs require each have a referral system to be in place and this initiative will help them build upon their network.
- The VA system and their community based outpatient clinics can become possible partners and providers would have more incentives to serve veterans.
- Regions will continue to find ways to reduce barriers to accessing services and improve quality improvement in the current system.

Stakeholder Questions

1. Is there more than one way to develop a PPS if so how might this be different than the PPS used by FQHCs?
2. Is this initiative intended to be best practice and if so should regions be organizing themselves this way?
3. Will DHS provide simple summaries to help consumers understand what is happening during planning and future implementation phase?
4. How will DHS choose the clinics to be the control group to compare with CCBHCs?
5. Why would control group participate without additional dollars to cover data collection time and expenses?
6. Will outside assistance be available to help develop the demonstration grant application similar to the process followed for the planning grant application?

Response

1. The grant allowed applicants to choose between two PPS methodologies. Iowa choose PPS-1 which is similar to the PPS methodology for FQHC.
2. SAMHSA will be collecting the data during the demonstration years and that data will determine if CCBHC models are best practice.
3. DHS has a website that includes information about this initiative. Stakeholders will receive a link to that site to help them share information with their membership and others.
4. CCBHC services will be compared to clinics that are not CCBHCs. SAMHSA is working through what the comparison means for data collection.
5. At this time DHS plans to use IDPH staff, DHS staff, the CCBHC grant Governance Team and CDD staff to write the demonstration application. They expect the Iowa Consortium for Substance Abuse Research to also provide guidance during the application process
6. Right now the demonstration grant does not include technical assistance funds for the clinics and their collaborating organizations but that could be revisited with SAMHSA.

Stakeholder Feedback

- It is great to know there is an existing readiness tool for stakeholders to review, and that there will be workforce development opportunities during the planning year.
- This planning grant might help the state prepare for future success and program development even if Iowa does not get a demonstration grant.
- Right now the members of the Iowa Behavioral Health Association are overwhelmed with new contracting issues as MCOs prepare to begin and changes with the regional system structure.
- The prospective payment system is new to most providers and the state will need to make sure information is provided to providers in simple, easy to digest terms.
- It will be critical to develop realistic reimbursement rates and have an open discussion about the EBPs Iowa wants a CCBHC to implement
- FQHCs might be poised to participate but each center would need to decide if the new PPS model fits their setting and makes sense to them.
- Be cautious that increased training does not always result in increased quality of care.
- Details on how the model is implemented are very important.
- Be sure to provide sufficient funds to pay salaries to those with appropriate training and licenses.
- Be cautious about the data needing to come from both the control and certified centers. SAMHSA speaks about data collection from both sites and the need for 80% follow up with people receiving services for similar needs, plus a comparison must be made in both rural and urban clinics. DHS has to describe how that data will be collected during

the demonstration period. CCBHCs will have a new PPS rate which can include data collection costs.

- Be cautious and do not assume co-location of services mean full integration. Workflow, care team approaches and billing systems must all be modified for full integration.
- Technical assistance may be needed to help providers define full integration and all services learn to talk and work together. There are great resources available that define the difference between paper integration verses procedural integration.
- IHH programs still lack in making consistent connections for peer support, and the current training for peer support staff should be enhanced. It is important to make sure the training offered is high quality training.
- The concept is excellent.
- It appears to be another opportunity to enhance the outcomes achieved by the IHH program, which is another excellent concept.
- More training on evidence based practices is great.
- One stop shops would appear to be less stressful. Peer support and positive supports really make a difference for the individual needing services.
- Excitement about the opportunities to enhance the system.
- Good concept with local services and no wrong door approach.
- This initiative will impact not just MH centers and SUD providers, but the entire community, and provides a potential for a tide of systems change.
- Providers are poised and excited to get things off the ground and the possibility of TA and training on EBPs.
- Because Iowa does not have a children's mental health system now it is difficult to see how this initiative will build on services for children

III. Proposed Evidence Based Practices Overview

Laura Larkin reviewed the EBP slides and asked if the stakeholder members had any input on proposed list of EBPs. She said they limited the list to six due to the short timeline for certifying clinics. The proposed EBPs were selected on need, what currently exists in Iowa, and feasibility of clinics being able to add new practices in a short time.

A. Assertive Community Treatment

Assertive Community Treatment (ACT) slides were reviewed. Laura Larkin noted Iowa ACT focuses on adults while other states also have youth ACT programs. Services are provided in the person's home and billed as a monthly service. People served need intensive services. Iowa administrative code chapter 77 has existing rules on requirements for a fully staffed ACT team and SAMHSA provides additional recommendations (slides 5 &6). SAMHSA has a fidelity tool

available along with the DACT and MACT tools**.** Bob Lincoln agreed there is a need for more ACT teams and mentioned his region recently released an RFP to develop an ACT team.

Stakeholder Questions

1. Will all CCBHCs have to provide ACT?
2. What was the maximum amount a state could be given for a demonstration grant award?

Response

1. All CCBHCs will have to offer each of the state selected EBPs.
2. There is no cap because the demonstration grant is based on the initial savings to the state through the enhanced FMAP for the participating number of Medicaid members.

Stakeholder Feedback

- Several stakeholder members expressed concern about the cost effectiveness of starting an ACT in a rural area where the number utilizing the team may be very small. DHS will seek more information and review the current costs to start an ACT team. Theresa Bomhoff shared the existing ACT Medicaid payment is about $1,400 to $1,500 a month for one client which is cheaper than one day in the hospital. Theresa Bomhoff mentioned ACT teams typically have a professional to consumer ratio of 1-10. Nancy Williams from Iowa's previous ACT Technical Assistance Program had told counties our state has about 3,000 Iowans eligible for ACT but the existing five teams are only reaching about 300 people. Larkin stated DHS will request additional information from the IMPACT team.

B. Intensive Psychiatric Rehabilitation

Intensive Psychiatric Rehabilitation (IPR) helps individuals take a more active role in recovery, achieve full community integration, and improve overall quality of life. Iowa has individuals trained in the IPR model which was developed at Boston University. CCBHC providers must meet Chapter 24 requirements for IPR. This presentation is just an overview of IPR. Gayla Harken commented that as a graduate of Boston University she has offered entry level Psychiatric Rehabilitation training in Iowa. The National Behavioral Health Council says states are looking at it as a broad approach and introductory training for person centered supports. Psychiatric Rehabilitation focuses on the stages of change and the individual's readiness for change. It is not therapist driven. Individuals are supported to achieve their wishes and desires.

Stakeholder Questions

1. Is it exactly accurate to classify IPR as an EBP, instead of just Psychiatric Rehabilitation?

Response

1. Larkin encouraged stakeholders to share information on other models with the governance team to review. IPR training in Iowa has been based on the Boston model and we have providers that have been trained as trainers for their agencies, and other providers with varying levels of training.

Stakeholder Feedback

- IPR is only recognized by Iowa and not used in many other states.
- It is difficult and expensive for providers when they train their staff and then their staff leave.
- There is not a fidelity process outside of Chapter 24 in place at this time.
- IPR seems to be only for individuals at a high level of need which requires supports outside of traditional PR services.
- IPR is only one way to provide Psychiatric Rehabilitation. It is focused on individuals with intense needs. When you look at the model on the SAMHSA website and through Boston University it is just the Psychiatric Rehabilitation Process that is an EBP.

C. Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a model designed to treat trauma and accompanying emotional and behavioral challenges for children and adolescents. The model is focused on treatments for both the family and child, and usually involves the participation of a parent or caregiver. The national TF-CBT registry lists certified therapists in Cedar Rapids, Ames, Council Bluffs, Iowa Falls, Anamosa, and Burlington. In addition to those who are fully certified, there are also providers across the state who are in the process of becoming certified.

There were no stakeholder comments or questions following the TF-CBT overview.

D. Motivational Interviewing

Michelle Tilotta presented an overview of the three selected EBPs for substance use disorder treatment. Those EBPs are Motivational Interviewing, Feedback Informed Treatment, and Medication Assisted Treatment. Again SAMHSA did not select the EBPs for Iowa instead IDPH suggested the EBPs as they are Evidenced Based practices IDPH is currently implementing and would like to expand throughout the state.

Motivational Interviewing is a counseling technique with a therapist guiding the patient through the process. Motivational interviewing explores the person's motivation, desire, and commitment to make a change in a collaborative and non-judgmental way. Therapists have a directive to examine and resolve the client's ambivalence, helping them move from a pre-

contemplative state to action. This EBP can be used in a variety of settings such as those that are focused on health coaching, parenting, education settings, problem gambling, and substance use. It is widely used in substance use disorder treatment services and community mental health centers. FQHC's have a large number of staff trained to use MI from beginner to advanced levels. SAMHSA and HRSA have a combined resource site for trainings on MI. The VA has an intense training process and fidelity checks for support and consultation for practitioners. More info can be found at motivationalinterviewing.org.

Stakeholder Questions

1. Will there be fidelity monitoring and continuing education throughout the process for MI?

Response

1. Fidelity checks and –and continued training in MI is critical for sustainability of this EBP. IDPH will look at - continued training from beginner to advanced levels of MI implementation and will include discussions of fidelity monitoring within the context of these trainings. IDPH has used multiple MI trainers in past and most recently have worked with Kate Speck, from Nebraska, who is a minted MI trainer. IDPH will follow up with Kate or others dependent on ability to schedule.-

E. Feedback informed Treatment

Feedback Informed Treatment (FIT) is an approach for evaluating and improving the quality and effectiveness of behavior health services. Implementing at every therapy session allows therapists to make timely adjustments to therapy. In Iowa, Prairie Ridge is implementing FIT and other providers such as Jackson, Prelude and ASAC have attended trainings and at beginning discussions of FIT planning.-

FIT is an evidenced based practice which - developed by Scott Miller and a team of clinical researchers. FIT uses an outcome rating scale and session rating scale (ORS and SRS) at the end of therapy sessions. The patient is asked how the session went and did the therapist or session meet their expectations. Routine feedback from patient decreases the drop out or no show rate in half. FIT has also shown it can reduce hospitalization by 60%. The CCBHC planning grant has some funds to increase the providers' knowledge and implementation of - FIT. You can see instant results after one training instead of waiting for results following multi weeks training. Laurie Raymond agreed providers at the VA like the immediate feedback from patients on how the treatment was perceived.

F. Medication Assisted Treatment

Medication Assisted Treatment (MAT) is being increasingly focused on nationally, and in the state because of the high (and rising) rates of heroin and opioid abuse. Treatment depends on how individual responds to medication and reactions vary among individuals. MAT is an individualized decision between the prescriber and individual and is a medically managed clinical process. Research has demonstrated that combined with therapy, outcomes are much better. SAMHSA has a buprenorphine provider treatment locator. Iowa has 37 buprenorphine prescribers which is low compared to Nebraska and Kansas who have around 130+ providers. - Vickie Lewis shared there is need to have continued support to physicians in addition to the trainings.

Compared to other states Iowa has a relatively low incidence of deaths from substance use. However from 2007 to 2012 Iowa had a 157% increase. Overdoses and deaths from Opioids are of state and national significance.-

Current Opioid treatment providers in Iowa are located in Cedar Falls and Marion (Cedar Valley Recovery Services); Cedar Rapids (CRC Recovery); Davenport (Center for Behavioral Health Iowa); Des Moines (Center for Behavioral Health, United Community Service); and Sioux City (Center for Behavioral Health, Siouxland Treatment Center).

Close monitoring from a primary care physician is needed for effective treatment. MAT certified physicians have to complete 8 hours of training and there is a limit on the number of patients they can serve. Also integral to MAT, an individual has to have a motivation to change, stop using substances, and a willingness to participate in behavioral therapy. -

-

Iowa recently received a Medication Assisted Treatment grant through SAMHSA to focus efforts on these issues. In addition, individuals may access funding for MAT through the Access to Recovery (ATR) Grant; dependent on eligibility. -provides vouchers to clients to purchase recovery support services while in a treatment setting - - - The Mid –America Addiction Technology Transfer Center (ATTC) funded through SAMHSA is currently working with Iowa to provide MAT technical assistance with education.- Vickie Lewis shared that a physician at her center just went through Suboxone training, and though there were no grant funds that supported that, the decision was made through conversations that it was something they wanted to pursue. She said often a lot can happen by being willing to have conversations about what might be possible.

Stakeholder Questions

1. Will you introduce legislation?
2. What's the plan for workforce issues/development to get prescribers on board?
3. What about increasing the workforce trained to work with MAT prescribers?

Response

1. IDPH cannot take a position either way as they are a state agency. -
2. There are only 37 opiate treatment providers and more discussions/direction from SSA and SAMHSA need to occur as to how prescribers may be increased and/or if this could be a - Designated Collaboration Organization agreement. -
3. COPE is a free online training for prescribers -who treat individuals with chronic pain with opioids and IDPH is hoping more primary care providers will access the online training.

G. Public Comment

Ashley Adams, a student at St. Ambrose University, expressed her support for ACT being selected as an EBP. She said she would like to see ACT programs developed statewide and especially in the Davenport area based on research that it helps improve individual's lives and treatment outcomes, including an 80% reduction in homelessness. She will send information to Laura Larkin about the effectiveness of ACT programs.

Next CCBHC Stakeholder Council:

March 29, 2016
West Des Moines MCS Community Education Bldg.
3550 Mills Civic Parkway,
West Des Moines, IA 50265