Iowa

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/01/2017 6.28.01 PM)

Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
Start Year 2018
End Year 2019

State DUNS Number
Number 137348624
Expiration Date

I. State Agency to be the Grantee for the Block Grant
Agency Name Iowa Department of Human Services
Organizational Unit Division of Mental Health and Disability Services
Mailing Address 1305 E. Walnut
City Des Moines, IA
Zip Code 50319

II. Contact Person for the Grantee of the Block Grant
First Name Richard
Last Name Shults
Agency Name Iowa Department of Human Services
Mailing Address 1305 E. Walnut
City Des Moines
Zip Code 50319
Telephone 515-281-8580
Fax
Email Address rshults@dhs.state.ia.us

III. Expenditure Period
State Expenditure Period
From
To

IV. Date Submitted
Submission Date 9/1/2017 6:27:09 PM
Revision Date

V. Contact Person Responsible for Application Submission
First Name Laura
Last Name Larkin
Telephone 5152425880
Fax 5152426036
Email Address llarkin@dhs.state.ia.us

Footnotes:
## Fiscal Year 2018

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

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination 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 National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal 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.): (a)


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.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Jerry R. Foxhoven

Signature of CEO or Designee: __________________________

Title: Director, Iowa Department of Human Services

Date Signed: ______________

mm/dd/yyyy

1If the agreement is signed by an authorized designee, a copy of the designation must be attached.
June 29, 2017

Substance Abuse and Mental Health Services Administration
Office of Financial Resources, Division of Grants Management
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

To Whom It May Concern:

This letter designates Jerry Foxhoven, Director of the Iowa Department of Human Services, to function as my designee for the following Substance Abuse and Mental Health Services Administration (SAMHSA) programs for as long as I remain Governor of the State of Iowa and Mr. Foxhoven remains Director of the Iowa Department of Human Services.

1. Jerry Foxhoven is authorized to function as my designee for all activities related to the SAMHSA Projects in Assistance in Transition from Homelessness (PATH) program.

2. Jerry Foxhoven is authorized to function as my designee for all activities related to the SAMHSA Community Mental Health Block Grant (MHBG) program.

Please contact my office if you have any questions.

Sincerely,

Kim Reynolds
Governor of Iowa
State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

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protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h)

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential
components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as
amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic

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The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: 

Signature of CEO or Designee:

Title: Director Date Signed: 8/31/12

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

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

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**Signature:**

**Date:**

**Footnotes:**
Planning Steps

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

Narrative Question:

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

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

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

Overview of the State Mental Health System

System Changes since the submission of the Iowa 2016-17 MHBG Plan

Mental Health and Disability Service System Redesign

Since the last MHBG plan submitted in 2015, transformation of the Iowa mental health system has continued. Iowa implemented Medicaid Managed Care, referred to as IA HealthLink, effective April 1, 2016. Three managed care organizations (MCO)-Amerigroup, Amerihealth Caritas, and United Health Care provide Medicaid services to most Iowa Medicaid members. A small portion of the members continue to be served by traditional Medicaid Fee For Service (FFS). Prior to the MCO implementation, Iowa Medicaid behavioral health services were managed by a single behavioral health organization for 20 years with physical health benefits managed by Medicaid FFS.

The implementation of the redesign of the regional mental health and disability services system which began in 2011, also continues. Iowans are served by 14 regional entities in place of 99 separate county systems. The Mental Health and Disability Services (MHDS) redesign promotes statewide standards, regional management, and local access. The target populations for the regional service system are adults with a diagnosis of a mental illness or an intellectual disability whose incomes are at or below 150% of poverty level and who do not have other insurance coverage for mental health and disability services or who require services not covered by Medicaid or private insurance. MHDS Regions have begun implementation of crisis services across the state and also continue to implement evidence-based practices.

Iowa continues to move toward less reliance on facility-based care and more focus on community-based services and supports. The redesign referenced above has focused on development of local resources such as crisis intervention, crisis stabilization services, and jail diversion programs that will reduce the need for facility-based care or unnecessary incarceration due to untreated mental health needs.

Iowa implemented an Inpatient Psychiatric Bed Tracking system effective August 1, 2015. This system was implemented due to concern expressed by stakeholders and advocates regarding difficulty in locating inpatient psychiatric beds, leading to persons having to travel long distances to receive inpatient care. The bed tracking system allows access to an online, searchable database of available psychiatric beds by authorized users, which includes hospitals, law enforcement, regional administrators, and judicial representatives. Legislation enacted in 2017
requires hospitals with inpatient psychiatric units to report into the bed tracking system twice daily, in order to improve reliability of the data base. Inpatient bed availability for individuals with complex needs, including aggressive behavior or intellectual disabilities in conjunction with mental illness remains difficult to obtain.

**Legislative Actions and Workgroups Related to Mental Health**

**Children’s Mental Health and Well-being Workgroups**

In 2015, Senate File 505, Division XXII charged the Department of Human Services (Department), in cooperation with the Department of Education and the Department of Public Health, to facilitate a study on children’s mental health and children's services systems by a workgroup of stakeholders. The workgroup was required to submit a report to the legislature in December 2015.

The Workgroup was broken into two subcommittees; one on children’s mental health and another on children’s well-being. Over five meetings, the workgroup identified and defined services, supports, and essential characteristics necessary for children’s mental health and well-being. The Children’s Mental Health Subcommittee identified, defined, and prioritized a core set of mental health services for children. The subcommittee determined it would be difficult to implement the entire array of children’s mental health services at once, and recommended a process to phase in children’s mental health crisis services in two geographic areas at a time. The subcommittee recommended $300,000 for this effort. The subcommittee also recommended evaluating the expansion of telehealth for children’s mental health services, to better coordinate mental health crisis and referral telephone lines, to revise Iowa Code to reflect the recommendations of the subcommittees, and to develop a public information campaign.

The Children’s Well-Being Subcommittee worked to identify barriers to child and family success, operating elements for coordinated cross-system child and family support, and emerging examples of this approach in Iowa. The Children’s Well-Being Subcommittee recommended the development of three to five “learning labs” where systems engaged in cross-system, family-focused case management shall report on their approaches and outcomes. The subcommittee also recommended that an advisory group be established to prepare the learning labs, continue the subcommittee’s efforts, and coordinate with the Children’s Mental Health Subcommittee. During the 2016 Legislative session, the recommendations regarding Children’s Crisis Planning Grants and Learning Labs were enacted in legislation requiring the Department to award funds through request for proposal processes. Two grants for each project were awarded in 2016. The Department submitted a report to the legislature in December 2016 summarizing the work to date on each project.

The 2016 legislature also directed the Department to reconvene the Children’s Mental Health and Wellbeing Workgroup and to submit a report regarding children’s mental health crisis services. The Workgroup was charged with making recommendations regarding the next steps in establishing a children’s system. The Workgroup recommended building on the lessons learned by the two children’s mental health crisis planning grants and the two child well-being learning labs by requesting appropriations to fund competitively bid grants for Children’s Wellbeing Collaboratives that focus on child and family wellbeing, including mental health, through prevention and early intervention.
The goal of Wellbeing Collaboratives is to bring a broad cross section of entities together in a defined geographic area to collaborate and cooperate in their efforts to build and improve the effectiveness of prevention services. The Collaboratives’ prevention services are to measurably improve the wellbeing of children and families, including children’s mental health. The Workgroup recommended that Wellbeing Collaboratives’ use sound public health principles of prevention and population health. The Workgroup recommended that the Collaboratives regularly report their progress and that the Workgroup continue to meet to help steer the work of developing a children and family service system. The 2017 legislature enacted the recommendations to develop Children’s Wellbeing Collaboratives, allocated $300,000 and directed the Department to issue a request for proposals. The Department is currently in the review process for this procurement and stated its intention to issue up to 3 contracts for SFY18.

**Complex Needs Workgroup**

In 2017, SF 504 charged the Department of Human Services to convene a stakeholder workgroup to make recommendations relating to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services and supports for individuals with mental health, disability, and substance use disorder needs, particularly for individuals with complex mental health, disability, and substance use disorder needs. The workgroup will include representatives from community mental health centers, Iowa Department of Public Health, Iowa Hospital Association, judicial system, law enforcement agencies, Mental Health and Disability Services Regions, National Alliance on Mental Illness, substance use disorder treatment providers and other related stakeholder groups.

The workgroup will provide input and guidance on topics surrounding individuals with complex service needs including but not limited to treatment modalities, funding, and maintaining and expanding community based service options. The workgroup will submit a report to the Governor and General Assembly on December 15, 2017 with recommendations.

SF 504 also requires the regions to convene stakeholder workgroups to meet on a regular basis to create collaborative policies and processes relating to the delivery to, access to, and continuity of services and supports for individuals with mental health, disability, and substance use disorder needs, particularly for individuals with complex mental health, disability, and substance use disorder needs. Regions are also required to enter into MOUs with each of the MCOs to define roles and responsibilities for the regions and the MCOs. The regions are to submit community service plans to DHS which will be incorporated into the Complex Needs Workgroup legislative report to be submitted in December 2017.

**Inpatient Bed Tracking**

In 2017, HF 653 added requirements for hospitals with inpatient psychiatric units to enter bed availability in the online bed tracking system twice daily. The Department is in the process of promulgating administrative rules to implement this requirement.

**Olmstead Plan update**

Since early 2016, the Iowa Department of Human Services, Division of MHDS has been working with stakeholders to develop the framework for a new five-year Olmstead Plan to
continue moving Iowa’s mental health and disability service system closer to the vision of a “life in the community for everyone.” The Department has drafted a plan framework designed to achieve measurable progress toward target outcomes in nine domains: access to services, life in the community (integration), employment, housing, transportation, person-centeredness, health and wellness, quality of life and safety, and family and natural supports. The plan is intended to build on recent systems and policy changes, be flexible in responding to new challenges and opportunities, track and report on measurable person-centered outcomes that reflect community capacity, choice, and self-determination:

- Individuals with disabilities and mental illnesses have timely and convenient access to services and supports that are responsive to their needs and preferences, and are provided by a qualified, well-trained, and supported workforce.
- Individuals with disabilities and mental illnesses are valued, respected, and active members of their communities.
- Children with disabilities and mental health conditions are appropriately educated in integrated settings. Adults with disabilities and mental illnesses are employed in integrated settings of their choice, earning competitive wages and benefits. Older adults with disabilities and mental illnesses engage in meaningful activities of their choice.
- Individuals with disabilities and mental illnesses live in integrated settings of their choice that are safe, decent, affordable, and accessible.
- Individuals with disabilities and mental illnesses have adequate transportation to get to the places they need and want to go.
- Individuals with disabilities and mental illnesses are supported and empowered to make informed choices about their personal goals, daily activities, individualized service plans, and civic involvement.
- Individuals with disabilities and mental illnesses receive quality health care and are supported in living healthy lives.
- Individuals with disabilities and mental illnesses are safe, free from all forms of neglect and mistreatment, and are empowered to improve their quality of life.
- Individuals with disabilities and mental illnesses are supported by family members and friends of their choice, and have social connections within their communities.

In developing the plan, the Department has worked with a committee of the Olmstead Consumer Task Force, and continues to consult with the Mental Health and Disability Services Commission, the Mental Health Planning and Advisory Council, and the Iowa Developmental Disabilities Council, as well as other stakeholders, including individuals with mental illness or other disabilities and their families, advocates, service providers, and representatives of state agencies and county governments.
The State Mental Health Authority

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

MHDS includes:

- The two State Resource Centers for individuals with developmental and intellectual disabilities.
  - Woodward State Resource Center
  - Glenwood State Resource Center
- The two state Mental Health Institutes which provide inpatient mental health services to adults and children.
  - Cherokee Mental Health Institute
  - Independence Mental Health Institute
- The Civil Commitment Unit for Sexual Offenders (violent sexual predators)
- Eldora State Training School-for juvenile males adjudicated delinquent
- The Office of Facility Support
- The Bureau of Targeted Case Management
- The Bureau of Community Services and Planning (provides oversight of the MHBG)

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, insurance coverage, and service needs. Services specifically for children will be identified throughout this section.

Currently, adults and children who are eligible for Medicaid, including Iowa Health and Wellness Plan (IHWP) members with incomes of up to 133% of federal poverty level receive mental health and substance use disorder services funding and management through their assigned Medicaid MCO. Children eligible for HAWK-I, Iowa’s State Children’s Health Insurance Program are also served by MCOs. Members are randomly assigned but can request assignment to a specific MCO within 90 days of assignment or for good cause at any time. As stated before, a small portion of Medicaid members are not served by MCOs. These members’ services are directly funded by Iowa Medicaid FFS. Substance abuse disorder services funded by the Substance Abuse Prevention and Treatment Block Grant and associated State appropriations under the authority of the Iowa Department of Public Health SSA are also managed through Amerigroup, one of the Medicaid MCOs.

As of April 2017, Medicaid enrollment with the MCOs was:

- 429,301 individuals in traditional Medicaid
- 143,700 individuals in IHWP
- 44,966 individuals in HAWK-I
- 44,159 were enrolled with Medicaid FFS and not enrolled with an MCO

Adults without Medicaid or other insurance coverage, or who need services not otherwise covered by Medicaid or other insurance may access mental health services through the regional system if eligible by residence and financial eligibility.
MHDS Regional Services and Funding
Iowa has transitioned from a county based system to a regional system with expectations for provision of standardized core services, eligibility based on residency, and increased usage of functional assessments to determine need for services. Services are to be regionally managed and locally available, in compliance with statewide standards.

Iowa’s 14 MHDS regions, through property tax dollars raised by the counties, are required to make available a set of core services that include outpatient mental health services, mental health hospitalizations (and services associated with involuntary hospitalizations), basic crisis response, community support services, and work and/or day activity services, when no other funding is available through Medicaid or private insurance.

Under the regional MHDS system, regions provide services under a regional administrative entity with local access points available to individuals within the region. One county received a waiver to form a region of one county, while the remaining 13 regions are comprised of groups of 4 to 22 counties. With regionalization, counties are able to pool local tax dollars to deliver required core services and evidence-based practices as well as implement additional core services and share administrative responsibilities.

Regions are not required to fund services for children but some fund outpatient mental health services and sometimes coordinate the involuntary commitment process for juveniles. Regions are also developing and funding additional core services such as crisis lines, warm lines, mobile crisis services, crisis stabilization, civil commitment pre-screening, and jail diversion when funds are available. Regions are also supporting development of ACT teams in rural areas and crisis services using telehealth in rural areas where mental health professionals may not be available. The regions, the MCOs, and DHS are working collaboratively to ensure that all services that are Medicaid-reimbursable are billed, preserving regional funding for services and individuals not covered by Medicaid.

Integrated Health Homes for Individuals with an SMI or SED
As of July 1, 2013, Iowa implemented integrated health homes (IHH) for Medicaid-eligible adults with a serious mental illness and children with a serious emotional disturbance. The health home program was created through Section 2703 of the Patient Protection and Affordable Care Act. IHH services for individuals with an SED or an SMI are required under the contracts with the MCOs and are a Medicaid state plan service.

The goal of the IHH is to provide care coordination and integrated services to populations at high risk of poor health outcomes. Development of health homes is part of Iowa’s overall goal to increase availability of supports for individuals with serious mental health conditions that allow them to remain in their homes and communities and have improved health and wellness outcomes. Integrated health homes are available to residents statewide. There are 37 IHH programs across the state. 22 of the 37 IHH are CMHCs. 13 of the IHH are also licensed providers of substance use disorder services. Other IHH are providers of children’s residential treatment and community mental health providers. The role of Integrated Health Homes in delivery of services to individuals with an SMI or SED will be further explained in the sections on Children’s Mental Health Services, Habilitation, and Case Management.
The Iowa Health and Wellness Plan
Beginning January 1, 2014, the Iowa Health and Wellness Plan was offered for individuals, ages 19-64, with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. The goals of the plan are focused on improvements in health and outcomes, incentives for healthy behavior, an emphasis on care coordination, and local access to care. Individuals eligible for IHAWP coverage but deemed “medically exempt”, which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions may choose between IHAWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services and other community-based supports not available under the IHAWP plans.

STRENGTHS AND NEEDS OF IOWA’S MENTAL HEALTH SYSTEM
The strengths and needs of the mental health system will be described under the four primary headings of prevention, early intervention, treatment service, and recovery supports. Some organizations or services may be included in more than one category.

1. BEHAVIORAL HEALTH PREVENTION
Education for the general public and providers
Iowa offers a wide variety of training opportunities related to mental health. The focus on professional growth and development is a strength of the Iowa mental health and disability system. Individuals with lived experience and their families are integral participants of many of the training opportunities offered, either as attendees, planners, or presenters. Education on mental health conditions is essential to reduce stigma and increase public awareness of mental health conditions and appropriate interventions, as well as to improve quality and capacity of the mental health provider community.

The Iowa Mental Health Conference is held annually in October. This conference is planned by consumer groups including NAMI; state agencies including Iowa Department of Human Services-MHDS, Iowa Department of Public Health-SSA, and Iowa Department of Education; and private providers and individuals. This is an opportunity for professionals and experts to share the most recent trends and issues, treatment programs and research relating to mental health and mental illness. This conference traditionally brings mental health professionals, substance use disorder professionals and stakeholders, consumers, families, program funders, policy makers, and community partners together to learn and work toward establishing and improving the mental health system of Iowa. MHBG funds are used to support consumer stipends which promote conference participation by individuals served by the mental health system. In October 2016, 27 consumers of mental health services attended the conference with support from the Mental Health Block Grant. Presentations at the 2016 conference included presentations on first episode psychosis programs, management of peer support staff, behavioral and physical health integration, and trauma-informed care.
The Iowa Empowerment Conference began in 1999 to provide an opportunity for mental health consumers to join with each other and share ideas, talents, and experiences. The goal of the annual conference is to provide individuals, families, and youth dealing with mental health issues to learn coping skills and to strive for recovery through education. This consumer-led conference includes state and nationally recognized keynote speakers, peer support, social functions and more. The most recent conference was held in July 2017. Many of the workshops each year are presented by consumers. MHBG funds are used to promote mental health consumer participation in the conference through providing stipends for consumers with insufficient financial means to attend.

**Trauma-Informed Care Training**

Multiple private providers as well as MHDS regions have promoted trauma-informed care trainings to improve understanding and knowledge of trauma-informed care. MHDS regions are required to develop services that are trauma-informed.

**Community Connections Supporting Reentry Training**

In 2016, DHS entered into a contract with the State Office of Drug Control Policy to develop and coordinate training for the Iowa Department of Corrections (DOC). This training is part of the DOCs federal reentry grant. The training was designed to bring community mental health and substance use providers together with DOC and community corrections staff to educate each group about the other's roles and services. The goal of the training is to promote successful reentry to the community for individuals with a mental health and/or SUD diagnosis. A highlight of the training was the inclusion of panels of individuals with lived experience of reentry from the corrections system and behavioral health needs. 1,342 individuals participated in 24 trainings offered across the state and identified an 87% satisfaction rate with the trainings. DHS is developing a curriculum that DOC can use to continue community trainings after the end of the reentry grant.

**NAMI Signature Programs** – These programs are free and available to the public.

**NAMI Basics** is a class for parents and other family caregivers of children and adolescents who have either been diagnosed with a mental health condition or who are experiencing symptoms but have not yet been diagnosed.

**NAMI Family-to-Family** is a class for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members. This program was designated as an evidence-based program by SAMHSA.

**NAMI Peer-to-Peer** is a recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants.

**NAMI Provider Education** is a class for line staff at facilities providing mental health treatment services. The NAMI Provider Education class is designed to expand the participants' compassion for the individuals and their families and to promote a
collaborative model of care.

**NAMI Homefront** is a class for families, partners and friends of military service members and veterans experiencing a mental health challenge. The course is designed specifically to help these families understand those challenges and improve the ability of participants to support their service member or veteran.

**NAMI Ending the Silence** is an in-school presentation designed to teach middle and high school students about the signs and symptoms of mental illness, how to recognize the early warning signs and the importance of acknowledging those warning signs.

**NAMI In Our Own Voice** is a presentation for the general public to promote awareness of mental illness and the possibility of recovery.

**NAMI Parents & Teachers as Allies** is a presentation for teachers and other school personnel to raise their awareness about mental illness and help them recognize the early warning signs and the importance of early intervention.

**NAMI Connection** is a weekly or monthly support group for people living with a mental health condition. Find the NAMI Connection support group nearest to you.

**NAMI Family Support Group** is a weekly or monthly support group for family members, partners and friends of individuals living with a mental illness.

**NAMI Smarts for Advocacy** is a hands on advocacy training program that helps people living with mental illness, friends and family to transform their passion and lived experience into skillful grassroots advocacy.

**NAMI Say It Out Loud** is a program to raise mental health awareness with youth. It provides videos and a facilitator guide to help community facilitators (faith, civic, others) start a discussion about the basics of mental illness.

**NAMI on Campus** is a peer led campus organization. NAMI on Campus clubs provide students with what they have repeatedly said they want: peer-run mental health organizations on campus. These student-led clubs help:
- Support fellow students
- Raise mental health awareness
- Educate the campus community
- Promote and advocate for services and supports

NAMI on Campus clubs address mental health issues so that all students have a positive, successful and fun college experience.

Each NAMI affiliate may offer all or part of the Signature Programs listed above and may have additional classes advertised on their website. Classes can be through webinars, on-line trainings, and in-person training, for example:
- **30 Pearls of Wisdom in Treating a Person with Mental Illness** (an hour in-service)
- **Hearing Voices That Are Distressing** (a training and simulation experience)
Wellness Recovery Action Planning (WRAP)
Mental Health First Aid
Crisis Intervention Team training (NAMI is part of a community effort to present this training)
Online support group for parents and caregivers of children with mental illness
Support group for teens and college students

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

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

The state, through the Iowa Department of Education and local education agencies, also received several federal Project AWARE grants which have added significant capacity for Youth MHFA instruction across the state.

In Iowa there are 95 Mental Health First Aid instructors certified to train the adult MHFA course and 176 instructors certified to train the Youth MHFA course. The instructors are located across the state in a variety of settings which include state staff from the Department of Human Services, Division of Mental Health and Disability Services and the Iowa Department of Education, local law enforcement, regional MHDS staff, and, and providers of substance use disorder and mental health services. Many local education agency staff have also become Youth MHFA instructors due to the federal Project AWARE grants.

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

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

Disaster Behavioral Health Response Team members are trained in a wide range of response skills including but not limited to: Psychological First Aid, Critical Incident Stress Management, Mental Health First Aid and Basic Disaster Training.
The SMHA is in the process of providing DBHRT team training in six locations across the state, to promote the addition of new members and update training provided to existing volunteers.

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 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 develop and learn.

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/resource 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
- Sign Language & Cued Language
- Social Work
- Special Instruction
- Speech Language Therapy
- Vision
- Transportation

Age Requirements and Eligibility:
An infant or toddler under the age of three (birth to age three) who, has a condition or disability that is known to have a high probability of later delays if early intervention services were not provided, OR
is already experiencing a 25% delay in one or more areas of growth or development.

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

**Adverse Childhood Experiences (ACEs)**
The Central Iowa Adverse Childhood Experience (ACEs) 360 Steering Committee makes online training available regarding the impact of adverse childhood experiences and trauma on children’s current and future development, behaviors, and long-term health outcomes. Also available through the website is Iowa-specific data regarding ACES, trauma-informed services, and information on statewide activities related to awareness of the effects of ACES on children and adults. The website is: [http://www.iowaaces360.org/](http://www.iowaaces360.org/)

**1st Five Healthy Mental Development**
Iowa’s 1st Five Initiative builds partnerships between physician practices and public service providers to enhance high quality well-child care. 1st Five operates in 88 of Iowa’s 99 counties, serving 194 pediatric and family practice providers. 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. Often these intervention services are related to the behavioral health and developmental needs of the child and/or family. 1st Five supports a community-based systems approach to building a bridge between primary care and mental health professionals. In CY16, 1,780 were referred to 1st Five.

**Iowa Association for Infant and Early Childhood Mental Health**
In 2013, a group of public and private stakeholders formed the Iowa Association for Infant and Early Childhood Mental Health. This association is a collaboration among many public and private partners, including Early Childhood Iowa, Iowa Department of Public Health, and the Iowa Chapter of the American Academy of Pediatrics. A focus of this organization is to develop professional competency standards for providers of early childhood services and supports. The organization has developed a strategic plan that includes implementation of the Michigan Infant Mental Health Competencies and other workforce development strategies. A kickoff event to introduce the Michigan competencies to Iowa stakeholders was held in March 2015. The association continues to work to implement the Michigan competencies. The organization also offers webinars to the public on topics such as young children and autism, and provides resources to providers and the public on infant and early childhood mental health. Organization leaders participated in the Children’s Disability Services workgroups as part of the larger system redesign and continue to advocate for inclusion of promotion and prevention activities focused on young children and their families as part of the statewide mental health and disability services.
system. Members are also part of IDPH’s efforts to increase early childhood mental health consultation in Iowa. IDPH along with a private/public multi-agency stakeholder group is participating in SAMHSA-funded consultation with national experts for the purpose of developing an early childhood mental health consultation system in Iowa.

**Suicide Prevention Efforts**
In 2015, 433 Iowans lost their lives to suicide. Suicide was the second leading cause of death for Iowans ages 15 to 34, 3rd leading cause of death for ages 10-14, and the fourth leading cause of death for ages 35 to 54.

The Iowa Department of Public Health (IDPH) is the lead agency for suicide prevention efforts in Iowa. IDPH received a Garrett Lee Smith State Youth Suicide Prevention (GLS) Grant from SAMHSA in 2007 for the project period of 2007-2011 and a second GLS grant from 2014-2016. Iowa has applied for new federal suicide prevention grants available in 2017.

Iowa’s Department of Education received two grants in October 2014 that also support suicide prevention efforts. The grants are Now is the Time (NITT)-Project AWARE, from SAMHSA, and the School Climate Transformation (SCT) grant, from the U.S. Department of Education. Iowa’s grants are aligned with state suicide prevention efforts.

**Iowa Suicide Prevention Planning Group and Plan**
The Iowa Suicide Prevention Planning Group was convened in August 2014 and is comprised of about 25 members representing diverse suicide prevention organizations and experiences. The SMHA is represented on the planning group by the MHBG State Planner. The Planning Group has met regularly since then, and drafted the Iowa Suicide Prevention Plan 2015-2018. The plan incorporates a goal of reducing the annual number of deaths by suicide in Iowa by 10% by the year 2018, ultimately working toward zero deaths by suicide. The plan identifies objectives and strategies to promote the concept of Zero Suicide in Iowa’s health systems.

**“Your Life Iowa”**
- Your Life Iowa has three components: 1) 24/7 telephone hotline; 2) texting services from 2 p.m. to 10 p.m. seven nights a week; and 3) the Your Life Iowa website: [http://www.yourlifeiowa.org/](http://www.yourlifeiowa.org/).
- Your Life Iowa offers a range of services including:
  - 24/7/365 crisis call intervention and support;
  - Screening for immediate safety needs; connecting with first-responders;
  - Identification of and referrals to local resources;
  - Development of strategies with youth/parents/educators;
  - Collaborative problem solving;
  - Empowerment of youth and families; and
  - Helping youth and families make informed decisions.

IDPH is in the process of combining the Your Life Iowa call line with other IDPH hotlines for SUD to encourage coordinated responses to Iowans who call IDPH for assistance with behavioral health needs.
**Preadmission Screening and Resident Review (PASRR):**
Iowa has implemented a strong PASRR process by creating a collaboration within the Department between Iowa Medicaid Enterprise (Medicaid Authority, known as IME) and the SMHA. The Department has a contract with Ascend, Maximus to perform all functions of the PASRR requirements. Preadmission screening is required for all individuals entering a Medicaid-certified nursing facility in the state which includes all but four of the 450 nursing facilities in Iowa. The PASRR process helps assure that individuals with mental health, intellectual disability, and related conditions are not placed in nursing homes unless such a placement is necessary and appropriate. The process identifies the services and supports an individual may need related to their disability and those services and supports they may need in order to return home or to another place in the community. Within the PASRR process Iowa has implemented a review of all care plans to assure that the recommended services have been included in the care plan and are being provided to the individual. This review process includes technical assistance and intense training provided to the nursing homes.

**Crisis Services**
Crisis Services, including 24 hour crisis response, mobile crisis response, crisis assessment and evaluation, 23 hour crisis observation and holding, and crisis stabilization are required services in the MCO contracts. The regions have been working to develop the crisis service capacity and working with DHS and the MCOs to identify service descriptions, rules and rates to allow providers of crisis services to be reimbursed for all services that are billable to Medicaid. 43% of regions have mobile response capacity, 43% have access to 23 hour crisis observation and holding, and 93% have facility based crisis stabilization services.

**Crisis Intervention Team (CIT)**
The Iowa Law Enforcement Academy (ILEA) at Camp Dodge, in Johnston, Iowa, is a training facility for new recruits and experienced law enforcement officers from all over the state of Iowa. In 2017, ILEA will begin including Crisis Intervention Team (CIT) training (up to 40 hours) in the multi-week training for all new recruits. Separate classes of CIT training for experienced officers will also be offered.

The Des Moines Police Academy and Johnson County Sheriff’s office have CIT training. The Polk County Sheriff’s office has received a $50,000 grant for CIT training for representatives of police departments in the Polk County area, as well as for all the employees of the Polk County Sheriff’s office.

**3. TREATMENT SERVICES**
Iowa Medicaid is a major source of funding for mental health services in Iowa. Most services are managed through IA HealthLink which includes the three contracted MCOs. The contractors are required to provide high quality healthcare services in the least restrictive manner appropriate to a member’s health and functional status. Contractors are responsible for delivering coordinated services including, physical health, behavioral health, and long-term services and supports. The program is intended to integrate care and improve quality outcomes and efficiencies across the healthcare delivery system.
Services are provided by appropriately credentialed mental health service providers to assure availability of the following services to address the mental health and substance use needs of both adults and children. MCOs are also required to meet access standards for availability of services.

**Medicaid Mental Health and Substance Use Disorder Services**

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
- Medication management provided by a professional licensed to prescribe medication;
- Inpatient hospital psychiatric services including, except as limited, services in the state mental health institutes;
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring conditions;
- Community-based and facility-based subacute services;
- Crisis services including, but not limited to:
  - 24 hour crisis response;
  - Mobile crisis services;
  - Crisis assessment and evaluation;
  - Non-hospital facility based crisis services;
  - Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;
- Care consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated health home mental health services and supports;
- Peer support services for persons with a serious mental illness;
- Community Support Services;
- Habilitation services;
- Children’s Mental Health Waiver Services;
- Stabilization Services;
- In-home behavioral health management services;
- Behavioral Health Intervention Services (BHIS) and both Medicaid and non-Medicaid funded applied behavioral health analysis (ABA) services for children with autism;
- Psychiatric Medical Institutes for Children (PMIC)

**Medicaid Substance Use Disorder Services**
• Outpatient treatment
• Ambulatory detoxification
• Intensive outpatient
• Partial hospitalization (day treatment)
• Clinically managed low intensity residential treatment
• Clinically managed residential detoxification
• Clinically managed medium intensity residential treatment
• Clinically managed high intensity residential treatment
• Medically monitored intensive inpatient treatment
• Medically monitored inpatient detoxification
• Medically managed intensive inpatient services
• Detoxification services including such services by a provider licensed under Iowa Code chapter 135B
• Peer support and counseling
• PMIC SUD services
• Emergency services for SUD conditions
• Ambulance services for SUD conditions
• Intake, assessment and diagnosis services
• Evaluation, treatment planning, and service coordination
• SUD services when provided by approved opioid treatment programs licensed under Iowa Code Chapter 125
• SUD disorder, screening, evaluation, and treatment for members convicted of Operating While Intoxicated and members whose driving licenses are revoked, if medically necessary
• Court-ordered evaluation for SUD
• Court-ordered testing for alcohol and drugs
• Court-ordered treatment which meets criteria for treatment services
• Second opinion as medically necessary

Iowa Health and Wellness Plan members have a limited set of behavioral health benefits but are able to access the full Medicaid benefit package through determination of medical exemption.

IDPH-funded individuals also have a limited set of the listed Medicaid services available.
Iowa Department of Public Health Substance Use Treatment

The IDPH Single State Authority (SSA) leads, funds, monitors, supports and regulates statewide substance use treatment through the programs and efforts described below. Overall, the SSA is responsible for comprehensive statewide planning, coordination, delivery, monitoring and evaluation of substance use treatment services including: 24-hour information and referral at 1-866-242-4111; collaboration at local, state and national levels on treatment initiatives and policy; program licensure; counselor and practitioner training and workforce development; data management and reporting; evidence-based curricula and models; and public and professional information and education through the Iowa Substance Abuse Information Center at www.drugfreeinfo.org. Substance use disorder treatment is provided to residents of all 99 Iowa counties by a contracted network of treatment programs licensed and funded by the SSA. Un- and under-insured Iowa residents up to 200% of the Federal Poverty Level are eligible for IDPH-funded treatment with client co-pays determined by a sliding scale fee scale that considers family income and size.

For IDPH/SSA-funded services, Amerigroup provides certain administrative services and contracts with providers for at-risk, provider-managed services, with providers required to serve a minimum number of IDPH/SSA-funded clients. Additional details about the SSA’s programs will be included in the State SABG Plan.

Co-occurring Services
There are 292 adult residential treatment beds identified as dual substance abuse treatment beds and 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. Of the 24 accredited Iowa CMHCs, 10 are also licensed substance use disorder services providers.

DHS and IDPH collaborated on the Certified Community Behavioral Health Clinic (CCBHC) Planning Grant from 2015-2017. Staff from both agencies worked together to select and certify CCBHC clinics, conduct community needs assessments, identify methods of streamlining SUD licensure and CMHC accreditation processes for providers who provide both services, and coordinated training in evidence-based practices across mental health and SUD provider agencies. DHS and IDPH required that CCBHC clinic applicants hold credentials from both state agencies. Although the state did not receive a CCBHC implementation grant, the state agencies will continue to work toward integration of services and systems where appropriate.

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.
- **hawk-I** is included in the IA Health Link managed care program. Members are assigned to a Medicaid MCO.

**Inpatient Psychiatric Care and Residential Care**

**Mental Health Institutes (MHI)**
The Iowa Department of Human Services oversees two MHIs, located in Cherokee and Independence. The MHIs provide critical access to quality acute psychiatric care for Iowa’s adults and children needing mental health treatment.

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

- 64 beds of inpatient psychiatric services to adults
- 32 beds of inpatient psychiatric services to children and adolescents

**Specialized Psychiatric Units in General Hospitals**
There are twenty six hospitals in Iowa which have licensed inpatient psychiatric units serving children and adults with a total licensed capacity of 759 beds. Total staffed bed capacity is 731, with 515 adult beds, 78 geriatric beds, and 138 child beds. While inpatient psychiatric care is concentrated in metropolitan areas, facilities providing inpatient care are generally available within a two-hour drive of their residence. As part of the formation of mental health and disability service regions, inpatient psychiatric care is required to be available within the region or within reasonably close proximity (defined in administrative rule as 100 miles or a drive of two hours or less from the county or region). Iowa has a web-based inpatient psychiatric bed tracking system used by all inpatient psychiatric hospital programs as well as those seeking to locate beds for people in need of inpatient psychiatric services. This system streamlines the process of finding available inpatient psychiatric services. The bed tracking system has assisted the courts and law enforcement systems to locate available beds and has also provided data that demonstrates the need for inpatient services for persons with aggressive behaviors and complex needs such as co-occurring mental health, intellectual disability, and substance use disorders. Hospitals frequently have available beds but do not have adequate resources to serve individuals with complex needs.

**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). Eight programs, with 10 locations and 135 beds are currently licensed. These programs provide care in residential facilities to persons with severe
mental illness who require specialized psychiatric care. While they are scattered around the state, these programs are not readily available in every locale. Iowa is moving toward less dependency on institutional care, leading to some RCF-PMI providers reviewing their business models and seeking ways to provide care in more community-based settings.

**Intermediate Care Facilities for Person with Mental Illness:**
The Department of Inspections and Appeals also licenses Intermediate Care Facilities for person with mental illness (ICF/PMI). These programs provide care at the intermediate nursing level to persons who also have specialized psychiatric care needs. They may participate in Medicaid as a Nursing Facility for Persons with Mental Illness (NF/PMI). Medicaid will only fund persons 65 and over in this setting. Currently there are three Iowa facilities that hold this licensure with a capacity of 109. MHDS regions may pay for this level of care for individuals who are not eligible for Medicaid funding.

**Psychiatric Medical Institutions for Children (PMIC)**
These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are 10 private facilities with 430 Medicaid-funded beds. 45 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs. Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa. PMIC services are managed by the Medicaid MCOs.

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

**Case Management Services-Integrated Health Home**
Through the Integrated Health Home program, Medicaid-eligible individuals who qualify for targeted case management due to a chronic mental illness or a serious emotional disturbance receive care coordination through an Integrated Health Home (IHH) in place of traditional TCM. The goal is for the individual to receive coordination of services through a team that includes a care coordinator, nurse care manager, and family or peer support specialist. This promotes greater integration of the coordination/case management functions with the actual services and supports provided to the individual.

The MCOs are responsible to ensure that required case management functions occur for individuals with an SED or an SMI. MCOs also are required to provide community based case management (CBCM) to specified populations such as HCBS waiver participants (other than CMH and Habilitation) and long-term care populations such as individuals in nursing facilities and intermediate care facilities for the intellectually disabled.
**Habilitation Services**
The State Plan HCBS Habilitation program is a Medicaid program operated through a 1915(i) waiver. The Habilitation program provides services similar to HCBS waiver services to individuals with functional limitations typically associated with chronic mental illness. The goal of the HCBS Habilitation program is to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. The goal is to separate rehabilitative and non-rehabilitative services into distinct programs in order to continue the services needed by Iowans, while at the same time assuring that the state remains in compliance with federal regulations. Individuals receiving Habilitation also qualify to receive targeted case management.

As part of the Integrated Health Home program, most individuals receiving Habilitation services receive care coordination through an Integrated Health Home in lieu of case management. This aligns the community supports offered through Habilitation with the mental health and physical health care needs of the individual and provides additional coordination services to those with intensive health needs.

Habilitation services include the following:

- **Home-based Habilitation** which is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision.

- **Day Habilitation** consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the participant’s private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the participant’s service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.

  Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to: the ability to communicate effectively with supervisors, coworkers and customers, an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks, workplace problem-solving skills and strategies; general workplace safety and mobility training, the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment. Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community.
• Supported employment services are the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

**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, has implemented 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.
SERVICES TO VETERANS
Iowa has two Veterans Administration (VA) health centers located in Iowa City and Des Moines that provide comprehensive mental health care for veterans. Iowa Veterans are also served by VA systems in Omaha, NE and Sioux Falls, SD. The VA facilities work to connect with community providers to ensure that veterans, service personnel and their families have access to appropriate care and services. The Central Iowa VA system offers inpatient and outpatient MH and SUD treatment. Both Iowa VA systems have presented Veterans Mental Health Summits to education community providers on the behavioral health needs of veterans and service members and the services available through the VA. The summit offers community providers an orientation on VA services and how to help veterans and service members access them. The VA also provides information on the CHOICE program to assist veterans with access to community providers if adequate services are not available within the VA system.

Advocates for veterans continue to identify lack of providers and services, both outpatient and residential, as a gap in the system. Veterans at the summit identified peer to peer counseling as being highly effective in helping veterans in recovery.

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

SERVICES TO HOMELESS INDIVIDUALS
DHS- Division of MHDS (the State Mental Health Authority) administers the federal Projects for Assistance in Transition from Homelessness (PATH) program. It is a formula grant program administered by SAMHSA. Iowa will receive a $334,444 for state fiscal year 7/1/2017-6/30/2018.

PATH funds are used for community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illnesses—including those with co-occurring substance use disorders—who are experiencing homelessness or are at risk of becoming homeless. DHS-MHDS administers contracts with seven provider agencies located in Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City and Waterloo. Provider allocations range from $44,429.00 to $79,865.00 for SFY 2018. In recent years each provider agency exceeded goals for numbers of individuals who were contacted, engaged and enrolled in the program; the 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 1,070 individuals, enrolling 767 of them in PATH services. Two of the PATH providers are participating in a centralized intake process and the other four are in the process. Iowa has the statewide plan of using centralized intake to house the individuals with the most need first.

The Iowa Council on Homelessness (ICH) staffed by the Iowa Finance Authority is committed to ensuring that all Iowans have access to safe, decent and affordable housing. The ICH and its 38 members work to identify issues, raise awareness and secure resources that will allow all homeless Iowans to become self-sufficient. The SMHA has a voting member appointed to serve on the council. The SMHA 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 continuums of care, and local public housing authorities in
providing services to Iowans with a mental illness who are homeless.

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

**S.O.A.R- SSI/SSDI Outreach, Access, and Recovery**
SSI/SSDI Outreach, Access, and Recovery (S.O.A.R.) is a national project to provide intensive
assistance in applying for Social Security disability benefits for adults who are (a) homeless or at
risk of homelessness and (b) meet Social Security criteria for not being able to work due to the
disability. SMHA staff make the recommendation for people to attend the SOAR Leadership
Academy paid for by SAMHSA. Currently there are six Leadership positions across the state to
assist the 85 individuals trained to assist people in the application process for disability benefits.
These benefits help individuals with serious mental illness and other disabilities obtain access to
stable housing and health care.

The national SSI/SSDI approval rate for homeless individuals with serious mental illness without
S.O.A.R. assistance is less than 15%. National S.O.A.R.-assisted averages are 70% of
applications approved and an average of 90 days to approval. In FY 16, Iowa’s S.O.A.R
assisted applications were approved with an average length of 110 days to approval. FY 17 data
is expected to show improvement in these statistics.

**Housing Supports**
Many adults with serious mental illness utilize 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.

**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: Health and Disability; Elderly; AIDS/HIV;
Intellectual Disability; Brain Injury and, Physical Disabilities Waivers. The overall purpose of
this program is to encourage and assist persons who currently reside in a medical institution to
move to and live in community housing. Iowa like most other states, does not have a waiver
specifically targeted to individuals with mental illness; consequently, individuals with mental
illness who do not qualify for one of the listed HCBS waivers are not able to take advantage of
this potentially important opportunity.
**MHDS Regions**
MHDS Regions are required to make the evidence-based practice of supported housing available in each region. Regions are working with national experts on permanent supported housing to support programs that provide this service. Most regions provide initial financial support to assist individuals in establishing housing.

**SERVICES FOR OLDER PERSONS**
Iowa Medicaid has an HCBS Waiver for older persons. Elderly Waiver services are individualized to meet the needs of each member. Individuals must meet the Level of Care for nursing facility care. The following services are available:
- Adult Day Care
- Assistive Devices
- Assisted Living
- Case Management
- Chore Services
- Consumer-Directed Attendant Care
- Emergency Response System
- Home and Vehicle Modifications
- Home Delivered Meals
- Home-Health Aide
- Homemaker Services
- Mental Health Outreach
- Nursing Care
- Nutritional Counseling
- Respite
- Senior Companions
- Transportation
- Consumer Choices Option

**The Iowa Department on Aging (IDA)** has a significant collaborative and policy relationship with Iowa’s Area Agencies on Aging (AAA), covering all 99 counties. The AAA’s have a strong statewide membership organization, the Iowa Association of Area Agencies on Aging (I4a). There are six AAA’s in Iowa.

**Aging and Disability Resource Centers (ADRC)**
Iowa’s ADRC system has been branded with the name Lifelong Links, and can be found on the web at: [http://www.lifelonglinks.org/](http://www.lifelonglinks.org/) and via phone through a statewide toll free phone number: 1-866-468-7887. LifeLong Link is Iowa’s network of Aging and Disability Resource Centers, whose purpose is to expand and enhance the state’s information and referral resources for older adults, people with disabilities, veterans and caregivers as they begin to think about and plan for long-term independent living.

A collaborative partnership with Iowa’s six Area Agencies on Aging, LifeLong Links is modeled on the “no wrong door” approach, meaning it is available to any Iowan in need of home-based and community services and is accessible through physical locations across Iowa, a toll-free call center (1-866-468-7887) and this website.
With a mission to help Iowans achieve their personal goals for independence and full participation in their community, LifeLong Links provides information about topics and services and connects individuals to local service providers in an effort to support the philosophy of self-directed care.

**SUPPORTED EMPLOYMENT/EMPLOYMENT SERVICES**
The Department of Human Services (DHS) is involved with a number of initiatives intended to increase the number of people with disabilities in competitive integrated employment. DHS’ goal is to unify and coordinate these efforts in conjunction with the Olmstead plan, MHDS Regions, Iowa Medicaid, stakeholders and state agency partners so demonstrable improvement can be made in the number of persons with disabilities in competitive integrated employment. This effort will include the evaluation of any new or innovative approaches that can be adopted to help achieve the goal. Iowa Medicaid (Title XIX) provides healthcare and community supports and services for financially eligible children and adults with disabilities as well as a number of other target groups. The goal is for members to live healthy, stable, and self-sufficient lives.

Long term community services and supports for people with disabilities, including employment services, are funded through the Medicaid 1915 (c) Home and Community Based Services (HCBS) waivers and the 1915(i) State Plan HCBS Habilitation program. Iowa Medicaid’s Money Follows the Person (MFP) Initiative also has employment as a priority. The Partnership for Community Integration Project is a federal Medicaid demonstration grant to assist persons with intellectual disabilities or brain injuries who are currently residing in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) or Nursing Facilities (NF) to transition to the communities of their choice. Employment plays an integral part in community inclusion and the goals of the project.

Iowa Medicaid’s Buy-In Program or the Medicaid Program for Employed People with Disabilities (MEPD) is a Medicaid coverage group that allows persons with disabilities to work and continue to have medical assistance. MHDS is responsible for planning, coordinating, monitoring, improving and partially funding mental health and disability services for the State of Iowa. The division engages in a wide variety of activities that are designed to promote a well-coordinated statewide system of high quality disability-related services and supports including employment. Iowa’s community-based, person-centered mental health and disability services system provides locally delivered services, regionally managed with statewide standards. MHDS Regional leaders, guided by the regional management plan, coordinate quality community services that support individuals with disabilities not otherwise eligible for Medicaid in obtaining their maximum independence. Employment is a key to independence for all of us.

**PROVIDERS OF MENTAL HEALTH SERVICES**

**Community Mental Health Centers and other Mental Health Service Providers**
Community mental health centers and other mental health service providers who act in lieu of a community mental health center are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 24 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 72 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHC’s receiving MHBG funding, Iowa law mandates that CMHCs use MHBG funds for the development and implementation of evidence based practices and/or direct services to individuals not otherwise covered by insurance or for services not reimbursed by insurance. The CMHC identifies through its contract with the state how the organization will serve adults with an SMI and children with an SED.

EBP’s and best practices supported in FFY17 through MHBG funding to CMHCs include:
- Peer support services
- Trauma-informed care
- Co-occurring/multi-occurring capability
- Mental Health First Aid (MHFA)
- Parent Child Interaction Therapy (PCIT)
- WRAP services
- Motivational Interviewing
- Cognitive Behavioral Therapy (CBT)
- School-Based Mental Health
- Eye Movement Desensitization and Reprocessing (EMDR)
- Suicide Prevention
- Dialectical Behavior Therapy (DBT)
- Illness Management and Recovery (IMR)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Acceptance and Commitment Therapy
- Child Parent Psychotherapy
- Strengthening Families

CMHCs serve a defined catchment area, ranging from one county to seven counties. Other Mental Health Service Providers generally serve a specific geographic area. Agencies may be accredited to provide any of the following services: partial hospitalization, day treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient psychotherapy, emergency, evaluation, and crisis services. Accreditations rules are located in Iowa Administrative Code 441-Chapter 24. Community mental health centers, crisis providers, targeted case managers, and certain mental health providers are required to be accredited by the SMHA. Other providers of outpatient mental health services that are housed within larger licensed or accredited health systems such as hospitals, child welfare agencies, or mental health facilities are not included in this count.

**Federally Qualified Health Centers**
Iowa presently has 55 Federally Qualified Health Centers (FQHC’s) sites enrolled as Medicaid providers. FQHC’s receive an actual cost reimbursement for Medicaid patients rather than the established rate of reimbursement. To qualify to be an FQHC, the clinic agrees to treat all that present, regardless of insurance or method to pay for services. This has become a valuable resource for adults and families that may not have any insurance coverage and do not qualify for
any of the Medicaid programs. FQHC’s also provide screening and referral to behavioral health services and in some instances, provide direct behavioral health services. Iowa has one agency that is qualified as both an FQHC and a CMHC, encouraging coordinated care for individuals with co-occurring health and mental health needs. Other mental health providers have collaborative relationships with FQHCs to assist individuals to receive integrated health and behavioral health care.

**Mental Health Professionals Statewide**

According to the Iowa Health Professions Tracking Center, University of Iowa Carver College of Medicine, for calendar year 2015, there were approximately 228 psychiatrists in the state of Iowa. The majority of psychiatrists practice in metropolitan or urban counties. There were approximately 113 Psychiatric Nurse Practitioners and 30 Physicians Assistants with a Mental Health Specialty. According to the IDPH Bureau of Professional Licensure, there are: 679 licensed psychologists; 4,181 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 332 licensed marital and family therapists and 1,417 licensed mental health counselors, including temporary and fully licensed counselors and therapists. Availability of mental health providers is affected by the aging of the mental health workforce, the numbers of licensed providers who may not be actively practicing, and mental health professionals who work in systems not available to the general public, such as the Department of Corrections, Veterans Affairs facilities, state MHIs, and educational systems.

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 March 2016, the Health Resources and Services Administration listed 89 Iowa counties as having a Health Professional Shortage Area designation for Mental Health. Lack of access to qualified mental health professionals at all levels is an identified gap in the service system. IDPH manages The Primary Care Recruitment and Retention Endeavor (PRIMECARRE) which was authorized by the Iowa Legislature in 1994 to strengthen the primary health care infrastructure in Iowa. PRIMECARRE allocations currently support the Iowa Loan Repayment Program, with matching federal and state funds. The program offers two-year grants to primary care medical, dental, and mental health practitioners for use in repayment of educational loans. It requires a two-year practice commitment in a public or non-profit site located in a health professional shortage area (HPSA). HPSAs are designed to identify communities with diminishing health care services and provide them with opportunities to improve access to and availability of care. By identifying health professional shortage areas, communities become eligible for state and federal assistance to recruit and retain health professionals, access additional reimbursement dollars, and eventually alleviate the shortage.

Two central Iowa hospital systems are also adding psychiatric residency programs within the next year to support increased psychiatric capacity in Iowa.
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 four Systems of Care in Iowa which serve 14 of Iowa’s 99 counties. Other regions and counties in Iowa are at differing stages of development regarding the children’s mental health Systems of Care. In SFY17, as a result of the Children’s Mental Health and Wellbeing Workgroup, two children’s mental health planning grants were awarded to two local areas to develop collaborative plans for a children’s mental health crisis system. Each local area worked with multiple stakeholders to assess the needs of their area and develop crisis plans that expanded existing services to address gaps. Both areas identified limited access to crisis services, cultural and language barriers, stigma, categorical or limited funding, and workforce shortage, among the gaps identified in their needs assessment process. While the programs did not receive additional funding for SFY18, the recommendations for children’s services are to be considered in the next set of Children’s Wellbeing Collaboratives grants. The local areas are also exploring how they can implement crisis services in their areas with existing resources.

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

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

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

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

• The Juvenile Court System,
• Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
• Department of Public Health which includes Title V agencies such as the Child Health Specialty Clinics
• Department of Human Rights
• Department of Inspections and Appeals,

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

Iowa has a shortage of child psychiatrists. 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.

There is no Central Point of Coordination for children at the local level to provide coordination of children’s services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children’s system.

**Behavioral Health Intervention Services**

Behavioral health intervention services –BHIS are available to children who are Medicaid eligible. BHIS are supportive, directive, and teach interventions provided in a community-based or residential group care environment designed to improve the individual’s level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control.

BHIS enables Medicaid eligible children and their families, including children receiving the CMH waiver, 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.

Specific services available through 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 CMH waiver is 1,360. As of June 2017, 1,052 individuals are currently receiving services with 450 applications in process. The waiver has a waiting list of 972 with the next child to be served having an application date of March 2, 2016. The MHBG plan submitted in September 2015 reported August 2015 CMH waiver data of 736 children served and 2,298 children on the waiting list. This indicates an
increase in the numbers of children served and a decrease in the number of children on the waiting list since 2015.

Services included in the CMH waiver are respite, family and community supports, in-home family therapy, environmental modifications and adaptive devices, and care coordination through the Integrated Health Homes. In addition, every child receiving services through the CMH waiver has access to full Medicaid services. The goal is to better coordinate the services children with an SED and their families receive and to ensure that children with an SED are accessing all appropriate services that will enable them to remain in their homes and communities.

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

**Systems of Care**

Central Iowa System of Care, Community Circle of Care, Four Oaks System of Care, Tanager Place

The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), Four Oaks System of Care, and Tanager Place serve children and youth ages 0-21 who are diagnosed with a mental health disorder and meet the criteria for Serious Emotional Disturbance. The four programs serve non-Medicaid eligible children and youth and provide access to community-based services and supports. The children and youth served by these programs are assessed to be at risk of involvement with more intensive and restrictive levels of treatment due to their serious behavioral and mental health challenges. All programs provide the following services:

- Care Coordination
- Parent Support Services
- Wraparound Family Team Meeting
- Flexible Funding for BHIS or other in-home services, respite or other mental health services and supports

The purpose of the SOC program is to help the identified child remain successfully in, or return to, their home, school, and community unless safety or clinical reasons require more intensive services. Families referred to an SOC are often at the point of requesting assistance from the court or child welfare system or are seeking PMIC placement. SOC services offer a community-based alternative to children who are at risk of out of home treatment and their families. Services provided include care coordination, access to clinical mental health services, wraparound and family team facilitation, family peer support, and funding for flexible services that strengthen the child’s ability to function in the home, school, and community.
Referral sources for SOC programs include parents, schools, DHS Child Welfare, Juvenile Court Services, PMIC’s, therapists, and other mental health service providers.

For SFY17, CCC directly served approximately 290 children and youth in a ten county area. CISOC served 91 children and youth in a two county area. Four Oaks served 58 children. Tanager Place served 44 children. Outcomes for the Systems of Care programs demonstrate improved stability of living situation, improved school attendance and performance, and diversion from involuntary mental health commitment.

The SOC programs are all Integrated Health Homes for Medicaid-eligible children with an SED. IHH care coordination is reimbursed by Medicaid allowing the state SOC funds to be dedicated to providing similar services to non-Medicaid eligible children and families.

**Services to youth aging out of foster care/transition age youth**

**SAL/Aftercare/PALS**

Iowa offers supervised apartment living arrangements (SAL) for foster children ages 16 ½ and older with an environment in which they can live in the community with varying levels of supervision. SAL is the least restrictive type of foster care placement in Iowa and the program is designed for older youth for whom neither reunification nor adoption is likely and who are perceived by referring workers and SAL contractors as capable of living within the community with the appropriate level of services, supports, and supervision. Services and supports are tailored to prepare the youth for a level of self-sufficiency necessary to be successful in adulthood. Youth aged 18 or 19 who continue to meet foster care payment and other eligibility requirements may be served in SAL if they have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. Youth aged 18 or older must also agree to stay in care by signing a voluntary placement agreement.

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, court ordered Iowa juvenile detention, or the State Training School. Aftercare is voluntary, individualized support to help youth transition successfully to adulthood. Aftercare participants meet at least twice monthly with an Iowa Aftercare Services Network Self-Sufficiency Advocate. Advocates help set goals, develop important life skills, connect youth with community resources, and strengthen personal relationships. Regular payments are provided to aftercare participants who attend work or school and meet certain program requirements. These funds are referred to as Preparation for Adult Living, or PAL, and help with rent, transportation, or other needs determined by the youth to move them closer to self-sufficiency.

Iowa’s regional mental health and disability services systems are also involved in ensuring smooth transitions from child to adult services systems. In the regional MHDS system, individuals can receive services in the MHDS system three months before the age of 18 to allow them to move into the adult system in a planned manner. The Integrated Health Home program also assists with transitions for Medicaid-eligible children and youth with an SED or an SMI.
4. RECOVERY SUPPORT SERVICES

Peer Support Services have grown tremendously in Iowa and across the nation. Peer Support is an evidence-based practice which has been widely recognized by the Substance Abuse and Mental Health Services Agency (SAMHSA) and the Centers for Medicaid and Medicare Services (CMS). Peer Support Services are Medicaid billable in Iowa. In Iowa, Peer Support payment is authorized through the managed care organizations or the MHDS Regions.

In February 2015, the Division of MHDS contracted with the University of Iowa Center for Child Health Improvement and Innovation to provide training for core and continued education, technical assistance, oversight, and recommendation for a certification process for family peer support and adult peer support. This initiative is also working on workforce development for family peer support and peer support services. Peer Support Services are required in the Mental Health and Disability Service Regions. Iowa is experiencing increased demand for certified peer support specialists for employment within the Integrated Health Home, crisis services and peer services. In SFY17 four trainings were held with a total of 61 individuals trained as peer support and 29 as family peer support specialists. In SFY18 additional trainings will be held, including training for supervisors of both family and peer support specialists.

While mental health peer support services had been a Medicaid reimbursable service for several years under the former Iowa Plan for Behavioral Health managed care plan, individuals with a primary diagnosis of substance use disorder were previously not eligible to receive such services through Medicaid funding. IDPH used ATR grant funds for this service. Under IA HealthLink, peer support services for mental health and peer recovery coaching for SUD are both Medicaid reimbursable services. MCOs and state leadership are working on a process to identify training and supervision requirements for peer recovery services. IDPH and DHS have reviewed the curriculum content for the U of I sponsored peer support training and the CCAR curriculum promoted by IDPH. CCBHC planning grant funds were also used to provide additional CCAR training to expand availability of peer recovery coaching. Iowa will accept either version of the training with an additional 6 hours of specialized training either in substance use disorders or mental health so that peers wishing to work in either field do not have to duplicate training.

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

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

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

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

As part of Iowa’s redesign of the mental health and disability service system, IMR was identified as an EBP that must be available in each MHDS region or county approved to operate as a region. Regions are coordinating training and technical assistance on this EBP to regional staff and providers to develop capacity and competency in IMR.

**Intensive Psychiatric Rehabilitation**

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

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

Through the CCBHC planning grant, IPR was one of the required EBPs. Multiple IPR trainings were offered to existing and new providers to support fidelity in current programs, increase practitioner trainer capacity, and expand service capacity. Iowa added three new accredited IPR programs as a result of the CCBHC grant.

**Respite**

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

**Wellness Recovery Action Plan**
The Wellness Recovery Action Plan (WRAP) model is a person-driven program, which educates clients to manage illness and become active partners in their recovery. WRAP training has been funded by the MHBG in Iowa CMHCs for several years.

**Consumer/Advocacy 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.

The Office of Consumer Affairs Director and a statewide Advisory Committee function to represent Iowans across the state.

**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 people in recovery through direct membership and through indirect service such as education, advocacy and social inclusion efforts.

**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 11 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 13 local affiliates and 3 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 Iowa Children’s Mental Health Committee** (NCMHC) was established as a formal committee under the auspices of the NAMI Iowa Board of Directors in 2014. The CMHC advocates on behalf of children with behavioral, emotional, developmental, neurological, or mental health needs; offers parents and family members support; and strives to raise awareness of children’s mental health issues and the acceptance of neurodiversity.

**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.

**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. ASK also operates the Parent Training and Information (PTI) 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.

**Life Connections**
Life Connections Peer Recovery Services is a non-for-profit organization that supports individuals who are experiencing Mental Health and Substance addiction issues and who want to work on their recovery goals and situations before getting into a crisis situation.
PIT Academy
PIT Academy is a non-profit resource for those with mental and behavioral health disabilities. The Academy provides Administrative Services for other Mental Health Organizations, assists other peer-run organizations with regulatory oversight, while respecting the organizations decision making and autonomy. Spiritual and Trans-personal Counseling is offered as an alternative, recovery-based resources. Mental Health Education Services are offered in the form of peer support training and train the trainer model.

Please Pass the Love
Please Pass the Love (PPTL) is an organization committed to increasing school-based mental health supports to improve the quality of life and educational opportunities for children, families, and educators as well as offer culturally responsive comprehensive services and evidence-based supports to school systems. The organization works to bridge positive relationships between the educational and mental health communities to more effectively prevent and address mental health issues for children and adolescents throughout the state of Iowa. PPTL is offering its 5th annual Iowa School Mental Health Conference in October 2017.

Plugged-In Iowa
Plugged–In Iowa provides mental health peer support services to people in need of finding resources and services, of extra support, and want to begin their journey towards recovery. The agency believes that your mental health diagnosis doesn’t dictate who you are or what you can do.

Plugged-In Iowa believes that everyone deserves a better quality of life and sometimes need a little extra help and encouragement in order to achieve that. Peer support involves connecting an individual with assistance from someone with lived experience, someone who has been where they are and has found recovery. Peer support is an evidenced based practice and is becoming a vital part of treatment for many people all over the world.

Support includes providing an atmosphere in which an individual’s recovery is supported through the use of one-to-one intentional peer support, peer recovery zones, and crisis respite care.
Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

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 sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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 SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA’s Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA’s populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative1 HHS has identified a broad set of indicators and goals to track and improve the nation’s health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Footnotes:

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

This step should identify the unmet service needs and critical gaps in the state’s current behavioral health system as well as the data sources used to identify the needs and gaps of the required 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 step should also address how the state plans to meet the unmet service needs and gaps.

**Identified needs and gaps within the current system**

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

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2015, it is estimated that approximately 40,470 children in Iowa meet the criteria of serious emotional disturbance. Of that amount, according to June 2017 data, approximately 3.5% were served by the Children’s Mental Health Waiver and less than 1% were served by Systems of Care programs. The SAMHSA Behavioral Health Barometer 2015, Vol. 4 identifies that approximately 11.9% (29,000) of Iowa adolescents had at least one major depressive episode per year in 2014-2015. This is an increase from 10.4% in 2013-2014. The Iowa Youth Survey, a survey completed by approximately 84,000 Iowa 6th, 8th, and 11th graders also provided data regarding thoughts of suicide. 13.3% of all students surveyed, or approximately 11,000 students reported seriously thinking about killing themselves in the last year. 4% of the students in the survey reported that they had tried to kill themselves.

The waiting list for the Children’s Mental Health Waiver continues to be significant with an approximately 972 children on the waiting list for a slot as of June 2017. The length of time from application to consideration for a slot is over a year. SOC programs for non-Medicaid eligible children remain limited.

The combination of factors including limited waiver slots, limited access to community-based services if not Medicaid-eligible, and lack of providers available to treat children with an SED, places children with an SED at risk of higher-intensity, out of home treatment and placement.

Families of children with mental health issues continue to identify lack of trained providers, lack of crisis services for children, a need for therapeutic school settings, lack of services for children with multi-occurring conditions such as mental illness and autism as barriers to children with an SED being able to live successfully in the community.

**Adults with SMI/Older Adults with Serious Mental Illness/Rural/Homeless**

The need for intensive, community-based services for individuals with complex needs, including individuals with a serious mental illness, substance use disorders, and other co-occurring conditions has consistently been an identified priority of Iowa stakeholders. Multiple workgroups, stakeholders, and advocates have identified lack of appropriate services as a gap across the Iowa behavioral health system and a reason that individuals with complex needs have difficulty obtaining inpatient care when needed, and also have difficulty obtaining community-based care appropriate to the complexity of their behavioral health needs.
The following prevalences were found: According to the SAMHSA 2015 Behavioral Health Barometer, Vol. 4, in the years 2014-2015, 3.9% of all adults in the years within the year prior to the survey had serious thoughts of suicide, 4.2% had an SMI, and 50.3% of those identified as having any mental illness (AMI) received treatment. SAMHSA URS Table 1 2015 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 129,265.

**Early Serious Mental Illness**
Iowa has worked diligently to develop ESMI/FEP teams using the Set Aside funds from the MHBG. In 2015, two CMHCs volunteered to participate in training to develop teams but a need was identified by multiple stakeholders to expand the program. The DHS ESMI/FEP Program Manager has recruited a third provider to serve a community in Western Iowa beginning Oct. 1, 2017. SAMHSA URS Table 1 2015 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 129,265. The two operating ESMI teams served 25 individuals in SFY17, therefore the need for programs to assist people diagnosed with a serious mental illness at the beginning of their illness is essential.

**Other strengths and needs identified by Planning Council members include:**

**General concerns/gaps:**
- IHH management—concerns about management of the service under IA Healthlink
- Concerns about IA Healthlink administrative issues with providers
- Concerns about use of restraint and seclusion in school settings, correctional facilities, and facilities for juveniles.

**Children with an SED and their families:**
- Concern over the availability of residential care
- There is a need to develop children’s mental health services at all levels across the state
- There is a need to develop children’s mental health crisis services
- Workforce shortage—only 31 child psychiatrists in state
- There are children’s mental health crisis services being developed, however there is no long-term support for them at this time. Rural crisis for children also a gap.
- There is a concern over integrated health home (IHH) services operating as intended
- There is a need to increase children’s mental health support in schools-therapeutic classrooms, schools.
- There was a suggestion to check the suicide rate for children and adults, as well as the Iowa Youth Survey for information.
- **Strength:** Youth Mental Health First Aid, Children’s Crisis Planning Grant programs, Learning Labs programs
- **Strength:** Integration of IDPH helplines—combining Your Life Iowa for bullying and suicide, and the problem substance use and gambling lines into one line.
• Concern: Multiple crisis lines between state agency ones and MHDS regional ones may cause confusion for public
• Need: separate rooms in schools that would be designed to help children with mental health needs calm down.

Adults with SMI
• Workforce is a barrier for all populations
• Not all MHDS Regions have mental health crisis services
• There is a need for accessible and appropriate inpatient psychiatric services
• There is a need for mental health services to be developed in settings outside the corrections system
• Increased use of boarding in ERs while waiting for treatment
• Need more services for adults with aggressive behaviors or complex needs
• Concern about increase in suicide rate for women ages 45-64, veterans, and girls ages 10-14.
• Concern over how individuals with co-occurring mental health and substance use needs are treated. More collaboration among providers in each area is needed.
• Mental health services for veterans- concerns about lack of capacity at Iowa Veterans Home in Marshalltown
• Mental health services in the corrections system and in jails-concerns about people with mental health needs being in isolation in jails
• Strength: The DHS Director is holding workgroups with many different stakeholders in the state’s mental health system to assess the needs of the state.
• Strength: Through CCBHC grant, have expanded Intensive Psychiatric Rehab service and ACT

Older Adults with SMI
• There is only one geriatric psychiatrist in Iowa
• There is a lack of affordable housing venues available for older adults with and without SMI
• Concern over PASRR follow-through
• Concern over whether older adults in nursing facilities are medicated to treat their needs, or to make them easier to serve

Rural and Homeless Individuals with SMI
• There is a need for transportation services
• Peer support services would be very helpful for this population to avoid isolation
• There’s a lack of intensive community-based programs like ACT teams
• Strength: Development of two new ACT teams in rural areas of the state, some local programs are working with hospitals to coordinate care for individuals who are homeless
• First Episode of Psychosis: Strength-Two active programs working to support individuals after experiencing their first episode of psychosis
• Concern-Only two programs in the state
Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
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</tr>
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<tbody>
<tr>
<td>Priority Area:</td>
<td>Services to individuals with Early Serious Mental Illness</td>
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<tr>
<td>Priority Type:</td>
<td>MHS</td>
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<tr>
<td>Population(s):</td>
<td>ESMI</td>
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<tr>
<td>Goal of the priority area:</td>
<td>Increase capacity of Iowa's ESMI teams to identify and serve individuals identified with an ESMI</td>
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<tr>
<td>Objective:</td>
<td>Enhance capability of Iowa ESMI teams to deliver the NAVIGATE evidence based practice for individuals with an ESMI</td>
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<tr>
<td>Strategies to attain the objective:</td>
<td>Obtain technical assistance from national NAVIGATE consultants; develop a manual for community support worker role as part of NAVIGATE team</td>
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</table>

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Iowa's ESMI teams will receive in-person training from national NAVIGATE consultants</td>
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<tr>
<td>Baseline Measurement:</td>
<td>No training from national team has occurred prior to this report</td>
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<tr>
<td>First-year target/outcome measurement:</td>
<td>Training with Iowa ESMI teams will occur by Sept. 30, 2018</td>
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<td>Second-year target/outcome measurement:</td>
<td>Follow up technical assistance will occur with Iowa's ESMI consultant and the national NAVIGATE consultant</td>
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<td>Data Source:</td>
<td>Iowa DHS ESMI Program Manager will oversee procurement of the training and technical assistance.</td>
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<td>Description of Data:</td>
<td>Training contracts, records of training, training materials developed.</td>
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<td>Data issues/caveats that affect outcome measures:</td>
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<tr>
<th>Indicator #</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Increase numbers of individuals served by Iowa ESMI teams</td>
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<td>Baseline Measurement:</td>
<td>FFY17-36 individuals served by ESMI teams</td>
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<tr>
<td>First-year target/outcome measurement:</td>
<td>FFY18-55 individuals served by ESMI teams</td>
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<td>Second-year target/outcome measurement:</td>
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<tr>
<td>Data Source:</td>
<td>Required reporting on individuals served through data tool in development by DHS for the ESMI program.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Demographic and outcome data reported by each contracted ESMI program to the DHS ESMI program manager.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td></td>
</tr>
</tbody>
</table>
Priority #: 2
Priority Area: Develop services for individuals with a serious mental illness and other co-occurring conditions that promote community inclusion and utilization of community based services.
Priority Type: MHS
Population(s): SMI, Other (Rural, Criminal/Juvenile Justice, Persons with Disabilities)

Goal of the priority area:
Reduce unnecessary and lengthy hospitalization of individuals with complex service needs, including individuals with a serious mental illness, substance use disorders, and intellectual disabilities.

Objective:
Increase availability of community-based services for individuals with complex service needs

Strategies to attain the objective:
DHS and IDPH are leading a legislatively mandated workgroup that includes mental health and substance use disorder providers, community stakeholders, individuals with lived experience, family members to recommend solutions to increase access to the right services for individuals with complex service needs. The workgroup is required to report to the legislature by Dec. 15, 2017.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Legislatively mandated workgroup will meet to identify system strengths and gaps in 2017 and submit a report that includes recommendations for system improvements to the legislature by Dec. 15, 2017
Baseline Measurement: Workgroup met Aug. 24 for initial meeting; four additional meetings are scheduled.
First-year target/outcome measurement: Report is submitted to the legislature by Dec. 15, 2017
Second-year target/outcome measurement:
Data Source: SMHA and SSA staff are co-facilitating the Complex Service Needs workgroup that will develop the legislative report. Meetings are open to the public, are inclusive of individuals in recovery and family members, and the report will be publicly available.
Description of Data: Meeting minutes, legislatively mandated report.
Data issues/caveats that affect outcome measures:

Indicator #: 2
Indicator: Individuals with an SMI who are enrolled with an IHH will not be rehospitalized within 30 days of a hospitalization
Baseline Measurement: Baseline for CY15 (most recent data) - 13%
First-year target/outcome measurement: Less than 13% of members enrolled an Integrated Health Home will have a readmission within 30 days of a hospital stay
Second-year target/outcome measurement: Less than 13% of members enrolled in Integrated Health Home will have a readmission within 30 days of a hospital stay
Data Source: Core Health Home Measures-Iowa Medicaid Enterprise
Description of Data: Data reported by MCOs to IME from claims data
Data issues/caveats that affect outcome measures:

Priority #: 3
Priority Area: Services to children with an SED
Priority Type: MHS
Population(s): SED, Other (Adolescents w/ SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:
Children with an SED will receive services that promote community inclusion and success in family and community settings.

Objective:
Child-serving agencies will work together to identify and promote services that support children with an SED or at risk of developing an SED and their families. Children identified with an SED will receive timely and appropriate community services.

Strategies to attain the objective:
Legislatively mandated programs will develop local children's well-being collaboratives to identify and promote best practices to support children's mental health and well-being. Medicaid-eligible children with an SED are eligible to receive IHH care coordination. IHH have a responsibility to ensure that follow up care after a hospitalization occurs in order to reduce likelihood of rehospitalization.

### Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Child serving systems will collaborate to develop well-being collaboratives that promote children's mental health and well-being, including children with an SED or at risk of developing SED |
| Baseline Measurement: | No plans currently exist related to development of children's well-being collaboratives |
| First-year target/outcome measurement: | Well-being collaboratives in up to 3 selected areas will submit reports to DHS by December 15, 2017 documenting work done to develop Children's Well-being Collaboratives |
| Second-year target/outcome measurement: |  |
| Data Source: | DHS is the project manager for the Children's Well-being Collaboratives and will have access to the work and reports of the Wellbeing Collaboratives. |
| Description of Data: | Written reports documenting Wellbeing Collaborative work. |
| Data issues/caveats that affect outcome measures: |  |

| Indicator # | 2 |
| Indicator: | Children with an SED will receive follow up with a mental health practitioner within 7 days of discharge from inpatient psychiatric hospitalization. |
| Baseline Measurement: | CY15-51% received follow up within 7 days. |
| First-year target/outcome measurement: | Greater than 55% of individuals will receive follow up within 7 days. |
| Second-year target/outcome measurement: | Greater than 55% of individuals will receive follow up within 7 days. |
| Data Source: | Core Health Home Measures-Iowa Medicaid Enterprise |
| Description of Data: |  |
Data reported by MCOs to IME from claims data.

Data issues/caveats that affect outcome measures:

Footnotes:
## Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017       Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. 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>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></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>
<td></td>
</tr>
<tr>
<td>3. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Early Intervention Services for HIV</td>
<td></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>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. Other 24 Hour Care</td>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td>$5,334,498</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Mental Health Primary*</td>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$627,588</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Administration (Excluding Program and Provider Level)</td>
<td>$313,794</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)</td>
<td>$0</td>
<td>$6,275,880</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED
** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

### Footnotes:
## Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017  Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$330,704</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$249,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$161,828</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$35,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$5,030,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td>$5,806,932</td>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "health system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care. SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who
experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about Mental Health and Substance Abuse Act (MHPAA) could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


30 http://www.samhsa.gov/health-disparities/strategy-initiatives


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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   Since 2013, the state has implemented Integrated Health Homes for individuals with a serious mental illness or a serious emotional disturbance. The goal of the IHH program is to integrate and coordinate physical and mental health services to support improved outcomes for the target population. IHH care coordination teams include a nurse, a care coordinator and a peer or family peer support specialist to address all aspects of a person's life.

   As part of the development of Accountable Care Organizations in Iowa, several CMHC's have affiliated with major health organizations to further promote integration of physical and mental health services. A small number of providers also have on-site physical health care, while others work closely with local FQHCs and other clinics to coordinate services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   Individuals with co-occurring mental health and substance use disorders are accessing services through a behavioral health system that is continuing to integrate MH and SUD services. Provider associations which used to be divided by provider type are now increasingly comprised of members who provide both types of services. 10 CMHCs are also licensed as outpatient SUD providers and provide MH and SUD services on the same site. The SMHA and SSA worked together to develop the CCBHC planning grant, which brought together providers and consumers of MH and SUD services to identify strengths and needs of the BH system. CCBHC partners were required to be licensed and accredited to provide both types of services, leading to one CMC adding SUD licensure, and one SUD provider adding MH accreditation. The SSA and SMHA plan to continue conversations on streamlining the accreditation/licensure process for providers who serve both populations.

   The SMHA and SSA are currently co-facilitating a legislative mandated workgroup on services for individuals with complex service needs, including mental health, substance use disorders, intellectual/developmental disabilities, and aggressive behavior. This workgroup began meeting in August 2017 and will submit a report to the legislature in December 2017.
3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? and Medicaid?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

4. Who is responsible for monitoring access to M/SUD services by the QHP?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

6. Do the behavioral health providers screen and refer for:  
   a) Prevention and wellness education  
      | Yes | No |
      |-----|----|
      | No  |    |
   b) Health risks such as  
      ii)  
         | Yes | No |
         |-----|----|
         | No  |    |
    i) heart disease  
      | Yes | No |
      |-----|----|
      | No  |    |
   ii) hypertension  
      | Yes | No |
      |-----|----|
      | No  |    |
   viii) high cholesterol  
      | Yes | No |
      |-----|----|
      | No  |    |
   ix) diabetes  
      | Yes | No |
      |-----|----|
      | No  |    |
   c) Recovery supports  
      | Yes | No |
      |-----|----|
      | No  |    |

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?  

10. Does the state have any activities related to this section that you would like to highlight?  
    Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SM; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb-fedreg-race-ethnicity
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
   a) Race
   jn Yes jn No
   b) Ethnicity
   jn Yes jn No
   c) Gender
   jn Yes jn No
   d) Sexual orientation
   jn Yes jn No
   e) Gender identity
   jn Yes jn No
   f) Age
   jn Yes jn No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?
jn Yes jn No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?
jn Yes jn No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
jn Yes jn No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?
jn Yes jn No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?
jn Yes jn No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality / Cost, (V = Q / C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon Genera52, The New Freedom Commission on Mental Health53, the IOM54, and the NQF55. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."56 SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)57 are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)58 was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and
training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.

56 [Website URL]
57 [Website URL]  
58 [Website URL]

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   □ Yes □ No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) □ Leadership support, including investment of human and financial resources.
   b) □ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) □ Use of financial and non-financial incentives for providers or consumers.
   d) □ Provider involvement in planning value-based purchasing.
   e) □ Use of accurate and reliable measures of quality in payment arrangements.
   f) □ Quality measures focus on consumer outcomes rather than care processes.
   g) □ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) □ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year as required by law to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SM I.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  
   - jn Yes  
   - jn No
2. Has the state implemented any evidence based practices (EBPs) for those with ESM I?  
   - jn Yes  
   - jn No
   
   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESM I.
   
   Iowa is implementing the NAVIGATE model with three community mental health centers.

3. How does the state promote the use of evidence-based practices for individuals with a ESM I and provide comprehensive individualized treatment or integrated mental and physical health services?
   
   State staff have presented on the FEP/ESMI programs to the Mental Health and Disability Services Commission and the MHPC. State staff have worked to recruit new FEP/ESMI providers, leading to a new CMHC joining the state’s ESMI program effective October 1, 2017. FEP/ESMI providers are required to outreach in their catchment areas to referral sources such as schools, colleges, providers, and other stakeholders to promote the program. Through the NAVIGATE team-based model, services are coordinated and integrated among the team members. Iowa’s NAVIGATE teams also employ a community support worker to coordinate services needed outside of the NAVIGATE team.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESM I?  
   - jn Yes  
   - jn No
5. Does the state collect data specifically related to ESM I?  
   - jn Yes  
   - jn No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESM I?  
   - jn Yes  
   - jn No
7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESM I.
   
   Iowa continues to use the NAVIGATE model. Iowa provides ongoing technical assistance to the two teams and will provide intensive training to the new NAVIGATE team scheduled to start in October 2017.
8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Iowa has had two First Episode Psychosis Teams since 2015. A third team will start in Oct. 2017. All teams are using the NAVIGATE treatment model.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Iowa is developing a data collection tool which all three NAVIGATE Teams will use to collect data on client outcomes and the NAVIGATE treatment process.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The current list of diagnostic categories include: Non-affective psychoses – Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Psychotic Disorder NOS.

Does the state have any activities related to this section that you would like to highlight?

no

Please indicate areas of technical assistance needed related to this section.

Iowa is planning to request specific training from the national NAVIGATE team and a webinar from Dr. Delbert Robinson for the prescribers for the three teams.

Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning?  
   Yes  
   No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   Integrated Health Homes which provide care coordination for Medicaid-eligible individuals with an SED or an SMI, and recipients of the HCBS CMH waiver and HCBS Habilitation Services are required to use person centered planning (PCP) processes for all individuals they serve, whether they are receiving an HCBS service or not. DHS, in conjunction with the MCOs and provider agencies, has offered provided training in 2017 to IHH agencies on person centered planning. Training has included principles of PCP and practical examples to help providers be more inclusive in their treatment planning processes.

   For HCBS services, person centered planning is required, and is identified in Iowa Administrative rule. IHH care coordinators meet with individuals and families at the location of their choice to develop treatment plans, identify the individual’s strengths, needs, preferences, and goals, and develop plans that are representative of those goals. At a system level, the state engages consumers and their families through support of the Office of Consumer Affairs, support of peer/family support services to help individuals advocate for themselves and their families, and close collaboration with advocacy organizations such as NAMI.

4. Describe the person-centered planning process in your state.

   The person centered process for Medicaid members receiving Habilitation is described in Iowa Administrative Code 441 Chapter 78.27 (4). A link to the administrative rule is here: https://www.legis.iowa.gov/docs/ACO/chapter/441.78.pdf.

   The rule describes the requirements for the Medicaid member and/or legal representative’s involvement in the development of the plan based on the member’s strengths, needs, and preferences in all aspects of service delivery.

   For accredited mental health service providers, person centered principles are also described in Iowa Administrative Code 441 Chapter 24.4 (4). A link to this rule is here: https://www.legis.iowa.gov/docs/ACO/chapter/441.24.pdf

   Does the state have any activities related to this section that you would like to highlight?
   no

   Please indicate areas of technical assistance needed related to this section.
   none

Footnotes:
Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?  
   Yes  No

2. Are there any concretely planned initiatives in our state specific to self-direction?  
   Yes  No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question
SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  
   Yes  
   No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  
   Yes  
   No

   Does the state have any activites related to this section that you would like to highlight?
   no

   Please indicate areas of technical assistance needed to this section
   N/A

Footnotes:
8. Tribes - Requested

**Narrative Question**

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[^59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. 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 that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.


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**Please respond to the following items:**

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   **Does the state have any activities related to this section that you would like to highlight?**

   **Please indicate areas of technical assistance needed to this section**

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**Footnotes:**
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community-based mental health and substance use disorder (SUD) services:
Outpatient mental health therapy and psychiatry
Outpatient SUD services
Intensive outpatient/partial hospitalization-MH and SUD
Peer support/family peer support services
Peer recovery coaching
Behavioral Health Intervention Services
Habilitation-1915i waiver
Children's Mental Health Waiver-1915 C waiver
Integrated Health Home care coordination
Medication Assisted Treatment

2. Does your state provide the following services under comprehensive community-based mental health service systems?

   a) Physical Health
   b) Mental Health
   c) Rehabilitation services
   d) Employment services
   e) Housing services
   f) Educational Services
   g) Substance misuse prevention and SUD treatment services
   h) Medical and dental services
   i) Support services
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   k) Services for persons with co-occurring M/SUDs

Please describe as needed (for example, best practices, service needs, concerns, etc)

Descriptions of the service system are located in Step 1, Assessment of the Behavioral Health System

3. Describe your state's case management services

Case management for Medicaid-eligible individuals with a serious mental illness or children with a serious emotional disturbance are provided through Integrated Health Homes (IHH) care coordination teams. Teams consist of a care coordinator, a nurse care coordinator, and a peer support or family peer support specialist. Teams are to address whole person health and social service needs. For persons eligible for services through the Mental Health and Disability Services (MHDS) regions, IHH or coordinators of disability services provide case management of regionally funded services.
4. Describe activities intended to reduce hospitalizations and hospital stays.

Iowa's MHDS regions are developing an array of crisis services across the state. Services available or being developed include 24-hour hotlines, mobile crisis response, crisis intervention, crisis stabilization, and 23 hour crisis observation. Regions are specifically working on developing crisis services and ACT teams for rural areas. Work is being done with the Medicaid MCOs for crisis services to be Medicaid reimbursable. Currently, MHDS regions fund crisis services not reimbursable by Medicaid.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s behavioral health system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>129,265</td>
<td></td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>40,470</td>
<td></td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The state uses the most recent SAMHSA prevalence data (2015). The state does not specifically identify statewide incidence of the target population. The state plans services based on actual service usage, data collected from Iowa Medicaid and the MHDS regions, input from consumers, stakeholders and funders on strengths and needs of the mental health system, and direction of state and legislative leadership regarding overall system goals.
Narrative Question
Criterion 3: Children’s Services
Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a) Social Services
b) Educational services, including services provided under IDEA
c) Juvenile justice services
d) Substance misuse prevention and SUD treatment services
e) Health and mental health services
f) Establishes defined geographic area for the provision of services of such system
Narrative Question

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

Describe your state’s targeted services to rural and homeless populations and to older adults

The SMHA manages the federal PATH program for individuals with a mental illness at risk of experiencing homelessness. Seven agencies provide PATH outreach services in rural and urban communities across the state. The MHDS Regions are also working to develop supported housing programs to address needs of individuals with an SMI who are not able to maintain or obtain housing. The SMHA also works with the SOAR project to increase capacity of Iowa providers and agencies to assist individual in applying for SSI/SSDI.

The SMHA provides oversight of the PASSR process which screens all individuals seeking admission to nursing facilities for mental health or intellectual disabilities. The SMHA coordinates training on this process with providers and works with the PASSR contractor to review treatment plans to ensure that individuals are receiving all appropriate services while in nursing facilities and are also provided supports needed to return to community settings when indicated. Iowa’s PASSR process also emphasizes use of short-term stays in nursing facilities to encourage return to lower levels of care when appropriate. Iowa also has an HCBS Elderly Waiver which as of April 2017 had 7,806 enrolled members with no waiting list. Services provided on the Waiver include:
- Adult Day Care
- Assistive Devices
- Assisted Living
- Case Management
- Chore Services
- Consumer-Directed Attendant Care
- Emergency Response System
- Home and Vehicle Modifications
- Home Delivered Meals
- Home-Health Aide
- Homemaker Services
- Mental Health Outreach
- Nursing Care
- Nutritional Counseling
- Respite
- Senior Companions
- Transportation
- Consumer Choices Option
Criterion 5

Describe your state's management systems.

The SMHA is Rick Shults, Division Administrator, Division of Mental Health and Disability Services (MHDS), Iowa Department of Human Services (DHS). Also housed within DHS are Iowa Medicaid Enterprise, the Divisions of Adult, Child, and Family Services, Fiscal Management, and Data Management. MHDS works closely with other divisions of DHS to develop mental health policy and programs. The SMHA's estimated MHBG allocation for FFY18 is $3,137,940. The state projects expenditures of $156,897 on administration, $313,794 for the 10% ESMI set aside, and the remaining $2,667,249 on allocations to community mental health centers for services to individuals with an SMI or SED not covered by Medicaid or insurance, training on EBPs, peer support/family peer support training, MHPC support, and other mental health system development projects.
Environmental Factors and Plan

12. Quality Improvement Plan - Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? Yes No

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

Footnotes:

60 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

61 Ibid

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?  
   - Jn Yes  
   - Jn No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?  
   - Jn Yes  
   - Jn No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?  
   - Jn Yes  
   - Jn No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  
   - Jn Yes  
   - Jn No

5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.62 Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.63

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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


63 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? 

   jn Yes jn No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? 

   jn Yes jn No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? 

   jn Yes jn No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? 

   jn Yes jn No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient’s needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA’s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   - Yes  
   - No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women?  
   - Yes  
   - No

3. Does the state purchase any of the following medication with block grant funds?  
   - Yes  
   - No

   a)  Methadone  
   b)  Buprenorphine, Buprenorphine/naloxone  
   c)  Disulfiram  
   d)  Acamprosate  
   e)  Naltrexone (oral, IM)  
   f)  Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight?  
   Please indicate areas of technical assistance needed to this section.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.\(^{64}\) SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises\(^ {65}\),

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

\(^{64}\)http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848


Please respond to the following items:

1. Crisis Prevention and Early Intervention
   a)   Wellness Recovery Action Plan (WRAP) Crisis Planning
   b)   Psychiatric Advance Directives
   c)   Family Engagement
   d)   Safety Planning
   e)   Peer-Operated Warm Lines
   f)   Peer-Run Crisis Respite Programs
   g)   Suicide Prevention

2. Crisis Intervention/Stabilization
   a)   Assessment/Triage (Living Room Model)
   b)   Open Dialogue
   c)   Crisis Residential/Respite
   d)   Crisis Intervention Team/Law Enforcement
   e)   Mobile Crisis Outreach
   f)   Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a)   WRAP Post-Crisis
   b)   Peer Support/Peer Bridges
c) Follow-up Outreach and Support

d) Family to Family Engagement

e) Connection to care coordination and follow-up clinical care for individuals in crisis

f) Follow-up crisis engagement with families and involved community members

g) Recovery community coaches/peer recovery coaches

h) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

17. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

**Recovery** is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
  - Peer-run crisis diversion services
  - Telephone recovery checkups
  - Warm lines
  - Self-directed care
  - Supportive housing models
  - Evidenced-based supported employment
  - Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
  - Shared decision making
  - Person-centered planning
  - Self-care and wellness approaches
  - Peer-run Seeking Safety groups/Wellness-based community campaign
  - Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery...
Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
      Yes  No

   b) Required peer accreditation or certification?  
      Yes  No

   c) Block grant funding of recovery support services.  
      Yes  No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system? 
      Through participation in the MHPC, the MHDS Commission, and membership on state-run workgroups, individuals in recovery, peers, and family members have opportunity to participate in planning and development of the state’s behavioral health system.

   Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?  
   Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Peer support specialists are funded through Medicaid for Medicaid members and are also a core service through the MHDS Regions. Family peer support specialists for parents of children with an SED are also funded through Medicaid. Peer services may be provided as part of the IHH care coordination team for adults with an SMI or children with an SED, or may be provided as a standalone service. Various MHDS Regions also fund warm lines staffed by peers and wellness centers where peer supports are available. MHBG funds support statewide training of peer support/family peer support specialists and peer support and WRAP services through CMHCs.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   The Iowa Department of Public Health (IDPH) is the SSA for substance use disorders and leads all recovery support services related to SUD. The IDPH has multiple discretionary grants which focus on recovery support services. These include ATR, Pregnant and Postpartum Residential Treatment, Adolescent focused grants and Opioid related grants. The DHS supports IDPH by working collaboratively in assisting with education, referrals, linkages, and participating on grant advisory councils. For more information on specific RSS grants, please see the SABG application.

5. Does the state have any activities that it would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

   N/A

Footnotes:
Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C., 527 U.S. 581 (1999)*, provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state’s Olmstead plan include:
   - housing services provided.  
   - home and community based services.  
   - peer support services.  
   - employment services.  

   Yes  No

2. Does the state have a plan to transition individuals from hospital to community settings?  

   Yes  No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?  

   Does the state have any activities related to this section that you would like to highlight?  

   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

69The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America’s #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  
      Yes  No
   b) The recovery and resilience of children and youth with SUD?  
      Yes  No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
   a) Child welfare?  
      Yes  No
   b) Juvenile justice?  
      Yes  No
   c) Education?  
      Yes  No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?  
      Yes  No
   b) Costs?  
      Yes  No
   c) Outcomes for children and youth services?  
      Yes  No

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  
      Yes  No
   b) Mental health treatment and recovery services for children/adolescents and their families?  
      Yes  No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult behavioral health system?  
      Yes  No
   b) for youth in foster care?  
      Yes  No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   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 four Systems of Care in Iowa which serve 14 of Iowa’s 99 counties. Other regions and counties in Iowa are at differing stages of development regarding the children’s mental health Systems of Care. In SFY17, as a result of the Children’s Mental Health and Wellbeing Workgroup, two children’s mental health planning grants were awarded to two local areas to develop collaborative plans for a children’s mental health crisis system. Each local area worked with multiple stakeholders to assess the needs of their area and develop crisis plans that expanded existing services to address gaps. Both areas identified limited access to crisis services, cultural and language barriers, stigma, categorical or limited funding, and workforce shortage, among the gaps identified in their needs assessment process. While the programs did not receive additional funding for SFY18, the recommendations for children's services are to be considered in the next set of Children’s Wellbeing Collaboratives grants. The local areas are also exploring how they can implement crisis services in their areas with existing resources.

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

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

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

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

• The Juvenile Court System,
• Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
• Department of Public Health which includes Title V agencies such as the Child Health Specialty Clinics
• Department of Human Rights
• Department of Inspections and Appeals,

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

Iowa has a shortage of child psychiatrists. 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.

There is no Central Point of Coordination for children at the local level to provide coordination of children’s services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children’s system.

Additional detail about services provided in the Children’s Mental Health System are identified in Step 1-Strengths and needs of the service system.

7. Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:
Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  
   - Yes  
   - No

2. Describe activities intended to reduce incidents of suicide in your state.
   IDPH is the lead state agency for the prevention of suicide. DHS works collaboratively with IDPH on this effort by participating on the Suicide Prevention Planning Council which helps develop and implement the state suicide plan. One of the goals of the state plan is to reduce the stigma around seeking help for mental health issues and suicidal thoughts. One way this is addressed is through offering Mental Health First Aid and Youth Mental Health First Aid training of the public, educational providers, as well as providers of health/mental health services. IDPH has also promoted use of the Kognito suicide awareness training for educational staff. Iowa has several active community suicide prevention groups who promote community suicide awareness walks across the state and other prevention activities. IDPH also maintains Your Life Iowa, a phone and chat line for youth who may be experiencing suicidal thoughts or bullying. MHDS Regions are developing 24 hour crisis lines and other crisis services to address behavioral health emergencies including suicidal thoughts or behaviors.

3. Have you incorporated any strategies supportive of Zero Suicide?
   - Yes  
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?
   - Yes  
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?
   - Yes  
   - No

If so, please describe the population targeted.
3. The State Suicide Prevention Plan reflects a Zero Suicide philosophy and encourages adoption of this principle.

Does the state have any activities related to this section that you would like to highlight?
No

Please indicate areas of technical assistance needed related to this section.

none

Footnotes:
Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - Yes  
   - No  

   If yes, with whom?
   1. Iowa Department of Corrections - see below
   2. IDPH is not a new partner with DHS but since the last MHBG plan, DHS and IDPH partnered on the CCBHC planning grant project and entered into an MOU to carry out activities of the CCBHC planning grant. Iowa was not chosen for a CCBHC implementation grant but will continue to work with IDPH on opportunities to integrate MH and SUD services when available.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

DHS collaborates with the Iowa Department of Education (DE) in several ways. DHS-MHDS participates in the DE Learning Supports Advisory Team which is the advisory council to the DE Project AWARE grant. This allows DHS to provide input on mental health services provided in educational settings. DHS-MHDS staff also have co trained Youth Mental Health First Aid with DE staff and have consulted with DE on specific situations where individuals request assistance with school-related mental health needs.

Does the state have any activities related to this section that you would like to highlight?

In 2016, the state entered into a contract with the State Office of Drug Control Policy to develop and coordinate training for the Iowa Department of Corrections. (DOC). This training is part of the DOCs federal reentry grant. The training was designed to bring community mental health and substance use providers together with DOC and community corrections staff to educate each group about the other's roles and services. The goal of the training is to promote successful reentry to the community for individuals with mental health and/or SUD. 1,342 individuals participated in 24 trainings offered across the state and identified an 87%
satisfaction rate with the trainings.
Please indicate areas of technical assistance needed related to this section.

none

Footnotes:
Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question
Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.72

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

72http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
   The SSA leads planning and implementation of prevention, SUD treatment and recovery service programs. The MHPC has included SSA representation on the MHPC to encourage coordination and integration of mental health/SUD service systems. The SSA and SMHA work together on issues of mutual concern and are currently co-facilitating a legislatively mandated workgroup regarding services to individuals with complex needs.
   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into integration?

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistics, rural, suburban, urban, older adults, families of young children)?

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.
   The SMHA has three meetings with MHPC representatives to solicit input on the development of the FY18-19 plan. Meeting notes are attached. The MHPC has a strong composition of individuals in recovery, family members, and parents of children with an SED. Attached are the by-laws of the MHPC which describes its duties and responsibilities and meeting minutes from three SFY17 meetings. The MHPC works collaboratively with the SMHA as well as the Mental Health and Disability Services Commission to advocate for the needs of individuals with an SED or an SMI and their families. MHPC members are participants in other community advocacy organizations such as NAMI, in local community advocacy, parent and peer support groups, and in development of peer-run services. Planning council members provided comment on the plan via email which is attached.
   Does the state have any activities related to this section that you would like to highlight?
   N/A
   Please indicate areas of technical assistance needed related to this section.
   N/A

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.73

73There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.
Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee
January 17, 2017
10am-12pm

MHPC Committee Members Attending:
In person:
Teresa Bomhoff
Ken Briggs Jr.
Sharon Lambert
Craig Matzke
Michele Tilotta, Department of Public Health

On phone:
Jim Rixner
Kim Wilson

Other Attendees:
In person:
Laura Larkin, Department of Human Services
Peter Schumacher, Department of Human Services

Laura Larkin thanked members of the committee for meeting. The Committee planned to meet on the third Tuesday of the month, each month from January to April. More meetings will be added if the Committee decided they were necessary.

Laura explained that some states combine their applications for the Community Mental Health Services (MHBG) and Substance Abuse Prevention and Treatment (SABG) Block Grants, but that Iowa does not. Iowa does, however coordinate efforts between the Departments of Human Services and Public Health where they overlap. Laura noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) had released a draft joint application for the SAPT/MHBG and explained how the requirements for the two grants differed.

Teresa Bomhoff asked if there was still a section to include the Mental Health Planning Council's priorities. Laura answered that there was, but it had moved to the front of the application.

Laura presented the section on major changes in the mental health system and asked for the Committee's input. The committee discussed the following:

- Implementation of IA Health Link
- Expansion of mental health crisis services in MHDS Regions-legislative report
- Development of children's mental health services-legislative reports
- Iowa's Certified Community Behavioral Health Clinics (CCBHC) Planning Grant efforts
- Jail diversion services in MHDS Regions
- The Department of Human Services' workgroup to address meeting the needs of individuals with severe complex needs in the mental health system
- IDPH State Youth Treatment-Implementation (SYT-I) Grant
- DOC peer support training and DHS/DOC community services training
• ILEA mental health training, increased CIT training

The committee discussed sources for information on children’s mental health including the Department of Public Health’s youth survey and the Iowa Department of Education.

The Committee discussed areas to be considered for the gaps section of the plan as well as areas of the system overview that could be strengthened:
• mental health services for veterans-Ken mentioned concerns about lack of capacity at Iowa Veterans Home in Marshalltown
• mental health services in the corrections system and in jails-concerns about people with mental health needs being in isolation in jails
• IHH management-same under Iowa Health Link as under previous system?
• Concerns about Iowa Health Link administrative issues with providers

Laura encouraged the committee to suggest strengths and gaps in Iowa’s mental health system for the application as they review the current plan prior to the next meeting.
Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee
February 21, 2017

Committee Members Attending:
Teresa Bomhoff
Ken Briggs Jr.
Sharon Lambert
Jim Rixner

Other Attendees:
Laura Larkin, Department of Human Services
Peter Schumacher, Department of Human Services
Michele Tiotta, Department of Public Health

Laura Larkin thanked members of the committee for meeting. The Committee planned to meet on the third Tuesday of the month, each month from January to April. More meetings will be added if the Committee decided they were necessary.

Laura said she wanted to discuss some of the strengths and gaps in Iowa’s mental health system with regard to the specific populations. The committee identified the following strengths and gaps.

Children with SED and their families:
- Concern over the availability of residential care
- There is a need to develop children’s mental health services at all levels across the state
- There is a need to develop children’s mental health crisis services
- Workforce shortage—only 31 child psychiatrists in state
- There are children’s mental health crisis services being developed, however there is no long-term support for them at this time. Rural crisis for children also a gap.
- There is a concern over IHH services operating as intended
- There is a need to increase children’s mental health support in schools-therapeutic classrooms, schools.
- There was a suggestion to check the suicide rate for children and adults, as well as the Iowa Youth Survey for information.
- Strength: Youth Mental Health First Aid, Children’s Crisis Planning Grant programs, Learning Labs programs
- Strength: Integration of IDPH helplines-combining Your Life Iowa for bullying and suicide, and the problem substance use and gambling lines into one line.
- Concern: Multiple crisis lines between state agency ones and MHDS regional ones may cause confusion for public
- Teresa Bomhoff proposed separate rooms in schools that would be designed to help children with mental health needs calm down.

Adults with SMI
- Workforce is a barrier for all populations
- Not all MHDS Regions have mental health crisis services
- There is a need for accessible and appropriate inpatient psychiatric services
• There is a need for mental health services to be developed in settings outside the corrections system.
• Increased use of boarding in ERs while waiting for treatment.
• Need more services for adults with aggressive behaviors or complex needs.
• Concern about increase in suicide rate for women ages 45-64, veterans, and girls ages 10-14.
• Lack of follow through by IHH-per Jim, providers do not have enough time to do their jobs they way they want to due to administrative requirements.
• Strength: The Director is holding workgroups with many different stakeholders in the state's mental health system to assess the needs of the state.
• Strength: Through CCBHC grant, have expanded Intensive Psychiatric Rehab service and ACT.
• Concern over how we care for individuals with co-occurring mental health and substance use needs. More collaboration among providers in each area is needed.

Older Adults with SMI
• There is only one geriatric psychiatrist in Iowa.
• There is a lack of affordable housing venues available for older adults with and without SMI.
• Concern over PASRR follow-through.
• Concern over whether older adults in nursing facilities are medicated to treat their needs, or to make them easier to serve.

Rural and Homeless Individuals with SMI
• There is a need for transportation services.
• Peer support services would be very helpful for this population to avoid isolation.
• There's a lack of intensive community-based programs like ACT teams.
• Strength: Development of two new ACT teams in rural areas of the state, local programs such as Siouxland are working with hospitals to coordinate care for individuals who are homeless.

First Episode of Psychosis
• Two active programs working to support individuals after experiencing their first episode of psychosis.
• Only two programs.
Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee
April 18, 2017

Committee Members Attending:
Teresa Bomhoff
Ken Briggs Jr.
Sharon Lambert (phone)
Craig Matzke (phone)

Other Attendees:
Laura Larkin, Department of Human Services

Committee

Continued discussion of priority areas for the MHPC

1. Workforce development issues-concerns about future of psychiatric residency program expansion due to state budget cuts

   Would like to measure growth in number of different types of providers. This may be difficult as there is not a central provider clearing house.

   Teresa said that The Office of Clinical Practices at U of I measures number of psychiatrists, however there is a concern that the U of I doesn’t support recruitment to keep providers in Iowa.

   Sharon is concerned about negative image of Iowa in social media.

   Craig asked if we could get to the program/person level of workforce needs and focus on one area. Discussed that it is hard to gather data on workforce at a program level, it is well established that Iowa has a shortage in most behavioral health workforce areas.

2. MHPC members are concerned about MCO payment issues-MCOs paying less than cost of service being provided. This will cause providers to close or not provide specialty programs such as ACT, further affecting the workforce shortage. They would like to see incentives for workforce development.

   This is the last scheduled meeting for the MHPC committee, DHS will send a draft of the report to the MHPC for review and comment prior to submission to SAMHSA. Members are welcome to send any additional comments or information prior to then to Laura Larkin.
Iowa Mental Health Planning and Advisory Council
Bylaws

ARTICLE I – NAME

The name of this organization shall be the Iowa Mental Health Planning and Advisory Council.

ARTICLE II – DUTIES AND ACTIVITIES


Section 1. Duties

A. To participate in the development of and subsequently review mental health plans for Iowa provided to the Council pursuant to 42 USC 300X-4 (a) and to submit to the State of Iowa any recommendations of the Council for modifications to the plans;

B. To serve as an advocate for adults with serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems;

C. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Iowa; and

D. To affiliate, join, and collaborate with groups, organizations, and professional associations that the Council may designate or choose to advance its stated purposes under these bylaws and federal law; and, specifically, to join the National Association of Mental Health Planning and Advisory Councils.

Section 2. Activities

A. To organize as a proactive and effectively working Council;

B. To actively participate in the development of the State’s Center for Mental Health Services (CMHS) Community Mental Health Block Grant Application;

C. To provide recommendations on State goals according to the criteria of the CMHS Community Mental Health Block Grant;

D. To advise on the allocation of monies received by the State Mental Health Authority through CMHS Community Mental Health Block Grant funding;

E. To advise the State Mental Health Authority on matters that may affect the stated purposes of this Council;
F. To review the annual submission of the CMHS Community Mental Health Block Grant Application and comment on it to the Director of the Center for Mental Health Services;

G. To review the annual submission of a copy of the CMHS Community Mental Health Block Grant Application and comment on it to the Governor of the State of Iowa; and

H. To perform other duties as required by federal regulations.

Section 3. Records

A. The State Mental Health Authority shall maintain all official records of the Council in perpetuity.

B. Copies of any records deemed necessary for Council activities shall be maintained by the State Mental Health Authority.

ARTICLE III – MEMBERSHIP

Section 1. General

To the extent feasible, the membership of the Council shall represent the diverse population of the State of Iowa.

Section 2. Requirements

The Iowa Mental Health Planning and Advisory Council shall abide by the following federal requirements:

A. The ratio of parents of children with a serious emotional disturbance to other members of the Council shall be sufficient to provide adequate representation of children with SED in the deliberations of the Council; and

B. Not less than 50 percent of the members of the Council shall be individuals who are not State employees or providers of mental health services.

(1) A provider of mental health services is an individual who receives money, from any source, to provide direct or indirect mental health services to consumers.

(2) Advocacy, educational, and training organizations, and their employees, shall not be considered providers of mental health services under these bylaws. (Unless they also receive funding for the provision of direct services)

(3) Volunteers and members of advisory and governing boards (of mental health provider organizations) shall not be considered providers solely because of such status.
Section 3. Membership Categories

Membership shall be the following:

A. Seven (7) members representing the principal State agencies with primary responsibility for the following programs:
   - Mental Health
   - Education
   - Vocational Rehabilitation
   - Criminal Justice
   - Housing
   - Social Services
   - Medical Services (Title XIX)

   (1) Individuals nominated by the principal State agencies shall be reviewed and elected or accepted by the Council. If the Council has concerns or feedback to provide to a principal State agency, these can be shared with that agency prior to election of the individual nominee.

   (2) Any individual employed by or contracting with the State Mental Health Authority who directly manages or supervises the CMHS Community Mental Health Block Grant may not become a voting member of the Council.

B. Six (6) members representing public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services statewide.

C. Six (6) members who are adults with serious mental illness and current or past consumers of mental health services.

D. Four (4) members (age 16 and over) who are family members of adults with serious mental illness.

E. Six (6) members who are parents, guardians, or primary caretakers of children with serious emotional disturbance.

F. Four (4) other individuals with an interest in supporting the needs of children with serious emotional disturbance and adults with serious mental illness. (There is an expectation for child advocacy representation provided by a representative knowledgeable about the juvenile justice system.) Iowa Code 225C.4 subsection 1 “t” (2010 General Assembly) provides for one (1) representative by a military veteran who is knowledgeable concerning the behavioral and mental health issues of veterans.

G. Four (4) ex-officio members representing the Iowa General Assembly:
   - One representative of Senate Democrats
   - One representative of Senate Republicans
   - One representative of House Democrats
   - One representative of House Republicans
(1) Individuals representing the Iowa General Assembly will be nominated by the Majority and Minority leaders of their respective chambers and shall be accepted and confirmed by the Council. If the Council has concerns or feedback to provide to Majority or Minority leaders, these can be shared with that agency prior to election of the individual nominee.

**Section 4. Nominations**

A. All new members will be subject to a written application process. Renewing members need to notify the nominating committee in writing of their desire to be re-appointed.

B. To be considered, a designated recipient at the State Mental Health Authority must receive the written application for Council membership by the due date specified in the announcement for applications.

**Section 5. Voting Rights**

A. Each Council member in attendance shall hold one vote.

B. Members may attend meetings and vote by telephone, if technically possible at the meeting location and pre-arranged with staff.

C. No proxy voting is allowed.

D. Under General Ethical Principles Regarding Conflict of Interest in Iowa Code Chapter 68B (Conflicts of Interest), members of the Council shall recuse themselves from voting when they have, or anticipate having, a direct financial stake in the outcome of a Council decision, related to, or independent of, their status as a provider of mental health services. (See Article VI – Conflict of Interest)

E. The Council Chair casts a vote only in the event of a tie.

**Section 6. Vacancies**

A. Council membership ends when:

   (1) A member resigns or dies; or
   (2) A member’s term ends, and that member does not reapply for another term.
   (3) A member fails to meet the Council’s minimum attendance policy as defined in Sec. 6(B); or
   (4) A majority of the Council terminates the member for just cause, as defined by that majority subject to the procedures required by Sec. 8; or (5) In the case of a principal State agency member, the member’s term ends when a new individual is nominated by the principal State agency and confirmed by the Council.

B. All Council members will be held to an attendance policy, as follows: Members will, at a minimum, attend one-half of the regular meetings of the Council for each year. After three consecutive absences, a member shall be notified that his or her position will be considered vacant. Failure to notify the member does not constitute a waiver of the attendance.
requirements. A Council member will be contacted and the absence policy reviewed after a second consecutive absence.

C. Attendance may be accomplished in person or by telephone conference call.

D. The termination of an individual principal State agency member does not terminate the designated agency’s representation on the Council as provided for in Article III, Section 3(A).

E. Resignations by Council members will be automatically accepted and their positions considered vacant immediately.

**Section 7. Terms of Membership**

A. The membership term of a Council member shall be three years.

B. Membership terms shall be staggered so that one-third of the total number expires each year.

C. To maintain the staggered term structure, each full membership term will begin with the first meeting after the annual meeting.

D. Members elected to fill an unexpired term will begin their term at the first meeting following their election.

E. All new members will be subject to a written application Process. Renewing members need to notify the nominating committee in writing of their desire to be re-appointed.

F. A members elected to fill an unexpired term who wants to continue as a Council member at the end of their term will notify the Nominating committee in writing of their desire to be re-appointed.

**Section 8. Termination for Just Cause**

A. A Council member or members who feel just cause exists for another member of the Council to be terminated pursuant to Section 6(A)(5), must present a written statement of the reasons for the proposed termination to the Executive Committee.

B. The Executive Committee shall review any such written statement and determine if the matter has merit to be presented to the full Council.

C. Only the Executive Committee is empowered to present a motion for termination of a member for just cause before the full Council.

D. A motion for termination for just cause must be accompanied by a written statement of the reasons for the proposed termination.

E. The Council member who is the subject of the motion must be given an opportunity to respond to the written statement before the Council, prior to any action being taken.
ARTICLE IV – MEETINGS

Section 1. General

A. Regular and special meetings of the Council shall be called by either:

(1) The Executive Committee; or
(2) Eight (8) or more Council members

B. The Council shall meet no less than four (4) times a year.

C. Council meetings shall be conducted according to the current version of “Roberts Rules of Order,” as periodically revised, and comply with the requirements of Iowa Code Chapter 21 (Open Meetings) and Iowa Code Chapter 22 (Open Records).

(1) A parliamentarian may be elected by majority vote of the Council to interpret and enforce procedural rules.

D. Members shall be given at least two weeks advance notice of regular meetings. Special meetings may be called and noticed as necessary. Meeting notices must include place, date, and hour. Meeting agendas shall be posted as required by law.

E. The Council’s Annual Meeting shall take place at the next regular meeting following the annual federal review of Iowa’s CMHS Block Grant Application [November].

Section 2. Quorum

A. No less than two-thirds of the Council members eligible to vote will constitute a quorum. The number of members eligible to vote if all Council positions are filled is thirty-three (33).

B. If, during the course of a meeting the number of members present is reduced below a quorum, the meeting may continue but no vote may be taken.

C. A majority of the quorum is needed to accept any matter put to a vote.

ARTICLE V – OFFICERS AND COMMITTEES

Section 1. Officers

A. The officers of the Council shall be a Chairperson, a Vice-chairperson, and Secretary.

B. The outgoing Chairperson may be retained in an ex-officio capacity at the will of the council.
Section 2. Nomination and Election

A. Council Members interested in becoming an officer shall notify the Nominating Committee of their intention prior to the annual meeting. The nominating Committee shall bring the list of those interested forward to the full Council.

B. Officers shall be elected annually for one-year terms.

C. Election of officers shall normally take place at the Council’s Annual Meeting, but may be called at another date at the discretion of the Executive Committee, if necessary.

D. A quorum of Council members shall elect the officers by majority vote.

Section 3. Terms of Office

A. Officers shall be elected for a one-year term. There shall be no limit to the number of terms an individual member may be elected to office.

Section 4. Duties

A. The Chairperson shall:

   (1) Notify members of meetings;
   (2) Preside at Council meetings.

B. The Chairperson, in cooperation with the Executive Committee, shall:

   (1) Establish and publish the agenda for Council meetings;
   (2) Establish and publish an annual calendar for Council meetings;
   (3) Report to the federal government (CHMS), the Governor of Iowa, and designated persons or organizations;
   (4) Serve as liaison between the Council and other groups and organizations, including the State Mental Health Authority;
   (5) Communicate with and regularly report to the Council;
   (6) Designate ad hoc committee membership and monitor such committee’s areas of focus; and
   (6) Perform other miscellaneous functions, as determined or designated by the Council.

C. The Vice-Chairperson shall:

   (1) Assume the Chairperson’s duties for any period of time that the Chairperson is unable to do so;
   (2) In the event that the Chairperson is unable to complete his or her term, act as Temporary Chairperson until the Council elects a new Chairperson;
   (3) In the absence of the Secretary in a meeting, serve as Secretary,
   (4) Serve as a voting member of the Executive Committee and
   (5) Guide the mentoring process for new members and/or youth members.
D. The Secretary shall:

(1) Serve as a voting member of the Executive Committee
(2) Monitor the maintenance of minutes and records of the Council’s business and ensure that minutes and records are compiled and maintained by the State Mental Health Authority to be preserved in perpetuity;
(3) Assume the Chairperson’s duties for any period of time that both the Chairperson and Vice-Chairperson are unable to do so; at the will of the Council, staff shall take the minutes of all Council meetings and shall make minutes available for review and feedback by the Secretary and Executive Committee prior to presentation to the full Council; and
(4) If the staff person cannot be present or designate a replacement, the Chairperson shall appoint a council member to take minutes

Section 5. Standing Committees or Workgroups in General

A. Standing committee/workgroup members shall be elected annually by a majority vote of the Council at the meeting following the annual meeting.

B. Standing committee/workgroup chairs shall be elected by majority vote of the committee/workgroup members.

C. In electing standing committee/workgroup members, efforts will be made to reflect the diversity of the Council membership categories.

D. Three (3) standing committees are authorized by these bylaws:

   (a) Nominations Committee;
   (b) Executive Committee;
   (c) Monitoring and Oversight Committee.

Section 6. Nominations Committee

A. The Nominations Committee shall consist of five (5) Council members.

B. The Nominations Committee shall nominate persons for the offices of Chairperson, Vice-Chairperson, and Secretary for consideration by the entire Council.

C. The Nominations Committee shall be responsible for soliciting and reviewing applications for Council membership, and making recommendations to the Council.

Section 7. Executive Committee

A. The Executive Committee shall consist of: the Chairperson, the Vice-Chairperson, the Secretary, and the Chairs of the Standing Committees. At the will of the Council, the past Chairperson can be an ex-officio member.
B. The Executive Committee shall review Conflict of Interest Disclosures and make recommendations to the full Council on Conflict of Interest issues.

C. The Executive Committee shall establish ad hoc committees and work groups as needed.

D. The Executive Committee shall:

(1) Establish the agenda for Council meetings;
(2) Establish an annual calendar for Council meetings;
(3) Report, on behalf of the Council, to the federal government (CMHS), the Governor of the State of Iowa, and designated persons or organizations;
(4) Serve as liaison between the Council and other groups and organizations, including the State Mental Health Authority;
(5) Communicate with and regularly report to the Council;
(6) Monitor the maintenance of records of Council business, and deliver any official records to the Mental Health Authority to be maintained in perpetuity.
(7) Perform other miscellaneous functions, as developed or designated by the Council.

Section 8. Monitoring and Oversight Committee

A. The Monitoring and Oversight Committee shall consist of five (5) Council members.

B. The Monitoring and Oversight Committee shall, at their discretion, or on the recommendation of the Council:

(1) Review and comment on work plans submitted by contractors;
(2) Review and comment on budget expenditures made pursuant to the CMHS Block Grant;
(3) Review and comment on procedural issues connected with the CMHS Block Grant;
(4) Monitor and comment on the state of the mental health system in Iowa; and report or make recommendations for action to the full Council.

Section 9. Workgroups

A. The Executive Committee shall create and appoint workgroups committees to carry out any necessary Council business or activities that are not expressly provided for in these bylaws.

ARTICLE VI – CONFLICT OF INTEREST

Section 1. Conflict of Interest Policy

A. The Mental Health Planning and Advisory Council (hereinafter, “the Council”) respects the rights of all members in their activities outside of their association with the Council, should such activities not conflict with or adversely reflect upon the Council. It is Council policy to place trust in each member’s integrity, judgment, and dedication. It is also important to avoid even the perception of a conflict of interest. Accordingly, the policy set forth below has been adopted:
(1) All Council members are expected to declare any financial or personal affiliations that could interfere with their effectiveness in representing the interests of individuals with serious mental illness or serious emotional disturbance on the Council, or on their effectiveness in representing the Council to the public.

(2) All Council members shall complete a Conflict of Interest Disclosure Statement, including information on any of the following situations:

(a) Holding a financial interest in a company, organization, or agency that provides services to individuals with serious mental illness or serious emotional disturbance.
(b) Receiving federal CMHS Block Grant funding as a contractor, sub-contractor, employee, provider, or in another capacity.
(c) Membership on other councils, boards, commissions, or public bodies that may have interests conflicting with those of the Council.

(3) In the course of Council business, members will be expected to identify instances when a conflict or the appearance of a conflict of interest exists and voluntarily abstain from voting in those situations.

(4) Each member shall sign and place on file with the Council a Conflict of Interest Disclosure Statement annually. (See Appendix A).

(5) Any Conflict of Interest Issues that come to the attention of the Council shall be reviewed by the Executive Committee.

ARTICLE VII – BYLAWS

Section 1. Revision

A. These bylaws may be altered, amended, or repealed, by a majority vote of the Council members at any regular or special meeting of the Council, following a reading, provided that:

1. The proposed amendments have been given a first reading at a prior meeting, and
2. That the amendments were submitted to the membership in writing at least two weeks in advance of the meeting where the vote will take place.

B. A bylaws workgroup shall be created by the Executive Committee when necessary for the consideration and development of amendments proposed by Council members or by the officers.

First reading: May 28, 2008
Second reading: Waived May 28, 2008
Adopted: These By-laws are accepted and adopted by vote of the Iowa Mental Health Planning and Advisory Council on May 28, 2008.
By majority vote of the Council on March 21, 2012, Art. III, Sec. 6B Vacancies; Art. V, Sec. 4B Duties.

Iowa Mental Health Planning Council Bylaws ~ Page 10 of 11
Appendix A:

Conflict of Interest Disclosure Statement

I, ________________________________, have read the Mental Health Planning and Advisory Council Conflict of Interest Policy (as outlined in Article VI of the Bylaws) and state by my signature below that I am in compliance with it and will continue to observe this policy carefully throughout my association with the Council. In addition, I am disclosing possible conflicts of interest or the potential for the appearance of conflicts of interest, as follows:

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Signed: ___________________________________

Date: __________________

The information in this Conflict of Interest Disclosure Statement will be reviewed by the Executive Committee of the Mental Health Planning and Advisory Council and maintained as part of the official record of the Council by the State Mental Health Authority. If any actual or potential conflict requires attention, the Executive Committee will attempt to resolve the perceived conflict(s).

Ethical Considerations of Council Membership:

Individual Council members have no authority apart from the full Council and cannot act on their own or take action on behalf of the Council without being authorized to do so by the bylaws or the official act of the Council. All Council members are expected to support the decisions of the Council. Council members are discouraged from taking personal action to discredit the dignity and integrity of the Council, staff, or individual members.
MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Jim Chesnik (phone)
Jim Cornick
Jim Donoghue
George Estle
Kathleen Goines (phone)
Kris Graves
Michael Kaufmann (phone)
Gary Keller (phone)
Anna Killpack
Sharon Lambert
Todd Lange
Brenda Lechner

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:

Kenneth Briggs Jr.
Julie Kalambokidis
Amber Lewis
LeAnn Moskowitz

OTHER ATTENDEES:

Theresa Armstrong
Judy Davis
Christie Gerken
Peter Schumacher
John Stoebe
Kelli Todd
Kelsey Zantingh

Bureau Chief, Community Services and Planning, DHS
NAMI Iowa/Office of Consumer Affairs
Iowa Advocates for Mental Health Recovery
DHS, MHDS, Community Services & Planning
University of Iowa Health Systems
Managed Care Ombudsman Program
Managed Care Ombudsman Program

Chair Teresa Bomhoff called the meeting to order at 10:03 a.m. and led introductions. Quorum was established with sixteen members present and six participating by phone.

Tammy Nyden made a motion to approve the September and October meeting minutes as presented. Anna Killpack seconded the motion. The motion passed unanimously.
**Nominations Committee – Brad Richardson**
Brad said the committee has received two applications, but the Planning Council has not had a chance to review them. The two applications are for Earl Kelly and Harry Olmstead.

**Update on the Jackie Waiver and Jackie Skip – Anna Killpack**
Anna Killpack said the bill for the Jackie Waiver and Jackie Skip was combined into one bill known as Jackie’s Law. Anna said the bill was drafted very late, and therefore did not survive the first funnel.

Anna said the bill met opposition from the Iowa Sheriffs and Deputies Association and the Iowa State Association of Counties.

There was a discussion on the policy development process and emergency care for mental health.

**Peer Support Dashboard – Todd Lange**
Todd Lange thanked the Planning Council for their support of peer support over the last few years, and said as a result, peer support has become a priority in the state.

Todd explained that Adult Peer Support refers to an adult with lived experience with mental illness and specialized training providing non-clinical recovery support to other people with mental illness. Family Peer Support is similar, except it is a family member of a child with a Serious Emotional Disturbance (SED) providing support to other family members. Todd said peer support is an evidence-based practice, and a required core service for the fourteen MHDS Regions.

Todd spoke about the East Central Region which has both Adult and Family Peer Support, and peer have been actively involved in the development of services in the Region. Peers are working to be more active in services such as:

- Hospital Bridging, helping individuals transition from inpatient care back into the community
- Crisis Intervention
- Jail Diversion services
- Assisting in wrap-around services and post-crisis planning

Todd said he is also working with other Regions to help them invest in peer-run services.

Todd Noack spoke about utilizing peer support in mental health crisis response and prevention.

Brad Richardson asked for an update on Todd Noack’s plan to open a peer-run respite home. Todd answered that the house is currently being rezoned, and that their cost-estimate was very close.
Jim Rixner asked why the house needed to be rezoned. Todd Noack answered that the city has rules that this would be commercial work, and the house is currently zoned in a residential area.

Craig Matzke asked if peer support is being used to connect with people being released from corrections. Todd Noack answered that United Way is working with them on supporting people in jail, or being released.

Todd Lange spoke about ways peer support could be utilized to support individuals who have been involved in the criminal justice system.

Jim Rixner explained that he was asking questions because of his role on the Monitoring and Oversight Committee. The committee had concerns over the effectiveness of The University of Iowa’s peer support training program. Todd Lange said there had been a lapse in peer support funding, and he was encouraged that funding for peer support specialist training had resumed under this contract.

Brad Richardson asked about peer run warm lines. Todd Lange answered that there was a peer-run warm line being operated by Abbe Health in Cedar Rapids. The demand for the warm line has been steadily. This is for individuals to call in for non-crisis support. There is a protocol with Foundation 2 crisis line for a warm hand-off.

Sharon Lambert asked how the facility is set up. Todd Lange answered that peers work remotely, and can work from their cell phones.

Todd Noack said the phone number for the warm line is (844) 775-9276, and it is officially open from 5:00 to 10:00 pm, but it has been answered outside that time range.

Tammy Nyden asked if there was a similar resource for family peer support. Todd Lange answered that it is mostly people with their own lived experience on this warm line.

**Monitoring and Oversight Committee – Jim Rixner**

Jim Rixner said the Committee has spoken about peer support, and encouraged members of the Planning Council to advocate for peer support employment opportunities in MHDS Regions. Jim said peer support will continue to be a major priority for the committee.

Jim said his organization is owed a significant amount of money from Medicaid MCOs and Iowa Medicaid Enterprise (IME), and expressed concern for Iowa’s Medicaid program.

There was a discussion on Iowa’s Medicaid program, and concerns providers are having.
Children’s Committee – Tammy Nyden
Tammy said most of the legislative items she spoke about at the previous meeting did not advance after the first funnel.

Tammy said the Children’s Committee will focus on education in the next year. Tammy said she would like to see more health services being provided in schools.

Tammy said she is also the chair of NAMI Iowa’s Children’s Mental Health Committee, and they are working to start another coalition similar to the one they had in 2015. This time, the coalition would be focusing on education, and Tammy encouraged anyone who is interested to contact her.

Tammy mentioned a group

The Planning Council broke for lunch at 12:00 pm

The meeting resumed at 12:58 pm

Managed Care Ombudsman Program – Kelli Todd and Kelsey Zantingh
Kelli Todd and Kelsey Zantingh introduced themselves and thanked the Planning Council for inviting them to speak on the Managed Care Ombudsman Program.

Kelli explained that the Managed Care Ombudsman Program (MCOP) is fairly new and serves individuals on Medicaid Home and Community-Based Service (HCBS) Waivers, residential care situations, and children on the Children’s Mental Health Waiver from their eight offices across the state. Kelli said most of what the Ombudsmen do is answer questions, provide information, and help Medicaid members interact with Medicaid MCOs.

Kelsey said she is a Managed Care Ombudsman and presented materials from their office.

Anna Killpack asked if they work with people receiving habilitation services. Kelsey answered that those individuals are technically outside their designated population, but the MCOP would still work to support them as they are able.

Teresa Bomhoff asked how many Medicaid members the MCOP serves. Kellie answered that it fluctuates every month between approximately 37,000 to 56,000 members.

Tammy Nyden asked if the MCOP is a state-run organization, or run by the Medicaid MCOs. Kelli said they are all state employees. The MCOP is an independent office housed within the Iowa Department on Aging. They receive both federal and state funding.
Kelsey spoke about the MCOP’s monthly report, which contains aggregate data on contacts sorted by member issue and MCO. The report also lists referrals, services provided to the contacts, and the average resolution time in days.

Todd Noack asked about the difference in the number of calls between MCOs. Kelsey answered that not all calls are reporting issues or bad things, and many calls follow news stories, and one MCO has been in the news lately.

Rhonda Shouse asked if they receive calls from the populations that the MCOP does not serve, are they noted in the program’s reports? Kelsey said those calls are still noted in the reports.

Teresa Bomhoff asked if the MCOP is involved with critical incident reporting. Kelli said they are not part of that process, and are only brought in if they are notified.

Jim Rixner asked who the other Medicaid members should contact since the MCOP only serves members on HCBS waivers, in residential care situations, and children on the Children’s Mental Health Waiver. Kelli said members could call the Long Term Care Ombudsman’s office if they are in nursing facilities or other long term care facilities, and all members could call the State Ombudsman, which monitors all state programs.

George Estle asked if the program was created by Iowa Code. Kellie answered that it was because the Center for Medicare and Medicaid Services (CMS) requires that there be an advocate for the population receiving long term care if a state moves it under managed care.

Tammy Nyden asked what happens if they get a call from someone outside the scop of the MCOP. Kelli said they would work to help the individual as they could, but if they were not able to resolve it, they would refer the individual to the proper authority.

Rhonda Shouse asked how someone would get onto the email distribution list for the MCOP. Peter Schumacher said he would send an email to the Planning Council asking if anyone is interested, and will compile a list to send to Kelli to add to the distribution list.

There was a discussion about the scope of various ombudsman programs in Iowa.

**DHS/MHDS Update – Theresa Armstrong**

Theresa said the administrative rules regarding the Autism Support Program and mental health crisis services accreditation are posted in the February Administrative Bulletin, and the public comment period extends through April 7. If all goes well, they will be effective on July 1.

Theresa said invitations to Community Connections Supporting Reentry (CCSR) were sent out, and the Planning Council would have received those invitation as well.
Theresa said the final round of trainings would happen in April, and invited anyone who is interested to attend.

HF 546: A bill that would mandate all mental health and disability services currently listed as core plus services. This bill would also establish a statewide workgroup to address the care of people with the most complex needs. The bill also instructs MHDS Regions to form their own groups to address needs more locally. Theresa said this bill also contains changes to the inpatient bed-tracking system. The bill would require hospitals to update the system twice a day, whereas now hospitals provide updates voluntarily. The bill would also add gender as a sorting criterion.

SF 369: This bill would require the Department to contact all 29 hospitals with inpatient psychiatric beds twice a day to ensure they have updated the bed tracking system. Theresa said the Department already checks the system every day and contacts any hospital that has not updated their system in the last twenty-four hours.

HF 343/SF 365: is a bill on MHDS Region funding. Theresa said this bill would make a statewide levy cap of $47.28 per capita.

SF 302: is a bill that would allow counties and regions to contract with a third-party transportation provider to transport individuals under mental health commitment. Some counties are already contracting with other providers. Theresa said this bill would give expressed permission where the law is currently silent.

SF 464/HF 319: are bills that would allow mental health professionals to perform mental health assessments. This is within their scope of practice, but currently, doctors are required to sign off on all assessments.

SF 400: is a bill that would require that private health insurers to cover applied behavioral analysis services for children with autism up to age 19. Theresa said that this would only affect insurance plans governed by state law, and many insurance plans are through large employers and are “self-funded”, and those plans are governed by federal law.

Theresa said she expects to see something on children’s mental health, but thought it might be in the Health and Human Services Appropriations bill. Teresa spoke about the Planning Council’s legislative priorities and whether they had been addressed.

Public Comment
Teresa Bomhoff spoke about the Children’s Mental Health and Well-Being Workgroup, and asked if Jim Donoghue could arrange a meeting between members of the Planning Council and representatives from the Department of Education.

The meeting was adjourned at approximately 3:12 pm.
Minutes respectfully submitted by Peter Schumacher
MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Chesnik (phone)
Jim Cornick
Jim Donoghue
George Estle
Kathleen Goines (phone)
Julie Kalambokidis (phone)
Michael Kaufmann
Gary Keller
Anna Killpack
Sharon Lambert
Todd Lange (phone)
Brenda Lechner
Craig Matzke (phone)
LeAnn Moskowitz
Todd Noack
Tammy Nyden
Carole Police
Donna Richard-Langer
Brad Richardson (phone)
Jim Rixner (phone)
Lee Ann Russo
Dennis Sharp
Michele Tilotta
Tracy White (phone)
Kimberly Wilson (phone)

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:

Kris Graves
Amber Lewis
Rhonda Shouse
DJ Swope
Jennifer Vitko

OTHER ATTENDEES:

Tammie Amsbaugh
Theresa Armstrong
Judy Davis
Kim Murphy
Peter Schumacher
Annie Uetz
Caroline Wellman
The University of Iowa, CDD
Bureau Chief, Community Services and Planning, DHS
NAMI Iowa/Office of Consumer Affairs
Iowa Hospital Association
DHS, MHDS, Community Services & Planning
Polk County Health Services
Amerigroup

Chair Teresa Bomhoff called the meeting to order at 10:05 a.m. and led introductions. Quorum was established with thirteen members present and nine participating by phone.
Dennis Sharp made a motion to approve the September and October meeting minutes as presented. Donna Richard Langer seconded the motion. The motion passed unanimously.

**Monitoring and Oversight Committee – Jim Rixner**

Jim said the committee met on December 8, and talked about children's services, law enforcement projects, and the peer support and family peer support contracts. Jim said the committee continues to receive information and support from Theresa Armstrong, Karen Hyatt, and Peter Schumacher.

Jim said the committee would like to advocate the expansion of warm lines operated by peers and respite services for family care providers. The committee also continues to look at the inpatient psychiatric bed-tracking system.

Donn Richard Langer asked if anyone on the Planning Council was familiar with warm lines, because she was surprised to hear that there already was one in Iowa. Todd Lange said there was one in the Cedar Rapids area.

Teresa Bomhoff asked if Todd Lange could provide a report on call volume and how the warm line is working for the Region. Todd said he knows there is data, but did not have it handy.

Sharon Lambert asked how people can find the warm line number, and what is the area covered by it. Todd Lange said the line covers the nine counties in the MHDS of East Central Region (Bremer, Buchanan, Delaware, Dubuque, Benton, Linn, Jones, Iowa, and Johnson), and people find the number in a variety of ways including from providers and distributed materials.

Teresa Bomhoff said Todd Noack had sent her a proposal on a peer-run respite home, and asked Todd if it would be ok to send the proposal to the Planning Council. Teresa said the report talks about current challenges and the benefits to opening a respite home to be operated by peers. Todd spoke about the research he had done in the development of his proposal, how the respite home would operate, and the various partners he with whom he has been working.

Teresa recommended the monitoring and oversight committee meeting develop recommendations and show how they fit within the portion of the block grant for projects of statewide significance.

**Mental Health Block Grant Committee – Jim Rixner**

Jim said there was a meeting of the Block Grant Committee with Laura Larkin on January 17. Jim spoke about the various areas the Block Grant Application needed to address, and said it was a very detailed process. The committee continues to work with Laura Larkin to identify strengths and gaps within the system.
Teresa Bomhoff said the format for the application has changed substantially, but the contents are similar. Teresa encouraged the Planning Council members to read the last Mental Health Block Grant (MHBG) application.

There was a discussion about whether the MHBG application puts enough emphasis on the gaps that remain in Iowa’s mental health system. Sharon Lambert said she would like to see information on individuals who were not able to receive services.

Teresa spoke about the process for submitting recommendations to the Department to include in the MHBG application.

**Children’s Committee – Tammy Nyden**

Tammy spoke about the Children’s Mental and Well-Being Workgroup that was convened in 2015 and 2016. The Workgroup recommended a request for proposals (RFP) for two children’s mental health crisis service providers and an RFP for children’s learning labs. Learning labs are collaborative efforts to care for the whole child and family and meet all their needs.

The Workgroup’s 2016 report was released in December, and Tammy said there was an emphasis put on prevention efforts. The Workgroup recommended an RFP for $300,000 to be awarded to Wellbeing Collaboratives that would be partnerships between all the systems that serve children and families in various domains such as education, child welfare, juvenile justice, public health, medical health, housing, employment, and mental health.

George Estle asked how elementary schools are incorporated. Tammy Nyden said she could only speak about the University of Iowa Childhood Specialty Clinics learning lab, and that she was not satisfied with the degree to which schools are partners.

There was a discussion on the long term sustainability of children’s mental health services and learning labs.

Tammy Nyden spoke about HF 11 which is legislation that would add “or unable” to the definition of a child in need of assistance. Teresa Bomhoff expressed concern with the addition of unable.

There was a discussion on parental rights.

Jim Chesnik said that the term “unable” was removed from the definition around 2006 so that parents would not have to give up custody for their children to receive certain mental health services. Jim said he was not aware of the reasoning for adding the term again.
Update on Michael Dieckmann – Anna Killpack
Anna said the Legislative Services Agency is drafting a bill for the Jackie Waiver and the Jackie Skip. Anna said that Michael Dieckmann was found not competent to stand trial, and will be transferred to Oakdale.

Therapeutic Alternatives to Incarceration – Annie Uetz
Annie Uetz introduced herself and presented a PowerPoint presentation on the Therapeutic Alternatives to Incarceration (TAI) project. TAI is a learning community for law enforcement and mental health.

Annie said they have three day training sessions for Crisis Intervention Teams. Teresa Bomhoff noted that law enforcement officers normally get five days and forty hours of training, and asked if anything was being excluded from the curriculum to make it fit in three days. Annie answered that there is a portion of the training that is focused on local community resources, and that information is less useful when they have officers coming from all over the state.

Annie said many things are done differently in different communities, so not everything can be easily implemented in all areas. Annie said there are barriers such as the variation in the availability of mental health crisis services, and lack of adequate, accessible, and comprehensive community-based services.

Annie spoke about the Stepping Up Initiative, which is a technical assistance collaborative that is devoted to reducing the number of people who interact with the criminal justice system.

Annie spoke about the Data-Driven Justice (DDJ) initiative which was launched by the Obama administration. Polk County participates on bi-weekly phone calls with White House staff along with a group of jurisdictions that has grown from sixty-seven to 141 to divert low-risk offenders from jails so individuals are stabilized instead of incarcerated. Polk County also participates in a bi-weekly conference call group called “Divert to what?” which is devoted to developing a set of jail diversion services.

Teresa Bomhoff asked if Polk County planned to introduce legislation to increase communication between communication and law enforcement. Annie said they do not have any plans for legislation at this time. They are working to increase collaboration on a grassroots level, and have HIPAA guidance from the White House on how they are able to share information between mental health providers and law enforcement.

Lee Ann Russo asked how other people can access information from the John and Laura Arnold Foundation. Annie said the White House brought them in on the DDJ initiative, and said they are the lead partner on the risk assessment. The Foundation is also one of the resources that the partners are allowed to use through the DDJ initiative.
Sharon Lambert asked if there was a possibility of this being funded federally. Annie said there are a number of areas within the initiative that are funded with federal dollars.

The Planning Council broke for lunch at 12:00 pm

The meeting resumed at 1:00 pm

**Community Connections Supporting Reentry – Tammie Amsbaugh**

Tammie Amsbaugh introduced herself said that Community Connections Supporting Reentry (CCSR) is part of the $3 million, three year Second Chances grant aimed at reducing recidivism, and increase collaboration with resources in the community. There will be twenty-four total training sessions being done in three rounds. There will be one training in each of Iowa's eight judicial districts every round.

Tammie said there are approximately 8,000 individuals currently incarcerated in Iowa, and around 95% of them will eventually be released back into the community. It is estimated that around 65%-70% of these individuals have either a mental illness or a substance use disorder.

Tammie said they completed their second round of training in October, and presented the Training Report that includes information from the first two rounds. There have been 776 unduplicated attendees and 224 unique agencies were represented at these sessions. The sessions included corrections staff, community providers, MHDS Region representatives, State agency representatives and people with lived experience.

Tammie said the individuals with lived experience are extremely valuable and have been highly rated in the evaluations. The sessions are designed to promote conversations between the Department of Corrections and the mental health and disability services systems.

Tammie said the resource guide has been a great tool for attendees and anyone interested, and said Peter Schumacher will send the link to it out after the meeting. She also invited the Commission members and anyone interested to attend the sessions. Invitations for the next round of training sessions will be sent near the end of February, and said Peter Schumacher would send them out as well. Laura Larkin said people are welcome to forward the invitations widely to anyone who might be interested.

Todd Noack asked about the Robert Young facility and the Sequential Intercept model which helps stakeholders facilitate reentry for individuals, and if that was a similar effort. Theresa Armstrong answered that it was a community resource, and the type of resource that would be discussed at a CCSR session. Tammie said there would be a session in Todd’s area at some point in April.

Anna Killpack asked if there had been any discussion about taking the resource guide and making a resource website that would list similar information and be updated.
regularly. Tammie said The University of Iowa Center for Disabilities and Development (CDD) has a webpage for CCSR and will be updating it through September. CDD is also looking to marry this information with other information referral centers.

Tammy Nyden asked if the effects on the children of individuals being released are being discussed in these sessions. Tammie said there are countless local resources concerned with the effects on children. There are several state and federally funded resources contained in the resource guide.

Sharon Lambert asked if Tammie knew how many individuals were being held in county jails. Tammie said she did not have that information.

Teresa Bomhoff asked how the sessions are formatted. Tammie answered that people introduce themselves and why they came, there is an information sharing session, and a panel discussion including people with lived experience. Tammie said she would characterize the sessions as structured networking.

There was a discussion on probation and parole officers and mental health training.

Jim Cornick spoke about his work with a focus group convened by Director Palmer to discuss individuals with mental illness and the criminal justice system.

Jim Rixner spoke about a letter that was sent in error to Integrated Health Home (IHH) Providers but Iowa Medicaid Enterprise (IME). Theresa Armstrong said she did not know all the details, but did know that IME would be making contact with all IHH providers to clarify that the letters were sent in error.

There was a discussion on the role of the Planning Council and advocating for individuals with mental illness.

DHS/MHDS Update – Theresa Armstrong
Theresa Armstrong spoke about Legislative Reports that were submitted by the Department. One report submitted was a MHDS Redesign Progress Report, and one of the major recommendations was to convene a workgroup to discuss developing services to address the needs of individuals with complex mental health needs. Director Palmer has been meeting with a number of stakeholders who work in various areas in the mental health system.

Todd Noack asked if there would be ongoing meetings with peers in the workforce, and if there would be positions for peers in the mental health system across the state. Theresa answered that these are focus groups, and the intent was not for them to be ongoing, but that she and Karen Hyatt had had discussions on how to utilize the peer support contract with the University of Iowa to move to the next steps. Brenda Lechner said the Director asked for recommendations from peers. Sharon Lambert asked if that information could be shared with the Council. Theresa said it could.
There was a discussion on utilizing peer support specialists in mental health treatment.

Theresa spoke about the other two reports the Department wrote on children’s mental health. The Children’s Mental Health Study included recommendations to build Children’s Wellbeing Collaboratives which would be child and family centered and focused on prevention and early intervention in mental health. Theresa said these collaboratives would learn from the children’s mental health crisis grantees and the learning labs.

The workgroup recommended the formation of a group that would continue to serve as an advisory body for the development of a children’s mental health system.

Theresa said there were two grants awarded for children’s mental health crisis services to Seasons Center in Spencer and YSS in Mason City. The Department combined the grantees’ reports into one and their recommendations fell in line with the recommendations in the Children’s Mental Health Study Report.

Teresa Bomhoff asked how long the children’s mental health crisis providers have to submit reports to the Department. Theresa said they were required to submit one report, but they are under contract through June 30, 2017 and the Department will get additional information from them.

Contracts for Children’s Well-Being Learning Labs were also awarded to Four Oaks in Cedar Rapids and The University of Iowa Child Specialty Clinics in Iowa City. The Learning Labs will be studying collaborative approaches to meet the needs of children and families. The Learning Labs will be in contact with the Department through the end of the calendar year.

Theresa said the Department is required to submit an annual report on mental health services for children and youth which is on Iowa’s Systems of Care (SOC) program that provide IHH-type services for children and youth that are not Medicaid eligible. Iowa has four SOC programs:

- Community Circle of Care in Northeast Iowa gets $847,000 and served 252 children in state fiscal year (SFY) 2016
- Central Iowa System of Care, which serves Polk and Warren Counties, was appropriated $211,000 and served 83 children
- Four Oaks served Linn and Cerro Gordo Counties and got $235,000 and served 59 children. This includes Four Oaks’ Total Child program that follows children after services and provides continued support.
- Taneger Place, which serves Linn County was appropriated $110,000 and served 35 children.

Tammy Nyden asked if there was any data that compared counties that have SOC programs to those that do not. Theresa said the Department does not have that data.
Tammy asked how the Department could get such data. Theresa answered that it would be difficult as the children served by these programs do not touch other children’s mental health or support systems like Medicaid.

Theresa spoke about the Autism Support Program (ASP) which provides funding for applied behavioral analysis services for children with autism who are not Medicaid eligible and do not have the service covered by their family health insurance. Theresa said there were changes in code last year that raised the age of eligibility to fourteen years instead of nine, and raised the income limit from 400% of the federal poverty level (FPL) to 500% FPL. The Department received thirty-one applications, of which fifteen were approved. There were three families who re-applied after the code changes, and were approved under the new rules. Theresa said the program gets an appropriation of $1.7 million and spent $356,000 in State Fiscal Year (SFY) 2016, and served thirty-three children. Theresa said the Autism Support Fund gets appropriated a total of $2 million, and the ASP is funded out of that. $250,000 goes to a program to help people become Board Certified Behavioral Analysts (BCBA), and there were two $25,000 grants that went to providers, Four Oaks in Cedar Rapids and Mercy in Dubuque.

Teresa Bomhoff asked if some of the unspent funds in the Autism Support Fund could be used to help Drake develop a program to educate and train behavioral analysts. Theresa answered that there has been an interest in it, and Drake University has advocated for itself. Currently the only school in Iowa with such a program is at Breyer Cliff.

Theresa spoke about the Certified Community Behavioral Health Clinics (CCBHC) project, and said Iowa has a planning grant that runs through June, 2017 but that Iowa was not granted a demonstration grant. There were nineteen applications and eight states received demonstration grants. Theresa said the Department will continue to move forward with their plans for the rest of the fiscal year providing trainings and technical assistance.

George Estle asked about free-standing health centers consolidating into systems, and if we knew how many were consolidating. Teresa Bomhoff asked if a Community Mental Health Center (CMHC) joins with a larger hospital system, are they still eligible to receive MHBG funds. Theresa Armstrong said yes, they were. They are still CMHCs and are still operating independently, but affiliated with a larger system.

Teresa Bomhoff asked if the funds requested in the Children’s Mental Health Study Report were going to come from the General Fund or from the MHBG. Theresa said the plan was for them to come from a General Fund appropriation like they were last year.

Tammy Nyden asked if the children’s mental health crisis planning grants were being replaced with the Children’s Wellbeing Collaboratives. Theresa answered that the recommendation in the report was to direct the funds that were a part of the status quo budget to develop the Wellbeing Collaboratives.
Teresa Bomhoff asked if the MHDS Regional Dashboards would be ready in February. Theresa Armstrong said the Department is working to validate the data, and does not have a first draft of the Dashboard yet.

Teresa Bomhoff asked about recommendations from the MHDS Redesign Progress Report, and if the Department plans to propose legislation to codify them. Theresa said the Department does not have plans to introduce any legislation regarding the report. There Department wrote the report as recommended and took the opportunity to include some additional information and recommendations.

There was a discussion about mental health workforce development.

Anna Killpack asked if there were any applications for subacute providers. Theresa Armstrong answered that there was one application from Hillcrest in Dubuque, and that the Department had reviewed their application, so they are awaiting approval from the Department of Inspections and Appeals.

Teresa Bomhoff asked about progress with Iowa’s new Olmstead Plan. Theresa Armstrong answered that Connie Fanselow is working with the Olmstead Consumer Taskforce on making the plan more accessible to the general population.

Teresa Bomhoff asked about the progress on re-writing Chapter 24 for the accreditation for mental health service providers. Theresa Armstrong answered that the re-writing process was put on hold for a few months due to a number of applications. Several providers who did not need to be accredited before now need to be in order to bill Medicaid, and so focus shifted to getting those providers approved.

Public Comment
Sharon Lambert had expressed concern about Medicaid MCOs owing money to providers.

The meeting was adjourned at approximately 3:23 pm.

Minutes respectfully submitted by Peter Schumacher
Chair Teresa Bomhoff called the meeting to order at 10:05 a.m. and led introductions. Quorum was established with fifteen members present and eight participating by phone.
Dennis Sharp made a motion to approve the March meeting minutes as presented. Jim Cornick seconded the motion. The motion passed unanimously.

**Testimonial for Rhonda Shouse – Todd Noack**
Todd Noack spoke about Rhonda Shouse, a Planning Council member who recently passed away, and her years of service and advocacy on behalf of people with mental illness and disabilities. Teresa Bomhoff said Rhonda will be missed as she was a testament to persistence.

**Monitoring and Oversight Committee**
Jim Rixner said the committee wanted to arrange a meeting in June to talk to Theresa Armstrong about the priorities of the Planning Council and to get a progress report on the ongoing projects within the Mental Health Block Grant (MHBG) contracts. Jim said he would like to see the Planning Council have more involvement.

Teresa Bomhoff noted that the Planning Council’s MHBG priorities were listed on the bottom of the agenda, and spoke about the division of the MHBG funds.

**New Mental Health Initiatives at Grinnell College – Tammy Nyden**
Tammy Nyden said she wrote an op-ed on Iowa’s Medicaid Managed Care Organizations (MCO).

Tammy said she will be teaching a course at Grinnell University that will focus on mental health and the school-to-prison pipeline. The course will teach students how to use data analysis tools and how to tell stories with data.

There was a discussion on educating children with Serious Emotional Disturbances (SED) and disabilities and disabilities, and the culture within schools.

**State and Federal Legislation – Teresa Bomhoff**
Teresa Bomhoff spoke about the American Health Care Act (AHCA) that was passed by the US House of Representatives, but said the Senate would write their own bill. Teresa Bomhoff discuss some of the points included in the AHCA including repealing the Medicaid expansion, elimination of essential health benefits, and the 5:1 ratio for premiums between older and younger people versus the Affordable Care Act’s 3:1 ratio.

Tammy Nyden asked about the Home and Community-Based Services (HCBS) waiver waiting lists for children and individuals with Intellectual Disabilities (ID). Teresa Bomhoff answered that the cost to serve individuals with intellectual disabilities is higher than the general population.

There was a discussion on Medicaid waivers.

Teresa Bomhoff spoke about Iowa’s health insurance marketplace for individual health insurance. Teresa said a reporter from the Huffington Post expressed interest in
speaking to Iowans who would not have access to private health insurance if all the private insurers in Iowa declined to offer individual market health insurance on the marketplace.

There was a discussion about advocating for better healthcare legislation for people with mental illness and disabilities.

Teresa spoke about a bill that mandates private insurance plans in Iowa to cover applied behavioral analysis services for children with autism. This applies to all plans that are subject to Iowa insurance regulations.

Teresa mentioned a bill that would eliminate the need for Judicial Mental Health Advocates to report how many hours they worked to the courts regularly. They would still submit this report if requested by the courts.

HF 593: is a bill that would allow Mental Health Professionals to sign off on mental health assessments for mental health or substance abuse commitments rather than just doctors.

There was a discussion of step therapy and medication management for people with disabilities.

Teresa mentioned that the Health and Human Services Appropriations Bill had been signed by the governor, and funding for Drake University’s behavioral analyst program had been line-item vetoed by the Governor, but that Drake was able to establish their program without the funding.

There was a discussion about IA Health Link and MHDS Regional funding.

Public Comment
There was no public comment.

The meeting was adjourned at approximately 12:10 pm.

Minutes respectfully submitted by Peter Schumacher
Re: FY2018-19 MHBG Plan for review

1 message

Fri, Sep 1, 2017 at 7:29 AM

Sharon Lambert <lambertsha@gmail.com>
To: "Nyden, Tammy" <NYDEN@grinnell.edu>
Cc: Kris Graves <kgraves@live.com>, Theresa Armstrong <tarmstr1@dhs.state.ia.us>, "Keller, Gary J [DOC]" <gary.j.keller@iowa.gov>, "Tilotta, Michele L [IDPH]" <michele.tilotta@idph.iowa.gov>, Jim Chesnik <jchesnik@dhs.state.ia.us>, Earl Kelly <earl.kelly@gmail.com>, "Anderson, Barbara J [ED]" <barb.anderson@iowa.gov>, Teresa Bomhoff <tbomhoff@mchsi.com>, Donna Richard-Langer <drlk@msn.com>, Todd Lange <todd.lange@amerigroup.com>, Kathleen Goines <kathleen@waubonsiemhc.com>, Jim Rixner <jwrx@aol.com>, Julie Kalambokidis <jkalambokidis@embracelawinc.com>, Josh McRoberts <josh.mcroberts@iowa.gov>, Anna Killpack <annakilpack@yahoo.com>, LeAnn Moskowitz <immoskow@dhs.state.ia.us>, Donnis Sharp <dennissharp2007@gmail.com>, "Kaufmann, Michael" <mkaufman@dhs.state.ia.us>, Jennifer Vitko <jvito@wapellocounty.org>, George Estle <george.estle@gmail.com>, "Maas, Julie" <jmaas@dhs.state.ia.us>, Jim Comick <jcomick65@gmail.com>, Carole Police <Carole.police@icloud.com>, "Larkin, Laura L" <llarkin@dhs.state.ia.us>, Tracy White <712tracy@gmail.com>, "Russo, Lee Ann [DVRS]" <leeanne.russo@iowa.gov>, Ken Briggs <kebriggs@earthlink.net>, Brenda Lechner <brenda.lechner@uhc.com>, "Swope, DJ [IDA]" <dj.swope@iowa.gov>, Kim Wilson <kwilson@co.clay.ia.us>, Todd Noack <noacktodd@gmail.com>, "Donoghue, James T [ED]" <jim.donoghue@iowa.gov>, Brad Richardson <brad-richardson@uiowa.edu>

Thank you Tammy for your very well stated review. You have covered my concerns in numbers-4,7,8,and, 15.

Seclusion in our schools is totally unacceptable, as is in our jails. It violates so many rules, and has been litigated successfully as a violation of eighth Constitutional Amendment.

7 and 8 discuss my concerns about the whole bed tracking system. Beds are not being accurately represented just showing numbers. I have personal experience with spending 17 hours in the emergency room at UI. We’re sent to Genesis, only to be released the next day.

Number 8 appropriately follows with having facilities shut down without providing alternatives. Especially finding help (outside of jail) for individuals in crisis.

15-school seclusion must be addressed and banned.

I feel that although we want to be positive, we should also be able to show areas of concerns.

Sharon

Again thank you Tammy for your hard work.

On Sep 1, 2017 4:31 AM, "Nyden, Tammy" <NYDEN@grinnell.edu> wrote:

Hi Laura,

Please find my comments on the report listed below and attached.

Tammy

SAMSHA comments

1. The state never developed a public awareness campaign about children’s mental health as recommended by the 2015 Children’s Mental Health Workgroup
2. NAMI does not offer the NAMI Parents and Teachers as Allies anywhere in Iowa
3. The report does not address or even mention the closings of the Toledo girls home, the two state mental health institutions, or the impact these are having in the state. Given the time frame that is discussed, these should be mentioned.
4. The report does not mention significant problems Iowa is having in its schools and jails regarding the abuse of seclusion and restraint as evidenced by court decisions (Iowa City schools), the ACLU petitioning of the state to change code, the DRI report on the jails and the DRI report on the boys juvenile home.
5. Please Pass the Love is not mentioned among the list of private services in the state (see their work on mental health in the schools)
6. On page 18 it says that people generally can get an inpatient bed within 2 hours of their residence. This should be backed by data, as it is merely stated and seems to go against what we have been hearing and experiencing on council.
7. Also in speaking about the bed tracking system, it claims to have streamlined the process without discussing the ongoing problems of getting beds.
8. Several times the report states that Iowa is moving away from residential care and toward community supports but does not specifically say or show any data about what community supports the state claims to be replacing the institutional care with. In other words it shuts down facilities without offering anything in its stead (but rhetoric).
9. Has the data on page 26 regarding the number of service providers been checked against the study Teresa Bornhoff worked on which shows extremely inaccurate reporting that inflated these numbers?
10. The statement on page 28 about how confusing the children’s [lack of a coherent] system is causing families not to know where to turn is true, but as it is currently worded it seems to imply that the problem is the families ability to navigate existing services, when the key problem for most in the state is the lack of services to begin with. (Only 14 counties have a system of care model – that is 86 counties that don’t!) This is problematic as the only major initiative the state has done for children in the redesign is the PIH teams, but help coordinating and navigating services that don’t exist is a shell game.
11. Say explicitly that BHIS is NOT available for children not covered by Medicaid. Not only is it not covered by private insurance, such families cannot access it at all.
12. On page 29 the claim of the reduction of numbers on the waiting list does not seem consistent with council discussions in the past few years – are these for all waivers overall? – Say specifically what the numbers are for the Children’s mental Health waiver and brain injury waiver. Say whether the wait time has increased. (How long individuals wait is not addressed at all here – it only says later that the wait can be over a year – but that was the case at the time of the last report, since then it has been up to three years – a significant difference that is not illustrated in the report)
13. It is not mentioned that the majority of kids on the children’s mental health waiver cannot access services listed on page 29 because they do not exist or are not enough in their area (e.g. respite care)
14. Iowa does not have an Iowa Federation of Families for Children’s Mental Health – this simply does not exist in our state. (There appears to be one non-profit which is registered as a local chapter but it is not clear that it is providing Federation services and it is clear that it is not providing services on a statewide level.
15. A concern that needs to be added on page 48 is the misuse of seclusion and restraint in the schools as shown by various reports and court cases
16. The report lists many things done by private organizations and does not indicate that any state or SAMSHA money or support went into these programs. Is this how most states do these reports? I worry that one can get the wrong impression that these things are done with the help of SAMSHA funds or state support, when often they are in spite of no state programming, particularly for
children. It is not explicitly stated that there is still not system in place for children, especially children not on Medicaid. It is only something one reads between the lines.

From: Maas, Julie <jmaas@dhs.state.ia.us>
Sent: Tuesday, August 29, 2017 12:32 PM
To: Anderson, Barbara J [ED]; Anna Killpack; Brad Richardson; Brenda Lechner; Carole Police; Dennis Sharp; Donna Richard-Langer; Donoghue, James T [ED]; Earl Kelly; George Estle; Jennifer Vitko; Jim Chesnik; Jim Cornick; Jim Rixner; Josh McRoberts; Julie Kalambokidis; Kathleen Goines; Kaufmann, Michael; Keller, Gary J [DOC]; Ken Briggs; Kim Wilson; Kris Graves; LeAnn Moskowitz; Russo, Lee Ann [DVRS]; Sharon Lambert; Swope, DJ [IDA]; Nyden, Tammy; Teresa Bornhoff; Tilotta, Michele L [IDPH]; Todd Lange; Todd Noack; Tracy White
Cc: Larkin, Laura L; Theresa Armstrong
Subject: FY2018-19 MHBG Plan for review

Dear MHPC members:

Attached is a link to the FY2018-19 MHBG State Behavioral Health Assessment and Plan for your review and comment. As you are reviewing you may see some pages that are not complete; these are pages that are requested and not required. They are marked as such as the top of each section.

Comments on the plan can be sent to Laura Larkin at llarkin@dhs.state.ia.us by 12pm (noon) Friday, September 1 for inclusion in the final plan to be submitted to SAMHSA by end of day on September 1.

Here is the link:


Thank you to the MHPC members who helped with gathering information and provided input during the development of the plan. Your assistance and information is always appreciated.

Thank you,
Laura Larkin

Julie Maas
Department of Human Services
Division of Mental Health and Disability Services
1305 E. Walnut
Des Moines, IA 50319
(515) 281-3785
MHBG app Julie M sent out to MHPC
1 message

Donoghue, Jim <jim.donoghue@iowa.gov>  Tue, Aug 29, 2017 at 2:04 PM
To: llarkin@dhs.state.ia.us, "Maas, Julie" <jmaas@dhs.state.ia.us>

Laura,
I was surprised to read that HeartMath is considered an EBP or best practice.
I'd never heard of it so I tried to read more. It's no in SAMHSA EBPP directory and the research appears to be 3 papers cited in Cochrane, and the rest is from the HeartMath Institute.
So I'd be interested to know who awarded it the status of EBP or best practice. Thanks, Jim

Jim

---
Jim Donoghue, Education Program Consultant
Bureau of Finance, Facilities, Operation and Transportation Services
Iowa Department of Education
Des Moines, IA 50319-0146
(515) 281-8505 (office)
(515) 326-1032 (cell)

Regular office hours: M-F 8:00 AM - 4:30 PM
## Behavioral Health Advisory Council Members

<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>Teresa Bomhoff</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</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>Kenneth Briggs, Jr.</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
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<td><a href="mailto:kebriggs@earthlink.net">kebriggs@earthlink.net</a></td>
<td></td>
</tr>
<tr>
<td>Jim Chesnik</td>
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<td><a href="mailto:jchesni@dhs.state.ia.us">jchesni@dhs.state.ia.us</a></td>
<td></td>
</tr>
<tr>
<td>Jim Cornick</td>
<td>Others (Not State employees or providers)</td>
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<td><a href="mailto:jcornick@mchsi.com">jcornick@mchsi.com</a></td>
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</tr>
<tr>
<td>Jim Donoghue</td>
<td>State Employees</td>
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<tr>
<td>George Estle</td>
<td>Others (Not State employees or providers)</td>
<td>3163 Westview Drive NE Solon IA, 52333 PH: 319-360-9468</td>
<td><a href="mailto:george.estle@gmail.com">george.estle@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Kathleen Goins</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>129 West High Street Villisca IA, 50864</td>
<td><a href="mailto:Kathleen@waubonsiemhc.com">Kathleen@waubonsiemhc.com</a></td>
<td></td>
</tr>
<tr>
<td>Kris Graves</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>2631 Lakeside Drive Iowa City IA, 52240 PH: 319-383-4488</td>
<td><a href="mailto:kgraves@live.com">kgraves@live.com</a></td>
<td></td>
</tr>
<tr>
<td>Julie Kalambokidis</td>
<td>Parents of children with SED</td>
<td>6 North Hazel Glenwood IA, 51534 PH: 712-527-4188</td>
<td><a href="mailto:JKalambokidis@EmbracelowInc.com">JKalambokidis@EmbracelowInc.com</a></td>
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<tr>
<td>Michael Kaufmann</td>
<td>State Employees</td>
<td>Independence Mental Health Institute Independence IA, 50644 PH: 319-334-2583</td>
<td><a href="mailto:MKaufma@dhs.state.ia.us">MKaufma@dhs.state.ia.us</a></td>
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<tr>
<td>Dr. Gary Keller</td>
<td>State Employees</td>
<td>Iowa Department of Corrections</td>
<td><a href="mailto:gary.j.keller@iowa.gov">gary.j.keller@iowa.gov</a></td>
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<tr>
<td></td>
<td></td>
<td>2919 Druid Hill Drive</td>
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</tr>
<tr>
<td>Name</td>
<td>Category</td>
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<tr>
<td>Earl Kelly</td>
<td>Others (Not State employees or providers)</td>
<td>Des Moines IA, 50315</td>
<td>515-288-9646</td>
<td><a href="mailto:earlvpkelly@gmail.com">earlvpkelly@gmail.com</a></td>
</tr>
<tr>
<td>Anna Killpack</td>
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<td>32356 270th St. Neola IA, 51559</td>
<td>712-485-2016</td>
<td><a href="mailto:annakillpack@yahoo.com">annakillpack@yahoo.com</a></td>
</tr>
<tr>
<td>Sharon Lambert</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>719 13th Ave Coralville IA, 52441</td>
<td>563-499-3502</td>
<td><a href="mailto:Lambertsha@gmail.com">Lambertsha@gmail.com</a></td>
</tr>
<tr>
<td>Todd Lange</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>225 West 6th Street Dubuque IA, 52001</td>
<td>563-564-2933</td>
<td><a href="mailto:tjlane1@yahoo.com">tjlane1@yahoo.com</a></td>
</tr>
<tr>
<td>Brenda Lechner</td>
<td>Parents of children with SED</td>
<td>406 7th Street West Des Moines IA, 50265</td>
<td>515-343-6699</td>
<td><a href="mailto:brenda.lechner@uhc.com">brenda.lechner@uhc.com</a></td>
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<tr>
<td>Josh McRoberts</td>
<td>State Employees</td>
<td>Iowa Finance Authority</td>
<td>515-725-4927</td>
<td><a href="mailto:josh.mcroberts@iowa.gov">josh.mcroberts@iowa.gov</a></td>
</tr>
<tr>
<td>LeeAnn Moskowitz</td>
<td>State Employees</td>
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<td>515-256-4653</td>
<td><a href="mailto:lmoskow@dhs.state.ia.us">lmoskow@dhs.state.ia.us</a></td>
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<tr>
<td>Todd Noack</td>
<td>Parents of children with SED</td>
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<td>563-726-3244</td>
<td><a href="mailto:Todd.noack@ocaioawa.org">Todd.noack@ocaioawa.org</a></td>
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<tr>
<td>Tammy Nyden</td>
<td>Parents of children with SED</td>
<td>NAMI</td>
<td>52245</td>
<td><a href="mailto:namiowacmhc@mediacombb.net">namiowacmhc@mediacombb.net</a></td>
</tr>
<tr>
<td>Harry Olmstead</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1259 Shannon Drive, Apt. 326 Iowa City IA, 52246</td>
<td>319-855-2666</td>
<td><a href="mailto:Harry03@aol.com">Harry03@aol.com</a></td>
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<tr>
<td>Carole Anne Police</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>104 3rd Street Apt. 6 Neola IA, 51559</td>
<td>712-485-2016</td>
<td><a href="mailto:carolepolice@wiaw.net">carolepolice@wiaw.net</a></td>
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<tr>
<td>Donna Richard-Langer</td>
<td>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>
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<tr>
<td>Brad Richardson</td>
<td>State Employees</td>
<td>University of Iowa School of Social Work</td>
<td>52242-5000</td>
<td><a href="mailto:Brad-richardson@uiowa.edu">Brad-richardson@uiowa.edu</a></td>
</tr>
<tr>
<td>James W. Rixner</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>114 Midvale Avenue Sioux City IA, 51104</td>
<td>712-258-7855</td>
<td><a href="mailto:jwx@aol.com">jwx@aol.com</a></td>
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<tr>
<td>Lee Ann Russo</td>
<td>State Employees</td>
<td>Iowa Vocational Rehabilitation Services</td>
<td>50319</td>
<td><a href="mailto:Leeann.russo@iowa.gov">Leeann.russo@iowa.gov</a></td>
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<tr>
<td>Dennis Sharp</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1104 River Drive South Sioux City IA, 51109</td>
<td>515-281-4144</td>
<td><a href="mailto:Dennissharp2007@yahoo.com">Dennissharp2007@yahoo.com</a></td>
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<td>D.J Swope</td>
<td>State Employees</td>
<td>Iowa Department on Aging</td>
<td>510 E, 12th Des Moines IA, 50319</td>
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<td>Michele Tilotta</td>
<td>State Employees</td>
<td>Iowa Department of Public Health, Division of Behavioral Health</td>
<td>321 E. 12th Street Des Moines IA, 50319</td>
<td>712-899-2809</td>
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<tr>
<td>Jennifer Vitko</td>
<td>Others (Not State employees or providers)</td>
<td>South Central Iowa Behavioral Health Region</td>
<td>102 E. Main Box 217 Ottumwa IA, 52501</td>
<td>515-371-1564</td>
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<tr>
<td>Tracy White</td>
<td>Parents of children with SED</td>
<td></td>
<td>901 W. Tarkio St. Clarinda IA, 51632</td>
<td>712-542-7492</td>
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<tr>
<td>Kimberly Wilson</td>
<td>Others (Not State employees or providers)</td>
<td></td>
<td>2510 320th Street Spencer IA, 51301</td>
<td>712-262-9438</td>
</tr>
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**Footnotes:**
### Environmental Factors and Plan

**Behavioral Health Council Composition by Member Type**

Start Year: 2018  
End Year: 2019

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<th>Type of Membership</th>
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<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
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<td>have received, mental health services)</td>
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<td>Others (Not State employees or providers)</td>
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<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
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<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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</tr>
<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Footnotes:**
Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings? [ ] Yes [ ] No
   
   b) Posting of the plan on the web for public comment? [ ] Yes [ ] No
   
   c) Other (e.g. public service announcements, print media) [ ] Yes [ ] No

   If yes, provide URL:
   
   http://dhs.iowa.gov/mhds-providers/providers-regions/block-grant

Footnotes: