Iowa

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/23/2023 1.27.21 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	S47QLSY37VS1

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

Agency Name	Iowa Department of Public Health
Organizational Unit	Division of Behavioral Health
Mailing Address	321 E. 12th St.
City	Des Moines
Zip Code	50319-0075

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	DeAnn
Last Name	Decker
Agency Name	Iowa Department of Public Health
Mailing Address	321 E. 12th St.
City	Des Moines
Zip Code	50319-0075
Telephone	515-281-0928
Fax	515-281-4535
Email Address	deann.decker@idph.iowa.gov

State CMHS Unique Entity Identification

Unique Entity ID	Q7P9B28J8BY4

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

Agency Name	Iowa Department of Human Services
Organizational Unit	Division of Mental Health and Disability Services
Mailing Address	321 E 12th Street
City	Des Moines
Zip Code	50319

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Marissa
Last Name	Eyanson
Agency Name	Iowa Department of Human Services
Mailing Address	321 E 12th Street, 5th Floor
City	Des Moines

Zip Code	50319-0114
Telephone	515-901-7598
Fax	
Email Address	meyanso@dhs.state.ia.us

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Justin
Last Name	Edwards
Telephone	5152143693
Fax	
Email Address	justin.edwards@idph.iowa.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Kelly Garcia

Signature of CEO or Designee[1]: _____

Title: Director, Iowa Department of Health and Human Services

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

August 4, 2023

Substance Abuse and Mental Health Services Administration
Division of Grants Management
5600 Fishers Lane
Rockville, MD 20857

To Whom It May Concern:

As the Governor of the State of Iowa, for the duration of my tenure I delegate authority to the current Director of the Iowa Department of Health and Human Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following Substance Abuse and Mental Health Services Administration (SAMHSA) programs:

- Mental Health Block Grant (MHBG)
- Substance Use, Prevention, Treatment and Recovery Services (SUPTRS) Block Grant
- Projects for Assistance in Transitioning from Homelessness (PATH) Grant

Please contact my office if additional information is needed.

Sincerely,

Kim Reynolds
Governor

State Information

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

Fiscal Year 2024

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Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
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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.
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8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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 Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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: Kelly Garcia

Signature of CEO or Designee[1]: _____

Title: Director, Iowa Department of Health and Human Services

Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Table of Contents:

I. THE STATE MENTAL HEALTH AUTHORITY AND THE SINGLE STATE AUTHORITY

The Iowa Department of Health and Human Services (Iowa HHS) under the leadership of Director Kelly Garcia is the designated State Mental Health Authority (SMHA) and designated Single State Authority for Substance Use Prevention, Treatment, and Recovery Services (SSA) for Iowa. Previously these two authorities were housed in two separate state agencies, the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH). Legislation passed in 2022 codified the alignment of DHS and IDPH into Iowa HHS. SFY23 was identified as a transition year with the transition to Iowa HHS to be complete by July 1, 2023. As part of a new organizational structure of state government, effective July 1, 2023 additional state agencies became part of Iowa HHS. This included the Departments of Human Rights, the Department on Aging, Volunteer Iowa, the Iowa Child Advocacy Board, and Early Childhood Iowa. The new table of organization is at this link. https://hhs.iowa.gov/sites/default/files/HHS-Functional-Table-of-Organization.pdf

As a result of the alignment between the state agencies, mental health and substance-related programs are now housed together within the new Division of Behavioral Health (DBH). Marissa Eyanson is the state Behavioral Health Director and reports directly to Iowa HHS Director Garcia. In the state's previous plan submitted in September 2021, the process to begin aligning these two state agencies into one was described. This included the two authorities working together on common block grant goals for the FY22-23 applications although separate applications were submitted. This is the first year that the state has submitted a combined Block Grant application.

II. ORGANIZATION OF THE PUBLIC BEHAVIORAL HEALTH SYSTEM FOR CHILDREN AND ADULTS

The Iowa system of behavioral health services for adults and children with mental illness and substance-use disorders is managed and funded in various ways depending on an individual's income, insurance coverage, and service needs. This section addresses state agencies' responsibilities for mental health and substance-use disorder prevention, treatment, and recovery services. Services specifically for children will be identified throughout this section.

A. Iowa Department of Health and Human Services, Division of Behavioral Health

DBH provides leadership and sets the direction of state policy for the system of behavioral health services in Iowa. DBH includes the following bureaus:

- Services, Planning and Performance (includes oversight of the MHBG and SUPTRS Block Grants)
- Operations and Compliance

DBH plans for and oversees the provision of behavioral health prevention, treatment and recovery services and supports for children and adults with a wide range of conditions, including mental illness, serious mental illness, serious emotional disturbance, substance use disorders, and problem gambling. The division distributes and oversees the use of federal and state funding through contracts with providers or other agencies that offer services or coordinate projects that promote the division's goals. This includes oversight and distribution of

federal funds received through the Community Mental Health Block Grant (MHBG), the Substance Use Prevention, Treatment, and Recovery Supports (SUPTRS) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH) grant. DBH also manages other federal grants and projects including 988 Implementation, CCBHC Planning grant, State Opioid Response grants, Overdose Data to action, State Pilot Program for Treatment for Pregnant and Post-partum Women, and the Iowa Treatment for Individuals Experiencing Homelessness grant, among others.

DBH, through its SUPTRS Block Grant funded project, the Integrated Provider Network (IPN), contracts with 16 local agencies, through 23 contracts, to provide substance use and problem gambling prevention, treatment, and recovery services in nineteen service regions that together serve Iowans in all 99 counties. All contracted providers are licensed by Iowa HHS.

DBH works with service providers to assure quality by setting standards certain facilities and services that are provided to adults and children with mental illness, intellectual disabilities, developmental disabilities and brain injury and evaluating how well those standards are met through an accreditation process. DBH also licenses providers of substance use disorder services, including outpatient services and residential treatment.

DBH staff collaborate with mental health and disability services (MHDS) regional CEOs to ensure communication across the system regarding policy issues, service delivery and coverage, and coordination with other entities such as the MCOs and public health. DBH contracts with the MHDS Regions to distribute state funds for required mental health and disability core services and approve regional service and budget plans. DBH staff provide technical assistance and consultation to the regions both in the field or via phone or email as needed. The type of assistance varies from region to region as they continue to expand the array of services provided and the use of evidence-based practices (EBPs).

DBH houses the state disaster behavioral health coordinator and oversees and implements FEMA crisis counseling programs for persons affected by disasters as well as a volunteer Disaster Behavioral Health Response Team that can deploy quickly to assist with immediate behavioral health needs during a disaster or other traumatic event.

DBH works collaboratively with other state agencies to promote integrated employment options for individuals with disabilities, including mental illness.

DBH provides staffing and coordination to the state Mental Health and Disability Services Commission, Children's Behavioral Health System State Board, and the Mental Health Planning and Advisory Council.

When directed by legislation or other mandates, DBH organizes and facilitates workgroups designed to address behavioral health system gaps and barriers. Workgroups are typically comprised of other state agency staff, advocates, stakeholders, service providers, Iowans with lived experience and their family members.

DBH leads, funds, monitors and supports statewide substance abuse prevention, treatment, and recovery efforts. DBH is responsible for comprehensive statewide planning, coordination, delivery, monitoring and evaluation of substance abuse treatment, recovery supports and prevention services including: collaboration at local, state and national levels on prevention initiatives and policy; community- based activities, coalitions, and programs; data management and reporting; evidence-based curricula and models; prevention practitioner training and workforce development; and public and professional information and education at: www.yourlifeiowa.org.

DBH provides technical assistance to individuals, groups, and contracted agencies and organizations; coordinates and collaborates with multiple state agencies and organizations for assessment, planning, and implementation of statewide prevention initiatives; and coordinates, trains, and monitors funding to local community-based organizations for alcohol, tobacco, and other drug prevention services.

The new alignment of DBH has integrated tobacco, mental health, and substance use activities in one division. Alcoholic Beverages is now aligned with the Department of Revenue but work and partnership will continue to collect SYNAR-related information.

B. Collaboration with other HHS Divisions

DBH works collaboratively with other Iowa HHS divisions regarding behavioral health services. Other HHS divisions that are connected to the behavioral health system include the following:

1. State-Operated Facilities Division
   This division includes the following facilities:

   - The Civil Commitment Unit for Sexual Offenders (violent sexual predators)
   - 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-transitioning to a focus on specialized treatment and security for adults ordered by the court into the custody of the state for the purposes of competency restoration, adults who have been acquitted of a crime by reason of insanity, and similarly situated adults
     - Independence Mental Health Institute-transitioning to a focus on specialized treatment of behaviorally complex children and youth.
   - Eldora State Training School-for juvenile males adjudicated delinquent

2. Iowa Medicaid

Medicaid (including the Hawki program for children) is a primary funder of behavioral health services for Iowans. Effective January 1, 2014, Iowa expanded Medicaid through the Iowa Health

and Wellness Plan (IHWP) for individuals ages 19-64 with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. IHWP-eligible individuals receive a limited set of mental health services. Individuals eligible for IHWP coverage and deemed "medically exempt", which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions may choose between IHWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services, integrated health home care coordination, and other community-based supports not available under the IHWP plans. Access to state-plan Medicaid for the medically exempt IHWP-eligible population has increased access to services for individuals with serious mental health conditions.

The Department implemented the IA Health Link managed care program for the majority of the Medicaid and Hawki (the State Children's Health Insurance Program) population on April 1, 2016. Most Medicaid members are served by three managed care organizations (MCOs); Amerigroup, Iowa Total Care, and Molina. Iowa Medicaid continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care. Iowa HHS has contracted with MCOs to provide comprehensive health care services including physical health, pharmacy, behavioral health, and long term supports and services. This single system of care promotes the delivery of efficient, coordinated and high quality health care and established accountability in health care coordination.

3. Family Well-Being and Protection

This division administers adoption subsidies for families who adopt children with special needs. Special needs can include mental health needs. The subsidy can include financial payments to help meet the child's needs and provides eligibility to Medicaid. Family Well-Being and Protection also provides child welfare services to families and children who are either at risk for abuse or have experienced abuse and been adjudicated a child in need of assistance. These services can include mental health treatment and supports if needed. Children in foster care are eligible for Medicaid and can access the full array of Medicaid-funded mental health services. Services are also provided to youth aging out of the foster care system to assist in a successful transition to adulthood.

4. Aging and Disability Services

This is a new division within Iowa HHS that includes services and supports for persons age 60 and older as well a focus on community integration and services for persons with disabilities. Disability-focused services previously included within the legacy DHS Mental Health and Disability division will now be located within this new division. The PASSR program and supported employment services for persons with a disability are now located within this division but DBH and Aging and Disability staff will continue to collaborate closely on behavioral health services and supports. The division also operates Iowa's Aging and Disability Resource Center (ADRC) which helps older Iowans, adults with disabilities, veterans, and caregivers learn more about long-term living services and supports is coordinated through this division.

C. Iowa Department of Education (DE)

The Iowa Department of Education (DE) works collaboratively with Iowa HHS to support behavioral health services for children. The director of the DE is the co-chair, along with the director of Iowa HHS, of the Children's Behavioral Health System State Board. This board's mission is to provide guidance on the implementation and management of a children's behavioral health system for the provision of services to children with a serious emotional disturbance. The involvement of the DE with the development of the children's behavioral system informs stakeholders of the effect of children's mental health needs on the education system and encourages cross-system integration of services and supports for children.

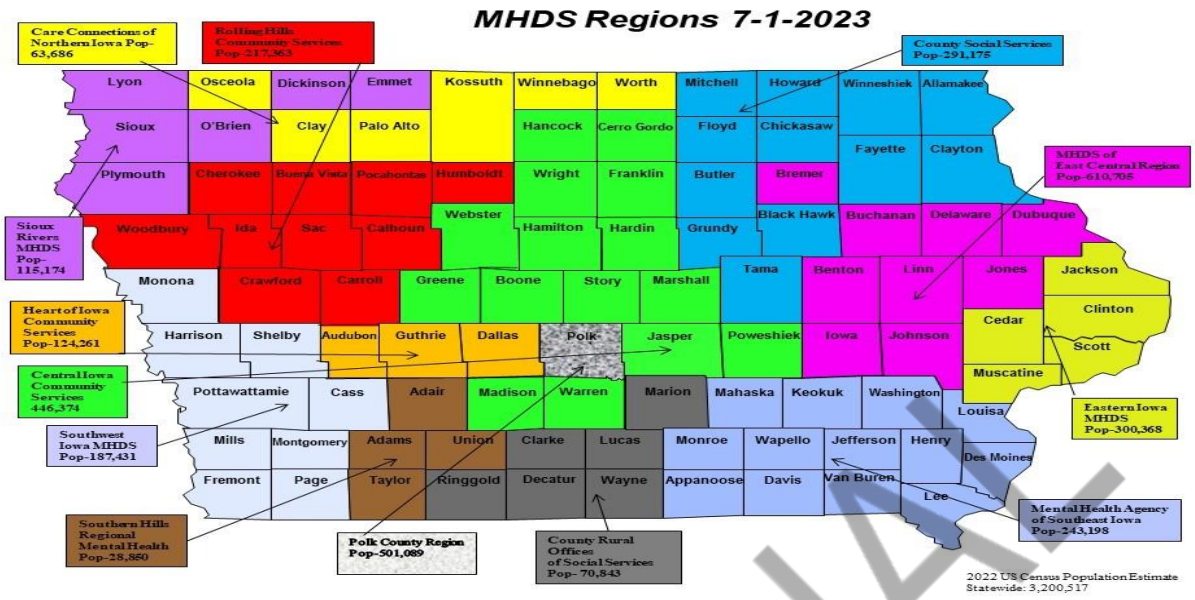
In 2020, Senate File 2360 was signed by the Governor. This implemented a therapeutic classroom grant program for Iowa schools. Schools could apply for competitive grants to establish therapeutic classrooms to assist students whose "emotional, social, or behavioral needs interfere with the student's ability to be successful in the current education environment…" Therapeutic supports include such things as social-emotional skill building, skills to cope with stress and trauma, mental health treatment and crisis intervention and follow-up. For the 2022-23 school year, 10 school districts were awarded grants to establish therapeutic classrooms. A third round of grants is being funded for the 2023-24 school year.

In 2021, the DE in partnership with the University of Iowa established the Scanlan Center for School Mental Health. The center's focus is on expanding support for mental health of students and educators, including training, resources, and outreach to educators and schools statewide. Services to be provided include crisis response services, short term counseling for students and staff, face-to-face and online training and coaching for teachers, and research-to-practice related to mental health.

D. MHDS Regional System for Adults and Children

In 2015, Iowa transitioned from a county-based system to a regional system for mental health and disability services. Services are required to be regionally managed and locally available, in compliance with statewide standards. Changes from the previous county-based system included the provision of standardized core services with defined access standards.

Under the regional MHDS system, regions of at least three counties 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 12 regions are comprised of groups of 3 to 15 counties. As of July 1, 2022, MHDS Regions are funded by 100% state dollars and contract with the state to deliver required core services and evidence-based practices as well as implement additional core services and share administrative responsibilities.



Iowa's 13 MHDS regions are required to provide access to the core services listed below. Regions are responsible for funding those services for residents that meet financial guidelines when no other funding is available through Medicaid or private insurance.

MHDS Regions are to ensure that the following services are available for adults in their regions:

- Access centers.
- Assertive community treatment.
- Assessment and evaluation.
- Case management.
- Crisis evaluation.
- Crisis stabilization community-based services.
- Crisis stabilization residential services.
- Day habilitation.
- Family support.
- Health homes.
- Home and vehicle modification.
- Home health aide.
- Intensive residential service homes.
- Job development.
- Medication prescribing and management.
- Mental health inpatient treatment.
- Mental health outpatient treatment.
- Mobile response.
- Peer support.
- Personal emergency response system.
- Prevocational services.

- Respite.
- Subacute mental health services.
- Supported employment.
- Supportive community living.
- Twenty-four-hour access to crisis response.
- Twenty-three-hour crisis observation and holding.

Regions are also developing and funding additional core services such as civil commitment pre-screening, and jail diversion when funds are available. Regions are also supporting development of crisis services using telehealth in rural areas where mental health professionals may not be available. The regions, the MCOs, and Iowa HHS 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.

In 2019, as a result of the passage of HF 690, the development of a children's behavioral health service system was added to the regions' responsibilities. Most of the children's services will be funded by Medicaid and other private insurance.

MHDS Regions are required to fund core services for children with a serious emotional disturbance (SED) whose families meet the financial guidelines of income between 150-500% of federal poverty level. Core services for children with an SED include:

- Assessment and evaluation relating to eligibility for services.
- Behavioral health inpatient treatment.
- Behavioral health outpatient therapy.
- Crisis stabilization community-based services.
- Crisis stabilization residential services.
- Early identification.
- Early intervention.
- Education services.
- Medication prescribing and management.
- Mobile response.
- Prevention.

In 2021, the legislature passed SF 619 which transitions the MHDS Regions to funding by state dollars through a standing appropriation and ends the authority of counties to levy for mental health and disability services after FY2022. This includes an incentive fund to help reimburse for reductions that result from the shift in funding, and to promote quality outcomes in regional services. Performance-based contracts will provide guardrails to assure that state funding is being used properly. The goal is a more equitable mental health system, allowing regions to develop services in areas that are currently lacking, and to provide additional new and potentially innovative services.

In 2023, the legislature passed HF 471 which made revisions to regional governance structure limiting representation of county elected officials to no more than 49 percent of the governing board membership. The intent was to provide a better balance between elected county officials

and other stakeholders such as persons who utilize MHDS services and their families, advocates, and providers. The legislation also added representatives from law enforcement and the judicial system and clarified that all board members are allowed to vote. Additionally, the legislation required regions to develop and fund a new Core service, Outpatient Competency Restoration, which is designed for people who are found incompetent to stand trial and are court-ordered to participate in treatment to restore competency.

E. Substance Use and Problem Gambling Services Integrated Provider Network

The Substance Use and Problem Gambling Services Integrated Provider Network (IPN) contracts with 16 local agencies, through 23 contracts, to provide substance use and problem gambling prevention, treatment, and recovery services in 19 service areas that together serve Iowans in all 99 counties. All contracted providers are licensed by Iowa HHS.

The IPN offers services statewide to individuals at or below 200% of the Federal Poverty Level guidelines. IPN services are funded by the State General Fund appropriation for substance use and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant. IPN contractors were selected in 2018 through a competitive Request for Proposals process and began providing services January 1, 2019.

IPN funds the following services:

- Network Support
- Substance Misuse and Problem Gambling Prevention
- Substance Use and Problem Gambling Treatment
- Medication for Opioid Use Disorder

IPN Service Area Map (Revised June, 2023)

F. Legislation Affecting the Public Behavioral Health System

1. 2022 Legislative Session:

Legislation related to behavioral health providers, services and programs included the following:

- HF 2246 allowed provisional licensure of psychologists.
- HF 2456 authorized funding of a tiered rate for inpatient psychiatric intensive care for individuals with complex needs was also authorized
- HF 2549 created a loan repayment program for mental health professionals
- HF 2578 enacted the transition process for the Iowa Departments of Human Services and Public Health to become the Iowa Department of Health and Human Services effective July 1, 2023 as described in Section I.

2. 2023 Legislative Session:

Legislation related to behavioral health providers, services and programs included the following:

- HF 93 prohibited agreements that limited where mental health professional could practice

- HF 183 clarified requirements for prescribing psychologists,
- HF 274 provided support for psychiatric residencies and fellowships in Iowa and requires that a portion of the residency and fellowship is completed at specified state facilities.
- HF 471 directed the state Mental Health Institutes to provide specialized services to certain populations including individuals with complex needs and individuals court-ordered for competency restoration. See above paragraph in regional section on changes in HF 471 related to the MHDS regions,
- HF 671 authorized Iowa to join a national professional counselors licensing compact which will enable licensed counselors to practice across state lines.
- SF 561 allocated $13,000,000 to increase reimbursement rates for mental health and substance use disorder providers. Increases were directed to individual mental health therapy providers, mental health providers, and substance use disorder providers.

G. Consumer Advocacy Organizations

1. Access for Special Kids (ASK) Family Resource Center

ASK identifies its primary focus as offering advocacy, training, resources, and supports for the benefit of individuals with disabilities and their families throughout the state of Iowa. ASK operates the Parent Training and Information (PTI) Center of Iowa and the Family 2 (F2F) Health Information Center. PTI helps parents, families, and students with disabilities understand their civil rights regarding early intervention services and special education supports so that they can be strong self-advocates. F2F provides a central resource for families of children and young adults with special healthcare needs and disabilities to obtain supports, advocacy, and information.

2. 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.

Besides the state office, Iowa has 14 local affiliates. Each local affiliate offers a variety of educational activities and support groups for individuals, 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 of NAMI is to advocate at the county, state and national levels for non-discriminatory access to quality healthcare, housing, education and employment for people with mental illness. Activities include:

- Educate the public about mental illness.
- Advocate for a comprehensive mental health system that provides effective and timely services for those struggling with mental health.
- Support those with mental illness, their loved ones and providers.

3. The Office of Recovery Services (ORS)

Iowa HHS funds the Office of Recovery Services through the Community MHBG.
The Office of Recovery Services (ORS) connects Iowans with resources and referrals to mental health and substance use services and supports. The ORS works with people with lived experience who are in recovery from mental health and/or substance use challenges and their family members and community.

The ORS provides a voice within state government for people with mental illness and their and people with substance use challenges and their family members. The ORS provides education and awareness opportunities through their website, social media, and phone support systems. The ORS is guided by a statewide advisory committee made up of peers and family members who meet regularly to guide the mission and elevate concerns to the Iowa Health and Human Service.

https://namiiowa.org/resources/iowa-office-of-recovery-services/

H. Certified Community Behavioral Health Clinic (CCBHC) Planning Grant

In March of 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Iowa HHS a one-year, $1 million, planning grant to develop Iowa's Certified Community Behavioral Health Clinics (CCBHC) program. Iowa was one of 15 states chosen to participate in this highly competitive planning grant cycle. CCBHCs are specially designed clinics modeled to comprehensively and collaboratively address patient needs relating to mental health and substance use disorders.

Iowa HHS has developed a Community Stakeholder Engagement committee made up of individuals with lived experience, family members, advocates, behavioral health providers and other stakeholders to advise the state on development of the state's CCBHC program. A series of public meetings was held in July 2023 to gather input from community members across the state on the strengths and needs of Iowa's behavioral health system. This information will help inform the development of Iowa's CCBHC program.

Iowa HHS is actively working across divisions, with multiple state departments and with stakeholders. Activities are focused on developing Iowa's CCBHC certification processes and requirements, development of a prospective payment system (PPS) and rate, statewide coordination of CCBHC effort and defining and refining data collection.

https://hhs.iowa.gov/mhds/mental-health/ccbhc

III. THE CONTINUUM OF SERVICES

A. Prevention

1. Substance Misuse Prevention

Iowa funds Primary Prevention activities through the Substance Use Block Grant via the Integrated Provider Network, certain State legislative appropriations, and other federal discretionary grants. Prevention services are based on a multi-strategic approach, encompassing

all six of the CSAP primary prevention strategies. Iowa's Prevention activities comply with the Institute of Medicine Prevention Classifications, and are driven by the Strategic Prevention Framework and Iowa Epidemiological Profile, which is reviewed and discussed regularly by the State Epidemiological Workgroup and Prevention Partnerships Advisory Council (SEWPPAC). Through Iowa's Substance Use Block Grant funded project, the Integrated Provider Network, Iowa assures Primary Prevention activities are provided in all 99 counties.

2. 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 behavioral health 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 behavioral health conditions and appropriate interventions, as well as to improve quality and capacity of the behavioral health provider community. The MHDS regions are also strong supporters of community education with several regions supporting Mental Health First Aid and Youth Mental Health First Aid trainings for their communities and other training in evidence-based practices. CMHCs also use MHBG funds to support training of staff in EBPs for children with an SED and adults with SMI, and also provide education to community members on mental health topics.

3. EBP training and services in FY23 by the CMHCs

- Acceptance and Commitment Therapy
- Assertive Community Treatment
- Cognitive Behavioral Therapy/Trauma Focused Cognitive Behavioral Therapy
- DBT EMDR
- Emotionally Focused Therapy
- Mental Health First Aid/Youth Mental Health First Aid/Teen Mental Health First Aid
- Multi-Systemic Therapy
- NAVIGATE
- Parent Child Interactive Therapy
- Peer Support Training
- Play Therapy
- QPR
- Seeking Safety
- Theraplay
- WRAP

4. Training for Crisis Providers

In December 2021, Iowa HHS was awarded a Transformation Transfer Initiative (TTI) Grant from the National Association of State Mental Health Program Directors (NASMHPD) to implement a workforce training and technical assistance initiative for providers of behavioral health crisis services with an emphasis on specific populations. Iowa HHS identified two populations: children and families experiencing crisis and individuals who identify as LGBTQ, as the populations of focus for this project.

- A standardized training toolkit has been developed to assist Iowa's 988 and crisis behavioral health providers in serving children and individuals who identify as LGBTQ+.
- The goal of the project is to promote all parts of the crisis system collaboratively working together to serve both populations during crisis.

This training toolkit offers two tracks for crisis service providers. One track addresses working with children and families experiencing crisis, and the other track addresses providing crisis services for individuals who identify as LGBTQ+. There are also trainings that apply to both tracks and are considered "universal" for all 988 and crisis behavioral health providers. This toolkit will:

- Strengthen the quality of services provided through Iowa's 988 and crisis system for children and individuals who identify as LGBTQ+, and all Iowans with a serious emotional disturbance (SED) or serious mental health (SMI).
- Help crisis service staff provide culturally competent care and communicate the lessons learned through the toolkit.

DBH is expanding Relias online behavioral health education, currently available to SUD providers, to CMHCs in the coming year. Relias offers staff compliance training and continuing education for behavioral health, developmental disability, community action, and child welfare organizations. The Relias LMS also assists providers track and manage courses provided and completed by provider staff.

Iowa HHS offers the annual Governor's Conference on Substance Use Prevention, Treatment, and Recovery Services. The purpose of this conference is to establish a meaningful dialogue among health professionals by focusing on trending topics, best practices, and strategies for addressing barriers in behavioral health. The scope of the conference includes provision of education to enhance knowledge of the behavioral health workforce, development of strength within each system discipline, and increasing of collaboration between system partners for coordinated response to substance use and problem gambling challenges. Attendance is encouraged for any professional in the behavioral health field, however all who have an interest in the content are welcome.

Iowa HHS offered a Suicide Prevention Webinar Series in 2022 and 2023. These are free sessions available to the public, including individuals, family members, professionals and community organizations to help raise awareness about suicide prevention. Sessions have focused on Iowa's crisis services continuum, suicide prevention response for Iowa agriculture, the CALM (Counseling on Access to Lethal Means), and support to suicide loss survivors.

5. Adverse Childhood Experiences (ACEs)

The 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/

6. Mental Health First Aid and Youth 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, has received several federal Project AWARE grants which have added significant capacity for Youth MHFA instruction across the state.

Since 2008, 59,990 Iowans have been trained in MHFA. In Iowa, there are certified Mental Health, Youth and Teen Mental Health First Aid instructors available to provide in-person or online training. The instructors are located across the state in a variety of settings including MHDS regions, health care facilities, higher education, local law enforcement, regional MHDS staff, 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.

7. Mindspring Mental Health Alliance (formerly NAMI-Greater Des Moines)

Mindspring offers a monthly schedule of webinars on topics related to mental health and self-care. Webinars are free and open to anyone. mindspringhealth.org

8. NAMI:

NAMI Iowa is a provider of multiple training and education programs for individuals and families of individuals with a mental illness. NAMI Iowa also presents an annual conference that provides training and education on mental health-related topics. A list of available trainings is posted on the NAMI Iowa website.
https://namiiowa.org/

9. Suicide Prevention / Iowa Suicide Prevention Planning Group

Iowa HHS is the lead agency for Suicide Prevention in Iowa. Iowa HHS' suicide prevention program works with communities and related partners to provide information about suicide risk factors, warning signs and protective factors and promotes the use of evidence-based suicide prevention strategies. Iowa HHS leads the Iowa Suicide Prevention efforts in Iowa and the Iowa Suicide Prevention Planning Group. This group of approximately 30 individuals meets quarterly and is comprised of state and local leaders active in suicide prevention and welcomes members with lived experience. Suicide Prevention staff from Veterans Administration Health Care facilities are active members of the group. Members provide updates on programs and events, trends and the latest information about suicide prevention in Iowa.
Members of the Planning Group guide the development of the Iowa Suicide Prevention Plan, A new five-year plan was completed in 2022. Priorities include:

- Build capacity in suicide prevention, intervention, and postvention infrastructure at the organizational, local, and state level
- Integrate evidence-based, culturally sensitive suicide prevention, intervention and postvention strategies in systems serving all people within Iowa.
- Promote community resilience through ongoing collaboration, public education, and equitable access to formal and informal supports.

https://hhs.iowa.gov/sites/default/files/portals/1/userfiles/133/iowa%20plan%20for%20suicide%20prevention_updated%20june%202022.pdf

To further support suicide prevention, IDPH received the SAMHSA Zero Suicide grant in September 2018. This five-year grant engaged the Integrated Provider Network in implementing the Zero Suicide Framework. The framework is a systems-change model with the core belief that no person under care should die by suicide. The Zero Suicide grant project period has concluded, however Iowa HHS intends to utilize the Garret Lee Smith grant received in 2023 to support ongoing suicide prevention work.

Data from the Iowa Public Health Tracking Portal indicates that 541 Iowa residents died by suicide in 2021. According to Iowa's 2021 suicide data, suicide was the second leading cause of death for ages 15-24, third for ages 25-44, and fourth for ages 5-14.

10. 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. Connections Matter training is a curriculum available to educate the public on the effects of trauma on children's development. These trainings are available through a variety of providers across the state.
http://www.connectionsmatter.org/iowa

11. Your Life Iowa

Your Life Iowa (YLI), a project of Iowa HHS is the integrated hub/system for free and confidential help and information for alcohol, drugs, gambling, mental health and suicide. YLI offers 24/7/365 resources including a telephone helpline, mobile-friendly internet-based communications (e.g., online chat), texting and social media (@yourlifeiowa). YLI services are provided by Foundation 2, an Iowa based nonprofit human service agency offering suicide prevention and crisis intervention programs to people of all ages. Foundation 2 has provided crisis counseling by phone since 1970. Iowa HHS is determining how 988 and YLI will coordinate and complement each other.

B. Early Identification/ Intervention

1. 988 Implementation

The National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline (988 Lifeline) on July 16, 2022. In preparation for this transition, SAMHSA released the Notice of Funding Opportunity for 988 State and Territory Cooperative Agreements. Iowa was awarded a cooperative agreement to assist with building capacity for Iowa's 988 Centers. Iowa has two

988 Crisis Centers, CommUnity Crisis Services and Foodbank (CommUnity) and Foundation 2 Crisis Services (Foundation 2), that provide 24/7 crisis call, chat, and text services. Foundation 2 is the statewide primary center for calls and CommUnity is staffing to answer the majority of chats and texts originating from Iowa. CommUnity is also a part of the chat and text backup and LGBTQ+ call subnetworks. During the first year of the 988 Lifeline, there were over 31,000 contacts from Iowans in emotional distress, mental health or substance use crisis, or experiencing a suicidal crisis. Iowa's 988 Centers have answered an increase of 142% from the previous year. Iowa's 988 Centers' crisis counselors helped 98% of call, chats, and texts without the need for further support. When further support is needed, the crisis counselors can connect individuals with local resources such as mobile crisis which dispatched crisis teams to respond in-person.

2. 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 MHDS regions are required to make the following array of crisis services available to adults:

- Access Centers
- Crisis Evaluation
- Crisis stabilization-community and residential
- Mobile Response
- 24- hour access to crisis response
- 23-hour crisis observation and holding
- Subacute mental health facility treatment

A similar set of crisis services is also mandated to be available for children. This includes the following:

- Assessment and Evaluation
- Crisis stabilization-community and residential
- Mobile Response

At this link are maps of the crisis services available statewide;
https://hhs.iowa.gov/mhds/crisis-services

3. 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. ILEA has included Crisis Intervention Team (CIT) training (up to 40 hours) in the multi-week training for all new recruits. MHDS Regions have also provided CIT training to local law enforcement agencies.

Multiple city and county law enforcement organizations have begun training their officers as well. 87 of Iowa's 99 counties have trained CIT officers as of June 30, 2022.

4. Early ACCESS

Early ACCESS is Iowa's system for providing early intervention services. It is available to infants and toddlers from birth to age three years who:

- Have a health or physical condition that may affect his or her growth and development
- Have developmental delays in his or her ability to play, think, talk, or move.

The first three years of a child's life are the most important when setting the foundation for ongoing development. Starting supports and services early improves a child's ability to develop and learn. The focus of Early ACCESS is to support parents to help their children learn and grow throughout their everyday activities and routines. Early ACCESS service providers work with parents and other caregivers to help their children develop to their fullest potential.

Iowa's area education agencies (AEAs) are responsible for administration of Early ACCESS across the state to ensure that no matter where a family lives in Iowa, services will be available. Currently, Iowa is divided into nine AEA regions. https://educateiowa.gov/pk-12/early-childhood/early-access

Service coordination, assessments, evaluations and any needed early intervention services provided by Early ACCESS are available at no cost to families.
Three state agencies are responsible for the state-level early intervention system:

- Iowa Department of Education (lead agency),
- Health and Human Services

University of Iowa's Child Health Specialty Clinics: https://chsciowa.org/

5. 1st Five Healthy Mental Development

1st Five is a public-private partnership bridging primary care and public health services in Iowa. The 1st Five model supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to 5 and coordinates referrals, interventions and follow-up. 1st Five operates in 88 of Iowa's 99 counties, serving local 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.

6. Iowa Association for Infant and Early Childhood Mental Health

A focus of this organization is to develop professional competency standards in the area of infant and early childhood mental health for providers of early childhood services and supports.

The organization offers endorsement pathways in infant and early childhood mental health for individuals working with young children using the national Infant and Early Childhood Mental Health 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 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.

7. Project LAUNCH

Iowa HHS is currently implementing a five-year Project LAUNCH grant. The purpose of the initiative is to support young children's healthy mental development by focusing on strategies that foster safe, stable, and nurturing relationships and positive experiences for children, newborn through age eight. The project is currently offering online training to healthcare providers on early childhood mental health topics.

8. Naloxone

Naloxone is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. It is an opioid antagonist, meaning that it binds to opioid receptors and can reverse and block the effects of other opioids, such as heroin, morphine, and oxycodone. Administered when a patient is showing signs of opioid overdose, naloxone is a temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical intervention as soon as possible after administering/receiving naloxone. The medication can be given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

To help address the issue of opioid misuse, the Iowa Department of Health of Human Services (HHS) is expanding their initiative to provide naloxone (the opioid overdose reversal medication) to Iowa organizations, businesses and schools, which may be in a position to render aid to a person at risk of experiencing an opioid overdose.

Since February of 2022, HHS has offered eligible organizations and businesses free naloxone nasal spray kits. Now, the program is expanding to include schools. The purpose of this initiative is to equip organizations, businesses and schools, in the event that their employees, agents, or volunteers encounter someone experiencing a suspected opioid overdose. Iowa HHS has distributed 7,216 Naloxone kits in sate fiscal year 2022, and 8,614 Naloxone kits as of the end of quarter 3 of state fiscal year 2023.

9. Drug Disposal

The State Opioid Response funded partnership between Iowa HHS and the Iowa Board of Pharmacy now includes offering free drug disposal packets. This option allows Iowans receiving an opioid prescription to also receive a free drug disposal packet to safely deactivate and throw out any unused prescription medications. In just over one month from its inception, the program had distributed over 1,500 disposal kits. In FY2022 (Sept 30, 2021-Sept 29, 2022), 15,745 disposal kits were distributed. In FY2023 (Sept 30, 2022-June 30, 2023), 21,089 disposal kits were distributed.

C. Treatment Services

Iowa Medicaid is a major source of funding for behavioral health services in Iowa. Most services are managed through IA HealthLink which includes three contracted MCOs; Amerigroup, Iowa Total Care, and Molina. 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 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. At this link is a reference guide describing eligibility and services available through Iowa Medicaid.
https://hhs.iowa.gov/sites/default/files/Comm580.pdf?040620211416

1. 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;
    - In-patient 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 condition;
    - Community-based and facility based sub-acute services;
    - Crisis Services including, but not limited to:
        - a 24 hour crisis response;
        - b. Mobile crisis services;
        - c. Crisis assessment and evaluation;
        - d. Non-hospital facility based crisis services;
        - e. 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;
    - Intensive psychiatric rehabilitation services;
    - Peer support services for persons with serious mental illness;
    - Family Peer Support for parents of a child with a serious emotional disturbance
    - Community support services including, but not limited to:
        - a. Monitoring of mental health symptoms and functioning/reality orientation,
        - b. Transporting to and from behavioral health services and placements,
        - c. Establishing and building supportive relationship,
        - d. Communicating with other providers,

    - e. Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and / Developing and coordinating natural support systems for mental health support;
- Habilitation program services;
- Children's mental health waiver services;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism;
- Psychiatric Medical Institutions for Children (PMIC).
- Functional Family Therapy
- Multi-Systemic Therapy

2. 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 substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;Emergency services for SUD conditions
    - Emergency services for substance use disorder conditions
    - Ambulance services for SUD conditions
    - Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
    - Evaluation, treatment planning, and service coordination
    - SUD counseling services when provided by approved opioid treatment programs licensed under Iowa Code Chapter 125
    - Substance use disorder treatment services determined necessary subsequent to an EPSDT screening

- 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 and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member.

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.

Iowa HHS-funded individuals also have a limited set of the listed Medicaid services available.

3. IPN Substance Use Disorder & Problem Gambling Treatment Services

The IPN offers substance use and problem gambling education, early intervention, and treatment services statewide to individuals at or below 200% of the Federal Poverty Level guidelines. IPN services are funded by the State General Fund appropriation for substance abuse and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant via a fee-for-service model.

IPN Funded Substance Use & Problem Gambling Treatment Services:

- Early Intervention
- Outpatient treatment;
- Substance use disorder assessment and OWI evaluation only
- Intensive outpatient;
- Partial hospitalization (day treatment);
- Clinically managed low intensity residential treatment;
- Clinically managed medium intensity residential treatment;
- Clinically managed high intensity residential treatment;
- Medically monitored intensive inpatient treatment;
- Medically managed intensive inpatient treatment;
- Enhanced treatment services
- Opioid treatment services

4. Co-occurring Services

There is one PMIC licensed to provide substance abuse treatment and mental health services to individuals up to age 21. Other providers of mental health services are also increasing their co-occurring capability. Of the 25 accredited Iowa CMHCs, 17 are also licensed substance use disorder services providers and 5 are Integrated Provider Network providers. Fourteen Iowa providers have received the SAMHSA CCBHC-Expansion grants as described in the new section. Through the COVID-19 Supplement and the ARPA Supplemental funds, IPN providers were able to fund service development projects intended to add new services to their current

menu of options, including mental health therapy. IPN providers were also offered funding to engage in technical assistance, where many providers sought assistance from Health Management Associates (HMA) to expand their preparedness for future CCBHC certification.

5. Certified Community Behavioral Health Clinic -Expansion (CCBHC-E) Grantees

CCBHCs are outpatient clinics designed to serve individuals with mental health and substance-use disorders with an array of evidence-based services. Fourteen Iowa providers have been recipients of SAMHSA CCBHC-E Grants. These providers are typically accredited community mental health centers, mental health service providers, and licensed substance use disorder treatment providers. These are grants directly to the providers to develop CCBHC programs in their organizations. These grants are separate from the CCBHC Planning Grant that Iowa HHS was awarded as referenced in section X although the expectations to meet the CCBHC criteria is the same for both programs. Iowa participated in a federal planning grant to develop CCBHCs in 2015-16 in addition to the current planning grant and has remained supportive of the CCBHC model and identified CCBHC development in the state's Co-Occurring Plan. Iowa providers have invested in the CCBHC model of integrated and coordinated behavioral health care through training, technical assistance, and participation in the federal CCBHC expansion grants.

D. Inpatient Psychiatric Care and Residential SUD Care

1. Inpatient Bed Tracking

Iowa implemented an Inpatient Psychiatric Bed Tracking system effective August 1, 2015. Iowa HHS manages the bed-tracking system. 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. Subacute mental health facilities were also added as a facility required to report to the bed tracking system.

Inpatient bed availability for individuals with complex needs, including aggressive behavior or intellectual disabilities in conjunction with mental illness remains difficult to obtain. Local hospitals continue to have issues with patients staying in emergency rooms while waiting for an inpatient bed. In 2021, legislation passed to convene an Inpatient Bed Tracking Study Committee for the purpose of addressing psychiatric bed acuity and submit recommendations to the Governor and Legislature. The Committee's recommendations included the development of a tiered reimbursement structure that accounts for varying levels of acuity in inpatient psychiatric care and utilizing a bed tracking system to locate beds based on acuity. Legislation enacted in 2022 required the development of a tiered reimbursement structure based on the committee's recommendations. Iowa Medicaid developed a psychiatric intensive care payment methodology to reimburse providers of inpatient psychiatric care for individuals with complex needs.

2. Mental Health Institutes (MHI)

The Iowa Department of Health and Human Services, State-Operated Facilities 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.

Cherokee Mental Health Institute (CMHI)-CMHI currently has 24 adult beds and 12 child/adolescent beds for short term psychiatric treatment and care for individuals with severe symptoms of mental illness. During this fiscal year CMHI will be transitioning to serving adults ordered by the court into the custody of the state for the purposes of competency restoration, adults who have been acquitted of a crime by reason of insanity, and similarly situated adults

Independence Mental Health Institute (IMHI) currently has 40 adult beds and 16 child/adolescent beds for short term psychiatric treatment and care for individuals with severe symptoms of mental illness. IMHI will be transitioning to a focus on specialized treatment of behaviorally complex children and youth.

3. 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 900 beds. Total staffed bed capacity is 681, with 484 adult beds, 72 geriatric beds, and 125 child beds. Iowa also has two free-standing private inpatient psychiatric facilities opened in the state in the last two years. While inpatient psychiatric care is concentrated in metropolitan areas, facilities providing inpatient care are generally available within a two-hour drive of an Iowan's residence. Mental health and disability service regions are required to ensure that inpatient psychiatric care is 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).

4. Residential Care Facilities for Persons with a Mental Illness

The Iowa Department of Inspections, Appeals and Licensing (DIAL) 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.

5. Intermediate Care Facilities for Person with Mental Illness

DIAL 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 (NFMI). 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 130. MHDS regions may pay for this level of care for individuals who are not eligible for Medicaid funding.

6. 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 8 private agencies with 432 licensed beds. 2 of the facilities are focused youth with substance use and co-occurring needs. 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.

7. Residential Treatment for SUD

Iowa HHS currently licenses 23 Residential SUD Treatment programs. 11 of those programs are currently funded under the SUPTRS-BG project, the Integrated Provider Network (IPN), and offer services statewide. Licensed covered Residential SUD Treatment services include ASAM levels 3.1, 3.3, 3.5, and 3.7 (low, medium, and high intensity residential treatment, and medically monitored inpatient treatment, respectively). Other covered services for clients include Medications for Opioid Use Disorder (MOUD) evaluations, medical care, drug testing, MOUD medication cost, and peer services. IPN funded providers are also offered reimbursement for care coordination at a fixed "per client-per month" rate.

IPN Residential Substance Use Treatment providers also offer comprehensive case management services for pregnant women and women with dependent children, assisting them with gaining access to:

- Transportation
- Assistance in establishing eligibility for public assistance programs
- Employment and training programs
- Education and special education programs
- Drug free housing for women and their children
- Prenatal care and other healthcare services
- Therapeutic daycare for children
- Other early childhood services

E. Community-Based Services

1. Assertive Community Treatment (ACT)

ACT is an evidence-based practice for individuals with a serious and persistent mental illness who need services outside of standard clinical services. The ACT team of prescribers, mental health professionals, nurses, substance use disorder professionals, and other support providers work with individuals in the community to provide holistic mental health care and supports. The goal is to help individuals with a serious and persistent mental illness be successful in the community and avoid more restrictive treatment settings. MHDS Regions are required to make ACT available in every region as of July 1, 2021. Iowa currently has 18 ACT teams serving 76 of Iowa's 99 counties. This is an increase of 4 teams and 26 additional counties over data reported in the 2021 plan.

2. Case Management Services-Integrated Health Home

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 39 IHH programs across the state. 20 of the 34 IHH are CMHCs. 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 and Habilitation.

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 IHH/ 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).

3. Habilitation Services

The State Plan HCBS Habilitation program is a Medicaid program operated through a 1915(i) state plan amendment. 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.

Services available through the Habilitation program include:

a. Home-Based Habilitation
Services provided in the person's home and community. Typical examples would be assistance with medication management, budgeting, grocery shopping, personal hygiene skills, etc.

b. Day Habilitation
Services that are usually provided in a day program setting outside the home. Focuses on areas such as social skills, communication skills, behavior management, etc.

c. Prevocational Services
May be provided in a variety of settings, and focus on developing generalized skills that prepare a person for employment. Typical examples include attendance, safety skills, following directions, and staying on task.

d. Supported Employment
Assists in obtaining and keeping a job in the community. Assists in placing the individual in a job in a regular work setting with persons without disabilities at minimum wage or higher, and provides support to maintain the job. Typical examples would include: skills assessments, consultation with the employer, job coaching, and behavior management.

4. IRSH
Intensive Residential Service Homes (IRSH) are intensive, community-based services provided 24 hours per day, 7 days per week, and 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Development of IRSH was recommended by the 2017 Complex Service Needs workgroup which was convened 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. This recommendation was enacted into law in 2018. MHDS Regions are required to make IRSH available to a minimum of 120 individuals statewide. Providers of IRSH are required to be enrolled Medicaid providers of Habilitation or Intellectual Disability Waiver services. There are currently 15 IRSH beds available statewide with more in development.

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

- Recovery strategies
- Practical facts about schizophrenia, bipolar disorder and major depression
- The stress-vulnerability model and treatment strategies

- Building social support
- Using medication effectively
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

IMR is 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. 11 providers in Iowa are offering IMR services.

6. Intensive Psychiatric Rehabilitation

Intensive Psychiatric Rehabilitation (IPR) 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 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. There are 16 IPR providers in Iowa.

7. Supported Employment/Employment Services

Iowa HHS is involved with several initiatives to increase the number of people with disabilities in competitive integrated employment. The goal is to unify and coordinate these efforts in conjunction with the Olmstead plan, MHDS Regions, Iowa Medicaid, state agency partners and federal, state and local stakeholders so demonstrable improvement is made in the number of persons with disabilities engaged in competitive integrated employment. This effort includes evaluating any new or innovative approaches that can be adopted to help achieve the goal, and seeking related program development opportunities.

Iowa Medicaid 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. The Partnership for Community Integration Project, Iowa's Money Follows the Person (MFP) initiative also has employment as a priority. MFP 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. In 2023, the program has 15,285 members enrolled.

Iowa HHS is responsible for planning, coordinating, monitoring, improving and partially funding mental health and disability services for the State of Iowa. Iowa HHS engages in a wide variety of activities that 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 evidence-based practices and 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.

Iowa HHS has a seat on the leadership teams of the Iowa Coalition for Integration and Employment (ICIE), along with other state agencies. The ICIE coalition includes service providers, as well as service recipients and family members from all parts of the state. Iowa HHS also holds a seat on the state's Employment First Steering Committee, which brings together staff from state agencies and other partners which play a role in employment for people with disabilities, for collaborative and strategic planning.

Iowa HHS co-led the 2021-2022 Advancing State Policy Integration for Recovery and Employment (ASPIRE) effort from the U.S. Department of Labor's Office of Disability Employment Policy (ODEP), with the University of Iowa Center for Disabilities and Development (CDD). This effort moves the strategic planning for IPS forward by aligning state policy and funding to better promote competitive integrated employment for people with behavioral health conditions, and builds Iowa's infrastructure to deliver IPS. IPS Supported Employment is an evidence-based practice for individuals with a serious mental illness or multi-occurring conditions. The ASPIRE state steering committee brings together key partners including state agency representatives engaged in Employment-First, with persons with lived experience and family members, as well as representatives of advocacy groups such as the National Alliance on Mental Illness (NAMI), providers of employment and mental health services, and others. IPS service delivery requires an enhanced partnership among providers, Behavioral Health, Iowa Vocational Rehabilitation, the MHDS Regions and others.

Iowa HHS and CDD now co-lead the 2022-2023 ASPIRE project. Iowa began 2021 with four IPS sites, led by two providers. Through ASPIRE 2021-2022 we trained and implemented an additional three teams covering a total of 23 counties. In 2023 we added three teams and an additional nine counties for a total of 32 counties. Expansion of these teams to ten surrounding counties is planned in 2024.

All IPS teams in operation for over six months have had baseline fidelity reviews which reflected "good" fidelity. Quoting from an independent review summary, "The collaboration and integration of employment within the mental health treatment services and care coordination partners reflects the significant work the partner agency staff members and leaders have put into implementing IPS in communities they jointly serve. The partner agencies are

congratulated for their commitment to evidence-based practices and using the IPS fidelity scale to provide direction in all aspects of program development and implementation."

Prior years of the Employment First State Leadership Mentoring Project (EFSLMP) focused on strategic planning for eventual statewide implementation of IPS in Iowa.

ASPIRE accomplishments from 2021-2023 include:

- Solving for sustainable IPS funding in three realms: team startup; services (billables); training, technical assistance, and fidelity reviews
- Strengthening integration among key partners
- Increasing Iowa sites delivering IPS from two to eight, and service delivery areas from 12 counties to 32 counties
- Increasing workforce trained in and delivering IPS
- Hiring and retaining our first and second State IPS Trainers/Fidelity Reviewers
- Conducting Baseline and Annual Fidelity Reviews of all sites in operation more than six months
- Iowa is training a cadre of adjunct IPS Fidelity Reviewers to assist our State Trainers/Reviewers as the number of IPS sites and the demand for Fidelity Reviews increase.
- Partnering with the University of Iowa's Center for Excellence in Behavioral Health to support training and technical assistance for evidence-based-practice statewide including IPS.

The ultimate goal is for everyone in the state who needs it, to have access to IPS services, and therefore have the best chance of going to work in the community or getting back to work.

October 2021 Iowa Vocational Rehabilitation Services (IVRS) made available training and funding for the Customized Discovery (CD) model of supported employment, to all their statewide community rehabilitation providers. Customized Discovery is a model of Customized Employment developed by Griffin-Hammis Associates which has a fidelity scale and is currently a promising practice for people with significant disabilities, including those with intellectual and developmental disabilities. Customized Discovery is undergoing research to evaluate whether it is a new evidence-based practice. IVRS continues to support technical assistance by GHA to select Iowa providers of CD.

IVRS and the University of Iowa CDD have teamed up to administer the 2022-2026 Disability Innovative Funds Subminimum Wage to Competitive Integrated Employment Iowa Blueprint for Change (DIF SWTCIE IBC or "Iowa Blueprint for Change"), awarded by the federal Rehabilitation Services Administration (RSA). This demonstration project has six objectives:

1. Create a Collective: Establish and engage a collective of diverse stakeholders to develop, pilot, refine and implement collaborative systems change models that support Iowans with disabilities who are employed or contemplating employment at subminimum wage, to move into competitive integrated employment (CIE).
2. Apprenticeships: Utilize the U.S. Department of Labor's recognized Direct Support Professional Registered Apprenticeship (RA) and Pre-Apprenticeship (PA) programs as a model to recruit, train, and retain interested Iowans with disabilities into CIE.

3. Focus on Youth: Increase ongoing delivery of preparation, placement, and support services that begin in early high school and result in uninterrupted transition to CIE for youth with disabilities.
4. Jobs that Lead to Economic Security: Facilitate an increase in Iowans with disabilities obtaining and maintaining CIE that leads to economic security.
5. Increase Expectation and Demand for community integrated employment for all Iowans with disabilities.
6. Align Public Policies, Funding and Practices to support CIE as the first and preferred outcome for all Iowans with disabilities.

8. Supported Community Living Programs

Supported Community Living Programs are accredited by Iowa HHS, to provide supervised supported living to persons with disabilities. There are 94 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.

9. ASAM Levels of Care for Substance Use Treatment

Iowa's licensed Substance Use Treatment providers utilize the American Society of Addiction Medicine (ASAM) Criteria, which is a comprehensive set of standards for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions. The ASAM Criteria defines six dimensions, each with their own risk rating, to determine the least intensive, but safe level of care for meeting the client's individual treatment needs.

The ASAM continuum of care includes five broad levels, represented by a number, as well as gradations of intensity within those broad levels, represented by a decimal. The ASAM continuum of care is:

- 0.5 – Early Intervention
- 1.0 – Outpatient Services
- 2.1 – Intensive Outpatient Services
- 2.5 – Partial Hospitalization
- 3.1 – Clinically Managed Low Intensity Residential Services
- 3.3 – Clinically Managed Population-specific High Intensity Services
- 3.5 – Clinically Managed High Intensity Residential Services
- 3.7 – Medically Monitored Intensive Inpatient Services
- 4.0 – Medically Managed Intensive Inpatient Services

F. Recovery Supports

1. Peer Support Services

Peer Support is an evidence-based practice 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, the MHDS Regions and HHS.

Peer support services for mental health and peer recovery coaching are both Medicaid reimbursable services. HHS funds the curriculum development and delivery of training through a contract with the University of Iowa and through contract with the Connecticut Community for Addiction Recovery (CCAR). Iowa will accept either version of the training for a co-occurring response with an additional 6 hours of specialized training either in substance use disorders or mental health trauma. The Iowa Certification Board certifies adult peer, family peer and recovery coaches following the national certification for the International Certification & Reciprocity Consortium (IC&RC).

HHS contracts with the University of Iowa to provide training for core and continued education, technical assistance, oversight, and training certification for family peer support and adult peer support. The contract also works on workforce development for family peer support, peer support services, and recovery coaching with provider agencies. Peer support services are required in the MHDS Regions by state legislation. Iowa utilizes peer support and family peer support specialists for employment within the Integrated Health Home, crisis services, as trainers of the family peer support and recovery coach training, the established peer network, and peer services in both wellness and recovery centers and through community based delivery.

2. Recovery Community Centers (RCC's)

RCC's are peer-operated centers that serve as local resources of community-based recovery support. People do not live at these centers, but rather these resources can help individuals build recovery capital at the community level by providing advocacy training, recovery information, and resource mobilization. To date, Iowa has awarded funding to four RCC's around the state and has partnered with national organizations to establish an Iowa National Alliance for Recovery Residences (NARR) affiliate, the Iowa Coalition of Recovery Support Providers (ICRSP).

3. Recovery Housing

Iowa HHS has contracted with the National Alliance for Recovery Residences (NARR) to both certify current recovery residences through the Missouri Coalitions of Recovery Support Providers and to establish an Iowa NARR affiliate to be known as the Iowa Coalition of Recovery Support Providers (ICRSP). Through this process, Iowa has begun certifying residences around the state and ICRSP has begun the process to become an independent non-profit organization and to establish policies and procedures to grandfather newly certified homes into the organization and to establish policies and procedures for certifications moving forward. ICRSP will not only certify homes based on Iowa policies, but will ensure residences continue to abide by best practices and maintain the properties in a safe and healthy way. This long term approach to recovery housing in Iowa will help to improve existing homes while expanding the network of recovery houses throughout the state.

4. Peer-Run Organizations

In 2022, through COVID-Supplemental and American Rescue Plan funds, Iowa contracted with four peer-run organizations to expand opportunities for peer-run services in Iowa. The organizations are Freedom Pointe, a peer wellness center where individuals can receive individual and group support; Iowa Peer Network, which supports the Peer Support Specialist workforce, Life Connections, a peer-run respite provider, and NAMI Johnson County, a peer wellness center and remote peer support provider,

5. 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 an SED in need of this service who are not receiving waiver services. Peer-run respite is available for adults through one provider.

6. Wellness Recovery Action Planning

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. Wellness centers also offer WRAP to individuals.

7. Wellness Centers

Wellness centers are available through community mental health centers statewide. Individuals can access peer support, crisis intervention, support groups, care coordination and connection to mental health services.

8. The Iowa Warmline

The Iowa Warmline is a statewide line that is staffed by individuals with lived experience who provide non-judgmental, non-directive support to individuals in crisis.

G. Providers of Mental Health Services

1. Community Mental Health Centers and other Mental Health Service Providers

Community mental health centers and other mental health service providers 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 25 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 children and one which serves primarily adults. Approximately 95 other agencies are accredited as Mental Health Service Providers. 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 FY23 through MHBG funding to CMHCs include:

- Acceptance and Commitment Therapy
- Assertive Community Treatment
- Child Parent Psychotherapy
- Cognitive Behavioral Therapy (CBT)
- Cool Kid Training
- Dialectical Behavior Therapy (DBT)
- Emotionally Focused Therapy
- Exposure and Responsive Prevention Therapy
- Eye Movement Desensitization and Reprocessing (EMDR)
- Internal Family Systems
- Heart Math
- Mental Health First Aid (MHFA)/Youth Mental Health First Aid (YMHFA)/Teen Mental Health First Aid
- Motivational Interviewing
- Multi-Systemic Therapy
- NAVIGATE model for Early Serious Mental Illness/First Episode Psychosis
- Parent Child Interaction Therapy (PCIT)
- Peer support services/wellness centers
- QPR Training
- Suicide Prevention
- Theraplay
- Trauma-informed care
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trust Based Relational Intervention
- Wellness Recovery Action Planning (WRAP) services

CMHCs serve a defined catchment area, ranging from one county to eight 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. The Community Mental Health Center designation process was added to the accreditation rules in Iowa Administrative Code 441-Chapter 24 in July 2022. These rules identified the requirements and process for an agency to be designated by the state as a CMHC and ended the designation of non-CMHC providers to fulfill the duties of a CMHC. Since adoption of the administrative rules, three additional agencies have received designation as a CMHC.

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.

2. Federally Qualified Health Centers

Iowa presently has 14 Federally Qualified Health Centers (FQHC's) with 73 sites. These centers are located across Iowa in both rural and urban areas. 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 behavioral health providers have collaborative relationships with FQHCs to assist individuals to receive integrated health and behavioral health care.

3. Mental Health Professionals Statewide

According to the Iowa Health Professions Tracking Center, University of Iowa Carver College of Medicine, for calendar year 2019, there were approximately 223 psychiatrists in the state of Iowa. The majority of psychiatrists practice in metropolitan or urban counties. This was a decrease of 9 from 2017. In 2021, there were approximately 254 Psychiatric Nurse Practitioners and 48 Physicians Assistants with a Mental Health Specialty. Both the number of PNPs and PA's increased over the 2019 previous report.

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. Provider agencies report continued difficulty hiring Master's level clinicians, especially in rural areas.

Effective July 1, 2023, health and occupational licensing is moving to the Iowa Department of Inspection, Appeals, and Licensing as part of the new organizational structure for state government. This includes medical professionals and mental and behavioral health professionals.

4. Workforce Initiatives/Mental Health Shortage Area Designation

The Health Resources and Services Administration listed 89 of 99 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.

Iowa HHS oversees the Primary Care Provider Loan Repayment Program (Primary Care Provider LRP) which aims to improve access to primary health care among underserved populations by providing assistance with repayment of educational loans to primary care medical, dental, and mental health practitioners. In exchange, practitioners must complete a minimum, 2-year service obligation at an eligible practice site/s located in a federally designated health professional shortage area (HPSA). Candidates must meet certain requirements to qualify and are subject to a maximum award depending on health care discipline.

Additional psychiatric residency programs have been added in central Iowa to support increased psychiatric capacity in Iowa. In 2021, $600,000 was allocated by the legislature for four rural psychiatric residencies who will provide mental health services in underserved areas

of the state. Funding was also allocated to increase access to mental health services through psychiatric training of additional physician assistants and nurse practitioners. There is also a state funded psychiatric residency and fellowship program that partners with the state facilities to provide training for residents and fellows at the state facilities.

5. ARPA/COVID Funding for SUD Sign on and Retention Bonuses

Through COVID-19 Supplement and ARPA Supplement funding, Iowa HHS developed projects which include opportunities for current SUPTRS Block Grant sub-recipients to provide a variety of workforce development and retention activities, including sign-in bonuses and retention bonuses, in an effort to increase the provider's competitiveness in hiring staff, and to assist with long-term retention of qualified clinicians.

IV. SUPPORTS FOR IDENTIFIED POPULATIONS

A. Children's Mental Health Services

The director of Iowa HHS is the co-chair, along with the director of the Department of Education, of the Children's Behavioral Health System State Board (Children's Board). The Children's Board is advisory and provides guidance in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need. The Children's Board consists of 17 voting members appointed by the Governor. Members of the Children's Board were selected based on their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.

MHDS regions are tasked with providing access to a set of core services for children with an SED in their regions and are required to convene children's behavioral health services advisory committees which include representation from the following: education, parent/relative of a child who utilizes services, early childhood, child welfare, behavioral health service provider, juvenile court, pediatrics, child care, law enforcement and a regional governing board member. MHDS regions have also identified Regional Coordinators of Disability Services for every county who are available to help parents find mental health resources in their local area.

The SMHA also oversees five Systems of Care programs in Iowa which serve 16 of Iowa's 99 counties. The SOCs currently serve children with an SED who are not Medicaid-eligible but require additional supports and services to be successful.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of Iowa HHS, 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.

Iowa HHS includes the following divisions which have some responsibility for meeting the behavioral health needs of children for whom the agency is responsible. Services and supports

for children that were previously housed in separate state agencies are now integrated under the Iowa HHS umbrella:

- The State Mental Health Authority and the Single State Authority for Substance Use (the Division of Behavioral Health)
- The State Child Welfare Authority (the Division of Family, Well-Being and Protection) which oversees child protective services, child-care, and early intervention and support.
- The Division of Community Access which oversees child support, economic assistance programs, preventive health programs, and community action agencies
- The State Medicaid authority (Iowa Medicaid).

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 programs, the Child Health Specialty Clinics, substance use disorder prevention and treatment, community health programs, home visiting, and suicide prevention programs
- 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 primarily to children who are Medicaid eligible.

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.

1. Youth SUD Services

Currently, among Iowa's 99 licensed substance use treatment providers, 3 provide a residential substance use disorder treatment level of care (ASAM level 3), for a total of 58 beds dedicated to this age group, statewide. Iowa recognizes youth substance use disorder services as an area of need and has addressed this in planning step 2.

2. Behavioral Health Intervention Services

Behavioral health intervention services –BHIS are primarily available to children who are Medicaid-eligible. A limited number of programs fund BHIS for non-Medicaid eligible individuals.

BHIS are supportive, directive, and teach interventions 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.

3. 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 1,339. The following chart shows the current status of the waiver usage and waiting list as of August 2023.

CMH Waiver Statistics

CMS Slot Cap	1,339	Total slots authorized
Reserved CMH Waiver slots per year	20	For children exiting PMICs, MHIs, or out of state placements
Slots approved	1,188	
Applications in process	489	
Waiting list	896	The next child to be served has an application date of 8/15/2022

https://hhs.iowa.gov/sites/default/files/8.3.23%20Monthly%20Slot%20and%20Wait%20list%20Public.pdf

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 annually makes available 20 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 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 benefit from access to services to support a successful transition back to their homes and communities.

Iowa HHS is engaged in the Hope and Opportunity in Many Environments (HOME), a project in Iowa that is working to improve and ensure that everyone has access to high-quality behavioral health, disability, and aging services in their communities. To achieve this, Iowa HHS collaborated with partners at Mathematica and The Harkin Institute. They conducted an evaluation of community-based services and published a final evaluation report in early 2023. The report provides recommendations on how Iowa can improve these services. These included:

A. Implement streamlined screening and improved processes to better align services with people's needs.

B. Take steps to align CBS, including Medicaid HCBS waivers, to the needs of Iowans.

C. Maximize access to Medicaid HCBS and other CBS supports for people with long-term services and support (LTSS) needs.

Based on those recommendations, the team created a transformation plan to guide the next steps and implement the suggested improvements. The transformation plan is available at this link: Hope and Opportunity in Many Environments (HOME) | Iowa Department of Health and Human Services

4. Educational System Services and Supports

For children in primary and secondary schools, Area Education Agencies (AEA) are significant providers of services to children under IDEA. Iowa's AEAs are regional service agencies which provide school improvement services for students, families, teachers, administrators and their communities.

AEAs 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 Education Agencies also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Programs 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.

5. Systems of Care for Children and Youth with an SED

The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), Four Oaks System of Care, Orchard Place 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 five programs serve non-Medicaid eligible children and youth and provide access to community-based services and supports. Iowa HHS added two new SOC programs in 2021 in areas not previously served. While a need was identified for SOC programs in these areas, starting new programs in rural areas where behavioral professionals are scarce was difficult. One program chose to end their contract with the state effective June 30, 2023.

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, Iowa HHS, psychiatric hospitals, Juvenile Court Services, PMIC's, therapists, and other mental health service providers.

The SOC programs are all Integrated Health Homes for Medicaid-eligible children with an SED. IHH care coordination is reimbursed by Medicaid for Medicaid-eligible children allowing the SOC funds to be dedicated to providing similar services to non-Medicaid eligible children and families. In SFY23, 351 children were served by the SOC programs.

6. Services to Youth Aging Out of Foster Care/Transition Age Youth

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, 19, or 20 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 or have been exited and were approved by HHS to return since age 18. Youth aged 18 or older must also agree to stay in care by signing a voluntary placement agreement.

The Iowa Aftercare Services Program (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 22 who have "aged out" of foster care, court ordered Iowa juvenile detention, or the State Training School. Youth who exit foster care for Iowa's Subsidized Guardianship Program or Adoption at age 16 or older are also eligible. Aftercare is voluntary, individualized support to help youth transition successfully to adulthood. Aftercare participants meet at least twice monthly with a Self-Sufficiency Advocate. Self Sufficiency Advocates help assess the needs of participants, set goals, teach important life skills, connect youth with community resources, and strengthen personal relationships. Limited funds are available for each participant to help participants in crisis, such as for shelter, food, or other needs associated with achieving identified goals. 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. The regional MHDS system can assist youth with the transition to the adult system. The Integrated Health Home program also assists with transitions for Medicaid-eligible children and youth with an SED or an SMI.

7. Therapeutic Foster Care

Therapeutic Foster Care (TFC) expands on current foster care models in Iowa. TFC focuses on supporting youth in the foster care system with behavioral health needs. TFC focuses on youth primarily in the ages of 8-12 years. The intent is to assist in stabilizing these children's medical/behavioral health needs and supporting the child with the goal of reunification and/or permanency. This is being accomplished with a focus on therapeutic case management. This model emphasizes engagement of the foster youth's family and supporting successful long-term

reunification. The program emphasizes Medicaid home and community-based services to support Foster Care youth at high risk for institutionalization or multiple placements.

B. Supports for Older Persons

The Iowa HHS Division of Aging and Disability Services serves all Iowans who are 60 and older, with particular emphasis on populations demonstrating the greatest social or economic need. The Division focuses on empowering older adults to maintain their independence and advocates on behalf of older Iowans to ensure their rights, safety, and overall well-being. The division works with Iowa's six Area Agencies on Aging (AAA), covering all 99 counties. The AAA's help Iowans connect to local services such as nutrition support, caregiver support, and case management

1. HCBS Elderly Waiver

Iowa Medicaid has an HCBS Waiver for older persons. Elderly Waiver services are individualized to meet the needs of each member to remain in their homes or communities who would otherwise require care in a medical institution. Members have access to Medicaid covered services and benefits. The Elderly Waiver currently serves 7,443 individuals with 2,242 applications in process. There is no waiting list for this waiver.

The following services are available:

- Adult Day Care
- Assisted Living Service
- Assistive Devices
- Case Management
- Chore Services
- Consumer-Directed Attendant Care
- Emergency Response System
- Home and Vehicle Modification
- Home Delivered Meals
- Home-Health Aide
- Homemaker Services
- Mental Health Outreach
- Nursing Care
- Nutritional Counseling
- Respite
- Senior Companions
- Transportation
- Consumer Choices Option

2. Preadmission Screening and Resident Review (PASRR):

Iowa has implemented a strong PASRR process by creating a collaboration within Iowa HHS between Iowa Medicaid (Medicaid Authority) and the Division of Behavioral Health (DBH), (the SMHA and SIDA). DBH has a contract with Maximus to perform all Preadmission Screening (Level I) and Comprehensive Assessment (Level II) PASRR activity. In SFY24, the PASSR

program is moving to the Iowa HHS, Division of Aging and Disability Services. Preadmission screening is federally mandated for all individuals who may enter a Medicaid-certified nursing facility everywhere in the country and Iowa's program has taken pride in operating a PASRR program with full federal compliance within the past twelve years since beginning to contract with Maximus on September 1, 2011. In SFY23, an RFP was released to put Iowa's PASRR program out for bid for the third time since 2011, and Maximus was awarded the contract, so they are beginning the 13th year of serving as Iowa's PASRR vendor in SFY24. In SFY23, 49,770 Level I PASSR screens were reviewed. Of the total Level I submissions, 16,967 received categorical (short term) exemptions from the full Level II assessment and 3606 received full PASRR Level II assessments, resulting in summaries of findings, which identified individualized services for each potential nursing facility resident.

Iowa has instituted a PASRR program that is among the most robust in the country and includes a very proactive training program for all Iowa hospitals and over 450+ nursing facilities, as well as an increasing number of community-based services providers. Statewide webinars on topics important to PASRR providers are offered twice monthly, and face to face full-day training events known as the "PASRR Road Show," events, have historically been offered in four locations across the state in the spring and fall of every year. The face-to-face training events were suspended in the spring of 2020, due to the pandemic, and were resumed in the fall of 2022. On the 23rd anniversary of the Olmstead Decision, June 22, 2023, and on many occasions before and since, Iowa's PASRR program has featured training events that celebrate the powerful connection between the PASRR program and the state's goals identified regarding implementation of the Olmstead Decision. There is a strong focus on how Olmstead goals can be achieved when the Community Placement Supports identified in PASRR LII summaries are implemented to support movement of individuals to lower levels of care.

The PASRR process is designed to assure that individuals with mental health, intellectual disability, and related conditions are not placed in nursing facilities unless such a placement is necessary and appropriate. The Level II process identifies the services and supports an individual will need related to their disability and those services and supports they may need in order to return to a lower level of care in the community. Iowa's PASRR process includes many innovations including short term approvals which are designed to facilitate faster return to a lower level of care and "links to payment," which permit us to link the PASRR program directly to the income maintenance process of Iowa Medicaid.

Since February 2016, Iowa nursing facilities have been required to enter all of their admission, transfer, and discharge notices into an electronic process known as "PathTracker Plus," which is linked to both PASRR and Medicaid. This electronic process sends an overnight notice to the income maintenance workers who process Medicaid eligibility and payments for facility-based care. This has increased efficiencies, eliminated a great deal of paper, and increased the speed and accuracy of payments to Iowa nursing facilities, while also increasing PASRR compliance, particularly with the preadmission completion of all PASRR activity.

Iowa has implemented a number of other innovations including an in-depth monitoring process of all the care plans developed for individuals identified at PASRR Level II as being in need of "specialized services." Beginning in SFY24, under the new contract with Maximus, 50% of care

plans developed for those individuals in the LII population who do not have any specialized services identified will also be completed. The most commonly identified specialized behavioral health services are psychiatric medication monitoring and individual therapy, and other specialized services include such things as Behavioral Health Crisis Intervention and Safety Planning, Peer Support Services, Functional Assessments, and Behavior Based Treatment Plans. The review process, known as "ServiceMatters," includes multiple training opportunities, offers in-depth technical assistance, and looks at whether the receiving nursing facility has developed a PASRR compliant care plan. It also explores the extent to which PASRR identified services are being delivered to the individual in a manner that will meet their needs and help them move toward recovery. Iowa was the first state in the country to develop a PASRR care planning tool to assist our nursing facilities to write care plans that are fully compliant with PASRR.

Some of the latest PASRR innovations include collaboration with the state's licensing and survey agency and Medicaid Managed Care Organizations around how PASRR service delivery and compliance is looked at collectively. Since 2020, the PASRR program has offered training to all Community Based Care Managers with Iowa's Medicaid MCOs and several training opportunities to the survey staff within Iowa's Department of Inspection, Appeals, and Licensing.
https://iowaaging.gov/#area-agency-on-aging-map

C. Supports for Individuals Experiencing Homelessness

1. PATH

Iowa HHS administers the federal Projects for Assistance in Transition from Homelessness (PATH) program. It is a formula grant program administered by SAMHSA.

PATH funds are used for community-based outreach, mental health, substance use services, case management, and limited housing services for people age 18 and over experiencing serious mental illnesses—including those with co-occurring substance use disorders, experiencing homelessness or are at risk of becoming homeless. Iowa HHS administers contracts with six provider agencies located in Cedar Rapids, Council Bluffs, Davenport, Dubuque, Iowa City and Waterloo. 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 who are literally homeless; and percent of enrollees who receive community mental health services. All of the PATH providers are participating in a centralized intake process to house individuals with the most need first.

The Iowa Council on Homelessness (ICH) staffed by the Iowa Finance Authority is committed to ensuring all Iowans have access to safe, decent and affordable housing. The ICH and its 16 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.

Iowa HHS does not directly fund or manage services targeted specifically to homeless youth, but it does collaborate with Iowa HHS, Division of Family Well-Being and Protection, the 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 other youth have access to.

2. 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. Iowa HHS staff make the recommendation for people to attend the SOAR Leadership Academy paid for by SAMHSA. Currently there are 4 leadership positions across the state to assist the 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.

3. 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.

4. Home and Community Based Services Waiver Rent Subsidy Program
The Iowa Finance Authority administers this 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. Individuals receiving Habilitation and Money Follows the Person are also eligible. The overall purpose of this program is to encourage and assist eligible persons to live successfully in the community until they become eligible for other local, state or federal rent assistance. In Iowa, the program helps an average of 330 Iowans each month to stay in their home and to remain a part of their community. Iowa 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 or Medicaid programs are not able to take advantage of this opportunity.
https://www.iowafinance.com/renter-programs/home-and-community-based-services-rent-subsidy-program/

5. Treatment for Individuals Experiencing Homelessness Grant (TIEH)
This grant serves to increase the capacity to provide integrated substance use disorder and mental health services to individuals experiencing homelessness, who also have co-occurring disorder diagnoses. Expanded capacity will be achieved using case management and recovery support services to assist individuals in treatment and through early recovery, providing

assistance for up to 18 months. This longer term case management model will utilize a holistic approach through recovery coaching and community partnerships, providing individuals with the resources and skill sets to maintain stability in recovery. TIEH is a federal discretionary grant with an award of $1,000,000 per year for 5 years (January 15, 2020 – January 14, 2025)

6. MHDS Regions

MHDS Regions are required to make the evidence-based practice of permanent supported housing (PSH) available in each region. Regions provide initial financial support to assist individuals in establishing housing and work with local providers to develop permanent supported housing programs . As of June 2022, MHDS Regions reported 14 providers implementing permanent supported housing with 2 providers implementing to fidelity, MHDS Regions are required to work with the Center for Excellence for Behavioral Health to complete fidelity reviews of their PSH programs.

D. Services for Veterans and Service Members

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. VA staff also partner with communities throughout Iowa to develop local suicide prevention coalitions for veterans and all Iowans. The Central Iowa VA system offers inpatient and outpatient MH and SUD treatment. Both Iowa VA systems have presented Veterans Mental Health and Caregiver Summits to educate community providers on the behavioral health needs of veterans and service members and the services available through the VA. The summits offer 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.

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.

In 2022, Iowa applied and was accepted to participate in VA/SAMHSA Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families. The Governor's Challenge Team (Team) is divided into three priority groups: Identify SMVF and screen for Suicide Risk, Promote Connectedness and Improve Care Transitions, and Increase Lethal Means Safety and Safety Planning. The Team's priority groups have met regularly to discuss action items related to their selected priority. The Team developed a survey that will be sent to community behavioral health providers gathering information on all three priority groups to inform the Team on knowledge and current involvement of community behavioral health providers with SMVF. The survey results will be used to inform the Team's next steps in providing education and trainings related to the three priority groups.

E. Disaster Behavioral Health Response Team/ Project Recovery Iowa

Iowa HHS is responsible for administering the disaster behavioral health plan for Iowa. Iowa HHS staff serves as the liaison between the federal government disaster grant 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, DBHRT 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.

DBHRT 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.

Iowa HHS is responsible for administering Project Recovery Iowa and current funding goes through June 30, 2024. The focus is on training in the workplace and community on working fatigue and other post-COVID related topics.

F. Services to SUPTRS Priority Populations

1. SUD Treatment for Pregnant Women and Women with Dependent Children

Four IPN contractors were selected to provide women and children treatment and ancillary services statewide. Individuals seeking treatment services can seek care from either the facility geographically closest and/or may choose to seek treatment at any state-wide facility. Partners and stakeholders from a system perspective may refer an individual to a Women and Children Facility. Women and Children facilities are required to advertise that services are prioritized for women and children and must make admission a priority.

The four providers/contractors who were awarded the women and children SAMHSA set-aside funding included: Heartland Family Services (Western Iowa), Area Substance Abuse Council (Eastern Iowa), House of Mercy (Central Iowa), and Rosecrance Jackson Centers (Northwest Iowa). These facilities are multi-service agencies that provide or coordinate all required SUBG treatment and ancillary services. All providers focus efforts around a case management model, which provides a central point to serve as the client's advocate. This model is foundational to assist the client in goal setting and coordination of all necessary and required services.

Women and children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and children treatment must be available when needed, with minimal wait time. Women and children providers must provide all ancillary services and requirements under Code of Federal Regulations (ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children). Other treatment funding may be funded by Medicaid if the client and/or their children have Medicaid (consistent with client enrollment). The women and children set aside are utilized as the payer of last resort.

These providers provide gender specific treatment and other therapeutic interventions which addresses the unique needs of the woman and her children. Evidence-based practices are provided and examples include; Healthy Living and Balance, Seeking Safety, Matrix Model, 12-Step Reinforcement and Enhancement, Releasing the Shame, Harm Reduction, Hazeldens Comprehensive Opioid Response, 12-Step, Dialectical Behavioral Therapy, Cognitive Behavior Therapy (CBT), Motivational Interviewing, Connections (Brene Brown) and Parent Child Interaction Therapy (PCIT).

Women and their children live in their own living space, participate in meal times and needs are individualized and assessed on the optimal functioning of the family unit. To help support fathers, providers also work with men and provide specific practices and evidence based practices including; Helping Men in Recovery, Beyond Anger, and 24/7 Dads. Providers utilize a variety of screening tools including, but not limited to; the Drug Abuse Screening Tool (DAST), the Clinical Opiate Withdrawal Scale (COWS), the Patient Health Questionnaire (PHQ-9), the Alcohol Use Disorders Identification Tool (AUDIT) and various intimate violence, trauma and other screening tools.

2. SUD Treatment for Persons who Inject Drugs

Per 45 CFR 96.126 (Capacity of Treatment for Intravenous Drug Abusers), all IPN providers must provide attestation to, and comply with the following requirements:

- Access to the appropriate SUD Treatment services within 14 days after making the request for admission.
    - Access within 120 days if all available programs are at capacity for admissions, and that SAMHSA's prescribed interim services are provided not later than 48 hours after request for admission.
- Report all individuals who are awaiting admission to Iowa's statewide waitlist.
- Provide outreach to encourage all individuals who inject drugs to engage in the appropriate SUD Treatment services.
- Report to Iowa HHS within 7 days of reaching 90% capacity for admissions.

3. SUD Treatment Requirements Regarding Tuberculosis (TB)

Per 45 CFR 96.127 (Requirements Regarding Tuberculosis), all IPN providers must provide attestation to, and comply with the following requirements:

- Directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in 45 CFR 96.121 to each individual receiving SUD Treatment.
- Referral to an alternative SUD Treatment program in the case of the original program's lack of capacity, or denial of admission.
- Will implement infection control procedures established by the principal agency of a State for substance abuse, in cooperation with the State Department of Health/Tuberculosis Control Officer, which are designed to prevent the transmission of tuberculosis, including the following:

- TB screening for all clients.
- Access to healthcare services for TB testing and, when necessary, TB treatment.
- Meet all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2.

4. Early Intervention Services for HIV/AIDS

While Iowa is not an HIV-designated state for the SABG, services for persons with or at high risk for HIV/AIDS are provided directly by IPN-funded providers or through interagency agreements with other local agencies. Services include counseling and education about HIV, the risks of transmission to sexual partners, the relationship between injecting drug use and communicable diseases, steps that can be taken to avoid HIV transmission, and referral for HIV treatment services. Early intervention services for HIV disease are undertaken voluntarily by, and with the informed consent of the individual. Such services are not required as a condition of receiving substance abuse treatment services.

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 systems, 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, including for 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 data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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 M/SUD system of care 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 M/SUD system of care.

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, SUD prevention, and SUD treatment goals at the state level.

I. State of Iowa Overview

State Demographic Summary

Iowa, named after the Ioway Indian tribe, became the 29th U.S. state in 1846. Iowa is known as the Hawkeye State and Des Moines, Iowa's largest populous county, is the capital city. The State of Iowa's 99 counties have an estimated population of 3,200,517 in 2022 which is an increase of 10,148 since 2020; https://www.census.gov/quickfacts/fact/table/IA#

Iowa's general population characteristics include:

- Male 49.8%/Female 50.2%
- Population under 5 years: 5.8
- Population under 18 years: 22.6%
- Populations 65 and over: 18.3%
- Population 85 years and over: 2.4%
- Median age: 38.3 years
- Educational attainment of High School degree or higher 92.8%/Bachelor's degree or higher 29.7%
- Civilian veterans: 5.7%
- Language spoken at home: English only 85.5%/ Spanish 3.94%/Asian and pacific Islander 1.59% and other 2.48%
- Median Household Income: $65,429
- Urban 63.2%/Rural 36.8%
- Individuals below poverty level: 11.1%

According to the 2020 U.S. Census estimate the following are Iowa's population characteristics:

- White alone, 89.8%
- Black or African American, 4.4%.
- American Indian and Alaska Native 0.6%
- Asian Alone, 2.8%
- Native Hawaiian and Other Pacific islander alone, 0.2%
- Hispanic or Latino, 6.9%.
- Two or more races, 2.2%

State Epidemiological Workgroup and Prevention Partnerships Advisory Council (SEWPPAC)

Iowa HHS's Division of Behavioral Health, Bureau of Services, Planning, and Performance chairs and supports the SEWPPAC.

The State Epidemiological Workgroup (SEW) was started in 2006 through a grant provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Prevention Partnerships Advisory Council (PPAC) was established in 2009 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) through SAMHSA. In 2019, these groups joined efforts to create one council (SEWPPAC). The SEWPPAC is composed of approximately 45 state and local members from across Iowa representing a variety of organizations. The SEWPPAC meets quarterly and corresponds more frequently as needed. The SSA Data Manager and Prevention Lead facilitate the quarterly meetings.

The SEWPPAC initiates processes to establish the Strategic Prevention Framework as the basis for ongoing state substance abuse prevention (and treatment) needs and outcomes monitoring. The SEWPPAC process involves forming an epidemiological team to assess, analyze, interpret, and communicate data about Iowa substance consumption patterns and consequences.

SEWPPAC Goals:

- Prevent the onset and reduce the progression of chosen priority substance misuse issues
- Reduce substance misuse-related problems in the community.
- Build and support prevention capacity and infrastructure at the state and community levels.

SEWPPAC Objectives:

- Support an array of services by coalitions, state agencies and other partners.
- Develop a plan to enhance the capacity, infrastructure and cultural responsiveness of substance misuse prevention efforts at the state and community levels.
- Promote the use of data driven decisions to select evidence-based practices.
- Build a foundation for delivering and sustaining effective substance misuse prevention services.

SEWPPAC Purpose:

- Assess the scope and extent of substance misuse and substance misuse-related problems in Iowa through the review of data and determine the substance misuse priorities for prevention funding and services.
- Increase the state and community level capacity to address the substance misuse priorities.
- Develop and support a Strategic Plan to address the substance misuse priorities.
- Recommend the implementation of effective prevention strategies that address the priorities and effect positive change in outcomes.

- Guide the evaluation of the Strategic Prevention Framework (SPF) process at the state and community levels.
- Promote cultural responsiveness and equity throughout the SPF process.
- Develop a plan to sustain the outcomes from the SPF process.

Various reports, data resources, common data reports, epidemiological profiles, substance use data briefs have been a priority of this workgroup and may be found at: Prevention Related Programs - Data, Publications and Reports | Iowa Department of Health and Human Services

II. Unmet Mental Health Service Needs and Gaps

Children with Serious Emotional Disturbance (SED)-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, 2021, it is estimated that the Iowa SED prevalence ranges from 19,226-42,297. The data is provided in a range due to SAMHSA providing prevalence estimates for children at different levels of functioning.

https://www.samhsa.gov/data/sites/default/files/reports/rpt39369/adult_smi_child_sed_prev_2021_508.pdf

The following data compares the prevalence rate to data available regarding services to children with an identified SED in Iowa:

	Number of children approved for the CMH waiver as of 8/1/23*	Percentage of the estimated Iowa SED population	SFY23 -Number of children receiving System of Care services for children with an SED*	Percentage of the estimated Iowa SED population
2021 Estimate of children age 9-17 with a serious emotional disturbance 42,297	1,339	3.2%	351	<1%

*This data includes children younger than the age of 9.

The waiting list for the Children's Mental Health Waiver has decreased since the state's last MHBG application in 2021. As of August 2023, 896 children were on the waiting list to be considered for a slot. 489 slots are currently in the process to determine eligibility for the CMH waiver. The length of time from application to notification of slot availability is one year, which is less than in previous years.
https://dhs.iowa.gov/sites/default/files/8.5.21_Monthly_Slot_and_Wait_list_Public.pdf?08182021 1421

SOC programs for non-Medicaid eligible children have increased availability from 14 to 16 of the 99 counties in Iowa, however this service is still available to a small portion of Iowa youth with an SED.

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 services including out of home treatment and placement.

The National Survey of Drug Use and Health, 2021 reports that 23.65 % of Iowa youth ages 12-17 had at least one major depressive episode in the previous year. This is an increase from 16.69% in 2019, however due to changes in survey methodology due to the pandemic, SAMHSA does not promote comparison of 2021 data with previous year's data.
https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf

The 2021 Iowa Youth Survey, a biannual survey completed by approximately 46,000 Iowa 6th, 8th, and 11th graders provided data regarding students' thoughts of suicide. According to the survey, 8 of 6th graders, 11% of 8th graders, and 12% of 11th graders made a plan to kill themselves in the last 12 months. 4% of 6th graders, 5% of 8th graders, and 5% of 11th graders reported attempting to kill themselves in the last 12 months.
https://hhs.iowa.gov/sites/default/files/idphfiles/2021%20Iowa%20Youth%20Survey%20State%20Report_1.pdf

Families of children with mental health issues and advocates continue to identify lack of trained providers for children and youth, lack of crisis services specifically for children, a need for more therapeutic school settings, need for more providers skilled in treating co-occurring MH and SUD, and access to school-based mental health 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 following prevalences were found:

- SAMHSA URS Table 1 2021 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 132,646.
- For adults 18 and above, the National Survey of Drug Use and Health, 2021, reported:
  - 4.94% of Iowans 18 years or older had serious thoughts of suicide in the past year
  - 9.33% reported a major depressive episode in the past year
  - 6.46 had an SMI, while adults 18-25 had almost double the rate at 11.98%
  - 25.26% reported having any mental illness in the previous year
  - For adults 18-25, higher rates of serious mental illness and major depressive episodes in the past year were noted while the overall adult population and the 18-25 population accessed mental health services at essentially the same rate of 20%.

https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf

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.

As part of the 2018 Complex Needs Workgroup process, the availability of Assertive Community Treatment services was measured across the state using the recommended measure that .06 percent of the population should have access to an ACT team. By this measure, it was determined that Iowa needed 22 ACT teams. It was enacted in legislation that 22 ACT teams be operational by July 1, 2021. Iowa currently has 18 ACT teams, an increase from 14 in the previous report. .

Early Serious Mental Illness

Starting in 2014, Iowa has worked diligently to develop Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) teams using the Set Aside for Early Serious Mental Illness funds designated in Iowa's MHBG allocation. The current set-aside percentage is 10% of the total award. These funds can only be used for ESMI/FEP services and program support. Iowa has implemented the NAVIGATE model for this population, which is an evidence-based coordinated specialty care practice. State staff provide technical assistance and contract management for the three programs. With MHBG COVID Supplemental Funds, in 2021 Iowa added a fourth team to serve individuals experiencing a first episode of psychosis. Teams are located in Cedar Rapids, Des Moines, Mason City, and Sioux City.

In FY23, the 4 teams served 102 individuals. SAMHSA URS Table 1 2019 identifies an Iowa prevalence rate for adults with SMI of 5.4% or 131,027. Estimated prevalence of individuals experiencing a first episode of psychosis in Iowa is 957. The number receiving NAVIGATE services is a small percentage of the estimated Iowans with an SMI or a first episode of psychosis, demonstrating that the need for programs to assist people diagnosed with a serious mental illness at the beginning of their illness is essential. The state is exploring how to assist the programs to expand their reach and serve more individuals.

III. Unmet Substance Use Disorder Service Needs and Gaps

Primary Prevention Services

Through the Integrated Provider Network (IPN), primary prevention services focus on the lifespan, but include priorities of alcohol, marijuana, methamphetamine, opioids and prescription medication as well as tobacco. Priorities align with data needs highlighted in

Iowa's Epidemiological Profile. IPN contractors are required to provide services to the priority focus areas including:

- Adult Alcohol Heavy Drinking (Ages 25-65)
- Youth Marijuana Use (Ages 12-20)
- Methamphetamine - All Ages
- Opioids - All Ages
- Adult Prescription Medication Misuse (Ages 65 and older)
- Youth Tobacco Use (Ages 12-20)

IPN contractors have been required to focus on addressing substance use with adults and older adults with a specific focus on alcohol use. Iowa HHS has been monitoring Iowa's alcohol related mortality related to alcohol involved deaths and data reviewed show a ten year trend in which deaths related to alcohol use doubled with those 45 years old and older. Iowa HHS has researched and promoted a variety of evidence-based programs, practices and policies focused on adults and older adult populations.

Iowa's underage drinking rate has declined over a ten year period and has continued to trend downward. These positive outcomes are in part related to the intensive work of Iowa's prevention field, including through IPN prevention contractors implementing a variety of individual and population level underage drinking prevention strategies.

Iowa HHS promotes use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in prevention services. Iowa HHS also supports culturally responsive prevention services through the use of the Strategic Prevention Framework (SPF) prevention planning model. Iowa HHS funds and recommends use of evidence-based programs, policies and practices that provide services to disparate populations at the county level. Iowa HHS prevention contractors are required to identify these populations within the Planning step of the SPF process in a county-level strategic plan and then provide services to these groups in the Implementation step of the SPF. In addition, Iowa HHS has provided training and educational resources to support these approaches.

The IPN prevention workforce is experiencing challenges related to workforce development including prevention staffing capacity and ensuring competency due to this turnover. Even though prevention service needs have increased, staffing levels have remained stagnant. Other challenges in the prevention field include larger geographic areas of coverage, workforce shortages and the ability to offer services with enough dosage and frequency.

Through the Iowa Board of Certification (IBC), Iowa has two levels of Prevention Specialist Certification; Certified and Advanced Certified Prevention Specialists. For additional information on prevention certification in Iowa, visit: Certified & Advanced Certified Prevention Specialist (CPS, ACPS) – Iowa Board of Certification. Iowa HHS requires IPN prevention funded staff to obtain and hold a prevention certification. Although the workforce of Certified Prevention Specialists has expanded, Iowa HHS is still focusing on ways to enhance available infrastructure to support the workforce and to coordinate workforce development

efforts by increasing the accessibility of learning, training and education opportunities for IPN prevention contractors.

Strategies to meet need-Primary Prevention

- Iowa HHS will support two in person learning communities for IPN prevention contractors focused on prevention needs and gaps to strengthen processes through the IPN grant.
- Iowa HHS will conduct one training needs assessment with IPN prevention contractors to determine priority training topics and will establish a two-year prevention training calendar which will include topics identified in the training needs assessment.
- Iowa HHS will create an online training portal for IPN prevention contractors which will include self-moderated and self-paced training opportunities focused on grant orientation, foundational processes and prevention practices.
- Iowa HHS will facilitate workforce training by engaging Iowa State University Extension to organize and host up five training opportunities over a two- year period. Trainings will include but are not limited to the topics of ensuring fidelity, evaluation processes and sustainability of positive outcomes.
- Iowa HHS will create at least five promotional items to highlight various prevention training opportunities.
- Iowa HHS will create and support a Project ECHO process for the prevention field including IPN prevention contractors to discuss timely and relevant prevention topics and share best practices.
- Iowa HHS will create four data visualizations focused on IPN prevention strategies, IPN prevention service allocations and IPN prevention service innovative success stories.
- Iowa HHS will continue to require IPN prevention contractors to use data to inform prevention services and ensure prevention services across the lifespan through the Strategic Prevention Framework process.
- Iowa HHS will continue to engage disparate populations through IPN prevention services driven through the Strategic Prevention Framework.

Development of Recovery Housing and Community Centers to support individuals with an SUD or in recovery from an SUD

On October 24, 2018, the "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities" (SUPPORT) was signed into law by then President Trump. Subtitle D, Ensuring Access to Quality Sober Living (SEC. 7031), of this law mandates that the Secretary of Health and Human Services, in consultation with other specified individual stakeholders and entities, shall identify or facilitate the development of best practices for operating recovery housing. These best practices may include model laws for the implementation of suggested minimal standards that:

- Consider how recovery housing is able to support recovery and prevent relapse, recidivism, and overdose, including by improving access to medication assisted treatment

- Identify or facilitate the development of common indicators that could be used to pinpoint potentially fraudulent recovery housing operators

The SUPPORT legislation seeks to improve resident care for individuals suffering from a substance use disorder (SUD) who are in need of supportive recovery-oriented transitional housing. Recovery Housing is an intervention that is specifically designed to address the recovering person's need for a safe and healthy living environment while providing recovery and peer support.

Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the following definition of recovery housing:

"Recovery houses are safe, healthy, family-like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to others in recovery, mutual support groups and recovery support services. Substance-free does not prohibit prescribed medication taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorders"

According to the National Overview of Recovery Housing Accreditation Legislation and Licensing January 2020 report, to deliver the best care possible, SAMHSA supports the levels of care, as identified by the National Alliance of Recovery Residences (NARR) and other stakeholder agencies. These levels accurately reflect the basic structural blueprint of quality recovery housing and highlights the continuum of support ranging from nonclinical recovery housing (Level I and II) to clinical and usually licensed treatment (Level II & IV).

A significant gap within Iowa's treatment continuum of care, is the lack of community centers and recovery housing arena to support Iowans access to recovery community centers and recovery housing. Historically, Iowa HHS has facilitated a Release for Proposals (RFP) and has provided extensive educational learning training across the state to assist in knowledge development and implementation of Recovery Housing Community Centers. Within the last several years, personnel from the Connecticut Community on Addiction Recovery (CCAR) have consulted with Iowa HHS to deliver this training series and to solicit interest. To address these needs, Iowa HHS has awarded funding to four recovery community centers around the state and has partnered with national organizations to establish an Iowa National Alliance for Recovery Residences (NARR) affiliate, the Iowa Coalition of Recovery Support Providers (ICRSP). These new organizations work specifically with individuals in different stages of recovery to provide support and resources as needed to maintain recovery successfully. During the ICRSP formation process, through a contract with NARR, Iowa HHS has worked with the NARR affiliates in both Missouri and Virginia to certify residences currently providing services, while concurrently establishing NARR guidelines specific to Iowa.

Strategies to Meet Needs

- Under the purview of the COVID-19 Supplement, SOR 2, and American Rescue Funding (ARP) Supplement, Iowa HHS has hired multiple internal staff to provide oversight of all recovery related efforts. These staff are responsible for implementation and expansion of various recovery initiatives; such as the Recovery Community Center(s), Recovery Community Organization (s), development of Recovery Housing; and expanding availability of Recovery Peer Coaching in Iowa.
- Under funding support of the COVID-19, State Opioid Response, and ARP funding, Iowa HHS is supporting four recovery community centers across the state. These centers are contracted to deliver recovery support services to individuals, such as: recovery peer coaching; recovery meetings; recovery calls; and referral services.

Pregnant Women and Women with Dependent Children; Persons who use Injection Drugs; Tuberculosis Services

Through the IPN, four women and children IPN providers were selected to provide women and children treatment and ancillary services statewide. Women and children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and children treatment must be available when needed, with minimal wait time. Women and children providers must provide all ancillary services and requirements under Code of Federal Regulations (ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children). The women and children set aside funding is utilized as the payor of last resort. Calendar Year 2022 data below, as reported by the contractors to the State of Iowa, provides percentages of the individuals who were admitted within 10 days or less, from date of first contact to admission, at each of the four women and children providers/contractors who receive the women and children set aside funding:

- House of Mercy- 64%
- Jackson Recovery Center- 100%
- Heartland Family Service-58%
- Area Substance Abuse Council-56%

IPN providers who provide substance abuse treatment services must meet SUBG requirements and provide services to individuals who seek treatment to persons who inject drugs and to individuals related to the tuberculosis requirements. Through the IPN, providers must sign annual attestation documentation which outlines the SABG regulations under 45 CFR 96.126 Capacity of Treatment for Intravenous Substance Abusers. These regulations include, but are not limited to, priority admission status, admission requirements, interim services provisions, referrals and counseling regarding HIV and TB, and waiting list requirements. In Calendar Year 2022, there were 765 admissions to treatment where at least one substance had been used in the previous 30 days intravenously. Of this number, 78% were admitted within 14 days from date of first contact to admission. Of the remainder of individuals, 99% were admitted within 120 days from date of first contact.

IPN providers, who are awarded a contract with Iowa HHS, are required to sign an annual attestation regarding meeting all required SABG regulations. Within IPN contracts, IPN providers are required to meet SABG TB and Persons who inject drugs requirements including: timeliness standards, capacity notification requirements, outreach efforts, providing or making services available to TB clients (including screening, counseling, education, referral to medical providers, as needed, and reporting to the Bureau of TB any active TB cases (within 1 day) and interim service provisions. See discussion in Step I.

Through the quality improvement efforts, Iowa HHS is collecting, analyzing and disseminating data to inform program policies, programs and practices. Iowa HHS is enhancing their quality improvement data collection, outcomes, and evaluation process to identify and address gaps in access to services within all priority population categories. Iowa HHS is directly working with IPN providers to improve the delivery of services, promote awareness of SABG regulations, and to inform policy and programmatic issues both at the provider level and within Iowa HHS monitoring processes.

Iowa HHS contracted with the University of Northern Iowa-Center for Social and Behavioral Research (UNI-CSBR) to initiate at least 200 calls to IPN funded programs using a substance use profile. This sub-report was requested by Iowa HHS specific to establishing a baseline regarding SABG priority populations. CSBR researchers placed calls to each IPN agency using simulated client profiles to evaluate the response received by those seeking SUD treatment services.

In the spring of 2023, researchers made 128 calls to IPN agencies. Of these calls, 89% (n=86) were made using profiles which were part of at least one priority population. Calls using simulated clients helped advance the understanding of current agency protocols for those in priority populations as described. The overall rate for successful outcomes among priority population simulated calls was 55%, which is an increase from approximately 21% overall success from the fall of 2022 reporting period. The increase in successful outcomes may be attributed to a technical assistance project carried out prior to the spring, 2023 call period. Iowa HHS intends to continue contracting with UNI for this research and will continue conducting targeted technical assistance as needed.

Several of the gaps identified suggest continued focus is needed at time of initial intake regarding: 1) inquiring if the client was pregnant and/or using drugs by injection, 2) requirements related to counseling regulations, 3) and timeframes of admission from date of first contact.to admission. Iowa HHS has provided extensive review of findings with IPN providers/contractors and is seeking to improve wait times, provision and understanding of interim services, and access and engagement in treatment services.

<u>Strategies to Meet Needs</u>

- Iowa HHS will continue providing targeted training to IPN providers about the SABG regulations regarding priority populations, interim service provision and TB requirements
- Iowa HHS has implemented a SUBG regulations policy attestation/ acknowledgement. IPN providers must sign acknowledgement of compliance and

submit policies on an annual basis of how they are meeting priority population regulations.

- Iowa HHS is continuing the contract with UNI-CSBR to continue to initiate client simulated calls for all IPN providers. Simulated calls are to occur again in September 2023 and March 2024. Iowa HHS will analyze and compare simulated call data to determine outcomes/trends and initiate quality improvement measures accordingly. Iowa HHS will communicate and share data with contractors/providers.
- Iowa HHS is promoting technical assistance, training and strategy development regarding SUBG priority population needs/regulations through IPN director monthly meetings. and community of practice quarterly meetings
- Iowa HHS is facilitating collaboration between all IPN contractor's Community of Practice quarterly meetings to develop sharing of best practices.
- Iowa HHS is working with IPN contractors to improve data collection and use of these simulated call data to improve service delivery to priority populations. One specific strategy is through the enhancement of data collection through the new Iowa Behavioral Health Data Reporting System (IBHRS) which has added many of these data points.

Youth Substance Use Disorder Services

Iowa recognizes youth in need of substance user disorder early intervention and treatment as an area of need. Data was collected from NSDUH (2020), BRFSS (2020), NIAAA (2021), IYAS (2019), and the Iowa Behavioral Health Reporting System (IBHRS) to assist with the creating the *Iowa Substance Abuse Brief: Substance Use among Young Adults (June, 2022)*. Per this report, substance misuse prevalence data ranks Iowa young adults (ages 18-24) at a higher risk than the US at large in many categories. 57% of Iowa young adults reported alcohol use in the past 30 days, compared to the national rate of 49%. Binge drinking was higher among Iowa young adults (about 1 in 3) compared to those nationwide (about 1 in 4). While the prevalence of smoking tobacco has reduced in Iowa young adults over the 5 years preceding this data, marijuana use continues to be the most widely used illicit substance by this age group in Iowa and the US. Over one-third of Iowa young adults reported using marijuana in the past year, and approximately 1 in 5 (21%) of Iowa young adults reported using marijuana in the past 30 days. 5% of Iowa young adults reported using cocaine in the past year, 4% of Iowa young adults reported prescription pain reliever misuse in the past year, 0.7% of Iowa young adults reported methamphetamine use in the past year, and 0.1% of Iowa young adults reported heroin use in the past year.

From 2017 to 2021, there were an average of 30 deaths per year involving drugs among Iowans 15 to 24 years old (IDPH, 2022). By gender, drug related deaths in this age group were 72% male and 28% female. By race, 82% of drug-related deaths among 15–24-year-olds were White, 13% African American, 2% Asian / Pacific Islander, and 4% another race. By ethnicity, eight percent were Hispanic (91% non-Hispanic). Since 2019, deaths have increased from their 5-year low of 18 deaths to their 5-year high of 42 deaths.

Currently, among Iowa's 99 licensed substance use treatment providers, 3 provide a residential substance use disorder treatment level of care (ASAM level 3), for a total of 58 beds dedicated

to this age group, statewide. Anecdotally, behavioral health professionals report difficulty finding and utilizing these services.

Strategies to Meet Needs

While there is an abundance of data available which demonstrates the ongoing and increased need for youth substance use services, state-run projects with outcome-based activities are limited. Additional information is needed from Iowa's licensed substance use treatment providers to understand Iowa's current capacity, needs, and gaps for serving youth in need of substance use services, in order to inform the creation of such projects. Areas of interest are Iowa's existing infrastructure for youth substance use services, intersections between substance use treatment providers, other behavioral health services, child welfare, law enforcement, education, etc., who serve youth in Iowa. To assess its current system, Iowa intends to carry out at least two activities for this purpose, by August of 2025.

Persons at Risk for HIV/AIDS

While Iowa is not an HIV-designated state for the SABG, services for persons with or at high risk for HIV/AIDS are provided directly by IPN-funded providers or through interagency agreements with other local agencies. Services include counseling and education about HIV, the risks of transmission to sexual partners, the relationship between injecting drug use and communicable diseases, steps that can be taken to avoid HIV transmission, and referral for HIV treatment services. Early intervention services for HIV disease are undertaken voluntarily by, and with the informed consent of the individual. Such services are not required as a condition of receiving substance abuse treatment services.

IV. Mental Health Planning Council Feedback

Needs and concerns identified by Mental Health Planning Council members:

Overall mental health system:

- The Planning Council recommends that the state focus on expanding peer support services, including ongoing support of the 4 peer-run programs which began in 2022 and will need ongoing funding after grant funds end.
- More access to peer-run respite houses is also recommended
- More warmline services including services focused on youth. Expand warmline to 24 hours per day operation.
- Decrease in workforce, specifically Licensed Independent Social Workers (LISW), psychiatric nurses, Advanced Registered Nurse Practitioners (ARNP), Physician Assistants (PA), Licensed Mental Health Counselors (LMHC), Psychiatrists etc. as well as the direct workforce.
- More training for the community and providers on brain injury and the effect on mental health
- Lack of a "place to go" for individuals in crisis in rural areas

Individuals with co-occurring mental health and substance use disorders:

- Lack of trained providers is of concern across all areas, including co-occurring services.
- There are barriers between mental health and substance use treatment funds
- Individuals needing substance use treatment sometimes struggle to access treatment if they are not actively using

Children with an SED and their families:

- Need to focus more on transition age youth and helping them be connected to mental health services in adulthood. This includes youth in foster care who have additional challenges as they transition from that system.
- Continue to support therapeutic classroom grants through the Department of Education, it is a relatively small number compared to the number of schools in Iowa.

Adults with SMI/Older Adults/Rural Individuals:

- Lack of funding for peer-run organizations. These organizations fill a special role and are able to do things that no other provider does, including crisis service.
- Lack of BH workforce in general was identified as a concern. Planning Council using UI data as a resource to identify numbers of psychiatrists and other MH professionals in IA.
- More services are needed for older Iowans due to facilities closing, workforce shortages, and lack of specialized mental health care for older persons.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Development of Certified Community Behavioral Health Clinics in Iowa

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PWID

Goal of the priority area:

The state will submit a CCBHC Demonstration Application in March 2024 with the goal of participation in the CCBHC demonstration project and expanding CCBHC services across the state.

Strategies to attain the goal:

Gather input from stakeholders, select and certify clinics, submit an application for the CCBHC Demonstration by March 2024.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Submit CCBHC demonstration grant application.

Baseline Measurement: State is in the CCBHC planning grant process 3/31//23-3/30/24

First-year target/outcome measurement: Demonstration grant application submitted by March, 2024, or SAMHSA prescribed due date.

Second-year target/outcome measurement: N/A

Data Source:

Iowa HHS will be the submitter of the demonstration application to SAMHSA by March 31, 2024.

Description of Data:

Demonstration application

Data issues/caveats that affect outcome measures:

N/A

Priority #: 2

Priority Area: Behavioral Health Workforce

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB

Goal of the priority area:

Improve capacity, retention, and quality of Iowa's behavioral health workforce.

Strategies to attain the goal:

Provide access to ASAM Training
Provide access to the Relias system for selected CCBHC clinics

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: ASAM

Baseline Measurement: Iowa HHS does not currently have confidence or competence measures for the use of the ASAM

First-year target/outcome measurement: By the end of year 1, Iowa will establish a baseline measure of confidence and competence in using the ASAM by Iowa providers.

Second-year target/outcome measurement: By the end of year 2, Iowa will provide a minimum of 2 ASAM trainings

Data Source:

Confidence and competence participant surveys.

Description of Data:

Iowa will examine pre and post training survey results to measure changes in confidence and competence with administering ASAM evaluations with fidelity.

Data issues/caveats that affect outcome measures:

Workforce shortages
ASAM 4th Edition releases in late 2023 which may increase the learning curve for clinicians currently utilizing ASAM 3rd Edition.

Indicator #: 2

Indicator: Training and Technical Assistance of CCBHC Clinics

Baseline Measurement: 0

First-year target/outcome measurement: 9 clinics enrolled with Relias and accessing training for their staff

Second-year target/outcome measurement: 9 clinics enrolled with Relias and accessing training for their staff

Data Source:

HHS-Division of Behavioral Health

Description of Data:

CCBHC Clinics will be enrolled through Relias for training supporting technical assistance needs for CCBHC certification. This may include CLAS standards training, training on payment methodologies,and other CCBHC specific areas of technical assistance.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 3

Priority Area: Treatment for Early Serious Mental Illness/First Episode Psychosis

Priority Type: ESMI

Population(s):

Goal of the priority area:

Increase number of individuals receive ESMI/First Episode Psychosis Treatment services through Iowa's NAVIGATE teams

Strategies to attain the goal:

Work with existing teams to address increasing people served including expanding service areas, technical assistance on education and outreach, improved staff orientation and training to improve stability and retention of team members.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Numbers of individuals served by Iowa NAVIGATE Teams

Baseline Measurement: 102

First-year target/outcome measurement: 120

Second-year target/outcome measurement: 135

Data Source:

Iowa HHS-Division of Behavioral Health Contract Management

Description of Data:

Data provided by each team quarterly regarding numbers of individuals admitted and discharged.

Data issues/caveats that affect outcome measures:

Staff turnover affects the ability of teams to engage with referral resources and find new clients. The criteria to qualify for NAVIGATE services is very specific, which limits eligibility and makes outreach and coordination activities essential.

Indicator #: 2

Indicator: Work with Iowa NAVIGATE teams to add peer support services to the NAVIGATE team structure

Baseline Measurement: 0 teams have peer support specialists

First-year target/outcome measurement: Teams work with HHS and technical assistance to incorporate peer support into the team structure

Second-year target/outcome measurement: 4 teams have peer supports

Data Source:

Iowa HHS-Division of Behavioral Health is the contract manager for the NAVIGATE teams and will monitor the activities and implementation.

Description of Data:

Quarterly provider reports

Data issues/caveats that affect outcome measures:

Availability of trained peer specialists to work with NAVIGATE teams.

Priority #: 4

Priority Area: Development of a Behavioral Health Planning Council

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s):

Goal of the priority area:

As the state has aligned its MHBG and SUPTRS grant, the Mental Health Planning Council is working toward becoming a Behavioral Health Planning Council.

Strategies to attain the goal:

1. MHPC is receiving TA
2. Need to increase membership to include persons with lived experience of SUD and professionals providing SUD treatment services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Membership of individuals with lived experience and SUD provider representation are Council members

Baseline Measurement: 0

First-year target/outcome measurement: 2

Second-year target/outcome measurement: 4

Data Source:

Planning Council Meeting minutes and HHS staff who work with the Planning Council

Description of Data:

Membership lists of the Planning Council.

Data issues/caveats that affect outcome measures:

The Planning Council is currently receiving technical assistance on expanding the scope of the council to include individuals with substance use disorders and their families. Changes will have to be made to their bylaws and processes to expand the scope of the council.

Priority #: 5

Priority Area: Access to Behavioral Health Crisis Services

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, Other

Goal of the priority area:

Increase access to mobile crisis statewide in compliance with CCBHC and Medicaid Section 9813 Standards

Strategies to attain the goal:

1. Clinics seeking CCBHC certification will either directly provide or contract with a state-sanctioned provider to ensure access to all required crisis services in the identified catchment area.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Counties with crisis services that meet CCBHC and Section 9813 criteria

Baseline Measurement: 0

First-year target/outcome measurement: 99

Second-year target/outcome measurement: 99

Data Source:

Iowa HHS-CCBHC certification process documentation

Description of Data:

certification documentation
accreditation records
MHDS regional review of crisis services

Data issues/caveats that affect outcome measures:

ability of providers to staff crisis services, especially in rural or underserved areas.

Priority #: 6

Priority Area: Primary Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Increase Iowan's Access to and Quality of Primary Prevention Services

Strategies to attain the goal:

Offer systems to support the prevention workforce to ensure quality primary prevention services occur including trainings, learning communities and materials.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access and quality of primary prevention programming.

Baseline Measurement: Training needs assessment

First-year target/outcome measurement: By the end of year one, Iowa HHS will conduct learning communities and a training needs assessment with prevention contractors to determine priority needs and training topics. Iowa HHS will establish a two-year prevention training calendar which will include topics identified in the training needs assessment. a) Engage Iowa State University Extension to organize and host at least five training opportunities over a two-year period. b) Create at least five promotional items to highlight various training opportunities. c) Create an online training portal on prevention training opportunities.

Second-year target/outcome measurement: By the end of year 2, Iowa HHS will provide additional workforce supports. a) Create a Project ECHO process for prevention b) Create visualizations to promote prevention processes and successes. c) Measure progress of training and support efforts/80% of participants will report an increase ability to provide quality prevention services.

Data Source:

Training needs assessment, attendance records, evidence of online training portal, five trainings over two-year period, promotional items to highlight training opportunities and data visualizations.

Description of Data:

Training needs assessment data, event attendance, event satisfaction surveys, calendar of trainings, materials created, contract with Iowa State University, survey of providers at end of two-year period to assess if learning objectives were met.

Data issues/caveats that affect outcome measures:

Workforce constraints on state and contractor levels.

Priority #: 7

Priority Area: Pregnant and Parenting Women

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Facilitate Access to Women and Children Treatment Services

Strategies to attain the goal:

Continuous Quality Improvement activities to increase access to services including data management, data reports and corrective action plans. Contracting with UNI for simulated calls to monitor knowledge, access and understanding of SUBG regulations among IPN contractors.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access for priority population-within 7 days from date of first contact to admission

Baseline Measurement: IBHRS data for women and children services providers; greater than seven days

First-year target/outcome measurement: By the end of year one, access to services will occur within 8 days from date of first contact

to admission

Second-year target/outcome measurement: By the end of year two, access to services will occur within 7 days from date of first contact to admission

Data Source:

IBHRS data-Residential Treatment Wait Time Report

Description of Data:

Iowa Behavioral Health Reporting System is Iowa's data management system

Data issues/caveats that affect outcome measures:

Workforce developments concerns

Priority #: 8

Priority Area: Recovery Support Services

Priority Type: SUR

Population(s): PWWDC, PWID

Goal of the priority area:

Advance Treatment Continuum of Care

Strategies to attain the goal:

Iowa HHS will introduce projects and programs dedicated to recovery & peer support services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Assign funding and pathways dedicated to the accessibility of recovery support services Iowa

Baseline Measurement: 2022 Recovery Support Services utilization

First-year target/outcome measurement: Assess needs and gaps in Iowa for recovery supports.

Second-year target/outcome measurement: Implement a statewide project dedicated to recovery support services.

Data Source:

IBHRS - Iowa's substance use data system
Iowa HHS Survey data

Description of Data:

IBHRS - to assess current utilization of recovery supports which are offered by SUBG sub-recipients.
Surveys - to assess needs and gaps.

Data issues/caveats that affect outcome measures:

Workforce challenges.

Indicator #: 2

Indicator: Incorporate peer support, family peer support and recovery peer coaching into the state's CCBHC model

Baseline Measurement: Planning Grant year-

First-year target/outcome measurement: Consult with the state's peer training contractor, peer support and family peer support specialists and recovery coaches on how to effectively integrate peer services into the state's CCBHC model.

Second-year target/outcome measurement: All certified CCBHCs in Iowa employ at least 1 FTE of each peer specialty by June 30, 2025

Data Source:

Iowa HHS

Description of Data:

Iowa HHS CCBHC certification records.

Data issues/caveats that affect outcome measures:

Priority #: 9

Priority Area: TB

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Iowan's will have increased access to TB services

Strategies to attain the goal:

Education on TB screening, testing, and regulations.
Provide training on SUBG regulations to ensure compliance with best practices and policies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Providers will demonstrate increased competency with serving individuals who may have TB.

Baseline Measurement: Iowa will collect pre/post survey questionnaires for all training opportunities, however there is not a current baseline measure.

First-year target/outcome measurement: A) All IPN providers will complete the SUBG Prevention and Treatment Regulations form which documents compliance with requirements for individuals who screen positive for TB.
B) By the end of year 1, 75% of training participants will report an increase in competency for serving individuals who may have TB.

Second-year target/outcome measurement: By the end of year 2, 85% of participants in a TB services quality improvement activity will report an increase competency for serving individuals who may have TB

Data Source:

SUBG policy attestation form.
Pre/Post activity questionnaire results.

Description of Data:

Iowa HHS will implement the SUBG Prevention and Treatment Regulations form, review compliance of policy against regulations. Iowa HHS will arrange training for SUBG regulations related to TB.

Data issues/caveats that affect outcome measures:

Workforce challenges.

Priority #: 10

Priority Area: Persons who Inject Drugs

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Iowan's who inject drugs will have increased access to services

Strategies to attain the goal:

Training to providers on SUBG regulations, contract with UNI for simulated calls, review data with providers, and corrective action as appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Competency and increased access to services for individuals who inject drugs

Baseline Measurement: Increased SUBG regulation competency and compliance for serving Iowan's who inject drugs.

First-year target/outcome measurement: All state contracted providers will complete the SUBG Prevention and Treatment Regulations form which documents SUBG requirements for individuals who inject drugs

Second-year target/outcome measurement: Iowa will provide at least 1 quality improvement activity to increase competency and compliance with SUBG regulations for persons who inject drugs.

Data Source:

SUBG Prevention and Treatment Regulations Form, policy review and quality improvement measures
Pre/post test competency and compliance survey results.

Description of Data:

Iowa HHS Prevention and Treatment Regulations Form, contractor policies, pre/post test competency and compliance survey results.

Data issues/caveats that affect outcome measures:

Workforce challenges.

Priority #: 11

Priority Area: Substance Use Treatment - Youth Services

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Increase access and quality of youth services in Iowa.

Strategies to attain the goal:

Review internal substance use treatment data for persons under age 18.
Survey Licensed providers on their capacity for youth services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Assess Iowa's substance use youth services system and identify gaps/disparities/areas of need.

Baseline Measurement: Carry out 2 activities for information gathering and data analysis for the purpose of surveying Iowa's substance use youth services system.

First-year target/outcome measurement: Review and analyze internal data to identify what substance use youth services are currently being offered.

Second-year target/outcome measurement: Survey Iowa licensed substance use treatment providers about their capacity for youth services, and information on needs/gaps/disparities.

Data Source:

Iowa Behavioral Health Reporting System (IBHRS)
Survey results from licensed Iowa Substance Use Treatment providers.

Description of Data:

IBHRS is Iowa's Substance Use Treatment services Database.
Targeted surveys will be built for the purpose of this performance indicator.

Data issues/caveats that affect outcome measures:

Incomplete data from licensed providers
Workforce limitations

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$10,044,289.00		$0.00	$13,464,759.00	$16,813,534.00	$0.00	$0.00		$2,229,663.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$1,390,939.00				$1,018,867.00					
b. Recovery Support Services	$2,000,000.00									
c. All Other	$6,653,350.00			$13,464,759.00	$15,794,667.00				$2,229,663.00	
2. Primary Prevention[d]	$3,368,804.00		$0.00	$3,078,753.00	$2,203,355.00	$0.00	$0.00		$0.00	$0.00
a. Substance Use Primary Prevention	$3,368,804.00			$3,078,753.00	$2,203,355.00					
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00			$0.00	$0.00					
6. Early Intervention Services for HIV	$0.00			$0.00	$0.00					
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$705,952.00			$2,643,992.00	$3,487,227.00				$117,351.00	
12. Total	**$14,119,045.00**	**$0.00**	**$0.00**	**$19,187,504.00**	**$22,504,116.00**	**$0.00**	**$0.00**	**$0.00**	**$2,347,014.00**	**$10,598,978.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:
COVID-19 Supplement No Cost Extension Remaining Balance: $2,347,014

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$1,547,882.00						$239,627.00		$1,119,845.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$12,383,064.00						$30,000.00		$5,096,422.00	
10. Crisis Services (5 percent set-aside)[f]		$773,941.00						$0.00		$2,987,717.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$773,941.00						$143,116.00		$338,935.00	
12. Total	**$0.00**	**$15,478,828.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$412,743.00**	**$0.00**	**$9,542,919.00**	**$1,243,896.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
Column H. COVID19 Supplemental
Line 3 10% set aside ESMI- $239,627
Line 9-
CCBHC Technical Assistance and Training $30,000
Line 11- Administration SFY 24 $143,116

Column J- ARP Funds
Line 3-10% set aside ESMI- $1,119,845
Line 9- non 24 hour/ambulatory
Grants to Peer-run organizations $2,400,000
SOC Care Coordination -1 program $400,000

Center of Excellence for EBPs $1,416,667
Gap services- $679,755
CCBHC Technical Assistance $200,000
Line 10- Crisis services 5% minimum set aside
988 implementation and support $2,987,717
Line 11 Administration $338,935

Column K-BSCA funds
Line 3-10% Set aside FEP Navigate programs $124,388
Line 9- Disaster Behavioral Health Support $ 759,754
Line 10-Crisis Services $359,754

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	1,805	280
2. Women with Dependent Children	64,251	3,433
3. Individuals with a co-occurring M/SUD	186,709	3,174
4. Persons who inject drugs	53,977	1,403
5. Persons experiencing homelessness	207	375

Please provide an explanation for any data cells for which the state does not have a data source.

Based on internal surveillance data

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Footnotes:

Data Sources: NSDUH & CDC Wonder Population Estimate

Data reflect ages 18+ only.

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$8,044,289.00	$2,229,663.00	$7,949,233.00
2 . Substance Use Primary Prevention	$3,368,804.00	$0.00	$2,119,796.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$2,000,000.00	$0.00	$0.00
6 . Administration (SSA Level Only)	$705,952.00	$117,351.00	$529,949.00
7. Total	**$14,119,045.00**	**$2,347,014.00**	**$10,598,978.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$14,119,045**	**$2,347,014**	**$10,598,978**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:
Iowa will plan and report activities utilizing IOM categories, however, no SUBG funds will be used for activities targeting individuals or subgroups.

No SUBG funds will be used for Section 1926-Tobacco.

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$2,834,562	$0	$1,732,079
Universal Indirect	$236,379	$0	$144,441
Selected	$202,705	$0	$123,864
Indicated	$27,732	$0	$16,946
Column Total	**$3,301,378**	**$0**	**$2,017,330**
Total SUPTRS BG Award[3]	**$14,119,045**	**$2,347,014**	**$10,598,978**
Planned Primary Prevention Percentage	**23.38 %**	**0.00 %**	**19.03 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024 A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$498,975.00	$39,630.00	$0.00	$2,229,663.00	$192,165.00
2. Infrastructure Support	$210,160.00	$0.00	$0.00	$0.00	$1,145,000.00
3. Partnerships, community outreach, and needs assessment	$160,331.00	$39,963.00	$48,726.00	$0.00	$110,732.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$2,663.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$83,291.00	$0.00	$0.00	$0.00	$7,909.00
6. Research and Evaluation	$173,000.00	$20,000.00	$0.00	$0.00	$7,909.00
7. Training and Education	$25,000.00	$45,000.00	$0.00	$0.00	$286,397.00
8. Total	**$1,153,420.00**	**$144,593.00**	**$48,726.00**	**$2,229,663.00**	**$1,750,112.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

COVID-19 expenditure is the total remaining no-cost extension amount.

ARP expenditures based on current approved contractor activities in Iowa's ARP Supplement funding opportunity.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total	**$**	**$**	**$**	**$**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Please wait while data loads...

Footnotes:

MHBG Grant
Line2- MHBG grant-Five Point psychiatric bed tracking FY
Line 2- MHBG grant Your Life Iowa-24 hour crisis line FY24-$574,586 FY25-$301,753
Line 3-MHBG Grant-Univ Iowa CDD FY24- $272,000 FY 25 $312,000
Line 3-Office of Recovery Supports FY24- $150,000 FY25 $150,000
Line 4-MHBG Grant-staff support and expenses for Planning Council FY 24 $80,000 FY25 $80,000
LIne 7-ESMI-NAVIGATE program training SFY24-$55,000 SFY25 $55,000
Line 7-UI Peer Support Training FY 24 $500,000 FY25 $500,000
Line 7-CMHC Relias training access FY24 $100,000, FY25$100,000

Covid Supplement-all FY24 expires March 14, 2024
Line 2-CCBHC technical assistance FY24 $30,000
Line 7-Support for training of First Episode of Psychosis/Navigate programs FY24 $24,000
Line 7-State staff- community post-COVID mental health training- $141,116

ARPA
Line 2-988 technical assistance and implementation FY24 $1,493,858 FY25 $1,493,858
Line 2-CCBHC technical assistance FY24 $200,000
Line 5-Center of Excellence for Development of EBPs-FY24 $479,167 FY25 $312,500
Line 7-Support for training of First Episode of Psychosis/Navigate programs FY24 $76,135 FY25 $76,135
Line 7-state staff-community post-COVID mental health training- FY 24 $338,935

BSCA
Line 2 Crisis services implementation Fy 24 $359,754
LIne 2 Disaster Behavioral Health team infrastructure development FY24 $159,754
LIne 2-Disaster Behavioral Health state plan development FY 24 $200,000
Line 7 Disaster Behavioral Health team training FY 24 $200,000. FY 25 $200,000
LIne 7-training and TA to NAVIGATE ESMI providersFY24 $62,194 FY 25 $62,194

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

The Departments of Human Services and Public Health have recently combined into one agency, the Iowa Department of Health and Human Services (Iowa HHS). Iowa HHS is now both the SMHA and SSA. Mental Health and Substance Use Prevention, Treatment, and Recovery Services are now provided via the Iowa HHS Division of Behavioral Health. Options for Individuals with mental health, substance use, or co-occurring mental health and substance use disorders to access integrated behavioral health services continue to increase in Iowa. Of the 23 accredited community mental health centers in Iowa, 17 are also licensed outpatient substance use disorder providers. This is an increase of 4 dually licensed/accredited CMHCs since the submission of the FY2022-23 MHBG plan. Of the state's 23 Integrated Provider Network providers, five are also CMHCs and all either directly provide or coordinate mental health services. Provider associations represent both mental health and substance-use disorder providers. Iowa is a recipient of the CCBHC Planning Grant, and is developing a proposal for the CCBHC Demonstration, that will promote integrated behavioral health services in Iowa. 14 providers have been awarded CCBHC state grants to implement the CCBHC model of providing integrated mental health and substance-use disorder care in the same agency.

Iowa HHS contracts with the University of Northern Iowa-Center for Social and Behavioral Research (UNI-CSBR) to initiate simulated client phone calls to IPN funded programs using a substance use profile. This sub-report was requested by Iowa HHS specific to establishing a baseline regarding SABG priority populations. CSBR researchers place calls to each IPN agency on a biannual basis, using simulated client profiles to evaluate the response received by those seeking SUD treatment services. Simulated phone call outcomes are analyzed to better understand client access to services, with an emphasis on pregnant women and women with dependent children, and persons who inject drugs, among others. Data collected from these simulated phone calls are used by Iowa HHS to provide technical assistance and corrective action when needed.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

Iowa Medicaid monitors parity of services provided through the state's contracted MCOs.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Promoting Integration of Primary and Behavioral Health Care (PIPBHC): Promotes the advancement of integrated substance use disorder treatment and primary health care services for individuals with substance use disorders. The advancement of integrated health services will be facilitated by an Integrated Care Team through a bidirectional model of care fostered by partnerships between Federally Qualified Health Centers (FQHC's)and Substance Use Disorder (SUD) treatment programs. This is a SAMHSA funded project for approximately $2,000,000 for five years, starting September of 2018.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Iowa's Substance Use Block Grant subrecipients receive a per client/per month Care Coordination rate to assist with bridging the gap for contractors while serving client's needs outside of traditional services.
Iowa Medicaid members with a serious mental illness or a serious emotional disturbance are eligible for Integrated Health Home care coordination which provides team-based care coordination focused on improving behavioral and physical health outcomes. Intensive care coordination is provided for members who receive Habilitation or Children's Mental Health waiver services.
MHDS regions also provide service coordination for individuals not eligible for Medicaid-funded case management or care coordination.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

In addition to the information provided for question 1, Iowa has MH and SUD providers that specialize in treating children and youth. Iowa's CMHCs who are MHBG recipients are required to provide evidence based services for children and adults. Fourteen behavioral health providers in Iowa have been recipients of the SAMHSA CCBHC-Expansion grants. These providers have implemented practices in their organizations to reduce barriers and promote access for individuals to receive the services they need, regardless of their diagnosis. The CCBHC model will also help providers focus on the unique needs of children and families. The state's CCBHC Planning Grant is the next step in moving Iowa toward an integrated behavioral health system that serves all of the identified populations with person-centered, holistic care.

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

N/A

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 SMI; 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

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, sexual orientation, gender identity, and age?

a) Race	(•) Yes	( ) No
b) Ethnicity	(•) Yes	( ) No
c) Gender	(•) Yes	( ) No
d) Sexual orientation	(•) Yes	( ) No
e) Gender identity	(•) Yes	( ) No
f) Age	(•) Yes	( ) 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? ( ) Yes (•) No

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

4. Does the state have a workforce-training plan to build the capacity of M/SUD 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? ( ) Yes (•) No

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

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

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

The Iowa Department of Health and Human Services has developed initial policies and plans for embedding health equity across internal and external work through accreditation, workforce development, data management, and planning efforts. There are a number of divisions and bureaus that have excelled at developing comprehensive strategies to address health inequities and develop internal strategies to support health equity infrastructure. In 2022 and beyond, Iowa HHS is in a position to significantly expand efforts to ensure that all people across the state have the ability to attain their highest level of health. We can accomplish this by explicitly tying a justice-centered approach to identifying and addressing pressing health inequities in historically excluded populations with a specific focus on people of color/indigenous people, people with disabilities, people who identify as LGBTQ+, people who are poor, and people with other demographic characteristics that have been historically excluded from access to opportunities and services to support optimal health.

Full details on Iowa's Health Equity plan can be found here:

https://hhs.iowa.gov/Health-Equity

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Question 1: SUPTRS Block Grant subrecipients report this data via Iowa Behavioral Health Reporting System.

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its 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 M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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. SAMHSA's Evidence Based Practices Resource Center (EBPRC) 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. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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 General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 M/SUD 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA 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)**[8] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. Each KIT 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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 focused 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.

3. 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.

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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 service efforts 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 outcomes 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.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. 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 Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year 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 SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
NAVIGATE	4

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
773941	773941

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Iowa does not have a specific Medicaid code for billing NAVIGATE. Any billable service provided within the NAVIGATE model such as individual or family therapy, psychiatry/medication management and community support/case management services are billed to Medicaid or other third party insurance when eligible.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

Iowa funds four teams to provide the NAVIGATE model for individuals experiencing a first episode of psychosis. The NAVIGATE model is a team-based approach that provides evidence-based individual, family, community, employment, and psychotropic supports to individuals and their families.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Individuals participating in NAVIGATE services have access to more community supports than other individuals initially accessing mental health services. The NAVIGATE model is focused on recovery and assisting individuals access the most effective treatments and supports for psychosis earlier in their illness, promoting wellness and recovery for the individual. When individuals experience a crisis, the NAVIGATE team is able to provide an enhanced level of support to coordinate services and assist the individual and their family.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Continue to support the four teams with training and technical assistance customized to meet the needs of each team's community. In FY23, the state provided all four teams a joint, in-person training from a national NAVIGATE trainer and co-creator of the program. In FY24, the state plans to continue training with this provider through webinars and consultation. In FY25, the state plans to organize another all -team training for all NAVIGATE providers. In FY24, the state is also considering expansion of one of the teams that would allow it to serve a wider geographical area and more individuals. The state also plans to work with the teams on incorporating peer support into the team structure.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Diagnostic categories include: Non-affective psychoses-Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, and Psychotic Disorder NOS
Methodology used:
https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300186

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Iowa's population is 3,190,369. The expected incidence rate is 20 to 30 cases per 100,000. This equates to a prevalence rate of 957.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

The state presents information on the NAVIGATE teams to statewide councils and committees focused on behavioral health needs. The state requires the four NAVIGATE teams to outreach in their community to many referrals sources including inpatient behavioral health units, schools, colleges, and community mental health providers.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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 team 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, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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 HCBS services, including the Children's Mental Health Waiver and HCBS Habilitation Services are all required to use person-centered planning processes. Person centered training is offered to care coordinators and case managers. For HCBS services, PCP is required in Iowa Administrative Code. Care coordination staff meet with individuals and their families/chosen participants at the location of their choice to develop treatment plans, identify the individual's strengths, needs, preferences, and goals, developing plans that reflect those goals. At the system level, Iowa HHS engages individuals and their families through community meetings, outreach through the Office of Recovery Supports, peer/family peer support/recovery peer coach services to help individuals advocate for themselves and their families, and collaboration with advocates and stakeholders.

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

The person centered planning process for Medicaid members who receive Habilitation is described in Iowa Administrative Code 441.78.27 (4). 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 listed in Iowa Administrative Code 441.24.4

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

None at this time.

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

N/A

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 M/SUD 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 M/SUD services funded by the MHBG and SUPTRS BG. 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 M/SUD 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:

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 program requirements, including quality and safety standards? (●) Yes ( ) No

3. 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

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Footnotes:

Environmental Factors and Plan

7. 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**[56] 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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

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?

3. 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.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [ ] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [ ] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

  Iowa HHS review a variety of data indicators in determining priority needs to assist contractors to prioritize strategies related to the Prevention Set Aside funding. Iowa HHS also utilizes the Iowa Epidemiological Profile, updated in 2020 and every two years, to assist in setting priorities and providing direction
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  Education about and utilization of the CLAS Standards is promoted through all Iowa HHS prevention grants. Through the Assessment step of the SPF, Iowa HHS requires completion of a county or community assessment process where data are collected on populations that experience disproportionate issues related to substance use (Standard 12).
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  Ongoing support of data review processes that drives substance misuse prevention services is a focus of all prevention grants. Funded contractors must consider ways to sustain county assessment processes, which include review of state and local data related to substance use in collaboration with a coalition. This process ensures that prevention services are addressing priority needs through a data driven lens. Iowa HHS requires that prevention grant funded contractors develop and establish a sustainability plan which addresses all steps of the SPF process.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The Iowa Board of Certification (IBC) credentials prevention and treatment professionals in addictions, (prevention, treatment and peer support). IBC promotes adherence to competency and ethical standards and provides a mechanism for Continuing Education and certification. IBC supports a Certified Prevention Specialist Certification and an Advanced Prevention Specialist Certification. Iowa has Information can be found at: https://www.iowaibc.org/cps

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Iowa HHS provides oversight of training and technical assistance to prevention professionals including a Substance Misuse Prevention Training team which provides foundational prevention trainings for Iowa's prevention field. Iowa HHS also contracts with four Capacity Coaches to provide coaching services to contractors utilizing the Strategic Prevention Framework process. Iowa HHS contracts with Iowa State University to organize and support statewide training to the prevention field offered through the Governor's Annual Conference on Substance Use Prevention, Treatment, and Recovery. Multiple trainings occur as needed and annual training is conducted on the SABG Prevention Set Aside regulations. For additional information on prevention trainings see: https://hhs.iowa.gov/Bureau-of-Substance-Abuse/Prevention-Related-Programs/Prevention-Supports

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Iowa HHS supports and requires use of the Tri-Ethnic Readiness Survey process to determine readiness on all priority areas through the Strategic Prevention Framework process

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Education about and utilization of the CLAS Standards is promoted through all Iowa HHS prevention grants. Through the Capacity steps of the SPF, Iowa HHS requires training on the standards for grant funded agencies and prevention professionals as well as grant partners, including community coalitions (Standard 4).

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Through Iowa HHS prevention grants, contractors must consider what types of capacity is needed to sustain positive outcomes generated through grant funded projects. Capacity can include staffing, monitoring, ongoing training and supports, etc. Iowa HHS requires that prevention grant funded contractors develop and establish a sustainability plan which addresses all steps of the SPF process.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

See attachments page for upload. Also see the Five Year Substance Abuse Prevention Strategic Plan for Iowa (2018-2022): at: https://idph.iowa.gov/Bureau-of-Substance-Abuse/Prevention-Related-Programs/Prevention-Strategic-Plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Bureau of Substance Use Prevention, Treatment, and Recovery Evidence-Based Practices Workgroup includes a diverse

membership of prevention professionals throughout Iowa. Working in collaboration with these partners, the Evidence-Based Practices Workgroup focuses on completing the following strategies:

Support and update the developed resource guide for substance misuse prevention best practices, programs, and policies that are evidence-based or evidence-informed as defined by Iowa HHS.

Develop a template of questions around substance use/misuse to be used in community needs assessments across Iowa.

Develop and launch a toolkit for communities to use when advocating for public policy change in the prevention of substance misuse.

The Evidence-Based Review Team serves as a subcommittee of the Evidence-Based Practices Workgroup. This Review Team is responsible for reviewing submitted Waiver Request and Adaptation Forms from contracted agencies. These forms are submitted if a contractor requests to utilize a program, policy, or practice not currently listed in the Iowa HHS approved list of evidence-based programs or if a contractor would like to request an adaptation of an evidence-based program, policy or practice.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Iowa HHS supports the definition of an EBP as developed by SAMHSA:

An EBP has documented effectiveness supported by other sources of information and the consensus judgment of informed experts based on the following guidelines:

The strategy is based on a theory of change that is documented in a clear logic or conceptual model.

The strategy is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.

The strategy is supported by documentation that has been effectively implemented multiple times in the past in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

Iowa HHS also utilizes the following definitions for evidence-based practice, program and policy:

Evidence-based practice: the process used to review, analyze, select and implement effective programs and policies using an objective, data driven approach.

Evidence based program: individual-level prevention strategies that have demonstrated effectiveness measured by empirical research.

Evidence based policy: population-level prevention strategies that have demonstrated effectiveness measured by empirical research.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Education about and utilization of the CLAS Standards is promoted through all Iowa HHS prevention grants. Through the Planning step of the SPF, Iowa HHS supports the selection of EBPs that meet community and cultural needs (Standard 1), including development and support of community-level policies that are culturally appropriate (Standard 13).

b) If no, please explain in the box below.

n/a

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Through Iowa HHS prevention grants, contractors develop a plan to sustain positive outcomes generated through funded programs and policies in collaboration with a community coalition. Contractors are required to create a plan for sustaining 2-3 strategies depending on the grant funding.

b) If no, please explain in the box below.

n/a

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

This strategy provides awareness and knowledge of the nature and extent of substance misuse and/or problem gambling. It also provides knowledge and awareness of available prevention programs and services. This strategy does not focus on agency promotion. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ Health fairs
+ Public Service Announcements
+ Speaking Engagements

b) Education:

This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its services. Services under this

strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis and systematic judgment abilities. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ Delivery of evidence-based programs
+ Parenting and family management classes
+ Education programs for faith communities
+ Delivery of evidence-based programs specifically for children of parents/ guardians with substance use disorders

c) Alternatives:

This strategy focuses on technical assistance or consultation that support implementation of effective activities that exclude substance misuse and/or problem gambling. The purpose of this strategy is to discourage use of alcohol and other drugs by providing healthy activities. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ After school programs
+ Mentoring programs
+ Alcohol, tobacco and other drug or problem gambling prevention focused school or community events
+ Teen or senior citizen community center activities

d) Problem Identification and Referral:

This strategy aims at identification of those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs as well as problem gambling behaviors. This strategy does not include any services to determine if a person is in need of treatment. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ Risk reduction education for work-related problems involving substance misuse
+ Student assistance programs
+ Court-mandated alcohol and other drug awareness and education programs

e) Community-Based Processes:

This strategy aims to enhance the ability of the community to more effectively provide substance misuse and/or problem gambling prevention services through the establishment of collaborative groups. Services in this strategy include assessing, building capacity, planning, implementing and evaluating the efficiency and effectiveness of interagency collaboration, coalition building, and networking. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ Guide the development of a strategic plan
+ Assist in assessing local data
+ Training or technical assistance services to the coalition members or chairperson to enhance understanding of ATOD trends and/or problem gambling prevention best practices

f) Environmental:

This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs and/or problem gambling used in the general population. This strategy is divided into two subcategories to permit distinction between services which center on legal and regulatory initiatives and those that relate to the service and action oriented initiatives. Examples of services conducted and methods used for this strategy include (but are not limited to) the following:

+ Establishing alcohol, tobacco and drug use policies
+ Technical assistance to communities on policy change efforts
+ Modifying alcohol and tobacco advertising practices at the community-level
+ Dissemination of a substance misuse and/or problem gambling prevention media campaign

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

IDPH monitors prevention services through a variety of means including contract review adherence, through technical assistance, through claims review, work plan reviews, site visits, and data system review and fidelity reviews. The IDPH prevention teams created a process to cross check all IDPH administered prevention funding to ensure there is no duplication in service billing.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Education about and utilization of the CLAS Standards is promoted through all Iowa HHS prevention grants. Through the Implementation step of the SPF, ensuring prevention services and materials meet the needs of participant who require language assistance is required in prevention grants (Standards 5-8). Iowa HHS recommends that there is a high level of training and competency of the individuals or agencies providing any language assistance (Standard 7).

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

As funded prevention contractors work through the Implementation step, they are asked to review the outcomes generated by the program or policy and the potential resources needed to continue to support that prevention service such as funding, personnel, etc. Iowa HHS requires that grant funded contractors develop and establish a sustainability plan which addresses all steps of the SPF process.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

Iowa HHS contracts with the University of Northern Iowa to provide evaluation of primary prevention services.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☐ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☐ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use

- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Education about and utilization of the CLAS Standards is promoted through all Iowa HHS prevention grants. Iowa HHS requires collection of data to monitor CLAS standard processes and that policies developed are evaluated to ensure cultural and linguistic appropriateness (Standards 11 and 13).

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

Iowa HHS recommends that grant funded contractors utilize evaluation data to highlight the successes of a program or policy and then utilize that data to promote that prevention service. Sustaining processes to evaluate and monitor positive outcomes generated through programs and policies is a required component of a sustainability plan. Through Iowa HHS prevention grants, Iowa HHS requires that grant funded contractors develop and establish a sustainability plan which addresses all steps of the SPF process.

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for 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-occuring 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 services
Outpatient mental health therapy and psychiatry
Outpatient SUD services
Intensive outpatient/partial hospitalization MH and SUD
Peer support/family peer support MH/recovery peer coaching SUD
Behavioral Health Intervention Services
Functional Family Therapy
Multi-Systemic Therapy
Habilitation 1915-I waiver services for individuals with functional impairment due to a mental illness
Children's Mental Health 1915-C waiver
Integrated Health Home Care coordination for adults with an SMI and children with an SED
Medication Assisted Treatment for individuals with an SUD
Medication management provided by a professional licensed to prescribe medication;
Residential treatment for SUD
In-patient hospital psychiatric services
Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
Community-based and facility based sub-acute services;
Crisis Services including, but not limited to:
a 24 hour crisis response;
b. Mobile crisis services;
c. Crisis assessment and evaluation;
d. Non-hospital facility based crisis services;
e. Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;
Intensive psychiatric rehabilitation services;
Assertive Community Treatment

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

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No

e)	Housing services	○ Yes	● No
f)	Educational Services	● Yes	○ No
g)	Substance misuse prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	● Yes	○ No
i)	Support services	● Yes	○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes	○ No
k)	Services for persons with co-occuring M/SUDs	● Yes	○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Description of the services and coordination processes 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 Home (IHH) care coordination teams. Teams consist of a care coordinator, a nurse care coordinator, and a peer support specialist (for adults) or a family peer support specialist (for children with an SED and their families). Teams are to address whole person health and social needs. MHDS Regions also coordinate services for individuals not eligible for Medicaid. For individuals served by IPN SUD providers, services are coordinated by the IPN provider.

4. Describe activities intended to reduce hospitalizations and hospital stays.

MHDS Regions are required to have an array of crisis services available for all Iowans. These services include mobile crisis response services, crisis stabilization-community based and residential, subacute mental health services, and 23 hour observation and holding services. MHDS Regions work closely with local law enforcement and judicial systems to divert individuals from involuntary hospitalization where appropriate by providing pre-commitment mental health evaluations and mental health evaluations in local emergency departments. Integrated health home programs and CCBHC-E providers work to coordinate with hospitals and emergency departments to reduce unnecessary hospital stays and ensure follow up services are provided.

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

N/A

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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 M/SUD system.

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	132,646	
2.Children with SED	42,297	

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 from URS Table 1 2021. The state does not calculate expected incidence of the target populations. The state plans services based on actual service usage, data collected from Iowa Medicaid and the MHDS regions, input from consumers and stakeholders on strengths and needs of the behavioral health system, and direction of state and legislative leadership regarding overall system goals.

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

N/A

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	○ Yes	◉ No
b)	Educational services, including services provided under IDEA	○ Yes	◉ No
c)	Juvenile justice services	○ Yes	◉ No
d)	Substance misuse preventiion and SUD treatment services	○ Yes	◉ No
e)	Health and mental health services	○ Yes	◉ No
f)	Establishes defined geographic area for the provision of services of such systems	○ Yes	◉ No

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

N/A

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

Most MHDS Regions are a combination of rural and urban counties and are required to meet access standards to core services for all counties in their regions. This includes making evidence-based practices like Assertive Community Treatment available in rural and urban areas. Crisis services are also available in rural areas.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Iowa HHS manages the federal PATH program for individuals with a mental illness at risk of experiencing homelessness. Six agencies provide PATH outreach services in rural and urban counties statewide. The MHDS Regions fund supportive and transitional housing programs for individuals with mental health and/or disabilities at risk of homelessness. Iowa HHS staff also work with the SOAR project to assist individuals applying for SSI/SSDI to promote financial stability. Iowa HHS also received a federal Treatment for Individuals Experiencing Homelessness grant focusing on providing integrated substance use and mental health services to individuals experiencing homelessness.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Iowa HHS oversees the PASSR process which screens all individuals seeking admission to nursing facilities for mental health or intellectual disabilities. Iowa HHS 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 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 is described in greater detail at this link: https://hhs.iowa.gov/sites/default/files/Comm513.pdf
The waiver allows individuals who qualify for nursing home level of care to remain in their homes with services. Mental health services are a service provided through the waiver.

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

N/A

Narratve Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The Iowa Department of Health and Human Services (Iowa HHS) under the leadership of Director Kelly Garcia is the designated State Mental Health Authority (SMHA) and designated Single State Authority for Substance Use Prevention, Treatment, and Recovery (SSA) for Iowa. Previously these two authorities were housed in two separate state agencies, the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH). Legislation passed in 2022 codified the alignment of DHS and IDPH into Iowa HHS. SFY23 was identified as a transition year with the transition to Iowa HHS to be complete by July 1, 2023. Iowa HHS also includes Iowa Medicaid and the Division of Family Well-Being and Protection (child welfare). As part of a new organizational structure of state government, effective July 1, 2023, additional state agencies became part of Iowa HHS. This included the Departments of Human Rights, the Department on Aging, Volunteer Iowa, the Iowa Child Advocacy Board, and Early Childhood Iowa. The estimated MHBG allocation for FY24 and 25 is $7,739,414 per year. The state projects to expend $386,970 per year on administration, $386,970 on crisis services (5% set aside), $$773,941 per year on early serious mental illness programs (10% set aside), and $6,191,532 per year on allocations to community mental health centers for services to individuals with an SMI/SED, training on EBPs, peer support/family peer support training, MH Planning Council support, and other system development projects.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

As a result of the pandemic, most providers greatly expanded their capacity to offer telehealth services and can bill Medicaid for them. Outpatient therapy and medication management are provided via telehealth. Barriers to telehealth include inconsistent broadband capacity in rural areas of Iowa as well as individuals not always having availability to access telehealth due to financial barriers (lack of data plan or equipment.) Providers have informed Iowa HHS that individuals generally prefer not to use telehealth for individual therapy as they prefer face to face contact. They will use telehealth if it is their only option but prefer Telehealth has been beneficial for individuals with SMI and SED to obtain services and remains useful to extend services to individuals with transportation barriers or where there are workforce shortages.

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

N/A

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/residential)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	( ) Yes (•) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services ( ) Yes (●) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Through Iowa's SUBG-funded project, the Integrated Provider Network (IPN), four women and children providers were selected to provide women and children treatment and ancillary services statewide. Women and children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and children treatment must be available when needed, with minimal wait time. Women and children providers must provide all ancillary services and requirements under Code of Federal Regulations (ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children). Other treatment services may be funded by Medicaid if the client and/or their children have the necessary Medicaid coverage (consistent with client enrollment). The women and children set aside are utilized as the payor of last resort.

Women and Children providers are monitored in a variety of ways. Primarily, Iowa contracts with the University of Northern Iowa (UNI) to conduct research via biannual simulated phone calls to SUBG subrecipients. One aim for these simulated calls, among many, is to evaluate the frequency and fidelity to which potential clients are screened for their inclusion in a priority population, as well as whether those individuals are offered services as prescribed by the SUBG regulations. Individualized simulated call results are provided to each subrecipient, along with a detailed report for the provider network at large. Results are then followed by individualized technical assistance/ corrective action, as needed, for each subrecipient.

Iowa HHS also monitors IPN contractors via quarterly and annual progress reporting, claims reviews, IPN director meetings, critical incident reporting, and/or may submit technical assistance as requested by the contractor via Iowa's grant management system (IowaGrants), or a monitored email inbox for the IPN grant project. Iowa HHS follows up with technical assistance and corrective action as needed based on these monitoring methods.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

IPN providers who offer substance abuse treatment services must meet all SUBG requirements, provide services to individuals who inject drugs, and provide services to individuals per SUBG tuberculosis requirements.

Through the IPN, providers must sign annual attestation documentation which outlines the SUBG regulations under 45 CFR 96.126 Capacity of Treatment for Intravenous Drug Abusers. These regulations include, but are not limited to, priority admission status, admission requirements, interim services provisions, referrals and counseling regarding HIV and TB, and waiting list requirements. For ease of reporting and tracking, interim services and regulations have been built into the Iowa Behavioral Health Reporting System (IBHRS) data collection system.

Data enhancements have also been made regarding the waitlist for priority populations including Individuals who Inject Drugs and Treatment Services for Pregnant Women. Iowa HHS has provided extensive annual training to providers regarding Priority Admission Preference, Interim Service Provision requirements, and has provided technical assistance to multiple providers.

To assist Iowa HHS in meeting the SUBG regulations for tracking treatment capacity for individuals who are pregnant and/or have used any injection drug(s) in the past 30 days, the Iowa Statewide Waitlist was integrated into IBHRS. Iowan's seeking treatment services who meet these criteria sign consent, are placed on the statewide waitlist according to the priority admission status as regulated, and allow programs to refer, admit, pend, reject or close cases. The Iowa Statewide Waitlist system allows for notifications upon referring and/or when cases are admitted or closed. IPN funded providers have received extensive training on use of the waitlist.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Per the CDC, the 2021 TB case rate for Iowa is 1.5 cases per 100,000 persons. This is significantly lower than the national average of 2.5 cases per 100,000 persons. Iowa owes its low TB case rate in part to proficient contact investigations, healthcare providers observance of treatment guidelines, adherence to DOT for active disease cases and the provision of medication for LTBI to more than 1,100 Iowan's annually.
Iowa HHS is the state agency which is responsible for TB Control. The TB Control Program is composed of two full time employees: the Program Manager and the Nurse Consultant. The program provides direct oversight of cases afflicted with latent tuberculosis infection (LTBI) and TB disease from admission to discharge in the TB Control Program. This includes consultation with physicians, nurses, local public health agencies (LPHAs) and other healthcare providers regarding TB transmission, pathogenesis, treatment, signs and symptoms, infection control practices and contact investigations. The purpose and scope of responsibilities is defined by the core functions of the TB Control Program which include:

Disease consultation and education
Investigation of active or suspect TB cases
Case management of LTBI and active TB cases
Administration of Iowa's TB Medication Program
Data management and analysis
Administration and finance

The Annual CDC Report for Iowa Tuberculosis Control indicates that 49 cases of TB were reported in Iowa in 2021.

IPN providers, who are awarded a contract with Iowa HHS are required to sign an annual attestation regarding meeting all required SUBG requirements. Within IPN contracts, IPN providers are required to meet SUBG TB and Persons who inject drugs requirements including: timeliness standards, capacity notification requirements, outreach efforts, providing or making services available to TB clients (including screening, counseling, education, referral to medical providers, as needed, and reporting to the Bureau of TB any active TB cases (within 1 day) and interim service provisions. Screening and services for persons with tuberculosis are provided directly by IPN funded providers or through interagency collaborative agreements with other local agencies. In the case of an individual in need of such treatment who is denied admission by a provider on the basis of the lack of capacity to admit the individual, the provider will refer the individual to another contractor for tuberculosis control procedures and protocols to address TB and other communicable diseases. Iowa HHS has moved from a narrative reporting function to tracking of SUBG requirements through the reporting of data to the Department's new data reporting system IBHRS; effective July 2021. In addition, IPN providers provide policies to Iowa HHS on an annual basis for review.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ○ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ○ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ○ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — ( ) Yes (●) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

1

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://hhs.iowa.gov/substance-abuse/program-licensure

If the answer is No to any of the above, please explain the reason.

Iowa does not plan to request any of the aforementioned waivers.

Footnotes:

Environmental Factors and Plan

11. 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 2022-FFY 2023? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	Yes No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	Yes No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	Yes No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	Yes No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	Yes No
6.	Does the state use an evidence-based intervention to treat trauma?	Yes 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

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☐ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☐ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☐ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☐ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☐ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☐ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☐ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☐ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☐ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☐ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☐ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☐ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ○ Yes ○ No

3. 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 M/SUD and other essential domains such as employment, education, and finances? ○ Yes ○ No

4. 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.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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 the use of medications for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, 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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Iowa's 13 Mental Health and Disability Services regions are responsible for making a set of crisis services available in each region. These services include mobile crisis response, crisis evaluation, crisis stabilization-residential and community-based, subacute mental health services, 23 hour observation and holding, The availability of these services is identified in coverage maps at this link: https://hhs.iowa.gov/mhds/crisis-services
Iowa has mobile crisis availability in all but 4 of the 99 counties. Iowa has two 988 centers that answer Iowa calls, chats and texts. The 988 centers have the capacity to warm transfer to mobile crisis response in the caller's area.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: YLI/ 988 take the call 24/7 statewide for MH /SUD Crisis and for individuals seeking services for themselves or others.
Someone to respond: 988/YLI is available statewide. YLI/ 988 offers warm hand-offs for some services but are not fully implemented for M/SUD
Safe place to go or to be: Iowa is actively developing a system for certifying recovery residences via NARR. Iowa has 15 crisis stabilization residential services for adults and six crisis stabilization for children. There are 12 23 hour observation and holding

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The state is in the CCBHC Planning Grant process and plans to integrate the required crisis services in the CCBHC criteria with the current crisis system, using the CCBHC framework to develop full statewide access to crisis services that are in compliance with the CCBHC criteria.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

MHBG crisis set-aside funds are used to support 988 implementation.

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

N/A

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

N/A

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. 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)	Use 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?	(●) 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 services are funded through Medicaid and are also a core service through the MHDS regions. Family peer support specialists for parents of a child with an SED are also Medicaid-funded. Peer support and family peer support may be provided as part of the Integrated Health Home care coordination team for adults with an SMI or children with an SED, or can be provided as a standalone service. MHDS regions support wellness centers where peer support is available. Iowa HHS is funding four peer-run organizations that provide a variety of peer services including peer respite, peer wellness centers and virtual peer support. Iowa HHS funds training of peer support specialists, family peer support specialists, and peer recovery coaches.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Please see Step I for a complete narrative of Recovery Support Services offered through the IPN and through discretionary grants. IPN (SUBG) funded:

1) Transportation. Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient's treatment plan or recovery plan.

2) Care Coordination. The Licensure Standards define Care Coordination as "the collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services, both internal and external to the program, to meet patient needs, using communication and available resources to promote quality care and effective outcomes." Care Coordination fosters long term engagement and ongoing remission/recovery support. Care Coordination services are provided to active patients. For Care Coordination billing purposes, a patient must receive at least one Licensed Program Service from the contractor during the month. Care Coordination encompasses the broad range of patient-specific people, systems, and issues related to the patient's current situation and future recovery. These may include, but are not limited to, family members, referral sources, employers, schools, medical and mental health professionals, the child welfare system, the courts and criminal/juvenile justice systems, housing status, legal needs, and recovery support. Care Coordination is generally conducted by contractor staff, outside of patient counseling sessions. Care Coordination includes use of electronic information and telecommunication technologies to support patients through check-in calls and texts. Contractors providing check-in calls and texts must have policies and procedures that assure safety, privacy, and confidentiality.

3) MAT Medical Evaluation means an assessment conducted by a physician or other licensed prescriber to determine the need for medication-assisted treatment and/or tobacco cessation services.

4) MAT Medical Care means ongoing medical evaluation services provided by a licensed medical prescriber to assess appropriateness for continued medication-assisted treatment and tobacco cessation services. Medical Care does not include routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen) or conducting other medical tests.

5) Medicated-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of Alcohol Use Disorders, Opioid Use Disorders, and/or tobacco use. MAT – Medication means medicine(s) ordered by the Medical Evaluation for MAT and/or tobacco cessation.

6) MAT – Drug Testing means routine monitoring of MAT compliance by testing for the presence of other substances (e.g., urine drug screen).

7) Recovery Peer Coaching. Recovery Peer Coaching means individual face-to-face meetings between a patient and a Recovery Peer Coach to discuss routine recovery issues from a peer perspective.

Non IPN funded RSS available through SSA system of care funded by other discretionary grants:

1) Promoting the Integration of Primary and Behavioral Health Care (PIPBHC): Care Coordination, Child Care, Contingency Management, Education (GED coursework and testing, ESL classes, etc.) Sober Living Activities (recovery conferences, community

recovery events, etc.), Transportation (gas cards, bus passes, rideshare), Wellness (health related needs not covered by other sources, fitness memberships, tobacco cessation, nutritional counseling, etc.)

2) Iowa Treatment for Individuals Experiencing Homelessness (TIEH) (discretionary grant): Educational and Vocational Training, Sober Living Activities, Wellness Needs (eyeglasses/contact lenses, fitness memberships, nutritional training, etc), and Transportation (gas cards, bus passes, rideshare).

3) Recovery Community Centers: Community centers focused on SUD recovery providing a variety of recovery support group meetings, recovery coaching, referrals and recovery calls. Funded through a collaboration between State Opioid Response grant and the COVID-19 Supplemental Funding award.

4) Recovery Housing: efforts to establish an Iowa affiliate of NARR funded by the State Opioid Response grant.

5) State Opioid Response: Care Coordination, Clothing/Personal Hygiene (interview and work clothes, toiletries, laundry), Contingency Management, Copays (for behavioral health services), Dental Services (related to the clients SUD), Education Assistance (GED coursework and testing, ESL classes, etc.), Employment Supports, HIV/HCV testing, Housing assistance, MAT/MOUD (FDA approved options), MAT/MOUD-related medical evaluation, drug testing and follow-up medical care, SUD and MH Counseling(not covered by other sources), Recovery Calls, Recovery Coaching, Recovery Housing, Survivor Advocacy in Recovery(sessions with certified victim advocate), Transportation (gas cards, bus passes, rideshare), Wellness (health related needs not covered by other sources, fitness memberships, tobacco cessation, nutritional counseling, etc.)

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

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Footnotes:

Environmental Factors and Plan

17. 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 M/SUD 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 M/SUD 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.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	○ Yes	○ No
Home and community-based services	○ Yes	○ No
Peer support services	○ Yes	○ No
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?

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

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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 M/SUD 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).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

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

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	○ Yes	◉ No
b) The resilience of children and youth with SED?	○ Yes	◉ No
c) The recovery of children and youth with SUD?	○ Yes	◉ No
d) The 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 M/SUD needs:

a) Child welfare?	◉ Yes	○ No
b) Health care?	◉ Yes	○ No
c) Juvenile justice?	◉ Yes	○ No
d) 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 M/SUD system?	◉ Yes	○ No
b) for youth in foster care?	◉ Yes	○ No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	○ Yes	◉ No
d) Does the state have an established FEP program?	◉ Yes	○ No
Does the state have an established CHRP program?	○ Yes	◉ No
e) Is the state providing trauma informed 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 director of Iowa HHS is the co-chair, along with the director of the Department of Education of the Children's Behavioral Health System State Board (Children's Board). The Children's Board is advisory and provides guidance in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being,

building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need. The Children's Board consists of 17 voting members appointed by the Governor. Members of the Children's Board were selected based on their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.

Iowa Medicaid provides a continuum of mental health service for children includd]ing outpatient therapy, psychiatry and medication management, in-home behavioral health services and evidence based practices including functional family therapy and mult-systemic therapy. Integrated Health Homes are available for children with an SED to provide care coordination to the child and their family.

MHDS regions are tasked with providing access to a set of core services for children with an SED in their regions and are required to convene children's behavioral health services advisory committees which include representation from the following: education, parent/relative of a child who utilizes services, early childhood, child welfare, behavioral health service provider, juvenile court, pediatrics, child care, law enforcement and a regional governing board member. MHDS regions have also identified Regional Coordinators of Disability Services for every county who are available to help parents find mental health resources in their local area.

7. 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

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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 M/SUD 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 using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD 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:

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.

The state's goals as stated in the 2022 Iowa Plan for Suicide Prevention:
1. Build capacity in suicide prevention, intervention and postvention infrastructure at the organizational, local, and state levels.
2. Integrate evidence-based, culturally sensitive suicide prevention, intervention, and postvention strategies in systems serving all people in Iowa.
3. Promote community resilience through ongoing collaboration, public education, and equitable access to formal and informal supports.

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

If yes, please describe how barriers are eliminated.

N/A

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Iowa HHS received the SAMHSA Zero Suicide grant in September 2018. The five-year grant aims to engage the 19 Integrated Provider Network agencies in implementing the Zero Suicide Framework. The framework is a systems-change model with the core belief that no person under care should die by suicide.

Near the conclusion of the Zero Suicide grant, Iowa HHS was awarded the Garret Lee Smith grant, which will be used to develop the Community Based Youth Suicide Prevention in Iowa Project (CBYSP Iowa). CBYSP Iowa has three main goals:

Goal 1: Increase the number of staff of youth-serving organizations who are able to identify and work with youth at risk of suicide by strengthening the capacity of counties of highest need to screen and identify youth at risk for suicide.

Goal 2: Increase the capacity of clinical service providers to assess, manage, treat, and provide continuity of care and follow up for youth and TAY at risk of suicide, including youth discharged from emergency departments and inpatient psychiatric units, by strengthening the capacity of selected counties to assess youth at risk for suicide, refer them to appropriate services, provide effective treatment, and provide continuity of care and follow-up.

Goal 3: Reduce the number of 10-24 year old's attempting or dying by suicide by improving the continuity of care and follow-up of youth identified as at risk for suicide and increasing the number of youth/TAY who access and use suicide prevention services through the 988 Suicide and Crisis Lifeline.

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

N/A

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

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

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

Effective July 1, 2023, the state agencies that oversee public health, human services, Medicaid, mental health, substance-use prevention, treatment, and recovery, aging and disability services, and human rights are now aligned in one agency, the Iowa Department of Health and Human Services. This alignment will promote collaboration and coordination of essential services to Iowans.

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.

The state of Iowa promotes coordination between internal and external stakeholders to ensure individuals may live, learn, and work in the community of their choice. This includes promotion of community-based services and supports for individuals with

complex needs who would otherwise be served in residential or inpatient settings. MHDS Regions have implemented services to divert individuals with behavioral health conditions from jails and inpatient settings and have also provided supports to school systems for children with serious emotional disturbance.

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

N/A

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, 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 an Advisory/Planning Council (PC). 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 PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

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 M/SUD 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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

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.)

Iowa HHS met with a subcommittee of the Mental Health Planning Council twice to review the structure and outline of the new combined MH/SUPTRS block grant and to solicit input on strengths and needs of the system. Requirements of each Block Grant were reviewed with the Council. Meeting minutes of the meetings held on 5/24/23 and 6/21/23 between HHS staff and committee members are attached. The Council has provided a letter outlining their recommendations for Block Grant priorities which is also attached. Individual council members have also provided input on areas of concern including the difficulty in recruiting parents of children with an SED, and provided feedback on ensuring accurate information about peer support activities in Iowa. Council members and the public will have opportunity to provide input on the BG plan prior to its submission on Sept. 1.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

Prior to 2023, the SMHA and SSA were housed in separate state departments. The Iowa Dept of Public Health oversaw substance use prevention, treatment and recovery and the Iowa Dept of Human Services oversaw mental health and disability services. The two departments collaborated frequently on projects of mutual interest and have worked together on their separate block grant applications. In 2021, the process was began to align the two departments into one department, the Iowa Department of Health and Human Services (Iowa HHS). As part of this alignment, the bureaus housing the SMHA and SSA were combined into one Division of Behavioral Health within the new Iowa HHS. This alignment will allow the state to plan collaboratively for mental health and substance use prevention, treatment, and recovery services and supports.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

5. Please describe 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 duties and responsibilities of the Council are described in the Council's bylaws (see attachment). The Council works collaboratively with Iowa HHS and has annual joint meetings with the state Mental Health and Disability Commission. The Council provides annual recommendations to Iowa HHS on the strengths and needs of the behavioral health system. MHPC members are also members of other advocacy organizations, work and volunteer to provide peer support and family peer support, and advocate in many venues for for individuals with an SMI or an SED. Attached are meeting minutes from the Council's last three meetings demonstrating their advocacy activities. The Council chair and Iowa HHS staff have been participating in the Planning

Council TA offered by SAMHSA. This TA will be helpful as the Council transitions to a Behavioral Health Planning Council in alignment with the state's decision to submit a combined MH and SUPTRS block grant application.

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

N/A

Footnotes:

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

May 24, 2023

Committee Members Attending:
Teresa Bomhoff
Jim Donoghue
Theresa Henderson
Todd Lange
Todd Noack

Other Attendees:
Laura Larkin, Iowa Department of Health and Human Services
Justin Edwards, Iowa Department of Health and Human Services
Wendy DePhillips, Iowa Department of Health and Human Services

Meeting Discussion

Laura Larkin notified the committee that with the alignment of the Department of Human Services (DHS) and the Department of Public Health (IDPH) into one agency, the Iowa Department of Health and Human Services (HHS), the decision was made to submit a single integrated application versus a separate Mental Health Block Grant (MHBG) and a Substance Abuse Block Grant (SABG). Laura reviewed the 2024-2025 Block Grant Application and Plan which can be found at Substance Abuse and Mental Health Block Grants | SAMHSA, noting that the committee would be focusing on Step 1 and 2 of the application, as well as providing input on priorities.

Laura indicated that the Step 1 section looks at assessing strengths and organizational capacity of the service system to address the specific populations, and that the Step 2 section identifies the unmet service needs and critical gaps with the current system, specifically the need to look at data for this section. Laura noted that she would be asking the Committee to provide feedback during the two scheduled meeting for these sections. Laura informed members that they could send her an email with feedback as well, if they think of something outside of the meeting.

The Committee discussed recent therapeutic classroom grants that were issued by the Iowa Department of Education. The grants were very beneficial but there were so few of them in relation to the number of school districts. The Committee saw this as illustrative of many great programs operating in isolated areas around the state, but not available statewide.

The Committee discussed the issue of environmental influences (e.g., climate change, air, ground, and water pollution, etc.) on mental health noting that Iowa has some of the most polluted waterways in the country with many chemicals present that other states have banned.

There was discussion regarding the peer-run organizations which are currently funded by COVID supplemental block grant dollars, and what they will look like moving forward once these supplemental dollars are expended.

Next Meeting

Committee members were asked to look at the comments provided by the MHPC committee on the previous MHBG related to gaps/concerns, and determined what suggestions they have for changes and if there is data that they are aware of that supports the gap.

The group will be focusing on Step 1 and Step 2 of the block grants (strengths and gaps) at the next meeting with the MHPC Block Grant Committee. Members were encouraged to review these sections from the last block grants and come back with feedback for the next meeting.

Next meeting is June 21, 2023

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

June 21, 2023

Committee Members Attending:
Teresa Bomhoff
Jim Donoghue
Todd Lange
Todd Noack
Brad Richardson
Monica Van Horn

Other Attendees:
Laura Larkin, Iowa Department of Health and Human Services
Justin Edwards, Iowa Department of Health and Human Services
Michele Tilotta, Iowa Department of Health and Human Services
Wendy DePhillips, Iowa Department of Health and Human Services

Meeting Discussion

Laura Larkin notified the committee that Todd Lange had provided an email to Laura and Justin with comments. Laura noted that some of the changes would be addressed due to recent changes. Laura had asked that Committee review the last block grant for updates and then to look at strengths and organizational capacity of the service system in addition to service gaps and unmet service needs and critical gaps. Laura noted that the last block grant was only the Mental Health Block Grant (MHBG), but this year HHS will be submitting an integrated block grant that combines the MHBG and the Substance Abuse Block Grant (SABG). Laura noted that even though the block grant is integrated there are separate requirements that relate to mental health versus substance use. Laura briefly walked through the different sections of the block grant that pertain to the Mental Health Planning and Advisory Council.

Teresa Bomhoff shared a document or letter that she had put together that referenced gaps in the service system. The document was lengthy at over 20 pages. Teresa reviewed this document during the meeting. The document was broken up into topics or populations served and reflected gaps and needs related to these topics (workforce, environmental factors, etc.) or populations (children/adolescents, aging, homeless, etc.).

Laura noted that not all parts of the letter would be applicable to the BG. Laura encouraged Teresa to have the Council finalize the letter and it could be submitted for reference, but that additional targeted information was needed for the sections on strengths and unmet service needs. Laura encouraged Committee members to share this information either in the final minutes of the meeting or to send her and Justin feedback via email that could be added to these sections of the application.

There was discussion regarding the peer-operated contracts which are currently funded by supplemental dollars to have some permanence with the block grant supporting on a more consistence basis. There was discussion regarding guidance for writing for the block grant, and the need for the Committee to prioritize. The populations of focus for the mental health side of the block grant were noted as individuals with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), Older Iowans, Homeless and Rural. Populations of focus for the substance side of the block grant were noted as pregnant and parenting women, IV drug users, primary prevention, and individuals with TB. There was discussion regarding the need to prioritize co-occurring and multi-occurring services and conditions. Laura encouraged Committee members to send any comments or feedback related to strengths and gaps as soon as possible so that it can be included.

Laura walked the Committee through the process of providing comment and formal comment for the block grant before it is submitted.

Iowa Mental Health Planning and Advisory Council
Bylaws

Effective May 28, 2008 as amended July 23, 2010, March 21, 2012, March 21, 2018, September 19, 2018, and January 18, 2023

ARTICLE I – NAME

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

ARTICLE II – DUTIES AND ACTIVITIES

The purposes of the Iowa Mental Health Planning and Advisory Council (the Council) shall be as set forth in federal law (42 USC 300x-3, Pub. Law 102-321, July 10, 1992, ADAMHA Reorganization Amendments, Public Health Service Act, 106 Stat. 382).

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 (Iowa Department of Health and Human Services, hereafter abbreviated as HHS) 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.

(1) At the will of the Council, HHS 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.
(2) If the HHS staff person cannot be present or designate a replacement, the Chairperson shall appoint a council member to take minutes.

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, through collaboration with the State Mental Health Authority, these concerns 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.

(2) Ex-officio members shall attend no less than biannually with at least one attendance coinciding with the fall session of the Assembly and at least one attendance coinciding with the spring Session of the Assembly.

(3) If an ex-officio Assembly member is not able to meet this obligation, the member should notify the Majority or Minority Leader (as appropriate) to nominate a new member.

(4) The council shall notify Majority or Minority Leader if an ex-officio member is not meeting their obligation, to allow for review of member appointment or making adjustments so that the member can achieve this obligation.

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 video conference or 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 (abstain) 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. If in the course of business a vote arises that a member perceives as potentially directly impacting the policies or operations of the entity that the member is employed by or represents, that member may recuse themselves (abstain) from a vote to allow time to seek further input from their governing bodies or executive management.

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. A Council member will be contacted and the absence policy reviewed after a second consecutive absence. 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.

C. Attendance may be accomplished in person, by video conference call, 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.

Section 3. Votes

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

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

C. In the process of voting, if a member recuses themselves (abstains) from a vote, it shall count neither for nor against the matter at vote. The vote may then be considered accepted by a majority vote of the remaining quorum of members.

D. Should at any time the passing quorum vote fall below the majority number of the total active council membership, the Council should consider a delay acceptance of the vote until such time as a majority of the active council can be either present or able to affirm the matter of action.

E. If a matter of action does pass with less than a majority number of the total active council, clarification and delineation of such should be made in the minutes of the meeting.

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.
(3) Not participate in voting as Chairperson unless called upon in case of tie (Article IV, Section 3 (B))

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;
(7) If the HHS staff person cannot be present or designate a replacement, the Chairperson shall appoint a council member to take minutes; and
(8) 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; and
(3) Assume the Chairperson's duties for any period of time that both the Chairperson and Vice-Chairperson are unable to do so.

Section 5. Standing Committees or Workgroups in General

A. Standing committee 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 members or appointing 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 conduct outreach to diverse communities.

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

D. The Nominations Committee shall be responsible for soliciting and reviewing applications for Council membership, and making recommendations to the Council. A Council vote accepts or does not accept the application for membership.

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.

Amended: By majority vote of the Council on July 23, 2010, Art. III, Sect. 3F Membership.
By majority vote of the Council on March 21, 2012, Art. III, Sec. 6B Vacancies; Art. V, Sec. 4B Duties.
By majority vote of the Council on March 15, 2023, all Articles, formatting and grammar.

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.

August 10, 2023

Laura Larkin
State Block Grant Planner
Iowa Department of Health and Human Services
llarkin@dhs.state.ia.us

Justin Edwards
State Block Grant Planner
Iowa Department of Health and Human Services
justin.edwards@idph.iowa.gov

The Iowa Mental Health Planning and Advisory Council (referred to as "Council") has been reviewing the needs and gaps in care in our state. We would like to make four recommendations for mental health block grant funds to fill gaps and meet the needs of all Iowans' behavioral health needs. Outlined in this letter are the four gap areas we propose be included in the state mental health block grant proposal: continuation and expansion of peer support services, increase in services to support teens and young adults transitioning to adult services, increase availability of services to the elderly population and providing community education on brain injury and subsequent development of behavioral health struggles. For each of these recommendations we will outline what the gap or need is for Iowa and how mental health block grant funds could help meet those needs.

Our first recommendation is for the continuation and expansion of peer support services in the state. Four peer run organizations received block grant funding that came from Covid funds. There is no plan in place to continue this funding when their contracts expire. All four organizations have been able to increase the amount of people with lived experience they reach and provide peer support services that improve recovery, resiliency and provide an alternative to crisis services. Iowa has only one peer run respite where other states such as Wisconsin have multiple. These respites don't bill Medicaid and rely on grants and other funding to continue to provide respite services. The respite house is an alternative to hospitalization. It is important to the council that the warmline in Iowa continues to receive adequate funding to provide services 24 hours a day. It would also be beneficial if the warmline could expand their population served to include teenagers ages 13-17. Right now, the warmline serves only adults aged 18+. Peer support is an evidenced based practice. These services would benefit from fidelity monitoring to make sure they stay true to what the service is meant to be.

Block grant funding could be used to help with the continuation and expansion of peer support services in Iowa. The Council recommends that block grant funds be used to continue the funding for the peer run organizations: Iowa Peer Network, Freedom Pointe, Nami Johnson County and Life Connections. The block grant funding could also be used to develop additional peer-run respite houses in Iowa. Funding could be used

to provide additional training for the warmline to serve the teenage population and possibly training for additional peers if the extension increases volume. Block grant funds could also help fund fidelity monitoring for peer support organization, possibly through the same contracts that provide the peer support training or center of excellence.

The Council's second recommendation for the mental health block grant funds is to provide more services to help teens and young adults transitioning to adult behavioral health services. The council particularly sees this need with teens transitioning out of the foster care or state system as they age out. We have seen and heard stories from the community of children and young adults who fall through the cracks, many ending up in the justice system, homeless or other unacceptable conditions. The council sees that there isn't always long-term follow-up with individuals who transition out of the foster care system to make sure their needs are being met and they are accessing the services they need. We understand that teens and young adults who are transitioning out of the system are looking forward to independence and may be resistant to support from professionals and we see this is an opportunity to use peer support services. A peer could walk along the journey with the young adult and provide information, support, and experience. Young adults who have been in the system often lack the natural supports that other young adults rely on. A peer would give them support that can meet them where they are at. The council also believes that all those working with this population should have considerable training in trauma-informed care.

Block grant funds can be used to help assist teens and young adults transitioning from youth to adult services. Funds could be used to strengthen and expand transitional age youth programs including those with YSS and Ellipsis. Funds could be used to develop a service that follows up with young adults when they transition out of the foster care service to make sure that their basic needs are being met including access to behavioral health care. Increased training for those working with teens/young adults with behavioral health needs to have knowledge of transitional services could be funded by the mental health block grant. Funding could support programs such as the Kinship program at First Family Resources. Funding for a peer support program specific to this population and help with paying for training would help address the gap.

The Council's third recommendation is to increase the availability of services to the elderly population. There is a gap due to the closing of facilities and concerns about the level of care with recent cases of elderly abuse being reported. The number of facilities able to work with mental health or dementia related behaviors in the elderly is limited which makes finding adequate help difficult. The workforce shortages make it hard for nursing homes to provide care that meets the current needs. Workforce shortages also limit the availability of home health and home hospice services being provided. While the effect can be seen statewide, it is particularly impactful in rural areas. Finding mental health providers that specialize in geriatric behavioral health is difficult as there are very few in Iowa.

The Council believes that mental health block grant funding can help with these gaps and needs. The greatest impact we believe funding could have is to help with training. Staff working with the elderly population would benefit from training to work with elderly who have difficult behaviors, dementia, and mental health struggles. Training could increase services available to this population and reduce the risk of abusive behaviors towards the elderly in higher levels of care. Finding ways to use funding to help with the workforce issue would be beneficial.

The fourth and final recommendation to the Council is providing education to the community on brain injury and subsequent behavioral health issues. There has been a lot of information to communities, school, sport coaches and the medical community regarding mild TBI or concussions and returning to school and sports. Not a lot is available regarding mild TBI and the effects it has on mental health. According to the national institutes of health, approximately 1 in 5 individuals experience mental health symptoms up to 6 months after a mild TBI. The Concussion Alliance states that youth who sustain a concussion are at a 40% higher risk of mental health issues, psychiatric hospitalizations, and self-harm.

Mental health block grant funding could help with training and education on this topic. Education could be provided to coaches and teachers on what to look for and how mental health issues can manifest after mild TBI. Education could also be provided on a community level to educate parents and community members on the prevalence of mental health issues and mild TBI and what resources are available to help.

The Council has looked at gaps and needs in our state before making these recommendations. We have seen the benefits and impact of peer support and support the continuation and expansion of these services. We have seen a need to support teens and young adults who are transitioning to adult services for behavioral health – especially those who have been wards of the state and in the foster care system. We understand the needs of the elderly population to have services that support all persons with mental health issues as they age as well as those with behaviors related to dementia or Alzheimer's. Lastly, there is a need to provide education to the community about mild TBI and subsequent behavioral health issues. The mental health block grant funding can assist in providing services and support to close these gaps.

The Council appreciates the opportunity to provide input into the application for block grant funds. Please let us know if you have any questions or require clarification. Thank you.

Sincerely,

Teresa Bomhoff, Chair

Iowa Mental Health Planning and Advisory Council

Theresa Henderson, Chair

Monitoring and Oversight Committee

Mental Health Planning Council
January 18, 2023, 9:00 am to 2:30 pm
Zoom
Meeting Minutes – Approved 3/15/2023

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Rachel Cecil
Linda Dettmann
Jim Donoghue
Jen Gomez
Theresa Henderson
Vienna Hoang
Michael Kaufman
Todd Lange
Megan Marsh
Christina Maulsby
Katie McBurney
Ed Murphy
Hannah Olson
Brad Richardson
Dr. Shaad Swim
Lorraine Uehling-Techel
Monica Van Horn
Patricia Whitmarsh
Edward Wollner

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Kenneth Briggs
Sen. Nate Boulton
Leslie Carpenter
Kyra Hawley
Rep. Bob Kressig
Heaven Lorenz
Rep. Ann Meyer
Todd Noack
Amy Robasse
Kristin Rooff

OTHER ATTENDEES:

Theresa Armstrong
Kathleen Buckwalter
Kate Carico
Jennifer Day
Wendy DePhillips
Maggie Ferguson
Laura Larkin
Patti Manna
Devon McClurken
Denise Rathman
Libby Reekers
Flora Schmidt
Shannon Zehr

Materials Referenced:
November 16, 2022, IMHPC Meeting Minutes – DRAFT
2023 Legislative Priorities for Jan 18 Meeting
Attachment to Agenda
Geriatric Mental Health Presentation #1 – NASEM Report
Geriatric Mental Health Presentation #2 – IGEC & GWEP
Geriatric Mental Health Presentation #3 – Csomay Center
Geriatric Mental Health Presentation #4 – Changing Population of Clients & Healthcare Professionals in the Future

Welcome
Teresa Bomhoff called the meeting to order at 9:05 am. Quorum was established with 20 members attending. Teresa introduced herself and led introductions of Council members asking them to what seat they represent on the Council, where they live and/or work in the State, and something interesting about themselves.

Review and Approval of Meeting Minutes
Teresa Bomhoff entertained a motion to approve the November 16, 2022, meeting minutes. Rachel Cecil motioned to approve the minutes. Jen Gomez seconded the motion. There was no discussion, the motion passed, and the minutes were approved.

Nominations Committee Report
Jen Gomez stated that the Nominations Committee had received and reviewed an application from Mary McKinnell from Waterloo, for one of the Public/Private vacancy on the Iowa Mental Health Planning Council. Jen noted that the Nominations Committee recommended Mary's application for approval by the full Council. There was no additional discussion on the application. Jen Gomez motioned to approve Mary McKinnell's application to the Planning Council. Brad Richardson seconded the motion. There was no discussion, and the motion was approved.

Jen also noted that three new members had been reviewed and recommended by the Nominations Committee and approved by the full Council via email vote in December 2022. These three individuals were Amy Robasse who fills one of the individuals in recovery vacancies, Ed Wollner who fills the other vacancy for an individual in recovery, and Patti Whitmarsh who fills the seat for a parent of a child with SED. Patti will be considered a provider as she is the Program Manager for Family and Professional Partnerships at the University of Iowa Child Health Specialty Clinics (CHSC.) Jen indicated that Ed and Patti were at today's meeting.

Jen Gomez stated that there were three members who were in jeopardy of losing their seat due to three consecutive absences. Jen noted all these members were contacted and notified about their status, and that they planned to attend the next meeting. With these additions to the Planning Council the remaining vacancies include one Family Member of an Adult with SMI, one Parent of a Child with SED, two "Other", and one Public/Private which was being held for the nomination from a state agency (HHS) for staff with a specialty in substance use disorders. This person would replace Michele Tilotta who accepted a different position within HHS.

Monitoring and Oversight Committee Report
Theresa Henderson indicated that the Monitoring and Oversight Committee met with Julie Maas, HHS, in December to review the Center of Excellence for Behavioral Health (CEBH) contract. The CEBH provides training and fidelity review for community providers on evidence-based practices (EBPs). Currently the three EBPs are Assertive Community Treatment (ACT), Individual Placement & Support (IPS) and Permanent Supportive Housing. The CEBH has conducted a landscape analysis to determine how EBPs are being used in the state, submitted plans, and are looking at implementing a training plan. IPS is the current focus of the Center, and as this EBP is not as well-known they are looking at additional funding. The CEBH is currently funded through COVID supplemental and American Rescue Plan Act (ARPA) funding, which will expire in March 2025. It was noted that Permanent Supportive Housing is the EBP that most community providers struggle with implementing.

Theresa stated that committee met with Julie Maas, HHS, in January to review the Community Mental Health Centers contracts. It was noted that one of the big changes with the new contracts were the addition of a workforce deliverable that allows CMHCs to pay for supervision of an intern or for professional licensing, which has been beneficial in helping address workforce issues. Julie noted that all contract deliverables must be EBPs or a promising practice with evidence of significant research. CMHCs are currently in the first quarter of the contract, and everything has been on track. There have been some staffing issues that have interfered with being able to send staff to trainings, which is one of the ways that CMHC utilize block grant dollars. However, contract deliverables can be changed if or when necessary.

There was some discussion regarding how block grant dollars are divided amongst the different programs/contracts. It was noted that off the top five percent is allocated for crisis, and ten percent for First Episode Psychosis (FEP). After those allocations are removed, five percent is then allocated to

administration and 70 percent of the remaining funds are allocated to the CMHCs per Iowa law, with the final 25 percent going to state contracts.

Council Policy & Bylaws Workgroup
Michael Kauffman indicated that upon review of the Council Policy and Council Bylaws by Jim Donoghue and himself there were no substantive changes to either document, with the main change being the references to the Department of Human Services (DHS) being changed to the Department of Health and Human Services (HHS).

Michael noted that the Bylaws document can be amended at any time. He also indicated that he made some grammatical and formatting changes to the Bylaws document as well as some clean up to Section 5, E. Voting Rights, but again, no substantive changes. Michael notified the Council that this was the first reading of the documents, and there would need to be a second reading prior to voting. Michael indicated that her would make necessary changes based on discussion and send these documents out to all the Council for review so that they could vote on changes to the documents at the March meeting.

Legislative Priorities
Teresa Bomhoff reviewed the Legislative Priorities document, including the purposes for the Iowa Mental Health Planning and Advisory Council for discussion and input from the full Council. Teresa noted she included comparisons to the Governor's Condition of the State Report. Teresa stated that the table of contents page could be a one-pager that could be shared with state legislators.

There was discussion regarding changes to the document, including moving the bullet for peer support to immediately follow direct care (Workforce Crisis & Training) as these both have a lot in common as well as the addition of employment support providers (job developers, job coaches). There was discussion regarding adding rate relief for employment support services, as well as FPL percentage for eligibility and whether this percentage should be increased and consistent across regions. Currently regions must fund individuals at or below 150% FPL, but regions can choose to fund up to 500% FPL. It was noted that 150% FPL still leaves many without assistance as the work to be economically independent.

Teresa indicated some key legislators that need to receive the priorities including Sen. Jeff Edler, Rep. Joel Fry, and Rep. Ann Meyer, and that the Council should request a 30-minute session with them to review. It was noted that these individuals are also all part of the HHS Appropriations Subcommittee. Teresa recommended that Council members review the document closely, and if they had any suggestions to send them to Teresa for addition to the document.

Public Safety Workgroup
Brad Richardson noted that the Public Safety Workgroup had not met recently. Brad noted that Iowa Code Chapter 229 on Hospitalization of Persons with Mental Illness could benefit from changes. Brad referenced an article by Michael Judge regarding the right to die in Iowa. The article, which will appear in the February MindSpring newsletter, is about a veteran who was approached by law enforcement several times to go to the hospital or shelter. The individual refused and ultimately froze to death. Brad noted that there needs to allowance for help to occur if it is in the person's best interest. There was discussion regarding potential speakers or presentation topics, including SolutionPoint+ who teach Crisis Intervention Training and de-escalation, mental health courts, and medication monitoring. Some county jails do not allow individuals to bring in medication. Polk County does allow medications to be brought in.

There was discussion regarding what project the workgroup should be working on. Topics of interest included continuity of services for individuals when discharged from the Department of Corrections or the development of a civil forensic unit as there is a need for facilities that can handle individuals who are experiencing aggressive behaviors. There was discussion regarding Intensive Residential Service

Homes and how they will function as a no eject/no reject service. Teresa Bomhoff noted that the workgroup should meet to discuss and determine what project they want to work on.

Mental Health Block Grant (MHBG) Discussion
Laura Larkin, HHS introduced herself noting that she was the State Block Grant Planner for the Mental Health Block Grant (MHBG). Laura reviewed the process for the MHBG, noting that the allocation for last year was approximately $6.5 million as well as separate supplemental funds. Laura noted that the state must apply for block grant dollars annually. However, every other year was a full application that included an assessment of the mental health system, priorities, etc. The opposite year the application was a short report noting that the state was applying for block grant funds.

Laura provided a high-level of the current MHBG plan, which was submitted in September 2021. The Planning Council participates in identifying system strengths as well as gaps and concerns by participating in the MHBG Planning Workgroup along with the state planner with HHS. The workgroup also works to identify priorities for the application period. Teresa inquired who would like to participate in the MHBG Planning Workgroup for the 2024-2025 Application and Plan. Teresa Bomhoff, Theresa Henderson, Monica Van Horn, and Brad Richardson all volunteered for the workgroup. Teresa noted that Jim Donoghue served on this workgroup last time but was unsure if he would like to serve on the workgroup again. Teresa noted that any interested individuals should let her know as soon as possible, as the group will begin meeting this Spring. There was discussion about the combination of the MHBG and the Substance Abuse Block Grant (SABG) with the alignment of the Department of Health and Human Services.

Teresa, using the agenda attachment document, reviewed the FY22-23 MHBG Priorities with Laura Larkin providing updates on their status. Teresa reflected these updates in the agenda attachment. Teresa also reviewed the priorities for the SABG, the 2021-2022 recommendations from the IMHPC, specifically notes on the priority regarding marginalized populations, the 2022-2023 IMHPC recommendations, the record of the MHBG allocations and which programs, were funded by the MHBG regular and supplemental funds.

There was discussion regarding the dollars allocated through the COVID supplemental, which expire in March 2024 and ARPA, which expire September 2025, and the sustainability of these projects. It was noted that the carry over for peer run organization, Systems of Care programs, Center of Excellence for Behavioral Health (CEBH) are in the HHS ARPA plan as well as 988 implementations.

Iowa Mental Health Planning and Advisory Council took a break at 12:05 p.m. and reconvened at 12:34 p.m.

Geriatric Mental Health
Kathleen “Kitty” Buckwalter, PhD, RN, FAAN, University of Iowa, College of Nursing provided a presentation on Geriatric Mental Health, including topics on the NASEM nursing home report “The National Imperative to Improve Nursing Home Quality – Consensus Study Report”, the Iowa Geriatric Education enter and the Geriatrics Workforce Enhancement Program at the University of Iowa, the Barbara and Richard Csomay Center for Gerontological Excellence at the University of Iowa, and the changing population of clients and healthcare professional in the future. Kitty referenced the Iowa Supreme Court’s Guardianship and Conservatorship Reform Task Force (2015-2017), and reform legislation in 2019 that incorporated and reflected the reforms of this task force.

There was discussion regarding solutions that other countries have implemented. There was discussion regarding issues that China is having due to their one-child policy as well as the communities centered around gerontological care in the Netherlands. There was discussion regarding what age is considered “geriatric”, noting that it was dependent on the situation as many think it is age 65, while the work that

Kitty does defines it as age 55. There was discussion regarding senior peer support services, noting that they are not as widespread as they need to be. It was noted that there is a good peer program for caregivers for individuals with dementia.

HHS Update

HHS Legislation

Theresa Armstrong informed the Council that HHS has submitted an omnibus bill this legislative session. Theresa noted the bill consists of four sections. One section is focused on Mental Health Institutes and bed specialization, another section is focused on forensics and Iowa Code 812 competency and competency restoration. Theresa noted that Dr. Derek Hess worked extensively with various stakeholders including the Department of Corrections and Mental Health and Disability Services Regions. Another section references the MHDS Regions Study Report and moves the law regarding the MHDS Regions from Chapter 331, County Home Rule Implementation to 225C, Mental Health and Disability Services as mental health services are now 100% state appropriation versus the county tax levy. It also asks for governance changes seeking broader stakeholder representation and caps county board of supervisors' representation to 49% of the regional governing board. It asks for community-based competency restoration to be added to required core services, increases the MHDS Regions' carry forward from 5% to 10% and eliminates HHS quarterly reporting, changing it to an annual report with dashboards. The fourth section is not related to Behavioral Health and Disability Services (BHDS) as it is a cleanup or technical change regarding Family First legislation.

HHS Alignment

Theresa Armstrong informed the Council that BHDS is building its table of organization and how best to align the work of the Division. It was also noted that the initial HHS website has launched, but there is a lot of work still to be done. Theresa noted that this is the first step in this change, as the main purpose up to this point was to ensure that information from the legacy websites was transferred to the new one. The next step will be a focus on making the website more accessible and user friendly. HHS will be gathering stakeholder input for this step.

Theresa discussed the Governor's Condition of State and the aligning of state government with the reduction of state departments from 37 to 16. Theresa noted that the Department of Human Rights and Volunteer Iowa are possible additions to HHS, along with the Iowa Department on Aging and Early Childhood Iowa which were already slated to join HHS later this year. Theresa also informed the Council that Disability Rights Iowa has filed a lawsuit against HHS regarding access to children's services. Theresa noted that she was unable to comment further on the lawsuit but wanted to ensure the Council was informed.

Certified Community Behavioral Health Clinics (CCBHCs)

Theresa informed the Council that the CCBHC Planning Grant has been submitted and that the Substance Abuse and Mental Health Services Administration (SAMHSA) will be announcing which states will be awarded a planning grant in March. It was noted that this was a very competitive grant with 40 states offering applications and only 15 states being awarded the grant to apply to be a demonstration state.

Transformation Transfer Initiative (TTI) Grant

Theresa informed the Council that BHDS was awarded a TTI grant in 2022 to create two crisis toolkits and training curriculum for crisis services provides specifically those who work with children and LGBTQ+ individuals. It was noted that TTI grants are awarded by National Association of State Mental Health Program Directors (NASMHPD) through funds provided by SAMHSA. Theresa noted that BHDS has received another TTI grant in 2023 to hire a contractor to do an expanded landscape analysis and provide recommendations and a roadmap to accessing behavioral health and crisis systems.

ASPIRE Grant

Theresa informed the Council that HHS has recently applied for an Advancing State Policy Integration for Recovery and Employment (ASPIRE) grant through the US Department of Labor, Office of Disability

Employment Policy (ODEP). HHS has received this grant in the past. There are no funds associated with this grant, as it is a technical assistance grant that provides training and technical assistance from subject matter experts, Westat is the contractor, on Individual Placements & Supports (IPS), which is an evidence-based practice for supported employment. Iowa currently has five ISP providers in the state and HHS would like to expand to additional providers. It was also noted the Center of Excellence for Behavioral Health is focused on IPS as one of the EBPs in their contract with the state.

988

Theresa informed the Council that HHS has received an additional $450K from SAMHSA for the implementation of 988. HHS will use these dollars for marketing, training, and technical assistance to 911 partners and mobile response warm handoffs. HHS is also looking how a centralized tracking for crisis services might operate. Theresa noted that MHDS Regions have begun collecting data related to crisis services beginning January 1, 2023, with all data going to the same place and MHDS Regions using the same definition. Theresa noted that 988 crisis lines are providing warm handoffs to mobile response dispatch. Theresa also stated that the crisis lines are seeing an increase in call, text, and chat. There was discussion regarding the need to market 988 to older adults and the alternative methods for marketing outside of online social media. Methods include using billboards, flyers in local bars, salons, libraries, etc., and print media. It was noted that this may help with marketing to the rural community. Theresa informed the Council that HHS will start a few pilot projects with 911 providers to work on coordination between 988 and 911.

DOJ Investigation

Theresa notified the Council that Director Kelly Garcia had recently attended a townhall meeting at Glenwood Resource Center (GRC) along with families and guardians. Themes of DOJ consent decree for GRC include establishing processes to ensure all services and care is consistent with current, generally accepted standards of care, monitoring effectiveness of all treatments, supports and interventions, use valid, reliable, and sufficient data to inform decision-making, utilize person-centered planning, and maintain detailed records of assessment, treatment, and diagnosis. Changes being made at GRC are also being implemented at Woodward Resource Center. While a report has been issued, a consent decree on the second part of the investigation regarding Americans with Disabilities Act (ADA) compliance has not been received. However, HHS continues to move forward with making changes for more community options.
However, HHS continues to work on community integration and the array of necessary services.

Medicaid Updates

Theresa noted that with the announcement that the Public Health Emergency (PHE) will end on May 11, 2023, Medicaid will begin returning to normal operating procedures or “unwinding”, which will entail individuals having to submit documentation and requalify for Medicaid services. During the PHE, members could not be removed from Medicaid and did not have to submit financial documentation. Theresa noted that Iowa Medicaid has released an Information Letter (IL) with more information. Molina Healthcare is currently doing onboarding and will begin as a third MCO on July 1, 2023. Iowa Medicaid will be sending letters to members to see who may be interested in opting to change to Molina from their current MCO. Iowa Medicaid has filed a state plan amendment (SPA) to make Functional Family Therapy and Multi-Systemic Therapy, two evidence-based practices for children, Medicaid funded services in Iowa. Theresa noted that a rate has been identified for these services. Theresa also noted that intensive inpatient psychiatric rates went into effect on January 1, 2023. There are two rates (general and intensive) for inpatient psychiatric care. Theresa also noted that the systems assessment being conducted by Mathematica was still in progress. Mathematica has provided some initial recommendations as well as a preliminary report, but the final report is not done. There was discussion regarding the waivers specifically the children’s mental health waiver and the need for one for kids with autism.

Agenda Attachment Review

Teresa Bomhoff reviewed the agenda attachment pages 6 to 13 with the Council making additions or deletions based on input from Theresa Armstrong. Teresa noted that she uses this document to track information for Council reference.

Additional Discussion/Planning for Future Meetings
Teresa Bomhoff noted that the next Planning Council meeting would be Wednesday, March 15, 2023.

Public Comment

- Shannon Zehr addressed the Planning Council indicating her possible interest in applying for the Council. Shannon expressed interest in if the state was tracking individuals who have left the State Resource Centers and other RCF/IDs to ascertain successful placement. Shannon spoke about a situation she has experienced as a guardian, concerns she has with the placement of her family member, lack of communication with the family by the provider, issues with telehealth providers and oversight.

Adjourn
The meeting adjourned at 3:27 p.m.

Mental Health Planning Council
March 15, 2023, 9:00 am to 1:00 pm
Zoom
Meeting Minutes – Approved 5.17.2023

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Leslie Carpenter
Rachel Cecil
Jim Donoghue
Jen Gomez
Kyra Hawley
Theresa Henderson
Michael Kaufman
Todd Lange
Megan Marsh
Christina Maulsby
Katie McBurney
Mary McKinnell
Ed Murphy
Todd Noack
Hannah Olson
Kristin Rooff
Lorraine Uehling-Techel
Monica Van Horn
Patricia Whitmarsh
Edward Wollner

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Kenneth Briggs
Sen. Claire Celsi
Linda Dettmann
Rep. Bob Kressig
Vienna Hoang
Heaven Lorenz
Rep. Ann Meyer
Brad Richardson
Dr. Shaad Swim

OTHER ATTENDEES:

Wendy DePhillips
Jenny Erdman
Torie Keith
Brenna Koedam
Julie Maas
Patti Manna
Devon McClurken
Caleb Prevo
Libby Reekers
Flora Schmidt
Jill Vogel

Materials Referenced:

January 18, 2023, IMHPC Meeting Minutes – DRAFT
Committees and Workgroups
IMHPC Policy 1-18-23
IMHPC Bylaws 1-18-23
HSB126 Analysis of Reorganization of State Government
2023 First Funnel Results – UPDATED
Center of Excellence for Behavioral Health- Updated March 2023
Attachment to Agenda

Welcome

Teresa Bomhoff called the meeting to order at 9:05 am. Quorum was established with 21 members attending. Teresa introduced herself and led introductions of Council members.

Update on Peer Support Services

Todd Lange noted that an email was sent out to the Council on Monday with information on statewide peer support resources as well as the upcoming Peer Support Summit. Todd reviewed this information sharing that these resources consisted of the Abbe Statewide Warm Line, R Place in Iowa City which

has remote peer support as well as virtual support groups including the only “Hearing Voices, Special Messages” group in the state, as well as Rhonda’s House, which is a peer run respite house in DeWitt, but is open to statewide referrals. Todd noted that LifeConnections which operates Rhonda’s House also has a virtual recovery center available. Todd also noted that the Iowa Peer Network was putting on the 1st Annual Statewide Conference Peer Support Summit to be held in West Des Moines on May 19 and 20, 2023. Todd indicated that block grant dollars fund many of these programs. Todd encouraged Council members to share the resource information as well as the peer support summit. Finally, Todd notified the Council that he had put together an inventory of peer support services in the state, which he updated regularly.

There was discussion regarding the warm line and where funding for peer run organizations will come from in the future. There was discussion regarding legislation that was introduced that would make changes to the state boards and commissions. There was discussion regarding the Certified Community Behavioral Health Clinic (CCBHC) planning grant and opportunities around CCBHCs including opportunities for peer support services to address some of the workforce issues experienced by CCBHCs.

Review and Approval of Meeting Minutes
Teresa Bomhoff entertained a motion to approve the January 18, 2023, meeting minutes. Jen Gomez motioned to approve the minutes. Kristin Rooff seconded the motion. There was no discussion, the motion passed, and the minutes were approved.

Nominations Committee Report
Jen Gomez stated that the Nominations Committee had received and reviewed an application from Nina Richtman from Des Moines to fill the Parent of a Child with SED vacancy on the Iowa Mental Health Planning Council. Jen noted that the Nominations Committee recommended Nina’s application for approval by the full Council. There was no additional discussion on the application. Todd Noack motioned to approve Nina Richtman’ s application to the Planning Council. Todd Lange seconded the motion. There was no discussion, and the motion was approved.

Jen welcomed Mary McKinnell, who was a new member to the Planning Council filling one of the public/private seats. It was also noted that Heaven Lorenz had missed more than three consecutive meetings and that her seat would be declared vacant, which would leave the following Council vacancies, one family member of an individual with serious mental illness, two individuals with experience/in recovery, two “other” category, and one public/private vacancy to be filled by a staff nomination from the Iowa Health and Human Services with a focus on substance use disorders.

Monitoring and Oversight Committee Report
Theresa Henderson indicated that the Monitoring and Oversight Committee met with Laura Larkin, HHS, in March to review the Systems of Care (SOC) contracts. There are currently five providers of Systems of Care with six separate contracts. Orchard Place has two contracts. One for Polk and Warren Counties and one for Dallas and Madison Counties. The other organizations include Ellipsis, Four Oaks, Tanager Place, and the University of Iowa Circle of Care. The contracts provide Integrated Health Home (IHH) coordination and funding for different mental health interventions (e.g., Behavioral Health Intervention Services [BHIS]), which would normally be funded under Medicaid, but the individuals are either privately insured or enrolled in Hawk-I, which doesn’t fund these services. There are currently 400 children enrolled in SOC. It is likely that more will be enrolled due to Medicaid unwind. The fall is also a time for more referrals/enrollment due to conferences between parents and teachers. SOC is funded through block grant funds, MHDS Regions and state appropriation. The University of Iowa Circle of Care has the highest target of enrollment but will be looking at adjusting this when their contract is renewed this summer. Workforce, available providers, and referrals are the biggest barriers with flexibility being the biggest success of the program. The University of Iowa and Tanager Place

have the longest established contracts and are due at the end of the fiscal year. Theresa noted that there will likely be new targets with the new contracts.

Theresa informed the Council that there was no meeting in February due to meeting conflicts, but that the committee planned to review the Iowa Peer Workforce Collaborative (IPWC) at their April meeting.

Council Policy & Bylaws Workgroup
Michael Kauffman noted that copies of the updated Council Bylaws and Council Policy documents had been sent to all Council members for a second and final reading prior to the meeting. Michael indicated there were no substantive changes to either document, with the main change being the references to the Department of Human Services (DHS) being changed to the Iowa Department of Health and Human Services (HHS). Michael noted that the Bylaws document can be amended at any time. He also indicated that he made some grammatical and formatting changes to the Bylaws document as well as some clean up to Section 5, E. Voting Rights, but again, no substantive changes.

There were no questions or discussion from Council members regarding the documents or the updates. Teresa Bomhoff entertained a motion to accept the Council Policy and Council Bylaw changes. Leslie Carpenter motioned and was seconded by Christina Maulsby. The motion passed and the updated documents were accepted and are in effect.

Public Safety Workgroup
Teresa Bomhoff informed the Council that Brad Richardson was absent from the meeting so there wouldn't be a workgroup update. Teresa shared information from the back of the committee and workgroup document that could help with the workgroup determining its focus.

Mental Health Block Grant (MHBG) Planning Workgroup
Teresa shared information about the combined Behavioral Health Block Grant and noted that it was anticipated that the MHBG Planning Workgroup would not meet until at least April. Teresa noted that the members of this workgroup include, Teresa Bomhoff, Jim Donoghue, Brad Richardson, Theresa Henderson, and Monica Van Horn. Todd Lange and Todd Noack both indicated that they would like to be added to this workgroup.

Teresa also informed the Council that the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Program Technical Assistance (State TA) Project will conduct two listening sessions (April 18th at 3:00 p.m. CST and April 19th at 5:00 p.m. CST) for planning councils and state block grant staff. The goal of the sessions is to allow state staff and planning councils to inform the State TA team about the topics on which technical assistance (TA) is needed and which require the highest priority; identify training needs for planning councils to fulfill their statutory functions; get to know the State TA team; etc. Teresa noted that she and Jim Donoghue planned on joining one of the sessions.

Legislative Discussion
Teresa Bomhoff noted that Infonet which is put out by the Iowa Developmental Disabilities (DD) Council is a fantastic resource on what is happening at the legislature with a lot of useful information. Quarterly newsletters are issued as well as monthly Capitol discussions.

Teresa reviewed the HSB126 analysis document of Governor Reynold's State Reorganization Bill noting changes that Council should look at more closely. There was discussion regarding who sat on the Governor's Executive Council. The Governor's Executive Council consists of the Governor, the Secretary of State, the Treasurer of State, the Secretary of Agriculture, and the Auditor of the State. Teresa reviewed the updated 2023 First Funnel Results document noting specific bills that have been signed as well as legislation that was still alive following first funnel.

Wendy DePhillips shared that HHS had just received notification from SAMHSA that Iowa has received one of fifteen CCBHC Planning Grants. This grant will allow Iowa to work on a developing and implementation and certification plan for CCBHCs in Iowa and put forth an application for Iowa to be awarded as a demonstration state.

Center of Excellence for Behavioral Health (CEBH) Update
Torie Keith, Program Manager, Center of Excellence for Behavioral Health, University Center of Excellence in Developmental Disabilities (UCEDD), University of Iowa Health Care introduced herself, and provided a presentation on the CEBH and the work of the organization. Torie provided a update on the environmental scan and its preliminary results summarizing the conversations with those who participated. Torie reviewed key takeaways, successes and barriers related to fidelity reviews and trainings as well as additional evidence-based practices (EBPs) for the Center to look at moving forward as well as the barriers to these practices. Torie indicated that they are continuing to examine other states work towards EBP implementation. Finally, Torie noted ways in which the CEBH could help as well as upcoming trainings.

There was discussion regarding the need for a central repository of evidence-based training manuals that providers or individuals can refer to. It was noted that CEBH was working on building up their website to be that one-stop shop for resources. Links to the general CEBH website and one for training was shared https://www.iowacebh.org/ & https://www.iowacebh.org/training. There was discussion on whether the training or resources reflect Medicaid billing and the opportunity to connect with Medicaid to add helpful resource information on this specifically. There was discussion on how to share information with others. A link to EBPs was shared with the group https://div12.org/treatments/.

Agenda Attachment Review
Teresa Bomhoff briefly reviewed the agenda attachment document noting that she uses this document to track information for Council reference and encouraged Council members to refer to it for information.

Additional Discussion/Planning for Future Meetings
Teresa Bomhoff noted that the next Planning Council meeting would be Wednesday, May 17, 2023, and that the afternoon would be a joint meeting with the MHDS Commission and the Iowa Developmental Disabilities (DD) Council.

Public Comment
No public comment.

Adjourn
Teresa Bomhoff entertained a motion to adjourn. Todd Noack motioned to adjourn and was seconded by Rachel Cecil. The motion passed and the meeting adjourned at 12:21 p.m.

Mental Health Planning Council
May 17, 2023, 9:00 am to 11:30 am
Zoom
Meeting Minutes – approved 7.19.23

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Leslie Carpenter
Rachel Cecil
Sen. Claire Celsi
Linda Dettmann
Jim Donoghue
Jenny Erdman for Hannah Olson
Jen Gomez
Kyra Hawley
Theresa Henderson
Vienna Hoang
Michael Kaufman
Todd Lange
Megan Marsh
Christina Maulsby
Katie McBurney
Mary McKinnell
Ed Murphy
Todd Noack
Nina Richtman
Kristin Rooff
Dr. Shad Swim
Lorraine Uehling-Techel
Monica Van Horn
Patricia Whitmarsh

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Rep. Bob Kressig
Brad Richardson
Edward Wollner

OTHER ATTENDEES:

Theresa Armstrong, Iowa HHS
Cody Crawford, Iowa HHS
Wendy DePhillips, Iowa HHS
Justin Edwards, Iowa HHS
Maggie Ferguson, Iowa HHS
Karen Hyatt, Iowa HHS
Laura Larkin, Iowa HHS
Patti Manna, Iowa HHS
Devon McClurken, NAMI Iowa
Jancy Nielson, Iowa HHS
Libby Reekers, Tama County
Eric Richardson, LSA
Jennifer Robbins, Molina
Flora Schmidt, IBHA

Materials Referenced:

March 15, 2023, IMHPC Meeting Minutes – DRAFT
MHBG_FY22-23_Assessment_and_Plan-final.pdf (iowa.gov)
TIEH Project Fact Sheet
PATH PowerPoint

Welcome

Teresa Bomhoff called the meeting to order at 9:06 am. Quorum was established with 24 members attending. Teresa introduced herself and led introductions of Council members.

Review and Approval of Meeting Minutes

Teresa Bomhoff asked if anyone had any corrections or questions regarding the March 15, 2023, meeting minutes. Hearing none, Teresa entertained a motion to approve the March 15, 2023, meeting minutes. Todd Noack motioned to approve the minutes. Mary McKinnell seconded the motion. There was no discussion, the motion passed, and the minutes were approved.

Nominations Committee Report
Jen Gomez stated that the Nominations Committee had received and reviewed two applications. One from Jennifer Day from Iowa City to fill one of the Individual with Lived Experience/In Recovery vacancies on the Iowa Mental Health Planning Council. The second applications from Jennifer Riley from Waverly to fill the other Individual with Lived Experience/In Recovery vacancy. Jen reviewed highlights from the two applications and noted that the Nominations Committee recommended both applications for approval by the full Council. There was no additional discussion. Todd Noack motioned to approve Jennifer Day's and Jennifer Riley's application to the Planning Council. Todd Lange seconded the motion. There was no discussion, and the motion passed and both applications were approved.

Jen welcomed Nina Richtman, who was a new member to the Planning Council filling a Parent/Guardian of a Child with Serious Emotional Disturbance (SED) vacancy. Teresa Bomhoff noted that Ken Briggs had resigned his seat on the Planning Council which would add a vacancy for a veteran on the Council. Teresa noted that the Nominations Committee now has a vacancy since Ken has resigned. Teresa noted the following Council vacancies, two family members of an individual with serious mental illness, two in the "other" category, with one being a veteran, and one public/private vacancy to be filled by a staff nomination from the Iowa Health and Human Services with a focus on substance use disorders. Teresa also noted with the addition of the two new members that the Planning Council is at 50% provider/50% non-provider. Teresa noted that to be in compliance with Council bylaws the Council needs to be at least 51% non-provider.

Monitoring and Oversight Committee Report
Theresa Henderson indicated that the Monitoring and Oversight Committee met with Karen Hyatt, HHS, in April to review the Iowa Peer Workforce Collaborative (IPWC) contract. The training program which works with peers for peer support, family peer support and recovery coaches is within budget and going well. IPWC can provide the contracted trainings at the rate stipulated in the contract with all trainings well attended. It was noted that individuals in recovery developed most of the curriculum and how it is implemented for the peer support trainings. IPWC has partnered with LifeConnections for ethics training. This training is occurring more frequently than required by the contract due to high demand. Ethics training is an essential component along with other trainings for peer support specialists to be certified.

Theresa indicated that the committee began discussing at their May meetings recommendations for the 2024-2025 Mental Health Block Grant. Theresa noted that the committee will be continuing their conversations at their June meeting as a couple members were not present and want to ensure that all members are able to provide feedback. Teresa Bomhoff reviewed the allocation process for block grant funds and the conditions on how these funds can be used. Teresa noted that the Monitoring and Oversight committee reviewed the state contracts that utilize block grant funding.

There was discussion regarding the Iowa Peer Workforce Collaborative and the need for and importance of training continuity. There was discussion regarding the importance of funding for peer-run organizations.

Workgroups & Committees
Teresa Bomhoff reviewed the different workgroups and committees for the Planning Council. Teresa noted that there was a vacancy on the Nominations Committee and that if anyone was interested in volunteering for this committee to let her know. Teresa reviewed the different committees and workgroups for the Planning Council and noted that the main difference between committees and workgroups were the number of members that could serve on them. Committees were established in the bylaws and could have no more than five members. Workgroups are developed based on Council need and don't have a threshold for membership but must be less than the number needed to meet quorum.

Public Safety Workgroup
Teresa Bomhoff informed the Council that Brad Richardson was absent from the meeting so there wouldn't be a workgroup update. Teresa shared possible areas that this workgroup may want to focus on moving forward and noted that much of this information was on the agenda attachment that is shared with Council members.

There was discussion regarding possible workgroup topics including rewriting of commitment laws, law enforcement reimagined, mental health courts as well as mental health issues within corrections. There was discussion regarding Crisis Intervention Training (CIT) and the investment by the MHDS Regions for this training as well as the expansion of crisis services at the community level and how they work together as well as non-law enforcement crisis interventions. There was discussion regarding the importance of clear definitions especially with regards to peer support services (peer support specialist, family peer support specialist, peer recovery, etc.), and the value of peers in a mobile crisis/response setting.

Block Grant Update
Laura Larkin and Justin Edwards, HHS reviewed the upcoming changes to the block grant process with the change to a single Behavioral Health Block Grant application that combines the Community Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG). Laura reviewed the portions of the application and plan that she and Justin will be focusing on with the Planning Council's MHBG Planning Workgroup, noting that past plans can be found on the HHS website: Community Mental Health Services Block Grant | Iowa Department of Health and Human Services. Laura noted that the MHBG Planning Workgroup will meet with her and Justin (state block grant planners) twice, Wednesday, May 24, 2023, and Wednesday, June 21, 2023, to discuss strengths, gaps and recommendations for the behavioral health system in Iowa.

Treatment for Individuals Experiencing Homelessness (TIEH) Program
Cody Crawford, HHS shared information on the Iowa Treatment for Individuals Experiencing Homelessness (TIEH) grant program including sharing the project fact sheet. Cody noted that TIEH was a five-year grant from Substance Abuse and Mental Health Services Administration (SAMHSA) with HHS receiving $1M per year. The program is currently in third year of the grant and works with six treatment service providers in the state. There originally were seven providers in the state, but one pulled out due to staffing issues.

There was discussion regarding barriers for the state with discharging from the hospital, specifically in Mason City and the high population of people experiencing homelessness. There was discussion regarding dollars allocated to more to urban populations versus more rural areas.

Projects for Assistance in Transition from Homelessness (PATH) Program
Karen Hyatt, HHS provided a presentation on the PATH program including the goals and service provided by this program. Karen reviewed in what areas in the state the PATH program operates. Karen noted that the PATH program can only be offered in metropolitan areas. Karen also reviewed data points for those served by PATH.

There was discussion regarding the Iowa Council on Homelessness. There was discussion regarding a current individual being served by the PATH program to illustrate how PATH works in the state including the gaps and barriers. There was discussion regarding a program in New York City that utilizes extended care hospitalization for individuals who are homeless and experiencing homelessness, as well as possible barriers to this type of program based on the funding system being used. There was discussion regarding homelessness in urban versus rural areas including the opioid epidemic and the role it plays in this issue. There was some discussion regarding COVID Recovery Iowa, which was changed to Project Recovery Iowa and the changes to come. It was noted that certain aspects of PRI will continue after the program ends at the end of the fiscal year.

Public Comment
No public comment

Iowa Mental Health Planning and Advisory Council adjourned for lunch at 11:30 a.m. and reconvened for the joint meeting with the Mental Health and Disability Services (MHDS) Commission at 12:30 p.m.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Teresa Bomhoff	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Leslie Carpenter	Others (Advocates who are not State employees or providers)			
Rachel Cecil	Others (Advocates who are not State employees or providers)			
Jennifer Day	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Linda Dettmann	State Employees			
Jim Donoghue	State Employees			
Jennifer Gomez	Providers			
Kyra Hawley	State Employees			
Theresa Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Vienna Hoang	State Employees			
Michael Kaufmann	State Employees			
Todd Lange	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Christina Maulsby	Parents of children with SED			
Katie McBurney	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Mary McKinnell	Others (Advocates who are not State employees or providers)			
	Individuals in Recovery (to include adults with			

Ed Murphy	SMI who are receiving, or have received, mental health services)			
Todd Noack	Others (Advocates who are not State employees or providers)			
Hannah Olson	State Employees			
Brad Richardson	State Employees			
Nina Richtman	Parents of children with SED			
Jennifer Riley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kristin Rooff	Providers			
Shaad Swim	State Employees			
Lorraine Uehling-Techel	Parents of children with SED			
Monica Van Horn	Providers			
Patricia Whitmarsh	Parents of children with SED			
Edward Wollner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.
OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	2	
Parents of children with SED	4	
Vacancies (individual & family members)	2	
Others (Advocates who are not State employees or providers)	4	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**18**	**56.25%**
State Employees	8	
Providers	3	
Vacancies	3	
Total State Employees & Providers	**14**	**43.75%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**32**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

22. 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

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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

N/A

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Iowa does not have a Syringe Services Program.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: