IOWA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF SUBSTANCE ABUSE

Prevention Guide

August 2019

IDPH
IOWA Department of PUBLIC HEALTH

Preface

Welcome to the field of prevention. The Iowa Department of Public Health congratulates your agency for embarking on the journey toward creating a healthy Iowa by reducing substance misuse and problem gambling. The 2019 Prevention Guide provides foundational instruction and best practices for implementing prevention services throughout the state. This tool should be maintained at your agency to ensure adherence to each component provided within this document. Due to the evolving nature of the prevention field, the Prevention Guide will be reviewed and revised by a collective group of stakeholders every two years. This group will consist of, but will not be limited to, Iowa Department of Public Health representatives and contractors.

The 2019 Prevention Guide offers comprehensive instruction related to program performance standards for service availability and delivery, personnel onboarding and development trainings, fiscal practices, record keeping, and data reporting. Embedded throughout the guide are useful tips and tools to ensure contract compliance throughout the project period. Each component of this guide has been carefully drafted to assist your agency each step of the way.

Note: Throughout the Prevention Guide, the term "substance misuse" will refer to alcohol, other drugs (legal and illegal), and tobacco.

Introduction

This handbook serves as a guide for Iowa Department of Public Health (IDPH or Department)–funded prevention contractors. The creation of this handbook was funded by the Substance Abuse Prevention and Treatment Block Grant and the Partnerships for Success Grant through the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT OVERVIEW | PREVENTION SET-ASIDE

The Substance Abuse Prevention and Treatment Block Grant (SABG) is distributed by formula to all U.S. states and territories. The grant is the cornerstone of states' substance misuse prevention, treatment, and recovery systems. The SABG is administered by SAMHSA, within the U.S. Department of Health and Human Services.

Federal statute requires states to direct at least 20% of SABG funds toward the primary prevention of substance misuse. This "prevention set-aside" is managed by the Center for Substance Abuse Prevention (CSAP) in SAMHSA and is a core component of each state's prevention system. On average, SABG funds make up 68% of primary prevention funding in states and territories. In 21 states, the prevention set-aside represents 75% or more of the state agency's substance misuse prevention budget. In six of those states, the prevention set-aside represents 100% of the state's primary prevention funding.

In Iowa, the SABG is called the Integrated Provider Network (IPN), which includes funding from SAMHSA and state appropriations for substance misuse prevention and treatment, as well as problem gambling prevention and treatment. This funding provides prevention and treatment services for all 99 counties in Iowa through 19 service areas.

Foreword

STORY OF THE RIVER

This story is often used to illustrate our role as prevention specialists:

Two friends, Susan and Fernando, are fishing on a river when Fernando looks upriver and sees a man in the water. He is struggling to stay afloat, so Fernando drops his fishing pole and pulls the man out of the water. The man is sputtering and cold, and Susan calls an ambulance on her cell phone to take him to a hospital. Susan and Fernando go back to fishing. Pretty soon they look upriver again and see a woman in the water. She is struggling, too, so Fernando drops his fishing pole again and pulls the woman out of the water.

She is not in very good shape, so Susan calls another ambulance to take her to a hospital. The friends return to fishing when they look upriver and see a whole group of people in the water. They are struggling to stay afloat and look like they are dragging each other down. Fernando drops his fishing pole and starts hauling people out of the water. He looks up and sees Susan walking away, upriver. He calls to her to come help pull people out of the river, and Susan responds that she is going upriver to find out why all the people are ending up in the water.

What prevention is:

We go upriver to find out what contributes to people misusing substances or experiencing issues related to problem gambling. We want to know exactly what is causing people to fall into the river, which may be different from river to river. Perhaps we go upstream—like Susan—and find that a fence to keep people away from the river has fallen and needs to be rebuilt. Maybe we find a slippery slope running into the river and can plant vegetation to prevent people from falling down the banks. Perhaps we find a big sign announcing, “The water’s great; jump in!” and we can take the sign down and replace it with a warning. We in prevention work to discover what is causing people to misuse substances or engage in high-risk gambling activities in our community, and then we work to reduce those risks and to build protections against substance misuse and/or problem gambling.

Source: Introduction to the field of prevention, The Athena Forum by the Washington State Health Care Authority/Division of Behavioral Health and Recovery, 2018

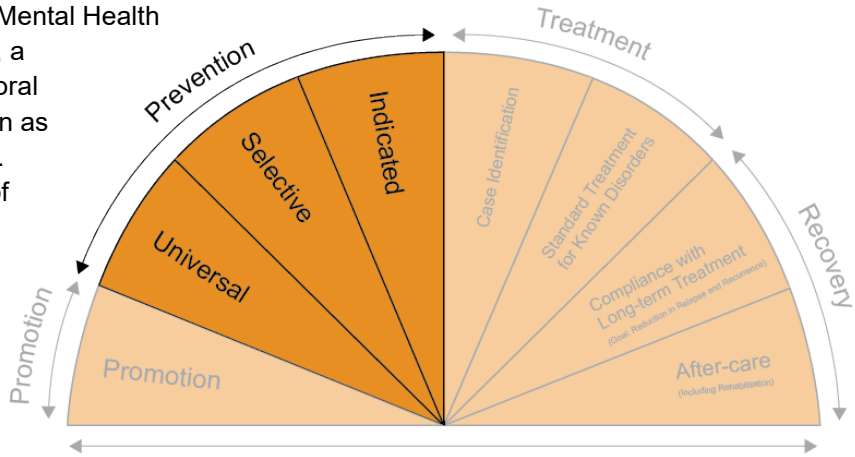
DEFINITION OF PRIMARY PREVENTION/CONTINUUM OF CARE

The term primary prevention refers to prevention services that are directed toward people who do not need treatment. Primary prevention should include a variety of strategies that prioritize populations and populations of focus with different levels of risk. Practitioners need to provide services in each of the Institute of Medicine (IOM) Model classifications (see below), which categorize prevention interventions by population of focus. The definitions for these population classifications are:

- **Universal:** The general public or a whole population group that has not been identified based on individual risk.
    - Universal Direct: Interventions directly serve an identifiable group of participants who have not been identified based on individual risk.
    - Universal Indirect: Interventions support population-based programs and environmental strategies.
- **Selective:** Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated:** Individuals in high-risk environments who have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

> **"The term primary prevention refers to prevention services that are directed to people who do not need treatment."**

According to the Substance Abuse Mental Health Services Administration (SAMHSA), a comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The Behavioral Health Continuum of Care Model recognizes multiple opportunities for addressing behavioral health problems and disorders. Based on the Mental Health Intervention Spectrum, first introduced in a 1994 Institute of Medicine report, the model includes the following components:



- **Promotion**: These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention**: Delivered prior to the possible onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription medication misuse, illicit drug misuse, and/or problem gambling.
- **Treatment**: These services are for people diagnosed with a substance misuse, problem gambling, or other behavioral health disorders.
- **Recovery**: These services support individuals' abilities to live productive lives in the community and can often help with abstinence.

Source: Substance Abuse and Mental Illness Prevention, Substance Abuse and Mental Health Services Administration, 2018

PREVENTION PRIORITIES FROM IDPH

Department prevention services typically focus on alcohol, tobacco, and illicit drug misuse, as well as problem gambling behaviors. All prevention strategies must endeavor to impact the established short- and long-term outcomes identified in the agency work plan. All services provided must also align with the information listed in the plan. If a community need that was not previously identified arises, contact the Department to discuss potential next steps for revision of the work plan. Priority areas may change based on the funding available.

Through the SABG funded Iowa Integrated Provider Network Grant, the Department has determined the following priorities for prevention services. Funded grantees are required to provide services across the lifespan of the grant for each of the following:

- Alcohol
- Marijuana
- Prescription medications
- Problem gambling
- Tobacco

Other additional prevention priority areas that will receive specific attention with direction from the Department have been identified, including:

- Methamphetamine
- Opioids
  Suicide

The Department also provides prevention funding through state and discretionary grant opportunities. These grants compliment the work of the SABG Integrated Provider Network Grant by focusing on specific prevention services and/or with specific populations of focus. Historically, these grants have focused on the following:

- Underage alcohol use
- Adult binge drinking
- Prescription drug misuse for person's ages 12-17 and 18 and over
- Youth development for youth ages 5-18
- Youth Mentoring

PREVENTION SPECIALIST

A prevention specialist is a "professional who uses a specialized set of knowledge, experience, training, and skills to encourage healthy attitudes and behaviors that prevent substance misuse and/or problem gambling. The role of the prevention specialist, as defined by the six Prevention Performance Domains (see below), is to empower individuals and communities to assess needs and to develop and implement strategies that effectively meet those needs."

Source: Application Handbook for Certified & Advanced Certified Prevention Specialists, Iowa Board of Certification, July 2017

For more information, please see Appendix A: Application Handbook for Certified & Advanced Certified Prevention Specialists.

FOUNDATIONAL SKILLS | PREVENTION PERFORMANCE DOMAINS

The International Certification and Reciprocity Consortium (IC&RC) has worked with subject matter experts in the field to identify the critical tasks, knowledge, and skills needed for working as a community prevention specialist. These essential functions are broken down into six domains:

Domain 1: Planning and Evaluation
Domain 2: Prevention Education and Service Delivery
Domain 3: Communication
Domain 4: Community Organization
Domain 5: Public Policy and Environmental Change
Domain 6: Professional Growth and Responsibility

Source: Application Handbook for Certified & Advanced Certified Prevention Specialists, Iowa Board of Certification, July 2017

The following, shared from the Maine Prevention Certification Board, are key tasks for each domain:

Domain 1: Planning and Evaluation

- Determine the level of community readiness for change.
- Identify appropriate methods of gathering relevant data for prevention planning.
- Identify existing resources available to address the community needs.
- Identify gaps in resources based on the assessment of community conditions.
- Identify the target audience.
- Identify factors that place people in the target audience at greater risk for the identified problem.
- Identify factors that provide protection or resilience for the target audience.
- Determine priorities based on a comprehensive community assessment.
- Develop a prevention plan based on research and theory that addresses community needs and desired outcomes.
- Select prevention strategies, programs, and best practices to meet the identified needs of the community.
- Implement a strategic planning process that results in the development and implementation of a quality strategic plan.
- Identify appropriate prevention program evaluation strategies.
- Administer surveys or pre- or post-tests at activities.
- Conduct evaluation activities to document program fidelity.
- Using evaluation data, identify opportunities to improve outcomes.
- Utilize evaluation to enhance the sustainability of prevention activities.
- Provide applicable work groups with prevention information and other support to meet prevention outcomes.
- Incorporate cultural responsiveness into all planning and evaluation activities.
- Prepare and maintain reports, records, and documents pertaining to funding sources.

Domain 2: Prevention Education and Service Delivery

- Coordinate prevention activities.
- Implement prevention education and skill development activities appropriate for the target audience.
- Provide prevention education and skill development programs that contain accurate, relevant, and timely content.
- Maintain program fidelity when implementing evidence-based practices.
- Serve as a resource to community members and organizations regarding prevention strategies and best practices.

Domain 3: Communication

- Promote programs, services, and activities, and maintain good public relations.
- Participate in public awareness campaigns and projects relating to health promotion across the continuum of care.
- Identify marketing techniques for prevention programs.
- Apply principles of effective listening.
- Apply principles of public speaking.
- Employ effective facilitation skills.
- Communicate effectively with various audiences.
- Demonstrate interpersonal communication competency.

Domain 4: Community Organization

- Identify the community demographics and norms.
- Identify a diverse group of stakeholders to include in prevention programming activities.
- Build community ownership of prevention programs by collaborating with stakeholders when planning, implementing, and evaluating prevention activities.
- Offer guidance to stakeholders and community members in mobilizing for community change.
- Participate in creating and sustaining community-based coalitions.
- Develop or assist in developing content and materials for meetings and other related activities.
- Develop strategic alliances with other service providers within the community.
- Develop collaborative agreements with other service providers within the community.
- Participate in behavioral health planning and activities.

Domain 5: Public Policy and Environmental Change

- Provide resources, trainings, and consultations that promote environmental change.
- Participate in enforcement initiatives to affect environmental change.
- Participate in public policy development to affect environmental change.
- Use media strategies to support policy change efforts in the community.
- Collaborate with various community groups to develop and strengthen effective policy.
- Advocate to bring about policy and/or environmental change.

Domain 6: Professional Growth and Responsibility

- Demonstrate knowledge of current prevention theory and practice.
- Adhere to all legal, professional, and ethical principles.
- Demonstrate cultural responsiveness as a prevention professional.
- Demonstrate self-care consistent with prevention messages.
- Recognize the importance of participation in professional associations locally, statewide, and nationally.
- Demonstrate the responsible and ethical use of public and private funds.
- Advocate for health promotion across the lifespan.
- Advocate for healthy and safe communities.
- Demonstrate knowledge of current issues of addiction.
- Demonstrate knowledge of current issues of mental, emotional, and behavioral health.

Source: IC&RC Prevention Domains, Maine Prevention Certification Board, 2018

ETHICS

According to the Iowa Board of Certification, “All prevention specialists must subscribe to the IBC Code of Ethics upon application for certification. The principles of ethics are models of exemplary professional behavior. These principles of the Prevention Think Tank Code express prevention professionals’ recognition of responsibilities to the public, to service recipients, and to colleagues within and outside of the prevention field. They guide prevention professionals in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The principles call for honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which prevention professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the prevention field.”

Iowa’s Code of Ethics for Prevention Specialists is guided by six principles:

- Non-Discrimination
- Competency
- Integrity
- Nature of Services
- Confidentiality
- Ethical Obligations for Community and Society

Iowa’s Prevention Specialists follow the Prevention Think Tank Code of Ethics, as recommended by the IC&RC.

Prevention Think Tank Code of Ethical Conduct Preamble

The principles of ethics are models of exemplary professional behavior. These principles of the Prevention Think Tank Code express prevention professionals’ recognition of responsibilities to the public, to service recipients, and to colleagues within and outside of the prevention field. They guide prevention professionals in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The principles call for honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which prevention professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the prevention field.

Principles

I. Non-Discrimination
Prevention professionals shall not discriminate against service recipients or colleagues based on race, ethnicity, religion, national origin, sex, age, sexual orientation, education level, economic or medical condition, or physical or mental ability. Prevention professionals should broaden their understanding and acceptance of cultural and individual differences and, in so doing, render services and provide information sensitive to those differences.

II. Competence
Prevention professionals shall master their prevention specialty’s body of knowledge and skill competencies, strive continually to improve personal proficiency and quality of service delivery, and discharge professional responsibility to the best of their ability. Competence includes a synthesis of education and experience combined with an

understanding of the cultures within which prevention application occurs. The maintenance of competence requires continual learning and professional improvement throughout one's career.

a. *Prevention professionals should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable standards.*
b. *Due care requires prevention professionals to plan and supervise adequately, and to evaluate any professional activity for which they are responsible.*
c. *Prevention professionals should recognize limitations and boundaries of their own competence and not use techniques or offer services outside those boundaries. Prevention professionals are responsible for assessing the adequacy of their own competence for the responsibility to be assumed.*
d. *Prevention professionals should be supervised by competent senior prevention professionals. When this is not possible, prevention professionals should seek peer supervision or mentoring from other competent prevention professionals.*
e. *When prevention professionals have knowledge of unethical conduct or practice on the part of another prevention professional, they have an ethical responsibility to report the conduct or practice to funding, regulatory, or other appropriate bodies.*
f. *Prevention professionals should recognize the effect of impairment on professional performance and should be willing to seek appropriate treatment.*

III. *Integrity*

To maintain and broaden public confidence, prevention professionals should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It cannot accommodate deceit or subordination of principle.

a. *All information should be presented fairly and accurately. Prevention professionals should document and assign credit to all contributing sources used in published material or public statements.*
b. *Prevention professionals should not misrepresent either directly or by implication professional qualifications or affiliations.*
c. *Where there is evidence of impairment in a colleague or a service recipient, prevention professionals should be supportive of assistance or treatment.*
d. *Prevention professionals should not be associated directly or indirectly with any service, product, individual, or organization in a way that is misleading.*

IV. *Nature of Services*

Practices shall do no harm to service recipients. Services provided by prevention professionals shall be respectful and non-exploitive.

a. *Services should be provided in a way that preserves and supports the strengths and protective factors inherent in each culture and individual.*
b. *Prevention professionals should use formal and informal structures to receive and incorporate input from service recipients in the development, implementation, and evaluation of prevention services.*
c. *Where there is suspicion of abuse of children or vulnerable adults, prevention professionals shall report the evidence to the appropriate agency.*

V. *Confidentiality*
Confidential information acquired during service delivery shall be safeguarded from disclosure, including—but not limited to—verbal disclosure, unsecured maintenance of records or recording of an activity or presentation without appropriate releases. Prevention professionals are responsible for knowing and adhering to the State and Federal confidentiality regulations relevant to their prevention specialty.

VI. *Ethical Obligations for Community and Society*
According to their consciences, prevention professionals should be proactive on public policy and legislative issues. The public welfare and the individual's right to services and personal wellness should guide the efforts of prevention professionals to educate the general public and policymakers. Prevention professionals should adopt a personal and professional stance that promotes health.

The Department expects that all prevention professionals will adhere to this ethical code of conduct, regardless of certification status. It is also expected that prevention specialists will receive both initial and ongoing training (a minimum of at least every two years) in ethics as it relates to work in substance misuse prevention and/or problem gambling.

"The Department expects that all prevention professionals will adhere to this ethical code of conduct, regardless of certification status. It is also expected that prevention specialists will receive both initial and ongoing training (a minimum of at least every two years) in ethics as it relates to work in substance misuse prevention and/or problem gambling."

Source: Prevention Think Tank Code of Ethical Conduct, International Credentialing, 2018

CERTIFIED PREVENTION SPECIALISTS IN IOWA

The Iowa Board of Certification (IBC) is the credentialing body for Certified Prevention Specialists in the state. According to their website, “The Iowa Board of Certification (IBC) grants certification to persons who have met certain standards defined by the organization. Certification is designed to promote and maintain integrity and quality of substance misuse, problem gambling, and other behavioral health professionals.”

Why does certification matter?

- Certification increases professionalism in the field.
- Certification marks the professionals who are specialists in their field.
- Certified professionals may be recognized in state and national insurance legislation, Federal Department of Transportation regulations, and agency staffing requirements.
- Certified professionals may receive opportunities for peer networking and involvement in IBC-sponsored education, conferences, and committee work.
- Most employers require certification for employment.
- If certified at a reciprocal level, professionals are free to move to another state or country that uses IC&RC credentials and receive certification in the new location.
- Department prevention grants may require certification.

Learn more about becoming a Certified Prevention Specialist. Visit the Iowa Board of Certification’s website.

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Introduction to the Strategic Prevention Framework

According to SAMHSA, the "Strategic Prevention Framework (SPF) is a planning process for preventing substance misuse and/or problem gambling. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and/or problem gambling and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and involves community members in all stages of the planning process."

FRAMEWORK OVERVIEW

Before looking closely at each of the SPF steps, it is important to understand some guiding principles and features that are distinctive to the SPF and are essential to implementing the process with fidelity.

The SPF is:

Data-driven: Good decisions require data. The SPF is designed to help practitioners gather and use data to guide all prevention decisions—from identifying which substance misuse and/or problem gambling issues to address in their communities to choosing the most appropriate ways to address those problems. Data also helps practitioners determine whether communities are making progress in meeting their prevention needs.

Dynamic: Assessment is more than just a starting point. Practitioners will return to this step again and again: as the prevention needs of their communities change and as community capacity to address these needs evolve. Communities may also engage in activities related to multiple steps simultaneously. For example, practitioners may need to find and mobilize additional capacity to support implementation after an intervention is underway. For these reasons, the SPF is a circular, rather than a linear, model.

Focused on population-level change: Earlier prevention models often measured success by looking at individual program outcomes or changes among small groups. But effective prevention means implementing multiple strategies that address the constellation of risk and protective factors in a given community. In this way, we are more likely to create an environment that helps people support healthy decision-making.

Intended to guide prevention efforts for people of all ages: Substance misuse and/or problem gambling prevention has traditionally focused on adolescent use. The SPF challenges prevention professionals to look at those two issues among populations that are often overlooked but at significant risk, such as young adults ages 18 to 25 and adults age 65 and older.

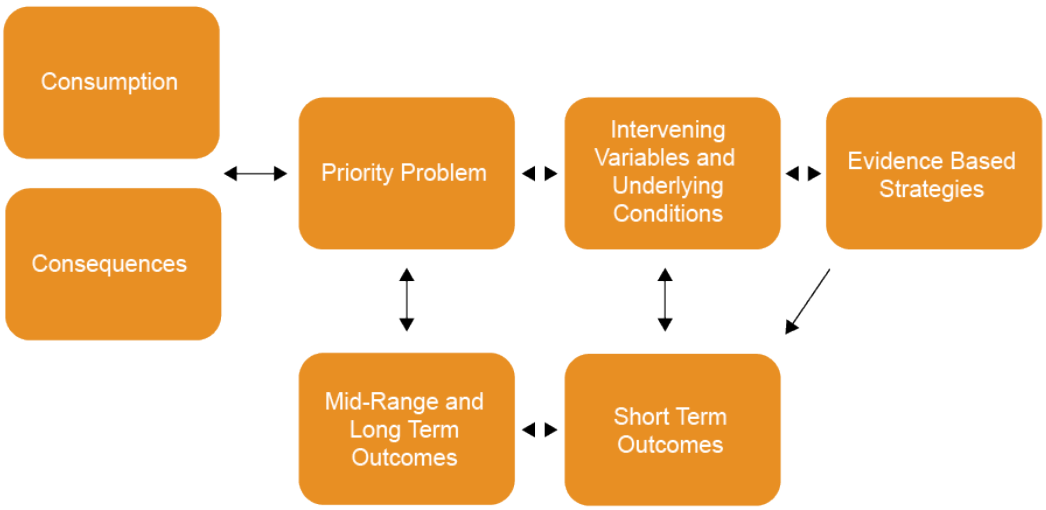
Reliant on a team approach: Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners. The individuals and institutions you involve will change as your initiative evolves over time, but the need for prevention partners will remain constant.

Read more on SAMHSA's Applying the Strategic Prevention Framework.

Read more on SAMHSA's Applying the Strategic Prevention Framework.

OUTCOMES-BASED PREVENTION

The foundation of the SPF model is Outcomes-Based Prevention (see below for a visual representation as a logic model). This process details the planning steps that must occur for community-level change. Building the logic model begins with careful identification or mapping of the local substance misuse and/or problem gambling issue (and the associated patterns and consequences among the population affected), as well as the factors or intervening variables that contribute to them.



Consumption refers to the way people misuse and consume substances or engage in problem gambling behaviors. For example, the number of underage youth in a community who have used a prescription medication in a way other than was prescribed in the last 30 days or the number of 11th-graders who report gambling in the last 30 days.

Consequences are the social, economic, and health problems associated with substance misuse and/or problem gambling. For example, the number of youths suspended from school for alcohol-related citations.

Intervening Variables are the underlying factors that contribute to the problem. For example, social access, where peers may be sharing prescription medications at parties or at other social gatherings for the “effect” of the medications, may contribute to the problem of prescription medication misuse in a community. Intervening variables answer the question: “Why here?”

Underlying Conditions continue to drill down to the intervening variables to figure out: “But, why here?” For example, maybe social access is an issue in your community because there are many multigenerational families in your community and youth have easy access to a grandparent’s medications. The more specific you can be in identifying the distinct conditions contributing to the problem in your community, the more likely you are to match them with a strategy that will have the most impact.

Evidence-Based Strategies have documented evidence of effectiveness and preferably have been rigorously tested and shown to have positive outcomes in multiple peer-reviewed evaluation studies.

The Strategic Prevention Framework

ASSESSMENT

Overview

The first step of the SPF is Assessment, where you gather and examine data related to substance misuse and/or problem gambling as well as related consequences, community climate, environment, infrastructure, and resources.

Just like when building a house, having a strong foundation is essential. Investing time in a thorough assessment will increase the likelihood that your efforts will achieve the desired change you are seeking. While many communities across the country are struggling with the devastating effects of substance misuse and/or problem gambling, the specific variables and conditions can be different from one community to another. By identifying the scope of the problem (by looking at the consequences and consumption trends in your county) and the specific variables and conditions that are contributing to these issues, you can better focus your resources on specific improvements.

Collecting and Analyzing Community Data

The following are guidelines from SAMHSA for collecting and analyzing community data:

- Take stock of existing data: Start by looking for state and local data already collected by others, such as hospitals, law enforcement agencies, community organizations, state agencies, and epidemiological work groups.
- Look closely at your existing data: Examine the quality of the data you have found, discard the data that are not useful, and create an inventory of the data you feel confident about including in your assessment.
- Identify any data gaps: Examine your inventory of existing data and determine whether you are missing any information. This could include information about a particular problem, behavior, or population group.
- Collect new data to fill those gaps: If you are missing information, determine which data collection method—or combination of methods—represents the best way to obtain that information. Data collection methods include surveys, focus groups, and key informant interviews.

Data may reveal that multiple areas are contributing to substance misuse and/or problem gambling in your community. You will want to establish criteria for analyzing assessment data to guide your decision on which issue(s) to make your priority.

Source: *Applying the Strategic Prevention Framework – Step 1: Assess Needs, Substance Abuse and Mental Health Services Administration, 2018*

Risk and Protective Factors

Biological and psychological characteristics can make people vulnerable or resilient to potential behavioral health problems. Individual-level protective factors might include a positive self-image, self-control, or social competence.

In addition, people do not live in isolation; they are part of families, communities, and society. A variety of risk and protective factors exist within each of these environmental contexts.

Learn more from the Risk and Protective Factors and Initiation of Substance Use: Results from the 2014 National Survey on Drug Use and Health. Review the chapter on Risk Factors and Protective Factors in the National Institute on Drug Abuse's report, Preventing Drug Use among Children and Adolescents.

Primary prevention services funded by the Federal Block Grant must focus on preventing substance misuse. Department-funded contractors are encouraged to collaborate with community stakeholders whose area(s) of expertise include shared risk and protective factors. Department contractors must adhere to their Department-approved work plans to ensure prevention efforts align with the appropriate funding expectations.

Identifying Disparate Populations

Definition of Health Disparities

Healthy People 2020 defines a health disparity as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Within 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 language, beliefs, norms, values and/or socioeconomic factors specific to that subpopulation.

Various subpopulations face elevated levels of mental and substance use disorders and experience higher rates of suicide, poverty, domestic violence and childhood and historical trauma, as well as involvement in the foster care and criminal justice systems. Historically, these diverse populations tend to have less access to care, lower or disrupted service use, and poorer behavioral health outcomes. These disparities may be related to factors such as a lack of access to health care, the need for a diverse health care workforce, a lack of information, and the need for culturally and linguistically competent care and programs.

Source: Behavioral Health Equity, Substance Abuse and Mental Health Services Administration, 2018

Consider these definitions from The Health Equity Institute at San Francisco State University.

Health Equity: Attainment of the highest level of health for all people. Health equity involves efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. Learn more from our Health Equity Framework.

- Health Inequities: Differences in health that are avoidable, unfair, and unjust. Health inequities are affected by social, economic, and environmental conditions. Learn more about what affects health inequities.
- Health Disparities: Differences in health outcomes among groups of people.

This brief video gives an overview of health equity.

Source: Defining Health Equity, Health Equity Institute, 2018

ADDITIONAL RESOURCES

The National Culturally and Linguistically Appropriate Services (CLAS) Standards, Office of Minority Health, U.S. Department of Health & Human Services

What is Health Equity? Health Equity Institute for Research, Practice, and Policy

What Works: Promoting Health Equity, The Community Guide, Centers for Disease Control and Prevention

Assessing Community Readiness

Community readiness is a community's willingness to engage in and support prevention efforts, as well as the availability of skills and resources within that community. The Community Readiness Model was developed at the Tri-Ethnic Center to assess how ready a community is to address an issue. The basic premise is that matching an intervention to a community's level of readiness is essential for success.

According to the Tri-Ethnic Center, the Community Readiness Model (CRM) can help a community move forward and succeed in its efforts to change in a variety of ways. Some of these include:

- Measuring a community's readiness levels in several dimensions to help diagnose where to put initial efforts.
- Helping to identify a community's weaknesses and strengths, and the obstacles they are likely to meet as they move forward.
- Pointing to appropriate actions that match a community's readiness levels.
- Working within a community's culture to come up with actions that are right for the community.
- Aiding in securing funding, cooperating with other organizations, working with leadership, and more.

Source: Community Readiness, Tri-Ethnic Center, College of Natural Sciences, Colorado State University, 2018

BUILDING CAPACITY

According to SAMHSA:

Step 2 of the Strategic Prevention Framework (SPF) helps prevention professionals identify resources and build readiness to address substance misuse and/or problem gambling." This "involves building and mobilizing local resources and readiness to address identified prevention needs. A community needs both *human* and *structural* resources to establish and maintain a prevention system that can respond effectively to local problems. It also needs people who have the motivation and willingness—that is, the *readiness*—to commit local resources to address identified prevention needs." Prevention programs and interventions that are well-supported with adequate resources and readiness are more likely to succeed.

Engaging a broad range of stakeholders is key to unlocking a community's capacity for prevention. Effective prevention depends on the involvement of diverse partners—from residents to service providers to community leaders. These people can help you share prevention information and resources, raise awareness of critical substance misuse and/or problem gambling issues, build support for prevention efforts, and ensure that prevention activities are appropriate for the populations they serve.

Build relationships with those who support your prevention efforts, as well as with those who do not. Recognize that potential community partners will have varying levels of interest and/or availability to get involved. One person may be willing to help with a specific task, while another may be willing to assume a leadership role. Keep in mind that, as people come to understand the importance of substance misuse and problem gambling prevention efforts, they are likely to become more engaged.

Source: *Applying the Strategic Prevention Framework – Step 2: Build Capacity*, Substance Abuse and Mental Health Services Administration, 2018

Community Engagement

Community engagement is key for making data-informed decisions, as well as building ongoing sustainability. Agencies should attempt to involve not only the 12 required sectors but also seek out a diverse variety of stakeholders that connect with the priority issue, shared risk, and protective factors or activities. This should include a wide range of people, especially individuals whose behavior the funded entity is working to change (population of focus) and individuals who will implement the strategies impacting that population (agents of change). Other key stakeholders include community members who can speak to local conditions, culture, and available data and resources; gatekeepers with the access or influence to effectively implement strategies; and those with the skills to complete the process, such as the ability to gather and interpret information, knowledge of prevention, or experience with evidence-based practices.

Building capacity is most likely to have success when it is done in a purposeful way, specifically considering fidelity to the SPF steps. The following components have been identified by SAMSHA's Center for the Application of Prevention Technologies (CAPT), in their resource Fidelity in the Strategic Prevention Framework (SPF) Process, as essential components of the process:

- Develop a working structure.
  - Create and document infrastructure.
- Mobilize community capacity.
  - Recognize individual talents and solutions.
  - Help the coalition be embraced and supported by the community.
  - Ensure the community has a level of awareness and knowledge about the coalition and its efforts.
  - Directly involve the target population in planning and efforts.
- Nurture coalition capacity.
  - Engage broad community participation from all sectors.
  - Encourage participation of members that represent the cultural and linguistic composition of the community.
  - Ensure sufficient resources to carry out the activities of the SPF step.
  - Ensure that members are clear about their roles and responsibilities and consistently follow through.
  - Offer skill building and trainings related to the SPF, prevention effort, or coalition development, through the coalition.

Community Coalitions

As stated in the Community Tool Box from the University of Kansas's Center for Community Health and Development, "In simplest terms, a coalition is a group of individuals and/or organizations with a common interest who agree to work together toward a common goal. That goal could be as narrow as obtaining funding for a specific intervention, or as broad as trying to improve permanently the overall quality of life for most people in the community. By the same token, the individuals and organizations involved might be drawn from a narrow area of interest or might include representatives of nearly every segment of the community, depending upon the breadth of the issue."

Check out the Community Tool Box from the University of Kansas's Center for Community Health and Development

Source: Section 5 – Coalition Building I: Starting a Coalition, Community Tool Box, Center for Community Health and Development, University of Kansas, 2018

Diverse community input and engagement is a central tenet of the SPF. Creating or working with a community coalition, collaborative council, or other advisory council increases the likelihood that data-driven decisions and planning are done within the context of the community's culture, capacity, and readiness.

Required Sectors

According to SAMHSA, “Substance use and misuse are complex problems that require the energy, expertise, and experience of multiple players, working together across disciplines, to address. Collaboration can help you tap the resources available in your community, extend the reach of your own resources by making them available to new audiences, and ensure that your prevention efforts are culturally competent. By working in partnership with community members and involving them in all aspects of prevention planning, implementation, and evaluation, you demonstrate respect for the people you serve and increase your own capacity to provide prevention services that meet genuine needs, build on strengths, and produce positive outcomes.”

*Source: **Cultural Competence**, Substance Abuse and Mental Health Services Administration, 2016*

Diverse collaboration may look different for each community, but the Department uses an approach initially put forth through the national Drug-Free Communities Program that requires the inclusion of 12 sectors of the community to ensure a foundational level of input and community engagement. Various Department prevention funding opportunities may have additional sectors to include in prevention efforts.

The 12 required sectors are:

- Youth
- Parents
- Law enforcement
- Schools
- Businesses
- Media
- Youth-serving organizations
- Religious and fraternal organizations
- Civic and volunteer groups
- Health care professionals
- State, local, and tribal agencies with expertise in substance misuse and/or problem gambling
- Other organizations involved in reducing substance misuse and/or problem gambling

Source: Drug-Free Communities (DFC) Program, Community Anti-Drug Coalitions of America, 2019

Additional Resources

CADCA (Community Anti-Drug Coalitions of America)

Capacity Primer: Building Membership, Structure and Leadership, CADCA

Starting a Coalition, Community Tool Box, Center for Community Health and Development, University of Kansas

PLANNING

Step three of the Strategic Prevention Framework (SPF) helps prevention professionals form a plan for addressing priority problems and achieving prevention goals.

Strategic planning increases the effectiveness of prevention efforts by ensuring that prevention professionals select and implement the most appropriate programs and strategies for their communities. To develop a useful plan, practitioners need to:

- Prioritize risk and protective factors associated with identified prevention problems. (See Step 1: Assess Needs)
- Select effective interventions to address priority factors.
- Build a logic model that links problems, factors, interventions, and outcomes.

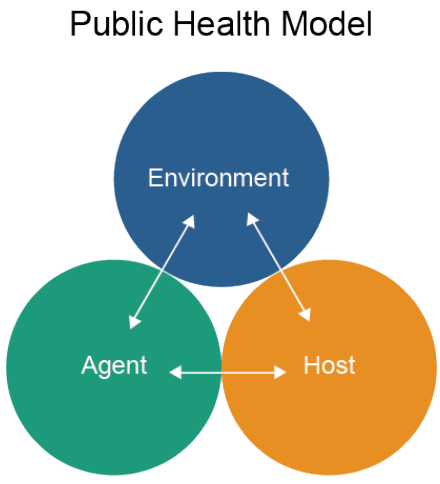
An effective prevention plan should reflect the input of key stakeholders, including community members. Collaborative planning processes are more likely to address community needs and be sustainable over time.

Source: *Applying the Strategic Prevention Framework – Step 3: Plan*, *Substance Abuse and Mental Health Services Administration, 2018*

Public Health Model

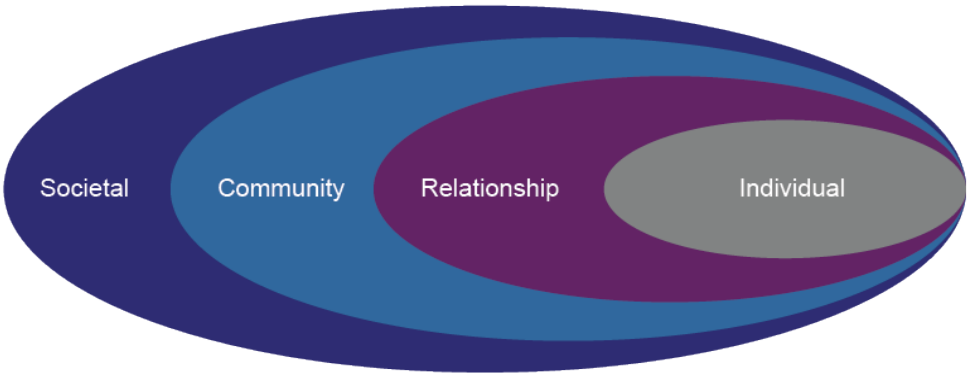
There are certain model definitions and associated strategies that are helpful to consider when moving into the planning step.

The public health model embraces a comprehensive approach to community change. Instead of focusing efforts on changing individuals one at a time through prevention efforts, the public health model looks at changing the environment that surrounds those individuals.



Social-Ecological Model

The social-ecological model is a multi-faceted public health model grounded in the understanding that to achieve sustainable changes in behavior, prevention efforts must focus on individuals within the population of focus at the different levels of influence surrounding them.



This model consists of four levels of impact.

Individual: This level encompasses the knowledge, attitudes, and skills of the individuals within the population of focus. It is characterized by individual-level strategies, such as educational and skill-building programs, as well as county-wide media and social marketing campaigns. An example of an individual-level strategy would be a six-week program targeted toward high-risk students to improve their self-confidence and teach the skills needed for resisting drug use.

Relationship: This level includes the family, friends, and peers of individuals within the population of focus. These people have the ability to shape the behaviors of the individuals in the population. Strategies include enhancing social supports and social networks, as well as changing group norms and rules. An example of a relationship-level strategy would be an educational program targeted at parents of 12- to 14-year-olds to teach them how to better communicate with their children and establish rules around substance misuse and/or problem gambling.

Community/County: This level includes the unique environments in which individuals in the target population live and spend much of their time, such as schools, places of employment and worship, neighborhoods, sports teams, and volunteer groups. Strategies include changes to rules, regulations and policies within different community organizations and structures. An example of a community-level intervention would be the adoption of a drug-education policy by a local company for all new employees. An example at the school level would be creating or strengthening a Good Conduct policy as it relates to substance misuse and/or problem gambling.

Societal: This level includes the larger, macro-level factors that influence the behaviors of individuals in the population of focus, such as laws, policies, and social norms. Strategies include changing state and local laws, policies, and practices, as well as other initiatives designed to change social norms among the population of focus, such as a media campaign. An example of a societal-level intervention would be requiring health care providers to register for the Prescription Monitoring Program.

Types of Prevention Strategies

Prevention strategies typically fall into two categories: environmental and individual.

Environmental strategies target the broader physical, social, cultural, and institutional forces that contribute to problem behaviors. These strategies are found in the outer layers (or levels) of the social-ecological model.

Individual strategies target the knowledge, attitudes, and skills of individuals.

Individual Strategies	Environmental Strategies
Focus on behavior and behavior change	Focus on policy and policy change
Focus on the relationship between the individual and alcohol/drug-related problems	Focus on the social, political and economic context of alcohol/drug-related problems
Short-term focus on program development	Long-term focus on policy development
Individual generally does not participate in decision making	People gain power by acting collectively
Individual as audience	Individual as advocate

Source: The Coalition Impact: Environmental Prevention Strategies, Community Anti-Drug Coalitions of America National Community Anti-Drug Coalition Institute, 2018

The social-ecological model promotes a multi-strategy approach targeting the individual, as well as the different levels of influence surrounding them. Particular attention should be given to implementing evidence-based environmental strategies. According to the Community Anti-Drug Coalitions of America (CADCA), environmental strategies can produce widespread and lasting behavior change by making appropriate (or healthy) behaviors more achievable for the individuals in the target population. Furthermore, these strategies can result in behavior change that reduces problems for the entire county, including those outside the population of focus.

Environmental strategies can achieve this through changes to county policies, practices, systems, and norms. In addition, because environmental strategies require substantial commitment from various sectors of the community, long-term relationships can be established with key county stakeholders. Lastly, costs associated with environmental strategies can be considerably lower than those associated with ongoing education and services applied to individuals.

In summary, we strongly recommended using a multi-strategy approach to target the priority problems and intervening variables. As part of this multi-strategy approach, it is particularly important to choose one or more environmental strategies designed to impact the community and societal levels of the social-ecological model, as well as the individuals in the population of focus and in the identified disparate population. Failure to implement strategies at different levels of the social-ecological model will greatly decrease the likelihood of achieving long-term successes.

Particular attention should be given to the implementation of evidence-based environmental strategies.

SAMHSA's Prevention Strategies

Prevention services are intended to prevent or reduce the use and misuse of alcohol, tobacco, and other drugs and to prevent or reduce problem gambling. They are based on the six SAMHSA Primary Prevention Strategies.

Department-funded prevention contractors must use the following strategies to sufficiently meet the assessed needs throughout their service area:

1. **Information Dissemination**
   This strategy provides awareness and knowledge on the nature and extent of alcohol, tobacco and drug use, and misuse and addiction, as well as problem gambling and the effects on individuals, families, and communities. It also offers awareness and knowledge of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

2. **Education**
   Education involves two-way communication and interaction between the educator/facilitator and the participants. Activities are intended to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

3. **Alternatives**
   This strategy provides consultation to groups that offer opportunities for target populations to participate in activities that exclude alcohol, other drugs, gambling, etc. The purpose is to discourage substance misuse, problem gambling, or other risky behaviors.

4. **Problem Identification and Referral**
   This strategy aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol and individuals who have indulged in their first use of illicit drugs, as well as risky or problem gambling. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity to determine whether a person needs treatment.

5. **Community-Based Process**
   This strategy aims at building community capacity in order to more effectively provide prevention and treatment services for substance use disorders and problem gambling. Activities include organizing, planning, enhancing the efficiency and effectiveness of services, inter-agency collaboration, coalition building, and networking.

6. **Environmental**
   Environmental strategies establish or change written and unwritten community standards, codes, ordinances, and attitudes, thereby influencing the incidence and prevalence of alcohol, tobacco, and other drug use/misuse and problem gambling in the population.

Intervening Variables & Underlying Conditions

Intervening variables are the underlying factors that contribute to the problem. Intervening variables answer the question: “Why is this happening here?” Intervening variables are based on risk and protective factors for substance misuse and/or problem gambling.

Examples of intervening variables:

- Overprescribing
- Law enforcement
- Retail access
- Social access
- Individual factors
- Community norms

Underlying conditions continue to drill down the intervening variables to answer the deeper question: “But why here?” Identifying the specific conditions contributing to the problem in the community will help you match to a strategy that will have the most impact.

For example, for the intervening variable of individual factors, an underlying condition may be that 15- and 16-year-old male youth have a low perception of the risk of harm related to playing poker for money on the weekends with peers.

For the intervening variable of enforcement, an underlying condition may be that there are not enough certified Drug Recognition Enforcement officers due to limited resources for police departments.

For the intervening variable of education, an underlying condition may be that doctors are not registered with the Prescription Monitoring Program and are not checking it before prescribing opioids.

Population of Focus

A population of focus is the population who has been identified in relation to the priority problem, presumably those shown by assessment to have been impacted the most through consequences and/or consumption data.

Intervening variables may indicate that a subgroup of this population, also known as disparate populations, such as children of substance misusers or problem gamblers, may need specific attention and services to make the most change in the county.

Agents of change may also be targeted for some services. An example is key influencers of youth ages 12-25, such as parents. Agents of change may also be in a position to help contribute to the solution. These agents of change are a focus of efforts to help change the behavior of the targets of change.

Dosage and Frequency

Dosage for a strategy or intervention refers to how many in, or what percent of, the target population needs to receive the service for change on the priority or intervening variable to occur. The same dosage may not work for all strategies or similar populations. After a strategy has been selected, the Department will provide technical assistance to discuss dosage specific to the strategy. For most environmental strategies, there is an expectation of engaging at least 50% of the target population.

Frequency is how often a strategy or intervention needs to be offered to ensure the greatest impact. For many evidence-based programs, frequency is already established, such as facilitating eight, one-hour sessions over an eight-week period. For environmental strategies, the frequency often depends on research or Department expectations. For instance, one TIPS training per year is very unlikely to make an impact in a community. However, training services provided quarterly or every other month offer availability and consistency for retailers to participate in training and, in return, encourages attendance.

Strategic Planning

According to SAMSHA, “Strategic planning increases the effectiveness of prevention efforts by ensuring that prevention professionals select and implement the most appropriate programs and strategies for their communities.”

Strategic planning includes several steps:

1. Set priorities.
2. Select effective interventions to address priority factors.
3. Build a logic model that links problems, factors, interventions, and outcomes.

In addition, you will also be planning for:

- Implementation success, including planned adaptations and monitoring for fidelity
- Effective dosage and frequency
- Building needed capacity and resources

SAMHSA continues, “An effective prevention plan should reflect the input of key stakeholders, including community members. Collaborative planning processes are more likely to address community needs and be sustained over time.”

Source: *Applying the Strategic Prevention Framework – Step 3: Plan*, Substance Abuse and Mental Health Services Administration, 2018

Selecting Programs, Practices, and Policies

When choosing an appropriate prevention intervention, it is important to select programs and strategies that are:

- **Evidence-based**
  Evidence-based interventions have documented evidence of effectiveness. The best places to find evidence-based interventions are federal registries of model programs. It is important to note, however, that these sources are not exhaustive, and they may not include interventions appropriate for all problems and/or all populations. In these cases, look to other credible sources of information. Since states have different guidelines for what constitutes credible evidence of effectiveness, start by talking to prevention experts—including the state-level evidence-based workgroup.
- **A good conceptual fit for the community**
  An intervention has good conceptual fit if it directly addresses one or more of the priority factors driving a specific substance misuse and/or problem gambling issue and has been shown to produce positive outcomes for members of the population of focus in other communities.
  To determine the conceptual fit, ask, "Will this intervention have an impact on at least one of the community's priority risk and protective factors?"
- **A good practical fit for the community**
  An intervention has good practical fit if it is culturally relevant for the population of focus, if the community has capacity to support it, and if it enhances or reinforces existing prevention activities.
  To determine the practical fit, ask, "Is this intervention appropriate for the community?"

Effective Strategies | Evidence-Based Programs, Practices, and Policies

The Department will fund primary prevention services that are evidence-based or are found to be effective through research and are considered best practice approaches. These are considered evidence-based programs/practices/policies (EBPs). Department contractors must plan for, select, and implement prevention strategies that are proven to create positive behavior change.

Two approval categories for evidence-based strategies are listed below. If your selection is not pre-approved, it will need to go through a more detailed approval process.

1. Pre-approved by the Department:
   Pre-approved EBPs consist of those strategies designed to impact the Integrated Provider Network (IPN) or other grant priorities, for which strong and well-documented evidence of effectiveness is available. These EBPs have been recommended by federal agencies or national substance misuse and/or problem gambling prevention organizations and/or are strongly supported by peer-reviewed literature. The following is a list of national registries to explore when assessing evidence-based programs/policies/practices with community partners.

   - Blueprints for Healthy Youth Development
   - National Institute of Drug Abuse Red Book
   - SAMHSA EBP Resource Center
   - Stacked Deck

2. Not pre-approved, but meets the requirements of one of the other definitions of evidence-based provided by SAMHSA:

   Definition 1: The intervention is reported (with positive effects on the primary targeted outcome) in a peer-reviewed journal

Definition 2: The intervention has documented effectiveness supported by other sources of information and the consensus judgment of informed experts based on the following guidelines:

- The intervention is based on a theory of change that is documented in a clear logic or conceptual model.
- The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.
- The intervention is supported by documentation that it 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.

When selecting an evidence-based program/practice/policy, consider how the evidence was defined, the size of the research study, what criteria were set for the specific study, the population of focus for the program, and the population of focus for the research.

Strategies that are not pre-approved can be submitted to the Department for review through an EBP Waiver Request process.

Contractors who are wanting to utilize an EBP that is not listed on a national registry must complete an EBP Waiver Request Form. This form will need to be completed for any modification and/or adaptation to a program/practice/policy. Forms can be found on the Department website on the Integrated Provider Network webpage. The Evidence-Based Practice Review Team, which is a subcommittee of the Department-led Evidence-Based Practice Workgroup, will review all Waiver Request Forms and provide feedback accordingly.

Over the next two years, the Department will be compiling a resource guide which will contain a list of EBPs to be used with Department prevention funding. The group assisting with this process is the IDPH Evidence-Based Practice Workgroup, whose membership includes well-qualified prevention researchers who are experienced in evaluating prevention interventions, local prevention practitioners, and key community leaders as appropriate.

Feasibility Checklist

Feasibility means determining whether there are the right supports in place to implement a particular prevention service. These supports can include the following:

- Funding to implement the program as intended
- Buy in from school leadership for the program
- Prevention Specialist with the capacity to implement the program

Department-funded contractors will be required to use a feasibility checklist when exploring and implementing prevention services. A feasibility checklist serves as a tool to identify community support and resources around a specific substance misuse and/or problem gambling prevention activity. Using a checklist ensures that funding is dedicated towards prevention services that have community support, maximize positive behavior change, and are sustainable in the long-term.

Before planning a prevention service, reflect on the following question, “How do I know this prevention service will have a positive impact?” In order to fully respond to that question, an assessment must be conducted that asks key stakeholders to contribute their feedback on the potential strengths and weaknesses of a particular prevention service.

Feasibility checklists will be provided for all Department prevention grants.

Fidelity

Before implementing a prevention service, contractors need to decide how to monitor fidelity, how often, and who will be responsible for collecting and reporting the information. For services being facilitated by a professional outside of the contracted agency, this plan needs to be created in partnership with the individual(s), so everyone agrees on and understands the monitoring process.

At a minimum, fidelity will need to be checked in the following ways:

- Review the core components of any program, practice, or policy
- Complete a detailed assessment of any adaptations (planned or unplanned)
- Record detailed information, such as attendees, contractors, community, setting, evaluation, and sustainability

Guidance on the fidelity process will be provided for all Department prevention grants.

Creating Short- and Long-Term Outcomes

Short-term outcomes show progress changing the underlying conditions and intervening variables. This in turn leads to long-term outcomes that impact the priority problem.

All outcomes should be planned and written using the SMART technique described below.

- **S**pecific – Objective clearly stated, so that anyone reading it can understand what will be done and who will do it.
- **M**easurable – Objective includes how the action will be measured. Measuring objectives helps determine whether progress is being made. It keeps individuals on track and on schedule.
- **A**chievable – Objective is realistic given the realities faced in the community. Setting reasonable objectives helps set the project up for success
- **R**elevant – A relevant objective makes sense; that is, it complies with the purpose of the grant, it fits the culture and structure of the community, and it addresses the vision of the project.
- **T**ime-bound – Every objective has a specific timeline for completion.

Source: Setting Goals and Developing Specific, Measurable, Achievable, Relevant, and Time-Bound Objectives, Substance Abuse and Mental Health Services Administration, 2018

Creating a Strategic Plan

The Department will provide a template that can be used to create a strategic plan specific to each funding opportunity. This strategic plan is a summary that articulates the theory of change for the priority problem and provides both narrative and visual representation (in the form of a logic model) that connects the dots for stakeholders. It should outline how data-driven decisions were made, how intervening variables were prioritized, and strategies selected, and how implementation and evaluation were successfully undertaken.

The strategic plan should:

- Help articulate the theory of change
- Check assumptions and logic when moving from assessment and capacity building to planning and implementation—ensuring that the strategies, programs, and practices implemented will have the greatest impact
- Ensure clear communication and collaboration with stakeholders who are participating in, and making planning decisions for, the project
- Provide a concise summary for stakeholders, decision makers, and other community members to explain the project, plans, and expected outcomes

By creating a clear and concise document, you can use the plan as a tool to increase support and action when moving into the implementation phase, as well as to build a solid foundation for sustainability planning.

Creating a Logic Model

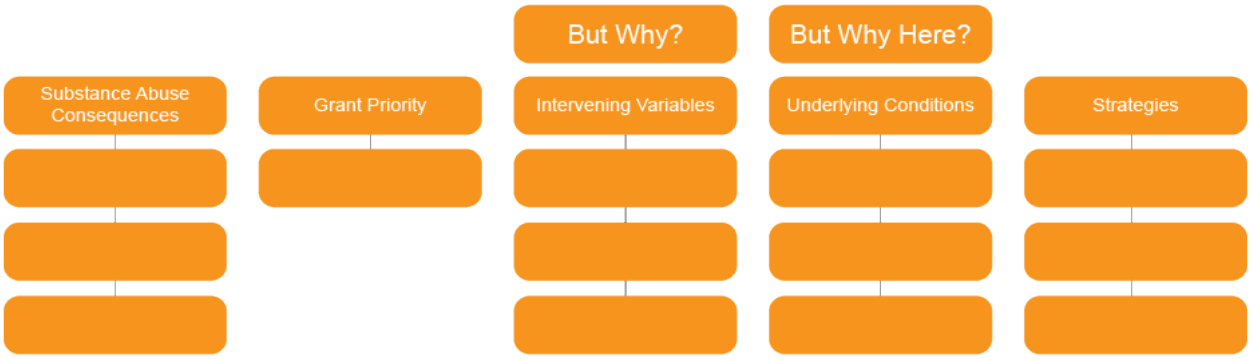
A logic model is a visual tool that shows the logic, or rationale, behind a program or process. The logic model template that the Department uses shows how all the related planning pieces are connected: consumption and consequence data, priority problem, intervening variables, underlying conditions, and outcomes.

According to SAMHSA, logic models can help:

- Explain why a program or intervention will succeed. By clearly laying out the tasks of development, implementation, and evaluation, a logic model can help explain what is to be done and why.
- Identify gaps in reasoning. A logic model helps identify those gaps or places where assumptions might be off track. The sooner mistakes are discovered, the easier they are to correct.
- Make evaluation and reporting easier. A logic model shows clear, explicit, and measurable intended outcomes.

Source: Applying the Strategic Prevention Framework – Step 3: Plan, Substance Abuse and Mental Health Services Administration, 2018

The Department will provide a logic model template for each specific prevention project. The format may vary but will include the components in the following example:



Creating a Work Plan

A work plan takes the logic model and breaks it into smaller, actionable steps. Work plans should include steps for:

- Building capacity
- Carrying out implementation tasks
- Ensuring fidelity
- Planning for sustainability
- Media advocacy

Find a balance for the number of action steps—not too many and not too few. The connection between each step and how it leads to the short-term outcome, which in turn leads to reaching long-term outcomes, should be easily articulated.

Work plans should also include specific timeframes, the location(s) where services will occur, indicators to identify whether the plan is on track, and necessary resources and people responsible for each step.

Communication Strategies

According to SAMHSA, "Messages communicated through the media influence how the public thinks and behaves. Communication strategies—public education, social marketing, media advocacy, and media literacy—can be used to influence community norms, increase public awareness, and attract community support for a variety of prevention issues."

Source: Prevention Approaches, Substance Abuse and Mental Health Services Administration, 2018

Media communication can, and should, be leveraged to:

- Raise the awareness of the community on the priority issue and spur them to get involved.
- Reach the population of focus, disparate populations, and necessary stakeholders and gatekeepers with messages and actionable items.

Plain Language

It is important to share public health information in an accessible and understandable way. Use plain language when creating media messages.

The CDC suggests the following:

- **Keep it short.**
- **Communicate as if talking to a friend.**
- **Respect and value the audience.**
- **Use an encouraging tone.**
- **Limit jargon.**
- **Use analogies.**
- **Avoid unnecessary abbreviations and acronyms.**
- **Limit statistics: Use words like "most", "many," and "half."**

According to the U.S. Department of Health and Human Services, "Plain language is "communication that users can understand the first time they read or hear it. With reasonable time and effort, a plain language document is one in which people can find what they need, understand what they find, and act appropriately on that understanding."

Source: Plain Language: A Promising Strategy for Clearly Communicating Health Information and Improving Health Literacy, U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2018

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- Respect and value the audience.
- Use an encouraging tone.
- Limit jargon.
- Use analogies.
- Avoid unnecessary abbreviations and acronyms.
- Limit statistics: Use words like "most," "many," and "half."

Source: Simply Put, U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2018

Media Advocacy through Strategy Implementation

The Department expectations for the use of media advocacy include but are not limited to: op-eds, letters to the editor, press releases, social media, newspaper articles, etc. Media advocacy should be connected to educating the county residents about the progress of each strategy in simple terms and promote opportunities for community engagement and involvement where appropriate.

IDPH Health Promotion Campaigns

Department-funded prevention contractors are required to use Department-created media campaigns and disseminate them in ways to best reach the targets of change with an appropriate dosage. Currently, the Department has campaigns focused on the following topics:

Alcohol

- What Do You Throw Away – Underage Drinking
- Stay Classy – Young Adult Binge Drinking
- What Changes You – Adult Binge Drinking

Prescription Drugs

- Prescription Drugs Are Still Drugs – Youth Prescription Drug Misuse

Gambling

- 1-800-BETS-OFF – Adult Problem Gambling
- Are You a Good Loser

Opioids

- Adult Opioid Use
- Women Opioid Use

Marijuana

- Weeds Not Worth It – Youth Marijuana Prevention Campaign

Methamphetamines

- Meth Never Ever

Suicide Prevention

- Your Life Iowa – Suicide Prevention, Treatment and Resources for All Ages

The Department recognizes the value of working with community stakeholders to create media campaigns focused on substance misuse and/or problem gambling prevention messages. While this collaboration is important, Department-funded contractors are expected to use media campaigns and/or media campaign materials that are shown to be effective with the population of focus. All media campaigns must receive Department approval before implementation.

Media Campaign Planning and Implementation

A considerable amount of planning needs to occur before implementing any media campaign. Thoughtful implementation is key to a successful campaign. Department prevention standards for media campaign planning and implementation include the following:

Media Planning Standards

- Secure support and/or participation from those community sectors that are responsible for providing access to the population of focus.
- Collect baseline survey data from a representative sample of the target audience.
- Baseline data cannot be more than two years old during planning or implementation.
- Identify media campaign distribution sources that are popular and credible with the population of focus.
- Develop a written marketing plan for the implementation phase that includes:
    - All message/material distribution sources: ads, posters, billboards, social media, presentations, etc.
    - Estimated distribution/delivery dates
- Ensure distribution of the media campaign.
- Gather feedback on campaign placement from a representative sample of the population of focus during both the planning and implementation phases (e.g., focus groups, surveying, etc.).

Media Implementation Standards

- Implement the campaign for a minimum of nine consecutive months.
- Disseminate campaign materials using a minimum of three media distribution sources. (This cannot include three different media campaign items, such as three types of posters.)
- Distribute messages through sources that are popular and credible with the population of focus.
- Release new types of campaign materials, consistent with project objective(s), at least once every six weeks.
- Collect survey data at least once every two years during the implementation phase of the campaign to help you refine the campaign messages and measure progress toward achieving the campaign objective(s).

Reaching the Appropriate Population of Focus

The *targets of change* include all the people who experience (or are at risk for) the issue or problem addressed through contractor services. Not all strategies need to impact the entire target population.

The *agents of change* are those in a position to help contribute to the solution. Examples include teens, teachers, guidance counselors, parents, lawmakers, retailers, and law enforcement.

Media Articles, Agency-Created Materials, and Websites

All media articles (press releases, letters to the editor, newsletter articles, etc.), materials created by contractors, or electronic communications funded by Department prevention grants need to follow this process:

1. Include the Department-prevention grant title in all articles.
2. Include the following statement in all articles, materials, and electronic communications:
    - “[prevention agency name receiving funding]’s project is funded through the (include specific grant title), Iowa Department of Public Health, through the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.”

IMPLEMENTATION

During implementation, prevention professionals put their strategic prevention plans into action by delivering their selected, evidence-based interventions.

According to SAMHSA, when preparing to implement your selected prevention interventions, it is important to consider issues of **fidelity** and **adaptation**.

Fidelity describes the degree to which a program or practice is implemented as intended.

Adaptation describes how much, and in what ways, a program or practice is changed to meet local circumstances.

Evidence-based programs are defined as such because they consistently achieve positive outcomes. The greater fidelity to the original program design, the more likely positive results will be reproduced. Customizing a program to better reflect the attitudes, beliefs, experiences, and values of the focus population can increase its cultural relevance. However, it is important to keep in mind that such adaptations may compromise program effectiveness.

Remaining faithful to the original evidence-based design while addressing the unique needs and characteristics of the population of focus requires balancing fidelity and adaptation. When interventions are changed, outcomes can be compromised. However, implementing a program that requires some adaptation may be more efficient and cost-effective than designing a program from scratch.

It is important to maintain fidelity to not only a chosen program, policy, or practice, but also to a planning model such as the Strategic Prevention Framework (SPF) and its five phases. That is, to meet the goals of grants of increased prevention capacity and decreased substance misuse and/or problem gambling, a community must systematically step through each phase of the Framework, always with an eye toward sustainability and cultural competency. Incomplete or missing activities within each phase compromise the success of the endeavor.

However, adaptation to the local needs and priorities is important for stakeholder buy-in and programmatic success. Too much adaptation may degrade the intent of the program, policy, or practice so much that success is out of reach. The best results occur when program fidelity is maintained with regard to the core components. However, if the program is not completely relevant or a perfect fit to community needs, then rigid adherence to the program implementation plan may not produce positive outcomes.

Balancing Fidelity and Adaptation

Striking a balance between fidelity and adaptation is crucial. This balancing act is a dynamic process, often evolving over time. The ideal balance involves retaining elements of the program that analysis shows are most likely to account for its positive outcomes and adapting non-critical elements. At a minimum, contractors must adhere to the following guidelines:

Guidelines for Balancing Fidelity and Adaptation

1. Identify and understand the theory base behind the program.
2. Locate or conduct a core components analysis of the program.
3. Assess fidelity/adaptation concerns for the implementation site.
4. Consult as needed with a program developer or TA provider.
5. Consult with the organization and/or community where the implementation will take place.
6. Develop an overall implementation plan based on these inputs (create a logic model).

Here are some additional guidelines to consider when balancing fidelity and adaptation.

Retain core components: Evidence-based programs are more likely to be effective when their core components (that is, those elements responsible for producing positive outcomes) are maintained. Core components are like the key ingredients in a cookie recipe. Bakers may be able to omit the nuts, but if they leave out the flour, the recipe will not work. Here are some general guidelines for maintaining core components:

- Preserve the setting, as well as the number and length of sessions.
- Preserve key program content: It is safer to add rather than subtract content.
- Add new content with care: Consider program guidance and prevention research.

Build capacity before changing the program: Rather than changing a program to fit with local conditions, consider ways to develop the resources or build local readiness so the program is delivered as it was originally designed.

Adapt with care: Even when interventions are selected with great care, there may be ways to improve a program's appropriateness for a unique focus population. Cultural adaptation refers to program modifications that are tailored to the values, attitudes, beliefs, and experiences of the population of focus. To make an intervention more culturally appropriate, it is crucial to consider the language, values, attitudes, beliefs, and experiences of focus population members.

If adapting, consult experts first: Experts can include the program developer, an environmental strategies specialist, Department staff, or an evaluator. They may be able to explain how the intervention has been adapted in the past and how well (or not) those adaptations worked. For cultural adaptations, cultural leaders and members of the focus population should be consulted.

It is important to note, that even if a program developer approves program adaptations and/or modifications, the Department may not approve such changes. Department funded prevention contractors must submit an EBP Waiver Request Form for any proposed changes to an evidence-based program.

Establish Implementation Supports

Many factors combine to influence the implementation and support the success of prevention interventions, including the following:

Favorable prevention history: An individual or organization with positive experiences implementing prevention interventions in the past will likely be more ready, willing, and able to support a new intervention. If an individual or organization has had a negative experience with—or does not fully understand the potential of—a prevention intervention, then it is important to address these concerns early in the implementation process.

On-site leadership and administrative support: Prevention interventions assume many different forms and are implemented in a variety of settings. To be effective, interventions require leadership and support from key stakeholders.

Practitioner selection: When selecting the best candidate to deliver a prevention intervention, consider professional qualifications and experiences, practical skills, and their fit with the focus population.

Practitioner training and support: Pre- and in-service trainings can help practitioners responsible for implementing an intervention understand how and why the intervention works, practice new skills, and receive constructive feedback. Since most skills are learned on the job, it is also very helpful to connect the practitioners with a coach or professional mentor who can provide ongoing support.

Program evaluation: By closely monitoring and evaluating the delivery of an intervention, the practitioners can make sure that it is being implemented as intended and improve it as needed. By assessing program outcomes, they can determine whether the intervention is working as intended and worthy of sustaining over time.

When prevention practitioners promote both fidelity and cultural relevance and anticipate and support the many factors that influence implementation, their efforts go a long way toward producing positive outcomes. But to sustain these outcomes over time, it is important to get others involved and invested in the prevention interventions. Find concrete and meaningful ways for people to get involved, keep cultural and public opinion leaders well-informed, and get the word out to the broader community through media and other publicity efforts.

Source: Applying the Strategic Prevention Framework – Step 4: Implement, Substance Abuse and Mental Health Services Administration, 2018

EVALUATION

According to SAMHSA, “Evaluation is the systematic collection and analysis of information about program activities, characteristics, and outcomes. The evaluation step of the Strategic Prevention Framework (SPF) is not just about collecting information but using that information to improve the effectiveness of a prevention program. After evaluation, planners may decide whether to continue the program.

“Prevention practitioners need to evaluate how well the program was delivered and how successful it was in achieving the expected outcomes. Once the program has been evaluated, prevention planners typically report evaluation results to stakeholders, who can include community members and lawmakers. Stakeholders can promote their program, increase public interest, and possibly help to secure additional funding.”

Source: Applying the Strategic Prevention Framework – Step 5: Evaluate, Substance Abuse and Mental Health Services Administration, 2018

Evaluation is a process, not a discrete task or one-time event. Planning for evaluation should be ongoing and involve key stakeholders, especially those with specific skills needed to plan, conduct, and interpret evaluation, as well as members of the target population and any disparate populations.

CADCA has outlined five essential functions of evaluation:

Improvement: The first, and most important, function of information gathered by a coalition evaluation is improvement. Volunteers, leaders, and supporters should get better at the work of community problem-solving because of what they learn from the evaluation.

Coordination: Coalitions are made up of many partners working on different parts of an overall response to community problems. Keeping these partners and activities pointing in the same direction can be difficult unless the evaluation fosters coordination. Members should know what others are doing, how this work fits with their own actions and goals, and what opportunities exist for working together in the future.

Accountability: Volunteers want to know if their time and creativity make a difference. Funders want to learn how their money factors into community improvements. Everyone involved in coalition work wants to see positive outcomes. A good evaluation allows the coalition to describe its contribution to important population-level change.

Celebration: A stated aim of any evaluation process should be to collect information that allows the coalition to celebrate genuine accomplishments. The path to reducing substance misuse and problem gambling at the community level is not easy. Regular celebration of progress is needed to keep everyone motivated and encouraged in the face of difficult work.

Sustainability: The path to reduced substance misuse or problem gambling behavior can be long, often requiring years of hard work to see movement in population-level indicators. Likewise, new community problems emerge, requiring renewed response. Evaluation should help a coalition stay in the game long enough to make a difference by sharing information with key stakeholders and actively reinforcing their continued support.

Source: Evaluation Primer: Setting the Context for a Community Anti-Drug Coalition Evaluation, Community Anti-Drug Coalitions of America, National Community Anti-Drug Coalition Institute

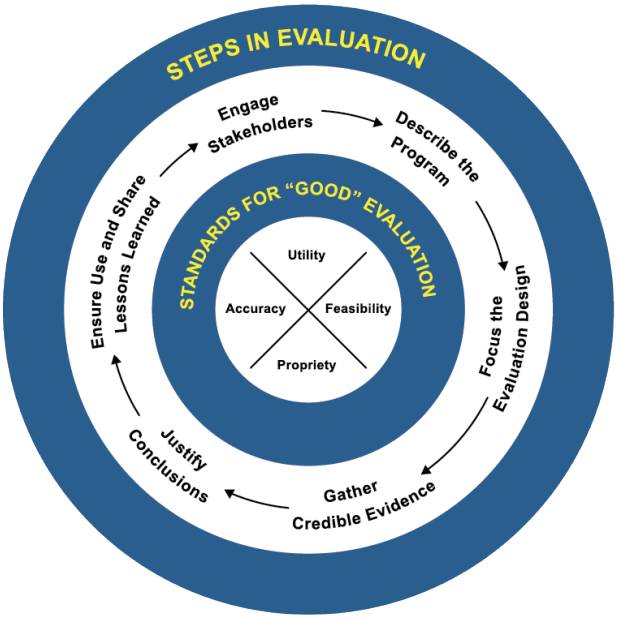
The Department will provide programs with specific project guidance related to evaluation. According to The Community Tool Box from the University of Kansas, it is important to consider these questions:

- What will be evaluated?
- What criteria will be used to judge program performance?
- What standards of performance must be reached for the program to be considered successful?
- What evidence will indicate performance on the criteria relative to the standards?
- What conclusions about program performance are justified based on the available evidence?

Source: Community Tool Box, Center for Community Health and Development, University of Kansas

A Framework for Program Evaluation

Program evaluation offers a way to understand and improve community health and development practices through useful, feasible, proper, and accurate methods. This framework from the University of Kansas's Community Tool Box is a practical, non-prescriptive tool that summarizes in a logical order the important elements of program evaluation.



The framework contains two related dimensions:

- Steps in evaluation practice
- Standards for good evaluation

The six connected steps of the framework should be a part of any evaluation. Although the steps may be completed out of order, it usually makes sense to follow them in the recommended sequence. That is because earlier steps provide the foundation for subsequent progress. Decisions about how to carry out a given step should not be finalized until previous steps have been thoroughly addressed.

However, these steps are meant to be adaptable, not rigid. Sensitivity to each program's unique context (for example, the program's history and organizational climate) is essential for sound evaluation. They are intended to serve as starting points around which community organizations can tailor an evaluation to best meet their needs.

The Six Steps:

1. Engage stakeholders.
2. Describe the program.
3. Focus the evaluation design.
4. Gather credible evidence.
5. Justify conclusions.
6. Ensure use and share lessons learned.

Understanding and adhering to these basic steps will improve most evaluation efforts.

The second part of the framework is a basic set of standards to assess the quality of evaluation activities. There are 30 specific standards, organized into the following four groups:

- Utility
- Feasibility
- Propriety
- Accuracy

These standards help answer the question: "Will this be a good evaluation?" They are recommended as the initial criteria by which to judge the quality of the program evaluation efforts.

Source: A Framework for Program Evaluation: A Gateway to Tools, Community Tool Box, Center for Community Health and Development, University of Kansas

Evaluation can also be a strong influencer for sustainability. According to CADCA:

“Evaluation plays a central role in sustaining your coalition’s work. Evaluation enables you to take key pieces of data and analyze and organize them, so you have accurate, usable information. This process facilitates development of the best plan possible for the community and allows your group to accurately share its story and results with key stakeholders. It also can help members and staff track and understand community trends that may have an impact on your coalition’s ability to sustain its work.”

Source: Evaluation Primer: Setting the Context for a Community Anti-Drug Coalition Evaluation, Community Anti-Drug Coalitions of America, National Community Anti-Drug Coalition Institute, 2018

Additional Resources

A Framework for Program Evaluation, Centers for Disease Control and Prevention

Hints for Conducting Strong Evaluations, Centers for Disease Control and Prevention

Tools for Evaluation, Community Tool Box, Center for Community Health and Development, University of Kansas

SUSTAINABILITY

During this step, prevention practitioners ensure the sustainability of prevention outcomes by building stakeholder support for the program, showing and sharing results, and obtaining steady funding.

The sustainability of prevention outcomes is often seen as the culmination of program planning and implementation. However, that assumption will place your program at a disadvantage. Effective programs plan for sustainability from the beginning of program design. Sustainability should be revisited and revised throughout the life of a program.

The ultimate goal is to sustain prevention outcomes, not programs. Programs that produce positive outcomes should be continued. Programs that are ineffective should not be sustained.

Key activities involved in ensuring sustainability involve building support, showing results, and obtaining continued funding. All these activities require time, people, and ongoing planning and evaluation.

Additionally, SAMHSA's Strategic Prevention Framework (SPF) emphasizes sustaining the prevention process itself, recognizing that practitioners will return to each step of the process, again and again, as communities face evolving problems.

Sustainability should be revisited and revised throughout the life of a program.

Source: Applying the Strategic Prevention Framework: Sustainability, Substance Abuse and Mental Health Services Administration, 2018

Crosswalk of SPF Steps with Sustainability Milestones and Skills

The following pages outline the crosswalk that identifies tasks commonly associated with each step of SAMHSA's Strategic Prevention Framework (SPF) and aligns them with sustainability milestones and contractor skills needed to meet these milestones. This helps determine capacity-building needs within communities/counties implementing the SPF process.

Step 1: Needs Assessment

Gather and assess data from a variety of sources to ensure that substance misuse and/or problem gambling prevention efforts are appropriate and targeted to the needs of communities/counties.

Tasks	Sustainability Milestones	Skills Needed
Develop a profile of consumption patterns and related problems and consequences. Provide demographic context, including geographic and target population differences. Identify intervening variables and underlying conditions.	Key stakeholders are engaged. Data sharing agreements are formalized. County substance misuse and/or problem gambling problems are prioritized.	Identify and engage key stakeholders. Conduct key informant interviews. Build collaborative relationships, including the development of effective initial MOA/MOUs.
Conduct community capacity assessment by appraising community readiness and identifying prevention resources and gaps in services/capacity.	Use readiness data in the selection of prevention priorities. Identify service and capacity gaps.	Analyze community readiness data and create a plan to increase community readiness. Plan for prevention workforce development.
Conduct and document a county needs assessment.	Reach a countywide consensus on prevention priorities.	Communicate prevention priorities to a broad group of stakeholders.

Step 2: Capacity Building

Identify resources and determine readiness for addressing substance misuse and/or problem gambling in communities.

Tasks	Sustainability Milestones	Skills Needed
Develop prevention workforce knowledge, skills, and competencies.	Identify internal coalition or agency staff capacity needs.	Plan for long-term internal and external capacity needs. (Cultural issues are considered for the capacity-building plan.)
Ensure current and ongoing current knowledge of culturally relevant issues and programs.	Consider broader community capacity needs in the creation of a capacity building plan.	Identify cultural issues in the county and incorporate them into a capacity-building plan
Build community-based capacity in prevention (e.g., Boys and Girls Clubs). Build and/or enhance local prevention infrastructure.	Engage the community in creating sustainable prevention efforts.	Create a working group to focus on sustainability.
Analyze readiness data while assessing community needs.	Factor in the needs of groups with varying levels of readiness.	Assess community readiness. Identify actions or strategies to advance readiness.
Develop and enhance data systems.	Collect data and identify gaps.	Identify data gaps and plan for data collection and analyses.

Step 3: Planning

Using capacity and needs assessment findings, develop a prevention plan by prioritizing intervening variables and underlying conditions and building related logic models and work plans.

Tasks	Sustainability Milestones	Skills Needed
Select priorities using a clear and transparent process.	Clarify priorities and link key factors and conditions. Reassess and address capacity needs for implementing the proposed strategies.	Identify specific individual and environmental strategies and the intervening variables/underlying conditions they can address.
Incorporate assessment results into strategic plan.		
Develop a logic model that demonstrates the intervening variables/underlying conditions that are well-aligned with the selected evidence-based programs.		
Develop a work plan that focuses on the strategy services to be provided.		
Identify multiple methods and measures for monitoring and measuring process/outcomes.		
Select strategies based on levels of evidence, as well as the practical and conceptual fit.	Identify key partners or settings for the implementation of specific strategies.	Negotiate/renegotiate working agreements with key partners.
Assess the current fiscal situation.	Begin business planning.	Create and maintain a business plan.

Step 4: Implementation

Develop work plans to implement your chosen prevention intervention.

Tasks	Sustainability Milestones	Skills Needed
Implement logic model/work plan.	Build community and stakeholder capacity to understand and support your selected strategies.	Use the logic model as a key driver in strategy implementation.
Collect and analyze measures throughout implementation.		
Document evidence of incremental continuous quality improvement (CQI) and strategy fidelity.	Continuously develop and improve on the prevention infrastructure.	Link logic models to key implementation partners and key sustainability stakeholders.
Provide training and coaching for prevention staff.		
Develop a media advocacy plan.	Begin to report on process and intermediate outcomes.	Communicate process and intermediate outcomes.
	Formalize relationships with key partners.	Formalize relationships, i.e. moving from MOAs to contracts.

Step 5: Evaluation

Quantify the challenges and successes of implementing a prevention program.

Tasks	Sustainability Milestones	Skills Needed
Identify key evaluation questions.	Develop evaluation plan.	Engage in evaluation planning.
Revisit baseline data from the needs assessment and process and outcome data.	Continuously engage in collaborative monitoring of the outcomes with project staff. Recollect and analyze baseline data.	Manage an evaluator. Analyze data.
Use fidelity data and describe quality improvements.	Include long-term outcomes in evaluation data reporting plans.	Review activities, outputs, and process measures against core component and fidelity guides to demonstrate reasonable alignment with outcomes or explain the lack thereof.
Build evaluation capacity.		
Implement media advocacy plan.	Report on outputs and increases in intermediate outcomes.	Communicate evaluation results with stakeholders.

Source: Assessing the Fidelity of Implementation of the Strategic Prevention Framework in SPF SIG-funded Communities: Users Guide and Fidelity Assessment Rubrics (Version 2), Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008

Building Capacity for Sustainability

Communities must build capacity at three levels to sustain a prevention effort:

1. **At the coalition level.** The coalition must be strong enough to effectively identify and prioritize populations whose substance misuse and/or problem gambling is contributing to community problems.
2. **Among community agencies.** The capacity of community agencies must be strengthened and expanded with a prevention-oriented operating mission. This will help agencies to understand and leverage their resources to effectively address factors among populations that contribute to substance misuse and/or problem gambling issues and/or their consequences.
3. **Among community members.** The community's capacity to understand the role and impact of substance misuse and/or problem gambling on community problems is critical to prevention planning efforts. Community members must support coalition efforts to strengthen the community's prevention system so that it employs strategies (programs, policies, and practices) that will most likely influence population-level consumption patterns and reduce resulting problems.

To build these capacities, communities, through their coalitions, must have the ability to:

- Ensure the effectiveness and alignment of the prevention system. The coalition, with the community agencies whose services contribute to prevention outcomes, must assess the prevention strategies supported by the community prevention system and ensure that:
    - Prevention strategies align logically and reach an appropriate number of the targeted population to achieve reductions in the substance misuse and/or problem gambling behavior targeted based on a local data-driven needs assessment
    - Agencies whose services contribute to strategic prevention outcomes regularly document the implementation process, including implementation fidelity, adaptations, and quality, and use this information for quality improvement
    - Contributing agencies regularly document, demonstrate, and communicate the accomplishment of intended outcomes
- Ensure organizations' ability to support the community prevention system through a strategic planning process that helps achieve targeted changes in substance misuse and/or problem gambling behaviors and related consequences at the population level. The coalition must determine that the agencies that are implementing the preventive interventions have the capacity to sustain the effort. The coalition, as the steward of the community's prevention system, ensures that organizations have the capacities needed to participate fully within the coalition and the community prevention system, including:
    - Administrative structures and linkages that support the efforts of the community's coalition to strategically integrate the skills and capacities of community organizations to achieve targeted reductions in substance misuse and/or problem gambling behaviors and consequences.
    - Administrative policies and procedures that permit community organizations to respond as data indicates to changes in community conditions.
    - Administrative structures within prevention-focused community organizations that support staff or contracted partners to ensure the community has the expertise needed to plan for and carry out prevention strategies that will achieve the expected outcomes.
    - The organization has multiple funding sources that support efforts in these areas.

The coalition must assure that the community can sustain the prevention system and its impacts by working to:

- Cultivate community support for the prevention system and its outcomes. The community coalition must assure it attains broad community support for its outcomes through:
    - Ongoing, dynamic interactive communication with key stakeholders and community leaders.
    - Cultivating stakeholders as leaders and champions who support the coalition.
    - Awareness and support for the coalition and its strategy by community members who integrate concern for substance misuse and/or problem gambling issues into their professional, social, or personal considerations.

Source: Planning for Sustainability*, Substance Abuse and Mental Health Services Administration, 2018*

One key to planning for sustainability is to create formal plans and linkages. The Department will provide specific guidance and templates for each specific project, including sustainability plan guidance and MOU templates.

Additional Resources

Chapter 46, Planning for Sustainability, Community Tool Box, Center for Community Health and Development, University of Kanas

Sustainability Primer: Fostering Long-Term Change to Create Drug-Free Communities, CADCA

Sustainability, Massachusetts Technical Partnership for Prevention

CULTURAL COMPETENCE

According to SAMHSA, "Cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent. Culture must be considered at every step of the Strategic Prevention Framework (SPF). 'Culture' is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as:

- Age
- Gender
- Sexual orientation
- Disability
- Religion
- Income level
- Education
- Geographical location
- Profession

Cultural competence means to be respectful and responsive to the health beliefs and practices – and cultural and linguistic needs – of diverse population groups. Developing cultural competence is also an evolving, dynamic process that takes time and occurs along a continuum."

Source: Applying the Strategic Prevention Framework – Cultural Competence, Substance Abuse and Mental Health Services Administration, 2018

SAMHSA's Center for Substance Abuse Prevention (CSAP) has identified the following principles of cultural competence:

- Ensure community involvement in all areas.
- Use a population-based definition of community. (Let the community define itself.)
- Stress the importance of relevant, culturally-appropriate prevention approaches.
- Employ culturally competent evaluators.
- Promote cultural competence among program staff who reflect the community they serve.
- Include the target population in all aspects of prevention planning.

Skills for Cultural Competency

SAMHSA's Center for the Application of Prevention Technologies further identified these skills.

When applying the five steps of SAMHSA's Strategic Prevention Framework (SPF), culturally competent prevention professionals are able to do the following:

Assess Needs

- Accurately assess the influence of their own values, perceptions, opinions, knowledge, and social position on their interactions with others.
- Provide and promote an atmosphere in which similarities and differences can be explored and understand that this process is not only cognitive but inclusive of attitudes and emotions, as well.

Build Capacity

- Learn to be an ally to groups that experience prejudice and discrimination in the community, as well as help others learn to be an ally to their own cultural groups.
- Help expand other people's knowledge of their own culture and affirm and legitimize other people's cultural perspectives.

Plan

- Learn to embrace new, ambiguous, and unpredictable situations, and be persistent in keeping communication lines open when misunderstandings arise.
- Encourage community members to see themselves in a multicultural perspective and promote the growth of skills in cross-cultural interactions and communication.

Implement

- Encourage and accommodate a variety of learning and participation styles, building on community members' strengths.
- Draw upon the experiences of participants or collaborators to include diverse perspectives in any given intervention.

Evaluation

- Be skeptical about the validity of diagnostic tools applied to people who are culturally different from those upon whom the norms were based.
- Understand, believe, and convey that there are no culturally deprived or culturally neutral individuals or groups, and that all cultures have their own integrity, validity, and coherence and deserve respect.

Source: Skills for Cultural Competency, Substance Abuse and Mental Health Services Administration, 2018

The National CLAS Standards

Health equity is the attainment of the highest level of health for all people. Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health. These are the conditions in which individuals are born, grow, live, work, and age, such as socioeconomic status, education level, and the availability of health services. Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve health care quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

Principal Standard:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce Standards:

- Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance Standards:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability Standards:

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality-improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Source: "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care", U.S. Department of Health and Human Services Office of Minority Health, 2018

Additional Resources

Behavioral Health Equity, Substance Abuse and Mental Health Services Administration

National Culturally and Linguistically Appropriate Services Standards, U.S. Department of Health and Human Services

Social Determinants of Health: Know What Affects Health, Centers for Disease Control and Prevention

Resources on Health Literacy

CDC Clear Communication Index, Centers for Disease Control and Prevention

Everyday Words for Public Health Communication, Centers for Disease Control and Prevention

Health Literacy Online: A Guide for Simplifying the User Experience Office of Disease Prevention and Health Promotion

Resources on Culturally Appropriate Organizations

Attributes of a Health Literate Organization, Centers for Disease Control and Prevention

Building Culturally Competent Organizations, Community Toolbox, Center for Community Health and Development, University of Kansas

Enhancing Cultural Competence, Community Toolbox, Center for Community Health and Development, University of Kansas

IDPH Prevention Guidance

CORRESPONDENCE AND IOWAGRANTS.GOV

IowaGrants.gov is the Department–approved web-based system used to communicate contract-related items. All Department documents will be posted through this site. It is expected that Department-funded contractors use the correspondence section of IowaGrants.gov for any questions related to personnel, budgets, progress reports, or other contract-related items. For questions not related to contracts, please feel free to contact a Department Prevention Consultant by email or phone.

When communicating through the correspondence section of IowaGrants.gov, please be sure to include your first and last name to clearly indicate who is making contract-related requests, as well as the Department grant title.

PREVENTION REPORTING REQUIREMENTS

Department-funded contractors are expected to complete progress reports to document prevention efforts that took place during a specified reporting period. Progress reports are completed on a quarterly basis, and at times, one final cumulative report that outlines whether outcomes were successfully achieved during a contract period. Progress reports also capture lessons learned.

Progress reports are available at IowaGrants.gov and are typically assigned at the beginning of each fiscal year. Contractors are responsible for completing the reports in their entirety and submitting on or before the established due date. Progress reports that are not submitted through IowaGrants.gov by the specified due date will be considered late.

At times, the Department receives requests for information related to prevention services that are taking place throughout Iowa. Thus, progress reports are an opportunity for contractors to highlight the level of effort that was expended each quarter toward the completion of the Department-approved short-term and long-term outcomes. It is important to include specific details in the report to clearly show the impact taking place throughout the entire service area.

Below are some helpful hints when completing the progress report:

- Address all services listed in an activity in the narrative update.
- Include the total number of implementations that occurred, the number of people served, and any outcome data that may have been obtained.
- Do not use acronyms or N/A. (If no service occurred during the quarter, please explain why).
- If the activity was completed in a previous quarter, note in the narrative when the service occurred.
- If the progress report has pre-determined character limits, words may be abbreviated if they would be universally understood. (Example: mtg. vs. meeting)
- If information is noted in another section, it is okay to reference the section rather than rewriting the information.

For additional guidance on progress reports, please see Appendix B: Progress Report Guidance Document. Data Collection, Surveying, and Qualtrics

Department-funded prevention services must be clearly and accurately documented in contractor records, the grant tracking system, and Department data systems. The Department requires periodic reporting of contractors' compliance with their proposed work plan, provision of services, and incurred expenses.

A contractor must document the provision of prevention services in order to support contractor billing and reporting, as well as Department monitoring. Contractors should specifically document use of the IOM classifications, the SPF steps, and the SAMHSA Prevention Services Categories.

The Department has systems in place for the collection of data. A contractor should report certain information and data as outlined below.

- **Community Toolbox:** Used to report process data related to implementation of environmental strategies.
- **Iowa Services Management and Report Tool (I-SMART) Prevention System**: Used to report all substance misuse and/or problem gambling services.
- **IDPH Approved Survey Instrument:** The Department utilizes the Qualtrics system to report pre- and post-survey results from the IDPH Prevention Survey tool. This survey should be used with all multi-session programming.

CONTRACT MONITORING

Department Prevention Consultants monitor all contract throughout each contract period. This monitoring includes, but is not limited to, data submission review to ensure services submitted are connected to approved work plans, claim monitoring through requests for documentation to support claims, notification to the Department related to key personnel changes and ongoing linkages to the County Board of Health.

DISTRIBUTORS AND COMPANIES

While distributors and companies selling a variety of substances may be stakeholders in the community that are engaged as part of the assessment, capacity, or planning process, Department-funded prevention contractors cannot partner with these distributors or companies to offer, host, or provide materials for any program or strategy funded by the Department. This type of partnership could be established as a part of a sustainability process.

ADVOCACY VS. LOBBYING

As agents of change in the community, it is important to provide information on the facts surrounding a particular prevention topic. To successfully communicate prevention messages, it is imperative to understand the difference between advocacy versus lobbying.

Lobbying is when a prevention specialist takes a position on legislation and publicly advocates for it in their role as a prevention professional representing a federally funded program or entity (e.g. coalitions and school districts). This is NOT allowed for public employees or for programs funded with federal dollars.

Advocacy is when a prevention specialist informs the community of a particular prevention topic using facts and an unbiased opinion.

Please note, this does not mean that an individual cannot speak out against a specific piece of legislation on their personal time; however, it is advised that prevention specialists communicate within their agencies regarding the boundaries surrounding this topic.

UNALLOWABLE COSTS AND SERVICES

The following lists unallowable costs and services under the Block Grant and is applied to all Department prevention grants. This list is intended to help Department-funded contractors as they plan for and develop their prevention work plans. It should help guide efforts to increase community-based behavior change by using effective strategies and services.

Unallowable Services for All Prevention Contractors:

- **Use of programs, policies, strategies and services with no evidence base.**
- **Duplicating services.** Federal and state funds must not be used to duplicate services. All contractors receiving funds must ensure that two or more grants or funding streams are not being used to provide the same activities or services to the same beneficiaries.
- **Use of education concealment activities** and other types of displays (including rooms, lockers, purses, or training/additional services/technical assistance about these activities, etc.). These activities have limited to no evidence to show that they are effective in changing behavior.
- **Use of simulated impairment tools, such as alcohol/cannabis goggles**. There is limited to no research to support long-term behavior change.
- **Supplanting services**. Federal funds must not replace (supplant) non-federal funds. All contractors who receive funds under the Block Grant must ensure that these funds do not supplant funds that have been budgeted for the same purpose through non-federal sources.

Unallowable Services for Integrated Provider Network Prevention Contractors:

- **Chaperoning/volunteering at alternative activities**. The role of a prevention specialist is to inform community stakeholders on the benefits of providing safe events for community members that are free from high-risk behavior. Staff time should not be directed toward setting up, tearing down, or assisting at the event.
- **Law enforcement strategies**. No funding of any enforcement strategies is permitted. Contractors may use funds to provide technical assistance to communities to maximize local enforcement procedures governing the availability and distribution of alcohol, tobacco, and other drugs. Capacity building and support services to law enforcement are permitted, but this distinction needs to be clearly noted in all work plans and data submitted to the Department.
- **Mental health promotion services**. According to the Block Grant statute, primary prevention set-aside funds can only be used to fund “activities to prevent substance abuse” for “individuals who do not require treatment.” However, substance misuse and/or problem gambling and mental illness share many of the same modifiable risk and protective factors. SAMHSA encourages contractors to fund strategies that address shared risk and protective factors AND those that are specific to substance misuse and/or problem gambling prevention.
- **Prevention services for those who require treatment**. No prevention services can be provided to those in need of or are receiving treatment services. In addition, tobacco cessation services will be supported.
- **Screening, Brief Intervention, and Referral to Treatment (SBIRT) services**. No screenings are permitted, nor training and/or technical assistance about the SBIRT or a screening process are allowable.
- **Statewide ATOD policy efforts**. Contractors are not permitted to work on statewide policy efforts through local or statewide coalitions and agencies.

Unallowable Costs:

- Banners
- Dues
- Financial assistance to for-profit entities
- Gift cards
- Incentives (cash incentives or gifts for program participation)
- Land purchase or improvement
- Meal purchases for program participants (individuals served by direct programming, coalition members/subcommittee members, individuals attending program hosted events, etc.) but light refreshments, e.g. chips, sodas, bottled water, raw vegetables, etc., are an allowable cost
- Naloxone purchase and materials for overdose kits
- Paraphernalia and concealment items
- Promotional or giveaway items such as T-shirts, magnets, pencils/pens, toys, etc.
- Subscriptions

A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.

Contractors need to have adequate policies and procedures in place for fiscal oversight. All grant spending needs to align with the contractor budget approved by the Department, as well as support the approved grant services. Grant spending should be allowable and reasonable in order to be good stewards of the funding.

A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. (2CFR 200.404)

If additional items not included in the approved budget are needed to complete the grant services, contractors should request a budget amendment through IowaGrants.gov correspondence. The specific request should include what funding will be adjusted within line items to cover the requested item, what new item is being requested, and a justification for the change

MATCH

Due to Department requirements, contractors are required to provide match funding for specific funding opportunities. Based on the Department General Conditions, “Program income may be retained by the Contractor and shall be used for the program in accordance with the conditions of the contract unless the Special Conditions of the contract specify otherwise. Program income may be used to meet the cost sharing or matching requirement of the contract.”

For additional information regarding cost sharing and match, see Appendix C: 2 CFR 215.23 – Cost Sharing and Match. Match cannot include state or federal dollars.

All matching funds must align with Department-approved work plans, and the source of the match must be clearly noted in the budget.

SITE VISIT PROCESS

Contractors are required to participate in an annual site visit. The Department monitors and evaluates prevention services and contractors to ensure contract compliance. Monitoring and evaluation areas include but are not limited to: information related to fiscal reporting, quality improvement, work plan progress, contractor policies, service documentation, contract barriers, technical assistance needs, and contractor reporting and evaluation. The Department is required to complete these reviews to demonstrate that the contractor network meets the standards set by the Substance Abuse Mental Health Services Administration (SAMHSA) or the Department.

The site visit process is a collaborative one that requires agency preparation before the on-site visit. Site visits last approximately four to six hours. The Department will send site visit documentation, through the Site Visit component of IowaGrants.gov, beforehand to provide clear guidance on the components to be reviewed. For additional guidance on the site visit process, please see Appendix D: Site Visit Checklist.

SUBCONTRACTS/WORK PLANS

Per the Iowa Department of Public Health General Conditions, Section 5. Procurement Standards and Subcontractors:

a. **Procurement.** The Contractor shall use procurement procedures that comply with all applicable federal, state, and local laws and regulations.

b. **Subcontracting.** None of the work or services relating to this contract shall be subcontracted to another organization or individual without specific prior written approval by the Department except for subcontracts under $2,000. To obtain approval, the contractor shall submit to the Department the proposed contract or written agreement between the parties. The proposed contract or agreement shall contain:
    - A list of the work and services to be performed by the subcontractor
    - The contract policies and requirements
    - Provision for the Department, the contractor, and any of their duly authorized representatives to have access, for the purpose of audit and examination, to any documents, papers and records of the subcontractor pertinent to the subcontract
    - The amount of the subcontract
    - A line-item budget of specific costs to be reimbursed under the subcontract or agreement or other cost basis for determining the amount of the subcontract as appropriate
    - A statement that all provisions of this contract are included in the subcontract including audit requirements
    - Period of performance
    - Any additional subcontract conditions

    Any subcontract or other written agreement shall not affect the contractor's overall responsibility and accountability to the Department for the overall direction of the project.

c. If, during the course of the subcontract period, the contractor or subcontractor wishes to change or revise the subcontract, prior written approval from the Department is required.
d. The contractor shall maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of their contracts or purchase orders.
e. The contractor shall maintain written standards of conduct governing the performance of its employees engaged in the award and administration of any subcontract. No employee, officer, or agent of the contractor or subcontractor shall participate in the selection or in the award or administration of a subcontract if a conflict of interest, real or apparent, exists.

LOCAL PUBLIC HEALTH & BOARD OF HEALTH INVOLVEMENT

Local public health services provide an array of care to Iowans and are responsible for public health in their jurisdiction and ensure that all communities have services that help promote healthy behaviors and self-management of chronic disease. Local public health services include, but are not limited to, the following:

- Communicable disease surveillance, investigation, and follow-up
- Immunization clinics
- Personal care and support services, including home care aide and homemaker services
- Skilled nursing visits in the client's home
- Screening services, including blood pressure and blood glucose
- Health education to community groups
- Prevention programs like fall prevention, bike safety, and home safety inventories

Source: Bureau of Local Public Health Services, Iowa Department of Public Health, 2018

Local boards of health have responsibility for public health in their jurisdiction. They support local public health vision, mission, and advocacy and encourage community involvement in setting public health priorities. In addition, local boards of health have been given the responsibility to oversee utilization of the Local Public Health Services Contract. For more information, see Appendix E: Local Board of Health.

"As a condition of the contract, the contractor shall assure linkage with the local board of health in each county where services are provided. The contractor will assure that the local board of health has been actively engaged in planning for, and evaluation of, services. It will also maintain effective linkages with the local board of health, including timely and effective communications and ongoing collaboration."

Both the Local Public Health and Board of Health play a vital role in the success of prevention services throughout Iowa. As a key player in the community, these entities can enhance and expand primary prevention services by connecting prevention specialists to key stakeholders, collaborate on evolving substance misuse and/or problem gambling issues that may arise, and systematically work to maximize initiatives that have shared risk and protective factors.

Per the Iowa Department of Public Health General Conditions language, "As a condition of the contract, the contractor shall assure linkage with the local board of health in each county where services are provided. The contractor will assure that the local board of health has been actively engaged in planning for, and evaluation of, services. It will also maintain effective linkages with the local board of health, including timely and effective communications and ongoing collaboration."

Contractors may be required to include how they engaged their local Boards of Health, in each county, in their quarterly progress report. For more information on this topic, please contact your Department Prevention Consultant.

IOWA DEPARTMENT OF PUBLIC HEALTH GENERAL CONDITIONS

Contractors awarded a General Conditions Service Contract with the Department are required to comply with the contract terms contained in the special conditions portion of the contract, as well as the general conditions specified in the correspondence document in Appendix F.

For additional information regarding the Iowa Department of Public Health General Conditions, please visit IDPH General Conditions for Service Contracts.

STAFFING AND PERSONNEL | HOURS OF OPERATION & SERVICE LOCATION

As per the Department Substance Use and Problem Gambling Services Integrated Provider Network Request for Proposal:

Hours of Operation and Service Locations

A contractor must provide prevention services in the service area. A contractor must have sufficient prevention services locations and hours of operation to support access for all residents in each county in the service area. A contractor may provide prevention services in person or through electronic means or written communications, with direct face-to-face services preferred. A contractor must offer prevention services in each county in each awarded service area. A contractor may request an exception from the Department. A contractor cannot limit prevention services to the school year and cannot limit prevention services locations to schools.

Staffing and Personnel

Contractors must ensure that staffing and staff qualifications are sufficient to implement prevention services. No single staff person may exceed 1.0 FTE. Staff providing prevention services must have the appropriate qualifications, experience, degrees, certifications or licenses required of their position, and the services provided and must meet all regulatory requirements. Each service must be provided by staff persons qualified to provide that service.

Prevention Organization Expectations

Information listed below is specific to the Integrated Provider Network Grant, but could be applied to other Department funded prevention grants.

POLICIES AND PROCEDURES MANUAL

BASED ON IAC 155.21(4)

Maintain and implement a written policies and procedures manual that documents the contractor's prevention services. Describe the prevention services and related activities, specify the policies and procedures to be followed, and govern all prevention staff.

- The manual shall have a table of contents.
- Revisions to the manual shall be entered with the date and with the name and title of the staff person making the revisions.

STAFF DEVELOPMENT AND TRAINING

BASED ON IAC 155.21(5)

Policies and procedures shall establish a staff development and training plan that encompasses all prevention staff and all prevention services, considers the professional continuing education requirements of certified staff, and is available to all prevention staff.

- Designate a staff person responsible for the staff development and training plan.
- The staff person responsible for the staff development and training plan shall conduct an annual needs assessment.
- The staff development and training plan shall describe orientation for new staff that includes an overview of the contractor's organization, prevention services, and confidentiality.

DATA REPORTING

BASED ON IAC 155.21(6)

Policies and procedures shall describe how the contractor reports data to the Department in accordance with Department requirements and processes.

FISCAL MANAGEMENT

BASED ON IAC 155.21(7)

Policies and procedures shall ensure proper fiscal management.

PERSONNEL

BASED ON IAC 155.21(8)

The contractor shall have personnel policies and procedures that address:

- Recruitment and selection of staff
- Wage and salary administration
- Promotions
- Employee benefits
- Working hours
- Vacation and sick leave
- Lines of authority

- Rules of conduct
- Disciplinary actions and termination
- Methods for handling cases of inappropriate service delivery
- Work performance appraisal
- Staff accidents and safety
- Staff grievances
- Prohibition of sexual harassment
- Implementation of the Americans with Disabilities Act
- Implementation of the Drug-Free Workplace Act
- Use of social media
- Implementation of equal employment opportunity

JOB DESCRIPTIONS

Each position and staff person shall have a written job description that describes the duties of each position and staff member and the qualifications required.

- A review of all job descriptions should happen annually and whenever there is a change in a position's duties or required qualifications.
- Job descriptions should be in the personnel section of the policies and procedures manual.

PREVENTION SPECIALIST CERTIFICATION

A staff person providing prevention services shall be qualified to provide prevention services by meeting at least one of the following conditions:

- Be certified as a prevention specialist by the Iowa Board of Certification or other organization as approved by the Department.
- A staff person employed to provide prevention services on and after January 1, 2019, who is not certified as a prevention specialist, shall be deemed qualified while the person is in the process of being certified as a prevention specialist. Such staff:
    - must meet the requirements of the certification process
    - must be supervised or mentored by a certified prevention specialist
    - must participate in Substance Abuse Prevention Skills Training within one year of hire
    - must receive a minimum of three hours of ethics training within three months of hire
    - must be certified as a prevention specialist within 18 months of hire.
- A staff person employed as the prevention supervisor or lead staff must be certified as a prevention specialist by a national or state organization approved by the Department by June 30, 2020.

EVALUATION OF JOB PERFORMANCE

Written evaluation of job performance with each staff person will happen at least annually. The evaluation shall include the opportunity for the staff person to comment.

PERSONNEL RECORDS

Personnel record on each staff person will be maintained. The record shall contain:

- Verification of training, experience, qualifications, and professional credentials
- Job performance evaluations
- Incident reports
- Disciplinary action taken
- Documentation of review and agreement to adhere to confidentiality laws and regulations

This review and agreement shall occur prior to the staff person's assumption of duties.

Personnel policies and procedures shall ensure confidentiality of personnel records and shall specify the staff authorized to have access to personnel information.

Notification will be made in writing within 10 days of being informed that a staff person has been sanctioned or disciplined by a certifying body. Such notice shall include the sanction or discipline order.

CHILD ABUSE, DEPENDENT ADULT ABUSE, AND CRIMINAL BACKGROUND CHECKS

BASED ON IAC 155.21(9)

Policies and procedures shall address child abuse, dependent adult abuse, and criminal background checks.

- Any mistreatment, neglect, or abuse of children and dependent adults is prohibited and shall be reported, and enforcement procedures shall be enacted.
- Alleged violations shall be reported immediately to the contractor's executive director and appropriate Department of Human Services personnel.
- Policies and procedures on reporting alleged violations shall be in compliance with subrule 155.21(10).
- A staff person found to be in violation of Iowa Code sections 232.67 through 232.70, as substantiated by a Department of Human Services investigation, shall be subject to the contractor's policies concerning termination.

SERVICE RECORDS

BASED ON IAC 155.21(10)

Policies and procedures shall describe compilation, storage, and dissemination of service records.

QUALITY IMPROVEMENT

BASED ON IAC 155.21(20)

Policies and procedures shall describe a written quality-improvement plan that encompasses all prevention services and related contractor operations.

SAFETY

BASED ON IAC 155.21(21)

Policies and procedures shall ensure that physical facilities are clean and safe.

- A written plan will be in place and will be followed in the event of fire or tornado.
- The plan shall be conspicuously displayed at the contractor's facility.

Conclusion

Substance misuse and/or problem gambling are concerning issues that impact many Iowans. The foundational concepts in the Prevention Guide were created to ensure that the prevention work implemented is data driven, evidence-based, and completed with the full engagement of Iowa communities. It is through this approach that we can see successful change that leads to healthy Iowans. Thank you for your hard work and dedication to the field of prevention.

Please visit Appendix G: Frequently Asked Questions and Appendix I: Glossary of Terms and Acronyms to learn more.

Appendices

Appendix A

Application Handbook

For

CERTIFIED & ADVANCED CERTIFIED

PREVENTION SPECIALISTS

(CPS and ACPS)

July 2017

Iowa Board of Certification

225 NW School St. ~ Ankeny, Iowa 50023
Telephone: 515.965.5509 ~ Fax: 515.965.5540
E-Mail: **info@iowabc.org** ~ www.iowabc.org

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IBC OVERVIEW

IBC Mission

The Iowa Board of Certification credentials prevention and treatment professionals in addictions and other behavioral health fields by promoting adherence to competency and ethical standards.

Residency Requirement: The applicant must physically live and/or work in Iowa at least 51% of the time at the time of application for initial certification, recertification or reactivation.

CERTIFICATION PURPOSE

The establishment of standards and a system of voluntary professional certification assures the opportunity for continued growth and development for prevention specialists in the substance abuse field. The purpose of the prevention certification process is:

1. To promote credibility of prevention professionals.
2. To assure the public of a minimal level of competency in prevention services.
3. To promote the delivery of competent, professional prevention services.
4. To establish a recognized credential of professional competency, which allows for national reciprocity.
5. To establish guidelines for new prevention specialists.
6. To promote continued professional development for the prevention specialist.

GENERAL INFORMATION

1. FEES

See attached Fee Schedule.

2. DEFINITIONS

Prevention: A proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles by reducing risks contributing to alcohol, tobacco, and other drug misuse and related issues.

Prevention Specialist: A professional who uses a specialized set of knowledge, experience, training and skills to encourage healthy attitudes and behaviors which prevent the abuse of alcohol, tobacco and other drugs. The role of the prevention specialist, as defined by the five Prevention Performance Domains, is to empower individuals and communities to assess needs and to develop and implement strategies that effectively meet those needs.

3. GLOSSARY OF TERMS

Alcohol and Drug Specific: The history, uses, trends and pharmacology of stimulants, depressants, psychotherapeutic drugs, alcohol, tobacco and various other substances as well as the psychological, biological and social aspects of substance abuse. Appropriate intervention for preventing and treating substance abuse in special populations is also acceptable.

ATOD: Alcohol, Tobacco and Other Drugs

CEU: Literally means a "continuing education unit" and is synonymous with "clock hour."

CSAP: Center for Substance Abuse Prevention

Clock Hour: Sixty minutes of participation in an organized learning experience.

Continuing Education: The variety of forms of learning experiences including, but not limited to, lectures, conferences, academic studies, institutes, workshops, extension studies, and home study programs undertaken by applicants.

Date of Application: The date on which the Iowa Board of Certification receives the completed application.

Distance Learning: Education that is obtained via internet, home study programs, videos, or other means in which the Prevention Specialist works independently from an instructor and classroom.

Education/Professional Responsibility: Participation in appropriate training, educational opportunities and current literature review that allows one to provide effective prevention services.

Employment Experience: The actual work involving performance of the five Prevention Performance Domains of the prevention specialist. In addition to full-time employment, this may include a practicum, internship, or part-time prevention.

IBC-Approved: When a sponsor submits workshop materials to IBC demonstrating that a workshop has relevant content and requesting IBC CEUs for all participants.

In-Service Training: The education and training which occurs within the applicant's agency, only for agency staff and conducted only by agency staff.

Performance Domain: These domains outline the knowledge and skills a prevention specialist needs to perform their job successfully.

Portfolio: Documentation of experience, education and professional responsibility on IBC forms.

Prevention Ethics: Moral and ethical conduct as described in the IBC Code of Ethics. Ethics courses are offered specifically for Prevention Specialists and must be IBC-approved.

Racial/Ethnic: Covers training including, but not limited to, the following categories: American Indian/Alaskan Native, Asian, African American, Native Hawaiian/Pacific Islander, and Hispanic/Latino.

Recipient: Any person who seeks or receives the services of a prevention specialist.

Reciprocity: A mutual or cooperative interchange of certification standards among IC&RC member boards.

Research/Science Based: A program that has met identified criteria and has been subject to rigorous evaluation that has proven its effectiveness.

Special Populations: Substance abuse training in working with recipients from various populations who are unique in their needs. The groups that are protected from discrimination (such as age, race, creed, gender, economic status) as well as sexual orientation and the criminal justice population will be considered Special Populations.

Substance Abuse: An addiction or dependency, either physical or psychological, to a chemical substance (alcohol as defined in the Code of Iowa, Chapter 123 and drugs as defined in the Code of Iowa, Section 203A.2, subsection 3).

4. INTERNATIONAL CERTIFICATION AND RECIPROCITY CONSORTIUM

The International Certification & Reciprocity Consortium (IC&RC), Alcohol and Other Drug Abuse Inc., exists to be the leader in the development of credentialed professionals. Its mission is to establish, monitor, and advance reciprocal competency standards for credentialing of professionals engaged in prevention and treatment of substance use disorders and related problems.

The Iowa Board of Certification has partnered with the IC&RC to offer reciprocity to both prevention and treatment professionals and in doing so has adopted the standards set forth by the consortium.

The CPS credential is reciprocal with IC&RC so long as the Prevention Specialist/Advanced Prevention Specialist has passed the IC&RC exam. The ACPS (Advanced) credential is NOT reciprocal at an advanced level with IC&RC, however it would be considered reciprocal as a CPS.

PERFORMANCE DOMAINS

IC&RC standards fall into six Performance Domains, each containing a series of tasks related to the role of the prevention specialist. Each task is further defined by a set of knowledge and skill areas that a prevention specialist must have and practice in order to effectively perform his/her job. In order to assist you, not only in the certification process, but in more thoroughly understanding your role as a prevention specialist, the IC&RC Performance Domains are summarized below.

Domain I – Planning and Evaluation (weight on exam: 30%)

- Determine the level of community readiness for change
- Identify appropriated methods to gather relevant data for prevention planning
- Identify existing resources available to address the community needs
- Identify gaps in resources based on the assessment of community conditions
- Identify the target audience
- Identify factors that place persons in the target audience at greater risk for the identified problem
- Identify factors that provide protection or resilience for the target audience
- Determine priorities based on comprehensive community assessment
- Develop a prevention plan based on research and theory that addresses community needs and desired outcomes
- Select prevention strategies, programs and best practices to meet the identified needs of the community
- Implement a strategic planning process that results in the development and implementation of a quality strategic plan
- Identify appropriate prevention program evaluation strategies
- Administer surveys/pre/posttests at work plan activities
- Conduct evaluation activities to document program fidelity
- Collect evaluation documentation for process and outcome measures
- Evaluate activities and identify opportunities to improve outcomes
- Utilize evaluation to enhance sustainability of prevention activities
- Provide applicable workgroups with prevention information and other support to meet prevention outcomes
- Incorporate cultural responsiveness into all planning and evaluation activities
- Prepare and maintain reports, records and documents pertaining to funding sources

Domain II – Prevention Education and Service Delivery (weight on exam: 15%)

- Coordinate prevention activities
- Implement prevention education and skill development activities appropriate for the target audience
- Provide prevention education and skill development programs that contain accurate, relevant and timely content
- Maintain program fidelity when implementing evidence-based practices
- Serve as a resource to community members and organizations regarding prevention strategies and best practices

Domain III – Communication (weight on exam: 13%)

- Promote programs, services, activities and maintain good public relations
- Participate in public awareness campaigns and projects relating to health promotion across the continuum of care
- Identify marketing techniques for prevention programs
- Apply principles of effective listening
- Apply principles of public speaking
- Employ effective facilitation skills
- Communicate effectively with various audiences
- Demonstrate interpersonal communication competency

Domain IV – Community Organization (weight on exam: 15%)

- Identify the community demographics and norms
- Identify a diverse group of stakeholders to include in prevention programming activities
- Build community ownership of prevention programs by collaborating with stakeholders when planning, implementing, and evaluating prevention activities
- Offer guidance to stakeholders and community members in mobilizing for community change
- Participate in creating and sustaining community-based coalitions
- Develop or assist in developing content and materials for meetings and other related activities
- Develop strategic alliances with other service providers within the community
- Develop collaborative agreements with other service providers within the community
- Participate in behavioral health planning and activities

Domain V – Public Policy and Environmental Change (weight on exam: 12%)

- Provide resources, trainings, and consultations that promote environmental change
- Participate in enforcement initiatives to affect environmental change
- Participate in public policy development to affect environmental change
- Use media strategies to support policy change efforts in the community
- Collaborate with various community groups to develop and strengthen effective policy
- Advocate to bring about policy and/or environmental change

Domain VI – Professional Growth and Responsibility (weight on exam: 15%)

- Demonstrate knowledge of current prevention theory and practice
- Adhere to all legal, professional and ethical principles
- Demonstrate cultural responsiveness as a prevention professional
- Demonstrate self-care consistent with prevention messages
- Recognize importance of participation in professional associations locally, statewide, and nationally
- Demonstrate responsible and ethical use of public and private funds
- Advocate for health promotion across the life span
- Advocate for healthy and safe communities
- Demonstrate knowledge of current issues of addiction
- Demonstrate knowledge of current issues of mental, emotional and behavioral health

HOW TO CERTIFY AS A PREVENTION SPECIALIST

CERTIFICATION REQUIREMENTS FOR CPS

A. Experience

2000 clock hours of supervised experience in performing the Prevention Performance Domains of the Prevention Specialist.

- Document this according to instructions on Form 05-PS, "Professional Experience Resume."
- You must document 120 hours specific to the IC&RC Prevention Domains with a minimum of 10 hours in each domain. Document these hours according to instructions on Form 06-PS, "Documentation of IC&RC Prevention Domain Experience."

B. Education/Professional Responsibility

Professional responsibility means practicing ethical behavior, attaining knowledge in current research, recognizing cultural diversity, and modeling healthy behaviors.

A minimum of 120 hours of prevention specific education, including:

- Successful completion of the "Substance Abuse Prevention Specialist Training" (if this course is not available in the time frame necessary, contact the IBC office)
- 6 clock hours in an IBC-approved prevention ethics course
- 6 clock hours of training in special populations
- 3 clock hours of training in racial/ethnic
- 50 clock hours of training in ATOD specific training

Some of these clock hours may come from your college transcripts if the course content is applicable. Documentation of this will be according to instructions on Form 04-PS, "Educational Clock Hour Documentation."

<u>Degree Requirement</u>:

- Bachelor's Degree, or
- Associate of Arts Degree and an additional 35 clock hours of prevention-related training, or
- High School Diploma or GED, and an additional 48 clock hours of prevention-related training.

Documentation of these hours will be according to instructions on Form 03-PS, "Education Resume."

CERTIFICATION REQUIREMENTS FOR ADVANCED CPS (ACPS)

For Prevention Specialists with a Bachelor's degree and more specialized education/ experience, the Advanced CPS credential may be preferred. IC&RC does not have an Advanced Prevention Specialist credential, so ACPS's in Iowa who have taken the IC&RC exam will be reciprocal through IC&RC at the CPS level.

Current CPS's may opt to upgrade to the ACPS by completing the ACPS Upgrade application found on the IBC website. New ACPS applicants need to complete the full ACPS application.

The applicable application for ACPS must be completed and needs to verify the following:

A. Experience

6000 clock hours (3 years full time) of supervised experience in performing the Prevention Performance Domains of the Prevention Specialist.

- Document this according to instructions on Form 05-ACPS, "Professional Experience Resume."
- You must document 120 hours specific to the IC&RC Prevention Domains with a minimum of 10 hours in each domain. Document these hours according to instructions on Form 06-ACPS, "Documentation of IC&RC Prevention Domain Experience."

B. Education/Professional Responsibility

Professional responsibility means practicing ethical behavior, attaining knowledge in current research, recognizing cultural diversity, and modeling healthy behaviors.

A minimum of 120 hours of prevention specific education as indicated for CPS. **In addition**, successful completion of 24 additional training/education hours as follows:

- 3 clock hours in use of technology in prevention (i.e. social media, website support, etc.)
- 3 clock hours in prevention applicable Ethics (in addition to the 6 hours in Prevention Ethics required for CPS)
- 6 clock hours in the Identification and Treatment of Substance Use Disorders (including SBIRT specific training)
- 3 clock hours in Stages of Change and Readiness
- 3 clock hours in Trauma Informed Care and ACES
- 6 clock hours in Coordination of Care (mental health/primary health issues related to substance abuse prevention)

Documentation of this will be according to instructions on Form 04-ACPS, "Educational Clock Hour Documentation."You can find a list of suggested online trainings in the instructional letter included with the application.

A minimum of a Bachelor's Degree is required.

C. Additional Requirements

The application process will include:

- Demonstration of experience providing a minimum of five advanced level prevention services (Form 08-ACPS)

- A narrative demonstrating understanding of (Form 09-ACPS):
  - Personal professional prevention philosophy
  - Resiliency and Recovery Oriented Systems of Care (RROSC)
  - The importance of the SPF and why it's a good way to do business
  - Continuum of care
  - Mental/physical/primary health integration with substance abuse prevention
  - Quality improvement implementation
  - Integration of cultural competency/responsiveness into programming
  - Collaboration with other prevention partners

- Three letters of recommendation from community partners (one can be a supervisor) confirming advanced work, collaboration on planning and implementation, and skill sets represented by applicant

- New applicants, as well as and current CPS's who have not taken the IC&RC exam, need to pass IC&RC's CPS exam. Current certified prevention specialists who have already taken this exam will not be required to test.

HOW TO APPLY

1. General

- **Read the ENTIRE Application Handbook, and contact all colleges/ universities you've attended to request that they forward an original transcript to the IBC office via U.S. Mail.**

- **For new Applicants: Complete the application** which can be found on the IBC website. The application should be completed online, saved to your computer, then printed and mailed to the IBC office with the non-refundable fee of $380.00 (this covers the application review, one exam and the first two years of certification), copies of certificates of completion and an official written job description. If the applicant does not pass the exam the first time, the test fee will be required for each subsequent exam. Applicants should retain a copy of their application. ***The application and its forms will expire one year from the date any portion of the application is received in the IBC office.***

- **For Applicants upgrading to ACPS**: Complete the upgrade application which can be found on the IBC website. The application should be completed online, saved to your computer, then printed and mailed to

the IBC office with the non-refundable application review fee. If you have not passed the IC&RC written/computer exam, include the test fee with your application. Once reviewed, IBC will contact you with next steps. ***The application and its forms will expire one year from the date any portion of the application is received in the IBC office.***

- **Checklist.** Verify the completeness of your application by reviewing the checklist on pages 27-28.

- When the application is received, the IBC office will notify the applicant to let them know if anything further is needed; if the application is complete, the applicant will be pre-registered for the exam.

- Questions? Contact the IBC office at 515-965-5509 or email at info@iowabc.org.

2. Exam

New applicants for CPS or ACPS will take the IC&RC national prevention (PS) test. The test covers information from the full description of domains. Free study guides are available on the IBC website.

The test consists of 150 multiple-choice questions and is focused on the five domains. Exam scores are accessed weekly and applicants are then notified of their exam score. Exams may be taken every 90 days.

Current CPS's upgrading to ACPS do not need to take the exam.

Should a candidate fail to pass the exam after 4 tries, a Remedial Action Plan is in place and must be met before the candidate can test for a 5th time:

- The candidate will need to develop a work plan with a certified mentor/supervisor who holds the same credential (or higher) that the candidate is applying for. This plan will need to be signed by both the candidate and the mentor/supervisor and will be sent to the IBC office. The work plan will include:
  1. Documented direct supervision by the mentor/supervisor for at least 4 hours of supervision with a minimum of one hour supervision per Domain.
  2. 12 hours of continuing education with at least 3 hours per Domain. These hours may come from either in-person or online trainings, and must be mentor/supervisor approved.

Before the candidate will be allowed to test for a 5th time, the candidate will need to send to IBC certificates of completion for the 12 hours of training attended as well as a signed narrative by their mentor/supervisor which will describe the hours spent in supervision and topics discussed/supervised.

CERTIFICATION APPEAL PROCEDURES

A. Appeal of the Denial for Certification

Every applicant shall be provided the opportunity to appeal the decision of the Board regarding the applicant's certification to the Committee on Ethics and Appeals.

If the applicant desires to appeal the decision of the Board regarding certification, the applicant shall send a written request for an appeal review meeting within thirty (30) days of receipt of the certified notice of denial of certification. The response shall be addressed to:

Iowa Board of Certification
225 NW School St.
Ankeny, IA 50023

B. Appeal Review Meeting

An appeal review meeting shall be held at a time and place fixed by the chairperson of the Committee on Ethics and Appeals.

a. All appeal review meetings of the Committee on Ethics and Appeals shall be closed to the public. Only committee members, those invited by the committee to testify including the applicant, or staff members shall be in attendance.
b. There shall be no contact prior to the appeal review meeting between the applicant and any member of the Committee on Ethics and Appeals for the purpose of discussing the appeal.
c. The Committee on Ethics and Appeals shall review with the applicant the reasons for denial of certification and the applicant may present any information he or she feels is relevant.
d. In making a decision on the validity of the appeal, the Committee on Ethics and Appeals shall consider only materials contained in the application as submitted and reviewed by IBC staff and the test score. The Committee on Ethics and Appeals may not consider additional materials presented by the applicant for the purposes of correcting deficiencies in the application.
e. If an applicant who has requested an appeal review meeting, and upon whom proper notice of the meeting has been served, fails to appear for the meeting, the Committee shall proceed with the review and the applicant shall be bound by the results to the same extent as if the applicant had been present.
f. The Board shall, at its next regular scheduled meeting, vote to accept or reject the recommendations of the Committee on Ethics and Appeals.
g. The applicant shall be notified by certified mail within two weeks of the decision of the Board concerning the appeal.

CERTIFICATION PERIOD. The Iowa certification period encompasses two calendar years, commencing from the first day of the month which follows approval

by the Iowa Board of Certification. Dates of validation are printed on the prevention specialist's certificate.

DUAL CERTIFICATION. To support those substance abuse professionals who wish to pursue more than one IBC credential, the certification fee of both credentials shall be discounted 25%.

This policy refers to IBC credentials only. CAPS National/state credentials do not apply.

CODE OF ETHICS FOR PREVENTION SPECIALISTS

Glossary of Terms

Board: The Iowa Board of Certification.

Client: A person who seeks or is assigned the services of a practitioner or counselor, regardless of the setting in which the practitioner or counselor works.

Complainant: A person who has filed an official complaint pursuant to these rules.

Disciplinary Proceeding: Any proceeding conducted under the authority of the Board.

Discipline: Any sanction of the Board may impose upon a counselor or prevention specialist for conduct, which denies or threatens to deny the citizens of this state a high standard of professional care.

Hearing Panel: A panel, comprised of directors of the Board, which conducts a disciplinary proceeding pursuant to these rules.

Recipient: A person who seeks or receives the services of a prevention specialist.

Reprimand: A formal written warning.

Respondent: Any individual charged in an official complaint with a violation of professional ethics.

Revocation: The permanent loss of certification.

Suspension: A time-limited loss of certification or of the privilege of making application for certification.

INTRODUCTION

All prevention specialists must subscribe to the IBC Code of Ethics upon application for certification. The principles of ethics are models of exemplary professional behavior. These principles of the Prevention Think Tank Code express prevention professionals' recognition of responsibilities to the public, to service recipients, and to colleagues within and outside of the prevention field. They guide prevention professionals in the performance of their professional responsibilities and express the basic tenets of ethical and professional conduct. The principles call for honorable behavior, even at the sacrifice of personal advantage. These principles should not be regarded as limitations or restrictions, but as goals toward which prevention professionals should constantly strive. They are guided by core values and competencies that have emerged with the development of the prevention field.

Violation of the IBC Code of Ethics shall be determined as grounds for discipline. Engaging in unethical conduct includes, in addition to violation of the Principles enumerated herein, any other violation which is harmful or detrimental to the profession or to the public.

SPECIFIC PRINCIPLES

Principle 1: Non-discrimination

A prevention specialist shall not discriminate against service recipients or colleagues based on race, religion, national origin, sex, age, sexual orientation, sexual identity, economic condition or physical, medical or mental disability. A prevention specialist should broaden his or her understanding and acceptance of cultural and individual differences, and in so doing render services and provide information sensitive to those differences.

Prevention specialists shall be knowledgeable about disabling conditions, demonstrate empathy and personal emotional comfort in interactions with participants with disabilities, and make available physical, sensory, and cognitive accommodations that allow individuals with disabilities to receive services. Prevention specialists should comply with all local, state and Federal laws regarding the accommodation of individuals with disabilities.

Principle 2: Competency

Prevention specialists shall master their prevention specialty's body of knowledge and skill competencies, strive continually to improve personal proficiency and quality of service delivery, and discharge professional responsibility to the best of their ability. Competence includes a synthesis of education and experience combined with an understanding of the cultures within which prevention application occurs. The maintenance of competence requires continual learning and professional improvement throughout one's career.

Incompetence includes but is not limited to a substantial lack of knowledge or ability to discharge professional obligations within the scope of the prevention profession, or a substantial deviation from the standards of skill ordinarily possessed and applied by professional peers acting in the same or similar circumstances.

A. Professionals should be diligent in discharging responsibilities. Diligence imposes the responsibility to render services carefully and promptly, to be thorough, and to observe applicable technical and ethical standards.

B. Due care requires a professional to plan and supervise adequately and evaluate to the extent possible any professional activity for which he or she is responsible.

C. A prevention specialist should recognize limitations and boundaries of competencies and not use techniques or offer services outside of his or her competencies. Each professional is responsible for assessing the adequacy

of his or her own competence for the responsibility to be assumed. When asked to perform such services, a prevention specialist shall, to the best of their ability, refer to an appropriately qualified professional. When no such professional exists, a prevention specialist shall clearly notify the requesting person/organization of the gap in services available.

D. Ideally prevention specialists should be supervised by competent senior prevention specialists. When this is not possible, prevention specialists should seek peer supervision or mentoring from other competent prevention specialists.

E. When a prevention specialist has knowledge of unethical conduct or practice on the part of an agency or prevention specialist, he or she has an ethical responsibility to report the conduct or practices to funding, regulatory or other appropriate bodies.

F. A prevention specialist should recognize the effect of impairment on professional performance and should be willing to seek appropriate professional assistance for any form of substance misuse, psychological impairment, emotional distress, or any other physical related adversity that interferes with their professional functioning.

G. Prevention specialists do not permit students, employees, or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience and competence.

H. Prevention specialists who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations, and constructive consultation.

Principle 3: Integrity

To maintain and broaden public confidence, prevention specialists should perform all responsibilities with the highest sense of integrity. Personal gain and advantage should not subordinate service and the public trust. Integrity can accommodate the inadvertent error and the honest difference of opinion. It *cannot* accommodate deceit or subordination of principle.

A. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements.

B. Prevention specialists should not misrepresent either directly or by implication professional qualifications or affiliations.

C. Where there is evidence of impairment in a colleague or a service recipient, a prevention specialist should be supportive of assistance or treatment.

D. Prevention specialists should not be associated directly or indirectly with any service, products, individuals, and organizations in a way that is misleading.

E. Prevention specialists should demonstrate integrity through dutiful cooperation in the ethics process of their certifying authority.

1. Prevention specialists must cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.
2. Grounds for discipline include failing to cooperate with an investigation by interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representatives; by use of threats or harassment against any participant to prevent them from providing evidence in a disciplinary proceeding or any person to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted or completed; failing to cooperate with a board investigation in any material respect.
3. Applicants for prevention certification are required to report any previous ethical violations from other disciplines or jurisdictions during the application process. The Ethics Committee is responsible for making a recommendation concerning the application. The applicant is responsible for providing any additional information needed to make a determination on the application.
4. If a prevention specialist is cited for an ethical violation from another discipline or jurisdiction, they must immediately report the violation to their certifying authority.
5. As employees or members of organizations, prevention specialists shall refuse to participate in an employer's practices which are inconsistent with the ethical standards enumerated in this Code.

F. Prevention specialists shall not engage in conduct which does not meet the generally accepted standards of practice for the prevention profession including, but not limited to, incompetence, negligence or malpractice.

1. Falsifying, amending or making incorrect essential entries or failing to make essential entries of services provided.
2. Acting in such a manner as to present a danger to public health or safety, or to any participant including, but not limited to, impaired behavior, incompetence, negligence or malpractice, such as:
    a. Failing to comply with a term, condition or limitation on a certification or license.
    b. Suspension, revocation, probation or other restrictions on any professional certification or licensure imposed by any state or jurisdiction, unless such action has been satisfied and/or reversed.
    c. Administering to oneself any controlled substance not prescribed by a doctor, or aiding and abetting another person in the use of any controlled substance not prescribed to that person.

d. Using any drug or alcoholic beverage to the extent or in such manner as to be dangerous or injurious to self or others, or to the extent that such use impairs the ability of such person to safely provide professional services.
e. Using drugs while providing professional services.

G. Prevention specialists make financial arrangements for services with service recipients and third-party payers that are reasonably understandable and conform to accepted professional practices. Prevention specialists:
1. Do not offer, give or receive commissions, rebates or other forms of remuneration for the referral of program participants.
2. Do not charge excessive fees for services.
3. Disclose any fees to participants at the beginning of services.
4. Do not enter into personal financial arrangements with direct program recipients.
5. Represent facts truthfully to participants and funders
6. Do not personally accept a private fee or any other gift or gratuity for professional work.

H. Prevention specialists uphold the law and have high morals in both professional and personal conduct. Grounds for discipline include, but are not limited to, conviction of any felony or misdemeanor during the period in which a prevention specialist holds a prevention certification, excluding minor traffic offenses, whether or not the case is pending an appeal.

Principle 4: Nature of Services

Practices shall do no harm to service recipients. Services provided by prevention specialists shall be respectful and non-exploitive.

A. Services should be provided in a way which preserves the protective factors inherent in each culture and individual.

B. Prevention specialists should use formal and informal structures to receive and incorporate input from service recipients in the development, implementation and evaluation of prevention services.

C. Where there is suspicion of abuse of children or vulnerable adults, the prevention specialist shall report the evidence to the appropriate agency and follow up to ensure that appropriate action has been taken.

D. Prevention specialists should adhere to the same principles of professionalism outlined in the Prevention Code of Ethics online as they would offline. With this in mind, the following are additional guidelines regarding the use of technology:
1. Prevention specialists are discouraged from interacting with current or past direct program participants on personal social networking sites. It is recommended that prevention specialists establish a professional social networking site for this purpose.

a. Prevention specialists should not affiliate with their own direct program recipients on personal social media sites.
b. Prevention specialists use professional and ethical judgment when including photos and/or comments online or in prevention materials.
c. Prevention specialists should not provide their personal contact information to direct program recipients, i.e. home/personal cell phone number, personal email, social media accounts, etc. nor engage in communication with direct program participants through these mediums except in cases of agency/professional business

2. It is the responsibility of the prevention specialist to ensure, to the best of his or her ability, that professional networks used for sharing confidential information are secure and that only verified and registered users have access to the information.
3. Prevention specialists should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. When posting content online, they should always remember that they are representing the prevention field, their organization and their community, and so should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. It is recommended that employees not identify themselves as connected to their agency on their personal website.
4. Employees should be aware that employers may reserve the right to edit, modify, delete, or review Internet communications and that writers assume all risks related to the security, privacy and confidentiality of their posts. When moderating any website, the prevention specialist should delete inaccurate information or other's posts that violate the privacy and confidentiality of participants or that are of an unprofessional nature.
5. Prevention specialists should refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.

E. Prevention Specialists must be aware of their influential position with respect to employees, supervisees, and direct program recipients, and they avoid exploiting the trust and dependency of such persons. Prevention specialists, therefore, make every effort to avoid dual relationships with prevention participants that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, Prevention Specialists take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with direct prevention recipients, their family members, employees or supervisees.

1. Soliciting and/or engaging in sexual conduct with direct prevention participants are prohibited.
2. Prevention specialists should avoid any action or activity that would indicate a dual relationship and transgress the boundaries of a professional relationship (e.g. developing a friendship with a program participant, socializing with participants, accepting or requesting services from a participant, providing "informal counseling" to a participant.)
3. Prevention specialists should not assume dual roles in a setting that could compromise the relationship with or confidentiality of participants (e.g. providing a skills group for students engaging in risky substance use behaviors, an "indicated population," and also teaching an academic subject where they are class members.)
4. Prevention specialists avoid bringing personal issues into the professional relationship. Through an awareness of the impact of stereotyping and discrimination, the prevention specialist guards the individual rights and personal dignity of participants.

F. Prevention specialists make reasonable arrangements for the continuation of prevention services when transitioning to a new position or no longer able to provide that service.

G. Prevention specialists should obtain written, informed consent from participants and/or parents/guardians for those under the age of 18 before photographing, videotaping, audio recording, or permitting third-party observations.

Principle 5: Confidentiality

Confidential information acquired during service delivery shall be safe guarded from disclosure, including – but not limited to – verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Prevention specialists are responsible for knowing the confidentiality regulations relevant to their prevention specialty.

Prevention specialists make appropriate provisions for the maintenance of confidentiality and the ultimate disposition of confidential records. Prevention specialists ensure that data obtained including program evaluation data and any form of electronic communication, are secured by the available security methodology. Data shall be limited to information that is necessary to and appropriate to the services being provided and be accessible only to appropriate personnel. Data presented publically shall be distributed only in ways that protects the confidentiality of individual participants.

Principle 6: Ethical Obligations for Community and Society

According to their consciences, prevention specialists should be proactive on public policy and legislative issues. The public welfare and the individual's right to services

and personal wellness should guide the efforts of prevention specialists to educate the general public and policy makers. Prevention specialists should adopt a personal and professional stance that promotes health.

Prevention Specialists should be aware of their local and national regulations regarding lobbying and advocacy, and act within the laws and funding guidelines.

Subscription to Code of Ethics

The applicant must subscribe to the Iowa Board of Certification's Code of Ethics for Prevention Specialists and so indicate by completing Form 02-PS.

1. Investigation and Hearing Procedures

Investigation of Allegations. The Committee on Ethics and Appeals, upon receipt of an official complaint or upon its own motion pursuant to other evidence received by the Board of the Committee, shall review and investigate alleged acts or omissions which the committee believes constitute cause for discipline.

a. The voluntary surrendering of certification will not excuse a certified prevention specialist from being investigated or disciplined for an ethics violation.
b. The chairperson of the Committee on Ethics and Appeals, or a committee or staff member designated by the chairperson, shall investigate the allegations of the complaint by contacting the party or parties involved and obtaining information in any other appropriate manner which will provide documentation upon which a decision for order of hearing may be based.
c. Both the respondent and the complainant shall be furnished with information concerning the investigation of the complaint and shall be given the opportunity to informally present a position concerning the allegations of the complaint. This position may be submitted either in writing or through personal conference with the committee investigator.
d. The identity of the complainant shall be revealed to the respondent unless circumstances govern the identity remain undisclosed. The Committee on Ethics and Appeals will determine the special circumstances.
e. The committee investigator shall make a written report to the Committee on Ethics and Appeals as to whether there is probable cause for a disciplinary hearing.
f. The Committee on Ethics and Appeals shall review the report of the investigator and make a determination to either:
    - Recommend to the President of the Board that a disciplinary hearing be held;
    - Provide a written response to the respondent and complainant explaining that no probable cause was found to recommend a disciplinary hearing; or

- Remand the matter to the investigator in order to obtain additional evidence sufficient upon which to base a decision.

g. Upon receipt of an internal complaint, any Board or committee member may make a recommendation for an internal investigation. The investigation shall follow the procedures (A-D) listed above. The investigator shall submit a written report to the Board. The Board will then determine a dismissal of the internal complaint or any disciplinary sanctions.

Order for Hearing. Upon recommendation of the Committee on Ethics and Appeals, the President shall issue an order fixing a time and a place for an ethics hearing and shall appoint a hearing panel for the proceeding.

a. The hearing panel shall be comprised of three directors of the Board, excluding any member having a conflict of interest in the matter. At least one of the three members of the hearing panel shall be certified.
b. A written notice shall be sent by certified mail to both the complainant and the respondent at least 21 days prior to the hearing.
c. The notice of the hearing shall state:
    - The date, time, and location of the hearing;
    - The respondent may, at his or her expense, be represented by legal counsel at the hearing; and
    - The rules by which the hearing shall be governed.

Conduct of Hearing. The hearing shall be conducted in compliance with the following rules:

a. The hearing shall be conducted by the person designated by the President.
b. The chairperson of the Committee on Ethics and Appeals, or a representative designated by the Committee on Ethics and Appeals, shall present information regarding the complaint before the hearing panel. The complainant and the respondent shall be allowed the opportunity to participate in the hearing. Witnesses will be called when appropriate. However, witnesses shall only be present in the hearing during their testimony.
c. The hearing panel shall not be bound by common law or statutory rules of evidence, and may consider all evidence having probative value.
d. No discovery shall be permitted and no access to Board files shall be allowed by either the complainant or the respondent.
e. There shall be no contact prior to the hearing between either the complainant or the respondent and any member of the hearing panel or director of the Board for the purpose of discussing the complaint. The Executive Director may act as a source of general information.
f. The members of the hearing panel shall have the right to ask questions to obtain the information necessary to make an accurate determination of the facts of the case.
g. The decision of the hearing panel shall be based solely upon the testimony and information presented at the hearing, in addition to information received during the investigation.

h. The hearing shall be closed to the public, unless otherwise specified in the original notice. Board members and committee members who are not serving in an official capacity during the hearing shall not be present unless both the complainant and the respondent agree to such circumstances.
i. A member of the IBC staff shall be responsible for record keeping at the hearing.
j. The hearing shall be recorded.

Failure by Respondent to Appear. If a respondent, upon whom proper notice of hearing has been served, fails to appear either in person or represented by counsel at the hearing, the respondent shall be bound by the results of the hearing to the same extent as if the respondent had been present.

Right to Waive Hearing. At any time during the ethics investigation process, a respondent has the right to waive an ethics hearing. In so doing, the respondent accepts the allegations of an ethics violation(s) as correct. At its next scheduled regular meeting, the Board shall determine any disciplinary sanctions, the decision of the Board shall be final.

Deliberation of the Hearing Panel. Once the chairperson of the Committee on Ethics and Appeals or a representative designee has presented the case information, the complainant and the respondent have had an opportunity to speak, and the hearing panel has asked any questions, the hearing panel will meet alone to discuss the facts. The complainant, respondent, chairperson of the Committee on Ethics and Appeals or a representative designee, witnesses, and other parties involved will remain in the area in the event the hearing panel needs additional clarification. A member of the IBC staff is permitted to be present during deliberation.

Decision of the Hearing Panel. The hearing panel shall make the determination regarding violation and disciplinary sanctions.

The hearing panel shall submit a written report to the IBC office which shall include:
a. A concise statement of the findings of fact;
b. A conclusion as to whether the specific Principles have been substantiated, unsubstantiated or unfounded; and
c. If the hearing panel concludes that a violation has occurred, the disciplinary sanction to be imposed.

Method of Discipline. The Board may impose the following disciplinary sanctions:
a. Revocation;
b. Suspension of certification or application privileges until further order of the Board or for a specified period of time;
c. Reprimand; or
d. Other sanctions which may be deemed appropriate by the Board.

Discretion of the Board. The following factors may be considered by the Board in determining the nature and severity of the disciplinary sanction to be imposed:

a. The relative seriousness of the violation as it relates to assuring the citizens of this state a high standard of professional service and care;
b. The facts of the particular violation;
c. Any extenuating circumstances or other counter-vailing considerations;
d. The number of complaints;
e. The seriousness of prior violations or complaints;
f. Whether remedial action has previously been taken; or
g. Other factors which may reflect upon the competency, ethical standards and professional conduct of the individual.

Announcement of Decision. At its next scheduled regular meeting, the Board shall be notified of the hearing panel's decision. The decision and the official hearing panel report shall be sent by certified mail to both the respondent and the complainant and include information on how an appeal may be requested. Each director of the Board shall also receive a copy of the decision.

Confidentiality. At no time prior to the release of the decision by the hearing panel shall any portion or the whole thereof of any action be made public or be distributed to any persons other than the directors of the Board, its Committee on Ethics and Appeals, and its staff.

Publication of Decisions. The decision in any disciplinary proceeding shall be published in whatever manner deemed appropriate by the Board. The employer, if any, shall be notified by certified mail of the final decision of the Board if a violation was found. IBC may report a disciplinary action against certified professionals to the Iowa Department of Public Health.

Reinstatement. An individual who has received a sanction for suspension of certification or of application privileges for certification may apply to the Board for reinstatement in accordance with the terms and conditions of the order of sanction.

a. If the order of sanction did not establish terms and conditions for reinstatement, an initial application for reinstatement may not be made until one year has lapsed from the date of the Board's final decision.
b. A request for reinstatement shall be initiated by the respondent. A letter of application for reinstatement shall present facts which, if established, will be sufficient to enable the Board to determine that the basis for sanction no longer exists.

Possible Consideration Following Revocation. It is recognized that there may be mitigating circumstances which could warrant granting permission to apply for certification following revocation.

a. Permission to apply for certification following revocation may be considered only after two years have lapsed from the date of the Board's final decision.
b. Permission to seek certification following revocation is granted solely within the discretion of the Board.

Notice of Right to Appeal. The respondent has the right to appeal the hearing panel's decision. The hearing panel shall provide notice to the respondent that he or she may file an appeal of the hearing panel's decision.

Filing of Appeal. Appeals must be postmarked or personally delivered to IBC within thirty (30) days of receiving the certified notice of the hearing panel's decision. Appeals shall be addressed to:

Iowa Board of Certification
225 NW School St.
Ankeny, IA 50023

Administrative Fee for Appeals. A non-refundable administrative fee must be submitted to IBC with the party's written appeal.

Content of Appeal. The appeal shall contain the following information.
a. Name, address, and telephone number of appealing party;
b. A written statement of the reasons supporting the appealing party's dissatisfaction with the hearing panel's decision;
c. A statement of the relief desired by the appealing party;
d. Copies of all relevant documents;
e. Signature of the appealing party.

Review and Adjudication of Appeal. The directors of the Board, excluding any member having a conflict of interest in the matter, will review the case within seventy-five (75) days of receipt of the request for appeal. The original hearing panel members may participate in the review with at least one member representing the hearing panel's decision.
The Board shall make the determination to do one of the following.
a. Uphold the decision of the hearing panel;
b. Overturn or otherwise alter the decision of the hearing panel; or
c. Recommend a new hearing.

Final Decision. If no request for an appeal is made within the required time frame stated above, the decision of the hearing panel shall be final. Once the appeal process is completed, the decision of the Board shall be final.

HOW TO RECERTIFY AS A PREVENTON SPECIALIST

Certification must be renewed every two years. Dates of validation are printed on the certificate. Recertification is a continuous process which involves earning continuing education credit on an ongoing basis, as well as submission of the recertification application.

Recertification applications can be found on IBC's website at www.iowabc.org, and may be completed online. In addition, certified professionals may check their recertification expiration date on the website. **Please note: it is the responsibility of the certified professional to keep track of recertification dates and to make timely application for recertification. Recertification reminders will not be sent.**

An application for recertification will include the following:

- Completion of both pages of the "Application for Recertification." This form can be found on the IBC website and needs to be completed online, saved to the applicant's computer then emailed (or mailed) to the IBC office.
- All continuing education hours must be completed within the validation dates shown on the certificate. While certificates of completion do not need to be included with the recertification application, it is advised that these be retained by the applicant in case the applicant's recertification is audited and the applicant is required to then send them to the IBC office.
- Submission of the recertification fee, as well as applicable CEU processing fees and the late penalty fee, if applicable. Fees may be paid by check, money order, cash at the IBC office or it may be paid on the IBC website via Dwolla.

Professional Development Requirements

Certified Prevention Specialists must obtain 40 clock hours of continuing education during the two-year certification period to qualify for recertification, and must meet the following criteria:

- Three (3) clock hours must be in ethics (moral conduct as described in the IBC Code of Ethics)
- The remaining hours must in training relevant to the position of a Prevention Specialist.

No more than 20 clock hours may be earned through distance learning.

There is a $15.00 CEU approval fee per workshop which is either not IBC approved or is obtained via distance learning which must be submitted to IBC at the time of recertification.

Up to 10 hours of credit may be obtained for in-service trainings which have been IBC-approved.

To receive college credit for clock hours a minimum grade of "C" is required. One semester hour equal fifteen (15) clock hours. One quarter hour equals ten (10) clock hours.

The required forty (40) clock hours may be obtained through a combination of pertinent courses, workshops and/or seminars. Accredited home study courses may be included.

Category A – Attending Formal Trainings
A minimum of 25 clock hours must be obtained through a combination of pertinent courses, workshops and/or seminars. Accredited home-study courses may be included.

Prevention Specialists will be assessed $15.00 per submitted workshop that has not been IBC approved or was taken online. The fee is not charged for college courses submitted for IBC credit. IBC approved training is listed on the website at www.iowabc.org.

Category B – Teaching Other Professionals
A maximum of 15 clock hours may be obtained in this category. The number of hours awarded will be equal to the number of hours spent in actual teaching time. For repeated workshop presentations offered by a Prevention Specialist as the presenter, a maximum of 15 clock hours may be received per certification period.

Category C – Participatory Learning Experiences/Community Involvement Prior approval is recommended. A maximum of 15 clock hours may be obtained in this category which includes documented credit for direct participation (i.e. public speaking or volunteering in a professional capacity) with substance abuse or community boards, committees, or task forces, as well as independent peer review. Volunteering as a parent, such as a teacher's assistant or Cub Scout leader, DOES NOT qualify for credit.

The intent of this category is to encourage Prevention Specialists to participate in the community in a professional capacity to promote the profession and the welfare of the public.

General Guidelines for Recertification

A. The content of all courses on continuing education must be relevant to the IC&RC Prevention Specialist Domains as listed in the Handbook.

B. The following is an example of continuing education that will NOT receive IBC credit:
   1. Parenting or other programs that are designed for lay people
   2. Living skills
   3. Orientation programs, meaning a specific series of activities designed to familiarize employees with the policies and procedures of an institution

C. Professional Development clock hours exclude non-program time such as coffee breaks, social hours, time allocated for meals, etc.

D. The 40 clock hours must be obtained within each certification period. Credit obtained prior to the date of submission of the last certification or recertification packet will not be accepted toward recertification.

E. Professional Development clock hours are not cumulative. Therefore, additional hours earned during one certification period will not be accepted for the next period.

F. One approved college or university semester hour credit is the equivalent of 15 clock hours, and one approved college or university quarter hour credit is the equivalent of 10 clock hours. **If using college hours, an original transcript must be sent from the college/university directly to the IBC office via U.S. Mail.**

G. One cannot repeat an identical Professional Development course within his or her recertification period.

H. The minimum acceptable unit of credit for any single experience is one clock hour.

I. It is the responsibility of each Prevention Specialist to maintain records of his/her Professional Development credit. IBC does not keep records of a Prevention Specialist's credits.

J. Recertification applications will be audited; if chosen for an audit, the applicant will be required to submit copies of his/her certificates of completion to the IBC office with 30 days of notification of audit.

Late Penalties

1. All applications for recertification must be emailed or postmarked on or before the date of expiration. A 45-day grace period following the certification expiration date is allowed, during which time the late fee will be due. If the Application for Recertification is not emailed/postmarked on or before the 45th day of the grace period, the certification shall expire.

2. During the probationary period of the certification, the Prevention Specialist may choose to do one of the following:
   a. Activate the certification by submitting the required documentation of Professional Development, the recertification fee and a late penalty fee of $50.00;
   b. Apply for voluntary inactive status, if applicable; or

c. Allow the certification to lapse. Certification will lapse on the 46th day. If certification is allowed to lapse, the Prevention Specialist may again apply for certification whenever he or she believes that the criteria can be met.

Continuing Education Definitions

Alcohol & Drug Specific: The history, uses, trends and pharmacology of stimulants, depressants, psychotherapeutic drugs, alcohol, tobacco and various other substances as well as the psychological and social aspects of substance abuse.

CEU: Literally means a "continuing education unit" and is synonymous with "clock hour."

Clock Hour: Sixty minutes of participation in an organized learning experience.

Continuing Education: The variety of forms of learning experiences including, but not limited to, lectures, conferences, academic studies, institutes, workshops, extension studies, and home study programs undertaken by applicants.

Distance Learning: Education that is obtained via internet, home study programs, videos, or other means in which the Prevention Specialist works independently from an instructor and classroom.

Ethics: Moral and ethical conduct as described in the IBC Code of Ethics.

IBC-Approved: When a sponsor submits workshop materials to IBC demonstrating that a workshop has relevant content and requesting IBC CEUs for all participants.

In-Service Training: The education and training which occurs within the applicant's agency, *only for* agency staff and conducted *only by* agency staff.

Racial/Ethnic: Covers training including, but not limited to, the following categories: American Indian/Alaskan Native, Asian, African American, Native Hawaiian/Pacific Islander, and Hispanic/Latino.

Relevant Content: Content relevant to the development and maintenance of current competency in the delivery of alcohol and drug prevention. Such course content may include but is not limited to, the Prevention Domains as defined in the Handbook.

Special Populations: Substance abuse training in working with recipients from various populations who are unique in their needs. The groups that are protected from discrimination (such as age, race, creed, gender, economic status) as well as sexual orientation and the criminal justice population will be considered Special Populations.

Sponsor: An organization or presenter seeking IBC hours for all participants at a specific workshop

Voluntary Inactive Status

The Iowa Board of Certification will grant inactive certification status under the following circumstances:

1. Behavior-Medical problems
2. Maternity, paternity or family
3. Education
4. Military service
5. Other valid reasons

Inactive certification status is intended for the Certified Prevention Specialist who is currently not working as a prevention specialist, yet plans to someday return to the prevention field.

Instructions. IBC certified individuals desiring inactive certification status shall send a letter of request to the IBC office which will include:

1. Current home address and telephone number.
2. Reason for request.
3. Final date of employment in the prevention field.
4. Anticipated date of return to employment in the prevention field.
5. Applicable fees.

Fees. The following fees must be remitted in order to obtain inactive certification status and reactivation of certification:

1. The enrollment fee of $25.00 (for the first year of inactive status).
2. The fee for inactive certification status is $60.00 annually. To maintain certification status, the fee shall be due annually on the inactive certification status expiration date.
3. The reactivation of certification fee is the same fee as for recertification.

Rights, Limitations and Responsibilities

1. While on inactive certification status, an individual shall continue to receive all bulletins, newsletters and other communications from IBC.
2. Inactive individuals are expected to subscribe to any of the aspects of the IBC Code of Ethics which are applicable during the period of inactive certification status.
3. The inactive individual may not use the initials of a certified prevention specialist.
4. Individuals on inactive status are not eligible for reciprocity.
5. The inactive individual must notify IBC immediately upon returning to work in the prevention field. Failure to notify the Board within thirty (30) days of returning to prevention employment will constitute a violation of the IBC Code of Ethics and will result in referral to the Board's Ethics and Appeals Committee for investigation, in accordance with the procedures outlined in the Code of Ethics.

Reactivation. To restore to active certification, the application for recertification must be submitted along with the applicable recertification fee.

RECIPROCITY

Iowa prevention specialists who are certified at the reciprocal level (those who have taken and passed the IC&RC exam) may apply for reciprocity to any certification board that is a member of the prevention credential with the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (IC&RC).

IC&RC does not have an Advanced Prevention Specialist credential, so ACPS's in Iowa who have taken the IC&RC exam will be reciprocal through IC&RC at the CPS level.

The reciprocity fee is made payable to the IC&RC. Applications for reciprocity can be found on IBC's web site, and shall be sent directly to the IBC.

Prevention boards that are currently members of the IC&RC are listed on their website, at www.icrcaoda.org.

Applicants for reciprocity should seek guidance on the process from the state in which they are credentialed. To obtain more information, please contact the IBC office.

CHECKLIST FOR CPS

The completed application for CPS sent to the Iowa Board of Certification needs to include the following:

____1. Form 01-PS “Applicant Information”

____2. Form 02-PS “Assurances and Release”

____3. Form 03-PS “Professional Experience”
(One form and job description for each relevant position)

____4. Form 04-PS “Education Clock Hour Documentation”
__ Substance Abuse Prevention Specialist Training (SAPST)
__ 6 hours Special Populations
__ 6 hours Prevention Ethics
__ 3 hours Racial/Ethnic
__ 50 hours ATOD Specific
__ Prevention Related Training

____5. Form 05-PS “Professional Responsibility Clock Hour Documentation”

____6. Form 06-PS “Education Resume”

____7. Form 07-PS “Applicant Statement”

____ 8. Original college transcript sent directly to IBC from institution via U.S. Mail (If applicable)

____ 9. Written job description

___10. Form 10-PS “Supervisor Evaluation”

___ 11. $380.00 non-refundable fee (covers application review, one exam and first two years of certification)

CHECKLIST FOR ACPS

The completed application for ACPS sent to the Iowa Board of Certification needs to include the following:

____1. Form 01-ACPS "Applicant Information"

____2. Form 02-ACPS "Assurances and Release"

____3. Form 03-ACPS "Education/Professional Experience"
(One form and job description for each relevant position)

____4. Form 04-ACPS "Education Clock Hour Documentation"
- __ Substance Abuse Prevention Specialist Training (SAPST)
- __ 6 hours Special Populations
- __ 6 hours Prevention Ethics
- __ 3 hours Racial/Ethnic
- __ 50 hours ATOD Specific
- __ Prevention Related Training
- __ 3 clock hours in use of technology in prevention (i.e. social media, website support, etc.)
- __ 3 clock hours in prevention applicable Ethics (in addition to the 6 hours in Prevention Ethics required for CPS)
- __ 6 clock hours in the Identification and Treatment of Substance Use Disorders (including SBIRT specific training)
- __ 3 clock hours in Stages of Change and Readiness
- __ 3 clock hours in Trauma Informed Care and ACPS
- __ 6 clock hours in Coordination of Care (mental health/primary health issues related to substance abuse prevention)

____5. Form 05-ACPS "Professional Responsibility Clock Hour Documentation"

____6. Form 06-ACPS "Education Resume"

____7. Form 07-ACPS "Applicant Statement"

____ 8. Form 08-ACPS "Demonstration of experience providing a minimum of five advanced level prevention services"

____ 9. Form 09-ACPS "Narrative"

____10. Original college transcript sent directly to IBC from institution via U.S. Mail (If applicable)

____11. Written job description

____12. Form 10-ACPS "Supervisor Evaluation"

____13. $380.00 non-refundable fee (covers application review, one exam and first two years of certification). If upgrading from CPS, only the $40.00 review fee needs to be sent with the application.

IC&RC RECIPROCAL STATES/COUNTRIES

Following is the current list of states/countries that carry the CPS credential:

U.S.

Alabama
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
Puerto Rico
South Carolina
South Dakota
Tennessee
Texas
U.S. Army
U.S. Navy
Utah
Virginia
Washington
West Virginia
Wisconsin

International

Bermuda
Canada
Greece, Malta, Cyprus,
Bulgaria Iceland/Nordic/Baltic
Mexico

Appendix B

Prevention Progress Report Guidance Document

This guidance document will serve as a tool to help department funded contractors identify key components requested in progress reports. This resource is a guide and does not serve as an approval of future reports. Please contact your IDPH Prevention Consultant directly if you have additional questions.

1. WHO

This section of the report will capture the sectors or the intended audience impacted by services. Clearly describe the audience served/reached for each activity. This information allows readers to understand the span of services within a service area.

Ex: Program staff provided Life Skills to 75 sixth grade students at the ABC Middle School.

Ex: The Healthy Habits Coalition hosted a community forum on the topic of underage drinking. This event took place on (date) with 75 River University College students in attendance.

Ex: XYZ Agency hosted a mentor training on the topic of engaging mentees in meaningful conversations. Fifteen mentors attended the training and received the following resources: conversation starters, a list of upcoming youth-focused community activities and a Making Health Decisions board game.

2. WHAT

This section of the report allows Contractors to provide details regarding the specific service provided in alignment with the IDPH approved Planned Activity or Strategy. Often containing the most content, this portion of the report allows Contractors to highlight services that work towards the completion of a goal. This information emphasizes the work that took place during a reporting period.

Ex: Program staff provided Life Skills to sixth grade students at the ABC Middle School. Three implementations of "EBP Name" Lesson 1 on the topic of alcohol, tobacco and other drugs served 75 youth. These lessons discussed signs and symptoms of misuse/abuse, ways to say no, and risk and protective factors.

Ex: The Healthy Habits Coalition sponsored a forum, titled "Preventing Underage Drinking: A Community Response to Data" which was held in Des Moines on (date) from (time) The two main goals of this event included identifying the (stated issue) and creating action steps to address (goal). Collaboration with A, B and C took place to plan the forum on (date) and (date).

In total, 75 college students from River University attended.

Ex: XYZ Agency hosted a mentor training on the topic of engaging mentees in meaningful conversations. This training provided mentors with additional information to increase their comfort level when discussing substance abuse prevention topics. In total, 15 mentors attended the training and received the following resources: conversation starters, a list of upcoming youth-focused community activities and Making Health Decisions board games.

3. WHERE

This section of the report should clearly describe where a service is located. Please avoid using proper names (except when listing schools or coalitions). Locations can include, but are not limited to, businesses, faith-based organizations, community-action organizations, law enforcement centers, internal agency meetings, etc.

Ex: Program staff provided Life Skills to 75 sixth grade students at the ABC Middle School.

Ex: The Healthy Habits Coalition sponsored a forum, titled "Preventing Underage Drinking: A Communities Response to Data" which was held in (city) on (date) from (time). The two main goals of this event included identifying the (stated issue) and creating action steps to address (goal). Collaboration with A, B and C took place to plan the forum on (date) and (date). In total, 75 college students from River University attended.

Ex: XYZ Agency hosted a mentor training on the topic of engaging mentees in meaningful conversations. This training was provided on-site at the (Contracted Agency Name) on (date). Fifteen mentors attended the training and received the following resources: conversation starters, a list of upcoming youth-focused community activities and a Making Health Decisions board game.

4. WHEN

This section of the report reflects when the service took place during the report period. This can include the date, time or month of the implemented service. This information shows the dosage (how much of the target population needs to be engaged through a strategy for a change to occur) and frequency (how often services will be provided through a strategy for change to occur) of a service.

Ex: Program staff began Life Skills on (date) at the ABC Middle School. Nine implementations took place during the report period from (date to date) serving 75 sixth grade students in three sections at the ABC Middle School.

Ex: The Healthy Habits Coalition sponsored a forum, titled "Preventing Underage Drinking: A Communities Response to Data" which was held in Des Moines on (date) from (time). The two main goals of this event included identifying the (stated issue) and creating action steps to address (goal). Collaboration with A, B and C took place to plan the forum on (date) and (date). In total, 75 college students from River University attended.

Ex: XYZ Agency hosted a mentor training on the topic of engaging mentees in meaningful conversations. This training was provided on-site at the (Contracted Agency Name) on (date). Fifteen mentors attended the training and received the following resources: conversation starters, a list of upcoming youth-focused community activities and a Making Health Decisions board game.

5. WHY

This information is often captured in the Goals and Objectives sections of IDPH Work Plans. Contractors can include information in their progress report to show why a service is included.

Ex: 2016 IYS Data shows that _- % of eighth Graders at ABC Middle School reported they did not have a caring adult in their lives. Due to this, collaborative meetings held with the two ABC Middle School Counselors identified the need to expand mentoring opportunities for youth.

6. HOW

This section of the report informs readers of the method used to contact, collaborate and provide services/activities. Information from this section portrays the level of effort that took place during the report period to work towards meeting a goal.

Ex: Program staff met directly with the ABC Middle School Principal on (date) to discuss the benefits of EBP. From this initial meeting, two additional face-to-face meetings took place with three sixth grade teachers at ABC Middle School to coordinate programming. Program staff began Life Skills on (date) at the ABC Middle School. Nine implementations took place during the report period from (date-to-date) serving 75 sixth grade students in three sections at the ABC Middle School.

Ex: The Healthy Habits Coalition sponsored a forum, titled "Preventing Underage Drinking: A Communities Response to Data" which was held in (city) on (date) from (time). The two main goals of this event included identifying the (stated issue) and creating action steps to address (goal). Collaboration with A, B and C took place to plan the forum on (date) and (date). In total, 75 college students from River University attended. "Preventing Underage Drinking: A Community Response to Data" was promoted using Facebook, an email blast and through one radio ads that aired on two radio stations in the month of February. Analytics showed the five Facebook posts resulted in 150 Likes, the email blast was disseminated to 50 faculty members at River University and the radio ad reached 40,000 individuals in February.

7. HELPFUL HINTS

- Address all the services listed in an activity in the narrative update.
- Include the total number of implementations that occurred, the number of people served, and any outcome data that may have been obtained.
- Do not use acronyms or N/A. if not service occurred during the quarter, please explain why.
- If the activity was completed in the previous quarter, note in the narrative when the service occurred.
- If the progress report has pre-determined character limits, words may be abbreviated if they would be universally understood (Example: Mtg vs. Meeting).
- If information is noted in another section, it is okay to reference the section rather than rewriting the information.

Appendix C

are not used. Federal awarding agencies, however, have the option of using this form for construction programs in lieu of the SF–271, ''Outlay Report and Request for Reimbursement for Construction Programs.''

(2) SF–271, Outlay Report and Request for Reimbursement for Construction Programs. Each Federal awarding agency shall adopt the SF–271 as the standard form to be used for requesting reimbursement for construction programs. However, a Federal awarding agency may substitute the SF–270 when the Federal awarding agency determines that it provides adequate information to meet Federal needs.

§ 215.23 Cost sharing or matching.

(a) All contributions, including cash and third party in-kind, shall be accepted as part of the recipient's cost sharing or matching when such contributions meet all of the following criteria.

(1) Are verifiable from the recipient's records.

(2) Are not included as contributions for any other federally-assisted project or program.

(3) Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.

(4) Are allowable under the applicable cost principles.

(5) Are not paid by the Federal Government under another award, except where authorized by Federal statute to be used for cost sharing or matching.

(6) Are provided for in the approved budget when required by the Federal awarding agency.

(7) Conform to other provisions of this part, as applicable.

(b) Unrecovered indirect costs may be included as part of cost sharing or matching only with the prior approval of the Federal awarding agency.

(c) Values for recipient contributions of services and property shall be established in accordance with the applicable cost principles. If a Federal awarding agency authorizes recipients to donate buildings or land for construction/facilities acquisition projects or long-term use, the value of the donated property for cost sharing or matching shall be the lesser of paragraphs (c)(1) or (2) of this section.

(1) The certified value of the remaining life of the property recorded in the recipient's accounting records at the time of donation.

(2) The current fair market value. However, when there is sufficient justification, the Federal awarding agency may approve the use of the current fair market value of the donated property, even if it exceeds the certified value at the time of donation to the project.

(d) Volunteer services furnished by professional and technical personnel, consultants, and other skilled and unskilled labor may be counted as cost sharing or matching if the service is an integral and necessary part of an approved project or program. Rates for volunteer services shall be consistent with those paid for similar work in the recipient's organization. In those instances in which the required skills are not found in the recipient organization, rates shall be consistent with those paid for similar work in the labor market in which the recipient competes for the kind of services involved. In either case, paid fringe benefits that are reasonable, allowable, and allocable may be included in the valuation.

(e) When an employer other than the recipient furnishes the services of an employee, these services shall be valued at the employee's regular rate of pay (plus an amount of fringe benefits that are reasonable, allowable, and allocable, but exclusive of overhead costs), provided these services are in the same skill for which the employee is normally paid.

(f) Donated supplies may include such items as expendable equipment, office supplies, laboratory supplies or workshop and classroom supplies. Value assessed to donated supplies included in the cost sharing or matching share shall be reasonable and shall not exceed the fair market value of the property at the time of the donation.

(g) The method used for determining cost sharing or matching for donated equipment, buildings and land for which title passes to the recipient may differ according to the purpose of the award, if paragraphs (g)(1) or (2) of this section apply.

(1) If the purpose of the award is to assist the recipient in the acquisition

of equipment, buildings or land, the total value of the donated property may be claimed as cost sharing or matching.

(2) If the purpose of the award is to support activities that require the use of equipment, buildings or land, normally only depreciation or use charges for equipment and buildings may be made. However, the full value of equipment or other capital assets and fair rental charges for land may be allowed, provided that the Federal awarding agency has approved the charges.

(h) The value of donated property shall be determined in accordance with the usual accounting policies of the recipient, with the following qualifications.

(1) The value of donated land and buildings shall not exceed its fair market value at the time of donation to the recipient as established by an independent appraiser (*e.g.*, certified real property appraiser or General Services Administration representative) and certified by a responsible official of the recipient.

(2) The value of donated equipment shall not exceed the fair market value of equipment of the same age and condition at the time of donation.

(3) The value of donated space shall not exceed the fair rental value of comparable space as established by an independent appraisal of comparable space and facilities in a privately-owned building in the same locality.

(4) The value of loaned equipment shall not exceed its fair rental value.

(5) The following requirements pertain to the recipient's supporting records for in-kind contributions from third parties.

(i) Volunteer services shall be documented and, to the extent feasible, supported by the same methods used by the recipient for its own employees.

(ii) The basis for determining the valuation for personal service, material, equipment, buildings and land shall be documented.

§ 215.24 Program income.

(a) Federal awarding agencies shall apply the standards set forth in this section in requiring recipient organizations to account for program income related to projects financed in whole or in part with Federal funds.

(b) Except as provided in paragraph (h) of this section, program income earned during the project period shall be retained by the recipient and, in accordance with Federal awarding agency regulations or the terms and conditions of the award, shall be used in one or more of the ways listed in the following.

(1) Added to funds committed to the project by the Federal awarding agency and recipient and used to further eligible project or program objectives.

(2) Used to finance the non-Federal share of the project or program.

(3) Deducted from the total project or program allowable cost in determining the net allowable costs on which the Federal share of costs is based.

(c) When an agency authorizes the disposition of program income as described in paragraphs (b)(1) or (b)(2) of this section, program income in excess of any limits stipulated shall be used in accordance with paragraph (b)(3) of this section.

(d) In the event that the Federal awarding agency does not specify in its regulations or the terms and conditions of the award how program income is to be used, paragraph (b)(3) of this section shall apply automatically to all projects or programs except research. For awards that support research, paragraph (b)(1) of this section shall apply automatically unless the awarding agency indicates in the terms and conditions another alternative on the award or the recipient is subject to special award conditions, as indicated in § 215.14.

(e) Unless Federal awarding agency regulations or the terms and conditions of the award provide otherwise, recipients shall have no obligation to the Federal Government regarding program income earned after the end of the project period.

(f) If authorized by Federal awarding agency regulations or the terms and conditions of the award, costs incident to the generation of program income may be deducted from gross income to determine program income, provided these costs have not been charged to the award.

Appendix D

DRAFT

Grant Name

Iowa Department of Public Health, Bureau of Substance Abuse

Administrative On-Site Review -*Date*-

Overview

Purpose

An administrative on-site review covers the following areas:

- Administration
- Organization and communication
- Personnel policies
- Job descriptions/Current staff
- Fiscal policies
- Fiscal control
- Inventory control
- Expenditures and documentation
- Direct Service hours
- Action Plan Outcomes
- Staff Certification
- Staff Trainings
- Progress Reports

State staff responsible

The - *Staff Name* - conducts administrative on-site reviews.

Schedule of reviews

Administrative on-site reviews are conducted annually.

Review forms

A copy of the administrative on-site review form begins on page 3.

Continued on next page

Documents for review	**Upload the below documents to the Requested Documentation section of the Site Visit component found in IowaGrants.gov. at least (15 days) prior to the review**. – Current table of organization, including all Prevention staff working on the program by name and position – Prevention Handbook – Financial Operations Policy Manual – Timesheets and support documentation (e.g., general ledgers, payroll reports, invoices, allocations, etc.) for the claims submitted for the months of ONLY -***select month(s)-*** (including mileage and travel expense reimbursements for -***select month(s)***-) – Current salary schedule for all staff paid with program funding – Personnel Policies (outlined in section VII) – Job Description for Prevention Specialist(s) – Support documentation for completed long-term outcomes (e.g., pre/post survey responses, policy changes, media metrics, etc.) – Support documentation for completed short-term outcomes within the Action Plan **These documents must be available during the on-site review.** • Verification of current certification status of Prevention Supervisor and Prevention Specialist • Support documentation for claims submitted in -***select month(s)***- • Subcontracts and agreements with other providers or agencies • Rent leases/agreements and space cost allocation plan

AGENCY ADMINISTRATIVE ON-SITE REVIEW

Agency:

Programs: AmC, IPN, PFS, SPF

Rx

Date of on-site review:

Agency staff consulted:

Department reviewer:

Date of last administrative review:

List any recommendations and requirements from previous administrative review that are still unmet:

Yes	No	N/A	
			I. Organizational Chart:
☐	☐	☐	A. The organizational chart is updated to reflect current Prevention staff and aligns with the Key Personnel in IowaGrants.gov
☐	☐	☐	B. Actual lines of supervision are reflected.
☐	☐	☐	C. The Contractor has reported changes in key personnel found in the Correspondence component of IowaGrants.gov, within 10 working days of staff notice, and updated the necessary components.
			II. Agency lines of Communication and/or Management:
☐	☐	☐	How often are staff meetings held? _____
☐	☐	☐	A. Staff minutes are dispersed to staff to read.
☐	☐	☐	B. Minutes reflect a regular schedule of meetings (including Subcontractor meetings).
☐	☐	☐	C. Documentation provides evidence of policies and procedures communicated to staff and subcontractors.
			III. Subcontractors:
☐	☐	☐	A. Draft agreements, contracts, and memoranda of understanding exceeding $2,000 have been submitted timely and approved by the Department before the signature process and as verified by the Subcontract Document report found in the Progress Reports component of IowaGrants.gov.
☐	☐	☐	B. Subcontracts written subsequent to the original application have been pre-approved by the Department as verified by the Subcontract Document report found in the Progress Reports component of IowaGrants.gov.

IV. Prevention Plan and Staff Onboarding:

☐ ☐ ☐ A. Does the agency have the following:

- Prevention Handbook
- Formalized onboarding process for new staff

☐ ☐ ☐ B. Date of last prevention handbook review:_____

☐ ☐ ☐ C. Prevention Handbook updates shared on a regular basis with staff and subcontractors.

V. Certification:

☐ ☐ ☐ A. Verification of current Certified Prevention Specialists certification
How many staff are certified? _____
How many staff are currently in the process to become certified?_____

VII. Personnel Policies:

☐ ☐ ☐ A. Conditions of employment include recruitment, selection, termination, promotion, and compensation

☐ ☐ ☐ B. Leave and absence

☐ ☐ ☐ C. Grievance procedure

☐ ☐ ☐ D. Employee performance evaluation

☐ ☐ ☐ E. Culturally and Linguistically Appropriate Services (CLAS) Standards and /or diversity training

☐ ☐ ☐ F. Employee orientation program

☐ ☐ ☐ G. Provision for career development or continuing education

☐ ☐ ☐ H. Fringe benefits

☐ ☐ ☐ I. Policies reviewed annually

VIII. Employee/Personnel Files:

☐ ☐ ☐ A. Confidentiality of personnel records is ensured in what way(s)? _____

X. Job Description:

☐ ☐ ☐ A. Every agency position in the budget has a written job description available.

☐ ☐ ☐ B. Job descriptions delineate qualifications and responsibilities.

☐ ☐ ☐ C. Job descriptions are dated and reflect current responsibilities and essential functions of the position.

☐ ☐ ☐ D. Qualifications and responsibilities are stipulated in the contract, or with contracted providers, as required by the Americans with Disabilities Act of 1990 (ADA).

XI. Salary Schedule:

☐ ☐ ☐ A. Agency's salary schedule is current and was submitted prior to the on-site review.

☐ ☐ ☐ B. Salaries for budgeted positions agree with this schedule and are based on the hours worked and not a one-twelfth rotation.

XIII. Purchasing/Inventory Control:

☐ ☐ ☐ A. Purchasing procedures are written.

☐ ☐ ☐ B. Purchase orders are pre-numbered and accounted for.

☐ ☐ ☐ C. All invoices and/or receipts for material/resources purchased with IDPH grant funds are maintained at the agency level. Examples of material/resources include but are not limited to curriculum, electronic devices, health promotion material, etc. An IDPH fiscal audit will take place annually during the site visit process. This audit will include a random selection of months for review during the current fiscal year.

☐ ☐ ☐ D. Annual physical inventories are conducted for all IDPH funded material/resources.

☐ ☐ ☐ E. The agency's claim system through Iowa grants.gov supports items purchased with IDPH grant funds.

XIV. Fiscal Policies and Control:

☐ ☐ ☐ A. Staff mileage is documented and reimbursed at the state rate as outlined in the contract.

☐ ☐ ☐ B. Travel expenses are documented and reimbursed at the state rates as outline in the contract.

☐ ☐ ☐ C. Actual receipts (**-select month(s)**-) match what was submitted in IowaGrants.

☐ ☐ ☐ D. Claims are submitted to the Department within the required contract timeframe.

☐ ☐ ☐ E. Financial Operations Policy Manual in place. A copy was provided prior to the on-site review

☐ ☐ ☐ 1. Lines of responsibility, accounting standards, segregation of duties, payment schedules, and the policy manual reflects approval authorities, and record-keeping requirements.

☐ ☐ ☐ 2. Manual reflects current practices.

☐ ☐ ☐ F. A general ledger is in place.

☐ ☐ ☐ G. A system to compare actual vs. budgeted expenditures is in place.

☐ ☐ ☐ 1. Monthly reports of budgeted and actual expenditures are reviewed and approved.

☐ ☐ ☐ 2. All prior approval budget revisions have been submitted to the department

☐ ☐ ☐ H. If costs are associated with a prevention program, a sliding fee scale has been established.

☐ ☐ ☐ 1. The sliding fee scale is applied after payment from other sources received.

☐ ☐ ☐ I. The methodology for deferring fees meets program requirements.

☐ ☐ ☐ J. Valid methodology for allocating administrative and/or indirect costs charged to programs.

1. Supporting documentation is available.

☐ ☐ ☐ K. Agency personnel performs all accounting functions.

☐ ☐ ☐ L. Participant bills show total cost of services, as applicable.

XV. Time Records:

☐ ☐ ☐ A. For staff who are funded under multiple funding streams, time records allow reporting for more than one program.

☐ ☐ ☐ B. Time records accurately reflect total distribution of work time.

☐ ☐ ☐ C. Time records are being used appropriately.

☐ ☐ ☐ D. All agency personnel are keeping time records.

XVI. Documentation

☐ ☐ ☐ A. Progress Reports submitted on-time in IowaGrants.gov

☐ ☐ ☐ B. Expenses are within contractual and budget parameters.

- ***Program Name* - Grant Questions**

SPF Steps

❏ Highlight successes and challenges_____

_____

_____

❏ Is the agency meeting project expectations and completing action steps?
YES NO
(If no,why?)_____

❏ Are all strategies being followed with fidelity?
YES NO

❏ How often is fidelity checked with each strategy?

_____

❏ Past the fidelity checklist, what other documentation demonstrates fidelity is maintained with the SPF steps?

_____

❏ How is CLAS being utilized during implementation?

_____

❏ Who is the disparate population identified in the strategic plan?

_____

❏ What steps are taken to monitor the disparate population is reached?_____

❏ What steps are in place to sustain ***- Program Name -*** strategies?

_____

Capacity

❏ Are all required sectors involved? YES NO

Tracking Outcomes

- ❏ What documentation is used to show outcomes have been successfully reached (spreadsheet, pre/post surveys, copies of passed signed policies, documentation of RBST trainings and attendance numbers, etc)?

  _____

- ❏ Explain how this documentation is stored?

  _____

- ❏ To date, how many short-term outcomes have been met this year? _____

- ❏ How many long-term outcomes have been met? _____

- ❏ Are short-term outcomes on track to be reached?
  YES NO
  (If no, what is being done to address barriers?)

  _____

- ❏ Are the long-term outcomes on track to be reached?
  YES NO
  (If no, what is being done to address barriers?)

  _____

Supervisor Questions

- ❏ How does the agency ensure no unallowable costs are occurring outside of indirect?

  _____

- ❏ What is the plan if the coordinator leaves before the end of the grant?_____

- ❏ Explain how the County Board of Health is involved in the project:

  _____

- ❏ Include the dates of the County Board of Health meetings attended this Fiscal Year:

  _____

- ❏ What documentation is available showing the agency's involvement?

  _____

XVII. In the exit interview, recommendations and requirements from this review were orally presented to the following agency personnel:

Challenges:

_____

_____

Successes:

_____

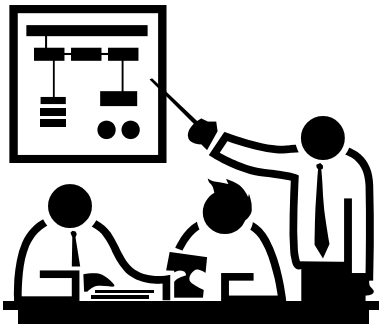
_____

Technical Assistance Requests:

_____

_____

Appendix E



The Local Board of Health

The local board of health is described in law in Iowa Code Chapter 137. It is described in rule in Iowa Administrative Code chapter 641.77. Law and rule define the structure, powers, and duties of the local board of health. The following information is a summation of the two.

LOCAL BOARD OF HEALTH JURISDICTION AND APPOINTMENT:

There are three types of local boards of health.

1. City (has to have been in existence before July 1, 2010)
2. County
3. District

- City boards of health have jurisdiction over public health matters within the city. City board members are appointed by the city council.
- County boards of health have jurisdiction over public health matters within the county. County board members are appointed by the county board of supervisors.
- District boards of health have jurisdiction over public health matters within the district. District board of health members are appointed by the county boards of supervisors from the counties represented by the district.

MEMBERSHIP OF A LOCAL BOARD OF HEALTH:

- Each local board of health shall consist of at least five members. One of the members must be a physician licensed in the state of Iowa.
- The membership term is three years, members may be re-appointed.
- Members shall serve without compensation, but may be reimbursed for necessary expenses.
- Vacancy due to death, resignation, or other cause shall be filled as soon as possible after the vacancy exists for the unexpired term of the original appointment.

ORGANIZATION OF A LOCAL BOARD OF HEALTH:

- Each year the local board of health needs to elect a member to serve as the chairperson.
- The board may choose to elect a vice-chairperson, secretary, or other officers as necessary.

MEETINGS:

- The board shall meet at least six times a year.
- The time, place, and date of regular meetings should be determined by vote of the local board.
- Meetings must comply with Open Meeting Law (Iowa Code Chapter 21) and Public Records Law (Iowa Code Chapter 22).
- A majority of the members shall be considered a quorum.
- An affirmative vote of the majority of the members present is necessary for action taken.
- Before approving any rule or regulation the board shall hold a public health on the proposed rule.

BOARD OF HEALTH REPORTING TO THE IOWA DEPARTMENT OF PUBLIC HEALTH:

- Each member's name and contact information is to be submitted once a year.
- Names of the chairperson and other officers are to be submitted once a year.
- A copy of regular and special meeting minutes should be submitted once they are approved. Meeting minutes should include a list of the members present and clearly document official action taken by the board.

FISCAL RESPONSIBILITY:

- Boards of health in Iowa should take an active role in assessing public health needs in their jurisdiction and evaluating whether current services are being successful in helping meet those needs. It is expected that this role will continue to expand and will include setting public health goals and priorities, shaping service delivery systems, and ensuring the efficient and effective use of resources. Boards of health will be bringing together contractors, payees, and other partners in order to fulfill the roles and responsibilities laid out in Iowa Code and Iowa Administrative Code.
    - Advantages to this control include better management of limited resources, increased flexibility to direct funds to address local needs and priorities, decreased duplication of services and support of regional linkages.
- When a board of health employs and directly oversees public health staff, the board's fiscal responsibilities will include:
    - Setting financial direction, approving the annual budget, approving financial guidelines, and policies and procedures.
    - Planning for expenses and revenues and monitoring financial status.

    - Delegating implementation of the budget
- When the local board of health does not directly oversee public health staff, but contracts with other entities for public health services, the board will have its own budget for board of health
- operating expenses. When the board of health is a contractor (a legal arrangement for the receipt of public health funds in exchange for services) or establishes subcontracts with nonprofit organizations, the board is required to meet the fiscal and reporting requirements of the funding source.

ALLOWABLE BOARD OF HEALTH BUSINESS EXPENSES:

- Reimbursement for travel in private car or public transportation.
- Lodging and meal expenses.
- Public transportation when traveling on board of health business.
- Training and education expenses.
- Reimbursement for necessary expenses in accordance with rules established by the state board or health or the applicable jurisdiction.

POWERS OF THE LOCAL BOARD OF HEALTH:

Local boards of health are the governing boards in their city, county, or district for public health. They establish the framework for public health. They provide local public health vision, mission, and advocacy and encourage community involvement in selecting public health priorities. Local boards of health:

- Enforce state health laws and the rules and lawful orders of the state department.
- Make and enforce such reasonable rules and regulations not inconsistent with law, the rules of the state board, or the Iowa public health standards as may be necessary for the protection and improvement of the public health.
    - Rules of a city board shall become effective upon approval by the council and publication in a newspaper having general circulation in the city.
    - Rules of a county board shall become effective upon approval by the county board of supervisors by a motion or resolution as defined in Iowa Code 331.101, subsection 13, and publication in a newspaper having general circulation in the county.
    - Rules of a district board shall become effective upon approval by the district board and publication in a newspaper having general circulation in the district.
    - Before approving any rule or regulation the local board of health shall hold a public hearing on the proposed rule. Any citizen may appear and be heard at the public hearing. A notice of the public hearing, stating the time and place and the general nature of the proposed rule or regulation shall be published in a newspaper having general circulation as provided in Iowa Code section 331.305 in the area served by the local board of health.

- Employ persons as necessary for the efficient discharge of its duties.

ADDITIONAL POWERS OF THE LOCAL BOARD OF HEALTH INCLUDE:

- May provide such population-based and personal health services as may be deemed necessary for the promotion and protection of the health of the public.
- May provide such environmental health services as may be deemed necessary for the protection and improvement of the public's health.
- May engage in joint operations and contract with colleges and universities, the state department, other public, private, and nonprofit agencies, and individuals or form a district health department to provide personal and population-based public health services.
- May enforce appropriate public health ordinances by agreement with the council of any city within its jurisdiction.
- May charge reasonable fees for personal and public health services. No person shall be denied necessary services within the limits of available resources because of inability to pay the cost of such services.
- May issue licenses and permits and charge reasonable fees in relation to the construction or operation of nonpublic water supplies or private sewage disposal systems.

LOCAL BOARDS OF HEALTH AND THE IOWA PUBLIC HEALTH STANDARDS:

- Local boards of health may:
    - Designate an agency to assure compliance with the Iowa Public Health Standards in the jurisdiction.
    - Demonstrate a commitment to comply with the Iowa Public Health Standards.
    - Request at least annually reports from organizations that provide public health services within the jurisdiction.

LEGAL RESPONSIBILITIES OF THE LOCAL BOARD OF HEALTH:

The local board of health may by contract, merger, or any other legal means see that certain responsibilities can be provided by another entity. If a local board of health chooses to subcontract services the board is still responsible for making sure that the services are delivered.

As stated earlier the local board of health's responsibilities and duties are established in Iowa Code, and implemented through Iowa Administrative Code. Duties covered above in this guidebook have come directly from Iowa Code Chapter 137 and Iowa Administrative Code 641.77, but these are not the only areas of code and administrative code that describe responsibilities and duties of the local board of health.

Iowa Code and Iowa Administrative Code authorize local boards of health to conduct a broad array of legal activities. This list is updated annually by the Iowa

Department of Public Health. The list is available on the department's website at http://www.idph.state.ia.us/hpcdp/local_board_of_health.asp.

LOCAL BOARD OF HEALTH PHYSICIAN RESPONSIBILITY:

The physician member of the local board of health has a unique responsibility as a liaison to the community and other medical professionals because of specific medical training and experience. The physician member of the board should:

- Know the health and threats to the health of the community the local board of health serves.
- Take an active role in healthcare discussions with physician colleagues.
- Explain the role of public health in prevention of disease and promotion of health in community settings.

CONFLICT OF INTEREST:

Because of the public service mission of public health, it is important that the community have confidence in their local board of health. In order to deal with the issue of conflict of interest and the disclosure of such it is recommended that the board of health consult with the local county attorney.

- Guidelines for avoiding conflict include:
  - Serve public health as a whole rather than any special interest group or constituency
  - Avoid the appearance of a conflict of interest and disclose any potential conflicts to the board in a timely fashion
  - Maintain independence and objectivity with a sense of fairness, ethics, and personal integrity
  - Comply with Iowa Code Chapter 68B which includes Iowa Gift Law.

WORKING WITH THE COUNTY BOARD OF SUPERVISORS:

It is very important that the local board of health and county board of supervisors have a good working relationship. Both have different responsibilities related to public health, but it is in the interest of both to have quality public health services available to the constituents they each serve.

- The local board of health is reliant on the county board of supervisors for:
  - Appointment of board of health members
  - Approval of adopted rules and regulations of the board of health
  - Appropriation of funding.
- A district board of health is reliant of local boards of supervisors for:
  - Appointment for members of a district board of health
  - Adopted rules and regulations approved and so they can be implemented by the district board of health
  - Financial support for public health of the district's constituents when appropriate.

WORKING WITH THE COUNTY ATTORNEY:

The county attorney has an obligation to represent and provide advice and opinion to local boards of health. The local board of health may under certain circumstances seek outside legal counsel.

GUIDELINES FOR MEETINGS:

- Meetings should be arranged for the convenience of the board members. If at all possible select a regular time and date for the meeting.
- Meeting materials should be provided to board of health members several days prior to the meeting. All materials should be reviewed by the board of health in preparation for the meeting.
- Board of health members should assist in determining meeting agendas.
- Begin meetings on time.
- Take attendance.
- Approve minutes from the last meeting.
- Receive reports from public health officials, directors, and other providers. Written reports may be submitted in advance.
- Handle unfinished business from earlier meetings before moving on to new business.
- End each meeting by stating the date and time of the next scheduled meeting.
- Adjourn the meeting at the conclusion of the meeting.
- A designated person should keep the minutes. The minutes should be on letterhead and include:
    - Date, time, place, board members and guests present.
    - Include all motions and actions taken by the board.
    - A record of the vote of each member present.
- Additional tips on meeting minutes:
    - Minutes do not need to include the discussion that led to the board action, but should have enough detail to explain the reasoning of the board.
    - Minutes should be kept concise and factual.
    - The minutes should reflect who took the minutes.

OPEN MEETINGS AND OPEN RECORDS:

Board of Health meetings need to be conducted according to the requirements of the Iowa open meetings and open records laws, which are in Chapters 21 and 22 of Iowa Code. For more information on this topic consult the "Iowa Open Meetings, Open Records Handbook" available from the Iowa Freedom of Information Council.

ELECTRONIC MEETINGS:

Requirements for holding electronic meetings are contained in the Iowa Open meetings law (Section 21.8 of Chapter 21 of the Iowa Code).

IOWA DEPARTMENT OF PUBLIC HEALTH
GENERAL CONDITIONS
Effective 07.01.2019

1. General

a. This is an integrated contract between the Department and the Contractor which consists of the specifications, terms, and conditions of all solicitation documents issued by the Department, the Contractor's proposal, the Special Conditions, these General Conditions, and any written amendments made in accordance with the provisions herein. In the event of a conflict between or among the provisions of the Contract Documents, the governing language shall be from the Contract Document listed first in the following list: (1) Written amendment mutually executed by the parties; (2) Special Conditions; (3) General Conditions; (4) Request for Proposal (RFP) or other solicitation document; and (5) Contractor's proposal.

b. The Contractor shall provide the necessary facilities, materials, services, and qualified personnel to satisfactorily perform and provide all the work and services set forth in this contract. The Contractor shall provide Deliverables that comply with and conform to the Specifications. The contract budget shall be the basis for the Contractor's expenditure of the contract amount.

2. Definitions

a. "Contract" means the collective documentation memorializing the terms of the agreement between the Department and the Contractor identified on the Contract Declarations & Execution Page(s) and includes the signed Contract Declarations & Execution Page(s), the Special Conditions, the RFP or other solicitation document, Contractor's approved proposal, these General Conditions, any Special Contract Attachments and Amendments, and all other attachments and amendments to the Contract Declarations & Execution Page(s).

b. "Contractor" means the organization or individual contracting with the Department.

c. "Department" means the Iowa Department of Public Health.

d. "Deliverables" means all of the goods, products, services, work, work product, items, materials and property to be created, developed, produced, delivered, performed or provided by or on behalf of, or made available through, Contractor (or any agent, contractor or subcontractor of Contractor) in connection with this Contract.

e. "Records" means all of the documents, papers, sound recordings or other material, regardless of physical form or characteristics and including electronic records, made, produced, executed or received pursuant to law in connection with the transaction of official business of state government.

f. "Related party transaction" means a contractual arrangement for the provision of services with an employee, consultant, or member of a governing body of the Contractor who has a family, business, or other tie to the service to be provided.

g. "Special Conditions" means the Contract attachment entitled "Special Conditions" that contains terms specific to this Contract, including but not limited to the Scope of Work, contract payment terms, and any amendments to these General Conditions. If there is a conflict between the General Conditions and the Special Conditions, the Special Conditions shall prevail.

h. "Specifications" means all specifications, requirements, technical standards, performance standards, representations and other criteria related to the Deliverables stated or expressed in this Contract, the Documentation, the RFP or other solicitation document, and the Proposal. The Specifications are incorporated into this Contract by reference as if fully set forth in this Contract.

i. "State" means the State of Iowa.

3. Accounts and Records

a. The Contractor shall maintain accurate, current, and complete records of the financial activity of this contract, including records which adequately identify the source and application of funds. Cash contributions made by the Contractor and third party in-kind (property or service) contributions shall be verifiable from the Contractor's records. These records must contain information pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures, income and third-party reimbursements.

b. The Contractor shall maintain accounting records supported by source documentation including but not limited to cancelled checks, paid bills, payrolls, time and attendance records, and contract award documents.

c. The Contractor, in maintaining project expenditure accounts, records and reports, shall make any necessary adjustments to reflect refunds, credits, underpayments or overpayments, as well as any adjustments resulting from administrative or compliance reviews and audits.

d. The Contractor shall maintain a sufficient record keeping system to provide the necessary data for the purposes of planning, monitoring and evaluating their program.

e. The Contractor shall retain all accounting and financial records, programmatic records, supporting documents, statistical records and other records reasonably considered as pertinent to the contract, for a period of five (5) years from the day the Contractor submits its final expenditure report. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five (5) year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five (5) year period, whichever is later. Client records which are non-medical must be maintained for a period of five (5) years.

f. The Contractor shall retain all medical records for a period of six (6) years from the day the Contractor submits its final expenditure report; or in the case of a minor patient or client, for a period of one (1) year after the patient or client attains the age of majority, whichever is later.

g. The Contractor shall maintain the confidentiality of all records of the project in accordance with state and federal laws, rules, and regulations, and the terms of section 9 of these general conditions.

4. Equipment

a. **Definition of Equipment**. Any item costing $5,000 or more and having an anticipated life of one year or more.

b. **Title and Disposition.** Title to equipment purchased in whole or in part with Department funds resides with the Department. Upon contract expiration or termination the Department reserves the right to transfer title to the equipment to the State, the Contractor, or another contractor. The Contractor must receive written approval from the Department before disposing of any equipment during the contract period.

c. **Records.** The Contractor shall maintain inventory control records and maintenance procedures for all equipment purchased in whole or in part with Department funds or obtained from state surplus or the Department. Equipment records shall include the following for each item: state tag number (or Contractor inventory number if no state tag has been assigned); description; physical location; name of the contract purchased under; percentage of total cost of item paid for by Department funds; and, if available, vendor name, manufacturer's serial number, purchase price, date of acquisition, date of disposition, disposition price, and type of disposition.

d. **Control System.** A control system (including an annual physical inventory) shall be implemented to ensure adequate safeguards to prevent loss, damage, or theft of the equipment. Any loss, damage, or theft shall be investigated, fully documented, and reported to the Department. The Contractor shall also report suspected theft to local law enforcement. Where the Contractor is authorized to sell the equipment, sale procedures shall provide for competition to the extent practicable and result in the highest possible disposition price.

5. Procurement Standards and Subcontracting

a. Procurement. The Contractor shall use procurement procedures that comply with all applicable federal, state, and local laws and regulations.

b. **Subcontracting.** None of the work or services relating to this contract shall be subcontracted to another organization or individual without specific prior written approval by the Department except for subcontracts under $2000. To obtain approval, the Contractor shall submit to the Department the proposed contract or written agreement between the parties. The proposed contract or agreement shall contain:

(1) A list of the work and services to be performed by the subcontractor.

(2) The contract policies and requirements.

(3) Provision for the Department, the Contractor, and any of their duly authorized representatives to have access, for the purpose of audit and examination, to any documents, papers, and records of the subcontractor pertinent to the subcontract.

(4) The amount of the subcontract.

(5) A line item budget of specific costs to be reimbursed under the subcontract or agreement or other cost basis for determining the amount of the subcontract as appropriate.

(6) A statement that all provisions of this contract are included in the subcontract including audit requirements.

(7) Period of performance.

(8) Any additional subcontract conditions.

c. Any subcontract or other written agreement shall not affect the Contractor's overall responsibility and accountability to the Department for the overall direction of the project.

d. If during the course of the subcontract period the Contractor or subcontractor wishes to change or revise the subcontract, prior written approval from the Department is required.

e. The Contractor shall maintain a contract administration system which ensures that subcontractors perform in accordance with the terms, conditions, and specifications of their contracts or purchase orders.

f. The Contractor shall maintain written standards of conduct governing the performance of its employees engaged in the award and administration of any subcontract. No employee, officer or agent of the Contractor or subcontractor shall participate in the selection or in the award or administration of a subcontract if a conflict of interest, real or apparent, exists.

6. Program Income

a. Program income means gross income earned by the Contractor from sources other than the Department that is directly generated by a contract-supported activity or is earned as a result of the contract agreement. It includes, but is not limited to, income in the form of fees for services performed during the contract or subcontract period, proceeds from the sale of tangible personal or real property or equipment, usage or rental fees, and patent or copyright royalties.

b. Program income may be retained by the Contractor and shall be used for the program in accordance with the conditions of the contract unless the Special Conditions of the contract specify otherwise. Program income may be used to meet the cost sharing or matching requirement of the contract.

c. When prior year refunds or rebates result from the expenditure of Department provided funds, they shall be returned to the Department in the same proportion that the Department funds are to the project's total income or income related to any subcontract, as appropriate.

d. Cash advances, whether permanent or in the form of working capital, must be maintained in interest bearing accounts. Interest earned by the Contractor on cash advances shall be allocated by the Contractor to the program for which the cash advance was received. All interest earned on cash advances shall be remitted to the Department on a quarterly basis, or more frequently if requested by the Department. Interest amounts up to $250 per contract period in the aggregate for all federal funded programs may be retained by the Contractor for administrative expenses only.

7. Non-Supplanting Requirement

Federal and State funds made available under this contract shall be used to supplement and increase the level of state, local and other non-federal funds that would in the absence of such federal and State funds be made available for the programs and activities for which funds are provided and will in no event take the place of state, local and other non-federal funds.

8. Publications, Copyrights and Rights in Data, and Patents

a. **Publications.** The Contractor shall not publish the results of contract activity without prior written approval by the Department. Such publication (written, visual, or audio) shall contain an acknowledgment of Department contract support. A copy of any such publication shall be furnished to the Department at no cost.

b. **Rights in Data**. Records and data provided by or collected on behalf of the Department pursuant to this contract shall remain the property of the Department at all times.

c. **Ownership and Assignment of Other Deliverables**. Contractor agrees that the State and Department shall become the sole and exclusive owners of all Deliverables. Contractor hereby irrevocably assigns, transfers and conveys to the State and the Department all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. Contractor represents and warrants that the State and the Department shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary or affiliate of Contractor. The Contractor (and Contractor's employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any purpose, without the prior written consent of the Department and the payment of such royalties or other compensation as the Department deems appropriate. Unless otherwise requested by Department, upon completion or termination of this Contract, Contractor will immediately turn over to Department all Deliverables not previously delivered to Department, and no copies thereof shall be retained by Contractor or its employees, agents, subcontractors or affiliates, without the prior written consent of Department. To the extent any of Contractor's rights in any Deliverables are not subject to assignment or transfer hereunder, including any moral rights and any rights of attribution and of integrity, Contractor hereby irrevocably and unconditionally waives all such rights and enforcement thereof and agrees not to challenge the State's rights in and to the Deliverables.

d. **Patents.** If any patentable invention is developed by an employee of the Contractor in the course of employment related to this contract, such invention shall be reported to the Department. The Department shall be entitled to a share, proportionate to Department funding, of rights to said invention, including title to and license rights under any patent application or patent which may be issued.

e. **Use of Department identifiers**. Any use of the Department's name, logo, or other identifying information must have prior written approval from the Department.

9. Release of Information and Confidentiality of Records and Data

a. Release of Contract Information to the Department. The Contractor agrees to provide to the Department,upon request, all records related to the contract including, but not limited to, client records, statistical information, data, board and other administrative records, and financial records, including budget, accounting activities, financial statements, and the annual audit in accordance with Code of Federal Regulations, Title 45.

b. **Confidentiality of Client Records**. The Contractor's policies and procedures shall provide that records regarding the identity, diagnosis, prognosis, and services provided to any client in connection with the performance of the contract are confidential and that such records shall be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations. The Contractor shall maintain all identifiable and personal indicators related to records and data as strictly confidential and shall not use or release such records or data for any purpose unless authorized by the contract. The Contractor may not link the data provided by the Department or collected by the Contractor with any other datasets without prior written permission from the Department.

c. **Security of Client Files and Data.** The Contractor's employees, agents, and subcontractors shall be allowed access to confidential records only as necessary for the performance of their duties related to the contract and in accordance with the policies and procedures of the custodian of the records. The Contractor shall maintain policies and procedures for safeguarding the confidentiality of such data, and may be liable civilly or criminally under state or federal confidentiality laws, rules or regulations for the unauthorized release of such information.

d. **Unauthorized Disclosure**. The Contractor shall maintain the confidentiality of all records related to this contract in accordance with state and federal laws and regulations. The Contractor shall protect from unauthorized disclosure all confidential records and data, including but not limited to the names and other identifying information of persons receiving services pursuant to this contract, except for statistical information not identifying any client. The Contractor shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this contract. The Contractor shall promptly transmit to the Department all requests for disclosure of such identifying information to anyone other than the Department and the Contractor shall not disseminate such information without prior written authorization from the Department. For purposes of this paragraph, the term "identifying" shall include, but not be limited to, name, identifying number, symbol, or other identifier particularly assigned to the individual. The Contractor shall immediately report to the Department any unauthorized disclosure of confidential information. The Contractor's obligations under this section shall survive termination of this contract.

e. The Contractor's obligations under this section of the Contract shall survive termination or expiration of this Contract.

10. Confidentiality, IT Standards and Security

a. The Contractor will comply with and adhere to the following Department and State information technology standards and provide training to Contractor's employees and subcontractors concerning such standards, procedures and protocols as applicable.

(1) Data Backup Standard: Applicable to Contractors which utilize data systems to process, store, transmit or monitor information essential to the performance of Department required services.
(2) Data Stewardship Standard: Applicable to Contractors which utilize data systems to process, store, transmit or monitor information essential to the performance of Department required services.
(3) Interconnectivity Standard: Applicable to Contractors which utilize data systems to process, store, transmit or monitor information essential to the performance of Department required services.
(4) Laptop Data Protection Standard: Applicable to Contractors which utilize laptops to process, store, transmit or monitor data essential to the performance of Department required services or connects to state owned or managed network.
(5) Removable Storage Encryption Standard: Applicable to Contractors which utilize removable storage devices to process, store, transmit or monitor information essential to the performance of Department required services.
(6) Web Application Security Standard: Applicable to Contractors which develop, manage or utilize state resources including but not limited to websites, data systems, desktop applications and web based services.
(7) Website Accessibility Standard: Applicable to Contractors which develop and maintain Department web pages.

Current state information technology standards are accessible online at https://ocio.iowa.gov/home/standards

b. The Contractor will take all precautions and actions necessary to: (i) prevent unauthorized access to the Department's and the State's systems, networks, computers, property, records, data, and information; and (ii) ensure that all of the Department's and the State's documentation, electronic files, data, and systems are developed, used, and maintained in a secure manner, protecting their confidentiality, integrity and availability. Contractor agrees that it will not copy, reproduce, transmit, or remove any Department (or State) information or data without the prior written consent of the Department. Contractor agrees that it shall be liable for any damages, losses, and expenses suffered or incurred by the Department or the State as a result of: (a) any breach of this section, or (b) any breaches of security (including those described below) that are caused by any action or omission of Contractor or Contractor's employees, agents and subcontractors. Breaches of security include, but are not limited to:

(1) Disclosure of confidential or sensitive information;
(2) Unauthorized access to Department or State systems;
(3) Illegal technology transfer;
(4) Sabotage or destruction of Department or State information or information systems;
(5) Compromise or denial of Department or State information or information systems;
(6) Damage to or loss of Department or State information or information systems; and
(7) Theft.

c. The Contractor shall immediately report to the Department any such breach of security. In the event of a breach of this section or any breach of security as described herein, the Department may terminate this Agreement immediately without penalty or liability to the Department and the State and without affording Contractor any opportunity to cure.

11. Conflict of Interest

a. The provisions of Iowa Code Chapter 68B shall apply to this agreement. In the event a conflict of interest is proven to the Department, the Department shall terminate the contract, and the Contractor shall be liable for any excess costs to the Department as a result of contract default.

b. The Contractor shall establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by the desire for private gain for themselves or others with whom they have family, business, or other ties.

c. The Contractor shall report any related party transaction to the Department. Written approval from the Department shall be required prior to such transaction.

d. The Contractor represents and warrants that no relationship exists or will exist during the Contract period between the Contractor and the Department that is a conflict of interest. No employee, officer, or agent of the Contractor or a subcontractor shall participate in the selection, award, or administration of a contract or subcontract if a conflict of interest exists.

12. Private Consultation

Employees of the Contractor whose salaries are paid by Department funds shall not engage in private consultation during the hours that are paid for by Department funds.

13. Qualifications of Staff

The Contractor shall be responsible for assuring that all persons, whether they are employees, agents, subcontractors or anyone acting for or on behalf of the Contractor, are properly licensed, certified or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified or accredited under state law or the Iowa Administrative Code.

14. Insurance

The Contractor, and any subcontractor, shall maintain in full force and effect, with insurance companies licensed by the State of Iowa, at the Contractor's expense, insurance covering its work during the entire term of this Contract and any extensions or renewals thereof. The Contractor's insurance shall, among other things, be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor's performance of this Contract regardless of the date the claim is filed or expiration of the policy. The State of Iowa and the Department shall be named as additional insureds or loss payees, or the Contractor shall obtain an endorsement to the same effect, as applicable. Unless otherwise requested by the Department in writing, the Contractor shall cause to be issued insurance coverages insuring the Contractor and/or subcontractors against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability. In addition, the Contractor shall ensure it has any necessary workers' compensation and employer liability insurance as required by Iowa law.

15. Audit or Examination of Records

a. Contractors that expend $750,000 or more in a fiscal year in federal awards (from all sources) shall have a single audit conducted for that year in accordance with the provisions of OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements. Single Audits must be completed and the data collection form and reporting package must be submitted electronically to the Federal Audit Clearinghouse within the earlier of 30 calendar days after receipt of the auditor's report(s), or nine months after the end of the audit period. The contractor shall submit to the Department one (1) copy of the separate letter to management addressing non-material findings, if provided by the auditor.

b. Contractors that are independently audited but not required to submit the audit report per the criteria above, Article 15.a. shall submit one (1) copy of the audit report to the Department within thirty (30) working days of its issuance, unless specific exemption is granted in writing by the Department. To be submitted with the audit is a copy of the separate letter to management addressing non-material findings, if provided by the auditor

c. The Department may require, at any time and at its sole discretion, that recipients of non-federal and/ or federal funds have an audit performed. The Contractor shall submit one (1) copy of the audit report to the Department within thirty (30) working days of its issuance, unless specific exemption is granted in writing by the Department. The Contractor shall submit with the audit report a copy of the separate letter to management addressing non-material findings, if provided by the auditor. The Contractor may be required to comply with other prescribed compliance and review procedures.

d. The Contractor shall be solely responsible for the cost of any required audit unless otherwise agreed in writing by the Department. When the Department has agreed in writing to pay for the required audit services, the Department reserves the right to refuse payment for audit services which do not meet Federal or State requirements.

e. The Department may require a pre-award survey by the State Auditor for contractors.

f. The Contractor agrees that the Department, Auditor of the State or any authorized representative of the State, and where Federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States Government, shall have access to, and the right to examine, audit, excerpt and transcribe any pertinent books, documents, paper, and records of the Contractor related to order, invoices, payments or other documentation pertaining to this contract.

g. The Contractor agrees that the Department or its authorized representatives may have access to medical records and quality assurance materials for purposes of an independent audit of quality assurance and quality of care.

h. The Contractor shall not charge the Department a fee to audit, inspect or examine Contractor's records.

16. Contract Performance

a. The Department reserves the sole right to monitor Contractor performance through site visits, reports, or other means deemed necessary by the Department. The Contractor agrees that the Department may conduct site visits to review contract compliance, assess management controls, assess relevant services and activities, and provide technical assistance. The Contractor agrees to ensure the cooperation of the Contractor's employees, agents, and board members in such efforts and provide all requested information to the Department in the manner determined by the Department.

b. Following each site visit or review of requested information, the Department may submit a written report to the Contractor which identifies the findings. A Corrective Action Plan with a timetable to address any deficiencies or problems noted in the report may be requested. The Corrective Action Plan shall be submitted to the Department for approval within the timelines outlined in the written report.The Contractor agrees to implement the plan after it is approved by the Department. Failure to do so may result in suspension or termination of the contract.

17. Availability of Funds

The disbursement of funds under this contract is contingent upon the continued availability of federal, state, or private funds to the Department.

18. **Withholding of Support**

a. With five (5) working days written notice, the Department may temporarily withhold payment of Department funds. The Contractor may be required to submit a corrective action plan for approval by the Department. Reasons for withholding payment of funds may include, but are not limited to:

(1) Delinquency in submitting required reports.

(2) Failure to show satisfactory progress in achieving the objectives of the project or failure to meet the terms and conditions of the contract.

(3) Failure to provide adequate management of contract funds or equipment.

(4) Failure of any Deliverable to meet or conform to any applicable Specifications.

b. Temporary withholding of funds does not constitute just cause for the Contractor to interrupt services to clients or to otherwise cease work under this Contract. No interest shall accrue or be paid to the Contractor on any amounts withheld or retained by the Department under this Contract.

19. Suspension

a. When, as determined by the Department, a Contractor has materially failed to comply with the terms and conditions of the contract, the Department may suspend the contract, in whole or in part, upon written notice. The notice of suspension shall state the reason(s) for the suspension, any corrective action required, and the effective date.

b. The Department shall have the right to suspend the contract without penalty by providing ten (10) days written notice to the Contractor if any of the following conditions exist:

i. The legislature or governor fail in the sole opinion of the Department to appropriate funds sufficient to allow the Department to either meet its obligations under this Contract or to operate as required and to fulfill its obligations under this Contract; or

ii. Adequate funds are de-appropriated, reduced, or not allocated or available or if funds needed by the Department, at the Department's sole discretion, are insufficient for any reason;

iii. The Department's authorization to operate is withdrawn or there is a material alteration in the programs administered by the Department;

iv. The Department's duties are substantially modified.

c. A suspension shall be in effect until the Contractor has provided evidence satisfactory to the Department that corrective action has been or will be taken, until the contract is terminated; or until sufficient funding is reallocated to the Department, as determined by the Department in its sole discretion.

d. Obligations incurred by the Contractor during the suspension period shall not be allowed unless expressly authorized in the notice of suspension or otherwise expressly approved by the Department. Necessary costs which the Contractor could not reasonably avoid during the suspension shall be allowed only if the Contractor had a prior obligation for those expenses.

20. Termination

a. This Contract may be terminated by the Contractor upon sixty (60) days advance written notice only for the failure of the Department to comply with any material term, condition, or provision of this Contract, including but not limited to the failure to make timely payment for work performed on the Deliverables. In this event, the Contractor shall deliver to the Department written notice specifying the nature of the Department's default. The Department shall have the sixty day notice period to correct the problem that resulted in the default notice.

b. This Contract may be terminated effective immediately by either party when circumstances beyond the control of the Department or the Contractor make continuation of this contract impossible.

c. This Contract may be terminated solely by the Department for any of the following reasons:

(1) **Default by the Contractor**. The failure of the Contractor to comply with any material term, condition, or provision of this contract shall constitute a default by the Contractor. In this event, the Department shall deliver to the Contractor written notice specifying the nature of the Contractor's default. The Department's notice shall also include any penalties due for late or unsatisfactory performance. The Department may make termination of the contract effective immediately. If the notice of default sent by the Department does not indicate that the contract shall be terminated effective immediately, the Contractor shall have ten (10) days after receipt of such notice to correct the problem which resulted in the default notice and to submit payment for the fine imposed. The Department may thereafter issue a notice of immediate termination if the default is not corrected to the satisfaction of the Department or payment of the proposed fine is not received within the ten-day period.

(2) **The Convenience of the Department**. The Department may terminate this Contract in whole or in part without the payment of any penalty or incurring any further obligation to the Contractor whenever, for any reason, the Department shall determine that such termination is in the best interest of the State. In this event, the Department shall issue a termination notice to the Contractor at least ten (10) days prior to the effective termination date. Following termination upon notice, the Contractor shall be entitled to compensation, upon submission of invoices and proper proof of claim, for services provided under this Contract up to and including the date of termination.

(3) **Bankruptcy or Insolvency.** Any of the following has been engaged in by or occurred with respect to Contractor or any corporation, shareholder or entity having or owning a controlling interest in Contractor:

i. Commencing or permitting a filing against it which is not discharged within ninety (90) days, of a case or other proceeding seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect; or filing an answer admitting the material allegations of a petition filed against it in any involuntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts; or consenting to any such relief or to the appointment of or taking possession by any such official in any voluntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts;

i. Seeking or suffering the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its assets;

ii. Making an assignment for the benefit of creditors;

iii. Failing, being unable, or admitting in writing the inability generally to pay its debts or obligations as they become due or failing to maintain a positive net worth and such additional capital and liquidity as is reasonably adequate or necessary in connection with Contractor's performance of its obligations under this Contract; or

iv. Taking any action to authorize any of the foregoing.

(4) **Lack of Funds or Change in Law**. Notwithstanding anything in this Contract to the contrary, the Department shall have the right to terminate this contract without penalty by providing ten (10) days written notice to the Contractor if any of the following conditions exist:

i. The legislature or governor fail in the sole opinion of the Department to appropriate funds sufficient to allow the Department to either meet its obligations under this Contract or to operate as required and to fulfill its obligations under this Contract; or

ii. Adequate funds are de-appropriated, reduced, or not allocated or available or if funds needed by the Department, at the Department's sole discretion, are insufficient for any reason;

iii. The Department's authorization to operate is withdrawn or there is a material alteration in the programs administered by the Department;

iv. The Department's duties are substantially modified.

(5) **Conflict of interest**. In the event that the Contractor is proven to have a conflict of interest, as defined in section 11 of this contract, the Department shall immediately terminate this contract.

d. In addition, the Department may terminate this Contract effective immediately without penalty and without advance notice or opportunity to cure for any of the following reasons:

i. Contractor furnished any statement, representation, warranty or certification in connection with this Contract, the RFP or other solicitation document or the Proposal that is false, deceptive, or materially incorrect or incomplete;

ii. Contractor or any of Contractor's officers, directors, employees, agents, subsidiaries, affiliates, contractors or subcontractors has committed or engaged in fraud, misappropriation, embezzlement, malfeasance, misfeasance, or bad faith;

iii. Contractor or any parent or affiliate of Contractor owning a controlling interest in Contractor dissolves;

iv. Contractor terminates or suspends its business;

v. Contractor's corporate existence or good standing in Iowa is suspended, terminated, revoked or forfeited, or any license or certification held by Contractor related to Contractor's performance under this Contract is suspended, terminated, revoked, or forfeited;

vi. Contractor has failed to comply with any applicable international, federal, state (including, but not limited to Iowa Code chapter 8F), or local laws, rules, ordinances, regulations or orders when performing within the scope of this Contract;

vii. The Department determines or believes the Contractor has engaged in conduct that: (a) has or may expose the Department or the State to material liability, or (b) has caused or may cause a person's life, health or safety to be jeopardized;

viii. Contractor infringes or allegedly infringes or violates any patent, trademark, copyright, trade dress or any other intellectual property right or proprietary right, or Contractor misappropriates or allegedly misappropriates a trade secret or ;

ix. Contractor fails to comply with any applicable confidentiality laws, privacy laws, or any provisions of this Contract pertaining to confidentiality or privacy.

e. In the event of termination, the Contractor shall be reimbursed by the Department only for those allowable costs incurred or encumbered up to and including the termination date, subject to the continued availability of funds to the Department. Upon receipt of notice of termination the Contractor shall cease work under this contract and take all necessary or appropriate steps to limit disbursements and minimize costs, and shall furnish a report within thirty (30) days of the date of notice of termination describing the status of all work under the contract. The Contractor shall also immediately cease using and return to the Department any personal property, equipment, or materials provided by the Department to the Contractor and shall immediately return to the Department any payments made by the Department for services that were not rendered by the Contractor.

f. In the event of termination, the Contractor agrees to deliver such information and items which are due as of the date of termination, including but not limited to partially completed plans, drawings, data, documents, surveys, maps, reports, and models. The Contractor shall ensure a smooth transition of services to clients, regardless of whether this contract terminates prior to or upon the expiration date of the contract. If the Contractor fails to ensure a smooth transition of services to clients, the Department may, at its sole discretion, place the Contractor on its list of contractors barred from entering into any contract with the Department and immediately terminate all other existing contracts between the Department and the Contractor. The Contractor shall cooperate in good faith with the Department and its employees, agents and independent contractors during the transition period between the notification of termination and the substitution of any replacement service provider. The Contractor shall immediately return to the Department any payments made by the Department for Deliverables that were not rendered or provided by Contractor. The Contractor shall immediately deliver to the Department any and all Deliverables for which the Department has made payment (in whole or in part) that are in the possession or under the control of the Contractor or its agents or subcontractors in whatever stage of development and form of recordation such property is expressed or embodied as that time.

g. Should this contract be terminated under subsection 20(c)(1) (“Default by the Contractor”) or subsection 20(c)(3) (“Bankruptcy or Insolvency” of the Contractor), or should the Contractor fail to ensure a smooth transition of services to clients as required by subsection 20(f), the Department may, at its sole discretion, place the Contractor on its list of contractors barred from entering into any contract with the Department. Such placement may be permanent or for an indefinite period of time with no possibility of reinstatement for a fixed period of time, at the sole discretion of the Department. The Department may also, at its sole discretion, immediately terminate all contracts between the Department and Contractor if the Contractor is placed on the barred list of contractors.

h. The Department shall not be liable for the following costs or expenses: unemployment compensation; the payment of workers’ compensation claims, which occur during the Contract or extend beyond the date on which the Contract terminates; any costs incurred by Contractor in its performance of the Contract, including, but not limited to, startup costs, overhead or other costs associated with the performance of the Contract; any damages or other amounts associated with the loss of prospective profits, anticipated sales, goodwill, or for expenditures, investments or commitments made in connection with this Contract; any taxes Contractor may owe in connection with the performance of this Contract, including, but not limited to, sales taxes, excise taxes, use taxes, income taxes or property taxes.

i. The Department reserves all administrative, contractual and legal remedies which are available in the event that the Contractor violates or breaches the terms of this contract.

j. In the event that Contractor owes the Department or the State any sum under the terms of this Contract, any other contract or agreement, pursuant to a judgment, or pursuant to any law, the Department may, in its sole discretion, set off any such sum against: (1) any sum invoiced by, or owed to, Contractor under this Contract, or (2) any sum or amount owed by the State to Contractor, unless otherwise required by law. The Contractor agrees that this provision constitutes proper and timely notice under any applicable laws governing setoff.

k. The Department's right to terminate this Contract shall be in addition to and not exclusive of other remedies available to the Department, and the Department shall be entitled to exercise any other rights and pursue any remedies, in law, at equity, or otherwise.

21. Recovery of funds

If the Department or any state or federal agency determines that the Contractor has been reimbursed for any cost that is unallowable, unallocable, or unreasonable under this contract, the Contractor shall repay those funds within thirty (30) business days of receiving written notice from the Department. The Department may additionally withhold any payment under this contract if the Contractor fails to repay those funds by the established deadline. The Contractor's obligation to repay funds survives the termination of this contract.

22. Indemnification

The Contractor and its successors and assignees agree to indemnify and hold harmless the State of Iowa and the Department and its officers, employees, agents, and volunteers from any and all liabilities, damages, settlements, judgments, costs and expenses, including the reasonable value of time spent by the Attorney General's Office and the costs and expenses and reasonable attorney fees of other counsel required to defend the Department or the State of Iowa, related to or arising from any of the following:

a. Any violation of this contract.

b Any negligent, intentional, or wrongful act or omission of the Contractor, its officers, employees, agents, board members, contractors or subcontractors, or any other person in connection with this project.

c. Any infringement of any patent, trademark, trade dress, trade secret, copyright, or other intellectual property right.

d. The Contractor's performance or attempted performance of this contract.

e. Any failure by the Contractor to comply with all federal, state, and local laws and regulations.

f. Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income, and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa.

g. The death, bodily injury or damage to property of any enrollee, agent, employee, business invitee or business visitor of the Contractor or any of its subcontractors.

h. Any failure by the Contractor to adhere to the confidentiality provisions of this contract.

23. Changes of Key Personnel

The Contractor's personnel specified by name and title in Article IV of the Special Conditions are considered to be essential to the work or services being performed. If, for any reason, substitution or elimination of a specified individual becomes necessary, the Contractor shall provide written notification to the Department. Such written notification shall include the successor's name and title. The Contractor shall notify the Department in writing within ten (10) working days of any change of key personnel. A copy of the resume for a director hired during the course of the contract shall also be sent to the Department within ten (10) working days from the date of hire.

24. Assignment

a. This contract shall not be assigned, transferred, or conveyed in whole or in part by the Contractor to any third party or parties without written approval in advance by the Department. The Department reserves the right to not contract with a new contractor.

b. A written agreement with the Contractor to relinquish all rights to the project, and a written agreement with the new contractor to accept all the terms and conditions of the contract shall be submitted to and approved in writing by the Department prior to the date of transfer.

25. Changes in Location

The Department shall be notified of any change in office or service location from that shown in the contract at least ten (10) working days prior to such change

26. Changes in Service

Changes in the services to be provided by the Contractor as outlined in the contract require prior written approval by the Department. Discontinuation of any service may result in a decrease in the contract amount or termination of the contract.

27. **Warranties**

a. Construction of Warranties Expressed in this Contract with Warranties Implied by Law. Warranties made by the Contractor in this Contract, whether: (a) this Contract specifically denominates the Contractor's promise as a warranty; or (b) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of samples to the Department, shall not be construed as limiting or negating any warranty provided by law, including without limitation, warranties that arise through course of dealing or usage of trade. The warranties expressed in this Contract are intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. The provisions of this section apply during the term of this Contract and any extensions or renewals thereof.

b. The Contractor represents and warrants that: (i) all Deliverables shall be wholly original with and prepared solely by Contractor; or it owns, possesses, holds, and has received or secured all rights, permits, permissions, licenses and authority necessary to provide the Deliverables to the Department hereunder and to assign, grant and convey the rights, benefits, licenses and other rights assigned, granted or conveyed to the Department hereunder or under any license agreement related hereto without violating any rights of any third party; (ii) Contractor has not previously and will not grant any rights in any Deliverables to any third party that are inconsistent with the rights granted to the Department herein; and (iii) the Department shall peacefully and quietly have, hold, possess, use and enjoy the Deliverables without suit, disruption or interruption.

c. The Contractor represents and warrants that: (i) the Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables); and (ii) the Department's use of, and exercise of any rights with respect to, the Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual property right, proprietary right or personal right of any third party. Contractor further represents and warrants there is no pending or threatened claim, litigation or action that is based on a claim of infringement or violation of an intellectual property right, proprietary right or personal right or misappropriation of a trade secret related to the Deliverables. Contractor shall inform the Department in writing immediately upon becoming aware of any actual, potential or threatened claim of or cause of action for infringement or violation or an intellectual property right, proprietary right, or personal right or misappropriation of a trade secret. If such a claim or cause of action arises or is likely to arise, then Contractor shall, at the Department's request and at the Contractor's sole expense: (i) procure for the Department the right or license to continue to use the Deliverable at issue; (ii) replace such Deliverable with a functionally equivalent or superior

Deliverable free of any such infringement, violation or misappropriation; (iii) modify or replace the affected portion of the Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation or misappropriation; or (iv) accept the return of the Deliverable at issue and refund to the Department all fees, charges and any other amounts paid by the Department with respect to such Deliverable. In addition, Contractor agrees to indemnify, defend, protect and hold harmless the State and its officers, directors, employees, officials and agents as provided in the Indemnification section of this Contract, including for any breach of the representations and warranties made by Contractor in this section. The foregoing remedies shall be in addition to and not exclusive of other remedies available to the Department and shall survive termination of this Contract.

d. The Contractor represents and warrants that the Deliverables (in whole and in part) shall: (i) be free from material Deficiencies; and (ii) meet, conform to and operate in accordance with all Specifications and in accordance with this Contract during the Warranty Period, as defined in the Special Terms. During the Warranty Period Contractor shall, at its expense, repair, correct or replace any Deliverable that contains or experiences material Deficiencies or fails to meet, conform to or operate in accordance with Specifications within five (5) business days of receiving notice of such Deficiencies or failures from the Department or within such other period as the Department specifies in the notice. In the event Contractor is unable to repair, correct or replace such Deliverable to the Department's satisfaction, Contractor shall refund the fees or other amounts paid for the Deliverables and for any services related thereto. The foregoing shall not constitute an exclusive remedy under this Contract, and the Department shall be entitled to pursue any other available contractual, legal or equitable remedies. Contractor shall be available at all reasonable times to assist the Department with questions, problems and concerns about the Deliverables, to inform the Department promptly of any known Deficiencies in any Deliverables, repair and correct any Deliverables not performing in accordance with the warranties contained in this Contract, notwithstanding that such Deliverable may have been accepted by the Department, and provide the Department with all necessary materials with respect to such repaired or corrected Deliverable.

e. The Contractor represents, warrants and covenants that all services to be performed under this Contract shall be performed in a professional, competent, diligent and workmanlike manner by knowledgeable, trained and qualified personnel, all in accordance with the terms and Specifications of this Contract and the standards of performance considered generally acceptable in the industry for similar tasks and projects. In the absence of a Specification for the performance of any portion of this Contract, the parties agree that the applicable specification shall be the generally accepted industry standard. So long as the Department notifies Contractor of any services performed in violation of this standard, Contractor shall re-perform the services at no cost to the Department, such that the services are rendered in the above-specified manner, or if the Contractor is unable to perform the services as warranted, Contractor shall reimburse the Department any fees or compensation paid to Contractor for the unsatisfactory services.

f. The Contractor represents and warrants that the Deliverables will comply with any applicable federal, state, foreign and local laws, rules, regulations, codes, and ordinances in effect during the term of this Contract, including applicable provisions of Section 508 of the Rehabilitation Act of 1973, as amended, and all standards and requirements established by the Architectural and Transportation Barriers Access Board and the Iowa Department of Administrative Services, Information Technology Enterprise.

g. Obligations Owed to Third Parties. The Contractor represents and warrants that all obligations owed to third parties with respect to the activities contemplated to be undertaken by the Contractor pursuant to this Contract are or will be fully satisfied by the Contractor so that the Department will not have any obligations with respect thereto.

28. Contract Administration

a. **Invalidity.** If any provision of this contract is in conflict with any state or federal law shall be declared to be invalid by any state or federal court of record, such invalidity shall affect only such portions as are declared invalid or in conflict with the law. Any remaining portion shall continue to be in effect.

b. **Status of Contractor.** The Contractor shall at all times be deemed an independent contractor. The Contractor, its employees, agents, and any subcontractors performing under this contract are not employees or agents of the State of Iowa or any agency, Department, or division of the state. The Contractor shall be responsible for all its withholding taxes, social security, unemployment, worker's compensation and other taxes and shall hold the Department harmless for any claims for same. If the Contractor is a non-profit organization or affiliated with a government organization, the Contractor shall file all required state and federal reports to maintain such status.

c. Compliance with the law.

i. The Contractor, its employees, agents, and subcontractors shall not engage in discriminatory employment practices which are forbidden by federal or state law, executive orders, or rules of the Iowa Department of Administrative Services.The Contractor, its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, executive orders, and orders when performing the work and services under this Contract, including without limitation the following: all laws applicable to the prevention of discrimination in employment (including Iowa Code section 19B.7 and chapter 216), all laws applicable to the nondiscriminatory provision of services or benefits, all laws applicable to accessibility of facilities, and all laws applicable to the use of targeted small businesses as subcontractors or suppliers.

ii. The Contractor, its employees, agents, and subcontractors shall also comply with all federal, state, and local laws regarding permits and licenses that may be required to carry out the work and services to be performed under this Contract.

iii. The Contractor may be required to submit its affirmative action plan, containing goals and time specifications and accessibility plans and policies, to the State to comply with the requirements of 11 IAC chapter 121.

iv. In the event Contractor contracts with third parties for the performance of any of the Contractor obligations under this Contract, Contractor shall take such steps as necessary to ensure such third parties are bound by the terms and conditions contained in this section.

v. The Contractor agrees that compliance with the provisions of Iowa Code section 19B.7 and all applicable rules of the Department of Administrative Services prior to the execution of the Contract shall be a condition of the Contract binding upon the Contractor, its successors, and assignees. Notwithstanding anything in this Contract to the contrary, Contractor's failure to fulfill any requirement set forth in this section shall be regarded as a material breach of this Contract and the Department may cancel, terminate, or suspend, in whole or in part, this Contract. The Department may further declare Contractor ineligible for future state contracts in accordance with authorized procedures or the Contractor may be subject to other sanctions as provided by law.

vi. If all or a portion of the funding used to pay for the Deliverables is being provided through a grant from the Federal Government, Contractor acknowledges and agrees that pursuant to applicable federal laws, regulations, circulars and bulletins, the awarding agency of the Federal Government reserves certain rights including, without limitation a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes, the Deliverables developed under this Contract and the copyright in and to such Deliverables. Contractor shall use procurement procedures that comply with all applicable federal, state, and local laws and regulations.

ci. Not a Joint Venture. Nothing in this contract shall be construed as creating or constituting the relationship of a partnership or joint venture between the parties hereto. Each party shall be deemed to be an independent contractor acting toward the mutual benefits expected to be derived here from. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this contract.

e. **Joint Entity.** If the Contractor is a joint entity, consisting of more than one individual, partnership, corporation or other business organization, all such entities shall be jointly and severally liable for carrying out the activities and obligations of this contract, and for any default of such activities and obligations.

f. **Choice of Law and Forum.** The terms and provisions of this contract shall be construed in accordance with the laws of the State of Iowa. Any and all litigation or actions commenced in connection with this contract shall be brought in Des Moines, Iowa, in the Iowa District Court in and for Polk County, Iowa. If, however, jurisdiction is not proper in the Polk County District Court, the action shall only be brought in the United States District Court for the Southern District of Iowa, Central Division, provided that jurisdiction is proper in that forum. This provision shall not be construed as waiving any immunity to suit or liability that may be available to the Department or the State of Iowa.

g. **Waiver.** Except as specifically provided for in a written waiver signed by duly authorized representatives of the Department and the Contractor, failure by either party at any time to require performance by the other party or to claim a breach of any provision of the contract shall not be construed as affecting any subsequent breach or the right to require performance with respect thereto or to claim a breach with respect thereto.

h. **Headings or Captions**. The section and subsection headings or captions are for identification purposes only and do not limit or construe the contents of the sections and subsections.

i. **Supersedes former Contracts**. This contract supersedes all prior contracts between the Department and the Contractor for work and services provided in connection with this contract.

j. **Counterparts**. The parties agree that this contract has been or may be executed in several counterparts, each of which shall be deemed an original and all such counterparts shall together constitute one and the same instrument.

k. **Amendments**. This agreement may be amended in writing by mutual consent of the parties. All amendments to this agreement must be fully executed by the parties.

l. **Integration**. This agreement represents the entire agreement between the parties and none of the parties are relying on any representation that may have been made which is not included in this agreement.

m. **Delays or Impossibility of Performance Based on a Force Majeure**. Neither party shall be in default under the Contract if performance is prevented, delayed, or made impossible to the extent that such prevention, delay, or impossibility is caused by a Force Majeure. If a Force Majeure delays or prevents the Contractor's performance, the Contractor shall immediately use its best efforts to directly provide alternate, and to the extent possible, comparable performance. The party seeking to exercise this provision shall immediately notify the other party of the occurrence and reason for the delay. The parties shall make every effort to minimize the time of nonperformance and the scope of work not being performed due to the unforeseen events. Dates by which performance obligations are scheduled to be met will be extended only for a period of time equal to the time lost due to any delay so caused.

n. **Obligations beyond contract term.** This contract shall remain in full force and effect to the end of the specified term or until terminated or cancelled pursuant to this contract. All obligations of the Department and the Contractor incurred or existing under this contract as of the date of expiration, termination or cancellation shall survive the termination, expiration, or conclusion of this contract.

o. **Authorization**. Each signatory to this Contract or subsequent Contract amendments represents and warrants to the other parties that:

i. The signatory has the right, power, and authority to enter into this agreement and to bind the party represented by the signatory to this agreement

ii. The party has the right, power, and authority to perform its obligations under the agreement;

iii. The party has taken all requisite action (corporate, statutory, or otherwise) to approve execution, delivery, and performance of this agreement and this agreement constitutes a legal, valid, and binding obligation upon itself in accordance with its terms.

p. **Immunity from Liability**. Every person who is a party to the Contract is hereby notified and agrees that the State, the Department, and all of their employees, agents, successors, and assigns are immune from liability and suit for or from Contractor's and/or subcontractors' activities involving third parties and arising from the Contract.

q. **Public Records.** The laws of the State require procurement records to be made public unless otherwise provided by law.

r. **Taxes**. The State is exempt from Federal excise taxes, and no payment will be made for any taxes levied on Contractor's employee's wages. The State is exempt from State and local sales and use taxes on the Deliverables.

s. **Legislative Changes.** The Contractor expressly acknowledges that the contracted Deliverables are subject to legislative change by either the federal or state government. Should either legislative body enact measures which alter the project, the Contractor shall not hold the Department liable in any manner for the resulting changes. The Department shall use best efforts to provide thirty (30) days written notice to the Contractor of any legislative change. During the thirty (30) day time period, the parties shall meet and make a good faith effort to agree upon changes to the Contract to address the legislative changes. Nothing in this subsection shall affect or impair the Department's right to terminate the Contract pursuant to the termination provisions.

t. **Right to Address Board of Directors or Other Managing Entity**. The Department reserves the right to address the Contractor's board of directors or other managing entity of the Contractor regarding Contract performance, expenditures, or any other issue as deemed appropriate by the Department.

29. Contractor's Certification regarding Suspension and Debarment

The Contractor certifies pursuant to 31 CFR part 19 that neither it nor its principles are presently disbarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any federal Department or agency. The Contractor further agrees to comply with the regulations implementing executive order 12549 regarding debarment and suspension.

30. Contractor's Certification regarding Lobbying

The Contractor certifies that:

a. No Federal appropriated funds or Other funds originating as Federal funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employe 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, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

i. If any funds other than Federal 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 any Federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

ii. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into and is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code of Federal Regulations. 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.

b. No State appropriated funds or Other funds originating as State appropriated funds shall be used for the compensation of a lobbyist. For purposes of this section, “lobbyist” means the same as defined in Iowa Code Section 68B.2; however, “lobbyist” does not include a person employed by a state agency of the executive branch of state government who represents the agency relative to the passage, defeat, approval, or modification of legislation that is being considered by the general assembly.

c. The Contractor shall require that the language of this section be included in the award documents for all subawards at all levels (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

31. Contractor’s Certification regarding Brokering

The Contractor certifies that no person or selling agency has been employed or retained to solicit and secure this contract upon an agreement or understanding for commission, percentage, brokerage, or contingency excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing business. For breach or violation of this certification, the Department shall have the right to terminate this contract without liability, or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

32. Contractor’s Certification regarding a Drug Free Workplace

The Contractor shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988 and all applicable regulations. The Contractor is required to report any conviction of employees under a criminal drug statute for violations occurring on the Contractor's premises or off the Contractor's premises while conducting official business. A report of a conviction shall be made to the Department within five (5) working days after the conviction.

33. Contractor’s Certification Regarding Environmental Tobacco Smoke

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children’s services provided in private residences; 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.

b. The Contractor certifies that it 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.

c. The Contractor agrees that it will require that the language of this certification be included in any subcontract or subaward that contains provisions for children's services and that all subrecipients shall certify accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $ 1000 per day.

34. Tobacco Free Environment

The Contractor agrees that it will not allow smoking or tobacco use within any portion of any indoor facility it leases, rents, or owns, and over which it has the authority to establish policy. The Contractor agrees that it shall comply with Iowa's Smokefree Air Act, contained at Iowa Code chapter 142D.

35. Compliance with Iowa Code chapter 8F.

If the Contract is subject to the provisions of Iowa Code chapter 8F, the Contractor certifies it will comply with the requirements of the Iowa Code chapter 8F. The Contractor shall forward any compliance documentation, including but not limited to certifications, and any compliance documentation received from subcontractors by the Contractor to the Department.

36. Compliance with Federal Funding Accountability and Transparency Act

If the Contract is subject to the provisions of 2 CFR Chapter 1 Part 170, the Contractor certifies it will comply with the requirements of this Act. The Contractor shall forward any required documentation, including but not limited to certifications to the Department.

37. Enhancement of Contractor Employee Whistleblower Protections

41 U.S.C. 4712 states, "employees of a contractor, subcontractor, grantee [or subgrantee] may not be discharged, demoted, or otherwise discriminated against as a reprisal for "whistleblowing." In addition, whistleblowing protections cannot be waived by any agreement, policy, form or condition of employment.

Whistleblowing is defined as making a disclosure "that the employee reasonably believes is evidence of any of the following:

- Gross mismanagement of a federal contract or grant;
- A gross waste of federal funds;
- An abuse of authority relating to a federal contract or grant;
- A substantial and specific danger to public health or safety; or,
- A violation of a law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant).

To qualify under the statute, the employee's disclosure must be made to:

- A member of Congress, or a representative of a Congressional committee;
- An Inspector General;
- The Government Accountability Office;
- A federal employee responsible for contract or grant oversight or management at the relevant agency;
- An official from the Department of Justice, or other law enforcement agency;
- A court or grand jury; or,
- A management official or other employee of the contractor, subcontractor, grantee, or subgrantee who has the responsibility to investigate, discover, or address misconduct.

The requirement to comply with, and inform all employees of the "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections" is in effect for all grants, contracts, subgrants, and subcontracts.

Appendix G

Frequently Asked Questions

Q: How do I gain access to the I-SMART system if my account has been locked?

A: In the event a Prevention Specialist is locked out of the I-SMART system, please contact the I-SMART Help Desk at ismart.helpdesk@idph.iowa.gov or call 866.339.7913.

Q: Who should I contact if the IowaGrants.gov website is not working?

A: Please contact the IDPH Iowa Grants Help Desk by calling 866.520.8987 or email IowaGrants.Helpdesk@idph.iowa.gov with concerns related to IowaGrants.gov. Please note, checking your spam folder or speaking with your agency's Information Technology (IT) staff may provide additional guidance.

Q: How do I communicate with an Iowa Department of Public Health representative if I have questions about the contract or have a prevention question?

A: Please use the Correspondence section of IowaGrants.gov if questions are specific to personnel, budgets, progress reports or other contract related items. For non-contract related questions, please feel free to contact an IDPH representative via email or phone.

Q: I would like to connect with other Prevention Contractors to network and learn how agencies provide services. Is there a way for us to connect?

A:Yes, regular prevention grant contractor meetings (face-to-face and via web conference) are coordinated by the Department. Contractors are encouraged to attend these meetings to receive updated information and network with prevention partners across the state. Meeting format and process varies depending on the prevention grant. Contract the Department representation for each prevention grant for more information.

Q: Why are staff responsible for achieving direct service hours?

A: Direct service hours are a reflection of the level of effort it takes to complete and sustain a prevention activity. It is important for prevention staff to achieve a minimum level of direct service hours, within the Service Area, to ensure prevention services are

implemented at an adequate level to achieve the desired behavior change. Direct service hour expectations vary depending on the funding opportunity awarded to your agency through the Department.

Q: A Prevention Specialist will be off of work due to a health related issue or other extenuating circumstances. Is our agency still responsible for the same amount of direct service hours expected by the Iowa Department of Public Health?

A: Services that are funded under an IDPH grant will need to continue in lieu of staff vacancy or absence. Please contact IDPH if additional technical support is needed.

Q: Are there commonly used websites our agency should be aware of to ensure the information provided is up-to-date and researched?

A: Yes, please see Appendix I - Prevention Terms and Acronyms to identify state and national websites to support and enhance prevention efforts.

Q: Our agency completed our Quarterly Progress Report, but forget to click "Submit". Is the Progress Report considered late?

A: Yes, if the Progress Report has been completed but not submitted in IowaGrants.gov, it will be considered late.

Q: Is our agency allowed to reimburse mileage at a higher rate than what is outlined in the Request for Proposal?

A: The Department will not reimburse travel amounts in excess of limits established by the Iowa Department of Administrative Services, State Accounting Enterprise. Current in-state maximum allowable amounts are: *Food - $12.00/breakfast, $15.00/lunch, $29.00 dinner; Lodging - $98 plus tax per night; Mileage - 39¢ per mile.* If your agency chooses to reimburse staff travel amounts above the Iowa Department of Public Health established rates, alternative funding will need to be utilized to support the increase.

Q: Our agency does not believe a short-term outcome will be met. What is the process for changing an activity in the IDPH approved Work Plan? (Review IPFS language)

A: The Department contract outlines the deadline for Work Plan revisions. Work Plan revisions are typically allowed until the end of March for Work Plans operating on the

state fiscal year. Prior to requesting an amendment to the Department approved Work Plan, ask yourself the following:

1. What has our agency done to ensure the Department approved activity is met?
2. How have key stakeholders been involved throughout the fiscal year to discuss any barriers to successfully achieving the Department approved activity?
3. Has our agency contacted the Department for technical assistance when the initial barrier was identified?
4. If applicable, how has the population of focus been engaged in the process?

Q: Our agency is needing additional support related to a prevention activity. How do we request assistance for our identified issue?

A: Any request for technical assistance can be sent via the Correspondence section of IowaGrants.gov. Technical assistance requests may include but are not limited to training needs or Work Plan related barriers. In addition to IowaGrants.gov, often times the quarterly progress reports allow for agencies to include a technical assistance request.

Q: Our agency has received an exception for a contract related requirement in the past from the Department. Do exception requests carryover from year-to-year or is a new request needed?

A: No, Department exceptions requests will need to be requested on an annual basis, via Correspondence in IowaGrants.gov. Situations have the potential to change from each fiscal year which will warrant a review of the request annually.

DRAFT

-Grant Name-

Iowa Department of Public Health
Bureau of Substance Abuse
Prevention Feasibility Checklist

Overview

IDPH funded Contractors will need to use a Feasibility Checklist when exploring, planning for, and implementing prevention services. Feasibility checklists serve as a tool to identify community support and resources towards specific substance misuse and/or problem gambling prevention activities. This vital step ensures that funding is being dedicated towards prevention services that have community support, are data driven, maximize positive behavior change and lead towards sustainability.

Conducting an internal analysis of the agency is the first step in identifying feasibility. Ensuring resources (i.e. time, people, space, funds, etc.) are secure will establish the necessary foundation needed for effective prevention services. Once an internal review is completed, a community assessment will need to be conducted to support prevention services which are based on community need and have the necessary buy-in to achieve the desired behavior change.

The Feasibility Checklist provided is intended to help guide community conversations. Agencies can add to the questions provided in order to best identify and support community needs. All questions may not be answered initially; however, it is important to continue having these discussions to identify any potential gaps that may arise.

**This checklist was developed by the Iowa Department of Public Health to be used when planning for prevention services.*

Staff Member Completing Checklist:

*Staff Name(s):*_____

*Agency Name:*_____

Grant Name:_____

Prevention Service:_____

*Feasibility Checklist Completed on Date (s):*_____

Sector(s) That Participated

Feasibility Checklists are conducted when planning for a prevention service. Check all sectors that were actively engaged in the planning process:

- ❑ Youth
- ❑ Parents
- ❑ Businesses
- ❑ Media
- ❑ Schools
- ❑ Youth-serving organizations
- ❑ Law enforcement
- ❑ Religious or fraternal organizations
- ❑ Civic or volunteer groups
- ❑ Healthcare professionals
- ❑ State, local, or tribal governmental agencies with expertise in substance misuse and/or problem gambling
- ❑ Other organizations involved in reducing substance misuse and/or problem gambling (treatment providers)
- ❑ Other (please specify): _____

Key Findings (Ex: all counties represented, barriers to identifying sectors, effective ways to engage sectors, etc.):

_____
_____
_____

Note: If all sectors were not represented, it is strongly encouraged to seek a representative from the missing sector(s), prior to implementation.

Feasibility Checklist:

I. Assessing Agency Resources

- ❑ Our agency has the capacity and resources to dedicate to the identified prevention service.
- ❑ In the event of staff turnover, our agency has established a back-up plan to ensure the prevention service continues.
- ❑ The identified prevention service aligns with the IDPH approved Work Plan and the agency's mission and vision?
- ❑ Our agency is addressing all Center for Substance Abuse Prevention strategies, as well as, all Institute of Medicine categories.

Note:_____
_____
_____
_____

II. Identifying Need

- ❏ Using data to identify the prevention service, multiple stakeholders including representatives from the population of focus, met to discuss the proposed services (strengths, weaknesses, resources, etc.).
- ❏ Multiple programs/policies/practices were identified and discussed to ensure the appropriate prevention services are explored.
- ❏ Community Assessment was or is planned to be conducted to ensure there is no duplication of services.
- ❏ Stakeholders agreed on the appropriate prevention service to be implemented to meet the needs of the population of focus.
- ❏ Community culture was discussed and strategies were discussed on ways to reach multiple audiences.

Note:_____
_____
_____
_____

III. Roles & Responsibilities

- ❏ Clear Roles & Responsibilities have been established.
- ❏ Time commitments, space, and resources have been discussed and agreed upon.
- ❏ A plan has been developed if an individual is no longer able to fill their role to ensure the prevention activity continues.
- ❏ Accountability measures have been established (Ex: timelines, check-ins, etc.).

Note:_____
_____
_____
_____

IV. Planning for Prevention Services

- ❏ A structured schedule has been established and takes into consideration competing events within a community. A backup date/time has been scheduled in the event of unexpected weather, illness or other extenuating circumstances.
- ❏ The proper notes (i.e. parental consent forms, active/passive consent forms, press releases, etc.) have been identified and created prior to implementation.
- ❏ An evaluation process has been established, including a process for analyzing the data upon completion of the prevention services.
    - ❏ Evaluation process established
    - ❏ Meetings are set based upon completion of prevention service to review results

Note:_____
_____
_____
_____

V. Implementing Prevention Services

- ❑ A plan has been developed to ensure the population of focus receives the prevention services (i.e. Save the Dates, consent forms, pre/post surveys, etc.) as planned.
- ❑ A clear schedule has been established.
- ❑ Resources have been identified and will be received prior to the date of the prevention service.

Note:_____
_____
_____
_____

VI. Evaluating Prevention Services

- ❑ IDPH evaluation requirements have been reviewed and shared with stakeholders.
- ❑ A process for analyzing data has been established including ways to share the data with the population of focus and community at-large.
- ❑ Individuals implementing the evaluation tool understand the process for discussing, implementing, collecting and reporting data.

Note:_____
_____
_____
_____

VII. Sustainability

- ❑ Potential community resources have been identified that may support the prevention service.
- ❑ If applicable, Train-the-Trainer opportunities have been discussed.

Note:_____
_____
_____
_____

We appreciate you taking the time to complete this Feasibility Checklist.

Appendix I

Prevention Terms and Acronyms

Many fields have acronyms as a part of their professional language. This is not different for professionals working in substance abuse and/or problem gambling prevention. Please reference the list below which compiles a list of commonly used acronyms. While not an exhaustive list, this document can serve as a quick reference tool.

View this video to get you started: https://youtu.be/W7MVm3AEIhY

ABD: Alcoholic Beverages Division
Their mission is "To serve Iowans through responsible and efficient licensing, regulation, and distribution of alcohol." https://abd.iowa.gov/

AC4C: Alliance of Coalitions for Change
"The Alliance of Coalitions For Change is a statewide network seeking to increase the synergy of substance abuse prevention efforts in Iowa."

https://sites.google.com/site/iaac4c/home

ATOD: Alcohol, Tobacco, and Other Drugs

CADCA: Community Anti-Drug Coalitions of America
"The mission of CADCA (Community Anti-Drug Coalitions of America) is to strengthen the capacity of community coalitions to create and maintain safe, healthy and drug-free communities globally. This is accomplished by providing technical assistance and training, public policy advocacy, media strategies and marketing programs, training and special events." http://www.cadca.org/

CAW: Community/County Assessment Workbook
This a workbook/project deliverable that is designed to assist communities/counties in identifying and prioritizing community data related to underage drinking and underage binge drinking for the IPFS project.

CCB: Community Check Box
Community Check Box is a tool that IPFS uses to collect evaluation data.
http://ctb.ku.edu/en/community-check-box-evaluation-system

CDC: Centers for Disease Control and Prevention
"CDC is the nation's health protection agency, working 24/7 to protect America from health and safety threats, both foreign and domestic. CDC increases the health security of our nation." http://www.cdc.gov/

CHNA & HIP (pronounced China Hip): Community Health Needs Assessment Health Improvement Plan
This is a planning process that local boards of health are required to engage in, at least every five years. They lead community wide, stakeholder discussions to identify community health needs and then identify objectives and strategies to address those needs. http://idph.iowa.gov/chnahip

CLAS: The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
According to their website "The National CLAS Standards are a **set** of 15 action steps intended to advance health equity, improve **quality**, and help eliminate health **care** disparities by providing a blueprint for individuals and health and health **care** organizations to implement culturally and linguistically appropriate services." https://www.thinkculturalhealth.hhs.gov/clas It is a PFS requirement to incorporate these standards in your work There are several project resources related to implementing these standards.

CSAP: The Center for Substance Abuse Prevention
"The mission of the Center for Substance Abuse Prevention is to improve behavioral health through evidence-based prevention approaches." http://www.samhsa.gov/about-us/who-we-are/offices-centers/csap

DFC: Drug Free Communities Grant
According to the White House.gov website "The Drug-Free Communities Support Program (DFC) is a Federal grant program that provides funding to community-based coalitions that organize to prevent youth substance use." There are several communities in Iowa that have previously held, or currently have DFC grants. https://www.whitehouse.gov/ondcp/Drug-Free-Communities-Support-Program

DPAC: Drug Policy Advisory Council
The Drug Policy Advisory Council, established by Iowa Code Chapter 80E, is responsible for "making policy recommendations to the appropriate departments concerning the administration, development, and coordination of programs related to substance abuse education, prevention, treatment and enforcement." https://odcp.iowa.gov/DPAC

DHS: Department of Human Services
For more information about Iowa's Department of Human Services, visit www.dhs.iowa.gov

EBP: Evidence Based Practices, or Evidence Based Programs
According to SAMHSA, **"**EBPs integrate clinical expertise; expert opinion; external scientific evidence; and client, patient, and caregiver perspectives so that providers can

offer high-quality services that reflect the interests, values, needs, and choices of the individuals served." What this means for PFS, is that we use practices, programs and intervention that have demonstrated evidence of effectiveness. You can find out more about substance abuse prevention EBPs in several places including http://www.samhsa.gov/ebp-web-guide and http://www.samhsa.gov/nrepp and in the PFS project resources.

EPI: Epidemiological
Definition from dictionary.com: The branch of medicine dealing with the incidence and prevalence of disease in large populations and with detection of the source and cause of epidemics of infectious disease.

IBC: Iowa Board of Certification
The Iowa Board of Certification credentials prevention and treatment professionals in addictions and other behavioral health fields by promoting adherence to competency and ethical standards. For more information about IBC or becoming a Certified Community Prevention Specialist, visit www.iowabc.org

IDPH: Iowa Department of Public Health
Their mission is to" promote and protect the health of Iowans." IDPH funds the IPFS project grants. www.idph.iowa.gov

IPACT: Iowa Program for Alcohol Compliance Training
This is an alcohol compliance program created by the Iowa Alcoholic Beverages Division (ABD), in response to legislation mandating its creation. The ABD website gives more information about the training, as well as information regarding legal protections for businesses that participate. https://abd.iowa.gov/education/i-pact

IPFS: Iowa Partnership for Success
The Partnerships for Success (PFS) grant is a cooperative agreement through the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). This grant program is designed to address: 1) underage drinking among persons aged 12 to 20; and 2) prescription drug misuse and abuse among persons aged 12 to 25. www.iowapfs.org
https://idph.iowa.gov/substance-abuse/programs/ipfs

ISASA: Iowa Substance Abuse Supervisors Association
ISASA' mission is to "foster the development and professional growth of current and future prevention and treatment supervisors through communication, cooperation and education of its membership." www.isasaiowa.org

IYS: Iowa Youth Survey
According to their website, "The Iowa Youth Survey is conducted by the Iowa Department of Public Health's Division of Behavioral Health in collaboration with the Iowa Department of Human Rights' Criminal and Juvenile Justice Planning and Statistical Analysis Center. In the fall of 1999, 2002, 2005, 2008, 2010, 2012 and 2014 students in the 6th, 8th, and 11th grades across the state of Iowa answered questions about their attitudes and experiences regarding alcohol and other drug use and violence, and their perceptions of their peer, family, school, and neighborhood/ community environments. In 2008 the survey was administered online for the first time. The 2016 survey will also be online and will be conducted in October." For more information visit http://www.iowayouthsurvey.iowa.gov/

LE: Law Enforcement

LEW: Local Epidemiological Workgroup

MCTC: Midwest Counterdrug Training Center
MCTC is funded through the Department of Defense and administered by the Iowa National Guard. They offer training for law enforcement officers, prevention and treatment professionals as well as military students throughout the United States. They are the current provider for Substance Abuse Prevention Skills Training (SAPST) in Iowa. They work closely with the Alliance of Coalitions for Change (AC4C) and the Iowa Department of Public Health to provide prevention programming and resources. https://counterdrugtraining.com

NIAAA: National Institute on Alcohol Abuse and Alcoholism
"The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being. It is the largest funder of alcohol research in the world." www.niaaa.nih.gov

NIDA: National Institute on Drug Abuse
Their mission is "advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health." www.drugabuse.gov

NPN: National Prevention Network
"The National Prevention Network (NPN) is an organization of State alcohol and other drug abuse prevention representatives that provides a national advocacy and communication system for prevention. State prevention representatives work with their respective State Agency Directors to ensure effective alcohol, tobacco, and other drug abuse prevention services in each State." http://nasadad.org/npn-4/

NREPP: National Registry of Evidence-Based Programs and Practices
"NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation." http://www.samhsa.gov/nrepp

ODCP: Office of Drug Control Policy
There is a Office of National Drug Control Policy (ONDCP) https://www.whitehouse.gov/ondcp as well as individual state level offices, including the Iowa Governor's Office of Drug Control Policy http://www.state.ia.us/odcp/ These offices provide guidance, collaboration and coordination of drug control policies at the national and state levels.

OJJDP: Office of Juvenile Justice and Delinquency Prevention
"OJJDP provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs and to improve the juvenile justice system so that it protects public safety, holds justice-involved youth appropriately accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families." www.ojjdp.gov

PIRE: Pacific Institute For Research And Evaluation
"PIRE is an independent, nonprofit organization merging scientific knowledge and proven practice to create solutions that improve the health, safety, and well-being of individuals, communities, and nations around the world." www.pire.org

RBST: Responsible Beverage Service Training
Training for those who sell or serve alcohol on how to do so responsibly (i.e., not providing service/sales to those under 21 or overserving)

RFA: Request for Application
This is an application to apply for continued grant funding

RFP: Request for Proposals
This is an application or proposal to apply for grant funding

ROSC: Recovery Oriented System of Care
Iowa Definition of a ROSC: A ROSC supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness, and recovery from alcohol and drug problems and problem gambling. A ROSC offers a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathway to recovery. ROSC is consumer and family driven, timely and responsive, person centered, effective,