STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

To our HHS stakeholders and team members,

Just over four years ago, in my initial interview with Governor Reynolds – we talked about a connected and comprehensive health and human services system that was user friendly and thoughtfully planned. One that Iowans could navigate with ease and integrity. In the first year of my tenure here – as I navigated some of the most complex issues of my career, a global pandemic, a DOJ investigation and some truly heartbreaking child welfare cases, I saw the deep cracks in our big system. I also began to see where we could fill in these cracks and where our work could lift up Iowa families and communities.

Now, as we work to align legacy Public Health and Human Services alongside Aging, The Child Advocacy Board, Early Childhood Iowa, Human Rights and Volunteer Iowa, the time is right to refocus our collective work toward a simple goal - **better outcomes for Iowans**. I'm not satisfied with the system we have today and we shouldn't settle for something just because it's the way we've always done things. It's in this spirit that we've conducted our System Alignment Assessment. After several months of hard work, we're ready to share the recommendations with you. As a reminder, the goals for of the assessment are:

- Create consistency in the way Iowans access health and human services from county to county
- Harness the expertise and passion of our HHS workforce and local partners
- Make better use of funding
- Improve the way we work with local partners
- Better reflect the evolution of our state's resources and partners

We contracted with Health Management Associates (HMA) to study the delivery of health and human service programs in our state. I am pleased to share the recommendations and options developed as part of that work.

When reviewing these recommendations, it's clear that the scope of this work is significant. We want to be thoughtful about the ordering and pace as we address opportunities for improvement. As such, we recommend a phased approach to this effort, that first focuses on the needs related to behavioral health while conducting ongoing stakeholder engagement related to the governance and structures outlined in the recommendations. Our next step will be to continue conversations with stakeholders and legislators to develop an implementation plan with a timeline for different phases. We will provide updates as this work progresses.

Through this work, we will create a more efficient system – a pathway for a new and collaborative approach to reach our shared goals of improving outcomes for Iowans. We will bring the community to the table and foster shared decision making by local leaders and the individuals, families, and communities they serve.

We are also considering the pace of a changing demographic of the state, our obligations related to litigation and ensuring resources are allocated equitably in way that meets the needs of our diverse communities. Reduce the administrative burden and allow for local flexibility to meet local needs and solve local problems.

I'd like to thank everyone who has collaborated with us on this process and want to encourage you to continue giving us your guidance and feedback. We can't do this work without you.

In partnership,

Kelly Garcia

HMA

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Iowa Department of Health & Human Services

Service Delivery Alignment Assessment

October 2023

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EXECUTIVE SUMMARY

Effective July 1, 2023, the Iowa Departments of Public Health (IDPH) and Human Services (DHS) merged and transitioned into the Iowa Department of Health and Human Services (HHS). The Iowa Departments of Aging, Department of Human Rights, Early Childhood Iowa, the Iowa Child Advocacy Board, and Volunteer Iowa also joined HHS. As part of this transition, HHS is working to ensure that services are delivered efficiently and effectively for individuals, families, and communities across the State of Iowa. To do so, HHS partnered with Health Management Associates (HMA) to conduct a statewide assessment to identify successes and gaps in service delivery as well as opportunities for further service integration.

HHS identified the following 19 service delivery systems for inclusion in this assessment.

Aging & Disability Services	Behavioral Health	Public Health	Community Access	Family Well-Being & Protection
• Aging & Disability Resource Centers (ADRC) • Area Agencies on Aging (AAA)	• Certified Community Behavioral Health Clinics (CCBHC) • Integrated Provider Network (IPN) • Mental Health & Disability Services Regions (MHDS) • Tobacco Community Partnerships (CP)	• Local Governmental Public Health • Emergency Preparedness Regions • Environmental Health • Local public health delivered Medicaid services	• Community Action Agencies (CAAs) • Family Planning • I-Smile • Maternal, Child, and Adolescent Health (MCAH) • Special Supplemental Nutrition Program for Women, Infants and Children (WIC) • Family Development & Self Sufficiency Program (FaDSS)	• Community Partnership for Protecting Children (CPPC) • Decategorization (Decat) • Early Childhood Iowa (ECI)

Health and Human Services Overview

Within the realigned HHS organizational structure, multiple divisions are responsible for oversight and administration of the 19 service delivery systems studied in this assessment. Collectively, these service delivery systems are serving Iowans across their lifespan to provide critical health and human services, including primary, preventive, and direct care services, as well as general and emergency assistance. Each program under the purview of Iowa HHS has a unique history, coupled with federal funding structures, regulatory requirements, and program eligibility criteria. Working within this framework, Iowa HHS currently has different geographic service provision areas across the 19 service delivery systems studied in this assessment.

HHS Division	Service Delivery System	Service Area and/or Number of Providers
Aging & Disability Services	ADRCs	6 Regions with 1 Statewide Network
	AAAs	6 Planning and Service Areas

HHS Division	Service Delivery System	Service Area and/or Number of Providers
Behavioral Health	CCBHCs	Under Development
	IPN	19 Service Area Providers
	MHDS	13 Regions
	Tobacco CPs	19 Regions 28 Partnerships
Community Access	CAAs	16 Agencies
	Family Planning	8 Providers in 15 of the CSAs
	I-Smile	15 Service Areas
	MCAH	15 Service Areas
	WIC	15 Service Areas
	FaDSS	15 Service Providers
Family Well-Being & Protection	CPPC	40 Sites
	Decat	40 Projects
	ECIs	38 Area Boards
Public Health	Local Governmental Public Health	96 Agencies 99 Local Boards of Health
	Emergency Preparedness Regions	8 Service Areas
	Environmental Health	85 Agencies

The recent HHS organizational alignment has created opportunities to improve alignment across the health and human services delivery systems. The structural and funding options described below are designed to advance the following goals across Iowa's health and human services delivery systems:

- All Iowans should have access to a core level of health and human services regardless of where they reside, including Iowans in rural and sparsely populated areas.
- Consumers should have a choice regarding where they receive services, when feasible.

- Governance structures, contracting strategies, and funding mechanisms should promote and enhance collaboration at local and system-wide levels to address service gaps and minimize administrative and service duplication.
- Funding should be integrated and flexible, where feasible, to minimize programmatic silos.
- Efforts to promote efficiencies and economies of scale should be balanced against the need to ensure local input and engagement.
- Where a single entity is a contractor for multiple HHS programs, contracting should be consolidated and streamlined to reduce administrative burdens at the state and local levels. This will free up resources to focus on delivering high quality services to consumers and improving outcomes.

Aging and Disability Services Findings and Recommendations

The current structure of having Area Agencies on Aging (AAAs) as the only designated Aging and Disability Resource Centers (ADRCs) has not provided an equitable focus on the disability side of ADRCs, possibly as a function of the Department on Aging formerly being a standalone department. Improved coordination is needed between Older Americans Act (OAA) services administered through the AAAs, disability services delivered through the Mental Health and Disability Services (MHDS) regions, and Medicaid long-term services and supports (LTSS). Additional outreach and public messaging about the breadth of information and assistance available through the ADRCs to populations beyond older adults would be beneficial. A greater understanding of the disability side of aging and disability services is needed across HHS divisions, in particular with lifespan service delivery areas such as behavioral health and community service agencies. Intentional efforts are needed to coordinate community services through the state's development of a multisector plan for aging and implementation of any recommendations from the Hope and Opportunity in Many Environments (HOME) project. Disability services, particularly for individuals with intellectual or developmental disabilities (ID/DD) or individuals with brain injuries should move from MHDS regions to ADRCs, with a broader set of designated organizations that can serve as an ADRC.

Recommendation 1: HHS should consider broadening the organizations either designated as ADRCs or with formal arrangements to fulfill ADRC functions to provide equitable support for older Iowans, younger Iowans with disabilities, veterans, and their caregivers.

- Action Items:
    - Amend Iowa Code §231.64, which solely designates AAAs to carry out ADRC functions and establish a coordinated system for providing a one-stop access point for LTSS and benefits, to allow additional organizations that have expertise in ADRC functions, specifically for younger Iowans with disabilities.
    - Amend the definition of "disability services" in Iowa Code §225C.2, presently defined as services and other support available to a person with mental illness, ID/DD, or brain injury. The definition should focus less on diagnostic categories unless those diagnoses are tied to specific state programs with eligibility limitations related to

diagnosis. This change would better align Iowa Code with the functional organization of the aligned HHS structure.

Recommendation 2: With the alignment of HHS and potential changes for the MHDS regions, state funding that goes toward supporting Iowans with ID/DD or brain injuries should be transferred to ADRCs, whether that is the model of the six current AAAs or an expanded model with the designation of disability-focused community organizations as ADRC sites.

- Action Items:
    - Identify the appropriate funding allocation formula if disability funds shift to existing AAA planning and service areas.
    - Develop disability-specific performance and outcome measures to be incorporated into ADRC reporting.

Recommendation 3: HHS should consider an internal, formal body that oversees ADRC objectives and outcomes led by the Division of Aging and Disability Services, which includes, at a minimum, the Division of Medicaid, the Division of Behavioral Health, and the Department of Veterans Affairs.

- Action Items:
    - Build on previous work of the Department on Aging and the technical assistance it receives from the National Center on Advancing Person-Centered Practices and Systems to:
        - Identify assets to support stakeholder engagement, align engagement efforts across agencies, and develop methods to increase connections with culturally, ethnically, and linguistically diverse communities
        - Create an Engagement Plan to identify strategies and best practices for engaging with stakeholders
        - Enhance cross-system consistency through ADRC systems, which serve as "one-stop" coordinated entry points into the long-term service and support system for anyone seeking those services, regardless of age, income, or disability
    - Monitor additional funding opportunities such as grants[1] from the US Administration for Community Living to support Community Infrastructure, No Wrong Door System Governance and training on ADRC/ No Wrong Door Key Principles.[2]

Recommendation 4: Increase communication, collaboration, and consistency in cross-division understanding of the Aging Network and the integration of disability services within the Division of Aging and Disability Services.

- Action Items:

- Coordinate state-level efforts to develop a multisector plan for aging and attain age-friendly state recognition inclusive of Iowa's aging population and people with disabilities.
    - The Iowa State Health Improvement Plan (SHIP) can serve as a model for including representatives with a state or regional focus and commitment to transforming the home and community-based services (HCBS) infrastructure and coordination of services to support Iowans as they age in their community or a location of choice.
- Closely coordinate system design recommendations between the HOME project and the HHS service delivery realignment efforts, with particular focus on Iowans who are not yet Medicaid-eligible or are on HCBS waiting lists as priority groups for state Aging and Disability Services.

Behavioral Health Findings and Recommendations

In direct support of the HHS alignment, the DHS-Division of MHDS-C and Iowa Department of Public Health (IDPH) Division of Behavioral Health have begun integration efforts. In addition, responsibility for the programs and services for individuals with ID/DD has transitioned to the newly formed HHS Division of Aging and Disability Services. The historical separation of the administration of the mental health and substance use delivery systems, under HHS and IDPH, respectively, has resulted in siloed systems and structures for delivering safety net services and likely has limited opportunities to add efficiencies that can be realized through integrated behavioral health systems. The Integrated Provider Network (IPN) and MHDS regions are geographically misaligned. In addition, IPN contracts include direct service provision as well as local system development activities, whereas MHDS Regional contracts primarily support local purchasing of services in addition to local system navigation supports.

In addition to the state alignment initiative, previous and emerging environmental factors have and will affect the mental health and substance use delivery systems. These circumstances are noteworthy when considering opportunities available to the emerging integrated Iowa behavioral health safety net system of care. As states have reinvented the role of the behavioral health safety net, Certified Community Behavioral Health Clinics (CCBHCs) have emerged as an option to standardize core services, require quality assurance practices, and expand integrated care practices, enhancing and updating the Community Mental Health Center (CMHC) model, while maintaining a safety net for people without coverage. As Iowa continues planning for CCBHC implementation, the impact of their entrance into the provider network further necessitates a review of existing structures in the behavioral health safety net and continued system realignment.

Recommendation: As HHS continues to support integration of substance use disorder (SUD) and mental health services, consider moving to a single administrative contracting model with flexibility to make reimbursement allocation decisions that advance HHS and Division of Behavioral Health (DBH) system goals.

- Action Items:
    - Consider updating funding models to allow HHS and DBH to move away from bifurcated and per capita allocation formulas for local contracts. Alternatively, target

resources through competitive procurement for certain initiatives, expand use of value-based payment structures to drive outcomes, and where possible, intentionally use funding allocation approaches to address disparities.

    - Per capita funding has been reported to limit flexibility in addressing emerging trends or crisis hotspots throughout the state. Adopting the funding approaches listed above would allow the state to strategically direct funding toward accomplishing state goals, while offering flexibility for local nuance.

- Consider adopting one of the following contracting models and make conforming changes to Iowa Code and Iowa Administrative Code (IAC), including Iowa Code Chapter 125, Iowa Code Chapter 225C, and 441 IAC 25.

Option A: State Contracting Structure	**Option B: Regional Structure**	**Option C: Hybrid State Contracting/Local Advisory Board Structure**
State transitions away from local intermediaries (MHDS Regions) to contracting directly with both mental health and SUD providers for non-Medicaid services, under a similar structure to the IPN contracts.	State continues to contract through regional entities and transitions IPN/SUD contracting to these entities to support the integration of behavioral health administration, including consolidated contracts for comprehensive providers (Colorado[3] and Ohio[4] operate similar models).	State contracts directly with both mental health and SUD providers as in Option A and contracts with newly integrated (SUD and mental health) regional entities to support local needs assessments, reporting, and monitoring to inform and support behavioral health statewide strategic planning and goal achievement (Nevada[5] operates similar model).
Considerations		
Care coordination functions being provided by MHDS Regions could be contracted directly with providers or become a condition of certification or licensure, as will be the case for CCBHCs and is currently the case for the IPN.	Regions could be required to contract with an existing IPN to ensure network adequacy for SUD. The emerging CCBHCs could provide geographic boundaries for future regional structure considerations as they, as comprehensive behavioral health providers,	The state could begin with current overlapping MHDS (Adult/Youth) Regions and require SUD representation, followed by consideration of factors described below for determining future structure, as well as geographies of other HHS local entities.

Option A: State Contracting Structure	Option B: Regional Structure	Option C: Hybrid State Contracting/Local Advisory Board Structure
Regional boundaries for service delivery can be eliminated as long as there is tracking of statewide core service availability by DBH, continued requirements for IPN providers to serve statewide, and CCBHCs are successfully implemented over time to also provide statewide coverage. This option would allow contracting for ID/DD services to transition from the MHDS Regions to oversight under of the Division of Aging and Disability Services in response to realignment.	are required to serve the under/uninsured and provide crisis services. As comprehensive safety net providers, CCBHCs will deliver the majority of core behavioral health services now required of the regions.	
Advantages		
The state has direct line-of-sight into system operations and performance. Decreased financial allocation for administration. Services are integrated.	Lower administrative burden for state staff, allowing for them to have greater focus on systemic outcomes and quality. Ability to be more regionally responsive to trends in needs. Services are integrated.	Incorporates an entity whose purpose is to evaluate efficacy of the treatment system as well as identify needs and future direction of services. Leverages local presence, permitting responsiveness to unique local needs. The state has direct line-of-sight into system operations and performance. Services are integrated.
Disadvantages		

Option A: State Contracting Structure	Option B: Regional Structure	Option C: Hybrid State Contracting/Local Advisory Board Structure
Higher administrative burden for state staff. Decreased ability to provide regionally responsive funding/programming. State staff turnover can result in disruption of services.	Performance of providers is managed through an intermediary. Managing and monitoring expectations can be challenging if communication and standardization is not strong.	Higher administrative burden for state staff. State staff turnover can result in disruption of services.

Community Access and Family Well-Being and Protection Findings and Recommendations

Community Access

Community Access administers programs designed to assist families in meeting economic needs and helping them to become self-sufficient. It also administers programs that provide preventive health services for infants, children, pregnant women, and new mothers. These services are delivered by a network of Community Action Agencies (CAA) and other contracted providers which are trusted by, and closely tied, to local communities. In addition, a subset of Community Access programs: WIC, Maternal, Child and Adolescent Health (MCAH), I-Smile, 1st Five, and Family Planning are organized into Collaborative Service Areas (CSAs) for more aligned and holistic service delivery to address the needs of the people who will be receiving services and the infrastructure that enables them to be served. The map for CSAs and CAAs is not the same except in one region. The Family Development and Self-Sufficiency (FaDSS) program offers support to families facing barriers to employment through a home visiting program. The FaDSS coordinator works with parents to develop skills and obtain resources needed to address family needs and identify career goals.

The relationships between CAAs and other contracted providers to the communities they serve reflect a history of strong collaboration between these agencies and local civic, religious, business, and county government. Iowa HHS is well served by having a network of trusted provider entities at the local level which can identify gaps or needs in the safety net and mobilize community funds and other resources to quickly meet the needs of local communities. In developing these recommendations, HMA sought to develop options that leverage local knowledge and ingenuity rather than disrupt existing collaborations. In developing these recommendations, we were mindful of federal requirements which shape CAA governance and federal limitations on changing CAA regions. Most of all, these recommendations seek to align programs to reflect the growing body of evidence which shows that prevention efforts and health outcomes are improved when linked to efforts to reduce barriers or limitations caused by factors such as economic instability, unsafe and/or unaffordable

housing, lack of reliable transportation, lack of English language skills or literacy, and lack of internet connectivity and/or access to a home computer.

Family Well-Being and Protection

Discussions with stakeholders and document review of the three programs reviewed, surfaced some overlap between Community Partnership for Protecting Children (CPPC), Decategorization (also known as Decat), and Early Childhood Iowa (ECI), including the populations served, participants in governance structure, program coordination, and program priorities. In addition, the increased focus and investment in prevention programming, including primary prevention, for children, youth, and families to reduce the risk of child maltreatment and improve child, youth, and family well-being outcomes is a thread that runs through all programs. The following options reflect ways in which HHS could restructure the three programs/approaches to better focus and streamline resources and service delivery. These approaches take into consideration national best practices for service delivery that include: impacted community input, multi-disciplinary planning and interventions, and local community needs-driven interventions. The overarching goal of these options are two-fold:

1. Increase local and state coordination in the delivery of family well-being and protection interventions/programs.
2. Decrease administrative overlap and duplication in contract and program administration.

Community Access and Family Well-Being and Protection Recommendations

Recommendation: Choose a model to align select Community Access and Family Well-Being and Protection programs utilizing a lead agency model with catchment areas through which Iowans can access services regardless of county of residence.

- Action Item:
    - Consider adoption of one of the models below. Option 1 can be chosen as a single option, but also HHS may want to choose *both* Option 2 and Option 3.
    - Make corresponding funding and legislative changes based on model selected.

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	**Option 2: Combine CSA Programs under Lead Agency Model**	**Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model**
Overview		
Combine the following programs to create a single contracting structure: • 1st Five	Combine the following programs to create a single contracting structure: • 1st Five • MCAH • FPP	Combine the following programs to create a single prevention and early intervention delivery model: • CPPC • Decat • ECI

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
• Maternal, Child and Adolescent Health (MCAH) • Family Planning Program (FPP) • I-Smile • Women, Infant, and Children (WIC) • Community Partnership for Protecting Children (CPPC) • Decat • ECI • FaDSS	• I-Smile • WIC • FaDSS	
Interaction with Community Action Agencies (CAA) [6]		
The lead agency must develop an MOU with CAAs that are located within the boundaries of the new catchment area to formalize mutually agreed upon collaborations where appropriate.		
Interaction with WIC Agencies		
HHS will want to consider whether to do a competitive application for WIC. If not, HHS will need to develop an application process for interested parties to apply to be a WIC agency and get USDA approval for that process.		
Catchment Area Options[7]		
1. Current CAA Map[8] 2. Counties granted a specified period of time to organize themselves into multi-county catchment areas[9] 3. Current CSA map	1. Current CAA Map 2. Counties granted a specified period of time to organize themselves into multi-county catchment areas 3. Current CSA map	1. Current ECI Maps 2. Current CAA Maps 3. Align with catchment area formed under Option 2
Governance Model Elements		
The lead agency under all three options must demonstrate the capacity to carry out the following administrative functions:		

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
1. Establish mechanisms to ensure multi-program communication needed to share emergent issues and promising practices. 2. Include processes to integrate local input and collaborative decision-making processes on how best to incorporate private, charitable, or local funds to enhance the delivery of services within the catchment area. 3. Utilize a community needs assessment process(es) that incorporates the perspectives of individuals and families who are eligible to receive Community Access or Family Well-Being and Protection services, providers of Community Access or Family Well-Being and Protection services, community advocates, civic leaders, and local elected officials. 4. Identify priorities for contracted services and supports for children, youth, and families; and contracting with providers to meet the needs of children, youth, and families. This program could be guided by a set of values/strategies similar to CPPC, which are: shared decision-making, community neighborhood networking, family and youth-centered engagement, policy and practice change. The CPPC approach also includes tools and strategies for implementing each component, which could be helpful to implementing this prevention and early intervention model.		
Advantages		
Eliminates multiple procurements and contracts at the state level. Fully realizes opportunities to support families through the combination of preventive health programs, family well-being and protection programs. Allows for greater coordination between FaDSS and Family Well-Being and Protection. Gives Iowans the right to choose where to receive services by incorporating a catchment area model. Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.	Eliminates multiple procurements and contracts at the state level. While not presently available in every CSA (8 of 15), in future RFPs the state can impose requirements that RFP bidders would have to provide or subcontract family planning in every county (e.g., subcontractors can furnish services in multiple catchment areas). Gives Iowans the right to choose where to receive services by incorporating a catchment area model. Less disruptive than Option 1 to current regional and provider communities.	Eliminates multiple procurements and contracts at the state level. Allows for greater coordination between FaDSS and Family Well-Being and Protection. Increases local and state coordination in delivery of family well-being and protection interventions/ programs and decreases administrative overlap and duplication in contract and program administration. Gives Iowans the right to choose where to receive services by incorporating a catchment area model.

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
	Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.	Less disruptive than Option 1 to current regional and provider communities. Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.
Disadvantages		
HHS organizational structure includes Community Access and Family Well-Being and Protection as separate Divisions. Therefore, internal structural changes would need to be considered. Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.	Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.	Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.
Legislative Changes Required		
Legislative action would be required to: 1. Eliminate CPPC, Decat, and ECI as separate programs/initiatives and establish the prevention/early intervention program. 2. Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected).	Legislative action would be required to: 1. Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected). 2. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant	Legislative action would be required to: 1. Eliminate CPPC, Decat, and ECI as separate programs/ initiatives and establish the prevention/early intervention program. 2. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
3. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.	requirements to conform to new lead agency model.	

Public Health Findings and Recommendations

Iowa's public health system operates under a decentralized "home rule" model in which local governments retain substantial autonomy to manage public health services and functions, including the structure, financing, size, and activities of Local Public Health Agencies (LPHA). While Local Boards of Health (LBOH) have jurisdiction over all public health matters within their designated geographic areas and are required to make and enforce reasonable rules and regulations necessary to protect and improve the public health, Iowa law establishes few specifically-required LBOH public health services or functions. LHPAs understand local needs, have strong local partnerships, and are an accessible and trusted resource in their communities. However, the foundational public health capabilities of LHPAs and the services they offer vary by county.

Capability and service disparities across counties are driven, in part, by inadequate and inflexible public health funding but also by local funding decisions made by county boards of supervisors. The majority of LPHAs across the country are small, serving populations of less than 50,000.[10] Small size, however, generally means a smaller tax base and fewer resources to meet public health challenges and difficulty achieving efficiencies through economies of scale. [11] Larger LPHAs may also benefit from larger pools of medical providers, community-based organizations, educational institutions, businesses, and other stakeholders that could be enlisted to participate in public health activities.

Recommendation 1: Regionalize the delivery of local public health services while preserving a public health presence in every county that, at a minimum, offers consumer-accessed services, such as immunizations and certain environmental health inspections and permitting.

- Action Items:
    - Adopt 10-15 regions comprised of contiguous counties that have a combined minimum population of at least 50,000.[12]
        - Make consistent changes to public health Emergency Preparedness regions.
        - Under Options A, B1, and B2, (described below) allow regions to delegate environmental health functions to counties where environmental health staff are currently county employees but employed outside of the LPHA.[13]
    - Adopt one of the public health delivery system models described below.

Option A: Regionally Administered Centralized Governance Model	Option B1: State Defined Regional Health District Model	Option B2: County Defined Regional Health District Model	Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations
Based in part on the Arkansas model, HHS would provide administrative, policy, managerial direction, and support and Local Public Health Agencies (LPHAs) would be organizationally a part of HHS.	Based in part on the Nebraska[14] and Idaho[15] models, the state would define and establish 10-15 regional health districts (RHDs) – governmental entities that are not state agencies or units of county government.	Based, in part, on the Minnesota model, [16] counties would be required to join a regional health district (RHD), subject to geographic and population size criteria for each RHD.	Based, in part, on the Indiana model, state would maintain current home rule governance structure, but HHS would provide technical assistance and financial incentives to promote LPHA consolidations and cross-jurisdictional sharing (CJS) arrangements.
Other Features			
HHS would establish a local presence in each county staffed by state employees. LBOHs would be eliminated, but each county would appoint a county Health Officer to enhance local input, engagement, and collaboration.[17] HHS would create 10-15 multi-county administrative districts accountable for the effective, efficient, and equitable allocation and use of	RHDs are required to maintain a local presence in each constituent county. RHDs are the governing body for local public health and the only governmental entity eligible for Iowa's Essential Public Health Services (LPHS) funding. LBOHs eliminated, but RHD governing boards comprised of members appointed by the constituent counties.[18]	RHDs are required to maintain a local presence in each constituent county. RHDs are the governing body for local public health and the only governmental entity eligible for Iowa's Essential Public Health Services funding. Counties could choose to retain LBOHs and LPHAs; RHD governing boards comprised of members appointed	Maintains local control; counties retain authority for designating local presence/offices. LPHAs choosing to consolidate are required to maintain a local presence in each constituent county. LPHAs choosing to accept financial incentives would be held accountable for delivering (including through consolidations or CJS arrangements) the state-defined foundational public

Option A: Regionally Administered Centralized Governance Model	Option B1: State Defined Regional Health District Model	Option B2: County Defined Regional Health District Model	Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations
public health resources and for ensuring foundational public health services and capabilities are available in all parts of the state.	RHDs may employ staff and contract for services. Counties could be required to financially contribute to RHDs. RHDs accountable for the effective, efficient, and equitable allocation and use of public health resources and for ensuring foundational public health services and capabilities are available in all parts of the state.	by the constituent counties. LBOHs could be allowed to retain local ordinance powers for specified functions (e.g., control of public health nuisances[19]) RHDs may employ staff, contract for services, and delegate to constituent counties. RHDs must meet geographic and population size criteria designed to create 10-15 RHDs.[20] RHDs accountable for the effective, efficient, and equitable allocation and use of public health resources and for ensuring foundational public health services and capabilities are available in all parts of the state.	health services and functions. HHS would provide technical assistance and supports to LPHAs under a regional structure, comprised of 10-15 regions, including technical assistance in formulating CJS arrangements.
Advantages (Compared to Current State)			

Option A: Regionally Administered Centralized Governance Model	Option B1: State Defined Regional Health District Model	Option B2: County Defined Regional Health District Model	Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations
Ensures more consistent public health service levels across the state. Potential to generate efficiencies/eliminate duplicative efforts. Potentially allows quicker response to emerging challenges and needs. Simplest Option	Ensures more consistent public health service levels across the state. Potential to generate efficiencies/eliminate duplicative efforts. Potentially allows quicker response to emerging challenges and needs.	Ensures more consistent public health service levels across the state. Potential to generate efficiencies/eliminate duplicative efforts. Potentially allows quicker response to emerging challenges and needs.	Maintains current local partnerships. Incentivizes/promotes: • More consistent public health service levels across the state • Efficiencies • Quicker response to emerging challenges and needs Able to maintain/ incentivize county funding contributions.
Disadvantages (Compared to Current State)			
Potential to lose current local partnerships. Individual county needs may not be a priority. Loss of county funds currently devoted to public health activities. Elimination of LBOHs and current LPHAs not consistent with the	Potential to lose current local partnerships, but less so than Option A. Smaller counties in RHDs with larger counties may feel their needs are not a priority. Elimination of LBOHs and current LPHAs not consistent with the majority of stakeholder feedback	Potential to lose current local partnerships, but less so than Options A or B1. Smaller counties in RHDs with larger counties may feel their needs are not a priority. Negotiation of affiliation agreements between counties and RHDs would be	Some counties may not respond to incentives to fully deliver foundational public health services and functions leaving some areas of the state underserved. HHS retains the challenge of supporting and coordinating and collaborating with a

Option A: Regionally Administered Centralized Governance Model	Option B1: State Defined Regional Health District Model	Option B2: County Defined Regional Health District Model	Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations
majority of stakeholder feedback during townhalls and group interviews. Significant expansion of state workforce required.	during townhalls and group interviews.* *(*Note: In both NE, and ID, the impetus for establishing regional health districts was the lack of local health departments in many or most counties.[2122])*	needed and could be complex. Most complex option	large number of local public health units. Potentially less able to achieve efficiencies and eliminate duplicative efforts.

Recommendation 2: Establish and build consensus for foundational public health capabilities that all LPHAs or Regional Health Districts (RHDs) should meet.

- Action Items:
    - Define foundational public health capabilities through a stakeholder engagement process that includes, at a minimum, state staff and LPHA staff representation.
    - Conduct outreach and education activities targeting local elected and public health officials and other stakeholders (e.g., health care providers, school nurses, etc.) to promote the adoption of the foundational public health capabilities in each county or region.

Recommendation 3: Provide LPHAs or RHDs with stable, recurring, and flexible funding to build and sustain baseline public health services and functions.

- Action Items:
    - Increase state-funded Essential Public Health Services (LPHS) allocations to support the provision of baseline public health services and functions in each county or RHD, taking into account county population and support services provided at the state level.
        - Undertake an assessment to quantify funding enhancements needed to meet baseline standards in each jurisdiction.
        - Consider formula changes needed and revise regulation (IAC 641-80) accordingly.
        - Under Option C, tie a county's increased LPHS allocation to:

- Metrics that reflect adoption of the foundational public health capabilities
- A maintenance of effort requirement for county tax revenues supporting public health activities

Recommendation 4: Expand HHS resources to support LPHAs or RHDs and interlocal collaboration.

- Action Items:
  - Expand HHS staff and resources, as needed, to support RHDs or LPHAs (and environmental health staff employed outside of an LPHA) in meeting/providing the foundational public health capabilities for public health services and functions which could include, for example, epidemiology supports, data analytics, code enforcement and other legal consultation, communications, grant writing/management, training, and other functions, as necessary.
  - Under Option C, provide technical assistance to support and enable LPHA cross-jurisdictional resource sharing to provide foundational public health services and functions as needed and desired by LPHAs.

BACKGROUND

Effective July 1, 2023, the Iowa Departments of Public Health (IDPH) and Human Services (DHS) became one department and transitioned into the Iowa Department of Health and Human Services (HHS). At this time, the Iowa Departments of Aging, Department of Human Rights, Early Childhood Iowa, the Iowa Child Advocacy Board, and Volunteer Iowa also joined HHS. As part of this transition, HHS is working to ensure that services are delivered efficiently and effectively for individuals, families, and communities across the state of Iowa. To do so, HHS partnered with Health Management Associates (HMA), to conduct a statewide assessment to identify successes and gaps in service delivery as well as opportunities for further service integration. Through this assessment, HHS sought to gain a foundational understanding of each studied service area, including:

- Purpose, rationale, and historical context of the current service delivery system
- Scope of providers within the service delivery system
- How the service delivery system is funded and resourced
- Linkages between service areas in the current delivery system and Medicaid programs
- Target and priority populations, including number of individuals currently being served
- Decision makers and partners involved in service delivery system
- Operational capabilities and gaps of the state and local system for service delivery system

In addition, HHS established the following objectives for this project:

- Develop recommendations to better align HHS service delivery for streamlined systems with improved outcomes while preserving and ensuring strong local presence, including:
    - Opportunities to standardize services based on evidence-based practices.
    - Opportunities to increase accessibility to Medicaid programs.
    - Revisions to service delivery models, levels of service delivery, funding models, and/or administrative responsibilities.
- Identify opportunities to better provide high quality, equitable services for individuals, families, and communities.

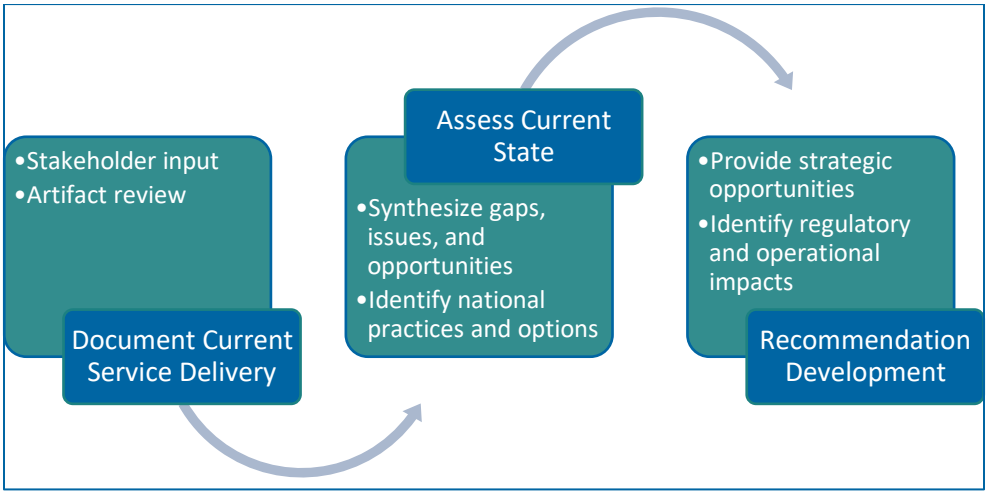
HHS SERVICE DELIVERY SYSTEMS REVIEWED

HHS identified the following 19 service delivery systems for inclusion in this assessment.

Aging & Disability Services	Behavioral Health	Public Health	Community Access	Family Well-Being & Protection
•Aging & Disability Resource Centers (ADRC) •Area Agencies on Aging (AAA)	•Certified Community Behavioral Health Clinics (CCBHC) •Integrated Provider Network (IPN) •Mental Health & Disability Services Regions (MHDS) •Tobacco Community Partnerships (CP)	•Local Governmental Public Health •Emergency Preparedness Regions •Environmental Health •Local public health delivered Medicaid services	•Community Action Agencies (CAAs) •Family Planning •I-Smile •Maternal, Child, and Adolescent Health (MCAH) •Special Supplemental Nutrition Program for Women, Infants and Children (WIC) •Family Development & Self Sufficiency Program (FaDSS)	•Community Partnership for Protecting Children (CPPC) •Decategorization (Decat) •Early Childhood Iowa (ECI)

APPROACH

HMA undertook a three-phased approach to this assessment including: documenting the current service delivery system, assessing the current state, and recommendation development.



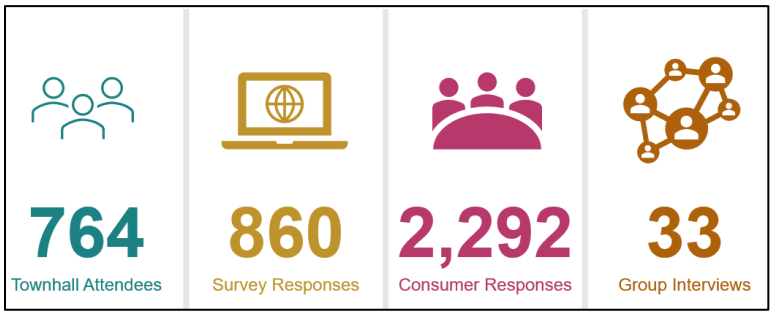
Limitations

This assessment was conducted over a four-month period between June and October 2023. Due to time constraints, the findings included in this report are limited to the review of documents provided by HHS and responses obtained through surveys and interviews. HMA did not conduct a comprehensive

analysis of statewide accessibility of services or funding outlays and shortages across the 19 service delivery systems. While many of the service areas have overlap or close borders with the Medicaid program and its array of service offerings, there are aspects of programs, services, and populations that are not fully covered in this assessment due to the scope of this study. Other efforts that can inform recommendations for linkages between Medicaid and the 19 service delivery systems have been completed or are underway through other HHS partners.

Stakeholder Input

Stakeholder input was obtained through multiple strategies, including town hall meetings, partner survey, consumer survey, and interviews. HHS reviewed and approved the list of interviewees to support broad representation across Iowa geographies, while town hall meetings and surveys allowed for broader stakeholder engagement and input. These strategies were utilized to obtain input from the diverse group of individuals and entities that interact with the HHS service delivery system. Feedback was sought on successes and gaps in current service delivery and opportunities for further service integration.



Town Halls

HHS, in partnership with HMA, hosted town hall meetings, four face-to-face and three virtual, in July 2023. A total of 764 stakeholders were in attendance. Participant comments primarily centered around the following general themes:

- Local control is critical in the delivery of HHS services.
- Stakeholders are concerned with the speed of the assessment process.
- Access to services in rural areas will be compromised in a regionalized model.
- Currently, the local service delivery system is not siloed. Rather, there are siloes at the HHS level.

Additional details regarding these predominant themes, and other issues raised, are catalogued in Appendix 5: Town Hall Themes.

Partner Survey

HHS partners were also invited to provide feedback on the strengths and challenges of the HHS service delivery system through an online survey. The survey was available in both English and Spanish and posted from July 27, 2023, through August 15, 2023. A total of 860 partners responded to the survey, with the majority (52%) representing contractors or providers who receive funds from HHS to provide services.[23] The remaining respondents represented a broad range of partners including provider and consumer advocates, elected officials, and state staff. Additionally, survey

respondents identified as interacting with or participating in a broad range of HHS programs and initiatives. A copy of the survey is available in Appendix 1: Partner Survey and detailed findings, including a further breakdown of respondent type and affiliation, in Appendix 2: Partner Survey Responses.

Strengths Identified by Survey Respondents

There was alignment among respondent groups regarding the strengths of HHS programs and services. All groups identified providers and coordination among service providers as a top strength. For example, the most frequently selected response among providers, contractors, provider advocates, consumer advocates, volunteer/committee/board members, and elected officials was "providers are very committed and really care about making sure the people they serve get what they need to reach their goals." Similarly, the most frequently selected strength by state staff was "service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person."

Additionally, across all respondent types, the statement "there is good communication and coordination between services and support providers" was among the top three most frequently selected strengths. Providers, contractors, provider advocates, and state staff also identified "local programs are administered very well and the level of waste and/or duplication is very low" among the top two most frequently identified strengths.

Challenges Identified by Survey Respondents

Funding was a top challenge identified by respondents. Respondents indicated funding is inadequate to meet service expectations and the needs of individuals and communities across the state. Access and statewide equity concerns were also identified as top challenges. For example, the third most frequently selected challenge among responding providers, contractors, and provider advocates was "individuals and communities across the state are not able to access and receive the same level of services to meet their needs." Consumer advocates, volunteer/committee/board members, and elected officials also raised access issues, responding that a top concern is "consumers are unable to receive services when needed because there is a wait list" and "it is difficult for consumers to travel to a program or service office because of lack of public transportation or distance from home."

Access & Duplication Themes Identified by Survey Respondents

The majority of survey respondents across all partner groups indicated Iowans must participate in duplicative processes when accessing services across multiple HHS program areas. Respondents noted the use of separate forms and applications across service areas with requests for duplicative information and indicated this creates barriers in accessing care. Additionally, most contractors and providers of HHS services and provider advocates do not agree that it is easy to make referrals to other HHS programs and services when needed or that service coordination across HHS programs is effective. It was noted that when other services needed are provided by another local agency, referrals can be accommodated due to the connections at the local level; however, barriers to accessing HHS-level resources were identified. For example, respondents noted HHS offices are not fully staffed or available in all areas of the state and responses are delayed. In addition, they indicated it is challenging to identify all programs and services which may be of benefit to their clients and noted there is not

comprehensive, easily accessible information on available services. The majority of responding contractors and providers of HHS services and provider advocates do not believe individuals have access to the same services and supports in all parts of the state.

Additionally, the majority do not believe individuals can receive the services they need within a reasonable timeframe or at a time and location convenient to them. Concerns raised included access disparities between rural and urban areas, transportation and language barriers, and waiting lists for certain services. Respondents identified several services for which disparate access was of particular concern, including behavioral health, dental, and in-home services. Some respondents noted differences in service availability beyond core services are due to programs being developed at the local level to address tailored needs of the community being served.

Most responding contractors and providers of HHS services and provider advocates do not agree that individuals have multiple ways to easily get individualized help in-person, by phone, or by email/text if they have difficulty accessing programs or services. Respondents described delays in access to HHS processes including untimely application processing, lengthy call center hold times, lack of access in multiple languages, confusing application processes, availability only during business hours or on a part-time basis, lack of in-person resources, and delayed response to inquiries.

Finally, the majority of responding state staff also did not believe coordination across HHS programs to prevent service delivery gaps or duplication is strong and effective. Additional data regarding survey responses is provided in Appendix 2: Partner Survey Responses.

Consumer Survey

Consumers were also asked to participate in a survey developed to identify current barriers in accessing HHS services and to seek feedback on what is most important to them when accessing services. The survey was available in the following languages identified by HHS as predominant among their consumers: English, Spanish, Arabic, Swahili, and French. The consumer survey was available from August 7, 2023, through August 25, 2023. A total of 2,292 consumer surveys were submitted.

As outlined in Table 1, most respondents reported knowing where to go for help and being able to get help when needed. Responses were nearly evenly split regarding perceptions of needing to go to multiple places to get help. In reviewing these results, it is important to consider local providers assisted in survey distribution. Therefore, responses were completed primarily by those already engaged with the HHS system.

Table 1. Consumer Survey Responses

Question	Yes	No
I know where to go for help.	80%	20%
I can get help when I need it.	74%	26%
I can get help close to home when I need it.	75%	25%

Question	Yes	No
I have to go to multiple places to get help.	49%	51%
I have to go to an office multiple times to complete paperwork before I can get help.	26%	74%
I'm told how much I will have to pay, if anything, when I receive help.	61%	39%
I have to wait too long for help.	35%	65%
If I have to wait for help, I am told how long wait times will be.	62%	38%
When I try to get help, providers say I need to go somewhere else.	32%	68%

When asked to identify the most important things when help is needed, the top selections were:

1. Getting all the help I need in one place (46% selected this among their top two priorities).
2. An easy application (43% selected this among their top two priorities).
3. Getting help when I need it (42% selected this among their top two priorities).

Additional survey findings are available in Appendix 4: Consumer Survey Responses.

Stakeholder Interviews

HMA conducted a total of 33 interviews with stakeholders representing each service area. Participants were selected by HHS to represent a broad range of individuals and entities interacting with the reviewed service areas. For example, inclusive of HHS staff and local level representation. A list of interviewee affiliation is provided in Appendix 6: Stakeholder Intervie.

HMA developed interview guides tailored to the specific service area and interview group. Questions were devised to gather information on current service delivery and perspectives on opportunities for improvement. Additionally, several questions were asked across interviews, such as:

- How do you coordinate services with other state or local programs and services to meet the needs of consumers? How would you describe the collaboration between your program and other local health and human service departments and service providers?
- Please describe your observations related to variability across the state. Are there inherent differences between contractors/partners? Does the variation affect contractors' ability to meet program goals/expectations?
- In your planning efforts, what considerations are being made to mitigate duplication of effort across assessment service areas?
- Please indicate the top challenges you face in meeting your goals for service access, delivery, and outcomes.

- How does the program/your agency intersect with Medicaid funded services and providers?

Artifact Review

HMA reviewed documentation provided by HHS for each service area. Where available, the documents outlined in Table 2 were analyzed.

Table 2. HHS Documents Reviewed

Category	Example Documentation
Service Area Overview	• Target and priority populations • Covered services • Partner entities • Decision makers and governance structure • Historical context • Linkages and connections with other service areas and Medicaid
Regulatory Framework	• Iowa Code • Iowa Administrative Code
Application for Funding Streams	• Cooperative agreement applications • Competitive grant applications
Funding Information	• Funding sources and amounts
Contractors	• Contracts • Service area maps • Grantee lists
HHS Staffing	• Workload staffing maps
Data	• Service utilization • Budget and expenditures • Recent assessments conducted • Data collection systems utilized
Operating Procedures	• Policies and procedures • Provider manuals
Compliance	• Compliance reports • Corrective action plans • Legal actions
Strategic Planning	• Strategic plans and initiatives • Description of planned changes

Category	Example Documentation
Performance Approach	• Performance measures and outcomes data • Performance management plans • Quality assurance efforts • Pandemic after action reports • Quality improvement plans and documentation

HEALTH AND HUMAN SERVICES OVERVIEW

Within the realigned HHS organizational structure, multiple divisions are responsible for oversight and administration of the 19 service delivery systems studied in this assessment. Collectively, these service delivery systems are serving Iowans across their lifespan to provide critical health and human services, including primary, preventive and direct care services, as well as general and emergency assistance. Table 3 outlines the populations served across each of the service delivery systems.

Table 3. HHS Service Delivery System Across the Lifespan

HHS Division	Service Delivery System	*Infants*	*Children*	*Pregnant Women*	*Adults*	*Families*	*Disabled*	*Aged*
Aging & Disability Services	ADRCs						✓	✓
	AAAs							✓
Behavioral Health	CCBHCs		✓	✓	✓	✓	✓	✓
	IPN		✓	✓	✓	✓	✓	✓
	MHDS		✓	✓	✓	✓	✓	✓
	Tobacco CPs		✓	✓	✓	✓	✓	✓
Community Access	CAAs	✓	✓	✓	✓	✓	✓	✓
	Family Planning			✓	✓			
	I-Smile	✓	✓	✓				✓
	MCAH	✓	✓	✓				

HHS Division	Service Delivery System	Infants	Children	Pregnant Women	Adults	Families	Disabled	Aged
	WIC	✓	✓	✓				
	FaDSS	✓	✓			✓		
Family Well-Being & Protection	CPPC	✓	✓	✓		✓		
	Decat	✓	✓			✓		
	ECIs	✓	✓	✓				
Public Health	Local Governmental Public Health	✓	✓	✓	✓	✓	✓	✓
	Emergency Preparedness Regions	✓	✓	✓	✓	✓	✓	✓
	Environmental Health	✓	✓	✓	✓	✓	✓	✓

Each program under the purview of Iowa HHS has a unique history, coupled with federal funding structures, regulatory requirements, and program eligibility criteria. Working within this framework, Iowa HHS now has different geographic service provision areas across the 19 service delivery systems studied in this assessment, as outlined in Table 4 below.

Table 4. Service Delivery System Overview

HHS Division	Service Delivery System	Service Area and/or Number of Providers
Aging & Disability Services	ADRCs	6 Regions with 1 Statewide Network
	AAAs	6 Planning and Service Areas
Behavioral Health	CCBHCs	Under Development

HHS Division	Service Delivery System	Service Area and/or Number of Providers
	IPN	19 Service Area Providers
	MHDS	13 Regions
	Tobacco CPs	19 Regions 28 Partnerships
Community Access	CAAs	16 Agencies
	Family Planning	8 Providers in 15 of the CSAs
	I-Smile	15 Service Areas
	MCAH	15 Service Areas
	WIC	15 Service Areas
	FaDSS	15 Service Providers
Family Well-Being & Protection	CPPC	40 Sites
	Decat	40 Projects
	ECIs	38 Area Boards
Public Health	Local Governmental Public Health	96 Agencies 99 Local Boards of Health
	Emergency Preparedness Regions	8 Service Areas
	Environmental Health	85 Agencies

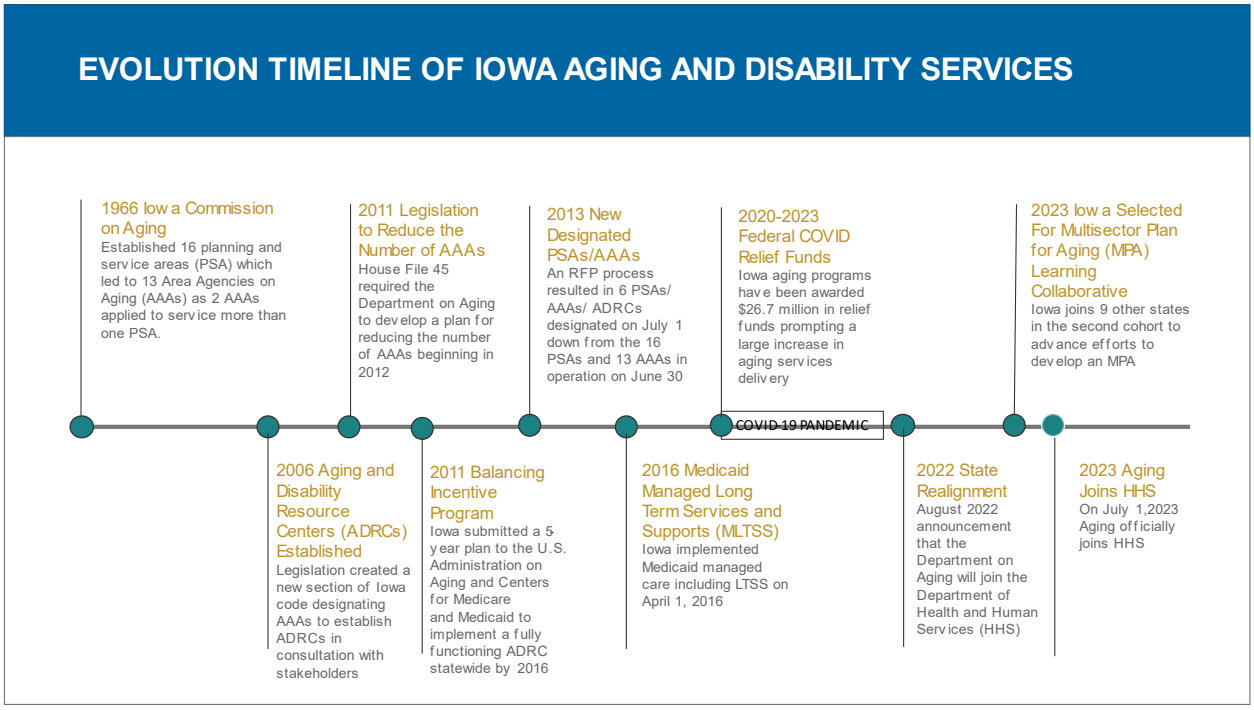
SERVICE DELIVERY SYSTEM OVERVIEW

Aging and Disability Services

In July 2023, changes at HHS resulted in a new organizational structure that aligned Adult Protective Services, Intellectual and Developmental Disabilities Service Coordination, Integrated Community Employment, PASRR, Office of the Public Guardian, and the Iowa Department on Aging (IDA). The newly formed division is known as the Aging and Disability Services Division.

Overview and Historical Context

Figure 1. Evolution of Iowa Aging and Disability Services



The Older Americans Act (OAA) established the State Unit on Aging and the aging network of local area agencies on aging (AAAs) in 1965. Iowa's State Unit on Aging, also known as the Commission on the Aging, was formed by the Iowa General Assembly in 1966. Along with the OAA, the "Elder Iowans Act" (Iowa Code Chapter 231) defines the role and responsibilities for the division and its commission as well as the AAAs. The Aging Network advocates for older Iowans and adults with disabilities and is responsible for developing a comprehensive, coordinated, and cost-effective system of long-term living and community support services.

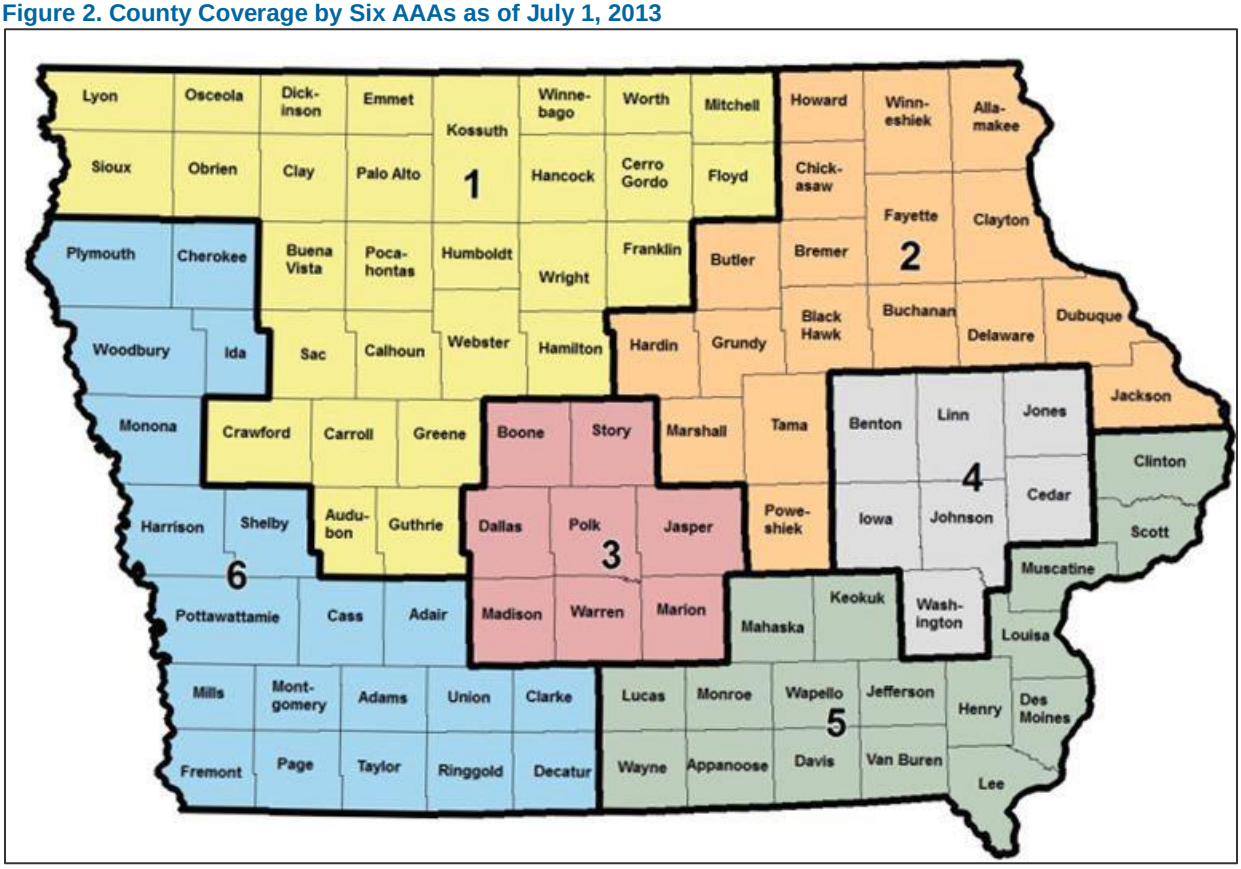
The State Unit on Aging's mission was to "provide resources, tools, and support to enable Iowa AAAs and partners with common goals to effectively deliver core services—Information & Service Assistance, Nutrition & Health Promotions, and Services to Promote Independence—to our consumers."[24] The vision was to support "accessible, integrated services to older adults, adults with disabilities, and caregivers to assist them in maintaining their independence, dignity, autonomy, health, safety, and economic well-being." Core functions include health and supportive services, specifically

those funded through OAA funding, as well as conducting planning, policy development, administration and evaluation of all state activities related to the objectives of the federal OAA.

Under the umbrella of the new Aging and Disability Services Division, the state and local AAA staff offer services such as information and assistance, case management, nutrition and health promotion, informal caregiver support services, elder rights and legal assistance, elder abuse prevention and more. An 11-member commission serves as the policymaking body for the division.[25]

At present, six AAAs serve older Iowans, caregivers, Iowans with disabilities ages 18 and older, and veterans. AAAs coordinate delivery of nutrition, supportive, elder rights, and caregiver services, and monitor and comment on policies, programs, hearings, and community actions that will affect those individuals and their caregivers.

Figure 2. County Coverage by Six AAAs as of July 1, 2013



Area 1: Elderbridge Agency on Aging (4 offices – Carroll, Fort Dodge, Mason City, Spencer)
Area 2: Northeast Iowa Agency on Aging (4 offices – Decorah, Marshalltown, Waterloo, Dubuque)
Area 3: Aging Resources of Central Iowa (1 office – Des Moines)
Area 4: Heritage Area Agency on Aging (1 office – Cedar Rapids)
Area 5: Milestones Area Agency on Aging (3 offices – Burlington, Davenport, Ottumwa)
Area 6: Connections Area Agency on Aging (3 offices – Council Bluffs, Creston, Sioux City)

Area Agencies on Aging

A federally mandated multi-year state plan guides the work and strategy of Iowa Aging currently in place for fiscal years 2022−2025. The US Administration for Community Living approved plans are the vehicle for states to receive federal funds under the OAA. The state plan must be based on AAA plans. Hence, each of the six AAAs has its own approved Area Plan that outlines its specific work in its designated planning and service area (PSA). Overarching State Plan on Aging and Area Plans on Aging Goals are as follows:

- The Iowa Aging Network will support older Iowans, Iowans with disabilities age 18 and older, caregivers, and veterans as they make informed decisions and exercise self-determination and control about their independence, well-being, and health.
- The Iowa Aging Network will enable older Iowans to remain in, or return to, their own residence and community of choice through the availability of and access to high-quality home and community services and supports, including supports for families and caregivers.
- The Iowa Aging Network will protect and enhance the rights and prevent the abuse, neglect, and exploitation of older Iowans and Iowans with disabilities.

The state plan also identifies several different priority activities:

- Implementing a statewide care transitions program—Iowa Return to Community
- Defining, identifying, and meeting the needs of Iowa's at-risk caregivers
- Revitalizing Iowa's nutrition services to increase participation and provide innovative service delivery methods that will also address strategies for individuals at risk of social isolation
- Addressing Iowa's senior housing issues through interagency collaboration on supportive housing services and home modifications
- Tailoring services to our diverse target populations and focused on emerging trends and topics
- Implementing policies and processes to identify consumers who might benefit from additional OAA or other services and developing referral mechanisms that direct those individuals to other appropriate service interventions
- Using a data-driven performance management system to evaluate impact of service delivery, identify best practices or areas for improvement, and share outcomes and trends with citizens and stakeholders

AAAs also pursue other initiatives and activities such as distributing US Department of Agriculture (USDA) Senior Famer's Market Nutrition Program nutrition vouchers, launching pilot congregate nutrition grant projects, partnering with food banks, and launching and expanding the Iowa Café restaurant partnership pilots through Administration for Community Living (ACL) funding. Additional

AAA partnerships include other key state initiatives such as the I-Smile Silver project and one AAA serving as a provider for managed care organizations (MCOs) delivering long-term services and supports.

Populations Served

AAAs, as the vehicle for most OAA services and programs, predominately target individuals ages 60 and older, with a few exceptions. In addition to direct support for older Iowans, services also are available for adult caregivers who care for older individuals or people with Alzheimer's disease and related disorders. Caregiver support is available for older caregivers (55 years of age or older) who serve as the primary caregiver for a grandchild 18 years old or younger or a relative ages 19−59 with a disability. With the designation of AAAs as ADRCs, the target population expands to offer objective, person-centered counseling to not only older Iowans, but also Iowans ages 18 or older with a disability and veterans. Iowans age 18 and over with a disability that reside with and accompany an older individual are also eligible for OAA meals.

The estimated number of Iowans aged 60 or older is 787,235, or 24.7 percent of Iowa's total population.[26] Approximately 41 percent of Iowa's households have one or more persons aged 60 or over[27], and an estimated 330,000 Iowans provide informal care to parents, spouses, or other adults.[28]

OAA services are available to Iowans ages 60 and older, caregivers, residents of long-term care facilities, and families of these individuals. The OAA prohibits means testing for services. However, AAAs must have a process for requesting/obtaining voluntary contributions.

The Older Iowan's Act and related legislation also include services to Iowans with disabilities seeking information and assistance on independent living supports and ombudsman services for a portion of Iowa's Medicaid managed care members. More than 393,000 Iowans living in the community have a disability, and of those, approximately 124,000 have an independent living disability that make it difficult to go outside the home alone to shop or visit a doctor's office.[29]

Because the scope of potential eligible individuals is broad, the OAA requires that the State Unit on Aging and the AAAs target for needs assessment and service delivery those with greatest economic need, greatest social need, at risk for institutional placement, and caregivers for individuals with dementia.

Scope of Providers

Each AAA must maintain its own network of service providers. The OAA requires AAAs to contract with network providers for all services unless the agency obtains a waiver to provide the services as a direct provider. Iowa Code Chapter 17 § 6.12 (231) identifies services as allowable to provide without a waiver.

In terms of network providers, comments during interviews inferred the AAAs and the managed long-term services and supports (MLTSS) MCO plans at times use an overlapping HCBS network. No formal network comparison work is under way between the OAA and MLTSS programs. Each AAA Area Plan indicates efforts to assess service gaps and attempts to develop more robust provider networks based on service need and geographic disparities.

Decision Makers and Partners

The Iowa aging and disability network consists of the Commission on Aging, the Division of Aging and Disability Services, AAAs, and ADRC partnerships and networks.

State code designates the Commission on Aging as the policy-making body of the sole state agency administering OAA funding and services. Eleven members are appointed by the legislature and governor. Duties include approving Area Plans, adopting policies emanating from the OAA, setting the intrastate funding formula, which is the methodology for distributing federal funds to individual AAAs, designating AAAs and PSAs, adopting administrative rules, and other responsibilities.

The Division of Aging and Disability Services is the designated State Unit on Aging. It administers and provides oversight of federal and state funded services delivered by AAAs and ADRCs. It also serves as the home of the Office of the Public Guardian.

The OAA requires that AAAs have an advisory council and identifies required members on the council.

Funding

Funding for aging and AAAs is predominately composed of federal funding from the OAA, representing nearly 60 percent of total dollars, with state appropriations representing approximately 35 percent of total dollars, and the remainder comprising government transfers from other agencies.[30]

Table 5. Aging Funding Sources

	FY 2022 Actuals	FY 2023 Current Year Budget Estimate	FY 2024 Total Department Request	FY 2024 Total Governor's Recommended
State Appropriation	$11,304,082	$11,304,082	$11,304,082	$12,006,290
Federal Support	$20,051,654	$18,418,082	$18,418,082	$18,418,082
Other	$1,815,331	$969,460	$969,460	$969,460
Total	**$33,171,067**	**$30,691,624**	**$30,691,624**	**$31,393,832**

The state appropriation primarily is a pass-through to the six AAAs for the provision of community-based services such as case management, transportation, home health and homemaker services, adult day services, respite service, chore services, and options counseling. Federal OAA funds are distributed to state units on aging under statutory funding formulas. Each State Unit on Aging sets an intrastate funding formula and state aging program formula as the framework for how Iowa's AAAs are funded. Funding formulas are included as part of the State Plan on Aging and must be approved by the federal Administration on Community Living. The formula was updated and approved in 2023 to

address funding needs across regions, particularly related to the impact of rural geography in serving older Iowans.

Recent federal OAA funding for Iowa has been relatively flat over the last several years.

Table 6. Federal Older Americans Act Funding

	Federal FY 2021	Federal FY 2022	Federal FY 2023
Total Title III	**$15,369,213**	**$15,523,112**	**$16,587,296**
Congregate Meals	$5,095,220	$5,068,669	$5,300,526
Home Delivered Meals	$2,645,785	$2,763,116	$3,465,749
National Family Caregiver Support Program	$1,838,752	$1,865,777	$1,880,830
Nutrition Services Inventive Program	$1,388,874	$1,383,242	$1,376,088
Preventive Services	$240,268	$238,377	$251,695
Supportive Services	$4,160,314	$4,203,931	$4,312,408
Total Title VII	**$239,438**	**$246,692**	**$264,868**
Elder Abuse	$55,927	$55,927	$55,735
Ombudsman	$183,511	$190,765	$209,133

The AAAs have match requirements for federal and state funds as outlined in Table 7.

Table 7. AAA Match Requirements

Federal: Funding Requirements from Non-Federal Sources	State: Funding Requirements from Non-State Sources
• Title III Admin: 25% • Title IIIB & C: 15% • Title IIIE: 25% *Note:* At least 1/3 of Title III non-federal share must be from state funds.	• State Elderly Services: 15%

In addition to the annual funding that the State Unit on Aging and AAAs receive, stakeholder interviewees noted that the enhanced funding that aging received during the COVID-19 public health emergency (PHE) has significantly increased the quantity of services that AAAs were able to provide. They are concerned that AAAs now have waiting lists for services. Of particular concern is waiting lists for nutrition and meals programs. As of August 2023, Aging programs have been awarded more than $26.7 million in enhanced funding since 2020. This was a one-time injection of funds to support programming during the PHE.

Table 8. Enhanced COVID-19 Funding

Enhanced Aging Funds During the Public Health Emergency Since 2020	Award
Elder Abuse Prevention Interventions Program	$38,952
National Family Caregiver Support, Title III, Part E	$2,412,567
Special Programs for the Aging, Title III, Part B, Grants for Supportive Services and Senior Centers	$6,903,516
Special Programs for the Aging, Title III, Part C, Nutrition Services	$15,957,362
Special Programs for the Aging, Title III, Part D, Disease Prevention and Health Promotion Services	$426,326
Special Programs for the Aging, Title IV, and Title II, Discretionary Projects	$692,290
Special Programs for the Aging, Title VII, Chapter 2, Long Term Care Ombudsman Services for Older Individuals	$292,850
Total	**$26,723,863**

Some emergency funding also had match requirements.

Linkage with Medicaid

The Medicare Improvements for Patients and Providers Act (MIPPA) provides formula funding to state Health Insurance Information Programs (SHIP), AAAs, and ADRCs to provide outreach on Medicare benefits and application assistance for the Medicare Low Income Savings program (known as Extra Help) or the Medicare Savings Programs. The Medicare Savings Programs are an important linkage to low-income Medicare beneficiaries who receive Medicaid coverage for co-pays and part B premiums.

The Iowa Return to Community program (IRTC) is a care transition program aimed at a pre-Medicaid population (130-1550% of the federal poverty level (FPL)) as a Medicaid Diversion program. One AAA has a contract with a local hospital system to provide care transition services to high-risk Medicaid consumers identified by the hospital.

Prior to the implementation of MLTSS, all AAAs were contracted providers of Medicaid Home Delivered Meals. Over the past several years, all declined to contract for this service as reimbursement rates did not cover cost of the meal. Additionally, there were delays in payments and notification for individuals no longer eligible for meals. This resulted in AAAs using OAA funds for those over the age of 60 or not receiving payment for the meals for younger individuals. One AAA recently signed a contract with an MCO to provide Medicaid Home Delivered Meals.

Operational Capabilities and Gaps

State and local aging staff are justifiably proud of the work they do on behalf of older Iowans with an intent to be innovative and collaborative with a focus on prevention and wellness across the life course. The state has demonstrated efforts to strengthen the Aging Network through initiatives such as participation in the Medicaid Administrative Claiming, Iowa Return to Community, pursuing an Age-Friendly state designation, and development of a multisector plan for aging. Additionally, one of the state's strengths is how it collects and analyzes data as well as using a data-driven performance management system to evaluate impact and share best practices and outcomes. Stakeholders are optimistic and enthusiastic about the possibilities for the Aging Network as it becomes aligned with other HHS programs. However, notable gaps can be reduced through the work to align service delivery areas across HHS.

Another significant gap is the lack of coordination between AAA services and MCOs particularly for people in the process of gaining Medicaid long-term services and supports (LTSS) eligibility or for individuals already using services. The lack of IT systems communication or connection with MCO community-based case managers creates both administrative obstacles for local AAA staff as well as negative experiences and consequences both for people receiving services and those who may attempt to access aging programs and services. Without understanding what services a person is receiving through Medicaid, AAAs and their provider network might be duplicating services that MCOs coordinate for their members. Furthermore, with limited resources available for aging programs, compared with an entitlement program like Medicaid, it is important that aging services be best targeted to people in need without access to other public programs and benefits available through Medicare, Medicaid, or other supports.

Prior to the Medicaid managed care implementation, the AAAs were the contracted providers for the Medicaid 1915(c) Elderly Waiver case management and service planning. AAAs provided Elderly Waiver case management and had clear line of sight to waiver timelines and activity. According to AAA staff interviewed, the implementation of MLTSS changes resulted in negative experiences systemically, as well as to the individuals the programs serve.

With the implementation of MLTSS, AAAs and state officials HMA interviewed said they no longer have an efficient way to identify where people are in the waiver application and service planning process. Delays in assessment, care planning and service start timelines have been a concern and have resulted in requests by consumers and their families for AAAs to fill service gaps while individuals

wait for MLTSS services to start. Communication is lacking when services do start in the MLTSS program, likely resulting in duplication of services between those funded through Medicaid and those funded through OAA sources. Duplications may mean that other older Iowans who are ineligible for or not participating in the Medicaid program will be unable to access community-based services if aging funding runs low or out. Furthermore, HMA heard complaints about the quality of MLTSS case management services.

Aging and Disability Resource Centers

The OAA defines an Aging and Disability Resource Center (ADRC) as:

> "… an entity, network, or consortium established by a State as part of the State system of long-term care, to provide a coordinated and integrated system for older individuals and individuals with disabilities (as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102)), and the caregivers of older individuals and individuals with disabilities, that provides, in collaboration with (as appropriate) area agencies on aging, centers for independent living (as described in part C of chapter 1 of title VII of the Rehabilitation Act of 1973 (29 U.S.C. 796f et seq.)), and other aging or disability entities—"

Legacy Aging received a series of federal grants to develop an ADRC system in Iowa, including the Balancing Incentive Program through a contract with Iowa Medicaid.

The goal of Iowa's ADRC network is to implement a No Wrong Door system. Legacy Aging, and now the Aging and Disability Services Division, has authority to administer the ADRC by Iowa Code § 231.64. Currently, only the AAAs and the Office of Public Guardian are designated as local ADRCs. With the alignment, however, Iowa is in a position to expand its ADRC network to include additional partners who perform ADRC activities as described below. Iowa would also be in a position to incorporate additional partners into the No Wrong Door/ADRC Medicaid Administrative Claiming process to increase funding to the state for these activities.

As local ADRCs, the AAAs perform all duties mandated by federal and state law and applicable rules and regulations. The AAAs provide ADRC services to older adults, individuals with disabilities, and their caregivers by offering streamlined access to information, advice, counseling, and assistance to make decisions for themselves about their long-term services and supports (LTSS). The ADRCs:

- Provide accurate and comprehensive information regarding available services, resources, and programs.
- Provide options counseling and non-Medicaid case management utilizing a person-centered approach to working with individuals to determine their needs and develop a service plan.
- Conduct outreach and education on LTSS services, impact, and payment options.
- Facilitate program applications.
- Facilitate access to LTSS by connecting and referring clients to providers, case managers, community agencies, and other related resources.

Funding

The only state funds supporting ADRC activities are appropriated to the AAAs. Though ADRC activities are an important component of AAA services, it was noted that the funding does not match the expected effort, particularly for younger disabled populations. Projected costs by AAA indicate that funding for ADRC services, accounts for 3.0−5.7 percent of total funding by AAA ($900,000 of a total $22,396,481).[31]

In 2020, the Centers for Medicare and Medicaid Services (CMS) approved a Medicaid State Plan Amendment to obtain federal financial participation (FFP) for ADRC activities that support the administration of the Medicaid State Plan. As ADRCs, the AAAs have been claiming FFP funds per the approved methodology. In SFY2023, they claimed a total of nearly $900,000 with the state funds providing the required 50 percent match for those funds. The average allowable rate for AAAs was approximately 26-30 percent. This means that the AAAs spent nearly one-third of their ADRC service delivery time providing information and assistance on Medicaid programs and services.

Operational Capabilities and Gaps

Iowans who connect with the ADRC often require a range of services and supports to address their expressed need, including services that fall outside the scope or current capacity of aging services. State and local staff have noted a deficit in focus, funding, and services particularly for the younger disabled population, which is included in the vision of the ADRC work. Renewed emphasis on convening public and private stakeholders for a multi-disciplinary advisory group around ADRC resources is essential. Closer coordination with the MHDS regions and service providers that offer non-Medicaid supports to individuals with disabilities should be a natural, but intentional, byproduct of the HHS realignment.

AAAs and Legacy Aging created a statewide point of entry into Iowa's LTSS system that includes one statewide number and website.[32] The statewide number is a virtual hub that routes callers, based on their area code, to their local ADRC. Iowa's ADRCs have a training system to ensure services are standardized, person-centered, and delivered with high quality across the state.[33]

An ADRC network has a foundation with AAAs being local ADRCs. Through a technical assistance grant, Legacy Aging has increased planning partnerships with disability services through development of a new LifeLong Links website. Integration efforts at the state level with the newly formed Aging and Disability Services Division will continue to enhance and expand partnerships among local ADRCs by increasing coordination and formalizing referral policies and procedures among the Hope and Opportunity in Many Environments (HOME) project, ID/DD services, brain injury, MHDS services and other disability services across the lifespan.

Other State Approaches

Research that the American Association of Retired Persons (AARP) Public Policy Institute, The Lewin Group, and ACL conducted showed that Iowa ranked 44th out of the 50 states and the District of Columbia for ADRC/No Wrong Door System on the LTSS State Scorecard.[34] The ranking represents a composite of survey responses across five domains: 1) state governance and administration, 2) target populations, 3) public outreach, 4) person-centered counseling, and 5) streamlined eligibility. State rankings indicate that all the top ten states had a full or partially functioning formal body that

coordinates and oversees ADRC objectives and outcomes. Typically, this body includes the State Unit on Aging, state Medicaid agency, and state agencies that serve people with ID/DD. No state in the bottom ten reported having a fully operational governance body.

Ohio

Ohio built a strong governance structure through intentional partnerships and continual quality improvement. The ADRC/No Wrong Door System governance team at the state level consists of the Ohio Department of Aging and the Ohio Department of Medicaid, and, at the local level, the AAAs. A three-party agreement between those entities recognizes the AAA as the network lead entity in what the state calls the "Aging and Disability Resource Network." The AAAs, in this capacity, maintain agreements with additional community partners, such as Centers for Independent Living (CILs) and other entities, to support ADRC operations. The governance team facilitates contract development between AAAs and community partners administering ADRC supports and drafted a memorandum of understanding (MOU) outlining the collaborative agreement between the lead agencies at the state level. The state reviews MOUs and contracts annually through a quality improvement process to ensure roles and responsibilities remain clear and coordination exists between the entities involved. This process guarantees that contracts remain dynamic and relevant.

South Dakota

South Dakota moved the Division of Adult Services and Aging from the Department of Social Services to the Department of Human Services and renamed the Division of Adult Services and Aging the Division of Long-Term Services and Supports, aligning the organizations responsible for the ADRC target populations. South Dakota also launched an outreach campaign, Dakota at Home, to promote the ADRC system at the state level, which involved community events at local sites, including churches, hospitals and discharge planners, and health fairs as well as targeting senior centers, through a variety of means, including posters and newspaper ads. The outreach strategy also included developing performance objectives with key partners. For example, a 211 helpline refers consumers to Dakota at Home, and intake staff attend 211 trainings to discuss the ADRC system.

Georgia

Georgia also launched an ADRC Advisory Council with representatives from the State Unit on Aging, state Medicaid agency, the Department of Community Health, Department of Behavioral Health and Developmental Disabilities, the Independent Living Council, all nine of Georgia's CILs, and the Brain Injury Association of Georgia. The Advisory Council serves as the ADRC Steering Committee. Contracts and memorandums of understanding solidify the partnerships. Georgia also developed a three-year ADRC plan with ACL discretionary funding.

The Department of Behavioral Health and Developmental Disabilities implemented a validated screening tool, used across other LTSS programs, which boasts slight modifications to capture population nuances. Georgia's ADRCs (including all 12 AAAs and all nine CILs) now use the same data system to collect and share key data elements, including demographic information and relevant assessments. This comprehensive system includes information and referral, person-centered counseling (including Minimum Data Set Section Q (MDS-Q) Options Counseling for nursing home residents and Community Options Counseling for individuals residing in the community), eligibility

screening, OAA-funded HCBS, eligibility prescreening, Georgia's 1915(c) Medicaid waiver program, and Money Follows the Person (MFP) and state-funded nursing home transition programs. The system allows individuals to move seamlessly from an initial call into publicly funded LTSS services with minimal duplication of effort in data collection.

Aging and Disability Services Findings and Recommendations

Service Delivery Area Options

The structure of having AAAs as the only designated ADRCs has resulted in an inequitable focus on the aging side of ADRCs, possibly as a function of the Department on Aging formerly being a standalone department and the OAA primarily providing funding for older adults. Improved coordination is needed between OAA services administered through the AAAs, disability services delivered through the MHDS regions, and Medicaid LTSS, particularly with MCOs. Additional outreach and public messaging about the breadth of information and assistance available through the ADRCs to populations beyond older adults would be beneficial.

A greater understanding of the disability side of aging and disability services is needed across divisions within HHS, in particular with lifespan service delivery areas such as behavioral health and community service agencies. Intentional efforts are needed to coordinate community services through the state's development of a multisector plan for aging and implementation of any recommendations from the HOME project, with particular focus on Iowans not yet Medicaid eligible or on HCBS waiting lists as priority groups for state Aging and Disability services. Disability services, particularly for individuals with ID/DD or those with brain injuries should move from MHDS regions to ADRCs, with a broader set of designated organizations that can serve as an ADRC.

Funding Model Options

At present, ADRC activities are largely reliant on state funds appropriated to the Aging and Disabilities Services Division and AAAs are largely reliant on OAA funding, which focuses on older adults and caregivers, leaving out equivalent resources for disability services. With the alignment of HHS and potential changes for the MHDS regions, funding supporting Iowans with ID/DD or brain injuries should be transferred to ADRCs, whether that is the current model of the six AAAs or an expanded model with the designation of disability focused community organizations as ADRC sites. The Medicaid administrative claiming available to ADRCs when they perform tasks that fall into Medicaid administrative categories, opens another sustainable funding source for possible ADRC expansion.

Other Recommendations

HHS should consider a formal body that has oversight of ADRC objectives and outcomes led by the Division of Aging and Disability Services, which includes, at a minimum, the Division of Medicaid, the Division of Behavioral Health, and the Department of Veterans Affairs. Recent technical assistance support for Aging efforts offers an opportunity to develop an engagement workgroup for ADRC functions. The alignment of Aging within HHS provides greater momentum and coordinated authority for HHS to bring together a multi-agency, representative stakeholder advisory body to follow the best practices. Iowa ranked 36th in State Governance and Administration for No Wrong Door/ADRC Functions on the 2020 LTSS State Scorecard,[35] indicating room for improvement. ACL has had recent

funding opportunities to support state efforts to explore and enhance ADRC system governance. HHS should explore other federal funding sources to support efforts to enhance the ADRC network.

An intentional alignment strategy will support the most effective integration of Aging and Disability Services into HHS. This strategy should prioritize opportunities to increase communication, collaboration, and consistency in cross-division understanding of the Aging Network and the integration of disability services within the Division of Aging and Disability Services. An intentional strategy is needed more for Aging and Disability Services than other areas given that until now Aging has functioned external to HHS, heightening the need for an intentional focus on alignment.

Prior to the HHS organizational changes, the Iowa Department on Aging was already collaborating with several different councils and boards to address key topics such as transportation, independent living, homelessness, adult protection, workforce and others.[36] Further coordination of efforts and work under way to meet the needs of older Iowans and persons with disabilities is needed. Iowa should further leverage some of the existing initiatives to improve coordination of efforts and elevate awareness. Specifically, Iowa should build on the IDA Collaborative Efforts with Health Care and Social Services work outlined in the Iowa State Plan on Aging Federal Fiscal Year (FFY) 2022-2025 to complete work that has started to develop an Iowa Multisector Plan for Aging as well as attain age-friendly state recognition inclusive of Iowa's aging population and people with disabilities.

Another key opportunity is to leverage future work that may be initiated as a result of the Recommendations for Strengthening Iowa's Community Based Services System final evaluation report (aka the HOME project) to further communication, collaboration, and consistency. HMA recommends that Iowa leverage the HOME project work to prioritize efforts specific to Iowans not yet Medicaid eligible or on an HCBS waiting list as the initial priority group for the Division on Aging and Disability Services. This focus builds upon one of the final evaluation sub-recommendations to develop infrastructure to share waiting list status with key agencies, including AAAs and ADRCs. Close coordination of these system redesign efforts offers a strong opportunity to further alignment.

Implementation Considerations

Iowa Code

HHS should consider amending Iowa Code §231.64, which solely designates AAAs to carry out ADRC functions and establish a coordinated system for providing a one-stop access point for LTSS. With other potential community partners that have greater expertise in serving younger individuals with disabilities that could serve as ADRCs, the current code is a limitation. Additionally, disability services are defined as services and other support available to a person with mental illness, an intellectual disability or other developmental disability, or brain injury in Iowa Code §225C.2. This definition should be amended to focus less on diagnostic categories unless they are tied to specific state programs with eligibility limitations related to diagnosis.

Behavioral Health

In direct support of the HHS alignment, the DHS Division of MHDS-C and IDPH, Divisions of Behavioral Health and Tobacco Use, Prevention and Control are now integrated as the HHS Division of Behavioral Health (DBH). In addition, responsibility for the programs and services for individuals with ID/DD has transitioned to the newly formed HHS Division of Aging and Disability Services. The historical separation of the administration of the mental health and substance use delivery systems, under DHS and IDPH respectively, has resulted in siloed systems and structures for the delivery of safety-net services and likely limited opportunities for some efficiencies that could be realized through integrated behavioral health systems.

As a result of the historical systemic siloes, the IPN and MHDS regions are geographically misaligned. In addition, IPN contracts include direct service provision as well as local system development activities, whereas MHDS Regional contracts primarily support local purchasing of services in addition to local system navigation supports. Though state and delivery system structures are informed by the similarly siloed federal funding streams and requirements, flexibility does exist to support improved integration. Iowa has experience with this framework through previous integration efforts with the substance abuse and problem gambling prevention and treatment systems, leading to the IPN operating in the state today.

Despite these efforts, the ongoing fragmentation between mental health and substance use systems of care has led to challenges for some individuals and families in navigating and accessing needed services and supports, especially people with co-occurring mental health and substance use conditions. Behavioral health integration at the state level (of mental health and substance use administration) is still in progress and will be key in reinforcing efforts to integrate at the delivery system level. To support this ongoing effort, the new DBH has engaged the service delivery system through multiple meetings with the Mental Health Planning Council (Advisory to the Community Mental Health Services Block Grant), the Mental Health and Disability Services (MHDS) Commission, and the Children's Behavioral Health State Board. The DBH has also engaged directly with system stakeholders, MHDS Regions, Provider Associations, IPN, and Community Mental Health Centers (CMHCs).

The goal of these meetings has been to seek input and public comment from the mental health and substance abuse providers, review block grant statutory requirements, and identify shared alignment goals between previously siloed departments, as these funding streams and their requirements inform provider and program contracts, as well as other behavioral health system administrative elements. According to the state's most recent Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) combined application, of the 25 accredited Iowa CMHCs, 17 also are licensed substance use disorder (SUD) services providers, and five are IPN providers. This represents an increase of four dually licensed/accredited CMHCs since the submission of the FFY22-23 MHBG plan. In all, 14 Iowa providers have received the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinics (CCBHC)-Expansion grants, and through the COVID-19 Supplement and the American Rescue Plan (ARPA) Supplemental funds, IPN providers were able to fund service development projects intended to add new services to their current service array, including mental health therapy.

In addition to the state alignment initiative, previous and emerging environmental factors have and will affect the mental health and substance use delivery systems and are noteworthy when considering opportunities available to the emerging integrated Iowa behavioral health safety-net system of care. The mental health safety-net system emerged in the 1960s as states shifted care from state psychiatric hospitals to community-based care. CMHCs were created with support from the Mental Retardation Facilities and Community Mental Health Centers Constructions Act of 1963 and are responsible for providing mental health services at the local level. Initially, CMHCs were the primary providers of outpatient services as mental health treatment was neither provided in other healthcare settings nor included in healthcare insurance plans.

Iowa's CMHC system has fluctuated in number, from 15 CMHCs in 1965, to 36 in 1998, to 25 in February 2023. CMHCs have geographic catchment areas and are not aligned with the State's MHDS Regions. The current MHDS Regional structure emerged as the state moved from a county-based structure to a regional approach. Over time, funding for mental health treatment has shifted from primarily state and federal block grant dollars and reimbursement approaches, prompted by increased Medicaid and commercial insurance coverage for behavioral health. This integration with Medicaid systems and other payers reduced the scope of the once siloed mental health safety net to a mission focused on funding and providing mental health services for individuals who are un/underinsured. Similarly, CMHCs have expanded their payer mix, participating in the Medicaid program, as expansion of Medicaid coverage has reduced the number of individuals without coverage, shrinking the numbers served within the safety-net system.

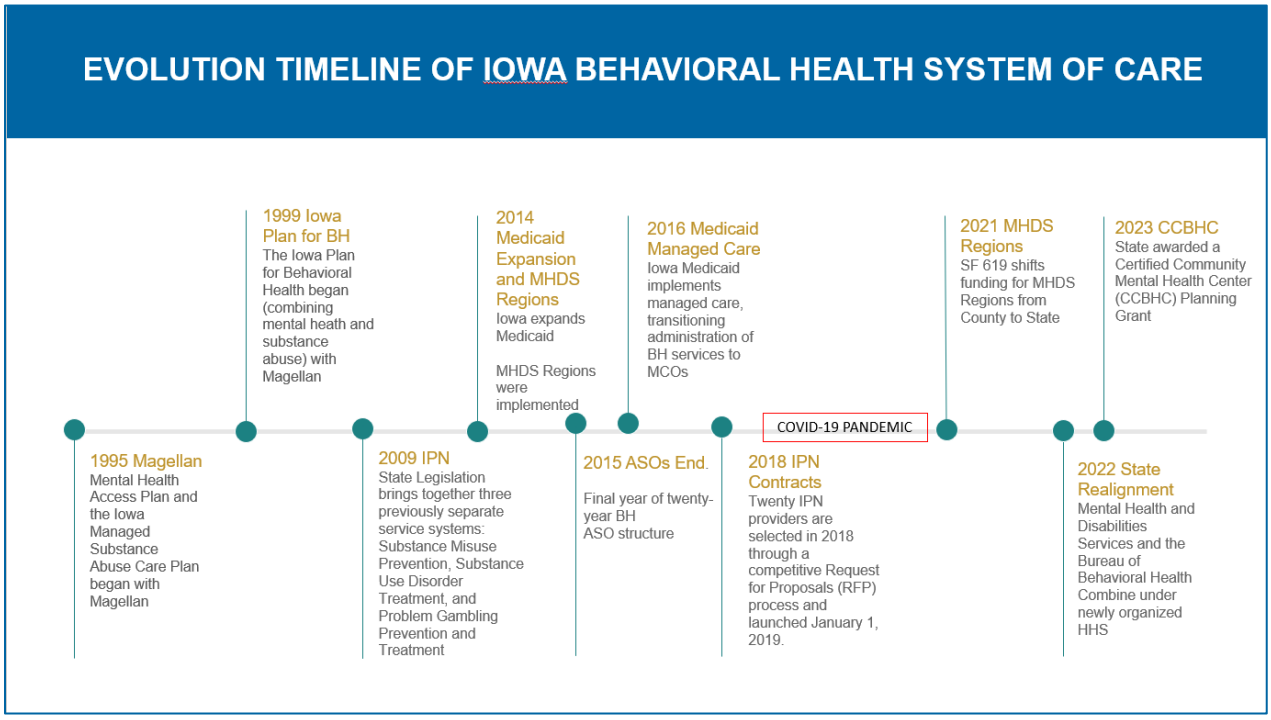
In SFY12 the MHDS Regions served 48,193 individuals; that number dropped to 20,279 in SFY15 following Medicaid expansion in Iowa. Since the expansion of Medicaid, numbers of individuals served by MHDS Regions has settled to an average of 30,262 individuals annually between 2016 and 2022, with little fluctuation noted during the COVID-19 pandemic.[37] The behavioral health system also has seen an expansion of providers beyond CMHCs during this period; however many of these providers, including those in Iowa, do not participate in the public system, opting to serve individuals covered by commercial insurance or who have the means to pay out of pocket, where reimbursement rates trend higher and with less administrative burden. It also contributes to the workforce shortage in public behavioral health treatment settings.

With fewer individuals receiving services through the safety-net systems, Iowa, like many states, has redefined the roles of safety-net providers and funding streams. The latter is further supported by similar action at the federal level, where both the MHBG and SUBG block grants directed states to focus funding on individuals and services who do not have Medicaid coverage, including an increased focus on prevention and early intervention. These changes have occurred over the last several years without the benefit of time to fully assess their impact. These transitions, discussed further in this section, were also complicated by the COVID-19 pandemic, when some efforts to shift reimbursement structures were temporarily suspended to support the financial stability of providers. The pandemic also exacerbated behavioral health workforce shortages, challenging even the most effective systems with increased demand as professionals left the field for new opportunities and to relieve mental and financial stress associated with service delivery during lockdown.

As states have reinvented the role of the behavioral health safety net, Certified Community Behavioral Health Clinics (CCBHCs) have emerged as an option to standardize core services, require quality

assurance practices, and expand integrated care practices, enhancing and updating the CMHC model, while maintaining a safety-net for those without coverage. As states like Iowa continue planning for CCBHC implementation, the impact of their entrance into the provider network further necessitates a review of existing structures in the behavioral health safety net and continued system realignment (see Figure 3).

Figure 3. Evolution of Iowa's Behavioral Health System of Care



Integrated Provider Networks

Overview & Historical Context

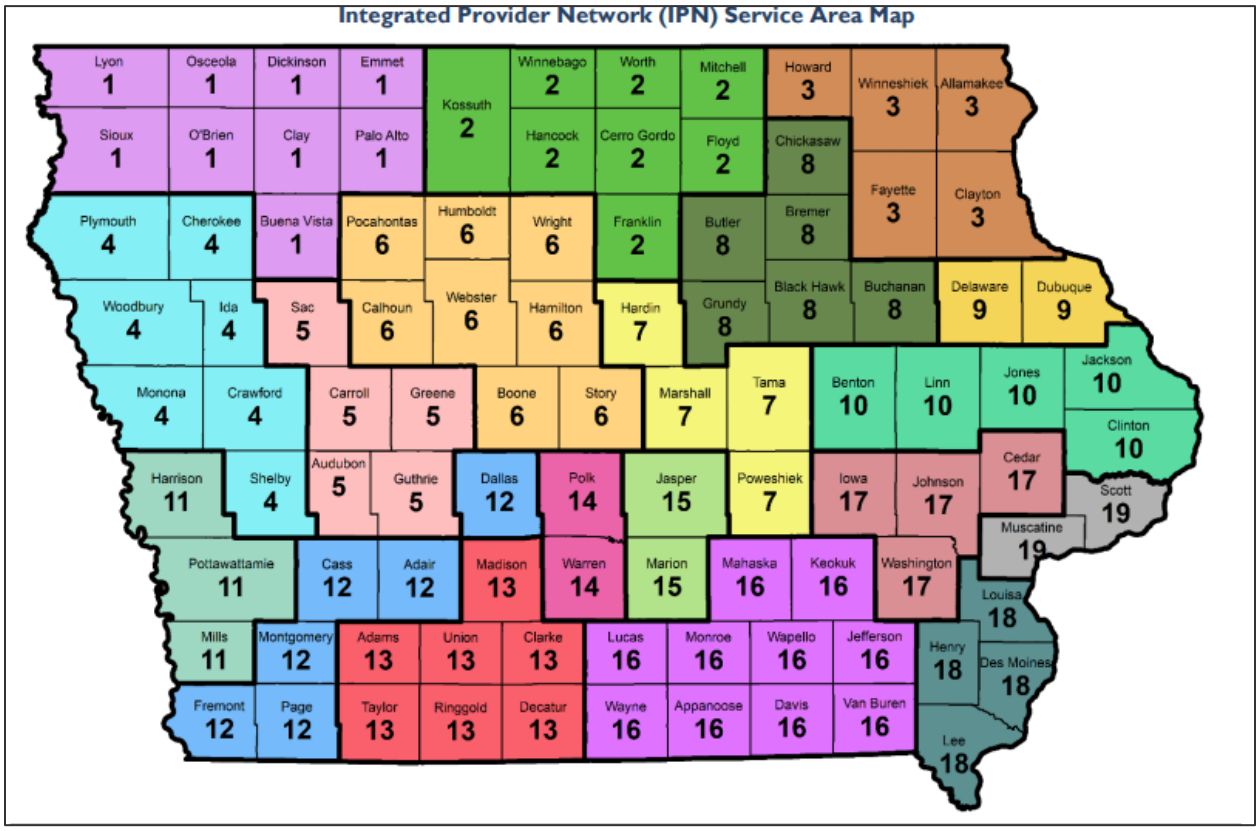
The IPN was developed as a statewide community-based system of care for SUD and problem gambling. This system of care unites three previously separate service systems: substance misuse prevention, SUD treatment, and problem gambling prevention and treatment. The current structure has resulted from multiple system changes beginning in 2009, including changes in reimbursement structures and carving treatment services into Medicaid managed care at the end of 2016. Current IPN contractors were selected in 2018 through a competitive request for proposals (RFP) process and were effective January 1, 2019. A total of 20 providers were selected among 100 licensed SUD facilities in Iowa that responded to the RFP. These providers serve 19 geographic regions in the state. The IPN is contractually required to provide statewide prevention and outpatient treatment services and may also apply to provide optional services such as population specific (adult, juvenile) residential, women and children focused services, and medications for opioid use disorder (MOUD).

The goals of the IPN include:

- Establish and maintain a comprehensive and effective system of care for substance use and gambling problems through a statewide integrated network of services and providers
- Reduce substance use and gambling problems in Iowa through public education, evidence-based prevention, and early intervention services
- Increase remission and recovery from substance use disorder and problem gambling through timely, accessible, ongoing, and effective treatment services

As such, the IPN, in addition to being direct service providers, also receive funds for network support activities including community assessments, outreach, and health promotion, as well as workforce development that includes training and implementation of evidence informed practices (see Figure 4).

Figure 4. IPN Service Area Map



Populations Served

All Iowa residents may participate in and receive network support and prevention services. However, treatment services are intended to support Iowa residents who are ineligible for Medicaid, who are uninsured, and who lack other resources to pay for necessary services. Specifically, Iowa residents who seek treatment services must have income at or below 200% FPL. Consequently, an IPN must

apply all available funding from third-party payers before determining a patient's eligibility for IPN contract funding and must ensure the correct party pays for services. In addition, IPN funding can pay for contracted treatment services that are not covered during the gap period between enrollment in Medicaid and assignment to an MCO because of Medicaid §1915(b)(3) requirements.[38]

Scope of Providers

The DBH contracts with 16 local agencies, through 23 contracts, to provide substance use and problem gambling prevention, treatment, and recovery services in 19 service regions that together serve Iowans in all 99 counties. Iowa HHS licenses all contracted providers.[39] All IPN providers must provide services under five categories: substance misuse & gambling disorder prevention; substance use disorder & gambling disorder treatment; other covered services for persons who are patients, such as care coordination and crisis services; other covered services for persons who are not patients (family education).

Interviews with both HHS staff and IPN providers indicate most providers also participate in Medicaid and deliver services to individuals beyond the scope of their IPN contract. In addition, stakeholders indicated some IPN providers also offer mental health services, although the breadth and depth of those services varied significantly.

Decision Makers & Partners

DBH provides leadership and sets the direction of state policy for the system of behavioral health services in Iowa under the leadership of the director of the Division of Behavioral Health. The division is divided into the Services, Planning and Performance, and Operations and Compliance bureaus. Services, Planning and Performance includes the administration of Prevention Treatment and Recovery Services Section, Data Analytics and Reporting Section, and Initiatives and Grant Planning Section. Operations and Compliance currently oversees the CCBHC planning process, including the Offices of Suicide Prevention, and Crisis Emergency, as well as operational and compliance activities. Specific to SUD, DBH administers funding that includes state funding allocated to the prevention and treatment of substance misuse, the SUBG funds, opioid response grants, the Overdose Data to Action Grant, State Pilot Program for Treatment for Pregnant and Post-partum Women, and the Iowa Treatment for Individuals Experiencing Homelessness grant.

With respect to the IPN contractors, lead staff identified in each contractor's application serve as HHS's contacts for network support services and participate in Network Support and other contract monitoring activities. IPN representatives indicated health and social service providers have strong partnerships at the local level.

State Epidemiological Workgroup and Prevention Partnerships Advisory Council

DBH's Bureau of Services, Planning, and Performance chairs and supports the State Epidemiological Workgroup and Prevention Partnerships Advisory Council (SEWPPAC). The State Epidemiological Workgroup (SEW) was initiated in 2006 through a grant from SAMHSA, and the Prevention Partnerships Advisory Council (PPAC) was established in 2009 as required in a SAMHSA Strategic Prevention Framework State Incentive Grant (SPF SIG). In 2019, these groups were combined to create the SEWPPAC. The SEWPPAC membership consists of approximately 45 state and local members from across Iowa representing a variety of organizations and meets quarterly. The

SEWPPAC initiates activities to establish the Strategic Prevention Framework (SPF) as the basis of ongoing state substance abuse prevention (and treatment) needs and outcomes monitoring for Iowa. The SEWPPAC process involves forming an epidemiological team to assess, analyze, interpret, and communicate data about Iowa substance use patterns and consequences that can be used to inform SUBG planning.

The Substance Abuse and Problem Gambling Treatment Program Committee under the Iowa State Board of Health was created through legislation to approve or deny applications for licensure received from substance abuse programs.

Funding

In SFY23, the IPN was allocated $28,437,559 in funds from two primary sources, state appropriations and the federal SUBG. Both funding sources have allocation requirements, prohibitions, and targeted focus populations (e.g., pregnant women and individuals with IV drug use) associated with specific populations and applications of funding. These funding streams also are interconnected as the federal block grant requires a maintenance of effort to draw down the federal block grant funds.[40] Breakdowns by population are provided in Table 9.

Table 9. SFY23 IPN Funding Sources

Funding Application/Population	State Appropriation	SUBG Funds
Treatment	$14,035,999	$7,125,176
Women and Children	$678,867	$1,390,939
Prevention	$89,643	$2,898,532
Gambling	$757,999	
Gambling	$1,460,404*	

*State Appropriation from Sports Wagering Receipts Fund

In SFY23, state funding represented $17,022,912 and federal SUBG funding represented $11,414,404 of funding to IPN.

Linkage with Medicaid

SUBG regulations prohibit the use of funding for services that Medicaid covers (for eligible enrollees), as well as prevention services that have another funding source. IPN core populations under the state contract are to serve people who are ineligible for Medicaid or are otherwise un/underinsured to receive contracted treatment services. As previously noted, the IPN also can enroll as Medicaid providers and receive reimbursement for covered services for eligible people.

Operational Capabilities and Gaps

Information gathered through stakeholder engagement and document review points to a shortage of individual and facility providers that meet the current demand for services, which is resulting in long waits to access services, especially residential care. Publicly funded program rates for SUD residential services, both IPN and Medicaid, were reportedly insufficient to sustain programs and are not competitive with commercial payers. As a result, many residential providers are unwilling to serve individuals with coverage from these publicly funded programs and instead are focusing on serving people with private health insurance.

Specific to federal funding, the state has begun reviewing and aligning the MHBG Block Grant and the SUBG. SAMHSA allows for joint applications for these funding streams, but Iowa historically has submitted separate applications to SAMHSA, including for SFY23. The integrated application for the SFY25 funding years is a necessary step to transition the DBH to integrated behavioral health strategic planning. The entry of CCBHCs into the Iowa behavioral health provider network also stands to further integrate mental health and substance use efforts and will require consideration of their role in serving people without healthcare coverage in the broader context of both the IPN and MHDS Regions roles in the HHS system.

Mental Health & Disability Services Regions

Overview & Historical Context

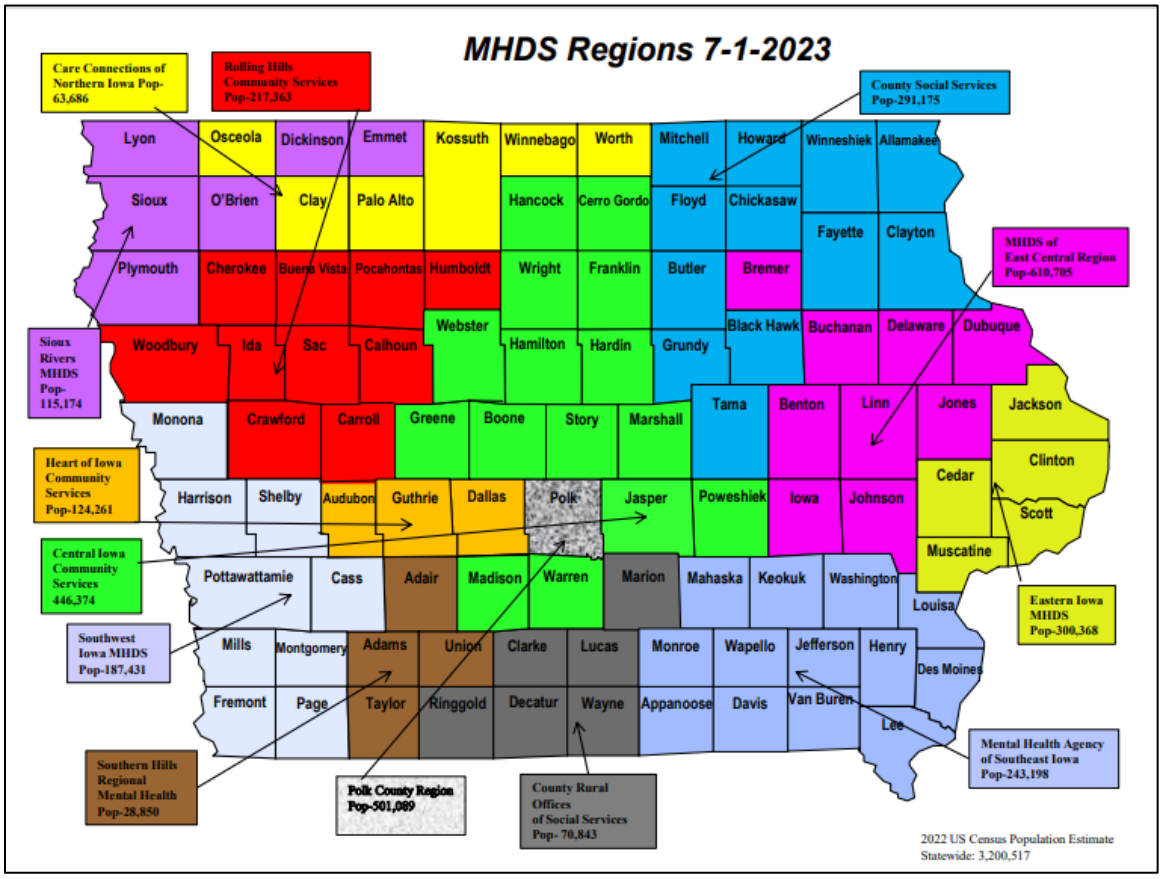
Local access to mental health services for adults with mental health and/or ID/DD, and children with serious emotional disturbances (SED) are administered within established mental health regions to individuals across Iowa regardless of where they reside in the state. This system has evolved with multiple recent changes to the reimbursement and structure of MHDS Regions.

Counties began the work of forming mental health and disability services regions in 2012 and MHDS Regions were fully implemented effective July 1, 2014. MHDS Regions contract with local providers to ensure access to an array of basic services. CMHCs continue to play a role as contracted service providers within regional networks. While MHDS Regions were being finalized, Iowa's adult Medicaid expansion, known as the Iowa Health and Wellness Plan, began on January 1, 2014. Iowa then transitioned from its use of an administrative services organization (ASO), known as the Iowa Plan for Behavioral Health to integrated managed care contracts with the implementation of Medicaid managed care on April 1, 2016.

Medicaid’s emerging role as the primary funder for behavioral health shifted the population focus of MHDS Regions to people who are un/underinsured and in need of behavioral health services. MHDS Regions focused on safety-net services, using county funds provided through property tax levies. MHDS Regional responsibilities included care coordination and linkage to a set of standardized core services with defined access standards. In 2019, the Iowa legislature passed House File (HF) 690, leading to the development of a children’s behavioral health service system, for youth and families with incomes up to 500 percent FPL. Development and implementation of the new children’s system was added to the MHDS Regions’ responsibilities; however, most of the children’s services delivered in Iowa continue to be funded by Medicaid and private insurers.

In 2021, the Iowa legislature passed Senate File (SF) 619, which transitioned the MHDS Regions to state funding through a standing appropriation and ended the authority of counties to initiate tax levies for mental health and disability services. This change included an incentive fund to help reimburse for reductions that resulted from the shift in funding and to promote quality outcomes in regional services. Performance-based contracts were implemented to provide guardrails to ensure that state funding is being used to meet requirements. The goal was to create a more equitable mental health system, allowing regions to develop services in areas that are currently lacking and to provide additional new and potentially innovative services.[41] In addition, MHDS Regions were now required to fund core services for children with SED whose families meet the financial guidelines of income between 150−500 percent FPL. Also effective on July 1, 2021, Iowa updated the list of core service requirements, with MHDS Regions administering those services for residents who meet financial eligibility guidelines when no other coverage is available. Most regions have accumulated a fund balance; excess funds are directed to an incentive fund, with a balance of $26.5 million in SFY23.

Figure 5. MHDS Regions and Populations Served as of July 1, 2023



Populations Served

Target populations for the MHDS Regions are defined as:

- Adults (age 18 and above) with Mental Illness (MI) and/or Intellectual Disability (ID)
- At or below 150 percent of FPL, with some MHDS regions extending eligibility to 200 percent FPL
- Ineligible for Medicaid or other third-party insurance or the services are not covered by Medicaid or other third-party insurance
- Children with an SED living in households earning less than 500 percent of FPL
- Core-plus populations include adults with a brain injury or other developmental disability (DD)

In SFY21, a total of 27,990 individuals received MHDS Region-funded services, most of whom received MHDS-funded services because of a mental illness diagnosis. An estimated 2,837 children received MHDS Region-funded services, and approximately 740 individuals with BI or DD received MHDS-funded services. Though fewer youth and/or individuals with BI or DD received MHDS funded services, a discrepancy attributed to the fact that they are more likely to qualify for Medicaid. An estimated three percent of individuals had a dual diagnosis and were included in more than one population eligibility category.

Scope of Providers

A total of 13 MHDS Regions serve adults and youths, down from 14 in 2023. The state has 25 CMHCs, each with a distinct service region encompassing one to five counties. At present, five counties are without a CMHC.

Core services for eligible adults include: inpatient mental health; outpatient mental health; mobile crisis response and other crisis services; supports for community living; support for employment; access centers; assertive community treatment (ACT); assessment and evaluation; and peer and family support. Core services for eligible children with an SED include assessment and evaluation relating to eligibility for services; behavioral health inpatient treatment; behavioral health outpatient therapy; crisis stabilization community-based services; crisis stabilization residential services; early identification; early intervention; education services; medication prescribing and management; mobile response; and prevention.

In 2023, Iowa enacted legislation that requires regions to develop and fund a new core service, outpatient competency restoration, for nonviolent individuals found incompetent to stand trial and in need of competency restoration.

Decision Makers and Partners

A previously stated, DBH provides leadership and sets the direction of state policy for the system of behavioral health services in Iowa. DBH distributes and oversees the use of federal and state funding through contracts with providers or other agencies that offer services or coordinate projects that promote the division's goals. Specific to mental health, this includes oversight and distribution of

federal funds received through the MHBG, and the Projects for Assistance in Transition from Homelessness (PATH) grant. DBH also manages other federal grants and projects including 988 implementation, CCBHC planning, and so on. Key partners include the Iowa Medicaid Division within HHS and Family Well-Being and Protection. Disability-focused services previously included within the legacy DHS Mental Health and Disability Division are now located within the new Aging and Disability Services Division. The Pre-Admission Screening and Resident Review (PASRR) program and supported employment services for persons with a disability are now located within this Division but DBH and Aging and Disability staff will continue to collaborate closely on behavioral health services and supports.[42]

The governance structure for both DBH and MHDS Regions include multiple advisory and oversight boards, commissions, and councils, including:

Mental Health and Disability Services Commission [43]

The Mental Health and Disability Services Commission (MHDSC) meets a minimum of four times per year and its membership and duties are outlined in Iowa Code 225C.5. The eighteen voting members serve staggered three-year terms and are limited to two consecutive terms. An additional four non-voting members are from the Iowa General Assembly. The MHDSC serves in an advisory capacity for DBH and is empowered to adopt administrative rules related to mental health and disability services, adopt standards for services and programs provided under the MHDS Regions, and adopt rules for awarding state and federal grant funding administered through DBH. The MHDSC provides an annual report of these activities, as well as the access and effectiveness of mental health and disability services across the state.

Children's Behavioral Health System State Board[44]

The Children's Behavioral Health System State Board (CBHSSB) was created in 2019 to provide guidance on the implementation and ongoing management of the children's behavioral health system serving youth with SED. The CBHSSB meets at minimum four times annually. Membership and duties are outlined in Iowa Code 225C.51. Membership includes directors, or their designee, from human services, education, public health, work force development, as well as a member of the MHDSC. Another 12 members are governor-appointed and serve four-year staggered terms, are subject to confirmation by the Iowa Senate, and limited to two consecutive four-year terms. As with the MHDSC, non-voting members include four members of the Iowa General Assembly. CHHSSB duties include providing advisory support to the state, consultation with agencies for administrative rule development, identification of quality and outcome measures for the system, and annual reporting to the Governor and General Assembly regarding these activities.

Mental Health Planning and Advisory Council

The Mental Health Planning and Advisory Council (MHPC) is a state advisory body that participates and provides feedback on planning for MHBG Block Grant activities. This includes monitoring, reviewing, and evaluating, annually at minimum, the allocation and adequacy of mental health services within the state. All states are required to have an advisory council as a condition for the receipt of federal Community Mental Health Services Block Grant funding. The MHPC consists of thirty-three voting members nominated and elected by majority vote of the Council membership. The members include individuals with lived experience in recovery, providers, family members, a veteran, State agency representatives, and other advocates with the purpose of providing input to, and evaluation and oversight of, the Iowa mental health system.[45]

MHDS Regional Governing Boards and Advisory Committees

MHDS Regions are governed by a local board who oversees the regional administrator. Regions with multi-county membership must enter into formal agreements to be compliant with governance requirements. These agreements include how the region will pool, manage, and expend the funds allocated to the regional administrator. MHDS regional governing boards include representation from each member county's board of supervisors, or a designee, and prohibit HHS staff or non-elected county staff from participation. The remaining required members represent one adult and one youth provider, an education system representative, and a parent of a child receiving services within the region, as well as representatives from law enforcement and the judicial system. With the passage of HF 471 during the 2023 legislative session, revisions were made to the regional governance structure of MHDS Regions, limiting representation of county elected officials to no more than 49 percent of the governing board membership. The spirit of the change was to provide a better balance between elected county officials and other stakeholders such as individuals with lived experience using MHDS services and their families, advocates, and providers. The legislation also clarified voting rights for all board members.

In addition, each governing board is required under Chapter 331.390 of Iowa Code to also have a regional advisory committee that consists of adults receiving services under the administrator or their actively involved relatives, providers, and regional governing board members. The governing board must also have a children's advisory committee whose membership includes children utilizing services or their actively involved relatives, a member of the education system, an early childhood advocate, a child welfare advocate, a children's behavioral health service provider, a member of the juvenile court, a pediatrician, a child care provider, a local law enforcement representative, and regional governing board members.

Funding

In SFY23, the state appropriated $121 million in state general fund dollars to the MHDS Regions. For SFY22, MHDS Regions had combined beginning fund balances of $84,583,633 and operated under a combined budget of $201,431,861. Their SFY22 expenditures totaled $152,120,154. Iowa received a total of $7,739,414 in MHBG funding in 2023.

State funding for the MHDS Regions is allocated on a per capita basis using each region's population and distributed on a quarterly basis. For the state fiscal year beginning July 1, 2023, MHDS Regions were allocated an amount equal to the product of forty dollars multiplied by the sum of the MHDS Region's population for the fiscal year. For the state fiscal years beginning July 1, 2024, they are allocated an amount equal to the product of forty-two dollars multiplied by the sum of the MHDS Region's population for the fiscal year. Beginning in 2025, an MHDS Region's population for the fiscal year will be multiplied by the sum of the dollar amount used to calculate the regional service payments for the immediately preceding fiscal year plus the regional service growth factor for the fiscal year. Iowa Code 225C.7A also requires regions to spend down their fund balances, setting the threshold at 40% of actual expenditures for SFY22; 20% for SFY23; and five percent for SFY24 and thereafter. Funds withheld by HHS do not revert back to the state general fund, but rather are reinvested in the system through a regional incentive fund for certain uses also set forth in Iowa Code 225C.7A.Table 10 provides an overview, by MHDS Region, of SFY22 budgeted revenue and expenditures.

Table 10. MHDS Region Financial Report: SFY22 Budget Information[46]

Region	SFY22 Budgeted Total Funds Available	FY22 Budgeted Ending Fund Balance	Budget Ending Fund Balance as a Percent of Expenditures
Central Iowa Community Services	22,979,458	9,479,458	70%
County Rural Offices of Social Services	7,508,683	831,720	12%
County Social Services	20,142,724	6,776,068	51%
Eastern Iowa MHDS Region	16,583,008	3,291,943	25%
Heart of Iowa Region	3,775,731	810,942	27%
MHDS of the East Central Region	42,506,763	7,915,603	23%
Care Connections of Northern Iowa	5,549,666	1,706,466	44%
Polk MHDS Regions	31,398,653	4,356,689	16%
Rolling Hills Community Services Region	11,812,683	2,889,347	32%
Sioux River MHDS	4,397,163	871,096	25%
South Central Behavioral Health Region	5,980,487	1,815,471	44%
Southeast Iowa Link	11,324,329	3,228,700	40%
Southern Hills Regional Mental Health	1,363,264	151,393	12%
Southwest Iowa MHDS Region	16,109,249	5,186,811	47%
Total	**201,431,861**	**49,311,707**	

Linkage with Medicaid

The MHDS Regions have primary responsibility for supporting access to a core set of mental health services for individuals who are not eligible for Medicaid. However, since the expansion of Medicaid in Iowa, that number is dropping. Effective January 1, 2014, Iowa expanded Medicaid through the Iowa Health and Wellness Plan (IHAWP) for individuals ages 19-64 with income at or below 133% FPL. IHAWP-eligible individuals receive a limited set of mental health services. Individuals eligible for IHAWP coverage and deemed "medically exempt," which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions, may choose between IHAWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services, integrated health home care coordination, and other community-based supports not available under the IHAWP plan. Access to state plan Medicaid for the medically exempt IHAWP-eligible population has increased access to services for individuals with serious mental health conditions. This expansion has led to a decrease over time in reliance on MHBG block grant and state funds to support mental health treatment services for individuals who are un/underinsured. According to Iowa's most recent MHBG application, Medicaid (including the Healthy and Well Kids in Iowa [Hawki] program for children) is a primary funder of mental health services for Iowans.

The MHDS Regions continue to serve a role in the lives of Medicaid members, providing services that the Medicaid program does not cover and often provide access to services if and when individuals have difficulty attaining or maintaining eligibility for the Medicaid benefit. Iowa Medicaid implemented the IA Health Link managed care program for most of the Medicaid and Hawki population on April 1, 2016. Three MCOs serve most Medicaid members. These MCOs provide comprehensive healthcare services including physical health, pharmacy, behavioral health, LTSS, and care coordination.

Iowa Medicaid continues to operate a limited fee-for-service (FFS) program for Medicaid members who are not in managed care. MHDS Regional stakeholders reported an ongoing burden associated to care coordination and navigation for Medicaid managed care enrollees. Stakeholders reported a lack of knowledge of MCO case managers and care coordinators and role confusion at the local level, leads Medicaid enrollees to seek navigational support from MHDS Regions.

Operational Capabilities and Gaps

MHDS Regions have been in a multi-year cycle of change, redefining their role and structure amid multiple environmental factors. Their longstanding local presence and partnerships have made them a resource for individuals with complex needs that call for creative solutions. However, despite the contractual requirements for a core set of mental health services in each Region, stakeholder survey feedback indicated challenges for individuals seeking access to mental health services. Though workforce shortages are likely a contributing factor, opportunities exist to meet the vision for elimination of geographic disparities. As discussed for the IPN, the entry of CCBHCs into the Iowa behavioral health provider network positively stands to further integration of mental health and substance use service delivery and will require consideration of their role in serving Iowans without health care coverage in the broader context of the MHDS Regions role in the HHS safety-net system.

With realignment, administration of ID/DD services has transitioned to the Division of Aging and Disability Services. However, MHDS Regions continue to have requirements to ensure access and services for this population. Regional reporting indicates that services for people with disabilities, including people with brain injuries, makes up a small and declining portion of services delivered within MHDS regional models. Although Medicaid covers HCBS services, MHDS Regions appear to be underserving the eligible population including individuals who are not yet eligible for Medicaid or waiting for waiver services and could benefit from safety net service provision. Going forward, administrative functions for disability services and planning such as eligibility determination, service planning, and counseling may be considered for transition to ADRCs to avoid individuals and families having to navigate two systems. This move may be necessary depending on the future role of the regions.

Certified Community Behavioral Health Clinics

Overview & Historical Context

Enacted April 1, 2014, Section 223 of the US Protecting Access to Medicare Act (PAMA) authorized a demonstration program to allow states to test new strategies for improving community behavioral health services through CCBHCs. The CCBHC demonstration is intended to improve the availability, quality, and outcomes of community-based behavioral health services by establishing a standard definition and criteria for CCBHCs and developing a new prospective payment system (PPS), similar

to that which is used to reimburse federally qualified health centers (FQHCs). The PPS methodology accounts for the total cost of providing comprehensive services to all individuals who seek care.

The CCBHC model also includes expectations regarding integrated behavioral health and primary care access, provision of 24-hour crisis services, and providing care to un/underinsured individuals. In March 2023, Iowa was among 15 states to receive a one-year planning grant from SAMHSA. The CCBHC planning grants assist states in developing CCBHC certification infrastructure, establishing reimbursement systems for Medicaid services, and preparing an application to participate in a four-year demonstration program providing federal funding for implemented CCBHC systems. Providing states with planning support is intentional, given that CCBHCs are being incorporated into systems with both longstanding safety net infrastructures and newly emerging and/or enhanced crisis systems. These factors, in addition to the transition from FFS or other reimbursement models for newly certified CCBHCs requires a thoughtful planning process, and in many cases, phased approaches to implementation.

The emergence of CCBHCs is serving as a system disruptor, requiring consideration of longstanding safety-net provider networks and their role given overlapping expectations regarding uninsured populations. In Iowa, this includes services that the IPN, MHDS Regions, and CMHCs provide. Potential overlap between current state and block grant funded providers/services in Iowa include requirements that CCBHCs:

- Provide behavioral health services regardless of ability to pay or lack of insurance
- Deliver services informed by a local needs assessment
- Provide transportation or transportation support through vouchers
- Have a role with provision of both voluntary and court-ordered services
- Provide coordination within and across physical and behavioral health care, including care required by specialty providers and for chronic conditions
- Provide 24/7/365 access to crisis management services
- Maintain partnerships with programs that can provide inpatient psychiatric treatment, opioid treatment, medical withdrawal management facilities and ambulatory medical withdrawal management providers for SUD, and residential SUD treatment programs, with established expectations regarding coordination of care, which all fall outside of required services
- Partner with the following organizations that operate within the service area:
    - Schools
    - Child welfare agencies
    - Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans, and other specialty courts)
    - Indian Health Service youth regional treatment centers

- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services

These CCBHC requirements are in addition to the nine core services described in the Scope of Providers section below that must be delivered by the CCBHC or through formal partnerships.[47] It is important to note that CCBHCs are limited in the number and types of core services that can be delivered through a designated collaborating organization (DCO) versus the CCBHC.

Populations Served

PAMA clearly outlined that CCBHCs must, regardless of condition, provide services to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, or age. This includes any individual with a mental or substance use disorder who seeks care, including those with serious mental illness (SMI); SUD, including opioid use disorder; children and adolescents with serious emotional disturbance (SED); individuals with co-occurring mental and substance disorders (COD); and individuals experiencing a mental health or substance use-related crisis.

Scope of Providers

CCBHCs are required to provide nine services directly or through DCO providers. These nine core services are: crisis services; screening, assessment, and diagnosis; person-centered and family-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management services; psychiatric rehabilitation services; peer supports and family/caregiver supports; and community care for uniformed service members and veterans.

Decision Makers & Partners

DBH's Bureau of Operations and Compliance and its CCBHC Transformation staff are leading CCBHC planning efforts. A CCBHC Stakeholder Engagement Committee has been formed and supported town hall meetings held in July 2023. During the stakeholder engagement process, IPN and MHDS Regions expressed appreciation that representation from both groups have also been included in the planning process via committees and advisory bodies, including the CCBHC Stakeholder Engagement Committee.

Funding

Iowa's SAMHSA Planning Grant provides $1 million in funding to support planning for implementation of CCBHCs in the state. Prior to this grant, HHS has leveraged MHBG and Covid Supplement Funds to support CCBHC grant development and technical assistance. Up to ten of the 15 states that are participating in the planning grants will be selected for the CCBHC demonstration. At the end of the planning grant period, participating states will submit their applications to join the CCBHC pilot for four years starting July 1, 2024. The selected states will bill Medicaid under an established PPS approved by CMS. After the demonstration, Iowa CCBHCs will receive Medicaid reimbursement once Iowa's

Medicaid program has received approval of the necessary authorities to add CCBHCs as Medicaid enrolled providers and for the reimbursement methodology, including PPS rates.

Linkage with Medicaid

CCBHCs in the Medicaid demonstration are paid using a PPS. CMS has recently updated guidance to states to support development of PPS for their CCBHCs. Should Iowa maintain CCBHCs following the pilot, Medicaid would serve as the payer under the current model.

Operational Capabilities and Gaps

Planning for CCBHC implementation in Iowa is still under way, with the SAMHSA grant providing technical assistance and guidance through the process. Stakeholders value their inclusion in the planning, which is essential in considering the potential impact on the IPN and MHDS Regions. As stakeholders indicated gaps with mental health and SUD service access and availability, consideration could be given to how CCBHCs might address these gaps within Iowa. The CCBHC certification criteria might also be used to inform a new licensure category for combined mental health and substance use providers to further integration efforts under the new DBH.

Tobacco Community Partnerships

Overview and Historical Context

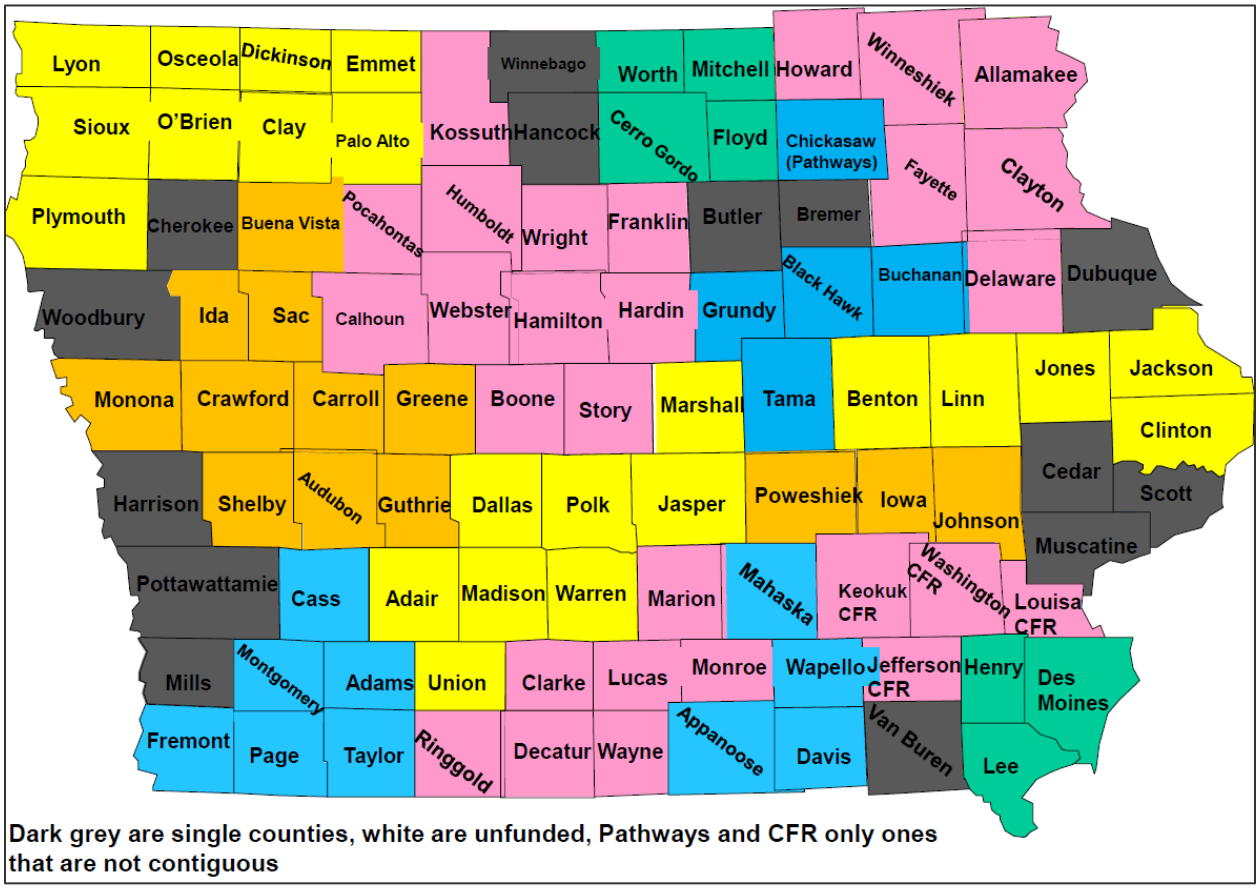
The Tobacco Community Partnerships (CPs) provide tobacco prevention and cessation services statewide, which include the development of coalitions, provision of education, and outreach activities. These services are provided through community partnerships.

The Tobacco CPs have four primary goals:

1. Prevent the initiation of tobacco use among young people.
2. Eliminate non-smokers' exposure to secondhand smoke.
3. Promote quitting among young people and adults.
4. Identify and eliminate tobacco-related disparities among population groups.

The Tobacco CPs offer statewide coverage of services that are provided through 28 community partners.

Figure 6. Tobacco CP Regions Map



Populations Served

The Tobacco CPs serve the entire state with a focus of reducing tobacco use by youth and pregnant women. Additionally, the Tobacco CPs aim to promote the compliance of minors with tobacco sales laws and ordinances.

Scope of Providers

Tobacco CPs must serve at least 4,000 people, including a minimum school-age population of 500. Additionally, they must serve a minimum geographic area of one county. Tobacco CPs are responsible for tobacco prevention and cessation activities, including development of coalitions, education, and outreach. The Tobacco CPs use several evidence-based practice interventions including: the Iowa Students for Tobacco Education and Prevention (ISTEP), You and Me Together Vape-Free curriculum, and My Life My Quit.

Decision Makers & Partners

The new alignment of DBH has integrated tobacco, mental health, and substance use activities in one division. Alcoholic Beverages is now aligned with the Department of Revenue but work and partnership will continue to collect Synar-related information. The Commission on Tobacco Use Prevention and Control (TUPC) works with state staff and the Tobacco CPs to further the goals of the program. Tobacco CP contracts are administered under the newly formed HHS Division of Behavioral Health's Prevention, Treatment and Recovery Services Section. The Tobacco CP contracts are with public agencies or nonprofit organizations who use broad community involvement and represent a broad coalition of community groups, organizations, and interests.

Funding

Iowa Administrative Code Chapter 641-151.7 (142A) Distribution of Funding establishes the formula for determining community partnership grant funding available to each county. Total funding available for a multiple-county community partnership is the combined total of funding available to each county included in their application, with no county receiving less than $10,000. The total allocation to the tobacco use prevention and control initiative for SFY23 was $2,163,764.[48] The funding allocation is calculated using a populations-based formula as follows:

- Rural Counties
    - $0.84 per school-age youth
    - $0.84 per non-school-age resident
- Urban Counties
    - $0.52 per school-age youth
    - $0.52 per non-school-age resident

Tobacco CPs must provide 25 percent of matching funds. The match may include in-kind services, office support, or other tangible offset of costs. A five percent disincentive is applied when counties fail to provide proof of staff attendance at training and/or if reports are submitted after the due date.

Linkage with Medicaid

Tobacco CPs are funded through state dollars and funded activities are non-reimbursable through Medicaid.

Operational Capabilities and Gaps

The Tobacco CPs have developed a strong, supportive working relationship between the state and its community partners. For many partnerships, the contractor is the local Board of Health or other local partnerships also responsible for other prevention activities, providing an opportunity to consolidate this funding within public health or prevention contracts, especially where other prevention dollars are included. Contracts could still ensure allocated dollars are focused on tobacco prevention through standard terms and conditions. In addition, there is an opportunity to expand the impact of the Tobacco

CPs through a more intentional integration with the mental health and SUD treatment systems. These populations have high instances of tobacco use and high rates of tobacco-related mortality, which could be significantly improved with more intentional efforts directed toward tobacco use reduction.

Other State Approaches

When states consider administrative changes, they often look to their peers in other states to leverage insight from their experiences and lessons learned. Several states have recently undertaken restructuring behavioral health administration at the state level, including mergers of public health and social service agencies, as well as integration of behavioral health authorities with Medicaid. Drivers of some recent behavioral health system changes in other states include the desire to address service access and health disparities; to increase collaboration across state agencies; to create administrative efficiencies that result in reduced provider burden and duplication in spending; and most importantly, to improve the experience of individuals served. No state model can be copied and pasted for Iowa, but many aspects of state models and their experiences through the change process could inform Iowa's realignment efforts.

Colorado

Colorado has been under a multi-year transformational process with its behavioral health system.[49] The Behavioral Health Administration (BHA) is a new cabinet member-led state entity, housed within the Colorado Department of Human Services (CDHS) with an intentional design to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs. In support of this model, the BHA has planned for and/or implemented several initiatives specific to system coordination that could inform planning in Iowa under the newly realigned HHS. These include centralized standards for addressing system gaps; building relationships between Colorado programs; supporting the system to treat co-occurring needs; and streamlined processes for credentialing, contracting, and quality measurement to reduce provider burden and build efficiency. Some of these approaches are underway in Iowa, such as consolidation of multiple commissions or committees to support a structure where more integrated advisory groups with meaningful representation and consideration of cross-program opportunities. Other strategies that may also support these goals for both DBH as well as HHS as whole include:

Behavioral Health Interagency Council: Created through legislation, the council is composed of state agency executive directors and convened by the BHA Commissioner to ensure consistent engagement and alignment of state programs, resource allocation, priorities, and strategic planning efforts specific to behavioral health.

The Behavioral Health Joint Information Center (BH JIC): The BH JIC coordinates and ensures consistent communication regarding behavioral health across state agencies, including identifying opportunities for joint messaging.

Formal Agreement Documents (FADs): The FADs are intended to support a shift from vertical to horizontal behavioral health governance in Colorado. The process of developing and refining FADs provided the BHA and state agency leadership the opportunity to strengthen partnerships across CDHS divisions and other state agencies that intersect with behavioral health such as the Departments of Education and Corrections. The FADs include components related to accountability and data

sharing; problem identification, resolution and mitigation; financial strategies, including budgeting, legislative planning, and resource allocation; standard setting and mechanisms for ensuring standard compliance; and strategic planning, including policy development and coordination. HHS and the DBH could leverage this approach at the state and local level (contractually required between vendors) to encourage horizontal collaboration and alignment of strategic planning and support for department initiatives.

Behavioral Health Administrative Service Organizations (BHASOs): BHASOs are new entities that consolidate the previous safety-net structure that included CMHCs and other providers, SUD provider networks, referred to as managing service organizations (MSOs), and crisis provider networks, referred to as ASOs. Two regional BHASOs are proposed to manage an expanded network of safety-net providers, including comprehensive providers such as CCBHCs. Like Iowa's IPN and MHDS regions, the BHASOs will help individuals and families navigate the system, provide care coordination, and interface and align with the Regional Accountable Entities that manage services and provide care coordination for Medicaid members. The BHA analyzed data to inform the number of BHASO's and potential geography for the regions. Data collected and reviewed included provider network adequacy, healthcare utilization, behavioral health key indicators, and certain demographics.[50]

Universal Contract Provisions (UCPs): The BHA has been working with the Colorado Medicaid authority and other state agencies to develop universal contracting provisions that state agencies can use when contracting for behavioral health services. Draft UCPs include a base module and advanced module for contracting depending on the scope of behavioral health services under contract. Provisions include standards for data collection and reporting, management and reporting of grievances, use of evidenced based practices, access to care and quality standards, and standards for serving priority populations.[51] When used effectively, UCPs can reduce the size and number of contracts through consolidation of multiple programs under a single vendor agreement, with agreed upon requirements that support aligned expectations across HHS divisions.

Nevada

The Nevada public behavioral health system leverages five Regional Behavioral Health Policy Boards (RBHPBs), with each supported by a (non-state) Regional Behavioral Health Coordinator position funded through the SAMHSA block grants. The five regions represent contiguous counties with populations that range from less than 16,000 to 2,282,226. Nevada's Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH) partners with RBHPBs to enable local stakeholders to:

- Promote improvements in the delivery of behavioral health services in the region
- Coordinate and exchange information with the other policy boards in the state to provide coordinated and unified recommendations to the DHHS, DPHB, and Commission regarding behavioral health services in the behavioral health region
- Review the collection and reporting standards of behavioral health data to determine standards for such data collection and reporting processes

- Establish an internet website that contains an accurate electronic repository of data and information concerning behavioral health and behavioral health services in the region that is accessible to the public
- Collect and analyze data regarding individuals admitted to mental health facilities and hospitals and to mental health facilities and programs of community-based or outpatient services, including treatment outcomes and measures taken upon and after the release of individuals to address behavioral health issues and prevent future admissions
- Identify and coordinate with other entities in the behavioral health region, as well as the state, which address issues relating to behavioral health to increase awareness and avoid duplication of efforts
- Advise the Commission on Behavioral Health, DHHS, and DPBH, including submitting an annual report to the Commission which includes:
    - The specific behavioral health needs of the behavioral health region
    - A description of the methods used by the policy board to collect and analyze data concerning behavioral health needs and problems or gaps in behavioral health region including a list of all data sources used by the board
    - A description of how the policy board has carried out its mandated duties
    - A summary of data regarding emergency admissions (mental health crisis holds) to mental health facilities, hospitals, and to programs of community- based and outpatient treatment and conclusions the policy board has derived from the data

Unlike regional and county entities in other states, the RBHPBs do not contract for local services. The RBHPBs are each composed of seven to 13 members and are statutorily required to include: one legislator; one member with behavioral social services delivery experience appointed by the governor; two members, one each appointed by each chamber of the legislature, representing the criminal justice system and law enforcement agencies; and members appointed by the DPBH administrator representing an array of behavioral health provider types and interests. In addition, the mandatory members may appoint other partners representing various interests, including insurers, county health officers, consumers who have received behavioral health services, administrators of residential treatment facilities or transitional housing, and CBOs that provide behavioral health services.[52]

Ohio

Like Iowa, Ohio has a county-operated, state-supervised behavioral health system composed of Mental Health and Recovery Services Boards (MHRSB). These 50 boards plan, evaluate, and fund both mental health and SUD services, with coverage across all 88 counties. The area governed by a MHRSB is referred to as a county district and must include a population of at least 50,000. Counties with a population of fewer than 50,000 people must join a joint-county district. This population threshold approach, when revised in statute, led to further consolidation of boards, with all joint county districts requiring approval from the director of mental health and addiction services. The withdrawal of a county

from a district must receive approval from the director if not fully supported by the remaining counties within the district.[53]

Like the MHDS Regions, the boards contract with a range of providers to ensure local access to prevention, treatment, and recovery support for their communities. Similarly, the MHRSBs have undergone changes in response to a variety of factors. MHRSBs are statutorily prohibited from providing direct care to clients and instead contract with numerous non-profit agencies to provide direct care in a community-based (non-hospital) setting.

In 1989, the Amended Substitute House Bill 317 provided that local mental health boards in all but the largest counties would be combined into a single mental health (MH) and Alcohol and Drug Addiction Services (ADAS) Board. Once responsible for managing the Medicaid dollars, this funding was returned to the state level for administration, with local boards funded primarily through federal block grant, state, and local funding. Though MHRSBs may receive tax dollars, recent changes to legislation require any county dollars levied must remain within that county, regardless of whether the MHRSB includes other counties as part of a joint district.

Another distinct difference in the Ohio funding structure is the use of a mixed funding allocation approach. MHRSBs receive funding through two primary methods, a portion of funding based on historical allocation formulas, as well as grants with specifications funded through federal and/or state dollars. Some grant funds are fixed funding amounts that are the same for all boards regardless of size, such as recovery housing, while others are based on distinct formulas.[54] In addition to annual approved budgets by the state, this approach provides transparency of how funding is being allocated across target populations and services, while also offsetting some of the disparities that can result from a purely per capita funding model.

Behavioral Health Findings & Recommendations

Service Delivery Area Options

The DBH uses two structures to contract for safety-net and other non-Medicaid services—a state model for SUD under the IPN and a regional model for mental health and the Tobacco CPs. Both contracting methodologies include funding for local assessments of need and the ability to use funds to meet these needs. **As the division continues to support integration of SUD and mental health, HHS should consider moving to a single administrative contracting model, either state level or regionally based (with local entities contracting with providers).** Though MHDS Regions are providing care coordination functions, these services could be contracted directly with providers or become a condition of certification or licensure, as will be the case for CCBHCs and is currently the case for the IPN.

Options for DBH's SUD, Tobacco CP, and mental health prevention and treatment service contracting options are as follows:

- **Option 1 − State Contracting Structure:** State transitions away from local intermediaries (MHDS Regions) to contracting directly with both mental health and SUD providers for non-Medicaid services, under a similar structure to the IPN contracts.

- **Option 2 − Regional Structure:** State continues to contract through regional entities and transition IPN/SUD contracting to these entities to support integration of behavioral health administration, including consolidated contracts for comprehensive providers (Colorado and Ohio examples).
- **Option 3 − Hybrid State Contracting/Local Advisory Board Structure:** Choose the state level contracting option above and continue to contract with newly integrated (SUD and mental health) regional entities to support local needs assessments, reporting, and monitoring to inform and support behavioral health statewide strategic planning and goal achievement (Nevada example).

Each model has advantages and disadvantages, some of which are described in Table 11 below.

Table 11. Behavioral Health Contracting Models—Advantages and Disadvantages

Contracting Option	Advantages	Disadvantages
Option 1 – State Contracting Structure	• State has direct line-of-sight into system operations and performance. • Decreased financial allocation for administration. • Services are integrated.	• Higher administrative burden for state staff. • Decreased ability to provide regionally responsive funding/programming. • State staff turnover can result in disruption of services.
Option 2 - Regional Structure	• Lower administrative burden for state staff, allowing for them to have greater focus on systemic outcomes and quality. • Ability to be more regionally responsive to trends in needs. • Services are integrated.	• Performance of providers is managed through an intermediary. Managing and monitoring expectations can be challenging if communication and standardization is weak.
Option 3 – Hybrid State Contracting/Local Advisory Board Structure	• Incorporates an entity whose purpose is to evaluate efficacy of the treatment system as well as identify needs and future direction of services. • Leverages local presence, permitting responsiveness to unique local needs. • State has direct line-of-sight into system operations and performance. • Services are integrated.	• Higher administrative burden for state staff. • State staff turnover can result in disruption of services.

Funding Model Options

As DBH continues to integrate policy, contracting, and other administrative tasks, HHS should consider updating funding models to allow HHS and DBH to:

- Move away from per capita allocation formulas for local contracts and target resources through competitive procurement for certain initiatives
- Expand use of value-based payment structures to drive outcomes
- Where possible, intentionally apply funding allocation approaches to address disparities

This task can be accomplished while still providing local flexibility for some funding through block grant approaches that align some requirements for use based on funding source requirements, balanced with flexibility to direct funds based on local needs. Though current per capita approaches may determine DBH allocation for MHDS Region and Tobacco Community Partnership programs, subsequent contracting at the local level should provide more flexibility for the state to incentivize contractors to meet the HHS goals. Having a single set of funding approaches for mental health, SUD, and tobacco prevention funding also will allow for integrated contracts, licensing, and other approaches, reducing provider burden.

Options for updating funding models include:

- **Review existing statute regarding allocation formulas for DBH contracting**, as well as language that limits use of DBH funds under newly emerging integrated administrative and service delivery models

- **Seek financing/allocation changes in Iowa Code and/or administrative rule to provide DBH with flexibility to use multiple funding mechanisms to advance HHS and DBH system goals**, such as increased use of value-based contracting, block grant approaches, and/or competitive procurement for discretionary spending on specific initiatives

Implementation Considerations

State Contracting Structure

- Regional boundaries for service delivery can be eliminated as long as there is tracking of statewide core service availability by DBH, continued requirements for IPN providers to serve statewide, and CCBHCs are successfully implemented over time to also provide statewide coverage.

- This option would allow contracting for ID/DD services to transition from the MHDS Regions to oversight under of the Division of Aging and Disability Services in response to realignment.

Regional Structure

- If choosing integrated BH regional entities, consider Colorado's approach to determining regions, leveraging metrics such as poverty level, behavioral health prevalence and service penetration, and geographic provider network adequacy.[55]

- Regions could be required to contract with existing the IPN to ensure network adequacy for SUD.

- The emerging CCBHCs could provide geographic boundaries for future regional structure considerations because they, as comprehensive behavioral health providers, are required to serve under/uninsured populations and provide crisis services, and as comprehensive safety-net providers will deliver most of the core behavioral health services now required of the regions.
- When redefining regions, it will be important to consider:
    - Population density
    - Access to the full continuum of care within the region
    - Geographical access and transportation
    - Socioeconomic disparities
    - Service pattern utilization (ex: where people go to receive BH care)
    - Claims data to identify duplication of effort in treatment (ex: a client who is receiving individual counseling twice a week—once for MH and once for SUD—versus having the care integrated and the touchpoints decreased)

Each of these factors should be weighted differently when determining a regional structure. For example, to increase prevention and decrease crisis, a region with a small population density but low access to transportation and a high service utilization rate per capita, may end up being of a smaller geographic area than if population alone were considered. This smaller geographic area may improve outcomes based on the understanding that the population in this area has high acuity and significant barriers to accessing services that could detrimentally affect outcomes if the region's size exacerbates access limitations.

Hybrid State Contracting/Local Advisory Board Structure

- Consider the Nevada model when redefining role of regional entities, with a focus on needs assessment, coordination with other HHS entities, and data-driven decision making.
- The state could begin with currently overlapping MHDS (adult/youth) regions and require SUD representation, followed by consideration of the factors Colorado uses to determine future structure, as well as geographies of other HHS local entities.

Changes to the Iowa Code and Iowa Administrative Code would be required to implement any of these models. Table 12 provides a high-level overview of required changes.

Table 12. Code Changes Required to Implement Behavioral Health Service Delivery Options

	Option 1: State Contracting Structure	Option 2: Regional Structure	Option 3: Hybrid State Contracting/ Local Advisory Board Structure
Iowa Code Chapter 125: Substance-Related Disorders (Governs current IPN structure)	Remove references to division of the state into regions for the conduct of the program (Iowa Code § 125.12).	Consider update to language in Iowa Code § 125.12 indicating "the director shall divide the state into appropriate regions for the conduct of the program…." to either (1) cross reference MHDS statute in Iowa Code Chapter 225; or (2) create new section to reflect integration of mental health and SUD regions.	Remove references to division of the state into regions for the conduct of the program (Iowa Code § 125.12).
Iowa Code Chapter 225C (Governs current MHDS Regions)	Repeal references to MHDS regions, including Iowa Code §§ 225C.55 through 225C.69 and the following subsections: Iowa Code § 225C.7A: Mental health and disability services regional service fund—region incentive fund Iowa Code § 225C.4(x): Administrator's duties which requires entry into performance-based contracts with	Update Regional Core Services (Iowa Code § 225C.65) to either (1) incorporate SUD required services; (2) cross reference Iowa Code § 125.12 which outlines IPN SUD services; or (3) create new section to reflect integration of mental health and SUD regions.	Repeal references to MHDS regions, including the following subsections and develop new language specifying responsibilities of the new integrated regional entities: Iowa Code § 225C.7A: Mental health and disability services regional service fund — region incentive fund. Iowa Code § 225C.4: Administrator's duties: Requires entry into

	Option 1: State Contracting Structure	Option 2: Regional Structure	Option 3: Hybrid State Contracting/ Local Advisory Board Structure
	regional administrators Iowa Code § 225C.20: Responsibilities of mental health and disability services regions for individual case management services		performance-based contracts with regional administrators Iowa Code § 225C.20 Responsibilities of mental health and disability services regions for individual case management services
441 IAC 25: Disability Services Management	Repeal and develop new IAC section to describe requirements of contracted mental health and SUD providers.	Modify language to include comprehensive providers, including a modification of the required services in the region to include capacity to treat SUD.	Repeal and develop new language specifying responsibilities of the new integrated regional entities.

Funding Model Options

- When considering contract allocation and reimbursement changes, consideration of cash flow for providers is necessary to sustain current access and service delivery.
- Changes to funding models would require review and possible amendment to sections of Iowa Code Chapter 225C as well as Iowa Administrative Code 441.25. Specifically, Iowa Code § 225C.7A describes the per capita allocation methodology. Stautory and regulatory changes made to the funding model for behavioral health services will also need to align with any service delivery model changes, as further described in Table 12 above.

These recommendations and options are intended to support both integration of mental health and SUD systems, administrative approaches to social service, prevention, and treatment programs, and horizontal coordination at state and local levels.

Community Access

The Community Access Division programs that HMA included in its review are: Community Action Agencies, Maternal, Child and Adolescent Health (MCAH), I-Smile, 1st Five, Family Development and Self-Sufficiency (FaDSS) program, Family Planning and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Our review did not include Child Support and Economic Benefit programs. Community Access has sought efforts to improve integration and reduce duplication. Most notably, in 2020, the state began the process to align service delivery for four preventive health programs in newly created Collaborative Service Area (CSA) regions.[56] The intent was to simplify administration, improve collaboration and address gaps/inequities of service within various preventive health programs serving women prior to pregnancy through postpartum as well as children younger than age six. Prior to the development of CSAs, local agencies self-determined service areas, which led to counties not covered during a competitive procurement and several WIC agencies commonly serving a single MCAH agency, or vice versa.

Plans for the CSAs evolved over the next two years as IDPH met with stakeholders and reviewed population and service utilization data to establish 15 catchment areas, or CSA regions. Initially the plan was to use a single procurement to award MCAH, 1st Five, and I-Smile to a single contractor in each CSA region, and to separately award the WIC contract within the CSA region. Over time, the Title X Planning Program was added to the CSA model. Based on the requirements and complexities of each of the programs, the decision to use a single procurement for a single contractor for MCAH, 1st Five, and I-Smile was abandoned. Ultimately, separate procurements were used for MCAH (including (I-Smile)) and 1st Five. HHS currently contracts with 27 agencies to provide the following coverages for the CSAs:

- 15 WIC agencies
- 15 MCAH, including I-Smile agencies
- 14 1st Five Agencies (one service area has no eligible counties)
- 8 Title X Family Planning agencies

The CSA project met its goal of creating a single service area map for all programs (MCAH, WIC, Family Planning, I-Smile and 1st Five). The aligned maps led to improved collaboration between programs serving similar populations and assuring equitable access to services to clients living within the CSA. Based on the federal and state requirements of each of the programs, a single contractor to administer all programs did not seem feasible from the beginning to program leadership during the development of the CSAs. The CSA concept is built around service providers within the CSA. Clients are able to receive services in any CSA, regardless of where they live, which aligns with the "catchment area" concept described later in the report.

Community Action Agencies

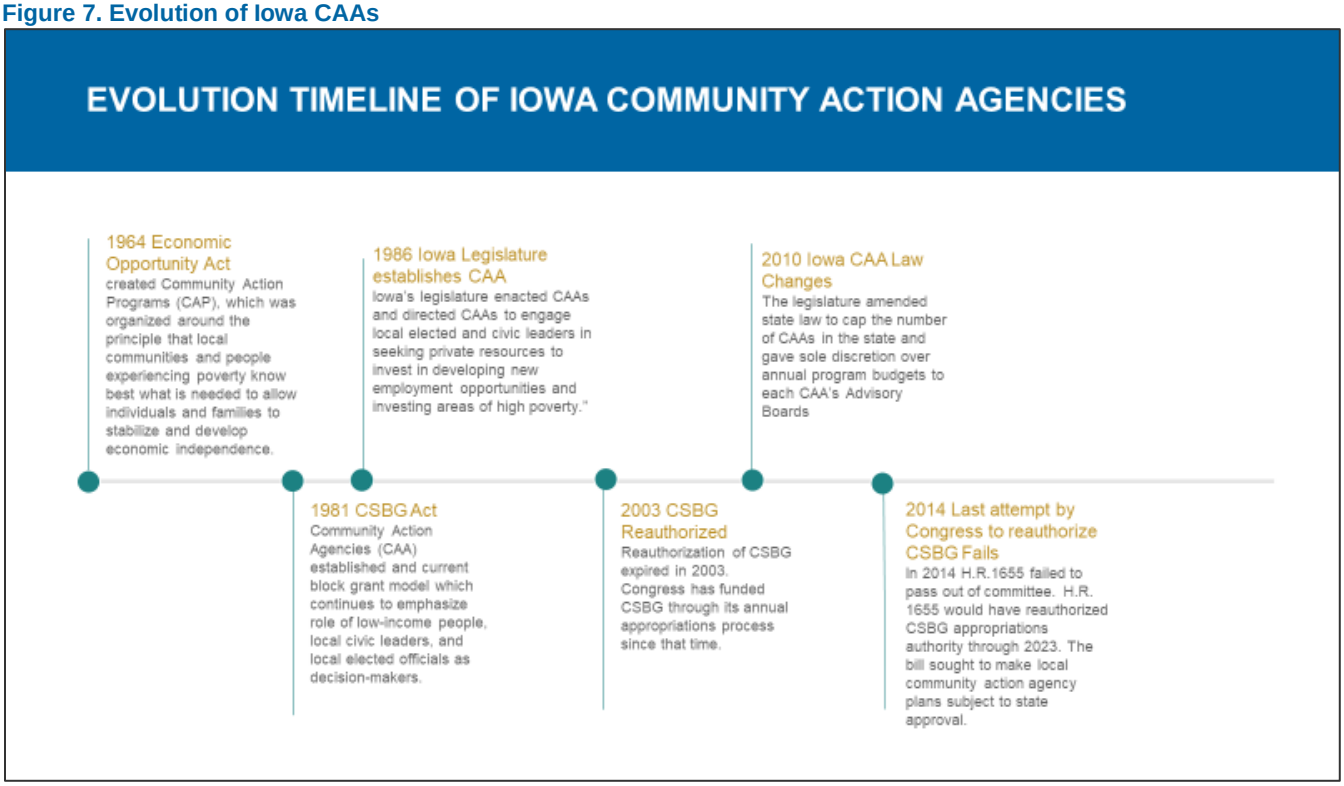
Overview & Historical Context

Community Action Agencies (CAAs) evolved from the Community Action Network concept established in the Economic Opportunity Act of 1964. The Community Action Network sought to harness the knowledge of people experiencing poverty and local communities to identify the most effective tools

and resources to assist people achieve stability and economic self-sufficiency and to grow local economies to reduce and prevent poverty.

In 1981, the Community Services Block Grant Act (CSBG)[57] replaced the Economic Opportunity Act. CSBG is the current federal authority for CAAs. CSBG carried forth the focus on local decision making and governance by establishing CAAs which are governed by a board composed of one-third elected officials, one-third members of business, industry, labor, religious, law enforcement, education or other major groups and interests in the community, and one-third are representative of the low-income individuals and families in the neighborhood they reside. The Community Action Agency Commission, a statewide body established using the tripartite formula, is responsible for collecting data on the services CAAs provide and making recommendations to the governor and Iowa General Assembly on actions necessary to improve opportunities for low-income Iowans.[58] At the local level, each CAA service area is governed by a CAA Board.[59] Under current Iowa law, the CAA Advisory Board has sole discretion to approve annual budget requests. In 2009, the Iowa legislature amended the law to clarify that CAAs are required to encourage self-help by soliciting private funds to support CAA activities.[62] (See Figure 7 for details.)

Figure 7. Evolution of Iowa CAAs



Populations Served

Iowans with household income at or below 125 percent FPL are eligible for CSBG-funded programs. The household income limit for Low-Income Home Energy Assistance Program (LIHEAP),

Weatherization Assistance Program (WAP), and Low-Income Household Water Assistance Program (LIHWAP) is capped at 200 percent FPL.

Scope of Providers

Each CAA provides programs funded by federal CSBG dollars and private and local government funds that the CAA raises. In addition to these programs, each CAA administers the LIHEAP and LIHWAP. 15 of the 16 CAA administers the WAP programs. Table 13 below breaks down the number of recipients in FY 2020−2021 by program.

Table 13. CAA Programs and Populations Served

Program	Households or Individuals Served
CSBG	120,000 households / 291,000 individuals
LIHEAP	82,274 households
Heating Crisis	9,577 households
LIHWAP	N/A (LIHWAP did not begin in Iowa until 2021)
WAP	613 households

Decision Makers and Partners

Federal law limits the role of states in CAA decision making. Under 42 U.S.C. 9906(a),[60] the United States Department of Health and Human Services (US HHS) pays the state's lead agency the state's CSBG allocation, which is calculated in accordance with the formula established in 42 U.S.C. §9907. A CAA must be governed by a "tripartite" board as defined in §9910. Finally, under §9915, state authority to terminate or reduce funding for a CAA is limited and subject to US HHS review.

Iowa Code §216A.92 authorizes the governor to appoint CAA commission members, subject to Senate confirmation. IAC §421.6(2) requires each CAA to submit an annual community action plan that documents the results of the CAA's use of the Results Oriented Management and Accountability (ROMA) cycle for the purposes of annual planning. In addition, the CAA must provide a description of how linkages with other community agencies will be made; how referral, case management, and follow-up will happen; and how the CAA will coordinate its private and public funds with other public and private resources to avoid duplication.

Iowa Code §216A.93 establishes LIHEAP, LIHWAP, and WAP as community action programs. These programs fall outside the scope of the CSBG Act. Nonetheless, as the administrator, the local CAA must comply with all state and federal regulatory requirements.

Funding

CSBG programs are exclusively funded with federal, local, and private charitable contributions. Under 42 U.S.C. 9907(b)(2) states are authorized to retain up to five percent of the state's annual CSBG

allocation to reimburse the state for CSBG administrative costs. However, in Iowa the state retains four percent and 96 percent is distributed to the 16 CAA's through a formula. A breakdown of the source of CSBG funds for SFY21-22 is provided in Table 14.

Table 14. CSBG Funding, SFY21−22[61]

Source of Funds	Amount
Federal CSBG allocation	$7,634,898
Local government funding	$2,207,173
Value of in-kind goods or services from local government	$1,720,399
Private funding	$16,124,692
Value of donated items	$17,275,290
Value of in-kind services received from businesses	$6,978,150

LIHEAP, LIHWAP, and WAP

Energy, water, and weatherization assistance primarily are funded with federal dollars. Iowa, however, has an Energy Crisis Fund that supplements federal LIHEAP dollars, as established in Iowa Code §216A.102. Funded with appropriations from the general fund and since July 1, 1988, the fund also may receive unclaimed patronage dividends from electric cooperative corporations or associations and donations from utility customers. For the project period starting October 1, 2022, and ending September 30, 2024, Iowa received $57,292,931. For FFY22, WAP received $6.1 million from the US Department of Energy, $7.4 million from LIHEAP, and $3.8 million from investor-owned utility companies. LIHWAP received $10.1 million in federal funds for LIHWAP.

Linkage with Medicaid

CSBG and Medicaid have no direct link aside from the fact that both programs are designed to meet the needs of low-income Iowans. During our stakeholder engagement we learned that CAA staff spend a significant amount of time helping clients who need assistance with completing the Medicaid application. CAA representatives said they felt compelled to provide application assistance despite lack of reimbursement because poverty-related barriers (lack of transportation, lack of computer/internet access, or computer literacy skills) made it difficult, if not impossible, for their clients to access application assistance via phone or the regional walk-in centers. CAAs also reported that the people they helped often required assistance to understand the meaning of a question in the application, or what type of verification to provide.

Operational Capabilities and Gaps

Federal and state law grant CAAs a high degree of autonomy. CSBG requirements related to governance, private and local fundraising, and the community needs assessment promote variation between CAAs in terms of specific program offerings.[62] Program offerings differ from CAA to CAA, and even within CAA some programs are county-specific and unavailable to all residents living in the same CAA region. Such variation can pose a challenge in terms of efforts to ensure that all Iowans can access a uniform set of services within their county of residence.

In many ways, however, the CAAs locally tailored program offerings are an operational strength. First, many stakeholders view the variation in program offerings as a positive reflection of local creativity and innovation. CAAs, working with other local agencies, local government, and private funders can quickly identify unmet needs and can mobilize to address them. Second, the tripartite governance structure builds local accountability.

By bringing together local elected officials, civic leaders, and people who have firsthand knowledge of the challenges facing individuals and families experiencing poverty in the area, CAAs have engendered a high degree of public trust. Stakeholders from HHS, CAA, and the community expressed a great deal of confidence in CAA efficiency and accountability. In their collective community action plans (applications for funding), Iowa's CAAs reported working with 5,935 public and private organizations in 2021. Of these organizations, 1,141 were non-profit agencies and 752 were faith-based.[63] Through frequent meetings with various affinity groups at the local level, CAAs and other local agencies said they were able to avoid duplication and use local funds where available, thereby saving CSBG funds for community needs not otherwise funded.

Even with the high degree of variation noted, a fair amount of commonality is evident in terms of the types of programs offered by CAAs. For example, currently every CAA has at least some physical presence in every county within their service area. All CAAs provide LIHEAP and LIHWAP, and 15 of the 16 provide WAP services. In addition, CAAs provide the FaDSS program in all but two of the FaDSS service areas.

Beyond these programs, while the details of programs or services differ, there is basic alignment in terms of the types of programs offered by each CAA statewide. All CAAs provide family and economic supports.[64] In terms of economic supports most CAAs provide resources beyond energy, water, and weatherization assistance. About three-fourths of the CAAs provide some form of food pantry services for adults and children.[65] Half of the CAAs offer some form of housing assistance, ranging from administration of Iowa rental subsidy program, direct provider of subsidized housing units, and/or homeless shelter beds. Three Iowa CAAs provide transportation support, ranging from a ride service to provision of bus tokens where public transportation is possible, to free or low-cost auto repairs. Only one CAA is contracted to administer Iowa county-based general assistance. In addition, about half of the CAAs offer some or all the five required services covered under the new CSA model.

Table 15 shows the services offered at each CAA. If a particular service or program is unavailable to all residents within the CAA service area, it is omitted from the chart.

Table 15. Services or Programs CAAs Offer

	LIHEAP LIHWAP WAP	FaDSS	Food Pantry	Housing/ Rental Asst	Cars/Rides	WIC	1st Five	MCAH	I-SMILE	Head Start Early Head Start	Family Planning
Community Action of Eastern Iowa	✓	✓								✓	
Community Action Agencies of Siouxland	✓	✓	✓	✓	✓					✓	
Community Action of Southeast Iowa	✓	✓	✓	✓	✓	✓				✓	
Hawkeye Area Community Action Program, Inc.	✓		✓	✓		✓				✓	
Impact Community Action Partnership, Inc.	✓		✓	✓							
Matura Action Corporation	✓		✓	✓		✓	✓	✓	✓	✓	
Mid-Iowa Community Action	✓	✓	✓			✓	✓	✓	✓	✓	
Mid-Sioux Opportunity Inc.	✓	✓	✓			✓				✓	
New Opportunities Inc.	✓	✓	✓				✓	✓		✓	
Northeast Iowa Community Action	✓	✓	✓	✓	✓					✓	
North Iowa Community Action	Not WAP ✓	✓				✓		✓		✓	✓
Operation Threshold	✓	✓		✓		✓					

	LIHEAP LIHWAP WAP	FaDSS	Food Pantry	Housing/ Rental Asst	Cars/Rides	WIC	1st Five	MCAH	I-SMILE	Head Start Early Head Start	Family Planning
Southern Iowa Economic Development Association (Sieda)	✓	✓	✓							✓	
South Central Iowa Community Action Program	✓	✓	✓							✓	
Upper Des Moines Opportunity, Inc.	✓	✓	✓	✓			✓	Free Clinic		✓	
West Central Community Action	✓	✓	✓							✓	

Another operational challenge identified was the need to increase opportunities for peer-to-peer learning and sharing between CAAs. Stakeholder interviewees strongly endorsed the claim that the Division of Human Rights, Division of Community Action Agencies worked in partnership with CAAs. CAA staff indicated that they were given the opportunity to weigh-in on decision-making and to participate in the preparation of legislative budget requests, etc. While the stakeholder input was essentially uniform in terms of the high degree of collaboration and integration of CAA with other local agencies, there was less confidence that CAAs had sufficient infrastructure, time, and opportunity to learn from one another and to share tips, best practices, etc.

Family Development and Self-Sufficiency

Overview & Historical Context

Iowa's Family Development and Self Sufficiency (FaDSS) program was implemented in 1988, predating federal welfare reform by five years.[66] The program model was developed to provide additional support to families identified to be at risk of dependency or instability. FaDSS is a state grant-funded program that uses a strengths-based, whole-family or two-generation approach to work in partnership with families to assist them in addressing their basic needs, improving child well-being, and developing career opportunities that can drive long-term independence and stability. Family development specialists conduct home visits to conduct self-assessment, goal development and setting, career development evaluations and to refer and link families with community supports and resources. In contrast to PROMISE JOBS, Iowa's mandatory work training and employment program, FaDSS is voluntary. Eligibility for FaDSS is not limited to families participating in the Family Investment Program (FIP) (Iowa's Temporary Assistance for Needy Families (TANF) program).

Populations Served

FaDSS is available to families with household incomes at or below 175 percent FPL. Families receiving FIP are given priority of service. In 2022, FaDSS served 2,323 families, 1,195 of which (comprising a total of 2,411 children) completed the program within the program year.

Scope of Providers

The state's 17 FaDSS Council regions directly align with the CAA regions; however, CAAs do not provide FaDSS in all regions. In FaDSS regions 1, 3, 9, and 17, a provider other than a CAA is the FaDSS provider. Mid-Iowa Community Action and Youth and Shelter Services Inc. provide FaDSS in Boone, Story, and Marshall counties.[67]

Decision Makers and Partners

State administrative responsibility for FaDSS has moved from the Human Rights Division to Iowa HHS, Community Access Division. The FaDSS Council, described at Iowa Code 216A.107, allocates funds to grantees across the state. In accordance with Iowa Code 216A.107, the Council's powers and duties are to serve in a policymaking and advisory role with respect to the FaDSS program and to award grants administered by Community Access Division. Membership on the Council is diverse and includes members from three state departments, the three regent universities, three current or former recipients of the Family Investment Program, two business representatives, one member representing service providers to persons experiencing domestic violence and four ex-officio members, two members from the Senate, and two members from the House of Representatives. The FaDSS Council is required to meet at least four times per year.

Funding

In SFY20, FaDSS received $7,192,834, approximately $4.3 million in federal TANF funds, and $2.8 million in state funds.[68] The program received an additional $1.5 million in other supports to supplement FaDSS.

Linkage with Medicaid

FaDSS and Medicaid are not formally linked.

Operational Capabilities and Gaps

Stakeholders including state staff, CAA staff, and community members expressed strong support of FaDSS, particularly for the strengths-based, whole-family approach, with many credited for the high level of engagement and trust of families that participate in the program. Many interviewees said they believe that although FaDSS specialists are mandatory reporters, families felt that they could ask for help with meeting basic needs or addressing sources of family conflict without risking the loss of their child(ren) "to the system."

The legacy Department of Human Rights, in its 2020 report, indicated that families participating in FaDSS earned wages in the amount of $7,727,658 and achieved $1,033,373 in FIP savings. In addition to the financial achievement of families participating in FaDSS, HMA learned from many stakeholders that the ability of CAAs to provide one-stop access to economic and other family well-being supports was extremely valuable.

Family Planning

Overview & Historical Context

The Title X Family Planning Program was enacted in 1970 as Title X of the Health and Human Services Service Act. Title X is the only federal grant program dedicated solely to providing individuals with voluntary, confidential comprehensive family planning and related preventive health services. The Title X program is designed to provide access to contraceptive services, supplies, preventative care related to reproductive health and information to all who want services, regardless of health insurance status. By law, Title X providers must give priority to low-income persons.

The Title X Family Planning Program provides funding "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). The program is administered by the U.S. Department of Health and Human Services (US HHS), Office of Population Affairs (OPA) and is implemented through a competitive process.

In Iowa, there are two federal grantees for the Title X Family Planning Program. The Iowa HHS Title X Family Planning Program covers 56 out of the 99 counties and the Family Planning Council of Iowa (FPCI) covers 47 counties, with both federally funded grantees providing services in four counties (Polk, Dubuque, Pottawattamie, and Johnson). Because FPCI is a direct federal grantee for Title X services, Iowa HHS does not have oversight for the services they provide.

Program funds support specific Title X clinics, determined by a competitive selection process, who must adhere to federal guidelines and statute associated with Title X funding. In Iowa, Title X clinics bill Medicaid, the State Family Planning Program (FPP), and other private and public payers. Title X clinics must also collect and submit program data, which is compiled at the federal level and publicly available through the US HHS OPA Family Planning Annual Report (FPAR). Specific federal requirements and mandates include the requirement that family participation is encouraged for all clients, particularly adolescents, and that Title X funds cannot be used to support abortion.

Federal statute also includes specific requirements around maintaining client confidentiality. Title X programs are required to ensure confidentiality including in billing practices and waiting rooms, and parent or guardian consent cannot be required for minor clients.

Iowa HHS also houses the FPP. This program is separate from the Title X Family Planning program and is a form of limited insurance. The FPP provides coverage for a variety of family planning services and is not considered minimum essential coverage under the federal Affordable Care Act. Coverage under the FPP is available to individuals meeting financial and non-financial requirements. Iowa HHS provides payment for services rendered under the FPP through the FFS model. Because the FPP is a statewide limited insurance program, service areas do not apply to this program.

Populations Served

The Title X Family Planning Program serves men and women of reproductive age with low incomes. There is no residency or citizenship requirement or application process to receive services. Individuals with income up to 250% FPL are eligible to receive discounted services and those with income above

this threshold may receive services at full cost. No one can be denied services due to the inability to pay. Recipients may have health insurance that does not cover family planning services.

Scope of Providers

Iowa HHS and FPCI contract with agencies to provide Title X services, which included local Health and Human Services agencies, CAAs, county nursing services, hospital clinics, and FQHCs. The Iowa HHS Title X program currently has eight contractors that align with the CSAs. Due to the long history of sharing state coverage with FPCI, HHS staff worked closely with FPCI to establish mutually agreed upon service areas to best meet the needs of Iowa families. This resulted in minor deviations from the established CSA map, with Iowa HHS covering additional counties in two of the CSAs.

Decision Makers & Partners

42 CFR Part 59, Subpart A establishes specific requirements for all Title X grantees. The Office of Population Affairs (OPA) issues program expectations and requirements for grantees as technical assistance resources, and within the Notice of Funding Opportunities for competitive grants. These requirements and expectations are explicit to how Title X clinics operate and how services are provided and include a heavy emphasis on contract monitoring and compliance at the grantee (Iowa HHS and FPCI) level. The Iowa HHS Title X program resides within the Community Access Division, Family Health Bureau, Maternal and Reproductive Health. Program staff have authority to develop competitive selection processes and provide guidance and oversight to local contractors. IAC 641-75.3 requires Iowa HHS to prioritize applicants that are public entities and also restricts the distribution of Title X grant funds to "any entity that performs abortions, promotes abortions, maintains or operates a facility where abortions are performed or promoted, contracts or subcontracts, becomes or continues to be an affiliate of any entity that performs or promotes abortions, or regularly makes referrals to an entity that performs or promotes abortions or maintains or operates a facility where abortions are performed."

Partners of the Title X program include FPCI, the Iowa Primary Care Association, Iowa HHS HIV, STD and Hepatitis programs, Maternal Health Centers, and Title X contractors.

Funding

Federal Title X funds for FFY23 were awarded to the Family Planning Council of Iowa, which received $2,217,990, and the Iowa HHS which received $1,555,410.

Linkage with Medicaid

Local Title X Family Planning Providers bill Medicaid, the FPP, and private insurance for services provided to clients and work closely with Medicaid policy staff to support providers in billing Medicaid or the FPP. Medicaid enrollees who have incomes that exceed the eligibility criteria following their 60-day postpartum coverage period may transition to the family planning services program. However, because the program is state-funded, it has no additional linkages with Medicaid.

Operational Capabilities and Gaps

According to stakeholders, family planning services have developed strong working relationships with maternal child health providers, WIC, and other local agencies that provide primary and preventive health services. Providers also indicated that using family planning services is critical for low-income women, and especially low-income women from cultural backgrounds opposed to the use of contraceptives. Providers reported that for these individuals, the privacy afforded by family planning services home visits or public health clinic locations for sexual health screenings and treatment, is highly valued. Another component of the program that is working well is the ability for nurses to use standing orders to make 12 months of birth control available to a patient during a home visit.

Stakeholders cited workforce shortages as the biggest challenge or gap in family planning services. This shortage affects rural areas of the state more than urban settings.

I-Smile

Overview and Historical Context

In response to the dental needs of children across the state, the Iowa legislature, in 2005, required all Medicaid-enrolled children ages 12 and younger to have a designated dental home. Legislators recognized the importance of early and routine dental care for children enrolled in Medicaid. The legislature acknowledged the risk to a child's long-term oral and physical health, as well as the impact on Iowa's healthcare spending if preventive care and dental care was not made more accessible. The legislature sought assurance that those children receive dental screenings and preventive, diagnostic, treatment, and emergency services as identified in the oral health standards of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. In response, the then separate DHS worked with the IDPH and other state partners to develop the I-Smile dental home concept. Currently, HHS administers I-Smile through contracts with local public health organizations, CAAs and other non-profit organizations that are part of the statewide Title V child and adolescent health (CAH) program, which ensure health services for low-income infants, children, adolescents. I-Smile also assists pregnant women served by the Maternal Health program. Each CAH contractor has an I-Smile coordinator in their communities.

The state has 15 I-Smile coordinators (dental hygienists) who are responsible for working with children and families; dentists and dental office staff; medical providers; school nurses, teachers and administrators; businesses; civic organizations; and social service organizations. They are responsible for:

- Developing relationships with dental offices to improve access to appointments for children
- Assisting families with scheduling dental appointments and linking to needed community resources
- Increasing awareness about oral health through partnerships with businesses, organizations, and schools

- Participating in community events and meetings to educate community members about the importance of oral health
- Incorporating oral health into health and social initiatives
- Addressing oral health issues through partnerships with local boards of health
- Training medical office staff to provide oral screenings and fluoride applications for children at well-child visits
- Educating parents, children, and the public about oral health and preventing cavities
- Ensuring that children have access to preventive care such as oral screenings and fluoride applications at WIC clinics, schools, Head Start centers, preschools, and childcare centers

Populations Served

Through a partnership that began with Iowa Medicaid and the state's public health department and local contractors, Iowa's I-Smile program addresses the disproportionate impact of dental disease on low-income individuals. I-Smile and its related I-Smile @ School for children and I-Smile Silver for adults, a pilot in 10 counties (Calhoun, Des Moines, Hamilton, Humboldt, Lee, Pocahontas, Scott, Van Buren Wright, and Webster), help promote preventive oral health services and reduce barriers to dental care across the state. The target population for I-Smile is low-income, uninsured, underinsured, Medicaid-enrolled children and pregnant women. I-Smile primarily targets the 47 percent of Iowa children ages 0-12 who are enrolled in Medicaid to provide dental care and disease detection early in life and limit costly, preventable dental procedures. In addition, given the link between mothers' oral health and their infants', I-Smile also serves pregnant women.

FY20 Numbers Served

63,795 children received assistance from I-Smile™ for dental care in 2022 and of those nearly 10,000 received specific personalized help for their dental needs.

Scope of Providers

I-Smile coordinators work for county health departments, CAAs, or private, not-for-profit organizations to administer the program in all 99 Iowa counties. As licensed dental hygienists, coordinators focus on preventing dental disease, identifying ways to help families receive care from dentists, and promoting the importance of oral health within the communities they serve. Other local staff that work with I-Smile include public health dental hygienists, dental assistants, registered nurses, care coordinators, and social workers.

Decision Makers and Partners

I-Smile decision-makers and partners include much of the state's dental network, county health departments, administering agencies, schools and other key stakeholders across the state who help support the goals of I-Smile (including I-Smile Silver). Key decision-makers include HHS staff in Community Access and Wellness and Preventative Health. In addition, because of the mix of funding (see below), federal and state partners, as well as Delta Dental of Iowa Foundation, are critical to the program's success.

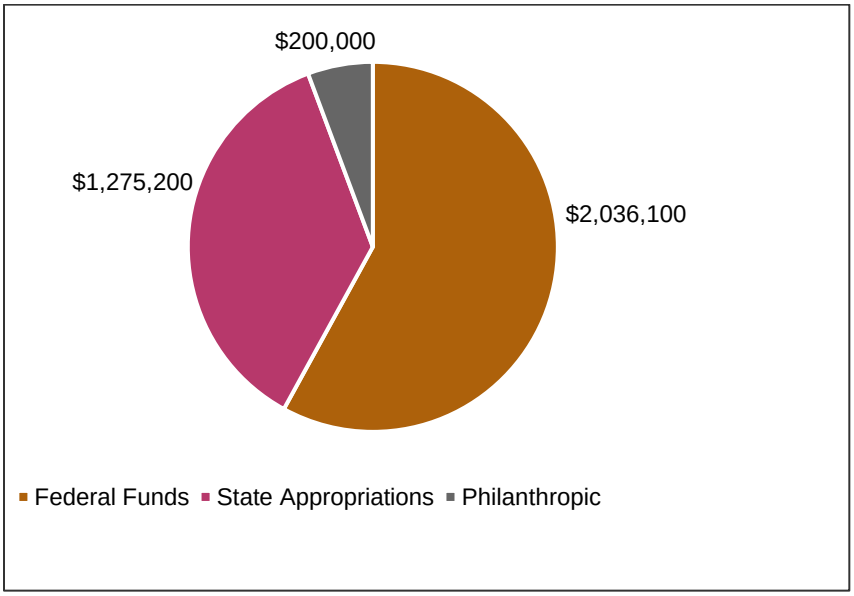
Funding

I-Smile uses state, federal and private funds to support the programs. Sources include:

- Federal funds from:
  - Health Resources and Services Administration (HRSA) Title V Block Grant
  - Medicaid and Medicare Services
  - CDC
  - Health Resources and Services Administration grant (I-Smile Silver)
- State appropriations
- Private/philanthropic funding
  - Delta Dental of Iowa Foundation

The SFY23−24 budget is shown in Figure 8, broken down by major funding source.

Figure 8. I-Smile Funding Sources SFY23-24



Unspent funds are rarely marked for I-Smile, as all funding per SFY is generally spent.

Linkage with Medicaid

Historically I-Smile and Medicaid have been linked as part of the Omnibus agreement with Iowa Medicaid; HHS staff develop program policies and procedures and manage the I-Smile program. In addition, as part of the Title V program, HHS staff provide reports to the MCAH Advisory Council and participate in writing the annual Title V block grant. Annual reports are also provided to Iowa Medicaid as part of the Omnibus agreement. This has not changed since the HHS integration effort. The program focus includes Medicaid enrollees. I-Smile works with people living in Iowa and dental and medical providers to make referrals for needed services.

Operational Capabilities and Gaps

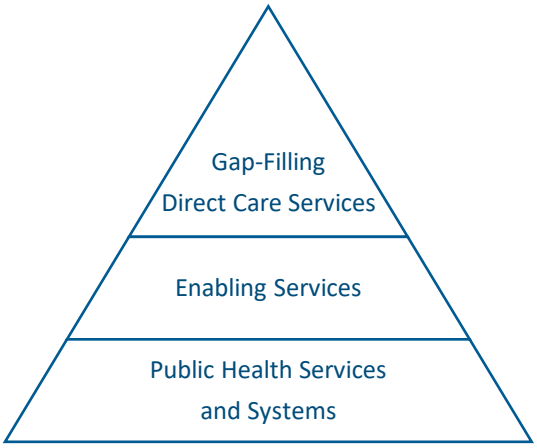
At present some of the biggest operational capabilities and gaps are concerned with connecting to dental providers for treatment. Dental health has long existed apart from traditional "health" with most insurance companies and Medicare treating the mouth as separate from the rest of the body. Strong evidence exists for the relationship between oral health and overall health. In addition to access to insurance to support good oral health, for many Americans, and especially those with Medicaid, there remains a real access problem to dental and dental specialty providers. Per the Des Moines Register, many providers don't want to or aren't able to see Medicaid members because of the low reimbursement rates – which have not been raised in over two decades. Because of this Iowa's Medicaid population has been forced to get on months' long waiting lists and/or travel long distances to receive critical care.[69]

Maternal, Child, and Adolescent Health

Overview and Historical Context

Beginning in 1935, the federal government has partnered with states to improve the health of mothers and children.[70] Iowa's Maternal, Child and Adolescent Health (MCAH) programs were previously administered through the IDPH, and are now administered through HHS' Family Health Section.[71] The purpose of MCAH is to promote maternal, child, and adolescent health of Iowans, with special focus on low-income Iowa families and/or those with limited access to health care services.[72]

MCAH programs are implemented in accordance with the MCH Pyramid, and the agency's core public health functions. Preventive maternal health services are provided at Maternal Health Centers to Medicaid eligible and other low-income pregnant women.



The maternal health program provides family-centered, community-based services to achieve the following goals:

- Ensure optimal health for pregnant, birthing, and postpartum mothers
- Ensure more babies can celebrate their first birthday (prevent infant mortality)
- Improve birth outcomes.

Iowa's CAH program promotes the health of Iowa's children, youth, and adolescents by providing health care services through public and private collaborative efforts. In addition to the services provided to all children and adolescents, Iowa has tailored programming to meet the unique healthcare needs of adolescents. The Family Health Section includes the following adolescent-specific programs:

- The Sexual Risk Avoidance Education (SRAE) program: Uses an evidence-based curriculum that promotes the positive development of adolescents through curriculum-guided interactive group discussions, positive adult guidance and support, and community service learning.

- The Hawki Outreach program: Provides assistance and outreach for enrollment in health insurance coverage for uninsured children of working families.
- Personal Responsibility Education Program (PREP): An adolescent development initiative that provides comprehensive sexuality education to assist youth in reducing their risk of unintended pregnancy, HIV/AIDS, and other sexually transmitted infections (STIs) while addressing life skills to prepare youth for a successful adulthood.
- EPSDT Care for Kids: Focuses on assuring that eligible children ages birth to 20 years receive preventive health care services, including oral health care. EPSDT is for children who are enrolled in Medicaid and services are provided at no cost.

Populations Served

The maternal health program serves pregnant, birthing, and postpartum mothers. The CAH program serves infants, children, and youth through 21 years of age and their families.

Scope of Providers

The state supports 15 maternal health centers that offer the following services: referral to health care providers, health education, and listening visits. The Family Health Section also has launched a doula pilot project to reduce health disparities in maternal outcomes for Black/African American woman in Black Hawk, Dubuque, Polk, and Scott counties.

For the CAH program, the Family Health Section contracts with 15 local community-based agencies serving all of Iowa's 99 counties with the charge of meeting the healthcare needs of infants, children, and youth through age 21 and their families.

Decision Makers and Partners

The Maternal Child Health Advisory Council provides assistance to HHS' Family Health Section with the development of the MCAH State Plan which includes completing an assessment of need, prioritization of services, establishment of program objectives, and community outreach.[73] The Advisory Council is comprised of at least 15 members, representing experts in the area of perinatal health, public health, pediatrics, and obstetrics.[74] The legislature had directed IDPH (now Wellness and Preventive Health subdivision of the Community Access Division) to contract with Child Health Specialty Clinics (CHSC) at the University of Iowa Stead Family Department of Pediatrics, Division of Child and Community Health (DCCH) to administer the Title V Children and Youth with Special Health Care Needs (CYSHCN) program.

Funding

Title V Maternal Child Health Block Grant is the largest single funding source for MCAH programs. For the current budget period (10/1/22 through 9/30/2024) Iowa received a total of $3,376,951.00 in Title V funds. Under Title V of the Social Security Act, Iowa must match every four dollars in federal Title V funding with one dollar in state funds.[75] Additional funding for the MCAH programs is provided through state appropriation, Medicaid Administrative Funding, and Hawki funding through the MCH Omnibus Agreement. In SFY22, the total federal/state expenditure for MCAH was $34,250,666.[76]

The HRSA also provides funding to Iowa for the maternal, infant and early childhood home visitation (MIECHV) program administered through the maternal and child health programs.

Table 16. MCAH Funding Sources

	SFY22 Budget	SFY23 Budget
Federal Allocation	$6,512,681	$6,549,016
State Funds	$6,334,543	$6,255,937
Other Funds	$8,847,074	$8,947,232
Program Funds	$480,000	$850,000
Other Federal Funds	$12,046,998	$11,648,481
Total	$34,221,296	$34,250,666

Linkage with Medicaid

Iowa's Title V MCAH program and Iowa Medicaid have had a mutually beneficial relationship for nearly three decades. The foundation of this relationship is the contract previously established annually between IDPH and the DHS−Iowa Medicaid Enterprise (IME).[77] This agreement is for six years and renewed each year through an amendment to address program updates.

The CAH program provides presumptive eligibility services for children who may qualify for Medicaid or Hawki and provides informing services for children who are newly enrolled in Medicaid. They provide care coordination services to help families access regular check-ups for their children through medical and dental homes. They also link families to other community-based services based upon need. The maternal health program provides presumptive eligibility services for pregnant women who may qualify for Medicaid during pregnancy and provides care coordination to help pregnant women find a medical home for prenatal care. The Iowa Presumptive Eligibility Program through Medicaid allows income-eligible pregnant women to access Medicaid coverage before a full Medicaid determination has been made. Both CAH and MH agencies are able to bill Medicaid for direct health care services provided to clients.

Operational Capabilities and Gaps

Iowa's maternal and infant health outcomes are below the national average. The interventions provided through a variety of locally tailored maternal infant health programs are key to improving

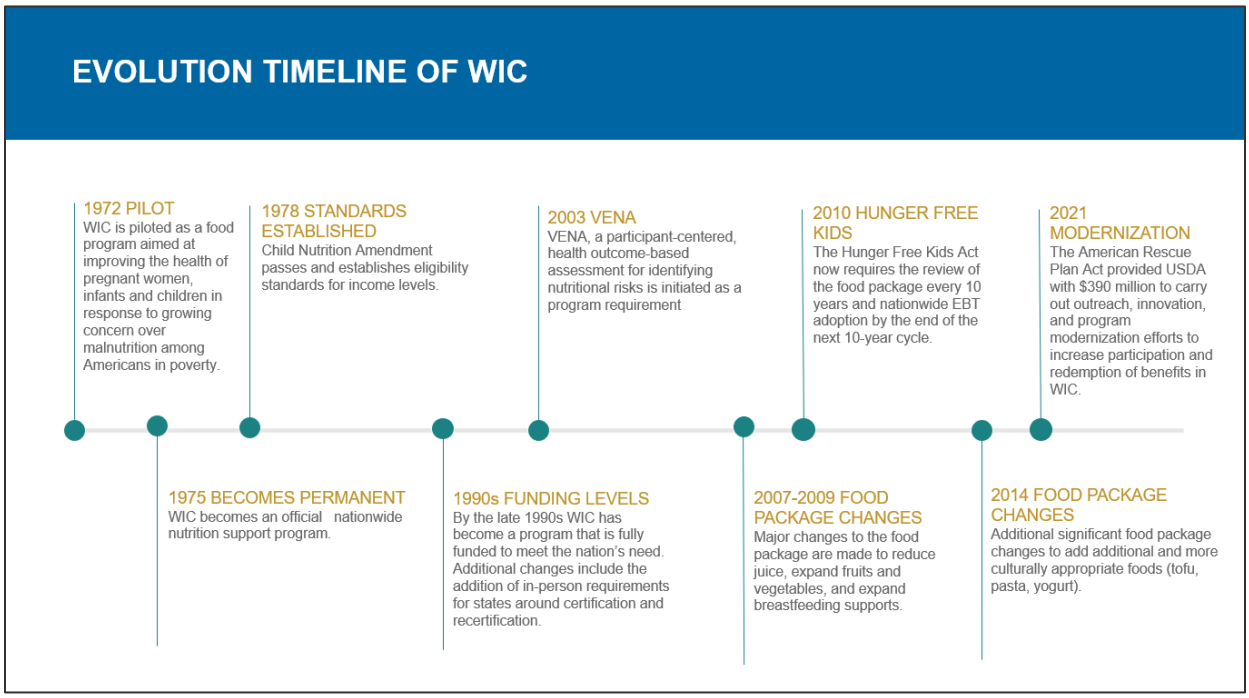
Iowa's standing. Iowa's programs use home-visiting to overcome barriers to care such as transportation and lack of childcare for older children. The degree of collaboration, and back office operational alignment (coding, billing, etc.) between maternal and child health programs with other programs along the child and family development spectrum can improve outcomes and allow maternal and child health home visitors to address and remedy stressors impacting maternal and early childhood health.

Special Supplemental Nutrition Program for Women, Infants, and Children

Overview and Historical Context

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a public health nutrition program under the jurisdiction of the USDA and has a long history, as Figure 9 illustrates.

Figure 9. Evolution of WIC



The USDA gives state WIC agencies a great deal of freedom with respect to developing goals and objectives for the WIC program. The only requirement is inclusion of a goal to encourage breastfeeding. The State of Iowa WIC Program has developed three goals for SFY24:

- Implementation of the WIC Outreach Strategic Plan
- Focus on improving the WIC experience
- Focus on improving the shopping experience

In addition, the state has separate plans for strategic outreach and breastfeeding in 2023, which include:

- 100 percent local agency participation in the Iowa WIC Outreach Plan
- Make Iowa WIC a household name
- An outreach plan that makes every partner's door a front entryway to services
- Form collaborative partnerships to share data for efficient outreach efforts
- Outreach efforts built around a strategy for a uniform Iowa WIC

Breastfeeding goals for 2023−2026 include:

- Build collaborative partnerships to improve coordination of maternal and child health breastfeeding programs
- Improve access to adequate and quality lactation services across Iowa
- Increase community-based support for breastfeeding
- Improve awareness, support, and access to donor breastmilk

Populations Served

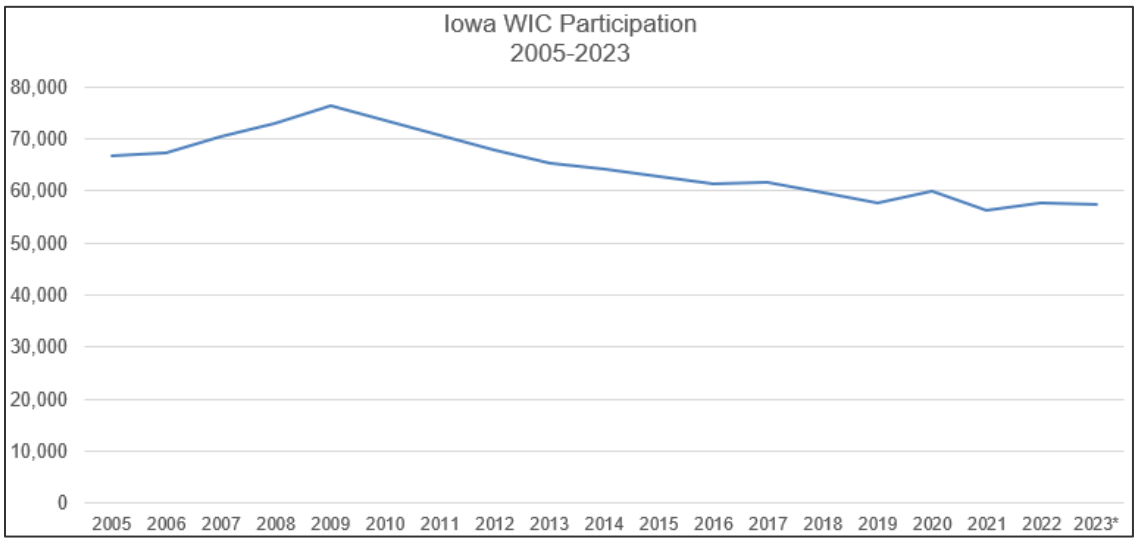
WIC serves pregnant, postpartum, and breastfeeding women, infants, and children up to age five. These population groups must meet income guidelines (gross income must fall at or below 185% FPL), a state residency requirement, and be determined at nutritional risk, according to a WIC healthcare professional. Iowans who meet the population criteria and who are presently on Medicaid, TANF, and Supplemental Nutrition Assistance Program (SNAP) are adjunctively eligible, meaning WIC does not have to determine additional income eligibility.

Figure 10. Major Program Categories for WIC

In addition, a small blip in 2020 notwithstanding, the state has seen a steady decline in WIC participation from a high of 76,000 in 2009 to an average monthly participation of 56,846 in 2023 (see Figure 11). Coverage rates (the percentage of the total eligible population covered) have also declined

from a high of 64 percent in 2009 to mid−high 50s in the last few years. Iowa follows national trends in seeing a decline in WIC participation.

Figure 11. Iowa WIC Participation, 2005−2023



Decision Makers and Partners

WIC is a federally appropriated program. HHS's Community Access Division, Wellness and Preventive Health, has a signed agreement with USDA to administer the program in Iowa. Iowa WIC partners with all programs in the CSA, including MCAH, Family Planning, I-Smile and 1st Five and also works closely with many social service providers, food banks, and medical providers in all Iowa counties. Key decision makers and partners include:

- Federal partners at USDA, Food and Nutrition Services (FNS)
- The Federal Senate and House Appropriations Committees who determine program appropriations
- Internal HHS partners, such as the Community Access and Family Well-Being and Protection, Medicaid, and Public Health Divisions
- Local CAAs, public health agencies, and other support programs

Funding

WIC is a nutrition program that falls under the purview of the USDA. It is 100 percent federally funded (7 CFR part 246.16). WIC is a discretionary program funded annually through appropriations from the US Senate and House Appropriations Committees. USDA Food and Nutrition Service (FNS) drafts WIC's annual budget proposal for the FFY (October 1−September 30) and Congress determines the annual level of funding that WIC will receive. Once Congress passes the appropriations bill and the

president signs it into law, FNS awards funding based on formulas prescribed in the WIC program regulations.

FNS allocates funding to Iowa as a grant that is divided into two parts: food costs and nutrition services and administrative (NSA) costs. These grants are then administered at the local level by public health, CAAs, hospitals, or private nonprofits. Grants to states are passed down once the funding is approved on an annual basis after receipt and approval of the State Plan of Operation. No state matching is required.

For SFY22, Iowa's total Food Grant was $30.5M and their total NSA Grant was $17.7M, for a total grant amount of $48.2M from the federal government.

Linkage with Medicaid

The biggest link between Medicaid and WIC is through the adjunctive eligibility process. In addition, in 2019, the Bureau of Nutrition and Physical Activity, Family Health and Oral Health Delivery Systems set a goal "to effectively serve families and provide consistency between programs along with appropriate funding to support the work."[78]

Operational Capabilities and Gaps

The biggest operational capabilities and gaps facing the Iowa WIC program, like many across the country, is the reduction in pandemic flexibilities and sagging caseloads. Declining caseloads is not specific to Iowa, but mirrors a national trend found in most other states. According to the USDA, "declining US births and improving economic conditions have likely played a role in the falling WIC caseloads."[79]

The Families First Coronavirus Response Act gave USDA's FNS the authority to issue waivers to state agencies to continue serving WIC participants during the COVID-19 pandemic. The authority expired at the end of FY20−21 and no new waivers are being issued. Many waivers stayed active, however, until 90 days (August 11, 2023) after the end of the PHE (May 11, 2023). However, most WIC flexibilities will continue to be available under ARPA, meaning states can continue to offer and build upon remote services now that the PHE has ended.

Other State Approaches

HMA reviewed the following states and their approaches to Community Access service delivery in the recommendations that follow. We ultimately focused on North Carolina and Texas because both states' approaches to improving coordination of administrative functions attempt to preserve local control. North Carolina's approach is well-established, having been in place since 2012. Texas's model is new and won't be fully in effect until April 1, 2025.

North Carolina

The General Assembly enacted legislation in 2012, which permits the County Board of Commissioners of any North Carolina county to voluntarily establish a consolidated human services agency (CHSA) with authority over the county board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board, or any other commission, board, or agency subject to the authority of the board of county commissioners.[80] The statute grants county

board of commissioners several options in terms of implementation. A county board may consolidate services under the human services director and county manager, create a consolidated human services board, or establish a consolidated human service agency. Regardless of the modality selected by the county board of commissioners to administer the CHSA, it has authority over all existing boards, commissions, or agencies previously authorized to administer any of the human services consolidated by the Board of Commissioners. The CHSA has been a popular option almost since the opportunity was enacted.

Texas

In the 2023 legislative session, Texas enacted a set of laws aimed at dramatically overhauling how it administers health and human services.[81] Effective April 1, 2025, a new consolidated Texas Health and Human Services System will become operational. The new Health and Human Services System will incorporate the Department of Aging and Disability Services, Department of Family and Protective Services, Health and Human Services Agency, Department of State Health Services, Department of Assistive and Rehabilitative Services, Rehabilitative Commission, Interagency Council on Early Childhood Intervention, Commission on Alcohol and Drug Abuse, Commission for the Blind, Commission for the Deaf and Hard of Hearing, Department of Mental Health and Mental Retardation, and Health Care Information Council. At the same time, new laws will go into effect that will require these newly combined agencies to develop a state-level and local-level interagency committees to clarify specific roles and responsibilities; procedures for resolving interagency conflict; quality improvement, outcome measurement and reporting; and methods to protect local autonomy and decision making for use of local funds (private, charitable, and local government), among other items.[82]

Community Access Findings and Recommendations

Community Access programs provide vital services and supports to the people of Iowa. At the local level, CAA and CSA providers are well integrated and coordinated. This coordination is achieved largely through meetings. There are many similarities between CAA and CSA provider agencies. In fact, in many places throughout the state, the CAA is the contracted provider of a CSA service. The common strengths and challenges between CAAs and CSA providers offer opportunities to increase administrative alignment, and coordination/collaboration at the state level, the former of which could allow for HHS to redirect current administrative resources towards direct services. It is worth noting that for CSBG funding, HHS retains four percent at the state-level and 96 percent goes to the CAAs and for FaDSS HHS retains five percent and 95 percent goes to the FaDSS grantees.

Iowans Need to Receive Services Locally. Though not all counties have full-time access to the full array of community access program staff, the fixed schedule allows residents to know when they can get in-person help, even if it is limited days/hours. Feedback from stakeholder interviews and town halls clearly indicated that in-person help is considered necessary to meet the needs of people who:

- Lack access to transportation to an office (especially in the family planning space)
- Can’t afford to take time off from work to visit an office
- Are without internet access or the computer literacy skills necessary to use online application tools

- Lack the language skills or time needed to feel comfortable trying to use the phone option

CAAs are Trusted Community Resources. CAAs are woven into the fabric of local communities and enjoy strong community trust. All CAAs have at least some regular physical presence in all 99 counties, which allows them to play a unique role in connecting low-income individuals and families to resources and supports needed to achieve self-sufficiency and improved health. As a largely rural state, transportation is a major barrier to accessing services. Unique governance structure and status as independent not-for-profit organizations gives CAAs the ability to develop strong collaborations with people and groups that are reluctant to engage with government agencies. Through their private and local government fundraising, CAAs leverage additional resources to meet local community needs. CAAs facilitate local decision making and control over the types of resources available in each community. In addition, CAAs at the local level have strong partnerships that combine local and private funds with federal and state dollars to ensure that all children and families have equitable access to high-quality childcare, early childhood education, parenting skills development, and support.

Additional Statewide Collaboration Opportunities Are Needed. State and local staff agree that at the local level there is a high degree of collaboration between CAAs and other local agencies that provide preventive health programs. At the time of HMA's review, the integration of community access and preventive health programs was extremely new, and most stakeholders felt it would take time to identify and eliminate communication siloes at the state level. Though neither state nor local staff used the term "silo," they generally agreed that additional opportunities for sharing information between CAAs and preventive health agencies statewide could be beneficial.

More specifically, Iowa's maternal and infant health outcomes are below the national average and the interventions provided through a variety of locally tailored maternal infant health programs are key to improving Iowa's standing. State programs use home visiting to overcome barriers to care such as lack of transportation and childcare. Collaboration and back office operational alignment (coding, billing, etc.) between maternal and child health programs with other programs on the child and family development spectrum can improve outcomes and allow maternal and child health home visitors to address and remedy stressors affecting maternal and early childhood health.

Opportunities to Improve CSA Contracting Approach. CSAs were implemented a little over one year ago in Iowa and were designed to provide equitable funding and improved collaboration. While it was not IDPH's goal of a single contractor for all implementing programs, IDPH did see collaboration improve between the programs implementing in the CSAs. By serving the same counties, programs are able to collaborate on community activities, co-location of services, provide outreach, family engagement and connections in many other ways. These collaborations continue to improve administrative efficiencies within each of the programs. The CSAs also addressed the large variances of funding received by pre-CSA agencies. The CSAs equalized, to the extent possible, funding to ensure contract agencies' funding adequately funded grant requirements.

Greater Alignment Between CAAs and CSAs Has Much Potential. Many CAAs provide all or some of the CSA preventive health programs.[83] In CSA service areas where the CAA is not a CSA-contracted provider, significant coordination and collaboration occurs between CAA and CSA contracted agencies. CAAs must collaborate with local agencies under the CSBG state plan, and stakeholders report that the CAAs and CSA agencies have created effective formal and informal partnerships at the local level. Moreover, CAA staff at the state and local level identified the connection

between CSA preventive health programs and CAA programmatic goals related to promoting family stability. Strong alignment between the CSAs and CAAs exist despite the lack of geographic alignment of the CSA and CAA service areas. Only one service area between the CAAs and CSAs completely aligns—CSA Region 6 and North Iowa Community Action Organization.

Figure 12. CAAs

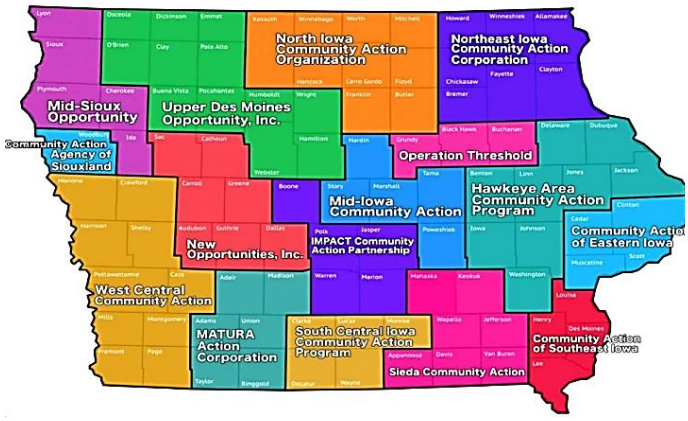
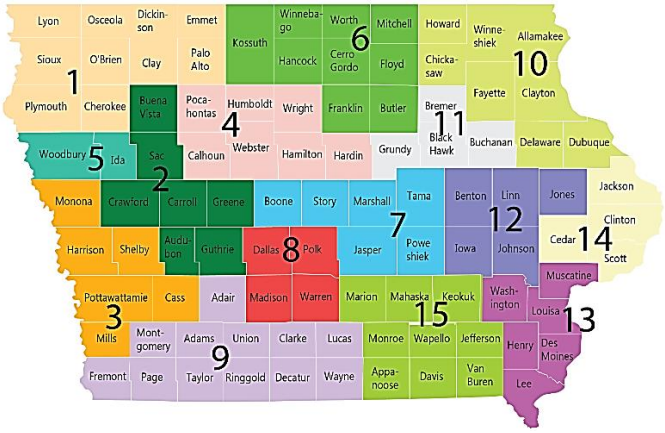


Figure 13. CSAs



Current Service Delivery Maps May Cause Confusion Where Iowans May Receive Services. At present, Iowa HHS plans and implements programs and funding based on where Iowans live. The arbitrary lines of a service area map may cause confusion on where Iowans can go to receive Community Access services for people who work outside their "assigned" service delivery area during normal business hours. For many individuals and families, the service delivery system requires them to choose between taking time off from work, usually without pay, or going without the assistance or support they need. Confusion about where to get various Community Access services is another factor that likely limits use of Community Access services or programs among eligible people. There are five separate service area maps for the 11 discrete Community Access services or programs HMA reviewed.[84] Better marketing may be needed for Iowans to understand that they may receive services wherever is most convenient for them, which may be outside of their "assigned" service area.

HHS Has Limited Flexibility in Creating New Community Access Maps. Three primary factors limit the flexibility of the state in terms of recreating Community Access service delivery maps. First, drawing a sustainable and well-functioning service delivery area is data intensive and requires the ability to forecast with a high degree of accuracy such factors as location of current providers, areas of population concentration, and areas of anticipated population and employment growth. Second, with respect to the service areas for CAAs, federal law imposes barriers to simply changing maps and prohibits terminating current CAAs without good cause and providing an opportunity to correct deficiencies.[85] By far, however, the biggest factor limiting how service area maps are drawn is the rural nature of the state and the need to limit travel time to ensure individuals and families can access services and supports and that providers (already a scare resource) are not further depleted by staff leaving the field because travel demands are excessive.

Service Delivery Area Options

Because of the tremendous opportunity that HHS has to better align programs to develop a true prevention model that fully realizes opportunities to support families through the combination of preventive health programs and family well-being and protection programs, options for Community Access have been combined with Family Well-Being and Protection as further described in the Recommendations for Community Access and Family Well-Being and Protection Programs Section below.

Family Well-Being and Protection

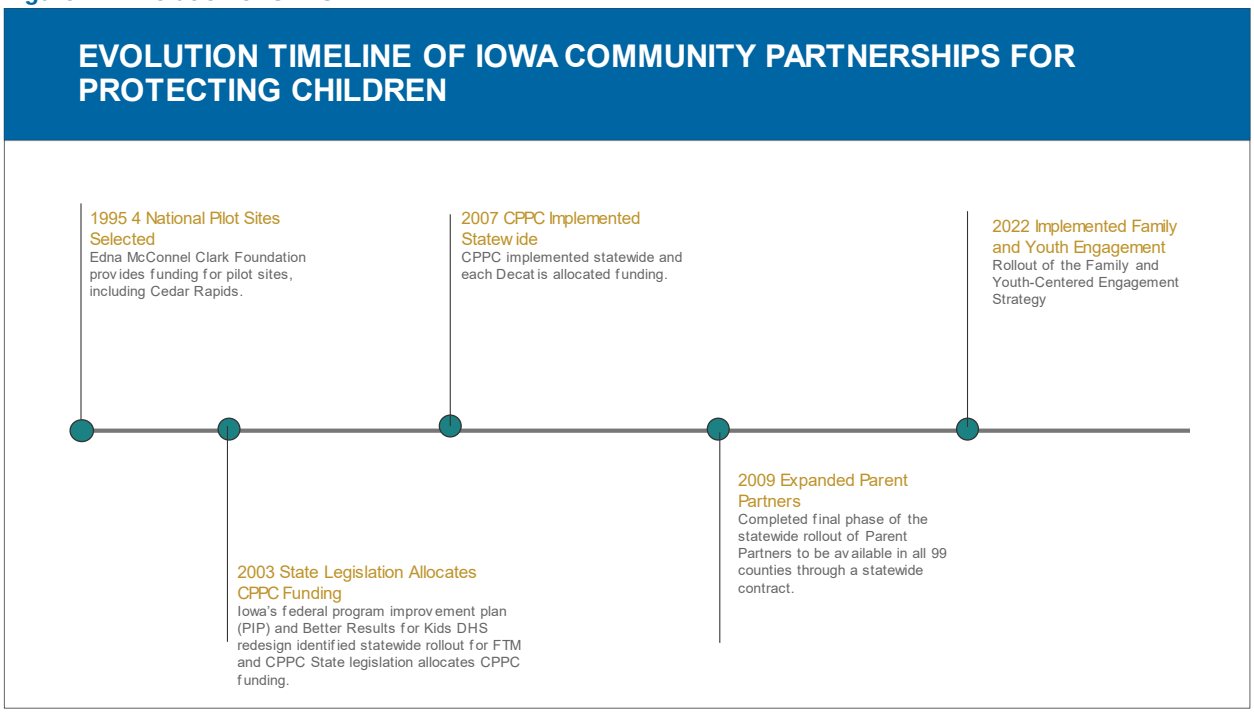
For this assessment, the programs and initiatives under review from Family Well-Being and Protection included Community Partnerships for Protecting Children (CPPC), the Decategorization Program (also known as Decat), and Early Childhood Iowa (ECI). Each of these programs has a focus on changing established practices, cultures, and systems to improve outcomes for children.

Community Partnerships for Protecting Children

Overview and Historical Context

CPPC is a community-based framework, which recognizes that keeping children safe is everybody's business and no single person, organization, or government agency has the capacity to protect all children. In 1994, Cedar Rapids, was awarded a national grant from the Edna McConnel Clark Foundation and became one of four original CPPC pilot sites in the country. The state has since expanded the program and invested in infrastructure and implementation of evidence-based programming to meet the needs of children and families across the state. Below are highlights of key milestones over nearly three decades of CPPC programs in the state.

Figure 14. Evolution of CPPC



In Iowa, local CPPCs seek to address the needs of children and families involved with or at risk for child welfare intervention and have the following articulated goals:

- Preventing child abuse, neglect, and repeated maltreatment
- Safely decreasing the number of out-of-home placements
- Promoting timely reunification when children are placed in foster care

The long-term focus of CPPC is to influence and improve child welfare processes, practices, and policies by shifting the child welfare ecosystem through a coordinated multidisciplinary approach. The Community Partnership approach involves four key strategies, illustrated in Figure 15, which undergird the interventions that are deployed to meet CPPC's goals.

Figure 15. Community Partnership Strategies to Meet CPPC Goals

All CPPC sites must meet the following criteria for each of the four strategies to be considered a community partnership site:

- CPPC Coordinator or shared decision making (SDM) member must attend all regional and statewide meetings
- Coordinator must complete and submit community partnership reporting/evaluation and budget forms by the specified dates
- Coordinator must agree to one annual site visit with the Community Partnerships State Coordinator or assigned representative

The CPPC team at the Child Welfare Research and Training Project (CWRTP) coordinated learning opportunities, facilitated technical assistance, and developed the CPPC approach in Iowa communities through an intergovernmental agreement between Iowa State University (ISU) and Iowa HHS from 2011 to 2023. CPPC statewide coordination is currently managed internally by HHS.

The statewide coordination of CPPC efforts that HHS provides includes technical assistance for CPPC sites to implement the CPPC approach, orientation of new CPPC Coordinators, Immersion 101 training on CPPC approach and strategies, reviews of CPPC plans and reports, creation and distribution of the CPPC newsletter, and site visits throughout the fiscal year. In addition, HHS coordinates the annual CPPC regional meetings and the statewide conference.

The 40 CPPC sites across the state align geographically with the Decat county structures described below. CPPC does not prescribe which partners should be included in the community-driven effort. Hence, the composition and structure of CPPCs vary across the state. Following are examples of what this relationship has looked like:

- CPPC and Decat work jointly as one board
- CPPC becomes a subcommittee of the local Decat
- CPPC operates more independently from Decat as a separate entity

In any of these examples, subcommittees through the CPPC site could be created to focus on each of the four CPPC strategies.

Populations Served

Each CPPC SDM team identifies specific needs and gaps in services/supports unique to its community and works to address these issues. CPPC efforts focus on strengthening and assisting families who have children 0-18 years old.

Scope of Providers

Iowa's CPPC teams bring together multidisciplinary teams, community members, families, and youth to understand community needs, identify community strengths, and spread and scale evidence-based approaches/practices to reduce the risk of child maltreatment. Examples of evidence-based practices that have been scaled through CPPC include family team decision making, Parent Partners, and Iowa Youth Dream Teams. CPPC invests in trainings, professional development opportunities, and train-the-trainer programs to ensure quality and consistency across the state. CPPC also supports regional networking opportunities, workshops, and forums to create ongoing learning opportunities for community members and key stakeholders.

Decision Makers & Partners

Membership within the local CPPC sites is intended to be representative of the community and include multidisciplinary partners who work with and on behalf of children, youth, and families. The CPPC site's SDM team (SDMT) must include representation from HHS, Decat, and both local community and professional members, which may include:

- HHS child protection staff
- Decat board members
- Service providers for substance use, mental health, and domestic violence
- Law enforcement
- Local businesses
- Judicial partners and juvenile court services
- Foster parents and caregivers
- Education/schools
- Child abuse prevention councils
- Health care providers,
- Faith based organizations
- Maternal, Infant, Early Childhood Home Visiting (MIECHV) partners
- Early Childhood Iowa
- Local public health agencies

Funding

CPPC funding is allocated through Decat. Each of the 40 CPPC sites receive an annual allocation of $20,000 to implement the CPPC approach and four strategies within their county/county cluster. The funding is intended as seed money to launch initiatives and test innovations. The counties are

expected to supplement their annual allocation with other funding sources for long-term implementation of interventions and strategies.

Linkage with Medicaid

There is no formal linkage between CPPC and Medicaid. However, the MCOs in Iowa are invited to participate in CPPC network meetings across the state.

Operational Capabilities and Gaps

CPPC is a community-based approach to child protection designed to support community-based stakeholders to work in partnerships to prevent child abuse, neglect, and re-abuse; safely decrease the number of out-of-home placements; and promote timely reunification when children are placed in foster care. The long-term focus of the Community Partnerships is to protect children by changing the culture to improve child welfare processes, practices, and policies. Given the small investment and the focus of CPPCs on structure, few CPPC resources are put into child and family services. More than 50% of the $20,000 allocation to CPPC sites supports coordinator staff, administrative expenses, and community-based trainings. The remaining funds are used for community focused programming and activities such as: mini-grants to community providers, support to local family and youth based programming and initiatives such as Parent Cafes, community resource information distribution such as community hubs for resources to meet family needs through providing goods and information, planning and support of community events such as family fairs, and activities to increase community awareness and education to strengthen families and increase accessibility to formal and informal supports available in their community.

There is significant overlap between CPPC and other family well-being and prevention programs, including the state's Decat program, and ECI. The three programs have similar goals and purposes, although some nuances distinguish the three. For example, CPPC prioritize efforts to improve outcomes for children, youth, and families at risk for or involved with child welfare, while Decat includes juvenile justice as a component of its charge. ECI's target population is young children and includes domains unrelated to child maltreatment; however, the program's focus on child well-being aligns with the prevention priorities of both CPPC and Decat.

There is mutual participation in governance between CPPC, Decat and ECI and, where possible, shared administrative support and service areas have overlapping clients and geographical areas. Identifying ways to consistently leverage shared goals and align resources is an opportunity that crosses all three programs within family well-being and protection.

Decategorization

Overview and Historical Context

Decategorization (also known as Decat) was designed to significantly change the child welfare system to make it needs-based, family-focused, easy to access, more intensive, less restrictive, and more cost effective by decategorizing services from a state level to the local level. It served as a new funding mechanism for child welfare and juvenile justice services and programming based on client needs, replacing existing categorical funding programs and funding sources, which had different service definitions and eligibility requirements. The program is designed to redirect child welfare and juvenile

justice funding to services that are more preventive, family-centered, and community-based to reduce use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

The Iowa General Assembly authorized Decat in 1987 as an initiative designed to deliver more effective services to children and families. The goals at the time were to:

- Enhance the array of services available to clients to better meet their needs
- Overcome some of the challenges that traditional categorical funding streams presented
- Accomplish major system changes without spending more than would have been spent in the former categorical system

The legal basis for Decat is outlined in Iowa Code Section 232.188, which was initially enacted in 1993 and substantially modified by the 2005 Iowa General Assembly.

The Decat initiative was developed in response to:

- The growing number of children placed in foster care
- The need to increase emphasis on early intervention and prevention services
- Community values that support the reality that most families, even dysfunctional ones, do a better job of raising children than the government
- The recognition that local jurisdictions are much more in touch with the needs of their children and families and have the ability to respond more quickly and appropriately than the state bureaucracy

Decat projects are organized by county or clusters of counties. Today 40 Decat projects operate across the state, covering all 99 counties.

Populations Served

Decat serves children and families involved with or at risk for child welfare or juvenile justice. Prioritized Decat projects and providers selected to provide identified services determine the specific populations eligible for services.

Scope of Providers

Decat counties and clusters develop annual plans that outline the programs, services, and administrative functions they will fund for the year. Counties and clusters assess needs and use various data and information sources to identify the specific project and services that they will support. Examples of some of the programs and services that many Decat counties and clusters fund include:

- Mental health services
- Parent education and support
- Family assistance

- Community-based juvenile justice interventions

Decision Makers and Partners

Iowa statute prescribes that each Decat project is directed by a governance board that must include representatives of administrators of HHS, Juvenile Court Services, and representatives designated by county government within the affected county or counties. The Decat Governance Board is charged with the following:

- Community Planning
- Establishment and adherence to board operation procedures
- Coordination with Department and Juvenile Court Services administrators
- Fiscal responsibility and authority
- Reporting October 1 and December 1

Statute mandates HHS and governance board coordination, stipulating the following:

- HHS, through the service area managers, work with the Decat governance boards to coordinate planning activities, funding allocations, and alignment of resources
- A Decat governance board shall coordinate the project's planning and budgeting activities with the departmental service area manager for the county or counties in the project area and the ECI area board or boards for ECI area or areas within which the Decat project is located[86]

Funding

Decat was designed to be a process that combines the individual state appropriations for child welfare services into a single funding pool to encourage the development of services that better meet the needs of youth and families by allowing the local county(s) flexibility in how these funds are used.

Pursuant to state statute:

> *[T]he governance board for a decategorization project has authority over the project's decategorization services funding pool and shall manage the pool to provide more flexible, individualized, family-centered, preventive, community-based, comprehensive, and coordinated service systems for children and families served in that project area. A funding pool shall also be used for child welfare and juvenile justice systems enhancements.*[87]

Decat funds are used in a wide variety of prevention, intervention, and support strategies for families with children 0-18. Examples of interventions and programs funded through Decat include: mobile crisis outreach services, funding direct family supports unavailable through the formal systems, efforts to reduce minority disproportionality in the juvenile justice and child welfare systems, parent skill development, and informal supports to meet various child, youth and family needs.

Funding for Decat comes from three primary sources, including state appropriations (which don't revert to the general fund if unspent and can be carried over to the next year), child welfare, and juvenile justice services funds.[88] Funding is good for three fiscal years, in addition to the original year of the allocated dollars.

Annual SFY legislative allocation is $1,717,000. Additionally, in SFY 23, Juvenile Court Services (JCS) estimates a transfer of $6.2 million. HHS did not authorize transfers to Decat in SFY22 or SFY23. Annual transfer amounts from JCS and HHS from SFY22–SFY23 are listed below in Tables 17 and 18.

Table 17. Juvenile Court Transfers to Decat

SFY	Juvenile Court System Transfers to Decat	Amount
SFY18	$5,303,502 + $422,610	$5,726,112
SFY19	$4,706,721 + $850,951	$5,557,672
SFY20	$5,016,544 + $949,420	$5,965,964
SFY21	$5,578,295 + $644,925	$6,223,220
SFY22	$5,457,270 + $970,373	$6,427,643

Table 18. Child Welfare End of Year Transfers

SFY	Child Welfare End of Year Transfers Amount
SFY18	$2,312,389
SFY19	$1,164,977
SFY20	$2,783,423
SFY21	$3,325,502 (two-year designation)
SFY22	$0

Beginning July 1, 2023, funds transferred by the juvenile court system to Decat boards will be held within the juvenile court system budget in the State Court Administration of the Iowa Judicial Branch. Previously, accounting of these funds was handled by HHS.

Linkage with Medicaid

Decat boards don't have a direct link to Medicaid. However, funded programs and providers may use Decat funds to pay for services to clients who are not eligible or enrolled in Medicaid.

Operational Capabilities and Gaps

One of Decat's greatest strengths is its flexibility. Local communities can use Decat funds to fill gaps. Some communities use Decat funds for graduation parties for children in foster care, some use Decat funds to develop leadership opportunities for children. Recent lack of funding for Decat has destabilized programs funded through the program and has made it difficult to establish new initiatives or partnerships.

As noted above, Decat functions similarly to and in collaboration with CPPC and ECI, which is discussed in the next section. The three programs and approaches have similar goals and priorities and, in some instances, invest in similar programs and services and share administrative resources. However, the programs are administered independently, presenting challenges with consistency and overlap, particularly when services and programs support the same populations.

Early Childhood Iowa

Overview and Historical Context

The first 2,000 days (five years) are the most critical stage of the human lifecycle and will affect a child's chances for success later in life. Early Childhood Iowa (ECI), formerly known as Community Empowerment, is a statewide initiative that unites public and private agencies, organizations, and stakeholders under one common vision, "Every child, beginning at birth, will be healthy and successful."

ECI was created in 1998 through legislation with the goal of developing a partnership between communities and state government to improve the well-being of families with children prenatal through five years of age. ECI has as its purpose the development of capacity and commitment, across Iowa, for using local, informed decision making to achieve desired results for Iowa's young children and their families. ECI provides leadership for facilitation, communication, and coordination for Iowa initiative activities and funding and for improvement of the early care, education, health, and human services systems. The initiative is an alliance of stakeholders in early care, health, and education systems that affect a child, prenatal to five years old, in the state of Iowa. ECI's efforts unite agencies, organizations, and community partners to speak with a shared voice to support, strengthen, and meet the needs of all young children and families. ECI Area Boards are formal units of local government and governmental subdivisions that have tort liability. This allows for direct service implementation from the Agency to local communities.

The 2023−2026 strategic plan offers the following goals:

Goal 1 **Infrastructure:** Promote a coordinated infrastructure to advance the early childhood system

Goal 2 **Communication:** Build public will for investing in young children and their families

Goal 3 **Workforce:** Transform the early childhood workforce through formal education, professionalism, increased skills and competence, and new approaches to implementing best practices

Goal 4 **Equitable Access:** Ensure that young children and families receive the services they need, when they need them

Goal 5 **Quality:** Improve the quality of early childhood services for young children and their families across early care and education, health, mental health and nutrition and family support services

Populations Served and Scope of Providers

ECI serves children across the state prenatal to age five. Iowa has 38 early childhood areas, representing all 99 counties. Each area has a citizen-led board to support activities to promote collaboration and develop systems in the community for young children and their families. ECI area boards develop a comprehensive community plan that includes data gathered through various assessment processes. This information assists the community in planning, funding, professional development, and overall support of early childhood programming in the community.

Services can include the following:

- Expansion of Head Start service delivery
- Transportation to Head Start and quality preschool programming
- Expansion of Child Care Resource and Referral (CCR&R) Consultants to increase childcare provider's adoption of quality initiatives and business investment programming to support childcare providers' incentives to start-up, expand, and improve their business operations
- Training, coaching, and health and safety consultation
- Extending quality early learning preschool programing hours when Statewide Voluntary Preschool Program funding ends
- Statewide promising practice and evidence-based family support home visiting services
- Group-based family support parent education services
- Prenatal and postnatal family support services
- Child Care Nurse Consultation for childcare programs' health and safety needs

- Early childhood mental health supports through the evidence-based Pyramid Model
- Infant and Early Childhood Mental Health Consultation for the early childhood workforce

Decision Makers & Partners

The ECI program itself, is centered on engaging key decision-makers and partners. This includes HHS staff and their Executive Committees/Advisory Boards. The statutory responsibilities of ECI Boards are found in Iowa Code Chapter 256I. Boards consist of:

- ECI State Board
- ECI Stakeholders Alliance (State Advisory Structure)
- Local Boards and Structures

In addition to the formal structures of the state and the advisory boards are the many informal partners that exist in each of the 38 areas whose input and partnership is critical to the success of the program.

Funding

The 38 local ECI area boards are designated to receive School Ready and Early Childhood funds. State appropriations make up ECI funding including:

- School Ready Grant Funds (inclusive of local disbursements to ECI Area Boards to be used for services that support families with young children 0-5 and evidence-based strategies in family support home visiting)
- Early Childhood Iowa Office (state-level administration FTEs and overhead)
- Early Childhood Iowa Professional Development (for statewide pilots that support early learning; health, mental health, nutrition; family support; and special needs)
- Early Childhood Funds (local disbursement to ECI Area Boards to be used for local services related to improving quality childcare)
- Integrated Data System for Decision-Making

A total $5.785 million was appropriated for SFY22−23. Local ECI Boards may carry forward school-ready funding. The amount of school-ready children grant funding an area board may carry forward from one fiscal year to the next must not exceed 20 percent of the grant amount for the fiscal year. All grant funds which remain unencumbered or unobligated at the close of a fiscal year are carried forward to the following fiscal year. However, the grant amount for the succeeding fiscal year is reduced by the amount in excess of 20 percent of the grant amount received for the fiscal year.

If an ECI Area Board exceeds the 20 percent carry-forward threshold those funds are redistributed to the other ECI area boards in the following state fiscal year.

Linkage with Medicaid

Generally speaking, ECI fills the gap where Medicaid reimbursement for preventive health services is unavailable. Each Board makes the determination of what priorities to fund locally. For example, ECI funds allow for children to have dental screenings, fluoride treatments, and referrals that are not otherwise available to the family through Medicaid or other insurance.

Other State Approaches

HMA reviewed the following states and their approaches to the programs under the Family Well-Being and Protection Division in the recommendations that follow.

Utah

In 2021, the Utah legislature passed a bill to create the Department of Health and Human Services and transition the then Department of Health and the Department of Human Services into the newly created single state agency. The Department's new organizational structure combined child welfare, juvenile justice, family health, early childhood, and population health under Community Health and Well-Being.

Colorado

The Colorado Early Childhood Leadership Commission includes over 100 state partners with a diverse set of perspectives (e.g., nonprofits, government agencies, funders, businesses, advocacy groups) to better align and coordinate programs and services for young children. The Colorado Partnership for Thriving Families brings together professionals from various sectors and jurisdictions to coordinate funding, regulations, implementation, and evaluation to promote well-being during a child's first year of life.

Pennsylvania

Pennsylvania's Department of Human Services is taking a comprehensive approach to serving children, birth to 21 years of age, through programs that focus on long-term prevention, early intervention and services that support family stability, child safety, community protection, and healthy child development. The state is integrating service coordination and delivery at the county level, with the following programs included in their approach: child welfare, juvenile justice, permanency planning, early intervention, intellectual disabilities services, behavioral health services, childcare and education. Counties are also being asked to seek meaningful coordination and cooperation with services provided by local school districts and Early Intervention programs, physical health care services, Food Stamps, and other public benefits programs that are not directly led by county governments. The state's integration framework incorporates the following elements for children and adolescents and their families, in every county, who need public "system" involvement:

- A continuum of care that provides for the healthy development, safety and well-being of the child
- A service plan that accesses resources from all appropriate sources to meet the needs of the child and family
- A prevention strategy for children that results in healthy development and stability

These approaches have been considered in the context of Iowa and the best elements of each are reflected in the recommendations that follow.

Family Well-Being and Protection Findings and Recommendations

Local child abuse prevention and early childhood services strengthen families to prevent violence or neglect and make it possible for children to grow and thrive. Parenting skills training and provision of needed resources is designed to strengthen families. These programs build parents' knowledge of child development and effective ways to cope with the stress of parenting. These services are successful because they are not punitive measures.

Decat and CPPC maps are completely aligned and all funding is administered through Decat. CPPC and Decat are geographically aligned by county/county clusters. In addition, the services provided through CPPC, Decat, and ECI are closely related as they all prioritize prevention of child maltreatment and/or child welfare involvement.

Recommendations for Community Access and Family Well-Being and Protection Programs

Individuals and families don't experience problems in siloes and therefore the programs that provide support should not be siloed either. Currently, in many counties, families and individuals experiencing economic hardship must go to multiple offices to get the help they need to resolve the immediate situation and to get the support and services they need to prevent future crises. Duplicative administrative requirements divert time and resources away from providing direct services. Additionally, state contracts often contain requirements that unintentionally make it difficult for smaller provider entities to come together to offer the full array of Community Access and Family Well-Being and Protection services.

To better meet the needs of individuals and families facing these challenges, and to build a system which is reducing the numbers of families in these situations using prevention-focused models, Iowa's CAA, CSA, and Family Well-being and Protection programs should:

- Make it possible for all Iowans to receive all contracted Community Access and Family Well-Being and Protection services where it is most convenient for them. As outlined above, the current service delivery area maps contribute to barriers accessing services. For this reason, we recommend that Iowa consider transitioning to a catchment model. Using the definition of catchment areas used by federal Community Health Services programs, meaning a geographic area that a provider must serve rather than a geographic area from which a person must seek services.[89] Another beneficial feature of a catchment area is that it can facilitate the use of subcontractors because there is no limitation on how many catchment areas a provider is able to serve. HHS will need to be mindful of the strict rules for subcontracting WIC services.

- Further align and realize opportunities to streamline contractual oversight of CAA, CSA, and Family Well-Being and Protection programs at HHS.

- Ensure that services continue to build off existing community strengths and resources and to fill gaps at the local level. This includes building off and expanding, as needed, the community needs assessment process that occurs every three years.

The three options offered below present different ways that HHS could achieve greater alignment of Community Access and Family Well-Being and Protection administrative functions, reduce unintentional administrative burdens on local agencies, enhance the quality of individual services by integrating service delivery where feasible, and preserve local decision-making related to service delivery. All three of the options utilize a lead agency model for catchment areas. As noted above, the catchment area model allows for Iowans to receive services anywhere that meets their needs and does not require they do so in their county/catchment area of residence. The differences between the options presented below are related to: which programs are recommended for integration and the method of determining catchment areas.

- **Option 1** – This option combines programs into a single contracting structure currently operating under the CSA structure with CPPC, Decat, ECI, and FaDSS and offers three sub-options for developing catchment areas: aligning with the CAA map, aligning with the CSA map, or letting counties self-align.
- **Option 2** – This option combines CSA programs and FaDSS into a single contracting structure and offers three sub-options for developing catchment areas: aligning with the CAA map, aligning with the CSA map, or letting counties self-align.
- **Option 3** – This option combines into a single contracting structure CPPC, Decat, ECI, and FaDSS and offers three sub-options for developing catchment areas: aligning with the ECI map, aligning with the CSA map, or aligning with the map that was determined when Option 2 was undertaken.

Option 1 can be chosen as a single option, but also HHS may want to choose both Option 2 and Option 3.

Table 19. Service Delivery Options

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
Overview		
Combine the following programs to create a single contracting structure: • 1st Five • Maternal, Child and Adolescent Health (MCAH) • Family Planning Program (FPP) • I-Smile	Combine the following programs to create a single contracting structure: • 1st Five • MCAH • FPP • I-Smile • WIC • FaDSS	Combine the following programs to create a single prevention and early intervention delivery model: • CPPC • Decat • ECI

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
• Women, Infant, and Children (WIC) • Community Partnership for Protecting Children (CPPC) • Decat • ECI • FaDSS		
Interaction with Community Action Agencies (CAA) [90]		
The lead agency must develop an MOU with CAAs that are located within the boundaries of the new catchment area to formalize mutually agreed upon collaborations where appropriate.		
Interaction with WIC Agencies		
HHS will want to consider whether to do a competitive application for WIC. If not, HHS will need to develop an application process for interested parties to apply to be a WIC agency and get USDA approval for that process.		
Catchment Area Options[91]		
1. Current CAA Map[92] 2. Counties granted a specified period of time to organize themselves into multi-county catchment areas[93] 3. Current CSA map	1. Current CAA Map 2. Counties granted a specified period of time to organize themselves into multi-county catchment areas 3. Current CSA map	1. Current ECI Maps 2. Current CAA Maps 3. Align with catchment area formed under Option 2
Governance Model Elements		
The lead agency under all three options must demonstrate the capacity to carry out the following administrative functions: 1. Establish mechanisms to ensure multi-program communication needed to share emergent issues and promising practices. 2. Include processes to integrate local input and collaborative decision-making processes on how best to incorporate private, charitable, or local funds to enhance the delivery of services within the catchment area. 3. Utilize a community needs assessment process(es) that incorporates the perspectives of individuals and families who are eligible to receive Community Access or Family Well-Being and Protection		

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
services, providers of Community Access or Family Well-Being and Protection services, community advocates, civic leaders, and local elected officials. 4. Identify priorities for contracted services and supports for children, youth, and families; and contracting with providers to meet the needs of children, youth, and families. This program could be guided by a set of values/strategies similar to CPPC, which are: shared decision-making, community neighborhood networking, family and youth-centered engagement, policy and practice change. The CPPC approach also includes tools and strategies for implementing each component, which could be helpful to implementing this prevention and early intervention model.		
Advantages		
Eliminates multiple procurements and contracts at the state level. Fully realizes opportunities to support families through the combination of preventive health programs, family well-being and protection programs. Allows for greater coordination between FaDSS and Family Well-Being and Protection. Gives Iowans the right to choose where to receive services by incorporating a catchment area model. Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.	Eliminates multiple procurements and contracts at the state level. While not presently available in every CSA (8 of 15), in future RFPs the state can impose requirements that RFP bidders would have to provide or subcontract family planning in every county (e.g., subcontractors can furnish services in multiple catchment areas.) Gives Iowans the right to choose where to receive services by incorporating a catchment area model. Less disruptive than Option 1 to current regional and provider communities. Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.	Eliminates multiple procurements and contracts at the state level. Allows for greater coordination between FaDSS and Family Well-Being and Protection. Increases local and state coordination in delivery of family well-being and protection interventions/ programs and decreases administrative overlap and duplication in contract and program administration. Gives Iowans the right to choose where to receive services by incorporating a catchment area model. Less disruptive than Option 1 to current regional and provider communities. Ensures that specific linguistic, cultural, or disability-related needs are met by expanding flexibility in subcontracting.

Option 1: Combine Community Access & Family Well-Being & Protection Programs under Lead Agency Model	Option 2: Combine CSA Programs under Lead Agency Model	Option 3: Combine Family Well-Being & Protection Programs under Lead Agency Model
Disadvantages		
HHS organizational structure includes Community Access and Family Well-Being and Protection as separate Divisions. Therefore, internal structural changes would need to be considered. Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.	Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.	Could reduce local control; however, this impact could be mitigated through HHS establishing contract requirements for the lead agency in this area.
Legislative Changes Required		
Legislative action would be required to: 1. Eliminate CPPC, Decat, and ECI as separate programs/initiatives and establish the prevention/early intervention program. 2. Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected). 3. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.	Legislative action would be required to: 1. Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected). 2. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements to conform to new lead agency model.	Legislative action would be required to: 1. Eliminate CPPC, Decat, and ECI as separate programs/ initiatives and establish the prevention/early intervention program. 2. Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.

Implementation Considerations

Iowa Code

Each of the options would require legislative action to successfully execute. In addition, WIC Federal Regulations on who is allowed to be a local agency and the process for approval should be considered for all options.[94] Additional requirements are laid out below.

Option 1: Legislative action would be required to:

- Eliminate CPPC, Decat, and ECI as separate programs/initiatives and establish the prevention/early intervention program.
- Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected).
- Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.

Option 2: Legislative action would be required to:

- Grant counties a specified period of time to organize themselves into multi-county catchment areas (if this sub-option is selected). Historical experience with this has not been positive so HHS would need to reflect on what went poorly in the past and what could change to make this more successful in the future.
- Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements to conform to new lead agency model.

Option 3: Legislative action would be required to:

- Eliminate CPPC, Decat, and ECI as separate programs/initiatives and establish the prevention/early intervention program.
- Modify statutory requirements in Iowa Code § 216A.107 regarding FaDSS Council and grant requirements.
- Iowa Code Section 256I.12, subsection 8 for the early childhood stakeholders alliance duties.
- Review any modifications to Iowa Code Section 135.173A for the Child Care Advisory Committee.

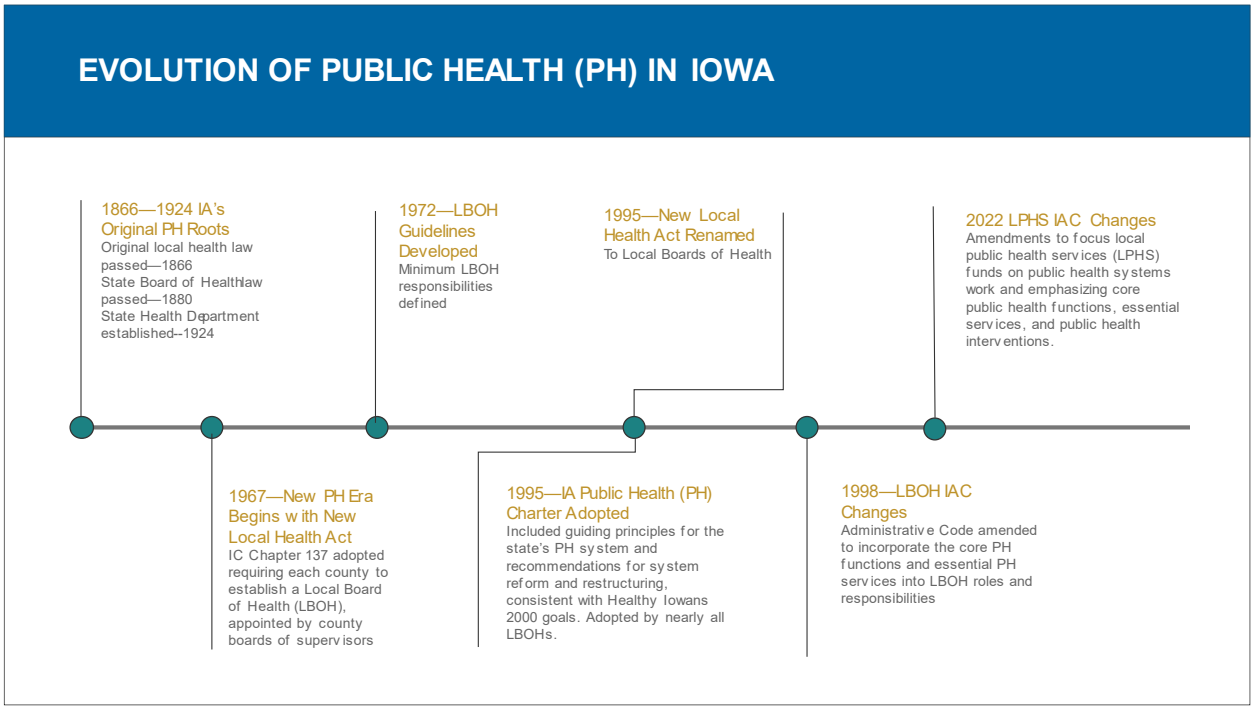
Public Health

Iowa's public health system is comprised of:

- The Iowa HHS and its policy-making body, the State Board of Health
- The State Hygienic Laboratory at the University of Iowa that serves all Iowa counties as a public health laboratory whose responsibilities include disease detection, environmental monitoring, and newborn and maternal screening
- Ninety-nine county-based Local Boards of Health (LBOHs) overseeing 96 recognized Local Public Health Agencies (LPHAs)

Iowa's public health system operates under a decentralized "home rule" model in which local governments retain substantial autonomy to manage public health services and functions, including the structure, financing, size, and activities of LPHAs.

Figure 16. Evolution of Public Health



Local Governmental Public Health

Overview and Historical Context

The Local Health Act, passed in 1967, required each county to establish an LBOH with members appointed by the county board of supervisors.[95] While current law also provides for city health departments, if established prior to July 1, 2010, and district health departments, comprised of two or

more geographically contiguous counties,[96] currently all local health departments in Iowa are county-based with the following caveats in SFY 2022:

- LBOHs for two counties (Adams and Audubon) contracted for services with an LBOH in a contiguous county (Taylor and Guthrie counties, respectively)
- Clayton County's LBOH contracted for services with Dubuque County's LPHA

Iowa law provides LBOHs with nearly total discretion over the public health services that they provide. While LBOHs have jurisdiction over all public health matters within their designated geographic areas and are required to make and enforce reasonable rules and regulations necessary to protect and improve the public health, Iowa law establishes few specifically-required LBOH public health services or functions. For example, Iowa law permits, but does not require, LBOHs to:

- Provide population-based and personal health services
- Provide environmental health services and issue licenses and permits
- Engage in joint operations and contract with colleges and universities, HHS, other public, private, and nonprofit agencies, and individuals to provide personal and population-based public health services
- By written agreement with the council of any city, enforce appropriate city ordinances relating to public health[97]

Iowa regulations (at IAC 641—77) further define "core public health functions" (related to assessment, policy development, and assurance) and their related essential public health services, but states only that LBOHs "may" perform these services.

Iowa Code requires LBOHs to provide or perform only a few specific public health functions related to childhood immunizations, communicable diseases, and infectious diseases in animals including:

- Section 139A.6 Communicable diseases. If a person, whether or not a resident, is infected with a communicable disease dangerous to the public health, the LBOH shall issue orders in regard to the care of the person as necessary to protect the public health. The orders shall be executed by the designated officer as the local board directs or provides by rules.
- Section 139A.7. Diseased persons moving – record forwarded. If a person known to be suffering from a communicable disease dangerous to the public health moves from the jurisdiction of a local board into the jurisdiction of another local board, the local board from whose jurisdiction the person moves shall notify the local board into whose jurisdiction the person is moving.
- Section139A.8 Immunization of children.
    - Requires LBOHs to provide HHS with evidence that all children enrolled in elementary or secondary schools have received required immunizations.
    - Requires LBOHs to provide the required immunizations to children in areas where no local provision of these services exists.

- 139A.12 County liability for care, provisions, and medical attendance. The local board shall provide proper care, provisions, and medical attendance for any person removed and isolated or quarantined in a separate house or hospital for detention and treatment and the care, provisions, and medical attendance shall be paid for by the county in which the infected person has residence, if the patient or legal guardian is unable to pay.
- 139A.34 Examination of persons suspected. The local board shall cause an examination to be made of every person reasonably suspected, on the basis of epidemiological investigation, of having any sexually transmitted disease or infection in the infectious stages to ascertain if such persons infected and, if infected, to cause such person to be treated. A person who is under the care and treatment of a health care provider for the suspected condition shall not be subjected to such examination. If a person suspected of having a sexually transmitted disease or infection refuses to submit to an examination voluntarily, application may be made by the local board to the district court for an order compelling the person to submit to examination and, if infected, to treatment. The person shall be treated until certified as no longer infectious to the local board or to the department. If treatment is ordered by the district court, the attending health care provider shall certify that the person is no longer infectious.
- 163.17 Infectious and contagious diseases among animals, local boards of health. All local boards of health shall assist the department of agriculture and land stewardship in the prevention, suppression, control, and eradication of contagious and infectious diseases among animals, whenever requested to do so.
- 351.37 Dogs and other animals. A dog shall be apprehended and impounded by an LBOH or law enforcement official if the dog is running at large and not wearing a valid rabies vaccination tag or a valid rabies vaccination certificate is not presented to the local board of health or law enforcement official. The LBOH or law enforcement official shall provide written notice to the dog owner.
- 351.39: Confinement. If an LBOH receives information that an animal has bitten a person or is suspected of rabies the board shall order confinement.

Populations Served and Workforce Size

Two-thirds of Iowa's 99 LPHAs (66) serve populations of fewer than 20,000 and only 11 serve populations greater than 50,000. A majority of LPHAs employed 20 or fewer full-time employees and five counties reported fewer than two full-time employees in SFY 2022.[98] As shown in Table 20 below, while the average number of full-time employees appears to be proportional to county size, the range by population category is wide.

Table 20. Number of LPHAs and Average Number of Full-Time LPHA Employees by County Size Served[99]

Population Size	Rural (< 20,000)	Micropolitan (20,000—49,999)	Metropolitan (>50,000)
# of LPHAs	66	22	11
Average Number of FTEs (SFY 2022)	8.2	13.2	37.4
Range of FTEs (SFY 2022)	1.2–23.4	1.0–39.6	3.5–64.1

Scope of Providers

Each LBOH recognizes a single agency as the LPHA for the county. This may be a county entity—typically a department within the county's governance structure—or an outside entity that contracts with the LBOH to provide LPHA services. In SFY22, 62 counties employed LPHA staff directly while 37 counties contracted with an external entity (for example, a hospital or health system).[100] Most local environmental health staff, however, are not employed directly by the LPHA, but are instead employed by the county outside of the LPHA or by an outside entity under contract with the LBOH. In SFY22, only 34 LPHAs employed environmental health staff directly.

Decision Makers and Partners

LBOHs must consist of at least five members and at least one member must be a licensed physician, physician assistant, advanced registered nurse practitioner, or an advanced practice registered nurse. All LBOH members are volunteers, are appointed by the county board of supervisors, and serve three-year terms.[101] Each LPHA, in turn, is led by a local public health administrator responsible for the day-to-day operations of the LPHA and function as the face of public health in their communities.

LPHA administrators interviewed for this assessment reported that local partnerships and networks were a key strength for their agencies. HHS staff also reported that one of the required work areas for current Local Public Health Services (LPHS) contracts with LPHAs was strengthening local public health infrastructure by developing local partnerships and engaging and collaborating with partners to create sustainable systems.[102]

At the HHS Division of Public Health, six Regional Community Health Consultants (RCHCs) provide consultation and technical assistance to LBOHs and LPHAs including assistance in (a) setting expenditure priorities so available resources are used in the most effective and efficient manner, and (b) developing high quality and effective services which are community-driven, culturally appropriate, and responsive to their community health needs assessment. Through orientation, education, and technical assistance, the RCHCs also provide LBOH members and Local Public Health Administrators with the information needed to perform their important work.

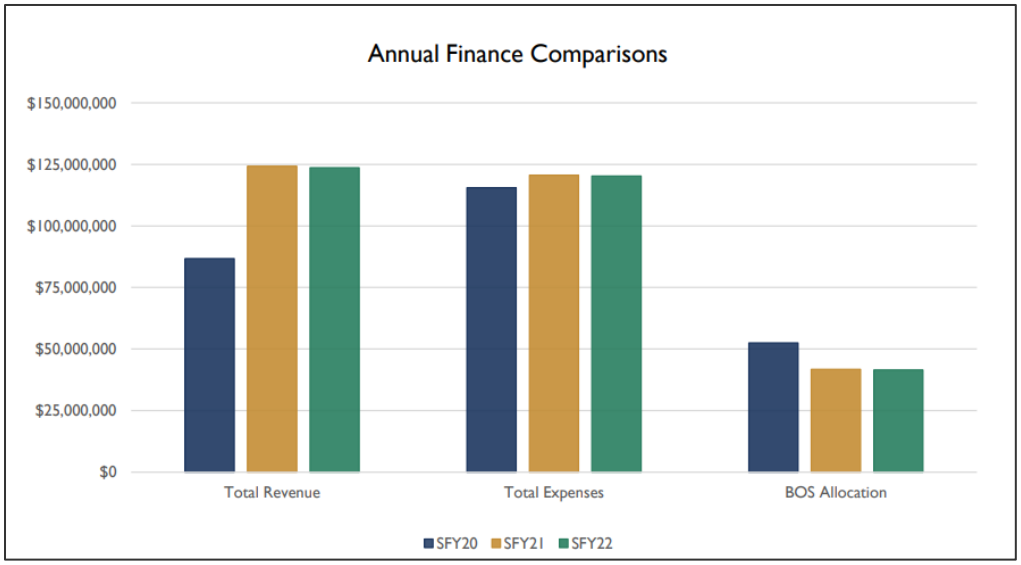
Funding

LPHAs are supported by a variety of funding sources which vary from county to county. These funding sources can include, but are not limited to:

- County tax dollars (designated by the county Board of Supervisors)
- Donations
- Fees for services
- Federal grants or programs
- Foundations or private grant opportunities
- Public health insurance (Medicare or Medicaid)
- Private health insurance
- State grants or programs

Total Revenue. For SFY22, local public health administrators reported total LPHA revenues of $123.7 million, comparable to the amount reported for SFY21, but notably higher than the amount reported for SFY20 reflecting increased federal COVID relief funds made available in SFYs 21 and 22 (see Figure 17). Conversely, allocations of county tax revenues for public health declined from SFY20 to SFY21.

Figure 17. Comparison of LPHA Total Revenues, Total Expenditures, and Total County Tax Allocations from Boards of Supervisors, SFY20–SFY22[103]



Federal Funding. The HHS Division of Public Health receives federal grant funding for public health and public health-related activities from various federal agencies including the Centers for Disease Control and Prevention (CDC) – the primary federal public health agency – but also from the Health Resources and Services Administration (HRSA) within the federal Department of Health and Human Services (U.S. HHS) (e.g., the Maternal and Child Health Block Grant, Ryan White HIV/AIDS program, etc.), and others.[104] Federal funding is used to support the work done at both the federal and state level.

County Tax Revenue. In SFY22, county tax revenues invested in LPHAs totaled $41.5 million statewide (approximately one-third of total revenues), a slight decrease (0.5%) from SFY21 but a substantial decrease (21%) from SFY20 (when the total was $52.5 million).[105] An HHS official reported, however, that a significant share of this total (possibly up to half) was devoted to home care related services in the fiscal year.[106] County tax revenue is determined by county boards of supervisors with substantial variation across counties. As shown in Table 21 below, half of Iowa's counties allocated less than $200,000 of county tax revenues to public health in SFY22.

Table 21. SFY22 County Tax Revenues Allocated to Public Health[107]

County Tax Public Health Allocation Amount	No. of Counties*
Zero	3
$1–$100,000	14
$100,000–$199,999	34
$200,000–$499,999	33
$500,000–$999,999	6
$1,000,000–$2,999,999	6
$3,000,000–$5,000,000	2

**Note: One county did not report.*

State Local Public Health Services (LPHS) Funding. The primary source of state funding for LPHAs is the Essential Public Health Services General Fund appropriation used to fund LPHS contracts with each LBOH. For SFY24, the Iowa General Assembly appropriated $7,662,464 for this purpose.[108] Each county's allocation is based on the formula described in Table 22 below, which is found at IAC 641—80.5:

Table 22. LPHS Funding Allocation Formula

Percentage of Total LPHS Funding	How Allocated to Counties
18%	Divided equally across each county in the state
8%	Allocated based on each county's population
44%	Allocated based on the proportion of the state's elderly residents that live each county

Percentage of Total LPHS Funding	How Allocated to Counties
30%	Allocated based on the proportion of the state's low-income residents that live in each county

Over time, permissible uses of LPHS funding have evolved with a decreasing focus on non-population health services (e.g., homemaker, home care aide, and skilled nursing home health) and an increasing focus on population health. Beginning in SFY23, HHS restructured the LPHS contracts to phase-in limits on the use of LPHS funds for non-population health purposes starting with a 75% limit in SFY23 and SFY24, a 50% limit in SFY25, and a 25% limit in SFY26. In SFY27 and thereafter, all LPHS funds must be used for population health (i.e., foundational public health capabilities and essential public health services.)[109] For SFY24, HHS reports that:

LPHS-funded home care recipients served in SFY21	
Skilled nursing:	1,848
Homecare aide:	2,164
Total:	4,012

- 55 LPHAs will spend **all** LPHS funding on population health
- 11 LPHAs will spend more than **75 percent** of their LPHS funding on population health
- 17 LPHAs will spend **50 percent−75 percent** of their LPHS funding on population health
- 16 LPHAs will spend **25 percent−50 percent** of their LPHS funding on population health.[110]

Funding Challenges and Concerns. Public health funding across the United States has long been viewed as complex and inadequate. In 2012, the National Academy of Medicine (NAM) described public health finance as "a complex and often ad hoc patchwork of funding streams with federal, state, local, and private sources that vary widely among communities and exhibit considerable instability."[111] NAM further commented on "compartmentalized inflexible funding, often competitive, which leaves many health departments without financing for key priorities or for needed cross-cutting capabilities (such as information systems and policy analysis)."[112] HHS staff, LPHA staff, and other stakeholders, interviewed for this project echoed these concerns for Iowa today noting the need for more stable and flexible public health funding that is not time-limited and that is sufficient to fully fund adequate service levels across the state.

Linkage with Medicaid

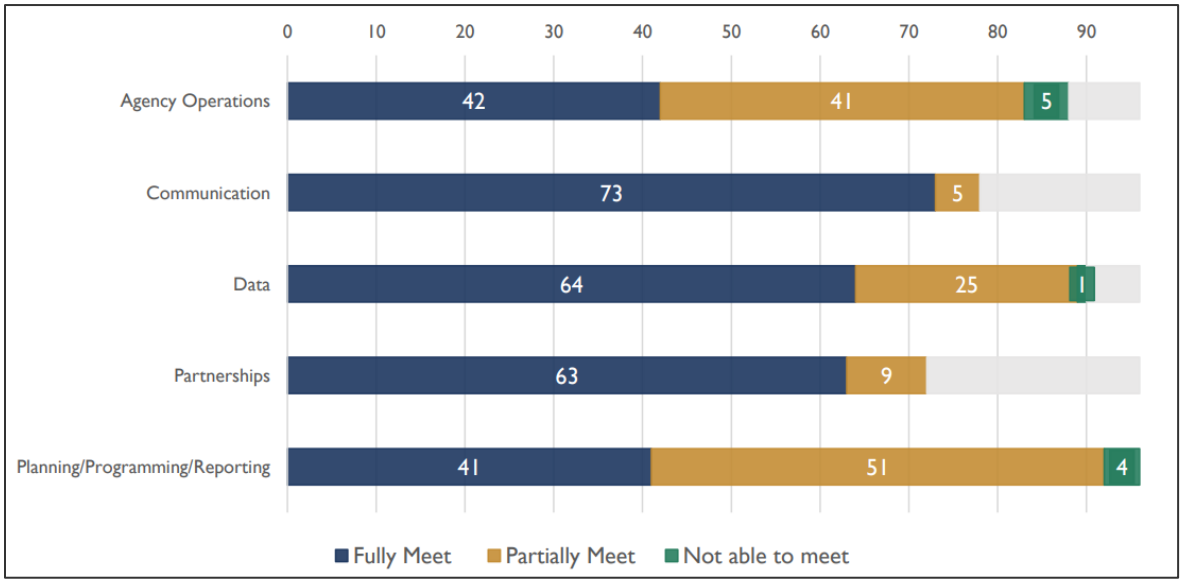
Some LPHAs engage with Medicaid and Medicaid MCOs as enrolled providers, most notably for home health and home care-related services. Eighty-two of Iowa's 99 counties provided home health services in SFY22 through 67 LPHAs, two LBOHs, and 13 contracts with external home health agencies. Of the LPHAs providing home health services, 42 were "certified" – that is, they met federal and state regulatory standards for home health providers and are therefore able to submit claims to public and private insurers. Uncertified agencies are not able to submit claims to insurers and must instead rely solely on county tax revenues or state funds (e.g., LPHS funds) to cover the cost of these

services.[113] A few LPHAs reported providing direct service clinics, but it is unknown the extent to which these LPHAs submitted Medicaid claims for these services.[114]

Operational Capabilities and Gaps

According to the HHS Division of Public Health's 2022 Local Public Health Systems Survey, Iowa's LPHAs vary in their ability to perform foundational public health capabilities.[115] The survey asked Local Public Health Administrators to report the level in which their agency was able to meet 29 capabilities relating to the following broad categories: agency operations, communication, data, partnerships, planning, programming, and reporting. Figure 18 below shows how administrators reported their agencies' ability to meet these capabilities in these categories. Communications is the strongest category with most LPHAs able to fully meet all capabilities.

Figure 18. Number of LPHAs Able to Fully Meet, Partially Meet, or Unable to Meet Foundational Public Health Capabilities Across Five Broad Categories in SFY22



Public Health Emergency Preparedness

Overview and Historical Context

Three bureaus within the HHS Division of Public Health are primarily responsible for various aspects of public health emergencies.

The **Bureau of Emergency Preparedness and Response (EPR Bureau)** is the main bureau focusing on emergency preparedness and response and administers the CDC Public Health Emergency Preparedness (PHEP) Cooperative Agreement and Cities Readiness Initiative (CRI) grants, and the Hospital Preparedness Program (HPP) grant. Funds administered by the EPR Bureau are allocated for preparedness purposes and spent in accordance with PHEP and HPP preparedness capabilities.

The **Bureau of Emergency Medical and Trauma Services (EMTS Bureau)** works with Iowa's emergency medical and trauma systems to develop systems that provide high-quality, timely care to Iowa's sick and injured patients of all ages. The bureau regulates and provides technical assistance and education to EMS training programs, providers, services, and trauma care facilities. Additionally, the EMTS Bureau staff maintain and deliver the First Responder Comprehensive Addiction and Recovery grant through SAMHSA and the Law Enforcement AED grant program through the Helmsley Charitable Trust.

The mission of the **Bureau of Radiological Health (RH Bureau)** programs is to protect Iowans from excessive exposure to radiation. Each year, Iowans are exposed to an average of 300 millirem of natural radiation and 60 millirem of manmade radiation. Program activities include licensing of facilities using radioactive materials; registration of facilities using radiation-producing machines or operating tanning units; inspection of facilities using radioactive materials; credentialing of persons using radioactive material or operating radiation-emitting machines; approval of training courses and continuing education; and emergency response as it relates to radioactive materials and nuclear power plant incidents. The bureau functions under legislative mandates found in the Iowa Code, Chapters 136B, C and D.

According to EPR Bureau staff interviewed for this project, as a result of the ongoing HHS alignment efforts, these three bureaus are currently conducting internal planning to ensure program continuity, resource sharing, and coordination with local stakeholders.

Populations Served

The emergency preparedness and response programs cover all populations across Iowa's 99 counties and are organized across eight service areas and regional Health Care Coalitions.

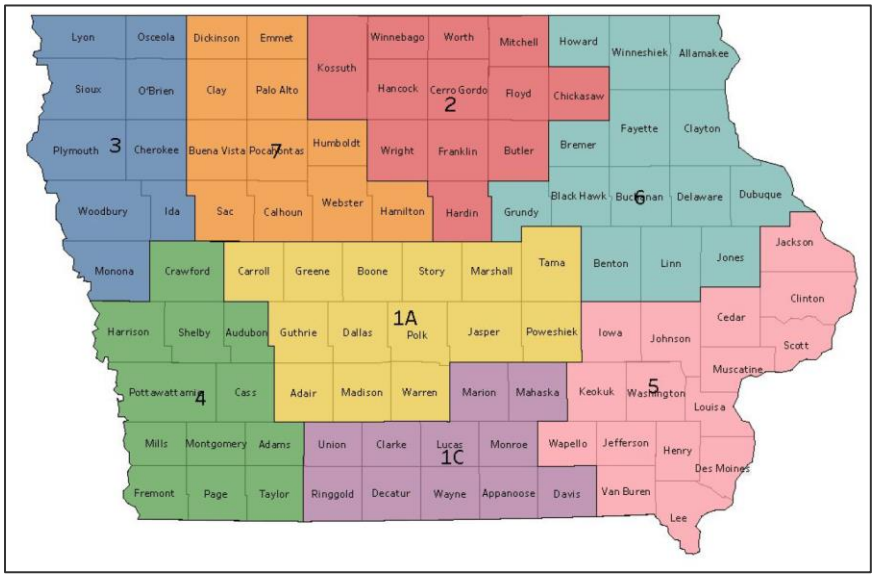
Scope of Providers

The eight Preparedness Program services areas (described further below) are subrecipients of the PHEP and EMS Systems Development grants and seven of the eight service areas are funded through the HPP grant. (Service Area 6 does not accept HPP funding.) CRI funding is limited to the two service areas with the largest populations (per the terms of the federal grant). The EPR Bureau also has response contracts with all LPHAs and with each eligible hospital. These six-year contracts are in place to swiftly allocate response funding that may funnel through the EPR Bureau during times of emergencies such as during the COVID-19 pandemic.

Decision Makers and Partners

In addition to HHS leadership and the leadership for the three bureaus (EPR Bureau, EMTS Bureau, and RH Bureau), key public emergency preparedness decision makers and partners include eight Preparedness Program Service Areas (SAs) (see Figure 19) comprised of representatives from LPHAs, hospitals, emergency management agencies, county EMS agencies, and other key stakeholders. Each SA has a governing body or executive committee that makes decisions on the use of HHS funding for the SA related to emergency preparedness.

Figure 19. Preparedness Program Service Areas as of July 1, 2020



The SA map was developed to better meet the needs of patients who need capable facilities that can treat time-critical conditions. Time-critical conditions include STEMI, stroke, trauma, and highly infectious diseases. In developing the map, migration, inpatient, and outpatient data were used to compare patient geographic locations with the location of facilities that could provide care. As a result of implementing these data-informed SAs, healthcare coalitions are able to share unique vulnerabilities and rely on one another to share resources and the state is better able to provide proper preparedness and response planning.

Funding

As noted above, Iowa allocates federal public health preparedness funding to local LPHAs and eligible hospitals. Table 23 below shows recent total state funding levels for the CDC Public Health Emergency Preparedness (PHEP) Cooperative Agreement, the CDC Public Health Crisis Response Finding, and the Administration for Strategic Preparedness and Response (ASPR), Hospital Preparedness Program (HPP).

Table 23. Selected Federal Public Health Emergency Preparedness Grants

Agency	Federal Grant		Grant Period	Amount
CDC[116]	PHEP[117]		FY 2022 FY 2021 FY 2020	$7,158,236 $6,825,471 $6,718,250
	Public Health Crisis Response Funding[118]	Mpox 2023 Funding	$271,958 $19,452,788 $6,347,829	

Agency	Federal Grant	Grant Period	Amount
	COVID-19 2021 Funding COVID-19 2020 Funding		
ASPR[119]	HPP[120]	FY 2023	$2,132,111

Operational Capabilities and Gaps

According to BEPR staff interviewed for this project, the bureau has been recognized by its federal funders for its efficient grant distribution and grant management policies and practices which enable the bureau to distribute funding quickly when needed. Staff also commented on the need to complete the alignment of emergency preparedness functions across the agency including the "ESF-6" function (mass care, emergency assistance, housing, and human services) previously performed by the legacy DHS agency (prior to the merger with the Department of Public Health) and the "ESF-8" function (public health and medical services) that is the responsibility of BEPR.[121]

Environmental Health

Overview and Historical Context

The Bureau of Environmental Health Services (EHS Bureau) focuses on assisting LBOHs with environmental health issues and the epidemiology and surveillance of environmental health related diseases. Previously, the EHS Bureau also included licensing and regulatory functions; however, as of July 1, 2023, all licensing functions, including Swimming Pools & Spas, Tattoo, Migrant Labor Camps, Backflow Prevention Assembly Tester, Plumbing and Mechanical Systems Board, and Lead Certification, transitioned to the Iowa Department of Inspections, Appeals and Licensing (DIAL).

There are three major programs in the EHS Bureau:

- The **Childhood Lead Poisoning Prevention Program (CLPPP)** works to reduce the number of children exposed to lead in Iowa by
    - Educating parents, providers and communities about the risk of lead poisoning in children and how it can be prevented
    - Identifying children with elevated blood lead levels (EBLs)
    - Linking families to services that can help reduce additional lead exposure
    - Providing supportive care through case management
    - Identifying lead hazards and providing guidance to eliminate or control any hazards found
    - Monitoring blood lead levels of children over time to determine prevention and intervention methods

    - Referring families for additional services when needed

- The **Public Health Tracking Program** collects, integrates, analyzes, interprets, and disseminates data on environmental hazards, exposures to those hazards, and health effects that may be related to the exposures.
- The **Grants to Counties Water Well (GTC) Program** provides grants to LPHAs to provide financial assistance to their residents for private water well services. In addition to overseeing the program, the bureau works closely with the Iowa Department of Natural Resources, who provides technical oversight of water well testing, water well closure, and water well renovation through the GTC program.

Other EHS Bureau programs and services include:

- Collection of reportable environmental and occupational diseases, poisonings & conditions
- Addressing specific public health questions arising from exposure to chemicals and toxic substances

At the local level, Iowa Code Chapter 137 gives LBOHs the authority to provide such environmental health services that may be deemed necessary for the protection and improvement of public health. Activities and services can include:

- Private water well services
- Private sewage disposal (septic) system services
- Safety inspections
- Environmental health related complaints
- Environmental health related education

Local environmental health staff can be directly employed by an LPHA, employed by a county outside of an LPHA, or employed by an outside entity that contracts with an LBOH (such as a hospital system). For SFY22, LPHAs in only 34 of Iowa's 99 counties reported directly employing environmental health staff.[122]

Populations Served

EHS Bureau programs cover all populations across Iowa's 99 counties.

Scope of Providers

The EHS Bureau contracts with 18-19 LBOHs to deliver CLPPP services in 47 counties while state staff provide these services in the remaining counties. The EHS Bureau also provides GTC grants to all 99 Iowa counties.

Decision Makers & Partners

In addition to HHS leadership and BEHS leadership, other key decision makers and partners include LBOHs, local environmental health departments, environmental health contractors, and the Iowa Environmental Health Association (IEHA).

Funding

The EHS Bureau is funded, in part, from the following sources:

- State general fund appropriations for the Childhood Lead Poisoning Prevention Program which totaled up to $504,000 for SFY24.[123] [124]
- Agriculture-related fee revenues deposited in the state's Groundwater Protection Fund[125] are used for the Grants to Counties Water Well Program. A percentage of the revenues allocated to HHS from this fund are divided equally among awarded LBOHs and are expected to amount to $50,505 per awarded county for the August 1, 2023—June 30, 2024, grant period (if the same number of counties receive awards as in SFY23).[126]
- State general fund appropriations for the State Poison Control Center totaling up to $750,000 along with federal matching funds from the Children's Health Insurance Program administrative allotment.[127] CDC environmental health grants[128] for Childhood Lead Poisoning ($250,000 in FFY22) and Environmental and Health Outcome Tracking Network ($615,000 in FFY22 to fund Iowa's Public Health Tracking Program).[129]

Operational Capabilities and Gaps

According to EHS Bureau staff interviewed for this project, the bureau faces staffing challenges due, in part, to the transition of licensing functions and staff to the Iowa Department of Inspections, Appeals and Licensing (DIAL) as of July 1, 2023. For example, staff noted that the EHS Bureau lost three staff to DIAL that had also been responsible for lead inspections that remain a bureau responsibility and that the Bureau must now find a new way to fill the gap. The EHS Bureau also lost its staff person previously responsible for the statutory requirement to match school enrollment data with state child lead testing data and report back to schools and school nurses on students who have not received at least one blood lead test by their sixth birthday. As a result, the EHS Bureau is currently in the process of rebuilding and restaffing the bureau.

EHS Bureau staff also indicated that counties report that the contracted funding available through the Childhood Lead Poisoning Prevention Program is not sufficient to support the level of services required under the contract. This has resulted in fewer LBOHs willing to contract to provide these services placing greater demands on state staff to cover more counties, even while the number of available state staff has decreased. As a result, counties covered by state staff have a lower service level than counties that are willing to contract.

At the same time, bureau staff cited their close working relationship with the HHS Bureau of Family Health - Child & Adolescent Health as a strength, allowing them to continue to provide Childhood Lead Poisoning Prevention services statewide despite limited resources. EHS Bureau staff also opined that there may be other opportunities to align the more clinical aspects of that program (as compared to the public health surveillance functions) with other agency programs that provide direct services.

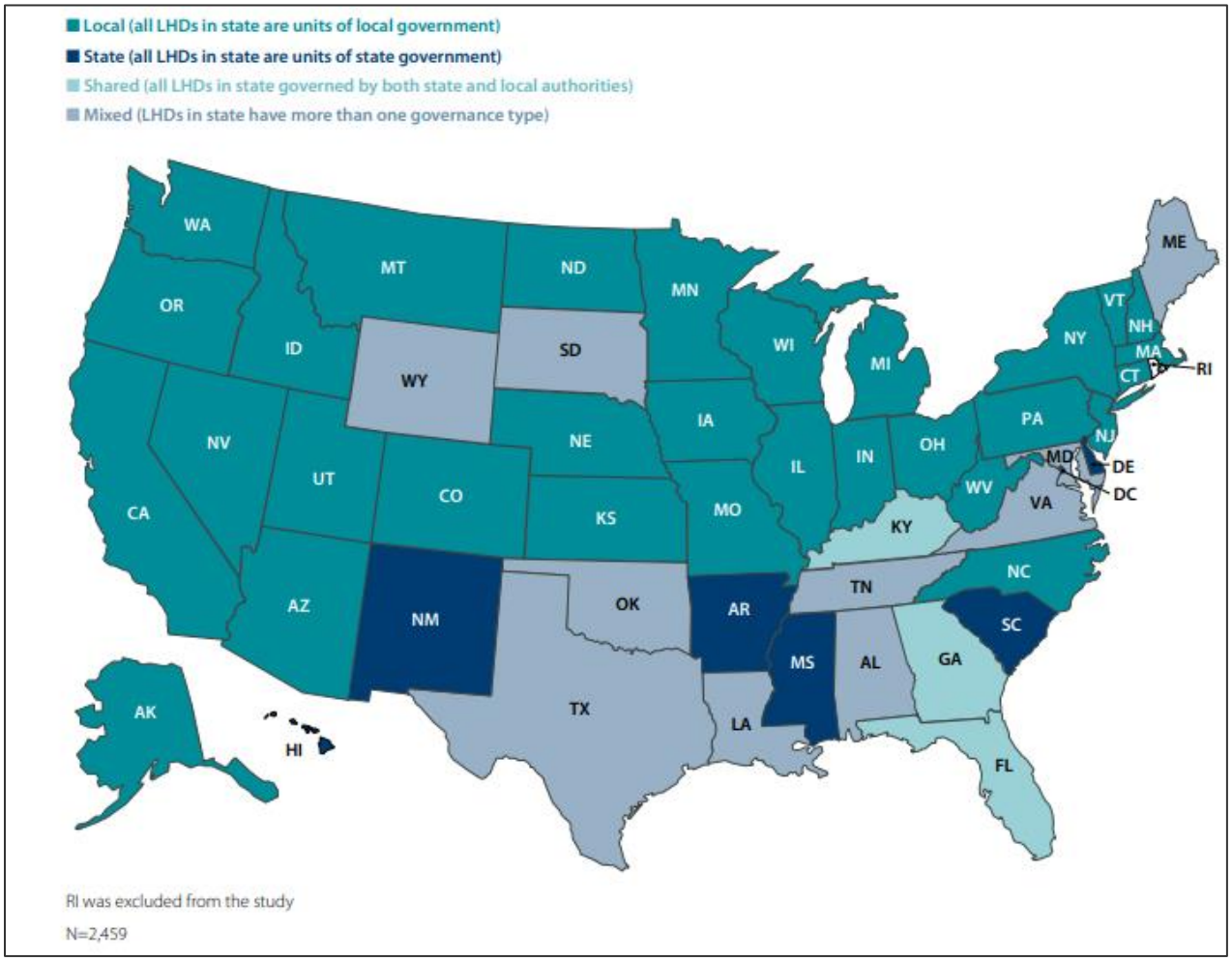
Bureau staff also noted that there may be opportunities in the future to reconsider the local role with regard to environmental reportable conditions. Currently, state staff are responsible for follow-up and investigations of all environmental health reportable conditions, unlike infectious disease reportable conditions where there is a local role.

According to local environmental health staff employed outside of an LPHA, who were also interviewed for this project, opportunities exist to improve communications between the EHS Bureau and local environmental health staff, including more timely responses to questions and requests for technical assistance. Interviewees also cited a need for better grants management support and more timely distributions of quarterly grant payments. Some interviewees also expressed frustration that, as a core public health service, environmental health is often left out of major public health discussions at the state level.

Other State Approaches

All states deliver public health services at the local level but use varied governance structures to define often complex state and local government relationships.[130] In the majority of states, including Iowa (30 states), all local health departments are locally governed; three states have a shared governance structure (Florida, Georgia, and Kentucky); ten states used a mixed approach, and six states deliver services locally through a centralized state agency (Figure 20).

Figure 20. Type of Local Health Department Governance by State[131]



Across all governance models, states also vary in the local units used to deliver public health services (i.e., counties, municipalities, substate regions, or a combination approach). Table 24 below summarizes the governance model and local health unit(s) used for service delivery in selected states.

Table 24. Summary of Selected State Local Public Health Governance and Local Health Unit Approaches

State	Governance Model	Local Health Units	Description
Arkansas	Centralized	County (primarily)	The Arkansas Department of Health is a unified health department, with a main office in Little Rock and 94 local health units in each of the state's 75 counties.[132]

State	Governance Model	Local Health Units	Description
Georgia	Shared	County	Georgia has 159 local health departments (one in each county) led by the county board of health and staff employed by the local government. Each local health department is part of one of the state's 18 public health districts. The regional district offices are led by a health director who is employed by the state government. The district offices provide technical assistance and administrative support such as billing and data analysis for the county health departments.[133]
Kansas	Decentralized	County	There are 100 local health departments in Kansas, each governed by a local board of health which is often the board of county commissioners. There are some variations from this typical model: • There are 2 multi-county local health departments • 4 local health departments are hospital-led • 4 are managed by the county emergency medical services (EMS) agency • One local health department is led by a federally qualified health center • There are 2 city-county local health departments.[134]
Idaho	Decentralized	Multi-county districts	Idaho has seven independent health districts which cover all of the state's 44 counties.[135]
Indiana	Decentralized	County (primarily)	Indiana has 95 local health departments (92 county-based and three municipal). Recent legislation passed in 2023 allows counties to opt-in to new funding contingent on providing core public health services.[136]
Minnesota	Decentralized	Community Health Boards (which may be single or multi-county or city-based) comprised of city, county, and multi-county	There are 51 Community Health Boards (CHBs) which are the legal governing authority for local public health in Minnesota. A CHB may be a single county or city health department, or multiple local health departments working together. There are approximately 70 local health departments (city, county, and multi-county) that comprise the 51 CHBs, although the exact number has varied over time and is subject to change.[137]

State	Governance Model	Local Health Units	Description
		health departments	[138]Also 11 tribal nation health departments operate within the state.[139]
Nebraska	Decentralized	Multi-county regions	A total of 18 multi-county local health departments cover 91 of the state's 92 counties. Dakota County[140] has a single county health department.
Tennessee	Mixed	County	Each of Tennessee's 95 counties has a local health department. The state operates 89 of them, while Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan counties run their own.[141]
Texas	Mixed	Combination of Municipalities, counties and regions	Across the state's 254 counties, there are more than 160 city and county health departments that serve the vast majority of Texas residents. Eleven state-administered regional public health offices take on the public health functions/services for any parts of the state that do not have city or county public health departments—mostly rural unincorporated areas and smaller towns and counties.[142]

Public Health Findings & Recommendations

Service Delivery Area Options

The majority of LPHAs across the country are small, serving populations of less than 50,000.[143] Small size, however, generally means a smaller tax base and fewer resources to meet public health challenges and difficulty achieving efficiencies through economies of scale.[144] Larger LPHAs may also benefit from larger pools of medical providers, community-based organizations, educational institutions, businesses, and other stakeholders that could be enlisted to participate in public health activities.[145] HMA therefore recommends that HHS consider options for regionalizing the delivery of local public health services while preserving a public health presence in every county that, at a minimum, offers consumer-accessed services, such as immunizations and certain environmental health inspections and permitting. We describe four possible regional model options in Table 25 below.

Table 25. Local Public Health Delivery System Models

Less Local Control ← → More Local Control

Option A: Regionally Administered Centralized Governance Model	Option B1: State Defined Regional Health District Model	Option B2: County Defined Regional Health District Model	Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations
Based in part on the Arkansas model, HHS would provide administrative, policy, managerial direction, and support and Local Public Health Agencies (LPHAs) would be organizationally a part of HHS.	Based in part on the Nebraska[146] and Idaho[147] models, the state would define and establish 10-15 regional health districts (RHDs) – governmental entities that are not state agencies or units of county government.	Based, in part, on the Minnesota model,[148] counties would be required to join a regional health district (RHD), subject to geographic and population size criteria for each RHD.	Based, in part, on the Indiana model,[149] Iowa would maintain current home rule governance structure but HHS would provide technical assistance and financial incentives to promote LPHA consolidations and cross-jurisdictional sharing (CJS) arrangements.
Other Features:			
HHS would establish a local presence in each county staffed by state employees. Local Boards of Health (LBOHs) would be eliminated, but each county would appoint a county Health Officer to enhance local input, engagement, and collaboration.[150] HHS would create 10-15 multi-county administrative districts accountable for the effective, efficient, and equitable allocation and use of public health resources and for ensuring foundational public health services and capabilities are	RHDs required to maintain a local presence in each constituent county. RHDs are the governing body for local public health and the only governmental entity eligible for Iowa's Essential Public Health Services (LPHS) funding. LBOHs eliminated, but RHD governing boards comprised of members appointed by the constituent counties[151] RHDs may employ staff and contract for services.	RHDs required to maintain a local presence in each constituent county. RHDs are the governing body for local public health and the only governmental entity eligible for Iowa's Essential Public Health Services funding. Counties could choose to retain LBOHs and LPHAs; RHD governing boards comprised of members appointed by the constituent counties. LBOHs could be allowed to retain local ordinance powers for specified functions	Maintains local control; counties retain authority for designating local presence/offices. LPHAs choosing to consolidate are required to maintain a local presence in each constituent county. LPHAs choosing to accept financial incentives would be held accountable for delivering (including through consolidations or CJS arrangements) the state-defined foundational public health services and functions. HHS would provide technical assistance

available in all parts of the state.	Counties could be required to financially contribute to RHDs. RHDs accountable for the effective, efficient, and equitable allocation and use of public health resources and for ensuring foundational public health services and capabilities are available in all parts of the state.	(e.g., control of public health nuisances[152]) RHDs may employ staff, contract for services, and delegate to constituent counties. RHDs must meet geographic and population size criteria designed to create 10-15 RHDs.[153] RHDs accountable for the effective, efficient, and equitable allocation and use of public health resources and for ensuring foundational public health services and capabilities are available in all parts of the state.	and supports to LPHAs under a regional structure, comprised of 10-15 regions, including technical assistance in formulating CJS arrangements.

Compared to the current state, each model has advantages and disadvantages, some of which are described in Table 26 below.

Table 26. Local Public Health Delivery System Models—Advantages and Disadvantages Compared to Current State

Model	Advantages	Disadvantages
Option A: Regionally Administered Centralized Governance Model	• Ensures more consistent public health service levels across the state • Potential to generate efficiencies/eliminate duplicative efforts • Potentially allows quicker response to emerging challenges and needs • Simplest option	• Potential loss of current local partnerships • Individual county needs may not be a priority • Loss of county funds currently devoted to public health activities • Elimination of LBOHs and current LPHAs not consistent with the majority of stakeholder feedback during townhalls and group interviews. • Significant expansion of state workforce required

Model	Advantages	Disadvantages
Option B1: State Defined Regional Health District Model	• Ensures more consistent public health service levels across the state • Potential to generate efficiencies/eliminate duplicative efforts • Potentially allows quicker response to emerging challenges and needs	• Potential to lose current local partnerships, but less so than Option A • Smaller counties in RHDs with larger counties may feel their needs are not a priority • Elimination of LBOHs and current LPHAs not consistent with the majority of stakeholder feedback during townhalls and group interviews.* • (*Note: In both NE, and ID, the impetus for establishing regional health districts was the lack of local health departments in many or most counties.)
Option B2: County Defined Regional Health District Model	• Ensures more consistent public health service levels across the state • Potential to generate efficiencies/eliminate duplicative efforts • Potentially allows quicker response to emerging challenges and needs	• Potential to lose current local partnerships, but less so than Options A or B1 • Smaller counties in RHDs with larger counties may feel their needs are not a priority • Negotiation of affiliation agreements between counties and RHDs would be needed and could be complex • Most complex option

Option C: Home Rule Model with Incentives for Regional Partnerships/ Consolidations	• Maintains current local partnerships
	• Incentivizes/promotes:
	  ○ More consistent public health service levels across the state
	  ○ Efficiencies
	  ○ Quicker response to emerging challenges and needs
	• Able to maintain/ incentivize county funding contributions
		• Some counties may not respond to incentives to fully deliver foundational public health services and functions leaving some areas of the state underserved
		• HHS retains challenge of supporting and coordinating and collaborating with a large number of local public health units
		• Potentially less able to achieve efficiencies and eliminate duplicative efforts

Implementation Considerations—Service Delivery Area Options

Number of Regions. We recommend that HHS adopt 10-15 regions comprised of contiguous counties that have a combined minimum population of at least 50,000 and make consistent changes to the

current Emergency Preparedness regions. We note that the ten least populated Iowa counties in 2022 had a combined population of approximately 60,000 and the seven least populated counties had a combined population of approximately 39,000. A 50,000 minimum standard therefore seems feasible. Also, of Iowa's six accredited Local Public Health Agencies (LPHAs), one (Cerro Gordo County) served a county population of 42,409 in 2022 while the other five (Blackhawk County, Johnson County, Linn County, Scott County, and Siouxland Health District in Woodbury County) served populations ranging from 105,671—229,033. While region sizes greater than 50,000 could promote greater economies of scale and efficiencies, we believe that this advantage needs to be balanced against public access concerns and travel distance challenges for public health staff in larger geographic regions.

Environmental Health. We also recommend that under Options A, B1, and B2, regions be allowed to delegate environmental health functions to counties where environmental health staff are currently county employees but employed outside of the LPHA. Participants in a group interview with local environmental health staff employed outside of an LPHA in July 2023 reported having other job responsibilities beyond environmental health such as zoning and land use roles. Allowing delegation of environmental health functions to counties currently using this arrangement will avoid staffing disruptions which could have local impacts beyond public health.

State Statute and Regulatory Changes Needed. A full review of Iowa Code and administrative rule changes needed should be conducted once a delivery system model is adopted. For example, throughout the Iowa Code and Iowa Administrative Code – especially Iowa Code Title IV – Public Health and the public health section of the Iowa Administrative Code (641 IAC), -- conforming changes will be needed to replace references to LBOHs with references to RHD governing boards under Options B1 and B2. More detail on the changes needed, by option, to Iowa Code Chapters 135 and 137 is provided in Table 27 below.

Table 27. Changes Needed to Iowa Code Chapters 135 and 137 by Delivery System Option

	Option A	Option B1	Option B2	Option C
Chapter 135 Department of Health	Remove LBOH references and revise chapter as needed to reflect HHS' local and regional public health structure	Change LBOH references to the RHD governing board	Change LBOH references to the RHD governing board	Revise chapter as needed to reflect HHS' regional local public health support structure
Chapter 137 Local Boards of Health	Repeal chapter	Replace: define RHD governing board duties and how members appointed by	Revise LBOH provisions to reflect primary RHD role. Replace District Boards of Health provisions with	Modify provisions pertaining to LBOH duties to reflect expectations related to the

	Option A	Option B1	Option B2	Option C
		constituent counties	process for counties to form RHDs and RHD criteria. Define RHD governing board duties and how members appointed by constituent counties.	provision of foundational public health services and capabilities

Foundational Public Health Capabilities

As described above, Iowa's LPHAs currently vary in their ability to perform foundational governmental public health capabilities. HMA recommends that HHS should establish and build consensus for foundational public health capabilities that all LPHAs or RHDs should meet.

Implementation Considerations

HHS should consider using a stakeholder engagement process to define foundational public health capabilities for the State of Iowa that, at a minimum, includes both state staff and current LPHA staff representation. Once defined, HHS should consider conducting outreach and education activities targeting local elected and public health officials and other stakeholders (e.g., health care providers, school nurses, etc.) to promote the adoption of the foundational public health capabilities in each county or region.

State Statute and Regulatory Changes Needed.

Iowa Code Chapter 137 and 641 IAC Chapter 77, which currently define the core public health expectations for LBOHs, LPHAs, and district boards and health departments, should be modified to reflect the newly defined foundational public health capabilities.

Funding Model Options

HMA recommends that the state provide LPHAs or RHDs (depending on the delivery system option adopted) with stable, recurring, and flexible funding to build and sustain baseline public health services and functions.

Implementation Considerations

HHS should undertake an assessment to quantify funding enhancements needed to meet baseline standards in each jurisdiction. The state should then increase state-funded Essential Public Health Services (LPHS) allocations and revise the funding formula as needed to support the provision of baseline public health services and functions in each county or RHD, taking into account county population and support services provided at the state level. If the state adopts delivery system Option C (described above), HHS should tie a county's increased LPHS allocation to: (a) metrics that reflect adoption of the foundational public health capabilities, and (b) a maintenance of effort or matching requirement for county tax revenues supporting public health activities.

State Statute and Regulatory Changes Needed.

HHS should revise IAC 641-80 to make the needed LPHS allocation formula changes.

HHS Support for Local Public Health

HMA recommends that HHS expand its staff and resources, as needed, to support RHDs or LPHAs (and environmental health staff employed outside of an LPHA) in developing the foundational public health capabilities for public health services and functions which could include, for example, epidemiology supports, data analytics, code enforcement and other legal consultation, communications, grant writing/management, training, and other functions, as necessary.

Implementation Considerations

The expanded HHS staff and resources needed will depend on the public health delivery system option adopted and, in part, on the decisions of LBOHs and/ RHD governing boards regarding whether to develop public health capabilities "in-house," engage in cross-jurisdictional resource sharing, and/or rely on HHS supports.

State Statute and Regulatory Changes Needed

Any changes needed to current statutes and regulations will depend on future decision making by HHS, RHDs, and/or LBOHs regarding the needs to be addressed and the resources available to do so.

CONCLUSION

With the recent HHS organizational restructuring, opportunities exist to improve alignment across the health and human services delivery systems. The options set forth in this report provide potential pathways toward further system integration to better support whole-person care. They are intended to build upon the strengths of the current system while driving toward improved access to vital services for all Iowans.

Appendices

APPENDIX 1: PARTNER SURVEY

Beginning July 1, 2023, Iowa Departments of Aging, Human Rights, Early Childhood Iowa, Iowa Child Advocacy Board and Volunteer Iowa joined the Iowa Department of Health and Human Services (HHS) as the new organizational structure for state government goes into effect. As part of this transition, Iowa HHS is working to ensure that services are delivered efficiently and effectively for individuals, families and communities across the state of Iowa. To do so, Iowa HHS has partnered with a consulting organization, Health Management Associates (HMA), to conduct a statewide assessment to identify successes and gaps in service delivery as well as opportunities for further service integration.

We believe your input is an important part of this process and ask that you complete the following survey by August 15, 2023.

This survey will take approximately **15** minutes to complete. **Survey responses will be compiled by HMA to assist with their analysis and recommendation development.** At the end of the survey, you will have the opportunity to provide your name and contact information if you are interested in HMA contacting you for follow up questions. **You are not required to provide your name or contact information to complete this survey.**

Additional information on the HHS Service Delivery System Assessment is available at https://hhs.iowa.gov/service-delivery-alignment-assessment-project

1. **In what capacity are you responding to this survey?**
   - ☐ I am a contractor or provider who receives funds from HHS to provide services (for example: local public health agency or local board of health, area agency on aging, mental health region). **[skip to Q2]**
   - ☐ I am part of an organization that advocates on behalf of providers delivering HHS programs and services (for example: Iowa Public Health Association or Iowa State Association of Counties). **[skip to Q2]**
   - ☐ I am affiliated with an organization that advocates on behalf of consumers and families receiving services. **[skip to Q14]**
   - ☐ I am a volunteer/committee/board member for an HHS program. **[skip to Q14]**
   - ☐ I am an elected official. **[skip to Q14]**
   - ☐ I am employed by Iowa HHS. **[skip to Q21]**
   - ☐ I am an employee of another State of Iowa agency. **[skip to Q22]**

If on Question #1 you indicated you are responding to this survey as a provider who receives funds from HHS to provide services, or as part of an organization that advocates on behalf of providers delivering HHS programs and services, you will be prompted to answer the following questions (#2 - 13):

2. **What type of agency/organization do you represent? Select all that apply.**
   - ☐ Area Agency on Aging (AAAs: e.g., Elderbridge, Milestones, NEI3A, Heritage, Aging Resources, or Connections)

- ☐ Behavioral health provider
- ☐ Community Action Agency (CAA)
- ☐ Community mental health center
- ☐ County government (e.g., local board of health)
- ☐ EMS Provider
- ☐ EMS Service
- ☐ Environmental health agency
- ☐ Family planning agency
- ☐ Gambling prevention provider
- ☐ Gambling treatment provider
- ☐ Hospital or Health System
- ☐ Local Early Childhood Iowa (ECI)
- ☐ Local public health agency
- ☐ Visiting Nurse Association (VNA)
- ☐ Maternal and child health agency
- ☐ Mental Health and Disability Services (MHDS) Region
- ☐ Mental health service provider
- ☐ Substance use prevention provider
- ☐ Substance use treatment provider
- ☐ Other non-profit agency, please specify **[TEXT BOX-required if chosen]**
- ☐ Other for-profit agency **[TEXT BOX-required if chosen]**
- ☐ Other, not listed above **[TEXT BOX-required if chosen]**

3. **Which Iowa HHS programs or initiatives do you currently interact with and/or participate in? Select all that apply.**

- ☐ Alzheimer's Disease and Related Dementias Program (Public Health)
- ☐ Care for Yourself Program (Public Health)
- ☐ Caregiver Support Program - Respite care and counseling (Aging and Disability Services)
- ☐ Case Management (Aging and Disability Services)
- ☐ Certified Community Behavioral Health Clinics Initiative (Behavioral Health)
- ☐ Child and Adolescent Health Program (Community Access)
- ☐ Cities Readiness Initiative (Public Health)
- ☐ Community Partnership for Protecting Children (Family Well-Being and Protection)
- ☐ Community Partnership Tobacco Control Program (Behavioral Health)
- ☐ Community Services Block Grant Program (Community Access)
- ☐ Comprehensive Cancer Control Program (Public Health)
- ☐ Decategorization (Decat) (Family Well-Being and Protection)
- ☐ Diabetes Prevention and Management Program (Public Health)
- ☐ Disaster Response Initiative (Public Health)
- ☐ Early Childhood Iowa - ECI (Family Well-Being and Protection)
- ☐ Elder Abuse Prevention and Awareness Program (Aging and Disability Services)
- ☐ Emergency Medical Services (EMS) and Trauma Program (Public Health)
- ☐ Emergency Preparedness and Response Program (Public Health)
- ☐ Environmental Health Program (Public Health)
- ☐ Family Development - CSBG (Community Access)
- ☐ Family Development and Self Sufficiency (FaDSS) Program (Community Access)

- ☐ Family Planning Program (Community Access)
- ☐ Health Promotion - Chronic disease and falls prevention (Aging and Disability Services)
- ☐ Healthy Child Care Iowa (Family Well-Being and Protection)
- ☐ Hepatitis Program (Public Health)
- ☐ HIV/AIDS Program (Public Health)
- ☐ Hospital Emergency Preparedness (Public Health)
- ☐ Immunization Program (Public Health)
- ☐ Integrated Provider Network (Behavioral Health)
- ☐ Iowa Gets Screened Program (Public Health)
- ☐ I-SMILE Dental Program - I-SMILE @ School and I-Smile Silver (Community Access)
- ☐ Legal Assistance (Aging and Disability Services)
- ☐ Lifelong Links - Information & assistance and options counseling (Aging and Disability Services)
- ☐ Local Public Health Emergency Preparedness (Public Health)
- ☐ Local Public Health Services Program (Public Health)
- ☐ Low-Income Home Energy Assistance Program - LIHEAP (Community Access)
- ☐ Maternal Health Program (Community Access)
- ☐ Mental Health and Disability Services Regions (Behavioral Health)
- ☐ Nutrition Program - Congregate dining and home delivered meals (Aging and Disability Services)
- ☐ Sexually Transmitted Infection (STI) Program (Public Health)
- ☐ Supplemental Nutrition Program for Women, Infants and Children - WIC (Community Access)
- ☐ Supportive Services - Transportation, homemaker, personal care, chore, adult day, etc. (Aging and Disability Services)
- ☐ Tuberculosis (TB) Control Program (Public Health)
- ☐ Weatherization Assistance Program - WAP (Community Access)
- ☐ WISEWOMAN Program (Public Health)
- ☐ Other, please specify **[TEXT BOX-required if chosen]**

4. **What age groups does your organization serve? Select all that apply.**
   - ☐ Infants (age 0- under 1)
   - ☐ Children (age 1-11)
   - ☐ Youth (12-17)
   - ☐ Young adults (18 to 20 years)
   - ☐ Adults (21 to 59 years)
   - ☐ Older adults (60 and older)
   - ☐ Not applicable

5. **Who are the populations served by your organization? Select all that apply.**
   - ☐ Pregnant women
   - ☐ Post-partum women
   - ☐ Families (parents/guardians and children)
   - ☐ Adult caregivers
   - ☐ Adults with physical or intellectual disabilities or traumatic brain injuries
   - ☐ Adults with behavioral health conditions
   - ☐ Children or youth with physical or intellectual disabilities

- ☐ Children or youth with behavioral health conditions
- ☐ Veterans
- ☐ Other, please specify. **(TEXT BOX-required)**

6. **Which statement(s) best reflects the work your agency/organization does within Iowa communities? Select all that apply.**
   - ☐ My agency/organization provides prevention-based programs, activities or services.
   - ☐ My agency/organization provides general assistance to individuals/families to access services.
   - ☐ My agency/organization provides emergency assistance to meet the immediate and urgent needs of individuals/families.

7. **What do you think are the top THREE greatest challenges your organization is facing to meet its goals for service access, delivery, and outcomes? Select up to THREE responses.**
   - ☐ Administrative Burden: Data collection
   - ☐ Administrative Burden: Eligibility verification or determination
   - ☐ Administrative Burden: Grant/contract management (contracting process, reporting, data system, etc.)
   - ☐ Administrative Burden: Reimbursement process (claims/billing)
   - ☐ Environment: Lack of buy-in and support from community stakeholders
   - ☐ Environment: Lack of buy-in and support from local officials
   - ☐ Insufficient Funding: For state grant requirements
   - ☐ Insufficient Funding: For training for best practices, innovations, working with non-English speaking populations, and/or evidence-based programs
   - ☐ Insufficient Funding: Local investment
   - ☐ Lack of: Coordination among providers
   - ☐ Lack of: Integrated care sites (e.g., primary care and behavioral health providers not co-located)
   - ☐ Lack of: Technological resources/expertise
   - ☐ Staffing: Available Workforce
   - ☐ Staffing: Pay
   - ☐ Staffing: Retention
   - ☐ Staffing: Skills
   - ☐ Other **[TEXT BOX-required if chosen]**
   - ☐ This question does not apply to my organization

8. **To what extent do you agree with the following statements about HHS services and program delivery for the population(s) your organization serves?**

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
Individuals know how to access the services/programs they need	○	○	○	○	○
Individuals are able to receive the services/programs they	○	○	○	○	○

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
need within a reasonable timeframe					
Individuals have a choice of providers in their own communities when seeking programs/services	○	○	○	○	○
Individuals have access to the same services and supports in all parts of the state	○	○	○	○	○
Individuals and/or families are able to access services at a time and location that is convenient for them	○	○	○	○	○
For individuals eligible for or participating in multiple HHS programs/services, it is easy to make referrals to other HHS programs/services when needed	○	○	○	○	○
For individuals eligible for or participating in multiple HHS programs/services, they are provided a warm handoff to other HHS programs/services when needed	○	○	○	○	○
Individuals have multiple ways to easily get individualized help in-person, by phone, or by email/text if they run into difficulties accessing programs and services	○	○	○	○	○
Individuals with complex and/or multiple needs can easily get individualized help in-person, by phone, or by email/text if they run into difficulties accessing programs and services	○	○	○	○	○
Service coordination for individuals participating in multiple HHS programs and services is strong and effective	○	○	○	○	○
Individuals do not have to participate in duplicative processes when accessing	○	○	○	○	○

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
services across multiple HHS program areas					
Performance measures and outcomes are tracked and used to monitor and improve HHS programs and services	○	○	○	○	○
Programs and services are effective at building individual resiliency and/or empowering individuals to be more self-sufficient	○	○	○	○	○

9. **For any prompt in Question 8 to which you responded "Strongly Disagree" or "Disagree" to the statement you will be asked to provide additional information on your response.**

10. **What are the greatest strengths in how the HHS programs and services that you/your organization participates in are currently administered? Select up to THREE responses. *[MUST CHOOSE AT LEAST ONE TO SUBMIT]***
    - ☐ Access to Services & Supports: Individuals and providers/contractors across the state are able to access and receive the same level of services to meet their needs.
    - ☐ Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.
    - ☐ Access to Services & Supports: Individuals can get the services and supports they need in one location.
    - ☐ Access to Services and Supports: Programs and services are easily accessible to all people.
    - ☐ Administrative Burden: It is easy to get help if someone has a question about how to apply for a program, or what documents are needed to verify eligibility for a program.
    - ☐ Coordination: There is good communication and coordination between service and support providers.
    - ☐ Funding: Funding levels are adequate to meet the expectation of service provided.
    - ☐ Funding: There is adequate funding for programs and services to meet the needs of individuals and communities across the state.
    - ☐ Providers: Providers are very committed and really care about making sure the people they serve get what they need to reach their goals.
    - ☐ Quality: Local programs are administered very well and the level of waste and/or duplication is very low.
    - ☐ Quality: State programs are administered very well and the level of waste and/or duplication is very low.
    - ☐ Quality: The quality assessment and assurance system(s) in place are effective.
    - ☐ Staffing: Local programs are staffed adequately to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.

- ☐ Staffing: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.
- ☐ Staffing: It is easy to get an appointment to see a service or support provider within a reasonable amount of time based on the urgency of need.
- ☐ Staffing - Local: There is adequate staffing capacity to serve population groups across the state.
- ☐ Staffing - State: There is adequate staffing capacity to serve population groups across the state.
- ☐ Other, please specify. **[TEXT BOX-required if chosen]**

11. **What else should we know about what works well within Iowa HHS? [Text BOX – not required]**

12. **What are the greatest challenges in how the HHS programs and services that you/your organization participates in are currently administered? Select up to THREE responses. *[MUST CHOOSE AT LEAST ONE TO SUBMIT]***
    - ☐ Access to Services & Supports: Individuals and communities across the state are not able to access and receive the same level of services to meet their needs.
    - ☐ Access to Services & Supports: Individuals must go to multiple locations to receive needed services.
    - ☐ Access to Services & Supports: It is hard to know what other HHS services someone might be eligible for.
    - ☐ Collaboration: My input is not sought and/or included in HHS system planning or changes.
    - ☐ Communication: Coordination and communication between providers and/or providers and HHS offices is lacking.
    - ☐ Communication: I am not given advanced notice for administrative changes with programs.
    - ☐ Communication: It is challenging to find information when changes to programs occur (administrative rules, reimbursement, etc.).
    - ☐ Communication: It is hard to know where to go to get questions answered.
    - ☐ Funding: Funding levels are not adequate to meet the expectation of service provided.
    - ☐ Funding: Funding for programs and services is not adequate to meet the needs of individuals and communities across the state.
    - ☐ Provider Burden: Eligibility and intake requirements are repetitive and cumbersome for our consumers.
    - ☐ Provider Burden: There is duplication of requirements and activities across the multiple systems my agency participates in.
    - ☐ Quality: There is a lack of quality assessment and assurance system(s).
    - ☐ Staffing: Workforce is a challenge for meeting the demand I currently have for my agency's services.
    - ☐ Technology: My agency lacks the technology supports to provide requested data or meet other administrative requirements.

- ☐ Other, please specify. **[TEXT BOX-required if chosen]**

13. **What other challenges should we know about how HHS programs and services are administered today? (TEXT BOX- not required)**

If on Question #1 you indicated you are responding to this survey as an affiliate of an organization that advocates on behalf of consumers and families receiving services, or a volunteer/ committee/board member for an HHS program, or an elected official you will be prompted to answer the following questions (#14 – 20):

14. **Which Iowa HHS programs and initiatives do you partner with to support the individuals, families and communities on whose behalf you advocate? Select all that apply.**
    - ☐ Alzheimer's Disease and Related Dementias Program (Public Health)
    - ☐ Care for Yourself Program (Public Health)
    - ☐ Caregiver Support Program - Respite care and counseling (Aging and Disability Services)
    - ☐ Case Management (Aging and Disability Services)
    - ☐ Certified Community Behavioral Health Clinics Initiative (Behavioral Health)
    - ☐ Child and Adolescent Health Program (Community Access)
    - ☐ Cities Readiness Initiative (Public Health)
    - ☐ Community Partnership for Protecting Children (Family Well-Being and Protection)
    - ☐ Community Partnership Tobacco Control Program (Behavioral Health)
    - ☐ Community Services Block Grant Program (Community Access)
    - ☐ Comprehensive Cancer Control Program (Public Health)
    - ☐ Decategorization (Decat) (Family Well-Being and Protection)
    - ☐ Diabetes Prevention and Management Program (Public Health)
    - ☐ Disaster Response Initiative (Public Health)
    - ☐ Early Childhood Iowa - ECI (Family Well-Being and Protection)
    - ☐ Elder Abuse Prevention and Awareness Program (Aging and Disability Services)
    - ☐ Emergency Medical Services (EMS) and Trauma Program (Public Health)
    - ☐ Emergency Preparedness and Response Program (Public Health)
    - ☐ Environmental Health Program (Public Health)
    - ☐ Family Development - CSBG (Community Access)
    - ☐ Family Development and Self Sufficiency (FaDSS) Program (Community Access)
    - ☐ Family Planning Program (Community Access)
    - ☐ Health Promotion - Chronic disease and falls prevention (Aging and Disability Services)
    - ☐ Healthy Child Care Iowa (Family Well-Being and Protection)
    - ☐ Hepatitis Program (Public Health)
    - ☐ HIV/AIDS Program (Public Health)
    - ☐ Hospital Emergency Preparedness (Public Health)
    - ☐ Immunization Program (Public Health)
    - ☐ Integrated Provider Network (Behavioral Health)
    - ☐ Iowa Gets Screened Program (Public Health)
    - ☐ I-SMILE Dental Program - I-SMILE @ School and I-Smile Silver (Community Access)
    - ☐ Legal Assistance (Aging and Disability Services)

- ☐ Lifelong Links - Information & assistance and options counseling (Aging and Disability Services)
- ☐ Local Public Health Emergency Preparedness (Public Health)
- ☐ Local Public Health Services Program (Public Health)
- ☐ Low-Income Home Energy Assistance Program - LIHEAP (Community Access)
- ☐ Maternal Health Program (Community Access)
- ☐ Mental Health and Disability Services Regions (Behavioral Health)
- ☐ Nutrition Program - Congregate dining and home delivered meals (Aging and Disability Services)
- ☐ Sexually Transmitted Infection (STI) Program (Public Health)
- ☐ Supplemental Nutrition Program for Women, Infants and Children - WIC (Community Access)
- ☐ Supportive Services - Transportation, homemaker, personal care, chore, adult day, etc. (Aging and Disability Services)
- ☐ Tuberculosis (TB) Control Program (Public Health)
- ☐ Weatherization Assistance Program - WAP (Community Access)
- ☐ WISEWOMAN Program (Public Health)
- ☐ Other, please specify **[TEXT BOX-required if chosen]**

15. To what extent do you agree with the following statements about how HHS services are delivered and programs are administered for the consumers you represent?

	Strongly disagree	Disagree	Agree	Strongly Agree	Does Not Apply
I know how to help consumers and/or their families access needed services and supports in the community	○	○	○	○	○
The consumers and/or families I represent generally do not have to wait for services when needed	○	○	○	○	○
The consumers and/or families I represent can receive the same services and supports as individuals in other parts of the state	○	○	○	○	○
The consumers and/or families I represent know how to provide feedback about the services they receive	○	○	○	○	○
The consumers and/or families I represent are able to access services at a time and location that is convenient for them	○	○	○	○	○

	Strongly disagree	Disagree	Agree	Strongly Agree	Does Not Apply
The providers of the consumers I represent coordinate with each other	○	○	○	○	○
The consumers I represent do not have to repeat information, forms, or other activities for their different providers, programs, or services	○	○	○	○	○

16. For any prompt in Question 15 to which you responded "Strongly Disagree" or "Disagree" to the statement you will be asked to provide additional information on your response.

17. What are the greatest strengths of the Iowa HHS system? Select up to THREE responses. *[MUST CHOOSE AT LEAST ONE TO SUBMIT]*

- ☐ Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.
- ☐ Access to Services & Supports: Individuals can get the services and supports they need in one location.
- ☐ Access to Services & Supports: Individuals and communities across the state are able to access and receive the same level of services to meet their needs.
- ☐ Access to Services & Supports: It is easy to get an appointment to see a service or support provider within a reasonable amount of time based on the urgency of need.
- ☐ Access to Services & Supports: Programs and services are easily accessible to all people.
- ☐ Coordination: There is good communication and coordination between service and support providers.
- ☐ Funding: Funding levels are adequate to meet the expectation of service provided.
- ☐ Funding: There is adequate funding for programs and services to meet the needs of individuals and communities across the state.
- ☐ Provider Burden: It is easy to get help if someone has a question about how to apply for a program, or what documents are needed to verify eligibility for a program.
- ☐ Provider Burden: Programs are administered very well and the level of waste and/or duplication is very low.
- ☐ Providers: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.
- ☐ Providers: The providers are very committed and really care about making sure the people they serve get what they need to reach their goals.
- ☐ Quality: The quality assessment and assurance system(s) in place are effective.
- ☐ Staffing - Local: Local programs are staffed adequately to ensure that workers can carry out all their assigned tasks effectively and not feel spread too thin.

- ☐ Staffing - Local: There is adequate staffing capacity at the local level to serve populations groups across the state.
- ☐ Staffing - State: There is adequate staffing capacity at the state level to support HHS partners across the state.
- ☐ Other, please specify. **[TEXT BOX-required if chosen]**

18. What else should we know about what works well within the programs and services administered by Iowa HHS? [Text BOX – not required]

19. What are the greatest challenges of the Iowa HHS System? Select up to THREE responses. *[MUST CHOOSE AT LEAST ONE TO SUBMIT]*

- ☐ Access to Services & Supports: Completing applications for different services and supports is confusing and/or repetitive.
- ☐ Access to Services & Supports: Consumers are unable to receive services when needed because there is a wait list.
- ☐ Access to Services & Supports: It is difficult for consumers to travel to a program or service office because of lack of public transportation or distance from home.
- ☐ Access to Services & Supports: It is difficult for individuals to get to a program or service because of the agency or provider's hours of operation.
- ☐ Access to Services & Supports: It is hard to find information about programs and application/renewal processes or eligibility.
- ☐ Access to Services & Supports: It is hard to know what services someone might be eligible for.
- ☐ Communication: It is hard to know where to go to get questions answered.
- ☐ Coordination: Coordination and communication between providers and/or providers and program offices is lacking.
- ☐ Funding: Funding levels are not adequate to meet the expectation of service provided.
- ☐ Funding: There is not adequate funding for programs and services to meet the needs of individuals and communities across the state.
- ☐ Provider: Service and/or program office staff do not make consumers feel welcomed or valued.
- ☐ Resource Allocation: Funding for programs and services is not adequate to meet the needs of individuals and communities across the state.
- ☐ Staffing: There is insufficient access to services from providers who look like, speak the same language, and/or can meet the needs of those I advocate for.
- ☐ Technology: Consumers don't know how to use the technology that is required to get or use the services they need.
- ☐ Other, please specify. **[TEXT BOX-required if chosen]**

20. What other challenges should we know about how the HHS programs and services are administered today? (TEXT BOX- not required)

If on Question #1 you indicated you are responding to this survey as an employee of Iowa HHS you will be prompted to answer the following questions (#21 – 26):

21. Within which Iowa HHS programs or initiatives do you currently work in? Select all that apply.

- ☐ Alzheimer's Disease and Related Dementias Program (Public Health)
- ☐ Care for Yourself Program (Public Health)
- ☐ Caregiver Support Program - respite care and counseling (Aging and Disability Services)
- ☐ Case Management (Aging and Disability Services)
- ☐ Certified Community Behavioral Health Clinics Initiative (Behavioral Health)
- ☐ Child and Adolescent Health Program (Community Access)
- ☐ Cities Readiness Initiative (Public Health)
- ☐ Community Partnership for Protecting Children (Family Well-Being and Protection)
- ☐ Community Partnership Tobacco Control Program (Behavioral Health)
- ☐ Community Services Block Grant Program (Community Access)
- ☐ Comprehensive Cancer Control Program (Public Health)
- ☐ Decategorization (Decat) (Family Well-Being and Protection)
- ☐ Diabetes Prevention and Management Program (Public Health)
- ☐ Disaster Response Initiative (Public Health)
- ☐ Early Childhood Iowa -ECI (Family Well-Being and Protection)
- ☐ Elder Abuse Prevention and Awareness Program (Aging and Disability Services)
- ☐ Emergency Medical Services (EMS) and Trauma Program (Public Health)
- ☐ Emergency Preparedness and Response Program (Public Health)
- ☐ Environmental Health Program (Public Health)
- ☐ Family Development - CSBG (Community Access)
- ☐ Family Development and Self Sufficiency (FaDSS) Program (Community Access)
- ☐ Family Planning Program (Community Access)
- ☐ Health Promotion - chronic disease and falls prevention (Aging and Disability Services)
- ☐ Healthy Child Care Iowa (Family Well-Being and Protection)
- ☐ Hepatitis Program (Public Health)
- ☐ HIV/AIDS Program (Public Health)
- ☐ Hospital Emergency Preparedness (Public Health)
- ☐ Immunization Program (Public Health)
- ☐ Integrated Provider Network (Behavioral Health)
- ☐ Iowa Gets Screened Program (Public Health)
- ☐ I-SMILE Dental Program - I-SMILE @ School and I-Smile Silver (Community Access)
- ☐ Legal Assistance (Aging and Disability Services)
- ☐ Lifelong Links - information & assistance and options counseling (Aging and Disability Services)
- ☐ Local Public Health Emergency Preparedness (Public Health)
- ☐ Local Public Health Services Program (Public Health)
- ☐ Low-Income Home Energy Assistance Program - LIHEAP (Community Access)
- ☐ Maternal Health Program (Community Access)
- ☐ Mental Health and Disability Services Regions (Behavioral Health)

- ☐ Nutrition Program - congregate dining and home delivered meals (Aging and Disability Services)
- ☐ Sexually Transmitted Infection (STI) Program (Public Health)
- ☐ Supplemental Nutrition Program for Women, Infants and Children - WIC (Community Access)
- ☐ Supportive Services - transportation, homemaker, personal care, chore, adult day, etc. (Aging and Disability Services)
- ☐ Tuberculosis (TB) Control Program (Public Health)
- ☐ Weatherization Assistance Program - WAP (Community Access)
- ☐ WISEWOMAN Program (Public Health)
- ☐ Other, please specify **[TEXT BOX-required if chosen]**

If on Question #1 you indicated you are responding to this survey as an employee of another State of Iowa agency you will be prompted to answer the following questions (#22 – 26):

22. Which Iowa HHS programs or initiatives do you currently interact with? Select all that apply.

- ☐ Alzheimer's Disease and Related Dementias Program (Public Health)
- ☐ Care for Yourself Program (Public Health)
- ☐ Caregiver Support Program - respite care and counseling (Aging and Disability Services)
- ☐ Case Management (Aging and Disability Services)
- ☐ Certified Community Behavioral Health Clinics Initiative (Behavioral Health)
- ☐ Child and Adolescent Health Program (Community Access)
- ☐ Cities Readiness Initiative (Public Health)
- ☐ Community Partnership for Protecting Children (Family Well-Being and Protection)
- ☐ Community Partnership Tobacco Control Program (Behavioral Health)
- ☐ Community Services Block Grant Program (Community Access)
- ☐ Comprehensive Cancer Control Program (Public Health)
- ☐ Decategorization (Decat) (Family Well-Being and Protection)
- ☐ Diabetes Prevention and Management Program (Public Health)
- ☐ Disaster Response Initiative (Public Health)
- ☐ Early Childhood Iowa -ECI (Family Well-Being and Protection)
- ☐ Elder Abuse Prevention and Awareness Program (Aging and Disability Services)
- ☐ Emergency Medical Services (EMS) and Trauma Program (Public Health)
- ☐ Emergency Preparedness and Response Program (Public Health)
- ☐ Environmental Health Program (Public Health)
- ☐ Family Development - CSBG (Community Access)
- ☐ Family Development and Self Sufficiency (FaDSS) Program (Community Access)
- ☐ Family Planning Program (Community Access)
- ☐ Health Promotion - chronic disease and falls prevention (Aging and Disability Services)
- ☐ Healthy Child Care Iowa (Family Well-Being and Protection)
- ☐ Hepatitis Program (Public Health)
- ☐ HIV/AIDS Program (Public Health)
- ☐ Hospital Emergency Preparedness (Public Health)
- ☐ Immunization Program (Public Health)

- ☐ Integrated Provider Network (Behavioral Health)
- ☐ Iowa Gets Screened Program (Public Health)
- ☐ I-SMILE Dental Program - I-SMILE @ School and I-Smile Silver (Community Access)
- ☐ Legal Assistance (Aging and Disability Services)
- ☐ Lifelong Links - information & assistance and options counseling (Aging and Disability Services)
- ☐ Local Public Health Emergency Preparedness (Public Health)
- ☐ Local Public Health Services Program (Public Health)
- ☐ Low-Income Home Energy Assistance Program - LIHEAP (Community Access)
- ☐ Maternal Health Program (Community Access)
- ☐ Mental Health and Disability Services Regions (Behavioral Health)
- ☐ Nutrition Program - congregate dining and home delivered meals (Aging and Disability Services)
- ☐ Sexually Transmitted Infection (STI) Program (Public Health)
- ☐ Supplemental Nutrition Program for Women, Infants and Children - WIC (Community Access)
- ☐ Supportive Services - transportation, homemaker, personal care, chore, adult day, etc. (Aging and Disability Services)
- ☐ Tuberculosis (TB) Control Program (Public Health)
- ☐ Weatherization Assistance Program - WAP (Community Access)
- ☐ WISEWOMAN Program (Public Health)
- ☐ Other, please specify **[TEXT BOX-required if chosen]**

23. To what extent do you agree with the following statements about how the services and programs under HHS are administered today?

	Strongly disagree	Disagree	Agree	Strongly Agree	Does Not Apply
Individuals, families, and communities served by my program know how to access all needed services and supports administered by HHS	○	○	○	○	○
My program is able to serve clients on wait lists within a reasonable time frame to address the clients' immediate needs	○	○	○	○	○
Individuals, families, and communities have access to the same services and supports administered by my program in all parts of the state	○	○	○	○	○
Individuals can easily access all available services	○	○	○	○	○

	Strongly disagree	Disagree	Agree	Strongly Agree	Does Not Apply
and supports provided by my program					
Individuals can easily get assistance in-person, by phone, or by email/text if they encounter difficulties	○	○	○	○	○
Individuals with complex and/or multiple needs can easily access all available services and supports provided by my program	○	○	○	○	○
Individuals with complex and/or multiple needs can easily get assistance in-person, by phone, or by email/text if they encounter difficulties	○	○	○	○	○
Coordination across HHS programs to prevent service delivery gaps is strong and effective	○	○	○	○	○
Coordination across HHS programs to prevent service delivery duplication is strong and effective	○	○	○	○	○
Individuals do not have to participate in duplicative processes when accessing services across multiple HHS programs	○	○	○	○	○

24. For any prompt in Question 23 to which you responded "Strongly Disagree" or "Disagree" to the statement you will be asked to provide additional information on your response.

25. What are the greatest strengths in the Iowa HHS system? Select up to THREE responses. *[MUST CHOOSE AT LEAST ONE TO SUBMIT]*

- ☐ Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.
- ☐ Access to Services & Supports: All supports and services are easily accessible to all people.
- ☐ Access to Services & Supports: A person can get almost all the services and supports they need in one service location.
- ☐ Access to Services & Supports: I have access to information and resources on services and programs within other areas of HHS.

- ☐ Access to Services & Supports: Individuals have availability and access to the same types of services and programs across the state.
- ☐ Access to Services & Supports: Individuals have timely access across the state to programs and services.
- ☐ Coordination: There is good communication and coordination between all service and support providers.
- ☐ Duplication: State programs are administered very well and the level of waste and/or duplication is very low.
- ☐ Duplication: Local programs are administered very well and the level of waste and/or duplication is very low.
- ☐ Quality: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.
- ☐ Quality: The quality assessment and assurance system(s) in place are effective, and generally services and supports are consistently of high quality.
- ☐ Resource Allocation: Local programs and services receive adequate funding to support meeting the needs of Iowans.
- ☐ Resource Allocation: State programs and services receive adequate funding to support meeting the needs of Iowans.
- ☐ Staffing - Local: Staffing of local programs is adequate to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.
- ☐ Staffing - State: Staffing of state programs is adequate to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.
- ☐ Other, please specify. **[TEXT BOX-required if chosen]**

26. What else should we know about what works well within Iowa HHS? [Text BOX – not required]

27. Can HMA contact you for any follow-up questions they may have regarding your responses in this survey?

- ☐ Yes
- ☐ No

28. Please enter the name of your organization (If Answer Yes to #27, TEXT BOX displays not required)

29. Please provide contact information (If Answer Yes to #27 TEXT BOX- not required)

Thank you for taking the time to complete this survey! Your responses will provide significant value to our analysis and recommendations.

APPENDIX 2: PARTNER SURVEY RESPONSES

OVERVIEW OF RESPONDENTS

Table 28. Partner Survey Respondent Affiliation

Respondent Type	Count	Percent
Contractor or provider who receives funds from HHS to provide services (for example: local public health agency or local board of health, area agency on aging, mental health region)	447	52%
Part of an organization that advocates on behalf of providers delivering HHS programs and services (for example: Iowa Public Health Association or Iowa State Association of Counties)	38	4%
Affiliated with an organization that advocates on behalf of consumers and families receiving services	152	18%
Volunteer/committee/board member for an HHS program	76	9%
Elected official	24	3%
Employed by Iowa HHS	91	11%
Employee of another State of Iowa agency	32	4%
TOTAL	860	

Table 29. Contractor or Provider of HHS Services & Provider Advocate Survey Responses – "What type of agency/organization do you represent?"

	Count	Percent [154]
Area Agency on Aging (AAAs: Elderbridge, Milestones, NEI3A, Heritage, Aging Resources, or Connections)	10	2%
Behavioral health provider	30	6%
Community Action Agency (CAA)	73	15%
Community mental health center	15	3%

	Count	Percent [154]
County government (e.g., local board of health)	40	8%
EMS Provider	5	1%
EMS Service	5	1%
Environmental health agency	25	5%
Family planning agency	8	2%
Gambling prevention provider	14	3%
Gambling treatment provider	12	2%
Hospital or Health System	19	4%
Local Early Childhood Iowa (ECI)	61	13%
Local public health agency	172	35%
Visiting Nurse Association (VNA)	12	2%
Maternal and child health agency	41	8%
Mental Health and Disability Services (MHDS) Region	36	7%
Mental health service provider	27	6%
Substance use prevention provider	29	6%
Substance use treatment provider	27	6%
Other non-profit agency, please specify	57	12%
Other for-profit agency	5	1%
Other, not listed above	11	2%
Total	734	

Table 30. HHS Programs or Initiatives Respondents Reported Interacting With

HHS Program or Initiative	Providers, Contractors & Provider Advocates		Consumer Advocates, Volunteers & Elected Officials		State Staff	
	Count	%[155]	Count	%[156]	Count	%[157]
Alzheimer's Disease and Related Dementias Program (Public Health)	24	5%	24	10%	14	11%
Care for Yourself Program (Public Health)	78	16%	26	10%	13	11%
Caregiver Support Program - Respite care and counseling (Aging and Disability Services)	29	6%	25	10%	10	8%
Case Management (Aging and Disability Services)	74	15%	40	16%	22	18%
Certified Community Behavioral Health Clinics Initiative (Behavioral Health)	71	15%	46	18%	20	16%
Child and Adolescent Health Program (Community Access)	130	27%	46	18%	24	20%
Cities Readiness Initiative (Public Health)	21	4%	13	5%	0	0%
Community Partnership for Protecting Children (Family Well-Being and Protection)	121	25%	61	24%	17	14%
Community Partnership Tobacco Control Program (Behavioral Health)	103	21%	26	10%	14	11%
Community Services Block Grant Program (Community Access)	76	16%	48	19%	14	11%
Comprehensive Cancer Control Program (Public Health)	20	4%	5	2%	8	7%
Decategorization (Decat) (Family Well-Being and Protection)	130	27%	55	22%	22	18%
Diabetes Prevention and Management Program (Public Health)	32	7%	11	4%	12	10%
Disaster Response Initiative (Public Health)	86	18%	29	12%	8	7%

HHS Program or Initiative	Providers, Contractors & Provider Advocates		Consumer Advocates, Volunteers & Elected Officials		State Staff	
	Count	%[155]	Count	%[156]	Count	%[157]
Early Childhood Iowa - ECI (Family Well-Being and Protection)	222	46%	112	44%	27	22%
Elder Abuse Prevention and Awareness Program (Aging and Disability Services)	36	7%	31	12%	16	13%
Emergency Medical Services (EMS) and Trauma Program (Public Health)	66	14%	32	13%	13	11%
Emergency Preparedness and Response Program (Public Health)	164	34%	38	15%	13	11%
Environmental Health Program (Public Health)	135	28%	23	9%	11	9%
Family Development - CSBG (Community Access)	54	11%	37	15%	9	7%
Family Development and Self Sufficiency (FaDSS) Program (Community Access)	98	20%	49	19%	13	11%
Family Planning Program (Community Access)	65	13%	21	8%	10	8%
Health Promotion - Chronic disease and falls prevention (Aging and Disability Services)	82	17%	14	6%	14	11%
Healthy Child Care Iowa (Family Well-Being and Protection)	76	16%	35	14%	18	15%
Hepatitis Program (Public Health)	55	11%	11	4%	8	7%
HIV/AIDS Program (Public Health)	60	12%	14	6%	7	6%
Hospital Emergency Preparedness (Public Health)	56	12%	18	7%	4	3%
Immunization Program (Public Health)	177	36%	37	15%	24	20%
Integrated Provider Network (Behavioral Health)	58	12%	23	9%	10	8%

HHS Program or Initiative	Providers, Contractors & Provider Advocates		Consumer Advocates, Volunteers & Elected Officials		State Staff	
	Count	%[155]	Count	%[156]	Count	%[157]
Iowa Gets Screened Program (Public Health)	16	3%	7	3%	5	4%
I-SMILE Dental Program - I-SMILE @ School and I-Smile Silver (Community Access)	170	35%	49	19%	26	21%
Legal Assistance (Aging and Disability Services)	33	7%	23	9%	17	14%
Lifelong Links - Information & assistance and options counseling (Aging and Disability Services)	40	8%	16	6%	18	15%
Local Public Health Emergency Preparedness (Public Health)	171	35%	34	13%	14	11%
Local Public Health Services Program (Public Health)	211	44%	59	23%	31	25%
Low-Income Home Energy Assistance Program - LIHEAP (Community Access)	126	26%	61	24%	20	16%
Maternal Health Program (Community Access)	143	29%	41	16%	22	18%
Mental Health and Disability Services Regions (Behavioral Health)	117	24%	68	27%	33	27%
Nutrition Program - Congregate dining and home delivered meals (Aging and Disability Services)	46	9%	21	8%	13	11%
Sexually Transmitted Infection (STI) Program (Public Health)	99	20%	21	8%	16	13%
Supplemental Nutrition Program for Women, Infants and Children - WIC (Community Access)	145	30%	58	23%	22	18%
Supportive Services - Transportation, homemaker, personal care, chore, adult day, etc. (Aging and Disability Services)	94	19%	31	12%	21	17%

HHS Program or Initiative	Providers, Contractors & Provider Advocates		Consumer Advocates, Volunteers & Elected Officials		State Staff	
	Count	%[155]	Count	%[156]	Count	%[157]
Tuberculosis (TB) Control Program (Public Health)	113	23%	14	6%	10	8%
Weatherization Assistance Program - WAP (Community Access)	72	15%	36	14%	11	9%
WISEWOMAN Program (Public Health)	34	7%	4	2%	7	6%
Other, please specify	58	12%	44	17%	28	23%
Total	**4087**		**1537**		**709**	

ASSESSMENT OF HHS SERVICES & PROGRAM DELIVERY

Table 31. Contractor or Provider of HHS Services & Provider Advocate Survey Responses

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
Individuals know how to access the services/programs they need	7%	40%	40%	11%	2%
Individuals are able to receive the services/programs they need within a reasonable timeframe	10%	29%	42%	18%	2%
Individuals have a choice of providers in their own communities when seeking programs/services	10%	35%	40%	9%	6%
Individuals have access to the same services and supports in all parts of the state	35%	41%	16%	4%	4%

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
Individuals and/or families are able to access services at a time and location that is convenient for them	13%	41%	34%	9%	3%
For individuals eligible for or participating in multiple HHS programs/services, it is easy to make referrals to other HHS programs/services when needed	8%	29%	43%	10%	9%
For individuals eligible for or participating in multiple HHS programs/services, they are provided a warm handoff to other HHS programs/services when needed	10%	31%	37%	12%	10%
Individuals have multiple ways to easily get individualized help in-person, by phone, or by email/text if they run into difficulties accessing programs and services	14%	31%	37%	13%	6%
Individuals with complex and/or multiple needs can easily get individualized help in-person, by phone, or by email/text if they run into difficulties accessing programs and services	18%	35%	30%	11%	6%
Service coordination for individuals participating in multiple HHS programs and services is strong and effective	14%	36%	32%	10%	9%
Individuals do not have to participate in duplicative processes when accessing services across multiple HHS program areas	16%	42%	28%	4%	10%
Performance measures and outcomes are tracked and used to monitor and improve HHS programs and services	6%	22%	50%	14%	8%
Programs and services are effective at building individual resiliency and/or empowering individuals to be more self-sufficient	8%	25%	47%	13%	7%

Table 32. Consumer Advocate, Volunteer/Committee/Board Member & Elected Official Survey Responses

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
I know how to help consumers and/or their families access needed services and supports in the community	2%	7%	50%	39%	2%
The consumers and/or families I represent generally do not have to wait for services when needed	18%	36%	31%	12%	4%
The consumers and/or families I represent can receive the same services and supports as individuals in other parts of the state	13%	32%	33%	15%	6%
The consumers and/or families I represent know how to provide feedback about the services they receive	13%	31%	40%	12%	5%
The consumers and/or families I represent are able to services at a time and location that is convenient for them	15%	31%	36%	16%	2%
The providers of the consumers I represent coordinate with each other	6%	22%	40%	27%	4%
The consumers I represent do not have to repeat information, forms, or other activities for their different providers, programs, or services	21%	43%	21%	10%	5%

Table 33. State Staff Survey Responses

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
Individuals, families, and communities served by my program know how to access all needed services and supports administered by HHS	7%	42%	34%	7%	10%

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply
My program is able to serve clients on wait lists within a reasonable time frame to address the clients' immediate needs	10%	17%	29%	14%	30%
Individuals, families, and communities have access to the same services and supports administered by my program in all parts of the state	18%	24%	34%	12%	11%
Individuals can easily access all available services and supports provided by my program	6%	30%	37%	12%	15%
Individuals can easily get assistance in-person, by phone, or by email/text if they encounter difficulties	7%	15%	39%	25%	14%
Individuals with complex and/or multiple needs can easily access all available services and supports provided by my program	11%	21%	36%	15%	18%
Individuals with complex and/or multiple needs can easily get assistance in-person, by phone, or by email/text if they encounter difficulties	10%	19%	37%	18%	16%
Coordination across HHS programs to prevent service delivery gaps is strong and effective	23%	33%	28%	7%	10%
Coordination across HHS programs to prevent service delivery duplication is strong and effective	12%	33%	34%	7%	14%
Individuals do not have to participate in duplicative processes when accessing services across multiple HHS programs	17%	33%	31%	2%	17%

STRENGTHS[158]

Table 34. Contractor or Provider of HHS Services & Provider Advocate Survey Responses – "What are the greatest strengths in how the HHS programs and services that you/your organization participates in are currently administered?"

	Count	Percent
Providers: Providers are very committed and really care about making sure the people they serve get what they need to reach their goals.	240	49%
Quality: Local programs are administered very well and the level of waste and/or duplication is very low.	238	49%
Coordination: There is good communication and coordination between services and support providers.	140	29%
Staffing: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.	107	22%
Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.	69	14%
Access to Services & Supports: Individuals can get the services and support they need in one location.	48	10%
Access to Services & Supports: Programs and services are easily accessible to all people.	43	9%
Other, please specify.	41	8%
Administrative Burden: It is easy to get help if someone has a question about how to apply for a program, or what documents are needed to verify eligibility for a program.	33	7%
Staffing: Local programs are staffed adequately to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.	35	7%
Access to Services & Supports: Individuals and providers/contractors across the state are able to access and receive the same level of services to meet their needs.	22	5%
Quality: The quality assessment and assurance system(s) in place are effective.	26	5%

	Count	Percent
Staffing: It is easy to get an appointment to see a service or support provider within a reasonable amount of time based on the urgency of need.	23	5%
Funding: Funding levels are adequate to meet the expectation of service provided.	18	4%
Staffing - Local: There is adequate staffing capacity to serve population groups across the state.	20	4%
Quality: State programs are administered very well and the level of waste and/or duplication is very low.	15	3%
Funding: There is adequate funding for programs and services to meet the needs of individuals and communities across the state.	11	2%
Staffing - State: There is adequate staffing capacity to serve population groups across the state.	7	1%

Table 35. Consumer Advocate, Volunteer/Committee/Board Member & Elected Official Survey Responses – "What are the greatest strengths of the Iowa HHS system?"

	Count	Percent
Providers: Providers are very committed and really care about making sure the people they serve get what they need to reach their goals.	109	43%
Coordination: There is good communication and coordination between service and support providers.	78	31%
Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.	66	26%
Providers: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.	57	23%
Provider Burden: It is easy to get help if someone has a question about how to apply for a program, or what documents are needed to verify eligibility for a program.	40	16%
Provider Burden: Programs are administered very well and the level of waste and/or duplication is very low.	35	14%
Quality: The quality assessment and assurance system(s) in place are effective.	29	12%

	Count	Percent
Other, please specify.	30	12%
Access to Services & Supports: Programs and services are easily accessible to all people.	27	11%
Access to Services & Supports: Individuals can get the services and support they need in one location.	19	8%
Access to Services & Supports: It is easy to get an appointment to see a services or support provider within a reasonable amount of time based on the urgency of need.	15	6%
Access to Services & Supports: Individuals and communities across the state are able to access and receive the same level of services to meet their needs.	10	4%
Funding: There is adequate funding for programs and services to meet the needs of individuals and communities across the state.	11	4%
Staffing: Local programs are staffed adequately to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.	10	4%
Staffing - Local: There is adequate staffing capacity at the local level to serve populations groups across the state.	9	4%
Funding: Funding levels are adequate to meet the expectation of service provided.	8	3%
Staffing - State: There is adequate staffing capacity at the state level to support HHS partners across the state.	7	3%

Table 36. State Staff Survey Responses – "What are the greatest strengths in the Iowa HHS system?"

	Count	Percent
Quality: Service and support providers take time to learn about their clients' culture, beliefs, and values and integrate this knowledge into how they provide services and support to the person.	38	31%
Duplication: Local programs are administered very well and the level of waste and/or duplication is very low.	21	17%
Coordination: There is good communication and coordination between all services and support providers.	20	16%

	Count	Percent
Access to Services & Supports: Individuals can be assessed and referred for services that may further support their health needs at any intake point.	19	15%
Other, please specify.	18	15%
Access to Services & Supports: I have access to information and resources on services and programs within other areas of HHS.	17	14%
Quality: The quality assessment and assurance system(s) in place are effective, and generally services and supports are consistently of high quality.	17	14%
Duplication: State programs are administered very well and the level of waste and/or duplication is very low.	11	9%
Access to Services & Supports: Individuals have availability and access to the same types of services and programs across the state.	10	8%
Access to Services & Supports: A person can get almost all the services and supports they need in one service location.	7	6%
Staffing - State: Staffing of state programs is adequate to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.	6	5%
Access to Services & Supports: Individuals have timely access across the state to programs and services.	5	4%
Staffing - Local: Staffing of local programs is adequate to ensure that staff can carry out all their assigned tasks effectively and not feel spread too thin.	5	4%
Access to Services & Supports: All supports and services are easily accessible to all people.	4	3%
Resource Allocation: Local programs and services receive adequate funding to support meeting the needs of Iowans.	4	3%
Resource Allocation: State programs and services receive adequate funding to support meeting the needs of Iowans.	2	2%

Table 37. Contractor or Provider of HHS Services & Provider Advocate – "What do you think are the top three greatest challenges your organization is facing to meet its goals for service access, delivery and outcomes?"

	Count	Percent
Insufficient Funding: For state grant requirements	218	45%
Staffing: Pay	173	36%
Insufficient Funding: For training for best practices, innovations, working with non-English speaking populations, and/or evidence-based programs	125	26%
Staffing: Available Workforce	125	26%
Administrative Burden: Grant/contract management (contracting process, reporting, data system, etc.)	101	21%
Staffing: Retention	89	18%
Administrative Burden: Reimbursement process (claims/billing)	70	14%
Other	62	13%
Administrative Burden: Data collection	56	12%
Insufficient Funding: Local investment	52	11%
Lack of: Coordination among providers	44	9%
Administrative Burden: Eligibility verification or determination	39	8%
Environment: Lack of buy-in and support from local officials	39	8%
Lack of: Integrated care sites (e.g., primary care and behavioral health providers not co-located)	38	8%
Environment: Lack of buy-in and support from community stakeholders	32	7%
Staffing: Skills	18	4%

	Count	Percent
This question does not apply to my organization	14	3%
Lack of: Technological resources/expertise	11	2%

Table 38. Contractor or Provider of HHS Services & Provider Advocate Survey Responses – "What are the greatest challenges in how the HHS programs and services that you/your organization participates in are currently administered?

	Count	Percent
Funding: Funding levels are not adequate to meet the expectation of service provided.	181	37%
Funding: Funding for programs and services is not adequate to meet the needs of individuals and communities across the state.	175	36%
Access to Services & Supports: Individuals and communities across the state are not able to access and receive the same level of services to meet their needs.	139	29%
Communication: Coordination and communication between providers and/or providers and HHS offices is lacking.	104	21%
Access to Services & Supports: Individuals must go to multiple locations to receive needed services.	95	20%
Staffing: Workforce is a challenge for meeting the demand I currently have for my agency's services.	99	20%
Collaboration: My input is not sought and/or included in HHS system planning or changes.	94	19%
Access to Services & Supports: It is hard to know what other HHS services someone might be eligible for.	85	18%
Provider Burden: Eligibility and intake requirements are repetitive and cumbersome for our consumers.	79	16%
Communication: It is challenging to find information when changes to programs occur (administrative rules, reimbursement, etc.).	45	9%
Communication: It is hard to know where to go to get questions answered.	42	9%

	Count	Percent
Provider Burden: There is duplication of requirements and activities across the multiple systems my agency participates in.	39	8%
Communication: I am not given advanced notice for administrative changes with programs.	31	6%
Other, please specify	29	6%
Quality: There is a lack of quality assessment and assurance system(s).	16	3%
Technology: My agency lacks the technology supports to provide requested data or meet other administrative requirements.	12	2%

Table 39. Consumer Advocate, Volunteer/Committee/Board Member & Elected Official Survey Responses: "What are the greatest challenges of the Iowa HHS system?"

	Count	Percent
Access to Services & Supports: It is difficult for consumers to travel to a program or service office because of lack of public transportation or distance from home.	109	43%
Access to Services & Supports: Consumers are unable to receive services when needed because there is a wait list.	79	31%
Funding: There is not adequate funding for programs and services is not adequate to meet the needs of individuals and communities across the state.	78	31%
Funding: Funding levels are not adequate to meet the expectation of service provided.	75	30%
Access to Services & Supports: Completing applications for different services and supports is confusing and/or repetitive	57	23%
Resource Allocation: Funding for programs and services is not adequate to meet the needs of individuals and communities across the state.	43	17%
Staffing: There is insufficient access to services from providers who look like, speak the same language, and/or can meet the needs of those I advocate for.	36	14%
Communication: Coordination and communication between providers and/or providers and HHS offices is lacking.	32	13%

	Count	Percent
Technology: Consumers don't know how to use the technology that is required to get or use the services they need.	32	13%
Access to Services & Supports: It is hard to know what services someone might be eligible for.	27	11%
Access to Services & Supports: It is difficult for individuals to get to a program or service because of the agency or provider's hours of operation.	26	10%
Communication: It is hard to know where to go to get questions answered.	23	9%
Access to Services & Supports: It is hard to find information about programs and application/renewal processes or eligibility.	21	8%
Other, please specify	20	8%
Provider: Service and/or program office staff do not make consumers feel welcomed or valued.	9	4%

APPENDIX 3: CONSUMER SURVEY

The Iowa Department of Health and Human Service (HHS) wants to hear from you. We want to know how we can do a better job. We want to make sure you can get the services you or your family needs, when you need them. Answering these questions will help us know what is important to you and how we can do better.

1. I know where to go for help.
   - □ Yes
   - □ No

2. I can get help when I need it.
   - □ Yes
   - □ No

3. I can get help close to home when I need it.
   - □ Yes
   - □ No

4. I have to go to multiple places to get help.
   - □ Yes
   - □ No

5. I have to go to an office multiple times to complete paperwork before I can get help.
   - □ Yes
   - □ No

6. I'm told how much I will have to pay, if anything, when I receive help.
   - □ Yes
   - □ No

7. I have to wait too long for help.
   - □ Yes
   - □ No

8. If I have to wait for help, I am told how long wait times will be.
   - □ Yes
   - □ No

9. When I try to get help, providers say I need to go somewhere else.
   - □ Yes
   - □ No

10. When I need help, the two most important things to me are:

- □ An easy application
- □ Getting all the help I need in one place
- □ Getting help close to home
- □ Getting help in my language
- □ Getting help when I need it (not having to wait a long time)
- □ Having a choice in where I can go to get help
- □ Having transportation to the help I need
- □ Other – please describe

Thank you for your time!

APPENDIX 4: CONSUMER SURVEY RESPONSES

Table 40. Summary of Consumer Survey Responses

Question	Yes	No
I know where to go for help.	80%	20%
I can get help when I need it.	74%	26%
I can get help close to home when I need it.	75%	25%
I have to go to multiple places to get help.	49%	51%
I have to go to an office multiple times to complete paperwork before I can get help.	26%	74%
I'm told how much I will have to pay, if anything, when I receive help.	61%	39%
I have to wait too long for help.	35%	65%
If I have to wait for help, I am told how long wait times will be.	62%	38%
When I try to get help, providers say I need to go somewhere else.	32%	68%

Table 41. Consumer Responses: "When I need help, the two most important things to me are"[160]

	Count	Percent
An easy application	977	43%
Getting all the help I need in one place	1,052	46%
Getting help close to home	625	27%
Getting help in my language	87	4%
Getting help when I need it (not having to wait a long time)	961	42%
Having a choice in where I can go to get help	202	9%
Having transportation to the help I need	191	8%

	Count	Percent
Other	8[161]	0%

The three participants that selected “other” provided the following responses:

- “Our community is made up of more seniors. It’s important they do not have to travel far for assistance.”
- “Getting help in the area I need to get help in.”
- “Help that isn’t stereotyped into cookie cutter categories.”

APPENDIX 5: TOWN HALL THEMES

Overview

The Iowa Department of Health and Human Services (HHS), in partnership with Health Management Associates (HMA), hosted seven Town Hall meetings regarding the Service Delivery Alignment Assessment Project. These meetings provided an opportunity for the public to learn more about the assessment process and provide input. A total of 764 stakeholders were in attendance.

Table 42. Town Hall Meetings

Location	Date	Total Number of Participants
Keokuk	July 10, 2023	30
Waverly	July 11, 2023	71
Storm Lake	July 12, 2023	68
Atlantic	July 13, 2023	63
Virtual Town Hall #1	July 20, 2023	201
Virtual Town Hall #2	July 21, 2023	172
Virtual Town Hall #3	August 2, 2023	159

Themes Raised

The following themes were most commonly heard from participants:

- Local control is critical in the delivery of HHS services.
- Stakeholders are concerned with the speed of this project.
- Access to services in rural areas will be compromised in a regionalized model.
- Currently, the local service delivery system is not siloed. Rather, there are siloes at the HHS level.

Additional details regarding these predominant themes, and other issues raised, are catalogued below.

Importance of Local Control & Concerns with Regionalization

- Local control allows for timely response, development of public trust, and in-person service delivery that makes communication barriers less challenging.
- Local control is important to the quality of the services delivered to community members.
- Local control is vital to maintaining programs tailored to the needs of specific communities.
- Local control provides accountability as volunteer boards are part of the communities they serve and want to be accountable for every dollar spent.
- Increasing service delivery area, "regionalization," or consolidation of service delivery areas will result in loss of access to services for Iowans living in rural areas.
- Regionalization puts local supplementary funding at risk.
- Regionalization may limit the size and types of organizations that can contract with the state (due to state reliance on payment in arrears) causing loss of smaller agencies currently doing good work.
- Regionalization will adversely impact seniors who rely on home care provided by local public health agencies.
- Several local community service agencies have recently gone through service area consolidation. The time given for planning and implementation was not sufficient. There has not been enough time to let the recent changes settle in.
- If local communities can have a voice in their regionalization, it can be a positive as they know the needs of their areas.

Commentary on Assessment Process & Goals

- Anger at the speed of the assessment. More time is needed to study and implement service delivery alignment.
- Concern that time allowed for stakeholder input is too short to be meaningful. The time spent by agency staff to respond to the survey is not likely to have an impact on service delivery alignment policy development.
- Stakeholder input mechanisms are inadequate and confirm provider suspicions that HHS has already settled on a plan to regionalize community services. HHS is so removed from people served that consumer needs have not been adequately planned for.
- There are opportunities for improvement, but this process and timeline does not seem to be the appropriate path.
- Disagree with HHS assessment of problems necessitating alignment; the local service delivery system is not siloed.

- Stakeholder survey will not be adequate to gain full understanding of consumer wants and needs.
- Governance is a significant issue and not addressed by HHS in its vision for service delivery alignment.
- There is a request for ongoing dialogue with HHS during the process and allowing for feedback on interim recommendations from the stakeholder community.

Feedback on HHS

- Silos are at the HHS level, not the service delivery or provider level.
- There is a lack of responsiveness from HHS to local agency staff.
- Better and timely communication needed from the state to local partners.
- Greater data-sharing from the state with locals would improve service delivery.
- HHS grant requirements require duplication (e.g., lead testing required for three different public health grants).
- HHS application supports (online, phone, walk-in) are inadequate and reduce utilization. Consumers cannot receive timely responses or information.
- Local agencies provide application support to consumers because of the lack of HHS staff and because consumers report that they are not treated respectfully by the regional office staff.
- Administrative burden has been shifted from HHS to local community agencies in previous "regionalization" activities. For example, additional staff time is required to travel further distances to clients. However, subcontracting to reduce staff travel times adds administrative burdens to local agencies that are already struggling.
- Anger at decrease in Decat funding.

Strengths of the Current System

- Community service agencies collaborate and coordinate to fill gaps and address needs not addressed by State or Federal funding.
- Community service agencies have a presence in every county within their service area. This allows for in-person meetings between staff and clients. In-person assistance is important to: (1) assist with application support for Medicaid and other benefits; (2) educate consumers about available resources; and (3) bridge access barriers created by low-literacy, ESL clients, transportation costs, and unpaid time-off from work costs associated with travel to regional hub for service access.
- The local linkages across programs and service delivery areas are robust and able to reflect community needs, particularly through Community Action Agencies.

System Issues

- Transportation is the biggest barrier to access in rural areas.
- Focus should be on workforce concerns, including wage improvement.
- Medicaid managed care organization (MCO) denial of claims, last minute cancellation of non-emergency medical transportation (NEMT), and accessibility of pharmacy is a big problem now in service delivery. MCOs should be reviewed as part of alignment assessment.
- Low Medicaid reimbursement rates lead to fewer providers. There is similar concern with child-care reimbursement and wages.
- Eligibility for Medicaid (and other benefit programs) is extremely challenging. Applications are not easily understandable even for people with college degrees and higher. Lack of translation make forms difficult for individuals for whom English is a second language. There is a lack of timely response through phone system and refusal to provide application assistance at in-person walk-in centers.
- Applications for benefits are not synched and individuals must submit multiple applications.
- Data sharing between HHS and local community agencies is lacking. For example, even where there is some data shared such as Medicaid eligibility, additional data (e.g., demographic data, employment status, disability status, etc.) which is collected through the Medicaid application that is required by other programs such as WIC and Maternal Child Health programs is not shared.

Funding Concerns

- Local agencies are not reimbursed for staff time and resources that go into developing and maintaining close collaboration between local agencies. This coordination prevents duplication and allows for agile response to service gaps.
- Local agencies are not compensated for all the support they provide to people trying to complete applications for means-tested benefits administered by HHS.
- All local agencies provide unreimbursed case management-like services.
- More funding is necessary for outreach workers in local communities who make key referrals to existing service delivery systems in the community.
- Funding is needed for media outreach and marketing; local organizations need more resources to get the word out about their presence and how they can assist people in their communities. At times, that kind of activity is not allowed through grants.
- There is a need for flexible and sustainable public health funding.
- More flexibility is needed regarding how grant funding can be used. HHS has a history of strict interpretation of federal funding requirements which other states have not taken.

APPENDIX 6: STAKEHOLDER INTERVIEWEE LIST

Service Area	Stakeholder Groups
AAAs and ADRCs	• HHS Staff • AAAs
CCBHC	• HHS Staff
Community Action Agencies and FaDDS	• HHS staff – Department of Human Rights • Community Action Agencies
Community Partnership for Protecting Children	• HHS Staff and Local Staff
Cross Service Area	• Iowa State Association of Counties (ISAC) • Medicaid managed care organizations (MCOs)
Decat	• HHS Staff and Local Staff
ECI	• HHS Staff and Local Staff
Emergency Preparedness Regions	• HHS Staff – Bureau of Emergency Preparedness and Response
Environmental Health	• HHS Staff – Bureau of Environmental Health
IPN	• HHS Staff • IPN Network Providers
I-SMILE	• HHS Staff • I-SMILE Coordinators
Local Governmental Public Health	• HHS Staff – Local Public Health Services, Center for Acute Disease Epidemiology (CADE) Bureau, Bureau of Immunization and TB • PHAB Accredited Agency Administrators • Health System-Based/Other Agency Administrators • County-Based Agency Administrators • Environmental Health Administrators Not Employed by Public Health Agency
Maternal, Child, and Adolescent Health	• HHS Staff – MCH Program • Maternal Health and Family Planning Providers • Child and Adolescent Health Providers

Service Area	Stakeholder Groups
Mental Health Delivery Regions	• HHS Staff • MHDS Regions
Tobacco Community Partnerships	• HHS Staff – Tobacco Program • Community Partnerships
WIC	• HHS Staff

APPENDIX 7: ACRONYMS

Acronym	Meaning
AAA	Area Agency on Aging
ACL	Administration for Community Living
ADRC	Aging & Disability Resource Center
ARPA	American Rescue Plan Act
CAA	Community Action Agency
CAH	Title V Child and Adolescent Health
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CIL	Centers for Independent Living
CMS	Centers for Medicare and Medicaid Services
CPPC	Community Partnership for Protecting Children
CSA	Collaborative Service Area
CWRTP	Child Welfare Research and Training Project
Decat	Decategorization
DHS	Iowa Department of Human Services
ECI	Early Childhood Iowa
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FaDSS	Family Development and Self Sufficiency Program
FFP	Federal Financial Participation
FFS	Fee-for-service
FFY	Federal Fiscal Year
FIP	Family Investment Program
FPCI	Family Planning Council of Iowa
FPL	Federal Poverty Level
FPP	Family Planning Program
FQHC	Federally Qualified Health Center
HF	House File
HHS	Iowa Department of Health and Human Services
HOME	Home and Opportunity in Many Environments
HRSA	Health Resources and Services Administration
ID/DD	Intellectual Disabilities and Developmental Disabilities
IDA	Iowa Department on Aging
IDPH	Iowa Department of Public Health
IPN	Integrated Provider Network
LBOH	Local Board of Health
LPHA	Local Public Health Agency

Acronym	Meaning
LPHS	Local Public Health Services
LTSS	Long-Term Services and Supports
MCAH	Maternal, Child and Adolescent Health
MCO	Managed Care Organization
MHBG	Community Mental Health Services Block Grant
MHDS	Mental Health & Disability Services
MLTSS	Managed Long-Term Services and Supports
NAM	National Academy of Medicine
OAA	Older Americans Act
PASSR	Pre-Admission Screening and Resident Review
PHE	Public Health Emergency
PPS	Prospective Payment System
PSA	Planning and Service Area
RCHC	Regional Community Health Consultant
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SDM	Shared Decision Making
SED	Serious Emotional Disturbance
SEWPPAC	State Epidemiological Workgroup and Prevention Partnerships Advisory Council
SF	Senate File
SFY	State Fiscal Year
SNAP	Supplemental Nutrition Assistance Program
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
Tobacco CP	Tobacco Community Partnership
US HHS	United States Department of Health and Human Services
USDA	United States Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

ENDNOTES

[1] Administration for Community Living. Grant Opportunities. Available at: https://acl.gov/grants/open-opportunities. Accessed October 18, 2023.

[2] Boston University School of Social Work. ADRC / No Wrong Door Key Principles Certificate.

Available at: https://thenetwork.bu.edu/offering/adrc-no-wrong-door-certificate-cader/. Accessed October 18, 2023.

[3] More information on approach can be found in the meeting Colorado Behavioral Health Administration Advisory Council program book for the December 21, 2023. Available at: https://bha.colorado.gov/sites/bha/files/documents/BHAAC%20Slide%20Deck%2012-21-22.pdf. Accessed October 18, 2023.

[4] Ohio's regional oversight boards are responsible for both MH and SUD. Section 340.01 - Ohio Revised Code | Ohio Laws, amended in 2023.

[5] The Nevada public behavioral health system leverages five Regional Behavioral Health Policy Boards (RBHPBs), with each supported by a (non-state) Regional Behavioral Health Coordinator position funded through the SAMHSA block grants. The five regions represent contiguous counties with populations that range from less than 16,000 to 2,282,226.

[6] If the lead agency is a CAA, the lead agency must document how it will integrate the contracted services into its service delivery model.

[7] 42 CFR 51c.102 states, "*Catchment area* means the area served by a project funded under section 330 of the Act." In other words, eligibility for services is not limited based on place of residence. Instead "catchment area" refers to the geographic area that a provider must serve. Title 42 Part 51c applies to grants for community health services. This is the same for a CSA.

[8] The CSA map was developed using the state's most recent population data.

[9] This option adapts key concepts in North Carolina's Consolidated Human Service Areas (CHSA) model and Texas' 2023 consolidation model. Under this option, counties would be granted a specific timeframe to organize into multicounty catchment areas. Any counties not established in a new catchment area by a specified date would be placed into catchment area(s) established by state leadership.

[10] National Association of County and City Health Officials. 2019 National Profile of Local Health Departments, p. 21. Available at: https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf. Accessed October 18, 2023.

[11] Hoornbeek J, Morris M, Libbey P, Pezzino G. Consolidating Local Health Departments in the United States: Challenges, Evidence, and Thoughts for the Future. *Public Health Reports*. 2019;134(2):103−108.

[12] The 10 least populated Iowa counties in 2022 had a combined population of approximately 60,000 and the seven least populated had a combined population of approximately 39,000. A 50,000 minimum standard therefore seems feasible. Also, of Iowa's six accredited Local Public Health Agencies (LPHAs), one (Cerro Gordo County) served a county population of 42,409 in 2022, whereas the other five (Blackhawk County, Johnson County, Linn County, Scott County, and Siouxland Health District in Woodbury County) served populations of 105,671−229,033. Region sizes greater than 50,000 could promote greater economies and scale and efficiencies; however, this advantage should be balanced against public access concerns and travel distance challenges for public health staff in larger geographic regions.

[13] Participants in a group interview with local environmental health staff employed outside of an LPHA in July 2023 reported having other job responsibilities beyond environmental health, such as zoning and land use roles. Allowing delegation of environmental health functions to counties currently using this arrangement will avoid staffing disruptions, which could have local impacts beyond public health.

[14] As of June 30, 2022, a total of 18 local health departments covered 92 counties in Nebraska. One county (Dakota) has a single county health department. For details, go to:

https://dhhs.ne.gov/Reports/Health%20Care%20Funding%20Act%20LB%20692%20Annual%20Report%20-%202022.pdf.

[15] Idaho has seven independent health districts, which cover all of the state's 44 counties. For more information, go to: https://healthandwelfare.idaho.gov/health-wellness/community-health/public-health-districts.

[16] Minnesota's local public health system consists of approximately 70 local public health departments, which are organized as 51 community health boards (CHBs). CHBs are the legally recognized governing bodies for local public health in Minnesota. A CHB may be a single county or city health department, or multiple local health departments working together. See: https://cms6.revize.com/revize/lpham/Overview%20of%20LPH%20System%20-%202023%20Report%20-%20DRAFT.pdf.

[17] In Arkansas, the County Health Officer "serves as a key public health representative in the local community, promoting the use of local health unit services, advocating for public health policy initiatives with local and state policy makers, and providing assistance to local public health education and promotion initiatives. The County Health Officer also aids and assists the State Board of Health and collaborates with the State Health Officer and the Department of Health in county emergency preparedness response and planning including implementing orders of the State Health Officer if isolation, quarantine, or emergency legal measures are required. The County Health Officer participates in the development and review of local emergency plans and serves as a local spokesperson to the media, general public, and medical community in the event of a public health emergency." For details, go to https://www.healthy.arkansas.gov/county-health-officers#:~:text=The%20County%20Health%20Officer%20serves,health%20education%20and%20promotion%20initiatives.

[18] In Nebraska, members of the governing board of each health district are popularly elected. Neb. Rev. Stat. Section 71-1607.

[19] Minn. Stat. Section 145A.05 outlines permitted local public health ordinances.

[20] Minnesota requires each Community Health Board (CHB) to include 30,000+ population within its jurisdiction or be composed of three or more contiguous counties. For details, go to: https://www.health.state.mn.us/communities/practice/about/history.html.

[21] In 1907, Idaho Gov. Frank Gooding signed legislation, creating the Idaho State Board of Health, making it the last state in the nation at the time to do so. In the 1920s, Twin Falls County established the state's first county board of health in response to severe meningitis outbreak. Over the years, several more county-level health departments popped up, but some counties remained noncompliant with a federal recommendation that all Idaho counties follow Twin Falls lead. According to a 1967 state document, "Under the existing state law relating to county boards of health, only half of the counties up to the present time have organized full-time local health departments and many of the remaining counties have never complied with state law." To ensure that every Idahoan had access to public health services, in 1970, the state legislature created the existing structure of seven health districts. For details, go to: https://www.ktvb.com/article/news/local/208/history-of-idahos-health-districts-idaho-historical-society/277-83f7f62a-8bce-43db-b737-8c38207a7911.

[22] In 2001, L.B. 692 provided $11 million to expand Nebraska's statewide public health system. Until then, local public health departments served only 22 of the state's 93 counties. Today, almost all of Nebraska's counties have access to local or district health departments. For details, go to: https://www.trphd.ne.gov/about-us/a-history-of-public-health.html

[23] An additional 749 stakeholders began the electronic survey but did not officially submit their responses. Incomplete responses have been omitted from the analysis.

[24] Iowa Department on Aging. The Iowa Department on Aging. Available at: https://iowaaging.gov/. Accessed October 18, 2023.

[25] The Boards and Commissions Review Committee, responsible for reviewing the efficiency and effectiveness of all boards, commissions, and other similar entities created in Iowa law recommended in August 2023 consolidation/merger of the Commission on Aging.

[26] US Census Bureau. Table S0101: Age and Sex (2017-2021 American Community Survey 5-Year Estimates). Available at: https://data.census.gov/table?q=S0101&tid=ACSST5Y2021.S0101. Accessed August 30, 2023.
[27] US Census Bureau. Table B11006: Households by Presence of People 60 Years and Over by Household Type (2017-2021 American Community Survey 5-Year Estimates)." Accessed 8/30/2023. https://data.census.gov/.

[28] AARP Public Policy Institute. Number of Family Caregiver, Hours, and Economic Value of Caregiving, by State, 2021. March 2023. Available at: https://www.aarp.org/content/dam/aarp/ppi/2023/3/valuing-state-estimates.doi.10.26419-2Fppi.00082.009.pdf. Accessed October 18, 2023.

[29] State Data Center of Iowa & The Office of Persons with Disabilities. Iowans with Disabilities: 2022. July 2022. Available at: https://www.iowadatacenter.org/index.php/download_file/view/167/212. Accessed October 18, 2023.

[30] Iowa Department of Management. Iowa Budget Report, FY 2024. Available at: https://dom.iowa.gov/resource/state-budget-reports/iowa-budget-report-fy-2024. Accessed October 18, 2023.

[31] Iowa Department on Aging. Iowa State Plan on Aging Federal Fiscal Years 2022 – 2025. https://iowaaging.gov/sites/default/files/library-documents/IDA%20State%20Plan_0.pdf. Accessed October 19, 2023.

[32] https://lifelonglinks.org/, (866)468-7887

[33] https://adrc.training-source.org/

[34] US Administration for Community Living and The Lewin Group. Aging and Disability Resource Center/ No Wrong Door Functions: A Leading Indicator in the 2020 Long-Term Services and Support State Scorecard. AARP Public Policy Institute. November 5, 2020. Available at: https://ltsschoices.aarp.org/resources-and-practices/adrcno-wrong-door-2020-key-takeaways.. Accessed October 19, 2023.

[35] Ibid.

[36]Iowa Department on Aging. Iowa State Plan on Aging: Federal Fiscal Years 2022–2025." https://iowaaging.gov/sites/default/files/library-documents/IDA%20State%20Plan_0.pdf. Accessed October 19, 2023.

[37] Average calculated from Statewide Persons Served data compiled as of FY22.

[38] Under Iowa Medicaid's §1915(b) Waiver, the state has authority to provide additional behavioral health services to enrollees with Medicaid funding. However, in accordance with federal requirements, these enhanced services are not available to fee-for-service Medicaid enrollees.

[39] IPN contractor numbers were reported using information within the Iowa Application Behavioral Health Assessment and Plan for the FY2024/2025 Substance Abuse, Prevention and Treatment and Community Mental Health Services Block grant.

[40] 45 CFR 96.134 -- Maintenance of effort regarding State expenditures.

[41] Historical summary paraphrased from Iowa 2022-2023 Mental Health Services Block grant application.

[42] Based on realignment information provided within the Iowa Application Behavioral Health Assessment and Plan for the FY2024/2025 Substance Abuse, Prevention and Treatment and Community Mental Health Services Block grant.

[43] The Boards and Commissions Review Committee, responsible for reviewing the efficiency and effectiveness of all boards, commissions, and other similar entities created in Iowa law recommended in August 2023 consolidation of the Mental Health and Disability Services Commission.

[44] The Boards and Commissions Review Committee, responsible for reviewing the efficiency and effectiveness of all boards, commissions, and other similar entities created in Iowa law recommended in August 2023 consolidation of the Children's Behavioral Health System State Board.

[45] Details regarding membership can be found at Mental Health Planning and Advisory Council (IMHPC) | Iowa Department of Health and Human Services.

[46] Copied from the MHDS Regional Financial Report FY19−FY22.

[47] List is summary of information, with a full description of CCBHC requirements available at: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf.

[48] Information taken from G. FY23 Community Partnerships for Tobacco Use Prevention and Control Funding Allocation Table (iowa.gov).

[49] Colorado Behavioral Health Administration. 2023 Strategic Plan. Available at: https://drive.google.com/file/d/1EZXHhWtgoL_E7kp7g0gJ0QJOw33bqdSd/view. Accessed October 19, 2023.

[50] An overview of the approach was presented to the Behavioral Health Administration Advisory Council December 21, 2022, and can be accessed at: BHAAC Slide Deck 12-21-22.pdf.

[51] UCPs include information on contracting 16 elements. More information can be found at First Universal Contracting Provision Draft.pdf - Google Drive.

[52] Nevada State Legislature. Title 39—Mental Health. Available at: https://www.leg.state.nv.us/NRS/NRS-433.html#NRS433Sec429. Accessed October 19, 2023.

[53] Summary of Section 340.01 - Ohio Revised Code | Ohio Laws, which was amended in 2023

[54] Allocation guidelines and amounts are publicly posted and available at https://mha.ohio.gov/supporting-providers/apply-for-funding/for-current-awardees/06-fy24-allocation-guidelines.

[55] More information on approach can be found at BHAAC Meeting 12 21 22 (colorado.gov).

[56] See IDPH September 15, 2020, slides.

[57] 42 U.S.C. §9901 et. seq.

[58] Iowa Code §§216A.92A and 216.92B

[59] Iowa Code §216A.94

[60] USCODE-2021-title42-chap106-sec9906.pdf (govinfo.gov)

[61] Iowa Department of Human Services. CSBG State Plan: FY 2021-2022. Available at: https://humanrights.iowa.gov/sites/default/files/media/CSBG_Model_State_Plan_2022_2023_w.pdf. Accessed October 19, 2023.

[62] CSBG governance requirements that empower local decision making are found at 42 U.S.C. §9901 et seq. and at Iowa Code §216A.94, subsection 2 (2009).

[63] See 2021 to 9/30/2022 CSBG State Plan at p. 21 of the PDF.

[64] Family support services include Head Start, Early Head Start, Parent-to-Parent, and FaDSS.

[65] Several Community Action Agencies also provided diaper or personal hygiene product pantries.

[66] Iowa Code 216A.107

[67] The FaDSS Grantee Service Areas Map is available at: https://humanrights.iowa.gov/sites/default/files/media/FaDSS_Service_Area_Map_2.pdf.

[68] Iowa Department of Human Rights, Division of Community Action Agencies 2020 Annual Report and 2023 Iowa HHS Appropriations Bill Senate File 561, p. 27.

[69] Kouri Z. Opinion: Let Iowa Dentists Help More Medicaid Recipients by Increasing Rates. *Des Moines Register*. February 21, 2022. Available at: https://www.desmoinesregister.com/story/opinion/columnists/iowa-view/2022/02/21/dental-care-help-more-iowa-medicaid-recipients-higher-rates/6830900001/.

[70] US Health Resources & Services Administration - Maternal & Child Health, Title V Maternal and Child Health Block Grant

[71] Iowa Code §135.11(17).

[72] 641 IAC 76.1(1).

[73] 641 IAC 76.21.

[74] 641 IAC 76.23(2).

[75] US HRSA, Maternal Y Child Health, Title V Maternal and Child Health Block Grant.

[76] Maternal and Child Health Services Title V Block Grant Application FY 2022 and Annual Report FY 2020, 8/31/2021

[77] Iowa Acts 2022, HF 2578, Sec. 51(2)(a) establishes the Iowa Department of Health and Human Services as the successor entity assuming all contractual rights and obligations previously held by the Iowa Department of Public Health.

[78] Iowa HHS

[79] US Department of Agriculture, Economic Research Service. ERS Charts of Note. Available at: https://www.ers.usda.gov/data-products/charts-of-note/charts-of-note/?topicId=5eadd4c9-6c57-43cd-9b47-3cc26a882cd6#:~:text=Declining%20U.S.%20births%20and%20improving,and%20women%20constituted%2024%20percent. Accessed October 19, 2023.

[80] General Statutes of North Carolina, Sec. 153A-77

[81] Texas Government Code, §§521.0002; 522.0152; 522.0153; 522.0155

[82] Texas Government Code §522.0155

[83] Four Community Action Agencies (CAAs)—Mid-Sioux Opportunity, Inc., New Opportunities, Inc., North Iowa Community Action, and Mid-Iowa Community Action—are the local Maternal Health Agencies. Two CAAs (Matura Action Corp. and Mid-Iowa Community Action) are the local Child and Adolescent Health agencies. Eight CAAs are the local WIC agencies (Hawkeye Area Community Action Program, New Opportunities, Inc., Matura Action Corp., Mid-Iowa Community Action, Mid-Sioux Opportunity, Inc., North Iowa Community Action Org., Operational Threshold).

[84] FaDSS Grantee Service Areas, CSA Map, Family Planning Program Provider Map, Maternal Health Provider Map, and Community Action Agency regions map.

[85] 42 U.S.C. §9915

[86] Iowa Code §232.188 (17,1)

[87] Ibid

[88] Ibid

[89] 42 CFR 51c.102

[90] If the lead agency is a CAA, the lead agency must document how it will integrate the contracted services into its service delivery model.

[91] 42 CFR 51c.102 states, "*Catchment area* means the area served by a project funded under section 330 of the Act." In other words, eligibility for services is not limited based on place of residence. Instead "catchment area" refers to the geographic area that a provider must serve. Title 42 Part 51c applies to grants for community health services. This is the same for a CSA.

[92] The CSA map was developed using the state's most recent population data.

[93] This option adapts key concepts in North Carolina's Consolidated Human Service Areas (CHSA) model and Texas' 2023 consolidation model. Under this option, counties would be granted a specific timeframe to organize into multicounty catchment areas. Any counties not established in a new catchment area by a specified date would be placed into catchment area(s) established by state leadership.

[94] eCFR :: 7 CFR Part 246 -- Special Supplemental Nutrition Program for Women, Infants and Children

[95] Iowa Code, Chapter 137

[96] Iowa Code, §137.102

[97] Iowa Code, §137.103-104

[98] Iowa Department of Health and Human Servies, Division of Public Health Division of Public Health. *Iowa's Local Governmental Public Health System: A Report on the Results of the 2022 Local Public Health Systems Survey*. (Hereinafter, "2022 Local Public Health Survey Report"). Page 19. Available at: https://hhs.iowa.gov/sites/default/files/idphfiles/PHSS-Report-Final-4-26-23.pdf. April 2023. Accessed October 19, 2023.

[99] Ibid.

[100] 2022 Local Public Health Survey Report, p.12.

[101] Iowa Code, §137.105.

[102] Iowa Medicaid. Local Public Health Services Program Proposed Program Changes, October 2021 slide deck.

[103] 2022 Local Public Health Survey Report, p. 29.

[104] Trust for America's Health. The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2023. Available at: https://www.tfah.org/report-details/funding-2023/. Accessed October 20, 2023.

[105] 2022 Local Public Health Survey Report, p.24.

[106] Zoom meeting with Erin Barkema, Community Health Consultant, September 15, 2024.

[107] 2022 Local Public Health Survey Report, p.25.

[108] Iowa Legislature. Senate File 561. Enacted June 1, 2023. Available at: https://www.legis.iowa.gov/legislation/BillBook?ba=SF561&ga=90. Accessed October 20, 2023.

[109] Local Public Health Services Program Proposed Program Changes, October 2021 slide deck.

[110] Email from Erin Barkema, Public Health Systems Project Manage, August 17, 2023.

[111] Committee on Public Health Strategies to Improve Health, Institute of Medicine. *For the Public's Health: Investing in a Healthier Future*. Washington (DC): National Academies Press (US). April 10, 2012:page 27. Available at: https://www.ncbi.nlm.nih.gov/books/NBK201010/. Accessed October 20, 2023.

[112] Ibid at p. 51.

[113] 2022 Local Public Health Survey Report, p.15.

[114] 2022 Local Public Health Survey Report, Appendix B, Structure B, p. 3.

[115] The capabilities queried were derived from the nationally-recognized Foundational Public Health Services framework for governmental public health that was developed in 2013 to define a minimum package of public health capabilities and programs that no jurisdiction should be without. (See 2022 Local Public Health Survey Report, p.31.)

[116] Centers for Disease Control and Prevention (CDC), Office of Readiness and Response. Emergency Preparedness Funding. Available at: https://www.cdc.gov/orr/epf/index.htm. Accessed October 20, 2023.

[117] Ibid.

[118] Ibid.

[119] Administration for Strategic Preparedness & Response. Hospital Preparedness Program (HPP) Cooperative Agreement Funding. Available at: https://aspr.hhs.gov/HealthCareReadiness/HPP/Documents/FY-2023-HPP-Funding-Table.pdf. Accessed October 20, 2023.

[120] Ibid

[121] "Emergency Support Functions (ESFs) is the grouping of governmental and certain private sector capabilities into an organizational structure to provide support, resources, program implementation, and services that are most likely needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal following domestic incidents." From Office of the Assistant Secretary for Preparedness and Response. Emergency Support Functions. Available at: https://www.phe.gov/Preparedness/support/esf8/Pages/default.aspx. Accessed October 20, 2023.

[122] 2022 Local Public Health Survey Report, p. 13.

[123] Iowa Senate. Senate File 561-Enrolled 2023, Division IV, Section 5(7)(d). Available at: https://www.legis.iowa.gov/docs/publications/LGE/90/SF561.pdf. Accessed October 20, 2023.

[124] Iowa Department of Health and Human Services, Division of Public Health. Childhood Lead Poisoning Prevention Program, Application Guidance for State Fiscal Years 2024−26. Available at: https://iowagrants.gov/fileDownloadExternal.do?filename=1682449412847_A.+FY24+Application+Guidance+for+Childhood+Lead+Poisoning+Prevention+Program+CLPPP.pdf. Accessed October 20, 2023.

[125] Iowa Legislature. Iowa Code Section 455E.11.2.b(2)(b). Available at: https://www.legis.iowa.gov/docs/code/455E.11.pdf. Accessed October 20, 2023.

[126] Iowa Health and Human Services, Division of Public Health, Bureau of Environmental Health Services. Grants to Counties: Application Guidance for the August 1, 2023−June 30, 2024, Grant Period. Available at: https://www.iowagrants.gov/fileDownloadExternal.do?filename=1687980764651_A.+FY24+Grants+to+Counties+Application+Guidance.docx.pdf. Accessed October 20, 2023.

[127] Senate File 561-Enrolled 2023, Division IV, Section 5(7)(c).

[128] Centers for Disease Control and Prevention. CDC Fiscal Year 2022 Grants Summary Profile Report for Iowa. Available at https://fundingprofiles.cdc.gov/Report_Docs/PDFDocs/Rpt2022/Iowa-2022-CDC-Grants-Profile-Report.pdf. Accessed October 20, 2023.

[129] Iowa Department of Health and Human Services, Bureau of Environmental Health Services. Environmental Public Health Tracking Program. Available at: https://hhs.iowa.gov/Environmental-Health-Services/Environmental-Public-Health-Tracking. Accessed October 20, 2023.

[130] Hoornbeek J, Morris M, Libbey P, Pezzino G. Consolidating Local Health Departments in the United States: Challenges, Evidence, and Thoughts for the Future. *Public Health Reports*. 2019;134(2):103−108. doi: 10.1177/0033354919829054.

[131] National Association of County & City Health Officials. 2019 National Profile of Local Health Departments (hereinafter 2019 NACCHO LHD Profile). Available at: https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf. Accessed October 20, 2023.

[132] Arkansas Department of Health. About ADH. Available at:

https://www.healthy.arkansas.gov/about-the-arkansas-department-of-health. Accessed October 20, 2023.

[133] Harker L. Make Public Health a Priority in Georgia During the COVID-19 Pandemic and Beyond. Georgia Budget & Policy Institute. June 8, 2020. Available at:

https://gbpi.org/make-public-health-a-priority-in-georgia-during-the-covid-19-pandemic-and-beyond/. Accessed October 20, 2023.

[134] Kansas Public Health Collaborative. Public Health in Kansas. Available at:

https://kphcollaborative.org/public-health-kansas/. Accessed October 20, 2023.

[135] Idaho Department of Health & Welfare. Public Health Districts. Available at: https://healthandwelfare.idaho.gov/health-wellness/community-health/public-health-districts. Accessed October 20, 2023.

[136] Indiana Department of Health. Health First Indiana (HFI): A State Investment in Local Public Health. Updated September 15, 2023. Available at: https://www.in.gov/health/files/23_GPHC-60-40.pdf. Accessed October 20, 2023.

[137] Minnesota Department of Health. Minnesota's Public Health System: History and Context. Updated December 12, 2022. Available at: https://www.health.state.mn.us/communities/practice/about/history.html. Accessed October 20, 2023.

[138] Local Public Health Association of Minnesota. An Overview of Minnesota's Local Public Health System. Available at: https://cms6.revize.com/revize/lpham/Overview%20of%20LPH%20System%20-%202023%20Report%20-%20DRAFT.pdf. Accessed October 20, 2023.

[139] Minnesota Department of Health. Find a Local or Tribal Health Department of Community Health Board. Updated March 30, 2023. Available at:

https://www.health.state.mn.us/communities/practice/connect/findlph.html. Accessed October 20, 2023.

[140] According to Wikipedia, Nebraska's Dakota County borders both South Dakota and Iowa, had a population of 21,582 in 2020, and is part of the Sioux City, IA, metropolitan statistical area. For details, go to:

https://en.wikipedia.org/wiki/Dakota_County,_Nebraska.

[141] Spears M. Tennessee's Public Health Infrastructure. The Sycamore Institute. September 13, 2020. Available at: https://www.sycamoreinstitutetn.org/public-health-infrastructure-tennessee/. Accessed October 20, 2023.

[142] Texas Health and Human Services, Department of State Health Services of Regional and Local Health Operations. Available at: https://www.dshs.texas.gov/regional-local-health-operations.

[143] 2019 NACCHO LHD Profile, p. 21.

[144] Hoornbeek J, Morris M, Libbey P, Pezzino G. Consolidating Local Health Departments in the United States: Challenges, Evidence, and Thoughts for the Future. *Public Health Reports*. 2019;134(2):103−108. doi: 10.1177/0033354919829054.

[145] Mays GP, McHugh MC, Shim K, Perry N, Lenaway D, Halverson PK, Moonesinghe R. Institutional and Economic Determinants of Public Health System Performance. *American Journal of Public Health*. 2006;96(3):523-531. doi: 10.2105/AJPH.2005.064253

[146] As of June 30, 2022, Nebraska had 18 local health departments, covering 92 counties in Nebraska. One county (Dakota) has a single county health department. For details, go to: https://dhhs.ne.gov/Reports/Health%20Care%20Funding%20Act%20LB%20692%20Annual%20Report%20-%202022.pdf.

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Officer if isolation, quarantine, or emergency legal measures are required. The County Health Officer participates in the development and review of local emergency plans and serves as a local spokesperson to the media, general public, and medical community in the event of a public health emergency." For details, go to https://www.healthy.arkansas.gov/county-health-officers#:~:text=The%20County%20Health%20Officer%20serves,health%20education%20and%20promotion%20initiatives.

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[152] See Minn. Stat. Section 145A.05 for permitted local public health ordinances.

[153] Minnesota requires each CHB to include 30,000+ population within its jurisdiction or be composed of three or more contiguous counties. For details, go to: https://www.health.state.mn.us/communities/practice/about/history.html.

[154] Respondents were permitted to identify multiple affiliations. The percent displayed is based on the total number of respondents (i.e., 485).

[155] Respondents were permitted to identify multiple affiliations. The percent displayed is based on the total number of respondents (i.e., 485).

[156] Respondents were permitted to identify multiple affiliations. The percent displayed is based on the total number of respondents (i.e., 252).

[157] Respondents were permitted to identify multiple affiliations. The percent displayed is based on the total number of respondents (i.e., 123).

[158] Respondents were permitted to select up to three responses. Therefore, all percents displayed are based on the total number of survey respondents.

[159] Respondents were permitted to select up to three responses. Therefore, all percents displayed are based on the total number of survey respondents.

[160] Respondents were permitted to select up to two responses. Therefore, all percents displayed are based on the total number of survey respondents.

[161] Only three of the eight respondents who selected "other" included a narrative response.