Iowa

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 09/04/2025 9.38.15 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	S47QLSY37VS1

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

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

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

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

State CMHS Unique Entity Identification

Unique Entity ID	Q7P9B28J8BY4

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

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

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

First Name	Marissa
Last Name	Eyanson
Agency Name	Iowa Department of Health and Human Services
Mailing Address	321 E. 12th St.
City	Des Moines
Zip Code	50319
Telephone	515-256-4662
Fax	
Email Address	marissa.eyanson@hhs.iowa.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? (•) Yes ( ) No

First Name

Last Name	
Agency Name	Iowa Primary Care Association
Mailing Address	500 SW 7th Street, Suite 300
City	Des Moines
Zip Code	50309
Telephone	515-244-9610
Fax	
Email Address	info@iowapca.org

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

From

To

V. Date Submitted

Submission Date	8/28/2025 10:01:27 AM
Revision Date	8/28/2025 10:01:51 AM

VI. Contact Person Responsible for Application Submission

First Name	Justin
Last Name	Edwards
Telephone	515-214-3693
Fax	
Email Address	justin.edwards@hhs.iowa.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
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Section 1935	Core Data Set	**42 USC § 300x-35**
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Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: Director - Iowa Department of Health and Human Services

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

August 4, 2023

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

To Whom It May Concern:

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

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

Please contact my office if additional information is needed.

Sincerely,

Kim Reynolds
Governor

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
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as authorized by
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State: _____

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

Signature of CEO or Designee[1]: Kelly Garcia

Title: Director

Date Signed: 08/15/2025
mm/dd/yyyy

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

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to

all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

August 4, 2023

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

To Whom It May Concern:

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

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

Please contact my office if additional information is needed.

Sincerely,

Kim Reynolds
Governor

FY26 Mental Health Block Grant (MHBG) Supplemental Funding Plan-Bipartisan Safer Communities Act (BSCA)-4th allotment

The state was allocated $628,259 in Community Mental Health Block Grant funds from the BSCA. The expenditure period for the funds is 9/30/2025-9/29/2027. The state is required to follow existing federal requirements for use of the MHBG including the 10% set-aside for Early Serious Mental Illness and 5% set aside for crisis services.

1. Proposed expenditures for the 10% ESMI/FEP set aside:

Activities	Budget
The state plans to use the additional funds for expansion of an existing NAVIGATE team to serve an expanded service area. Funding will pay for team training and operations during the first and second years of operation.	**$220,000**
Total Category 1	**$220,000**

2. Proposed expenditures for the 5% crisis set aside:

Activities	Budget
Technical assistance and implementation of crisis services and supports as a result of a study of the statewide crisis system and the implementation of the state's Behavioral Health Alignment initiative. Services to be implemented are expected to include centralized dispatch for mobile crisis and mobile crisis services compliant with CCBHC criteria and SAMHSA best practices.	**$250,000**
Total Category 1	**$250,000**

3.Support for Disaster Behavioral Health Team

Activities	Detail	Budget
Continued support for the statewide disaster behavioral health response team in their role as the point of contact for guidance and direction related to any anticipated or unanticipated disaster behavioral health crisis.	SMHA staff currently coordinate a statewide volunteer disaster behavioral health response team (DBHRT) that provides immediate, short-term response to natural disasters and traumatic events for adults with a serious mental illness, children with a serious emotional disturbance and other Iowans.. The state proposes to use this funding to continue to recruit new volunteers, train and organize teams, and develop systems for deployment and tracking of the teams.	**$158,259**
Total Category 1		**$220,000**
Total Category 2		**$250,000**
Total Category 3		**$158,259**
Total All		**$628,259**

State Information

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

Fiscal Year 2026

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

Title XIX Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grant to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 U.S.C. 300x-9**
Section 1920	Crisis Services	**42 U.S.C. 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial, and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91- 616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C.

   §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act

of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

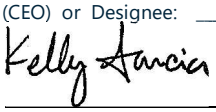
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or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

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

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

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

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

Signature of CEO or Designee[1]: 

Title: Director

Date Signed: 08/15/2025

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 01/8/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

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

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Statewide Behavioral Health System Organization

On May 15, 2024, House File 2673 was signed, combining mental health and substance use services into one Behavioral Health Service System. The new system launched on July 1, 2025. Behavioral health service system alignment activities involved the organization of local behavioral health districts, the procurement of a behavioral health administrative service organization (BH-ASO), and the formation of local advisory councils. The new system is a transition from Iowa's 32 separate mental health and substance use service regions across multiple legacy service systems, to a singular map with 7 distinct districts which encompass all behavioral health safety-net resources within.

On December 13, 2024, Iowa HHS announced the selection of the Iowa Primary Care Association (Iowa PCA) to serve in a statewide capacity as the Administrative Service Organization for the state's redesigned Behavioral Health System. Iowa PCA is responsible for ensuring all Iowans have clear, consistent pathways to care and the support they need within each behavioral health district. They will do this by instilling a unified operational approach for each of the seven districts and contracting with Community Based Organizations. Additionally, they will meet regularly with local leaders, school officials, law enforcement, health care providers and public health professionals to discuss behavioral health needs at a local level and ensure the state's Behavioral Health Service System is adapting and meeting those needs.

State Administered Behavioral Health Services

Within the Behavioral Health continuum, The Iowa Department of Health and Human Services (Iowa HHS) has maintained direct oversight of safety-net Mental Health Treatment, Substance Use & Problem Gambling Treatment, Crisis Services, and the Center of Excellence for Behavioral Health. Service recipient eligibility for these services includes being uninsured or underinsured and having an income which is less than or equal to 200% the federal poverty level. The service system outlined in question 1 is not inclusive of the Medicaid or Certified Community Behavioral Health Center (CCBHC) systems, which are discussed in question 2. Iowa HHS refers to providers participating in either state administered safety-net services or the BH-ASO model as Community Based Organizations (CBOs).

Mental Health Treatment

Mental health treatment in Iowa is provided through a network of state-accredited community mental health centers, certified community behavioral health clinics, and mental health service providers, as well as state-licensed mental health counselors, social workers, psychologists and therapists. Inpatient care is provided through 2 state mental health institutes and a network of private inpatient psychiatric units within hospitals as well as two freestanding psychiatric facilities. The SMHA is the accrediting body for community mental health services and other mental health service provider organizations. Individual practitioners are licensed through the Iowa Department of Inspections, Appeals and Licensing.

Substance Use Disorder & Problem Gambling Treatment

The Iowa HHS Division of Behavioral Health licenses providers to offer a broad spectrum of substance use and problem gambling treatment services which align with the American Society of Addiction Medicine (ASAM) 3rd Edition criteria and the 5th edition Diagnostic and Statistical Manual of Mental Disorders (DSM). These services include the ASAM 1.0, 2.1, 2.5, 3.1, and 3.5 levels of care. The Iowa Board of Certification serves as the credentialing body for substance use disorder treatment clinicians and offers certifications which are IC&RC reciprocal. Iowa HHS intends to initiate a statewide transition to the ASAM 4th Edition criteria starting in State Fiscal Year 2026.

Crisis Services

Crisis services are provided to individuals experiencing a behavioral health crisis and are aimed at assessment and intervention to stabilize the individual's level of functioning and refer the individual on to any needed services and supports. Crisis services are not subject to financial eligibility requirements and are available to any Iowa resident who needs them. Safety-net crisis service availability includes mobile response, crisis evaluation (including crisis screening and assessment), residential crisis stabilization, community-based crisis stabilization, and 23-hour observation and holding. Iowa's statewide 988 system provided by 2 Iowa 988 centers helps connect individuals in crisis to mobile crisis and other behavioral health and community supports.

Center of Excellence for Behavioral Health

Iowa HHS competitively selected University of Iowa to administer the Center of Excellence for Behavioral Health (CEBH), which began in April of 2022. The CEBH mission is to support and promote the use of centralized standards and best practices to advance behavioral health services for individuals with serious mental illness, serious emotional disturbances, and co-occurring conditions. CEBH provides training, technical assistance, and fidelity monitoring for entities responsible for developing and implementing evidence-based practices for individuals with serious mental illness, serious emotional disturbance, and co-occurring conditions. CEBH currently focuses on providing technical assistance to behavioral health service providers and stakeholders who provide Assertive Community Treatment (ACT), Individual Placement & Support (IPS) and Prevention/ Promotion activities including Suicide Prevention.

Behavioral Health Administrative Services Organization

As an instrumentality of the state, Iowa Primary Care Association (Iowa PCA) administers safety-net Substance Use Prevention, Mental Health Promotion, Early Intervention, and Crisis Access continuum areas, as well as System Navigation services. Iowa PCA will also provide monitoring, conveyance, training, and technical assistance for the continuum areas it administers. Funding for the BH-ASO and its behavioral health contracts are primarily state appropriations, however some MHBG and SUTPRS-BG funds are administered as well.

Substance Use Prevention

Prevention CBOs raise awareness of Iowa's behavioral health system through local collaboration and community engagement, provide substance misuse and problem gambling prevention services through a streamlined action plan. Prevention CBOs also work closely with tobacco prevention CBO's, mental health promotion organizations and coalitions. Substance misuse prevention strategies are provided based on the Center for Substance Abuse Prevention (CSAP) strategies and the Institute of Medicine (IOM) categories. CBOs will collectively create substance misuse prevention action plans for all 99 Iowa counties which outline approaches to prevention aligning with the unique needs of each county. Prevention CBOs are also required to engage in local coalitions to ensure the voices of people with lived experience, their loved ones and caregivers, and community stakeholders are centered in the development of prevention action plans. Mental Health promotion is held out as a new focus within Iowa HHS's new behavioral health system and is being actively developed.

Early Intervention

Early intervention are interventions, services and support to at-risk individuals to address early symptoms and prevent the development of behavioral health disorders. This includes identifying problems and offering referrals to reduce impact and improve well-being. Early intervention is a core component of Iowa's Behavioral Health Service System Statewide Plan. Iowa HHS's strategies for early intervention include: creating and supporting an integrated, statewide behavioral health early intervention

system to assist individuals, families, and communities in accessing behavioral health interventions and services; helping early intervention partners increase their behavioral health knowledge and skills; embedding low barrier access through System Navigation and expanding the behavioral health early intervention referral system; and creating and following an integrated, statewide approach to behavioral health early intervention activities. Access points for early intervention services include the BH-ASO System Navigators and Your Life Iowa.

Crisis Access

While direct services are funded via the SNMIS system, certain activities which support the development, expansion, and operation of Iowa's behavioral health crisis system are supported via BH-ASO contract agreements. "Access Funds" allowable costs are designed to be congruent with SAMHSA's Capacity Building & System Development budgeting categories, although Iowa's funding allocation is a blend of state and federal funds.

System Navigation

System Navigation is a non-crisis, but time-sensitive response service that helps individuals and those supporting them – their family members, caregivers, professionals, and community members – understand, access, and connect with behavioral health supports and services across Iowa. System Navigators do not provide clinical assessment, treatment, medication prescriptions or counseling services. Instead, they help people better understand their options and get connected to what is needed. System navigators may be positioned locally within a community or serve groups of counties (districts) remotely. System Navigation services are confidential and include information and education, referrals to behavioral health providers, assistance with obtaining Medicaid coverage, and assistance in finding residential treatment (mental health and substance use) beds, if needed. System navigation services are available to all Iowans free of charge.

Safety-Net Claims & Invoicing

Eligible behavioral health treatment services may be billed to the Safety Net Management Information System (SNMIS). SNMIS was developed as an adjacent line of business within the Medicaid Management Information System (MMIS), which facilitates Medicaid billing. SNMIS was designed with providers in mind who have historically served individuals qualifying for Medicaid. SNMIS has similar protocols for enrollment and electronic claim submission as Iowa Medicaid, which reduces administrative overhead involved with billing compared to Iowa HHS's historical "granting" model in various legacy behavioral health service systems. For behavioral health continuum areas administered by the BH-ASO, participating providers enter into a contract agreement with Iowa PCA. Billing for allowable activities within the BH-ASO model occur via invoicing and are monitored by Iowa PCA along with Iowa HHS oversight. Funding for behavioral health treatment services is a blend of state appropriations, MHBG, and SUPTRS-BG funding.

Certified Community Behavioral Health Clinics

On June 4, 2024, SAMHSA announced that Iowa was one of ten states selected to join the new cohort of Certified Community Behavioral Health Clinic (CCBHC) Demonstration programs for fiscal year 2025. Iowa's CCBHC Demonstration began July 1, 2025. Ten providers have received state certification as a CCBHC (map attached). CCBHCs are specially designed clinics that provide a comprehensive range of mental health and substance use services. CCBHCs serve anyone who walks through their doors, regardless of diagnosis or insurance status. CCBHCs must meet certification criteria and must provide or coordinate nine core services, including: crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization; screening, assessment, and diagnosis including risk assessment; patient-Centered treatment planning or similar processes, including risk assessment and crisis planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support, counseling services, and family support services; and intensive community-based mental health care for members of the armed forces and veterans. Iowa CCBHCs incorporate a wide array of standards including getting people into care quickly, ensuring access to 24/7 crisis services, serving all individuals regardless of diagnosis or insurance status, and providing comprehensive care coordination for navigating behavioral health, primary care, social services, and other needs.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

The Iowa Department of Health and Human Services (Iowa HHS) is under the leadership of Director Kelly Garcia. Marissa Eyanson, who reports to Kelly Garica, is the state Behavioral Health Director and the designated State Mental Health Authority (SMHA). DeAnn Decker, who reports to Marissa Eyanson, is the Deputy Directory of Services, Planning, and Performance, and is the

designated Single State Authority (SSA) for Substance Use Prevention, Treatment, and Recovery Services. Mental health and substance-related programs are housed together under the Division of Behavioral Health (DBH).

Medicaid

Iowa's Medicaid programs including Iowa Health Link, Iowa Health and Wellness Plan (IHAWP), and Healthy and Well Kids in Iowa (Hawki) provide free or low-cost health insurance coverage to Iowans with limited resources to ensure they can receive outpatient, inpatient, and residential behavioral health that is tailored to their needs. Effective Medicaid benefit design for behavioral health contributes to improved outcomes and is part of Iowa's comprehensive approach to improving the health status of all Iowans.

Aging and Disability Services

Aging and Disability Services provides connection and care to ensure that Iowans who experience challenges related to aging or disability can live in the home and community of their choice. Through Aging and Disability Resource Centers (ADRCs), older Iowans, people with disabilities and their families and caregivers can learn about long-term services and supports and find connection to behavioral health services.

Family Well-Being and Protection

Family Well-Being and Protection is dedicated to ensuring Iowa's children and families are safe, healthy, stable, and equipped to build and sustain positive relationships. Child Protective Services (CPS) and programs such as Family Centered Services (FCS) connect families to evidence-based behavioral health services that build on strengths, change unhealthy patterns, and provide trauma-informed, focused care to build healthy, supportive family environments.

Public Health

Public Health (PH) works with state and local partners to address health priorities, including behavioral health, by reducing health disparities, promoting healthy behaviors, and preventing disease. PH and behavioral health professionals work collaboratively to engage communities in prevention and early intervention efforts to decrease the impact of behavioral health conditions and improve the resiliency and overall health and well-being of Iowans.

State-Operated Specialty Care

Iowa's Mental Health Institutes (MHIs) provide specialized inpatient psychiatric care for children, youth, and adults with significant needs. Multi-disciplinary teams of doctors, nurses, social workers, and specialists support planning and treatment services including medication, psychotherapy, group counseling, and activities therapies. MHIs are a critical piece of the behavioral health continuum of care working to ensure Iowans receive care in the least restrictive setting possible and enabling Iowans to safely return to their home and community.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Behavioral Health Providers

The Iowa Department of Health and Human Services (Iowa HHS) functions as both the SMHA and SSA. Mental Health and Substance Use Prevention, Treatment, and Recovery Services are provided via the Iowa HHS Division of Behavioral Health. Options for Individuals with mental health, substance use, or co-occurring mental health and substance use disorders to access integrated behavioral health services continue to increase in Iowa. Iowa currently has 26 accredited community mental health centers, and 109 licensed substance use disorder treatment programs. 16 of Iowa's licensed SUD Treatment providers are SUPTRS-BG Designees, and 4 of those SUPTRS-BG designees specialize in services for pregnant and parenting women. As a participant in the CCBHC Demonstration, Iowa will have increased opportunities to promote integrated behavioral health services in Iowa.

District Advisory Councils

In addition to providing administrative oversight of the new Behavioral Health network, Iowa PCA has established a District Advisory Council (DAC) for each of Iowa's seven behavioral health districts. DACs identify opportunities, address challenges, and advise the BH-ASO. Each DAC contains ten members. Three members must be elected public officials. Three members must be individuals with lived/living behavioral health experience. Three members must be individuals who have experience or education related to core behavioral health functions. The final member must be a representative of law enforcement. Public engagement is encouraged at all convenings of each DAC.

Integrated Health Planning and Advisory Council (I-PAC)

I-PAC is a state advisory body authorized by federal law (42 U.S.C. Section 300x) and required as a condition for the receipt of federal Community Mental Health Services Block Grant funding. I-PAC's mission is to assess and promote the strengths of the Mental Health System while advising and advocating for system improvements to ensure peer supported, community-based, culturally competent, person-centered, family-driven, and evidence-based service alternatives are available to all Iowans. I-PAC's vision is that All Iowans have access to comprehensive mental health services and supports, hope for recovery, and resilience within the community of their choice. In alignment with Iowa HHS's decision to submit a combined block grant application, I-PAC has begun to review and advise on the SUPTRS Block Grant application content. As requested by the council, an expanded description was included in the attachments to this component.

State Epidemiological Workgroup & Prevention Partnerships Advisory Council (SEWPPAC)

Iowa's SEWPPAC aims to build prevention capacity and strengthen infrastructure at the state and local levels, serving as the State Epidemiological Outcomes Workgroup (SEOW). SEWPPAC discusses substance use data, trends, and data gaps to improve services, and directs the State Epidemiological Profile, data briefs, and other data collection and review processes. SEWPPAC supports and promotes evidence-based prevention programs, policies, and practices, and shares information and resources to support state and local prevention efforts. SEWPPAC is comprised of 45 state and local members from across Iowa representing a variety of organizations. SEWPPAC meets on a quarterly cadence and corresponds frequently as needed.

Youth Justice Council (YJC)

The Youth Justice Council is composed of young people between the ages of 16-28 who have lived juvenile justice experience. YJC creates their own priority areas and projects, provides recommendations to the Juvenile Justice Advisory Council, and advances youth engagement efforts within the juvenile justice system in Iowa. The Youth Justice Council solicited input from nearly 500 youth through the Talking Wall project. They coupled that information with their own lived expertise to develop their 2025 Action Plan. The YJC Action Plan priorities are supporting youth where they are, reimagining mental health and health supports for youth in the juvenile justice system, enhancing the quality of life for youth in the juvenile justice system, preventing youth from entering the juvenile justice system, and championing needed legislative changes.

State of Iowa Youth Advisory Council (SIYAC)

The purpose of The State of Iowa Youth Advisory Council (SIYAC) is to foster communication among a group of engaged youth from across Iowa between the ages of 14 and 20 and the governor, general assembly, and state and local policymakers regarding programs, policies, and practices affecting youth and families; and to advocate for youth on important issues affecting youth. SIYAC was originally established in 2001 by Governor Tom Vilsack as a way to inform legislators and policymakers on issues important to youth. In 2009, SIYAC was established in Iowa Code 216A.140(8) under the Department of Human Rights, Iowa Collaboration for Youth Development. These youth leaders are selected to represent all Iowa youth and engage in topics important to young Iowans, including a subcommittee on mental health. Concerns are drafted and shared with policy makers during the legislative session.

988 & Your Life Iowa

Iowa has two 988 Crisis Centers, CommUnity Crisis Services and Foodbank (CommUnity) and Foundation 2 Crisis Services (Foundation 2), that provide 24/7 crisis call, chat, and text services. Foundation 2, an Iowa-based nonprofit human service agency, is the statewide primary center for calls and CommUnity is staffing to answer the majority of chats and texts originating from Iowa.

When further support is needed, the crisis counselors can connect individuals with local resources such as mobile crisis which dispatches crisis teams to respond in-person.

Foundation 2 also administers the Your Life Iowa (YLI) web and phone/text platforms. Launched in October 2017 and expanded in December 2019, YLI is the trusted go-to 24/7 resource for Iowans when they have a question or concern about gambling, mental health, substance use, suicide or a related concern. YLI is the result of combining three previously distinct websites and their helplines into a single project with one vendor: 1-800-BETS OFF, the DrugFreeInfo.org website and helpline, and the Suicide and Bullying Prevention Help/Text lines. YLI resources include a plethora of behavioral health resource information, the "Find Help Near You" locator, and a live chat feature within the website (YourLifeIowa.org). YLI also offers 24/7 call and text support.

Education

In 2020, Iowa Code expanded access to behavioral health services for students by allowing telehealth in school settings. The legislation also allowed school districts, accredited non-public schools, and Area Education Agencies to contract with licensed behavioral health providers to conduct in-person, universal behavioral health screenings, which aids in expanding early intervention for our youth. Ongoing collaboration expanding behavioral health services is necessary for Iowa's youth.

Housing and Homelessness

Sixty-seven percent (67%) of people experiencing homelessness have a behavioral health disorder. Several grant programs and services in Iowa aim to improve access to care for people experiencing homelessness. Most are facilitated by community service organizations and funded through state agencies, such as the Iowa Finance Authority and Iowa HHS. Iowa HHS oversees the PATH grant to assist individuals with a serious mental illness who are also experiencing homelessness. These programs support adults who are homeless and by offering connection to hope, healing, housing, treatment and recovery.

Judicial

Individuals involved in the criminal justice system overwhelmingly present needs related to behavioral health, about 1/3 have a history of mental health disorder and about 3/5 have a substance use disorder. For many people, they learn about their behavioral health condition after they become involved in the judicial system. This speaks to the importance of building prevention, earlier intervention and clear pathways to care.

Law Enforcement

The intersection between our law enforcement system and the behavioral health continuum is significant. It is estimated that 20% of police calls involve a mental health or substance use crisis. Expanding current state and local efforts to intercept and support people in crisis, create access points, and build connections between systems is essential and enhances safety for individuals, families, and communities across Iowa.

Private Insurance

Most Iowans receive health services covered by their private (such as employer-sponsored) health insurance. Iowa Code requires larger employers to cover services for certain behavioral health conditions for fully insured plans but does not require smaller plans to cover any behavioral health treatment. Iowans who are uninsured or underinsured may rely on free or reduced cost behavioral health services through the state's behavioral health safety net service providers.

Veterans Affairs

Iowa has two Veterans' Administration (VA) health centers in Iowa City and Des Moines that provide comprehensive behavioral health for veterans. Iowa veterans are also served by VA systems in Omaha, NE and Sioux Falls, SD. The VA system connects veterans and families with providers in their communities to ensure access to care and services. VA staff also partner with communities throughout Iowa to develop local suicide prevention coalitions for veterans and all Iowans.

MHBG Populations Served

Iowa distributes a portion of MHBG funds to the state's community mental health centers who are required to serve adults with an SMI and children with an SED through provision of evidence-based practices and other community-based services including peer support/family peer support, consultation and education, and support for individuals to receive mental health treatment who are uninsured or underinsured. For required set-asides, Navigate teams are funded for early serious mental illness (ESMI) and crisis system initiatives are funded. Other funded programs provide peer support services, peer support training, and children's system of care services.

SUPTRS Populations Served

Historically, CBO adherence to the SUPTRS Block Grant regulations related to serving priority populations were included in the Integrated Provider Network (IPN) grant contract agreement. Although the IPN grant has sunset, these contract terms were retained within CBO contract agreements with the BH-ASO. All former IPN contractors, now recognized as "SUPTRS Designees," have opted to continue serving as safety-net providers in Iowa's new behavioral health service system. As a result, all SUPTRS designees adhere to the SUPTRS Block Grant regulations on timely access standards for persons who inject drugs (45 CFR 96.126) and Pregnant Women & Women with Dependent Children (45 CFR 96.131). In addition, all SUPTRS Designees offer Tuberculosis risk screening (45 CFR 96.127), and follow all applicable Iowa Code requirements for referral, testing, care, and reporting (641 IAC 155).

Iowa HHS continues to recognize four SUPTRS Designees who specialize in providing services for pregnant and parenting women. These four providers offer Residential SUD Treatment services (ASAM levels 3.1 and 3.5) for pregnant women and women with dependent children, as well as enhanced/ancillary access services per 45 CFR 96.124(e) (1-5).

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

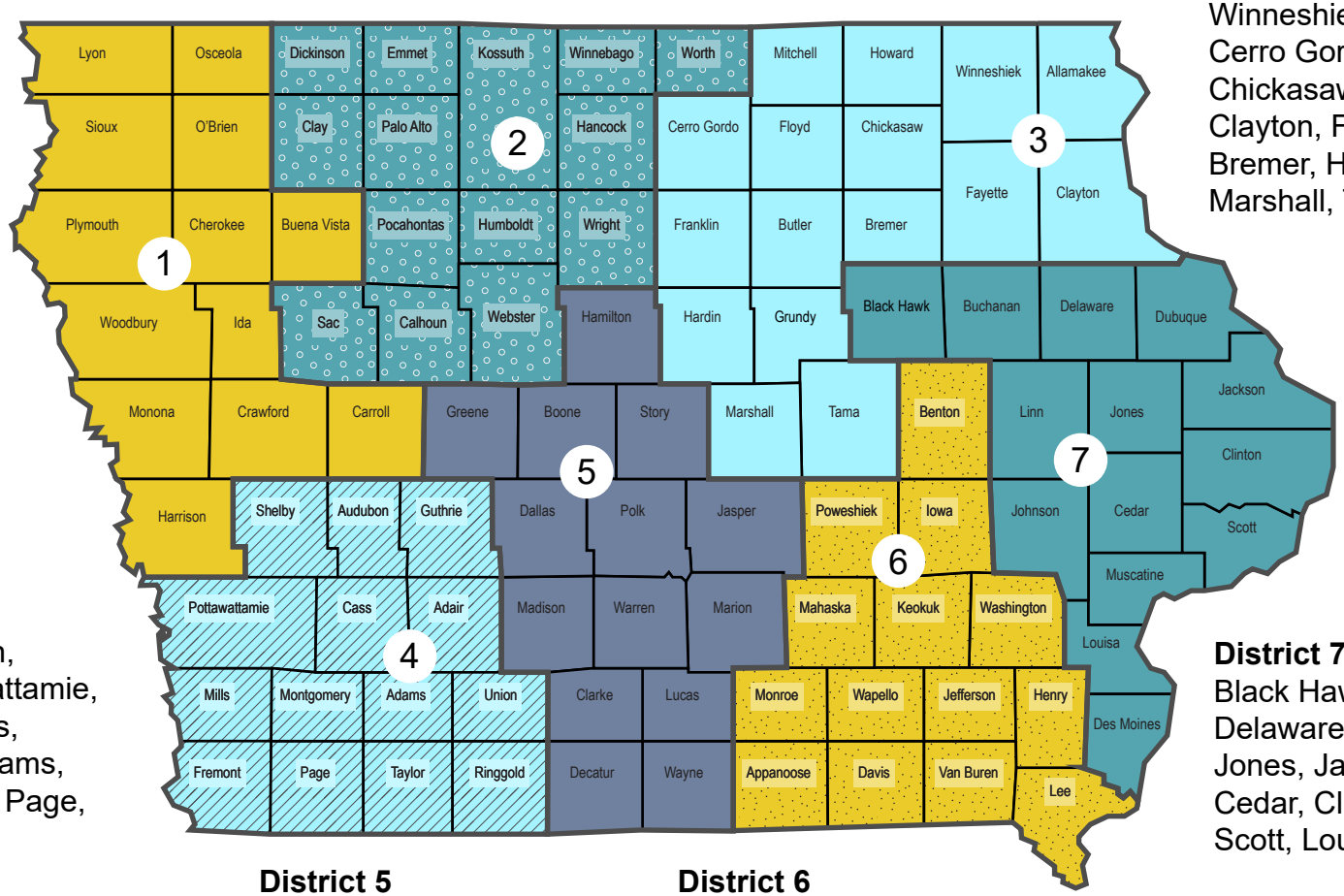
IOWA | Health and Human Services

Behavioral Health Districts

District 2
Dickinson, Emmet, Kossuth, Winnebago, Worth, Clay, Palo Alto, Hancock, Pocahontas, Humboldt, Wright, Sac, Calhoun, Webster

District 3
Mitchell, Howard, Winneshiek, Allamakee, Cerro Gordo, Floyd, Chickasaw, Fayette, Clayton, Franklin, Butler, Bremer, Hardin, Grundy, Marshall, Tama

District 1
Lyon, Osceola, Sioux, O'Brien, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Monona, Crawford, Carroll, Harrison



District 4
Shelby, Audubon, Guthrie, Pottawattamie, Cass, Adair, Mills, Montgomery, Adams, Union, Fremont, Page, Taylor, Ringgold

District 5
Hamilton, Greene, Boone, Story, Dallas, Polk, Jasper, Madison, Warren, Marion, Clarke, Lucas, Decatur, Wayne

District 6
Benton, Poweshiek, Iowa, Mahaska, Keokuk, Washington, Monroe, Wapello, Jefferson, Henry, Appanoose, Davis, VanBuren, Lee

District 7
Black Hawk, Buchanan, Delaware, Dubuque, Linn, Jones, Jackson, Johnson, Cedar, Clinton, Muscatine, Scott, Louisa, Des Moines

The **Iowa Integrated Health Planning and Advisory Council** (I-PAC) is a state advisory body authorized by federal law (42 U.S.C. Section 300x) and required as a condition for the receipt of federal Community Mental Health Services Block Grant funding. States are also required to submit annual applications to the Substance Abuse and Mental Health Services Administration and demonstrate compliance with federal requirements to receive block grant funds.

The I-PAC 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, State agency representatives, and other advocates with the purpose of providing input to, and evaluation and oversight of, the Iowa mental health system.

The Council is **governed** by **bylaws** developed and passed by the membership. Council members are elected to three-year staggered terms and may be reelected without term limit. **Members elect** a Chairperson, Vice-Chair, and Secretary annually. Representation on the Council is governed by federal requirements and the bylaws. Members must be Iowa residents. The membership categories are:

- **Seven** members representing the principal State agencies responsible for mental health, education, vocational rehabilitation, criminal justice, housing, social services, and the State Medicaid Agency
- **Six** members representing public or private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services
- **Six** adults in recovery who have lived experience with serious mental illness (who are receiving or have received mental health services)
- Four family members of adults with serious mental illness
- **Six** parents, guardians, or primary caretakers of children and adolescents with serious emotional disturbance
- **Four** other individuals with an interest in mental health issues

3 Additional membership requirements:

- Not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.
- In 2010 the Iowa Legislature acted to require that the membership include a military veteran who is knowledgeable concerning the behavioral and mental health issues of veterans (Iowa Code 225C.4)

The Purposes of the Iowa Integrated Health and Planning Council are:

1. To participate in the development of and subsequently review substance abuse prevention, treatment, and recovery services and mental health plans for Iowa provided to the Council pursuant to 42 USC 300X-4 (a) and to submit to the State of Iowa any recommendations of the Council for modifications to the plans;

2. To serve as an advocate for adults with serious mental illness, substance use disorder, children with serious emotional disturbance, substance use disorder, and other individuals with mental illnesses or emotional problems and/or substance use disorder;

3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health and substance prevention, treatment, and recovery services within Iowa.

I-PAC work is done through 3 types of committees – *Each I-PAC member is expected to participate in at least one committee or workgroup.*

3 - Standing Committees – required through the **Bylaws** – *each limited to 5 committee members*
Executive Board
Nominations – meets as needed to consider new applicants, monitor attendance and conduct election processes
Monitoring and Oversight – reviews state contracts for mental health and substance use services

5 - Workgroups with very **limited** and **irregular** meeting times – *no limit on # of members in each workgroup*
Orientation workgroup
Block Grant Education workgroup
Block Grant Feedback to IHHS grant writers (MH/SUD)
Bylaws/Policy/Procedures Workgroup
Steering Committee – completed strategic plan for 2025 – future years to be done when more is known about agency realignment strategic plans

6 - Workgroups with **Monthly** meetings - *no limit on # of members in each workgroup*
Children's Issues
Substance Use Disorders
Older Adults
CCBHC
Strategic Planning
Public Safety

I-PAC Vision: All Iowans have access to comprehensive mental health services and supports, hope for recovery, and resilience within the community of their choice.

I-PAC Mission: To assess and promote the strengths of the Mental Health System while advising and advocating for system improvements to ensure peer supported, community- based, culturally competent, person-centered, family-driven, and evidence-based service alternatives are available to all Iowans

Information about Council meetings and public access:

- Meetings of the Council are public meetings and are conducted in accordance with Iowa's open meetings law and rules.
- Robert's Rules of Order govern the conduct of the meeting.
- The Council has six regular meetings a year, generally scheduled on the third Wednesday of of January, March, May, July, September, and November.
- Meeting notices and other information are distributed by email about one week prior to Council meetings and posted as required by law.

For current information about Council meetings and activities, to be added to the electronic distribution list to receive meeting notices, or for information on how to apply for I-PAC membership, contact:

Patti Manna
Division of Behavioral Health
Iowa Department of Health and Human Services
Phone: 515-393-8088
Email: patti.manna@hhs.iowa.gov

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Overview of Needs Assessment Process and Responsibilities

Staff within the Division of Behavioral Health (including subject matter experts, evaluators and epidemiologists) assist with conducting and participating in state health and human services system planning processes. Examples of these planning processes include the State Health Assessment (SHA), State Health Improvement Plan (SHIP), Statewide Behavioral Health Service System Plan, and District Service System Assessment. By using national data sets to identify outcomes in our Behavioral Health Service System Statewide Plan, and linking Behavioral Health initiatives to other statewide initiatives, our Behavioral Health team is able to use a data-driven approach to ensure the needs of Iowans are the foundation to our work.

The national data sets utilized include TEDS, BRFSS, NSDUH, SUDORS, DOSE, and other relevant data sets to inform the creation of various needs assessment tools. Additional state data sources are utilized, including, but not limited to:

County Snapshots – HHS snapshots help describe health and social characteristics of populations in Iowa. Annually, HHS produces System Snapshots. These snapshots include demographic information as well as 15 key data indicators that describe social, economic, and environmental factors, as well as healthy behaviors and outcomes, including mental health and addictive disorders indicators. System snapshots are produced for the state of Iowa and each of Iowa's 99 counties.

Assessment of Crisis System - In 2024, Iowa HHS engaged Health Management Associates, Inc., (HMA) to assess Iowa's crisis

continuum of care and make recommendations to strengthen the system's design, service delivery, funding and sustainability, and, most importantly, individual experiences and outcomes.

Iowa Youth Survey - Every two years, the Iowa HHS partners with Iowa school districts to administer the Iowa Youth Survey (IYS). The IYS is an important source of data on adolescent health behaviors and experiences.

Process for Determining Service Adequacy

The Division of Behavioral Health (DBH) conducts statewide site visits to ensure adequate services are being delivered to Iowans and best practices are followed. Data team members also work with subject matter experts to design and monitor data for network and service adequacy. Public feedback is also sought through road shows, townhalls, and stakeholder meetings to further inform site visit information and data.

For targeted monitoring related to SUPTRS Block Grant regulations, DBH has historically contracted with the University of Northern Iowa's (UNI) Center for Social and Behavioral Research department. UNI has conducted "simulated calls" on a biannual cadence. Research callers utilize a variety of "personas" when contacting SUPTRS Designee providers and document their experience. Through the simulated call process, metrics including screening for pregnancy and injection drug use during the initial contact are recorded. These metrics assist DBH in understanding any barriers related to things like timely admission to SUD Treatment services for those populations. DBH finished its final round of Simulated Calls through UNI in SFY 2025 and will be developing new monitoring practices for SUPTRS Block Grant regulations, which align with Iowa's new behavioral health system, in SFY 2026.

Process for Identifying Key Gaps and Challenges in the Delivery of Quality Care and Prevention Services

Key gaps and challenges are informed by the needs assessment and adequacy processes described above within the Division of Behavioral Health. These are additionally informed by advisory councils described in Planning Step 1, including the Integrated Health Planning and Advisory Council (I-PAC), District Advisory Councils, Youth Justic Council (YCJ), State of Iowa Youth Advisory Council (SIYAC), and the State Epidemiological Workgroup Prevention Partnership Advisory Council (SEWPPAC), which serves as Iowa's State Epidemiological Outcomes Workgroup (SEOW).

SEWPPAC focuses on preventing the onset and reducing the progression of chosen priority substance misuse issues, reduce substance misuse-related problems within communities and build prevention capacity and infrastructure at the state and community levels. The work being done by this group has helped identify gaps and challenges in delivering quality care and prevention services to Iowans. While this work will continue, state Behavioral Health staff are exploring ways to strengthen the purpose and goals of SEWPPAC to better connect local communities with emerging concerns in Behavioral Health.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Statewide Needs Assessment

The statewide needs assessment processes, including the process of gathering feedback in development of a Behavioral Health Service System Statewide Plan for 2025-2027 (attached), identified three clear, consistent priorities for Iowans. These are to prioritize prevention and early intervention, improve system coordination, and improve access to behavioral health. The data guiding the Statewide Plan includes identification of the following areas of concern related to unmet needs and gaps for Suicide, Alcohol, Substance Use Treatment, Access and Overdose, and Tobacco for Iowan's including the populations served by the MHBG and SUPTRS BG.

Suicide

More adult Iowans received mental health treatment than the national average, but Iowans died by suicide at a higher rate than the U.S. overall. The 2021-2022 National Survey on Drug Use and Health (NSDUH) estimates indicated a similar proportion of Iowa and U.S. adults aged 18 and older attempted suicide, made any suicide plans, had serious thoughts of suicide, or experienced a major depressive episode in the past year. However, a higher percentage of Iowa adults reported receiving mental health treatment in the past year than the U.S. overall and the suicide mortality rates of adult Iowans were higher than the U.S. from 2018 -2023.

For Iowa youth aged 12-17, 2021-2022 NSDUH estimates indicate similar percentages of suicidality as the estimates of U.S. youth the same age. Unlike Iowa adults, the percentage of Iowa youth that reported receiving mental health treatment in the past year was similar to U.S. youth of the same age. However, suicide mortality rates among Iowa youth aged 12-17 were higher than U.S. youth of the same ages in 2019, 2021, and 2023.

Alcohol

National estimates indicate adult Iowans drink more alcohol than the U.S. overall. Iowa ranks third highest in the nation for adult binge drinking and adult Iowans died by alcohol-induced deaths at a higher rate than the U.S. The 2021-2022 NSDUH estimates that more adult Iowans used alcohol than the U.S. overall (59% of Iowans vs 52% of the U.S.). Behavioral Risk Factor Surveillance System (BRFSS) survey data from 2018-2023 indicates that more adult Iowans met criteria for heavy drinking and binge drinking than the U.S. overall. As of 2023, Iowa ranks third highest in the nation for adult binge drinking, after DC (27.1%) and North Dakota (21.2%).

Iowa's adult alcohol-induced mortality rates were also higher than the U.S. overall from 2018 to 2023 (CDC Wonder, 2025).

Substance Use Treatment, Access and Overdose

National estimates indicate that Iowa substance use was similar to the U.S. overall. However, overdose mortality rates were lower in Iowa than the U.S. The prevalence of past year and current use of illicit substances, along with past year use disorder and treatment access in Iowa were comparable to the U.S. overall for adults 18 and older, according to the 2021-2022 National Survey on Drug Use and Health (NSDUH) estimates. Similarly, Iowa youth aged 12-17 were comparable with U.S. youth for past year and current use of illicit substances as well as use disorder and treatment access.

Iowa's overdose mortality rates were almost half the U.S. rates for adults from 2018 to 2023 (CDC Wonder, 2025). However, according to the CDC's State Unintentional Drug Overdose Reporting System (SUDORS), 86% of Iowa's unintentional and undetermined overdose deaths had at least one potential opportunity for intervention in 2023.

Similarly, overdose mortality rates from 2018- 2023 among Iowa youth were low. The combined count for all overdose deaths in Iowa among youth aged 12-17 for the years of 2018- 2023 was 28, or a combined rate of 1.8, which is comparable to the U.S. rate of 2.1.

Tobacco

The 2021-2022 NSDUH estimates that almost a quarter of Iowa adults aged 18 years and older (23%) used a tobacco product in the past month, which is slightly higher than the U.S. overall (21%). In 2022 and 2023 (BRFSS, 2025), there were slightly more current cigarette smokers in Iowa than the U.S. average, and more adult Iowans reported daily smoking than the U.S. overall from 2018-2023.

In 2023, there were more adult Iowans reporting everyday e-cigarette use compared to the U.S, however, Iowans reported a higher percentage of those who have never used e-cigarettes and former e-cigarette users. Additionally, more Iowans reported using smokeless tobacco (chewing tobacco, snuff, and snus) then the U.S. overall, especially in 2022 and 2023.

Children with serious emotional disturbance (SED) and their families

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2023, it is estimated that the Iowa SED prevalence ranges from 19,144-42,116. The data is provided in a range due to SAMHSA providing prevalence estimates for children at different levels of functioning.

Based on the highest prevalence rate estimate (42,116) to data available regarding services to children with an identified SED in Iowa as of July 2025, the number of children approved for the Children's Mental Health Waiver is 1,339, which is 3.18% of the estimated Iowa SED population. The SFY25 number of children receiving System of Care services for children with an SED (including children younger than the age of 9) was 227, which is less than 1% of the estimated Iowa SED population.

Additionally, the waiting list for the Children's Mental Health Waiver has increased since the state's last MHBG application in 2023. As of July 2025, 1,150 children were on the waiting list to be considered for a slot. 552 slots are currently in the process to determine eligibility for the CMH waiver. The length of time from application to notification of slot availability is 15 months, which has increased from less than one year since the states last MHBG application in 2023.

The National Survey of Drug Use and Health, 2023 reports that 18.87 % of Iowa youth ages 12-17 had at least one major depressive episode (MDE) in the previous year. While this is a decrease from 23.65% in 2021, it is higher than the national estimate of 18.1% among adolescents aged 12 to 17 in the 2023 report. Also, as highlighted in the statewide needs assessment section, suicide mortality rates among Iowa youth aged 12-17 were higher than U.S. youth of the same ages in 2019, 2021, and 2023.

Overall, the combination of factors including limited waiver slots, limited access to community-based services if not Medicaid-

eligible, and lack of providers available to treat children with an SED, places children with an SED at risk of higher-intensity services including out of home treatment and placement. Families of children with mental health issues and advocates continue to identify lack of trained providers for children and youth, lack of crisis services specifically for children, a need for more therapeutic school settings, need for more providers skilled in treating co-occurring MH and SUD, and access to school-based mental health as barriers to children with an SED being able to live successfully in the community.

Adults with serious mental illness (SMI), Older adults with SMI, Individuals with SMI or SED in the rural and homeless populations

SAMHSA URS Table 1 2023 identifies a prevalence rate for Iowa of adults with SMI of 5.4%, or 133,736, for adults aged 18 and over. For Iowa adults aged 18 and over, the National Survey of Drug Use and Health, 2023, reported that 5.87% had serious thoughts of suicide in the past year, an increase from 4.94% in 2021; 9.53 reported a major depressive episode in the past year, an increase from 9.33% in 2021; 6.61% had an SMI, an increase from 6.46 % in 2021, and adults age 18-25 had almost double the rate at 11.82%; 25.72% reported having any mental illness in the previous year, an increase from 25.26% in 2021; and adults age18-25 reported higher rates in the past year for all mental health measures and received mental health treatment at a higher rate, 34.57% compared to 25.70% of adults 26 years and older.

The need for intensive, community-based services for individuals with complex needs, including individuals with a serious mental illness, substance use disorders, and other co-occurring conditions has consistently been an identified priority of Iowa stakeholders. Multiple workgroups, stakeholders, and advocates have identified lack of appropriate services as a gap across the Iowa behavioral health system and a reason that individuals with complex needs have difficulty obtaining inpatient care when needed and also have difficulty obtaining community-based care appropriate to the complexity of their behavioral health needs.

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

Individuals who have an early serious mental illness (ESMI)

Starting in 2014, Iowa has worked diligently to develop Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) teams using the Set Aside for Early Serious Mental Illness funds designated in Iowa's MHBG allocation. The current set-aside percentage is 10% of the total award. These funds can only be used for ESMI/FEP services and program support. Iowa has implemented the NAVIGATE model for this population, which is an evidence-based coordinated specialty care practice. State staff provide technical assistance and contract management for the four programs. Teams are located in Cedar Rapids, Iowa City, Des Moines, and Sioux City. The team located in Mason City ended NAVIGATE services effective June 30, 2025 due to staffing challenges and difficulty recruiting eligible clients. The team located in Iowa City is a new team that began operations in January 2025 and is already serving 10 individuals.

In FY25, the 5 teams served 130 individuals. SAMHSA URS Table 1 2023 identifies an Iowa prevalence rate for adults with SMI of 5.4% or 133,736. Estimated prevalence of individuals experiencing a first episode of psychosis in Iowa is 972. The number receiving NAVIGATE services is a small percentage of the estimated Iowans with an SMI or a first episode of psychosis, demonstrating that the need for programs to assist people diagnosed with a serious mental illness at the beginning of their illness is essential. The state is exploring how to assist the programs to expand their reach and serve more individuals by increasing public awareness of the NAVIGATE programs.

Individuals in need of behavioral health crisis services (BHCS)

The 2024 HMA assessment of the crisis system addressed the strengths and gaps of the historic array of crisis services, which were developed by Iowa's Mental Health and Disability Services Regions and focused on individuals with mental health-related crises. While Iowa's crisis continuum includes all three of the major elements of Someone to Talk To, Someone to Respond, and a Place to Go, access to behavioral health crisis care varies throughout the state due to services being developed in regional systems and being historically mental health focused. As part of the Behavioral Health System implementation, crisis providers are now expected to respond to individuals with mental health an/or substance use related crises. Iowa continues to work on implementing the assessment recommendations including expanding and supporting a high-quality behavioral health crisis workforce, streamlining access to reduce confusion for people in crisis, providing responsive crisis care across the lifespan, and centralizing mobile crisis dispatch to ensure timely access to crisis services statewide and enacting policy changes to

Residential SUD Treatment

Iowa HHS continues to recognize residential SUD Treatment bed availability as an ongoing need, which disproportionately affects

pregnant women and women who have dependent children, as well as persons who inject drugs, as many social determinants of health for these populations are associated with having access to safe and stable housing. In the 2025 SUPTRS report, Iowa indicated that wait times for pregnant and parenting women ranged from 0 days to 5.6 days. For all other populations, providers indicate wait times from 0 days to 2.5 weeks. Providers report that the main barrier for reducing wait times is residential SUD Treatment bed availability.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

2025-2027 Behavioral Health Service System Statewide Plan

Within the Statewide Plan (attached), Iowa HHS developed a milieu of strategies and tactics for each arm of the behavioral health continuum: crisis, prevention, early intervention, treatment, and recovery. Iowa HHS also developed a set of strategies and tactics directed inward toward Iowa HHS operations, which will assist in driving action toward assuring the state plan is met. The deployment and completion of this plan will impact all areas of the behavioral health service system, and potentially all individuals who utilize it.

Implementing a BH-ASO Model

Iowa HHS's intentions for installing an Administrative Services Organization were twofold: to reduce the administrative burden of operating the behavioral health network, and to ensure that the network is consistent, convenient, and timely to access regardless of where in Iowa a person lives. By integrating Your Life Iowa and the newly created System Navigation services, Iowa has created multiple ways to access needed services and a true no-wrong-door network.

Suicide Prevention

In 2025, Iowa HHS was invited to participate the SAMHSA & ACL Older Adult Suicide Prevention State Policy Academy. Iowa HHS participants include a multidisciplinary team from its Divisions of Behavioral Health and Aging & Disability, as well as its recently installed Behavioral Health Administrative Services Organization, the Iowa Primary Care Association. Iowa HHS has received consistent feedback from it's I-PAC council regarding limited services which are held out specifically for aging adults. Iowa HHS intends to use this policy academy as an opportunity to elevate services for aging adults regarding suicide prevention, mental health treatment, and substance use disorder treatment.

Recovery housing

In 2021 the legacy Iowa Department of Public Health began using the National Alliance for Recovery Residences (NARR) requirements to identify and certify recovery houses in Iowa. NARR is a nationally recognized subject matter expert in recovery housing that has affiliates in close to 40 states. Iowa does not have an affiliate but has contracted with Missouri's affiliate to certify houses throughout Iowa in an effort to expand recovery housing availability. This expansion has led to 289 beds in 18 houses being NARR-certified, up from zero in 2022. Iowa HHS continues to utilize NARR standards to educate current and prospective providers and to refer those in need to organizations following best practices.

Tobacco Cessation

In 2024 Iowa was competitively selected to participate in a Cross State Leadership Academy (CSLA) with the Center of Excellence for Tobacco Free Recovery. With feedback taken from the CSLA, Iowa HHS formed a multidisciplinary team within its Division of Behavioral Health to develop and implement a first of its kind project offering nicotine replacement products free of charge to individuals who utilize Recovery Community Centers (RCCs) as a resource. Today, all 5 of Iowa's funded RCCs offer this resource, and Iowa is in the process of expanding this resource to other environments. Iowa HHS's Nicotine Free Recovery project will be featured at the 2025 National Conference on Tobacco or Health (NCTOH).

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Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Behavioral Health Crisis Services

Priority Type: BHCS

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

Goal of the priority area:

Increase access to statewide crisis services in Iowa

Strategies to attain the goal:

Increase awareness of crisis services, create a closed-loop referral system for referrals, increase crisis workforce capacity through inclusion of peer support and peer recovery coaches.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Iowa HHS will develop and implement a plan to increase the peer workforce in the state behavioral health crisis system.

Baseline measurement (Initial data collected prior to and during 2026): Survey of crisis workforce capacity.

First-year target/outcome measurement (Progress to the end of 2026): Iowa HHS will disseminate and analyze the results of a workforce survey to inform training and technical assistance needs of the peer workforce, as part of the statewide plan for improving and expanding the crisis response workforce.

Second-year target/outcome measurement (Final to the end of 2027): Iowa HHS will establish and start implementation of the crisis peer workforce development plan.

Data Source:

Iowa HHS plans, public information efforts, training records, provider records, and survey of crisis workforce capacity.

Description of Data:

Administrative and program information describing workforce development efforts and results from the Iowa HHS workforce survey of behavioral health providers, including the peer crisis service workforce, to identify training and technical assistance needs.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 2

Indicator: Iowa HHS will develop a closed loop referral system for individuals served by Iowa's behavioral health crisis system.

Baseline measurement (Initial data collected prior to and during 2026): N/A-no data is available.

First-year target/outcome measurement (Progress to the end of 2026): By end of SFY26, Iowa HHS will develop a plan for crisis providers to use a closed-loop referral process to ensure that individuals are connected to needed follow up services after a behavioral health crisis.

Second-year target/outcome measurement (Final to the end of 2027): By end of SFY27, Iowa HHS will implement the closed-loop referral process in Iowa's behavioral health crisis system.

Data Source:

Iowa HHS plan documents, training documents, rule/policy documents, provider/contractor reports.

Description of Data:

See description in data source.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 2

Priority Area: CCBHC Demonstration Implementation

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

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

Goal of the priority area:

Implement the CCBHC model through the Medicaid Demonstration

Strategies to attain the goal:

Provide technical assistance to CCBHCs to ensure Iowa CCBHCs are in compliance with CCBHC criteria, monitor usage and quality data provided by CCBHCs to promote continuous quality improvement and compliance with access standards.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Iowans in crisis will receive CCBHC services within 24 hours of triage.

Baseline measurement (Initial data collected prior to and during 2026): Data on individuals seeking crisis services during demonstration year 1 will start January 1, 2026 with data reported quarterly. The benchmark for demonstration year 2 will be based on data reported in year 1.

First-year target/outcome measurement (Progress to the end of 2026): By end of SFY26, Iowa CCBHCs will begin data collection for demonstration year one on the average number of hours from triage to receipt of crisis services for Iowans seeking crisis services from the CCBHC.

Second-year target/outcome measurement (Final to the end of 2027): By the end of SFY27, Iowa CCBHCs will have completed data collection for demonstration year 1 and will have established a state benchmark for demonstration year 2 on the average number of hours from triage to services for individuals seeking crisis services from the CCBHC.

Data Source:

CCBHC quality measure data provided to the state on a quarterly and annual basis.

Description of Data:

Aggregate data submission to Iowa HHS at the clinic level on clients seeking crisis services from the CCBHC and average number of hours from triage to related crisis services.

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 2

Indicator: Iowa CCBHCs will increase numbers of individuals served from Demonstration Year 1 to Demonstration Year 2.

Baseline measurement (Initial data collected prior to and during 2026): Data on individuals served in demonstration year 1 will start January 1, 2026 with data reported quarterly. The benchmark for demonstration year 2 will be based on data reported in year 1.

First-year target/outcome measurement (Progress to the end of 2026):	By end of SFY26, Iowa CCBHCs will begin data collection for demonstration year one on the number of individuals served by Iowa's ten CCBHCs
Second-year target/outcome measurement (Progress to the end of 2027):	By the end of SFY27, Iowa CCBHCs will have completed data collection for demonstration year 1 and will have established a state benchmark for demonstration year 2 on CCBHC service utilization.

Data Source:

CCBHC quality measure data provided to the state on a quarterly and annual basis and Medicaid claims data for CCBHC services reported annually.

Description of Data:

Aggregate data submission to Iowa HHS at the clinic level on total caseload during demonstration year 1 and the start of demonstration year 2; Medicaid claims data for CCBHC services.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 3

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

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Promote awareness and referral to Iowa's ESMI teams, identify need for ESMI services through BH-ASO district assessments and outreach.

Strategies to attain the goal:

Providers will conduct outreach activities quarterly to potential referral sources, Iowa HHS will work with the BH-ASO to promote awareness and referral to ESMI services through HHS communication platforms, Your Life Iowa system navigation and outreach to the BH district advisory councils.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Iowa's 4 ESMI teams will increase or maintain the number of outreach contacts to potential referral sources.
Baseline measurement (Initial data collected prior to and during 2026):	Iowa's 4 ESMI teams have established 75 outreach contacts to potential referral sources.
First-year target/outcome measurement (Progress to the end of 2026):	By end of SFY26, Iowa's 4 ESMI teams will have established 96 outreach contacts to potential referral sources.
Second-year target/outcome measurement (Progress to the end of 2027):	By end of SFY27, Iowa's 4 ESMI teams will have maintained or increased the number of outreach contacts to potential referral sources from year 2026.

Data Source:

ESMI contractor reports to HHS.

Description of Data:

Contractor reports, contractor outreach materials and plans.

Data issues/caveats that affect outcome measures:

N/A

Indicator #:	2
Indicator:	Iowa HHS will develop and implement a communication plan to promote public awareness

of ESMI services in Iowa.

Baseline measurement (Initial data collected prior to and during 2026): 0

First-year target/outcome measurement (Progress to the end of 2026): By end of SFY26, Iowa's will create a communication plan and implement six public awareness activities to promote ESMI services in Iowa.

Second-year target/outcome measurement (Final to the end of 2027): By end of SFY27, Iowa consumers will access ESMI informational resources promoted in public awareness activities.

Data Source:

Contractor reports, HHS communications, public information releases, websites, information distributed through the BH-ASO.

Description of Data:

Description of public awareness campaign activities, dissemination methodology, and public use of information distributed through promotion activities.

Data issues/caveats that affect outcome measures:

N/A

Priority #: 4

Priority Area: Increase public awareness of Iowa's Behavioral Health System

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

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

Goal of the priority area:

Increase awareness of Iowa's new integrated Behavioral Health System, including access/entry points, the role of the BH-ASO, system navigation services, and crisis services.

Strategies to attain the goal:

Iowa HHS will work with the BH-ASO to promote awareness through HHS and BH-ASO communication platforms.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Iowa HHS will develop and implement a communication plan to educate the public on how and where to access behavioral services and resources within the new integrated Behavioral Health System.

Baseline measurement (Initial data collected prior to and during 2026): N/A

First-year target/outcome measurement (Progress to the end of 2026): By end of SFY26, Iowa HHS will create a communication plan and share materials with the public on where to access behavioral services and resources within the new integrated Behavioral Health System.

Second-year target/outcome measurement (Final to the end of 2027): By end of SFY27, Iowa consumers will access informational resources on the new integrated Behavioral Health System included in public awareness campaigns.

Data Source:

HHS communications, public information releases, websites, information distributed through the BH-ASO and adult survey data.

Description of Data:

Description of public awareness campaign activities, dissemination methodology, and public use of information distributed through promotion activities; results from population adult survey to identify population awareness of services.

Data issues/caveats that affect outcome measures:

Adult survey data availability is determined by the frequency of data collection, which is to be determined by Iowa HHS.

Priority #: 5

Priority Area: Behavioral Health Workforce

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

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

Goal of the priority area:

Strengthen Iowa's behavioral health workforce.

Strategies to attain the goal:

1) Gather a baseline understanding of the behavioral health workforce and their training needs; 2) Design and implement behavioral health workforce trainings.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Iowa's behavioral health workforce will report an increased belief that their training, technical assistance, and continuing education needs are met.

Baseline measurement (Initial data collected prior to and during 2026): No current baseline measure available. Iowa HHS will collect a baseline measurement by the end of year 1.

First-year target/outcome measurement (Progress to the end of 2026): By the end of year 1, Iowa will have gathered a baseline understanding of the behavioral health workforce and their training needs.

Second-year target/outcome measurement (Final to the end of 2027): By the end of year 2, Iowa will have designed and implemented behavioral health workforce trainings

Data Source:

Behavioral health workforce survey

Description of Data:

Iowa will design a survey to capture information about the behavioral health workforce and training needs.

Data issues/caveats that affect outcome measures:

Potentially low survey response rates.

Priority #: 6

Priority Area: Recovery Support Services

Priority Type: SUR

Population(s): PWWDC, PWID

Goal of the priority area:

Advance Treatment Continuum of Care

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected 2024 Recovery Support Services utilization

prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): Assess needs and gaps in Iowa for recovery supports.

Second-year target/outcome measurement (Final to the end of 2027): Implement a statewide project dedicated to recovery support services.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

Workforce challenges.

Indicator #: 2

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

Baseline measurement (Initial data collected prior to and during 2026): Planning Grant Year

First-year target/outcome measurement (Progress to the end of 2026): Consult with the state's peer training contractor, peer support and family peer support specialists and recovery coaches on how to effectively integrate peer services into the state's CCBHC model.

Second-year target/outcome measurement (Final to the end of 2027): All certified CCBHCs in Iowa employ at least 1 FTE of each peer specialty by June 30, 2027.

Data Source:

Iowa HHS

Description of Data:

Iowa HHS CCBHC Certification records.

Data issues/caveats that affect outcome measures:

None Anticipated

Priority #: 7

Priority Area: Primary Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Ensure the prevention workforce has the necessary support, knowledge and skills to administer and deliver effective prevention services

Strategies to attain the goal:

Collect data and develop a plan to ensure the prevention workforce has appropriate supports

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase prevention workforce capacity

Baseline measurement (Initial data collected prior to and during 2026): Survey of prevention workforce

First-year target/outcome measurement (Progress to the end of 2026): Create and disseminate a prevention workforce survey. Analyze results to inform training needs and to inform a workforce development plan.

Second-year target/outcome measurement (Final to the end of 2027): Based on prevention workforce survey results, establish a workforce development plan to include training and technical assistance needs and strategies for increasing and strengthening the prevention workforce.

Data Source:

Survey of prevention workforce

Description of Data:

Survey of prevention workforce to include workforce challenges, successes and training needs.

Data issues/caveats that affect outcome measures:

Turnover in prevention field, low survey response rate

Priority #: 8

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Facilitate access to women and children services.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access for priority population-within 7 days from the date of assessment to the date of admission to the required ASAM level of care.

Baseline measurement (Initial data collected prior to and during 2026): IBHRS data for women and children services providers; greater than seven days

First-year target/outcome measurement (Progress to the end of 2026): By the end of year one, access to services will occur within 8 days from date of first contact to admission

Second-year target/outcome measurement (Final to the end of 2027): By the end of year two, access to services will occur within 7 days from date of first contact to admission

Data Source:

IBHRS data-Residential Treatment Wait Time Report

Description of Data:

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

Data issues/caveats that affect outcome measures:

Workforce developments concerns

Priority #: 9

Priority Area: Tuberculosis

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Assure fidelity and compliance with State/Federal TB laws, processes, and protocols.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): Iowa will collect pre/post survey questionnaires for all training opportunities, however there is not a current baseline measure.

First-year target/outcome measurement (Progress to the end of 2026): A) All SUPTRS providers will complete the SUBG Prevention and Treatment Regulations form which documents compliance with requirements for individuals who screen positive for TB. B) By the end of year 1, 75% of training participants will report an increase in competency for serving individuals who may have TB.

Second-year target/outcome measurement (Final to the end of 2027): By the end of year 2, 85% of participants in a TB services quality improvement activity will report an increase competency for serving individuals who may have TB

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

Workforce challenges.

Priority #: 10

Priority Area: Persons Who Inject Drugs

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

Training to providers on SUBG regulations, review data with providers, and corrective action as appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): IBHRS Wait times for serving persons who inject drugs.

First-year target/outcome measurement (Progress to the end of 2026): All state contracted providers will complete the SUBG Prevention and Treatment Regulations form which documents SUBG requirements for individuals who inject drugs

Second-year target/outcome measurement (Final to the end of 2027): Iowa will provide at least 1 quality improvement activity to increase competency and compliance with SUBG regulations for persons who inject drugs.

Data Source:

SUBG Prevention and Treatment Regulations Form, policy review and quality improvement measures. Pre/posttest competency and compliance survey results, IBHRS database

Description of Data:

Iowa HHS Prevention and Treatment Regulations Form, contractor policies, pre/posttest competency and compliance survey results, IBHRS wait time report.

Data issues/caveats that affect outcome measures:

Workforce challenges.

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$16,499,914.00		$0.00	$1,000,000.00	$31,278,680.00	$0.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$2,781,878.00		$0.00	$0.00	$2,277,734.00	$0.00	$0.00	
b. All Other	$13,718,036.00		$0.00	$1,000,000.00	$29,000,946.00	$0.00	$0.00	
2. Recovery Support Services[c]	$500,000.00		$0.00	$5,000,000.00	$0.00	$0.00	$0.00	
3. Primary Prevention[d]	$5,820,714.00		$0.00	$700,000.00	$297,134.00	$0.00	$0.00	
4. Early Intervention Services for HIV[e]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
5. Tuberculosis	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$4,000,000.00		$0.00		$13,000,000.00	$0.00	$0.00	
13. Administration[g]	$1,411,612.00		$0.00	$1,200,000.00	$709,638.00	$0.00	$0.00	
14. Total	**$44,732,154.00**		**$0.00**	**$8,900,000.00**	**$76,564,132.00**	**$0.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planned Expenditures for "Other Federal" in Column D were made based on historical spending. A more accurate estimate was difficult as a result of various changes related to other federal funding sources.

State System Development costs are anticipated to be higher than previous state fiscal years due to funding administrative costs associated with the recently installed Behavioral Health Administrative Services Organization.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$1,545,960.00						$420,000.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care		$12,367,672.00						$236,518.00
11. Crisis Services (5 percent Set-Aside)[c]		$772,980.00						$600,000.00
12. Other Capacity Building/Systems Development								
13. Administration		$772,980.00						
14. Total		**$15,459,592.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,256,518.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

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

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

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	6976	229
Women with Dependent Children	21895	2841
Individuals with a co-occurring M/SUD	50851	6169
Persons who inject drugs	48681	975
Persons experiencing homelessness	504	615

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

Aggregate numbers in SUD treatment were pulled from Iowa's Behavioral Health Reporting System on July 14, 2025. This is Iowa's system that collects and sends TEDS data. The estimated in need for pregnant women was calculated using NSDUH's estimate of Iowans 12+ in need of substance use treatment (19%) and multiplying by Iowa's Vital Statistic's total births. The estimated in need for women with dependent women was calculated using NSDUH's estimate of Iowans 12+ in need of substance use treatment (19%) and multiplying by the number of Iowa families with a female householder (State of Iowa Data Center). The estimated in need for co-occurring M/SUD was calculated using NSDUH's 2023 Annual report showing that 7.9% of individuals have a SUD or AMI, applying that to the total adult population in Iowa and then applying NSDUH's 20% estimate of those in need of SUD treatment. The estimated in need for persons who inject drugs was calculated using Iowa's Adult Survey that was conducted in 2021 that found that 2% of Iowa's adult population reported injection drug use and multiplying 2% to the total adult population in Iowa. The estimated in need for persons experiencing homelessness was calculated using U.S. Dept of Housing and Urban Development's Annual Homeless Assessment Report that showed the number of Iowans experienced homelessness and multiplying that by NSDUH's estimate in need of SUD treatment.

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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$7,595,929.00
2 . Recovery Support Services[b]	$250,000.00
3 . Substance Use Primary Prevention[c]	$2,964,385.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$2,600,000.00
7 . Administration[f]	$705,806.00
8. Total	$14,116,120.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	1838989.00
1b. Crisis Services for Adults	386490.00
1c. CSC/ESMI program for Adults	927576.00
1d. Other outpatient/ambulatory services for Adults	0.00
1e. *Other Direct Services for Adults	1838986.00
2. Subtotal of Services for Adults	4992041.00
3. Services for Children	
3a. EBPs for Children	1838988.00
3b. Crisis Services for Children	386490.00
3c. CSC/ESMI program for Children	618384.00
3d. Other outpatient/ambulatory services for Children	0.00
3e. *Other Direct Services for Children	1838989.00
4. Subtotal of Services for Children	4682851.00
5. Other Capacity Building/Systems Development[a]	5011720.00
6. Administrative Costs[b]	772980.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**15459592.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$0**
Total Award [a]		**$14,116,120**
Planned Primary Prevention Percentage		**0.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Iowa has chosen to utilize table 5b.

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$2,441,171
2. Universal Indirect	$25,197
3. Selective	$299,699
4. Indicated	$198,318
5. Column Total	**$2,964,385**
6. Total SUPTRS Award[a]	**$14,116,120**
7. Primary Prevention Percentage	**21.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☐
Military Families	☐
American Indian/Alaska Native	☐
African American	☐
Hispanic	☐
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$2,600,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$1,000,000.00	$0.00	$0.00
b. All other subrecipient contracts	$1,600,000.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$2,600,000.00**	**$0.00**	**$0.00**

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support	$2,493,132.00	$836,517.00
3. Partnerships, Community Outreach, and Needs Assessment	$400,000.00	
4. Planning Council Activities	$160,000.00	
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education	$1,958,588.00	$0.00
8. Total	**$5,011,720.00**	**$836,517.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

MHBG
Line 2-Infrastructure Support Psychiatric Bed Tracking $76,804, Your Life Iowa Call Center Support $900,000 UI-CDD $316,328 Peer Warmline $1,200,000
Line 3-Partnerships, Community Outreach and Needs Assessment -NAMI-$ 400.000
Line 4 Planning Council Activities $100,000
Line 7 Training and Education Peer Support Training $1,000,000, UI-CEBH $958,588

BSCA
Line 2-Infrastructure Support Crisis Services $600,000, Disaster BH Team Support $236,517

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

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

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

State Agency

The Iowa Department of Health and Human Services (Iowa HHS) functions as both the SMHA and SSA. Mental Health and Substance Use Prevention, Treatment, and Recovery Services are provided via the Iowa HHS Division of Behavioral Health. Options for Individuals with mental health, substance use, or co-occurring mental health and substance use disorders to access integrated behavioral health services continue to increase in Iowa. Iowa currently has 26 accredited community mental health centers, and 109 licensed substance use disorder treatment programs. 16 of Iowa's licensed SUD Treatment providers are SUPTRS-BG Designees, and 4 of those SUPTRS-BG designees specialize in services for pregnant and parenting women. As a participant in the CCBHC Demonstration, Iowa will have increased opportunities to promote integrated behavioral health services in Iowa.

Iowa has added a new statewide System Navigation service to help Iowans access behavioral health services. System navigation is a non-crisis, but time-sensitive response service that helps individuals and those supporting them, their family members, caregivers, professionals, and community members understand, access, and connect with behavioral health supports and services across Iowa. Behavioral Health System Navigation does not provide clinical assessment, treatment, medication prescriptions or counseling services. Instead, it helps people better understand their options and get connected to what they need. Support is provided by System Navigators – trained and experienced peer support specialists, community health workers and behavioral health professionals. They bridge barriers to care by connecting community partners, health care professionals and the individuals they serve with confident support, information and education, referrals to mental health and substance use providers, and assistance in finding psychiatric beds if needed. System navigation is free of charge and has no insurance requirements.

Quality Improvement

Iowa HHS is current contracted with the University of Northern Iowa-Center for Social and Behavioral Research (UNI-CSBR) to initiate simulated client phone calls to IPN funded programs using a substance use profile. This sub-report was requested by Iowa HHS specific to establishing a baseline regarding SUBG priority populations. CSBR researchers place calls to each SUPTRS recipient agency on a biannual basis, using simulated client profiles to evaluate the response received by those seeking SUD treatment services. Simulated phone call outcomes are analyzed to better understand client access to services, with an emphasis on pregnant women and women with dependent children, and persons who inject drugs, among others. Data collected from these simulated phone calls are used by Iowa HHS to provide technical assistance and corrective action when needed. Iowa HHS has opted to make State Fiscal Year 2025 the final period for these simulated calls and will be developing new strategies for monitoring timely access to services for SUPTRS populations of focus for SFY 2026.

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

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

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Iowa has implemented the CCBHC model with the state's Medicaid Demonstration starting July 1, 2025. CCBHCs are required to screen for substance use and mental health needs and to provide integrated care.

a. Please describe how this system differs for youth and adults.

CCBHCs and CMHCs are required to serve both children and adults. Iowa also has child and adolescent providers of integrated behavioral health services.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Iowa does not have providers implementing IDDT.

c. How many IT-COD teams do you have? Please explain.

none

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

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

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

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

Iowa's CCBHCs have the responsibility of providing primary health care screening and coordination of physical health needs with behavioral health. Some of Iowa's CCBHCs have primary care co-located within their behavioral health clinics to encourage integration. Iowa's FQHCs also provide access to behavioral health within the primary care setting.

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

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

System Navigation, Your Life Iowa, & 911/998

Iowa Medicaid Care Coordination
Iowa Medicaid members with a serious mental illness or a serious emotional disturbance have been eligible for Integrated Health Home (IHH) care coordination which provides team-based care coordination focused on improving behavioral and physical health outcomes. Intensive care coordination is provided for members who receive Habilitation or Children's Mental Health waiver services. Iowa has submitted a Medicaid State Plan Amendment to end the IHH program effective Dec. 31, 2025. As IHH sunsets, CCBHCs, Iowa's 3 MCOs, and HHS Targeted Case Management will provide care coordination to individuals with identified behavioral health needs. As mentioned above, Iowa is also launching statewide system navigation which will be available to all Iowans to help guide them to appropriate resources.

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

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

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Iowa implements the following practices to support the provision of integrated services for individuals with co-occurring mental and intellectual disabilities:
Screening assessment
o System Navigation in both the BH-ASO and DAP models as a screening / intercept for people with co-occurring disorders with the ability to help with routing to assessment for those who need it.
o L2 PASRR (adults)
• Specialized treatment
o UIHC ID-MI program and Project Echo for DSPs
o IRSH (adults)-Intensive Residential Service Homes for adults with SMI and/or ID with high-intensity needs
o Enhanced PMIC for youth with IDD/SED (youth)
o START model (Provider Prevention and Support Services)
o In development: Iowa REACH (youth)-state initiative to build intensive community-based services and supports for high-needs youth
• Training professionals to practice
o State Resource Centers for persons with ID and Mental Health Institutes train / use of adaptive strategies: https://www.nasddds.org/i-dd-and-mental-health-support-resources/
o Partnership with University of Iowa Health Care for public psychiatry fellowship

8. Please indicate areas of **technical assistance needs** related to this section.

N/A

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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

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

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
NAVIGATE	4.00
	0.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
0.00	0.00

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

   Iowa does not have a bundled rate for ESMI services. Individual services within the model, including individual therapy, family therapy, medication management, community support and peer support are billable to Medicaid or private insurance.

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

   Iowa currently has four NAVIGATE teams. Three of the teams are well-established in three of Iowa's major urban centers; Des Moines, Cedar Rapids, and Sioux City. The Des Moines and Cedar Rapids teams began operation in 2015 while the Sioux City team began in 2018. Iowa added a team in Mason City, a small city in a rural area of the state, in 2021. This team struggled with recruitment and retention of clinical team members and recruitment of sufficient clients to support a team over the 3.5 years of operation and chose to end their NAVIGATE team effective June 30, 2025. The agency operating the existing team in Cedar Rapids has expressed interest for several years in starting a new team in Iowa City, home to the University of Iowa. The new team in Iowa City began operating in January 2025 and is already serving a significant cohort of clients. Iowa NAVIGATE teams are required to participate in monthly technical assistance and fidelity monitoring activities with the state's technical assistance provider and are required to have teams consisting of a prescriber, an individual resiliency technician, a family education provider, a supported employment and education specialist, and a community support specialist. The three established teams are also in their first year of adding a peer support specialist to their NAVIGATE teams.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

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

   Individuals participating in NAVIGATE services have access to more community supports than other individuals initially accessing mental health services. The NAVIGATE model is focused on recovery and assisting individuals access the most effective treatments and supports for psychosis earlier in their illness, promoting wellness and recovery for the individual. When individuals experience a crisis, the NAVIGATE team is able to provide an enhanced level of support to coordinate services and assist the individual and their family to access appropriate behavioral health services. When individuals experience a crisis, the NAVIGATE team is able to provide an enhanced level of support to coordinate services and assist the individual and their family. The NAVIGATE teams also have a strong recovery focus and promote social inclusion through voluntary group activities and support to begin or return to work and/or educational programming.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

   The Iowa City team began operations in January 2025 and will be working toward full implementation during FY2026 and FY2027. As Iowa is implementing its Behavioral Health-Administrative Service Organization model to implement a statewide behavioral health system., the state will consider opportunities for additional NAVIGATE teams in other major urban centers of Iowa as well as rural areas that exhibit a need for the service.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

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

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

    Iowa's population is 3,241,488 per 2024 American Community Survey data. The expected incidence rate is 20 to 30 cases per 100,000. This equates to a prevalence rate of 972

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

    Iowa plans to work with the BH-ASO's system navigation service tp ensure that there is awareness of Iowa's NAVIGATE teams for potential referrals through the system navigation process. Iowa is also considering public awareness activities to inform the public of the state's four NAVIGATE programs and how to access them.

12. Please indicate area of technical assistance needs related to this section.

N/A

Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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

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

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

Integrated health homes which provide care coordination for Medicaid-eligible individuals with an SED or an SMI and recipients of HCBS services, including the Children's Mental Health Waiver and HCBS Habilitation Services are all required to use person-centered planning processes. Person centered training is offered to care coordinators and case managers. Iowa is ending the IHH program effective Dec. 31, 2025. For HCBS services, PCP is required in Iowa Administrative Code and will continue through MCO and HHS-TCM care coordination. CCBHCs are also required to implement person-centered planning practices. Care coordination staff meet with individuals and their families/chosen participants at the location of their choice to develop treatment plans, identify the individual's strengths, needs, preferences, and goals, developing plans that reflect those goals. At the system level, Iowa HHS engages individuals and their families through community meetings and townhalls, outreach through the Office of Recovery Supports, peer/family peer support/recovery peer coach services to help individuals advocate for themselves and their families, and collaboration with advocates and stakeholders.

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

The person centered planning process for Medicaid members who receive Habilitation is described in Iowa Administrative Code 441.78.27 (4). The rule describes the requirements for the Medicaid member and/or legal representative's involvement in the development of the plan based on the member's strengths, needs, and preferences in all aspects of service delivery. For accredited mental health service providers, person centered principles are listed in Iowa Administrative Code 441.24.4

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

There are no organized efforts currently.

6. Please indicate areas of technical assistance needs related to this section.

n/a

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   N/A
4. Please indicate areas of technical assistance needs related to this section.

   N/A

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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

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

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

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

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

- **a)** ☐ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

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

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☐ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

Iowa HHS reviews a variety of data indicators in determining priority needs to assist contractors to prioritize strategies related to the SUPTRS BG Prevention Set Aside funding. Iowa HHS also utilizes the Iowa Epidemiological Profile, updated in 2022 and every two years, to assist in setting priorities and providing direction related to the Prevention Set Aside funding.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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

Capacity Building

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

a) If yes, please describe.

The Iowa Board of Certification (IBC) credentials prevention and treatment professionals in addictions, (prevention, treatment and peer support). IBC promotes adherence to competency and ethical standards and provides a mechanism for Continuing Education and certification. IBC supports a Certified Prevention Specialist Certification and an Advanced Prevention Specialist Certification.

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

a) If yes, please describe mechanism used.

Iowa HHS provides oversight of training and technical assistance to prevention professionals through collaboration with the Center of Excellence for Behavioral Health through the University of Iowa and Iowa State University Conference Planning and Management to organize and support statewide training to the prevention field. Multiple trainings occur as needed and annual training is conducted on the SUPTRS BG Prevention Set Aside regulations.

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

a) If yes, please describe mechanism used.

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

Narratve Question

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Planning

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

If yes, please attach the plan in WebBGAS

2025-2027 Behavioral Health Service System Statewide Plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

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

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

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

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

The Evidence-Based Workgroup supports the standardized definition by SAMHSA which states an evidence-based program or policy (EBP) has documented effectiveness supported by other sources of information and the consensus judgment of informed experts based on the following guidelines:
The strategy is based on a theory of change that is documented in a clear logic or conceptual model.
The strategy is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.
The strategy is supported by documentation that has been effectively implemented multiple times in the past in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.

Narratve Question

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

Implementation

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

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

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

a) Information Dissemination:

Approved services to support the Information Dissemination strategy include:
Materials developed such as newsletters, flyers, brochure and public service announcements.
Sharing of information about substance use through virtual meetings, informational sessions and speaking engagements.
Media interviews to provide information about substance use through radio, television, newspaper or other media events.
Health fairs and community events to provide information about substance use.

b) Education:

Approved services to support the Education strategy include:
Evidence-based programs (EBP) focused across the lifespan and pre-approved through the Evidence-Based Practice Workgroup. EBPs currently approved are Curriculum based Support Group, Familias Unidas, Generation Rx, Guiding Good Choices, LifeSkills Training, Prime for Life, Prime for Life 420, Project Alert, Project Towards No Drug Abuse, Reconnecting Youth, Strengthening Families Program for Parents and Youth 10-14, Strong African American Families, Team Awareness, Too Good for Drugs and Wellness Initiative for Senior Education.

c) Alternatives:

Approved services to support the Alternatives strategy include:
Technical assistance to community groups, agencies and coalitions on the benefits and best practices of alternative activities as a part of an overall prevention approach.

d) Problem Identification and Referral:

Approved services to support the Problem Identification and Referral strategy include:
Technical assistance and training to workplaces on substance use which may interfere with work performance.
Diversion services to youth and adults through court-mandated substance use awareness programs including Prime for Life and Prime for Life 420.

e) Community-Based Processes:

Approved services to support the Community-Based Processes strategy include:
Technical assistance with community groups, agencies and coalitions to provide guidance on effective prevention services through the Strategic Prevention Framework.

f) Environmental:

Approved services to support the Environmental strategy include:
Consultation, development and establishing of alcohol, tobacco and other drug (ATOD)-free policies that focus on social host policies, workplace policies, ATOD-free school policies, community event policies, prevention of underage alcohol sales policies, as well as changing codes, ordinances and regulation policies. Also includes implementation of responsible beverage service training and dissemination of media campaigns focused on ATOD education.

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

a) Yes (if so, please describe)

The Iowa Primary Care Association (Iowa PCA), contracted through Iowa HHS, serves as the Administrative Service Organization to monitor and manage the SUPTRS BG Prevention Set Aside funding. Community based organizations that provide prevention services funded through SUPTRS BG have contracts with Iowa PCA and will be monitored through claims review as well as reporting progress of their services and outcomes achieved to ensure effectiveness.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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

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

Evaluation

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

If yes, please attach the plan in WebBGAS

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

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

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

2025-2027

Behavioral Health Service System Statewide Plan

Kelly Garcia
Director, Iowa Department of Health and Human Services

Marissa Eyanson
Director, Division of Behavioral Health

IOWA™ | Health and Human Services
Division of Behavioral Health

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Message From the Director of Iowa HHS

Dear Iowans,

We are at an exciting moment in time because **together**, we are building a strong behavioral health system for Iowa. For two years, we've been collaborating, planning, meeting, and listening in every corner of our state to craft a comprehensive plan for change. This effort has resulted in the first-ever Behavioral Health State Plan.

Throughout this process, we've worked hand in hand with direct care professionals, behavioral health advocates, law enforcement, state law makers, local governments, anyone who wanted to contribute to this work to identify key issues and develop meaningful solutions. Our goal is simple: to ensure that every Iowan, regardless of where they live, has access to high quality behavioral health resources that best fits their needs.

The behavioral health solutions we've developed are built to make real, lasting change and coexist alongside the other resources and services in the state that make up our behavioral health system of care. I'm encouraged by the conversations we've had, proud of the ideas that have taken shape, and inspired by the passion and dedication of those working toward better outcomes for all Iowans.

> "For two years, we've been collaborating, planning, meeting, and listening..."

This is just the beginning. While we have laid a strong foundation, there is still work to be done, and we will continue to seek feedback and input as we, collectively, shape the future of the behavioral health system in Iowa.

All my best

Kelly Garcia

Kelly Garcia
Agency Director

Letter From Behavioral Health Division Director Marissa Eyanson

Fellow Iowans,

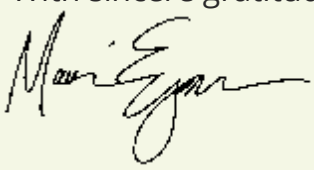
Our vision for Iowa's Behavioral Health Service System is simple, but impactful – we envision Iowa as a state where recovery is not only possible, but the expectation. The Iowa Department of Health and Human Services (Iowa HHS) team is committed to ensuring that all Iowans have access to high quality behavioral health services by removing barriers and engaging with individuals, families, and communities all over the state working together to improve everyone's health and well-being.

The system we are building together will focus on the building a full behavioral health continuum – prevention, early intervention, treatment, recovery and crisis services. Each piece is critical to our success. Many of you have joined us in this work to offer your feedback and comments, and we all agree that change won't happen overnight; it's a constant goal we have in our sights that we will strive for each day.

This Behavioral Health Statewide Service System Plan serves as our northern star, a guide to direct us towards completing our goals. We are grateful for the opportunity to provide this work that documents Iowa's vision for behavioral health and identifies the steps we will take together to make it a reality. We will also continue to seek feedback from you, on every step of the process.

Thank you for your interest and your contributions to this effort thus far. I look forward to continued partnership to make our vision a reality.

With sincere gratitude,



Marissa Eyanson
Director, Division of Behavioral Health

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Introduction

In 2024, Iowa Governor Kim Reynolds proposed landmark legislation to reimagine Iowa's Behavioral Health Service System. Built on feedback from Iowans and passed with bi-partisan support from the legislature, House File 2673 made changes to system structures. It brings together work and funding to form an integrated Behavioral Health Service System which will ensure consistent, statewide access to behavioral health prevention, early intervention, treatment, recovery and crisis services.

The Iowa Department of Health and Human Services (Iowa HHS) has worked collaboratively with partners all over the state to gather feedback, conduct assessments and develop the framework for the Behavioral Health Service System that is outlined by the new law. In town halls and round table discussions, Iowa HHS listened and learned

about what Iowans are experiencing in their hometowns, what they hoped would change, and what they hoped would remain in place as we built a new system together.

Based on this feedback, Iowa HHS developed this first Behavioral Health Service System plan. Guided by this plan, Iowans will work together to implement strategies and tactics designed to improve system collaboration, coordination and communication and improve health and outcomes for Iowans.

The 2025-2027 Behavioral Health Service System Statewide Plan provides context about current systems and partners, data that describes baseline system measures, summarizes system components and provides an overview of how the strategies and tactics were developed. The final section of the plan identifies desired outcomes for the system and details what is needed to operationalize and implement the Iowa's new Behavioral Health Service System.

(continued)

Throughout the process of gathering feedback and developing this initial plan,

three clear, consistent themes emerged as priorities for Iowans:

1 Prioritize Prevention and Early Intervention

Behavioral health refers to a general state of mental, emotional, and social well-being or behaviors and actions that affect wellness. Behavioral health is a key component of overall health. Improving the overall health and quality of life for individuals, families and communities by working to promote mental, emotional and social well-being and prevent the long-term impacts of mental illness and addictions is a shared goal across system partners.

The work of prevention promotes resiliency and healthy behaviors and the work of early intervention, to delay or divert the long-term impacts associated with serious behavioral health disorders are key components of the behavioral health continuum. This work includes educational programs and messaging as well as the promotion of healthy decision making to empower people to make good decisions about their health. It is also the work of early identification, intervention and support for individuals and families at risk or in the early stages of developing of a behavioral health condition or disorder to access treatment sooner and create opportunities for better long-term outcomes.

Historically, resource allocation has prioritized deep-end treatment and crisis services, too often waiting for people to be seriously ill before offering help. Across the state, Iowans voiced the need to intervene sooner by expanding prevention and early intervention programs, activities and services and identifying sustainable funding to support this vital work.

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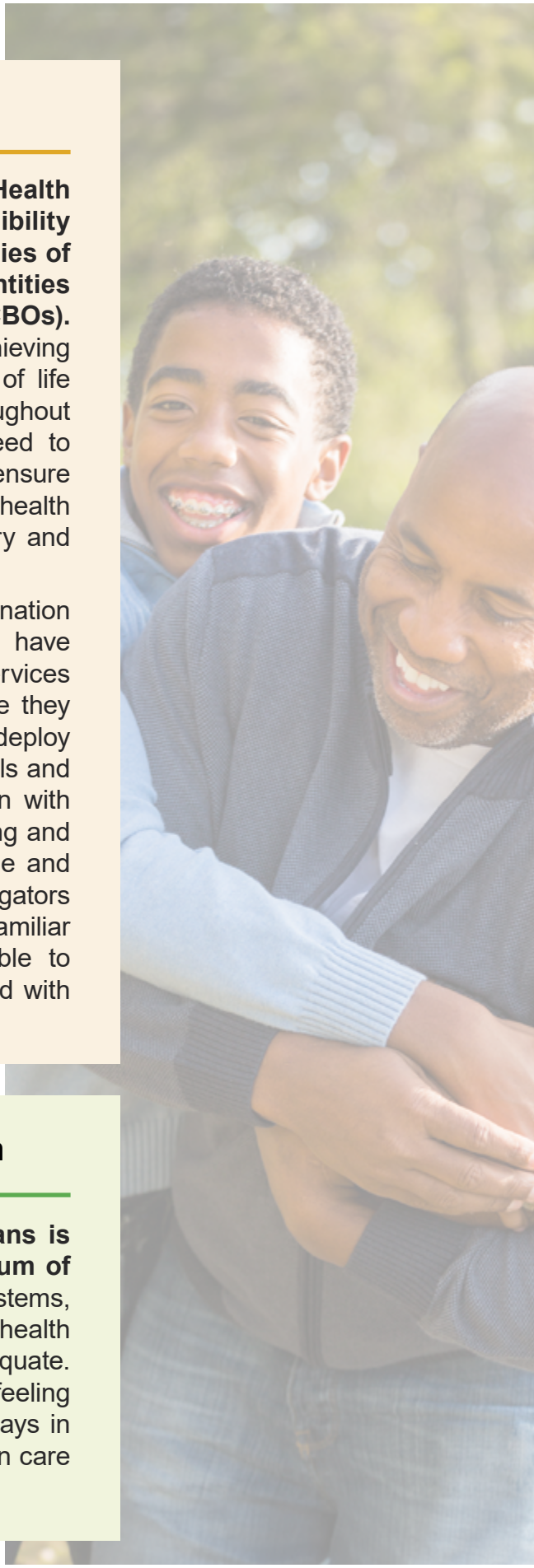
2 Improved System Coordination

The work envisioned for Iowa's Behavioral Health Service System will use a shared responsibility model that defines the roles and responsibilities of three main partners: Iowa HHS, district lead entities and community based organizations (CBOs). Each part of the system plays a key role in achieving goals and improving overall health and quality of life for individuals, families and communities. Throughout feedback sessions, Iowans emphasized the need to improve coordination and communication to ensure consistent access to high-quality behavioral health prevention, early intervention, treatment, recovery and crisis services.

An essential part of improving system coordination is the installation of system navigation. Iowans have expressed difficulties in navigating the array of services and supports. Often, people delay care because they don't know where to go. System navigation will deploy low barrier, just-in-time supports to help individuals and families with information, referral and connection with other system partners such as child welfare, aging and disability services, and Medicaid, including Home and Community Based Services (HCBS). System navigators will be an embedded part of their community, familiar with community resources and easily accessible to anyone in need of help. They are also connected with cross-system partners.



3 Improve Access to Behavioral Health

Another priority consistently voiced by Iowans is a lack of consistent access to a full continuum of behavioral health services. In Iowa's current systems, the type of care and accessibility behavioral health services is inconsistent and, too often, inadequate. Many rural areas lack access and often voice feeling left behind. This disparity creates barriers or delays in accessing care and supportive services. Delays in care predict poorer outcomes.

Three significant recommendations emerged related to improving access to behavioral health.

The first of these was that Iowa needs to take on significant regulatory reform.

Behavioral health providers said that it's too difficult for them to do their jobs. Iowa's current regulatory framework is outdated, providers are left to navigate multiple regulatory processes through different divisions of state government and private entities installed instead of consistent regulation. Providers stressed how the administrative burden by multiple entities makes some leave the practice altogether.

Other states have developed simplified, single stream regulatory processes focused on allowing providers to focus on practice rather than navigating bureaucratic red tape.

The second recommendation to emerge is for Iowa to examine its current crisis services and build a comprehensive crisis care system.

The current array of crisis services was developed by Iowa's Mental Health and Disability Services Regions and is not equipped to respond to substance use crisis and access to crisis care, such as mobile crisis, varies significantly throughout the state.

Health Management Associates (HMA) helped Iowa HHS conduct a focused assessment of Iowa's crisis care and provided a report. The recommendations address expanding and supporting a high-quality behavioral health crisis workforce, streamlining access to reduce confusion for people in crisis, and providing responsive crisis care across the lifespan.

The third recommendation is to adopt and expand access to high-quality, integrated outpatient behavioral health services through development of Certified Community Behavioral Health Clinic's (CCBHCs) across the state.

CCBHCs provide a range of outpatient mental health care and substance use disorder services, and serve anyone who walks through their doors. In June 2024, Iowa was one of 10 states selected by Substance Abuse Mental Health Services Administration (SAMHSA) and Centers for Medicare and Medicaid Services (CMS) to participate in a four-year Medicaid Demonstration.

Iowa's Medicaid CCBHC Demonstration will launch on July 1, 2025. Participation in the Demonstration allows Iowa to receive more federal funding to build a network of high-quality, certified clinics throughout the state. Iowa's initial cohort of 10 state-certified CCBHCs will begin offering services in 71 counties on July 1, 2025.

Iowans recognize the importance of accessing a full continuum of behavioral health that includes prevention, early intervention, treatment, recovery support and crisis services.

The Behavioral Health Continuum

Iowans recognize the importance of access to a full continuum of behavioral health that includes prevention, early intervention, treatment, recovery support and crisis services.

Prevention

Prevention includes information dissemination; education; wellness promotion; organizing and enhancing community-based processes; developing environmental approaches; offering alternative activities; and building resiliency skills through structured learning, including support of critical life and social skills such as decision making, coping with stress, problem solving, interpersonal communication, and improving judgment.

Early Intervention

Early Intervention are interventions, services and support to at-risk individuals to address early symptoms and prevent the development of behavioral health disorders. This includes identifying problems and offering referrals to reduce impact and improve well-being.

Treatment

Clinical inpatient, outpatient, and residential care for individuals with a behavioral health condition or disorder diagnosed utilizing the most recently published Diagnostic and Statistical Manual (DSM) criteria. The type, length, and intensity or frequency of intervention(s) used by a behavioral health provider is based on the presenting symptoms of the individual.

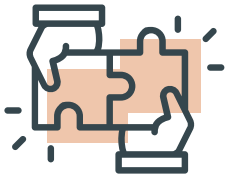
Recovery

Non-clinical support that promotes recovery, wellness, and connection, including system navigation, peer services and recovery supports to improve quality of life. The purpose of developing the recovery part of the continuum is to support individuals with multiple pathways of recovery. People access recovery in ways that work for them and for as long as they need, even for the rest of their lives

Crisis

Community-based services that focus on the immediate de-escalation and relief of the distress associated with a behavioral health crisis, reducing the risk that an individual in a crisis harms themselves or others, and providing after care and connection to ongoing follow up to ensure post-crisis stabilization and reduce the reliance on high acuity care or more restrictive environments.

Building Iowa's Behavioral Health Service System



Bring mental health and addictive disorders together in a comprehensive Behavioral Health Service System

- Eliminate the silos of Iowa's mental health and disability services (MHDS) regions, substance use service areas, and tobacco community partnership areas.
- Guided by common goals, strategies and tactics in a statewide plan.
- Focus on ensuring access to prevention, early intervention, treatment, recovery, and crisis services. corresponds

Transfer the management of disability services from the local Mental Health and Disability Services (MHDS) Regions to the Division of Aging & Disability Services

Create more intentional focus on systems of support, care, and connection for all Iowans and families.

- Identify additional organizations to participate in the Aging and Disability Resource Center (ADRC) network and the creation of a disability services system.

Strengthen important system connections to Medicaid, Public Health, and Child Protective Services

- Gather meaningful feedback from Iowans to inform system planning.

Shared Responsibility

Iowa is building a Behavioral Health Service System that leverages shared responsibility. This work will make significant changes in Iowa's state and local system structures to bring existing work together.

In response to assessment findings, Iowa HHS developed a model for coordination and collaboration amongst Iowa HHS system partners within a service delivery system. The Iowa HHS Shared Responsibility Model defines three main system partners within a service system: **Iowa HHS**, **district lead entities**, and **community based organizations (CBO)**. Each system partner plays a role in achieving shared system goals and improving health and social outcomes for Iowans. For the Behavioral Health Service System, district lead entities are known as **Behavioral Health Administrative Services Organizations (BH-ASO)**.

Iowa HHS Shared Responsibility Model

Iowa HHS

District Lead Entities

Community Based Organizations

Iowa's Behavioral Health Service System will:

- Offer information, coordination, and **clear access points** throughout each behavioral health district
- Ensure that individuals and families have **access to person-centered services and supports** no matter where they live
- **Reduce duplication** by linking federal, state and local governance and authority
- **Eliminate administrative red-tape**, and the same efforts happening in multiple places
- Link funding to **measurable outcomes**

Behavioral Health Districts

Behavioral health districts outline geographic boundaries for local coordination and connection and help inform budget targets.

During the summer of 2024, Iowa HHS sought stakeholder feedback and held a public comment period to develop new district maps for the Behavioral Health Service System. Feedback was sought through a variety of means including written comment and town hall style feedback sessions. Existing maps were utilized to gather stakeholder response.

From this feedback, Iowa HHS was able to identify common priorities of stakeholders and existing data to inform the district mapping.

Priorities identified were: access to care, level of need, and overall risk of poor health outcomes. County level data utilized included: Health Professional Shortage Areas (HPSA), Medicaid enrollment per 1,000 residents and Social Vulnerability Index scores. Stakeholders also identified that districts needed to be geographically balanced. Using a Build Balanced Zones tool, the resulting district map is balanced based on access, need, risk and geography with each county and district receiving an adjustment score to help inform a balanced approach to funding.

Full map of the seven behavioral health districts is in Appendix A on page 55.

Behavioral Health Administrative Service Organization

To ensure access to the behavioral health continuum throughout each district, Iowa HHS will work alongside a lead entity known as a **Behavioral Health Administrative Service Organization or BH-ASO**.

The BH-ASO will coordinate a wide array of functions within each district and serve as a connection point between Iowa HHS and district communities for assessment, resource planning, and network support. The BH-ASO will connect and collaborate with local decision-makers and systems such as schools, law enforcement, health and local public health. At the district level, advisory councils will help ensure key connections are embedded into the planning and oversight of the BH-ASO's work.

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Behavioral Health Administrative Service Organization

Partner
Partner with Iowa HHS and local stakeholders to assess needs, identify priorities, and develop plans.

Collaborate
Build and manage local collaborations such as education, judicial, law enforcement, public health, and health systems.

Administer
Meet all state and federal assurances and standards including collection and reporting of meaningful data.

Support
Maintain the district behavioral health safety net service system and provide low barrier information and support via System Navigation.

Led by this statewide Behavioral Health Service System plan, the BH-ASO administers the district service system, ensuring access, and supporting System Navigation. They will build, leverage, and fund local collaborations and partnerships to improve outreach, support public education and information, enhance collaboration, guide early intervention, and support recovery efforts. These are areas of significant focus and development for the BH-ASO because, unlike traditional behavioral health treatment services, they are not typically paid for by other payors.

Through improved connection and system navigation, the BH-ASO will assist people through eligibility processes, make referrals and direct connections to service providers, and help individuals connect to other necessary support such as applying for Medicaid, food, or housing.

The BH-ASO will also support Iowa's behavioral health safety net service providers through flexible funding to support the work that falls outside of the mechanisms of fee-for-service payment arrangements. This support will include technical assistance, network support, and other capacity building funds and activities to help ensure all Iowans have access to a full continuum of supports and services in the right place at the right time.

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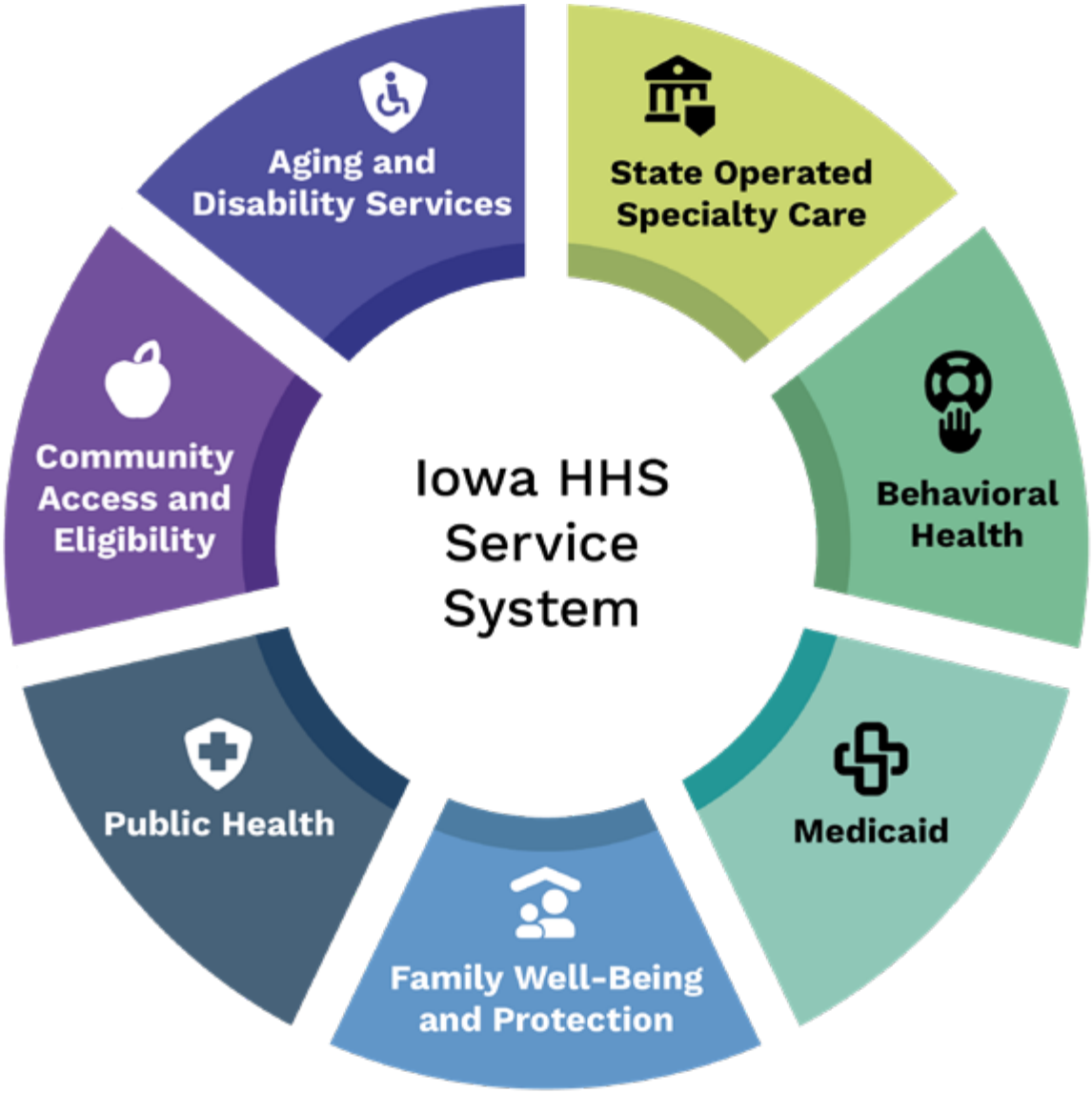
Intersections Across Systems

Behavioral health services connect across a wide of array systems and partners. Working together helps us identify strengths, gaps, and areas for improvement. Ongoing collaboration in the new Behavioral Health Service System will be key to creating effective strategies that ensure fair access to services and better outcomes for Iowans. Below is a summary of system partners and their role in Iowa's Behavioral Health Service System.



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Connections throughout the Iowa HHS Service System

State-Operated Specialty Care

Iowa's Mental Health Institutes (MHIs) provide specialized inpatient psychiatric care for children, youth, and adults with significant needs. Multi-disciplinary teams of doctors, nurses, social workers, and specialists support planning and treatment services including medication, psychotherapy, group counseling, and activities therapies. MHIs are a critical piece of the behavioral health continuum of care working to ensure Iowans receive care in the least restrictive setting possible and enabling Iowans to safely return to their home and community.

Medicaid

Iowa's Medicaid programs including Iowa Health Link, Iowa Health and Wellness Plan (IHAWP), and Healthy and Well Kids in Iowa (Hawki) provide free or low-cost health insurance coverage to Iowans with limited resources to ensure they can receive outpatient, inpatient, and residential behavioral health that is tailored to their needs. Effective Medicaid benefit design for behavioral health contributes to improved outcomes and is part of Iowa's comprehensive approach to improving the health status of all Iowans.

Public Health

Public Health (PH) works with state and local partners to address health priorities, including behavioral health, by reducing health disparities, promoting healthy behaviors, and preventing disease. PH and behavioral health professionals work collaboratively to engage communities in prevention and early intervention efforts to decrease the impact of behavioral health conditions and improve the resiliency and overall health and well-being of Iowans.

Family Well-Being and Protection

Family Well-Being and Protection is dedicated to ensuring Iowa's children and families are safe, healthy, stable, and equipped to build and sustain positive relationships. Child Protective Services (CPS) and programs such as Family Centered Services (FCS) connect families to evidence-based behavioral health services that build on strengths, change unhealthy patterns, and provide trauma-informed, focused care to build healthy, supportive family environments.

Community Access and Eligibility

Community Access and Eligibility serves as an entry point for Iowans to numerous services, programs, and benefits offered by and through Iowa HHS. Staff help Iowans understand what programs and services they are eligible for, assist with enrollment, directly provide health services to families and make referrals that support Iowans' timely access to care.

Aging and Disability Services

Aging and Disability Services provides connection and care to ensure that Iowans who experience challenges related to aging or disability can live in the home and community of their choice. Through Aging and Disability Resource Centers (ADRCs), older Iowans, people with disabilities and their families and caregivers can learn about long-term services and supports and find connection to behavioral health services.

Connections to External Partner Systems

Veterans Affairs

Iowa has two Veterans' Administration (VA) health centers in Iowa City and Des Moines that provide comprehensive behavioral health for veterans. Iowa veterans are also served by VA systems in Omaha, NE and Sioux Falls, SD. The VA system connects veterans and families with providers in their communities to ensure access to care and services. VA staff also partner with communities throughout Iowa to develop local suicide prevention coalitions for veterans and all Iowans.

Private Insurance

Most Iowans receive health services covered by their private (such as employer-sponsored) health insurance. Iowa Code requires larger employers to cover services for certain behavioral health conditions for fully insured plans but does not require smaller plans to cover any behavioral health treatment. Iowans who are uninsured or underinsured may rely on free or reduced cost behavioral health services through the state's behavioral health safety net service providers

Judicial

Individuals involved in the criminal justice system overwhelmingly present needs related to behavioral health, about 1/3 have a history of mental health disorder and about 3/5 have a substance use disorder. For many people, they learn about their behavioral health condition after they become involved in the judicial system. This speaks to the importance of building prevention, earlier intervention and clear pathways to care.

Law Enforcement

The intersection between our law enforcement system and the behavioral health continuum is significant. It is estimated that 20% of police calls involve a mental health or substance use crisis. Expanding current state and local efforts to intercept and support people in crisis, create access points, and build connections between systems is essential and enhances safety for individuals, families, and communities across Iowa

Education

In 2020, Iowa Code expanded access to behavioral health services for students by using the telehealth in school setting and telehealth. The legislation also allowed school districts, accredited non-public schools, and Area Education Agencies to contract with licensed behavioral health providers to conduct in-person, universal behavioral health screenings, which aids in expanding early intervention for our youth. Ongoing collaboration expanding behavioral health services is necessary for Iowa's youth.

Housing and Homelessness

Sixty-seven percent (67%) of people experiencing homelessness have a behavioral health disorder. Several grant programs and services in Iowa aim to improve access to care for people experiencing homelessness. Most are facilitated by community service organizations and funded through state agencies, such as the Iowa Finance Authority and Iowa HHS. These programs support adults who are homeless and by offering connection to hope, healing, housing, treatment and recovery.

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Behavioral Health Service System Data

Developing a baseline "data story" gives us a fixed reference point to measure progress over time. As we've collected the experiences of Iowans to guide Iowa's Behavioral Health Service System plan, we've connected those experiences to data using the 2021-2022 National Survey on Drug Use and Health (NSDUH) which provides context for both Iowa and national data. A limitation associated with this data is that it comes from interviews with people, so it is self-reported information. When we asked stakeholders to describe what they need from Iowa's behavioral health system, so many people shared their stories of loss and so many people shared their stories of hope.

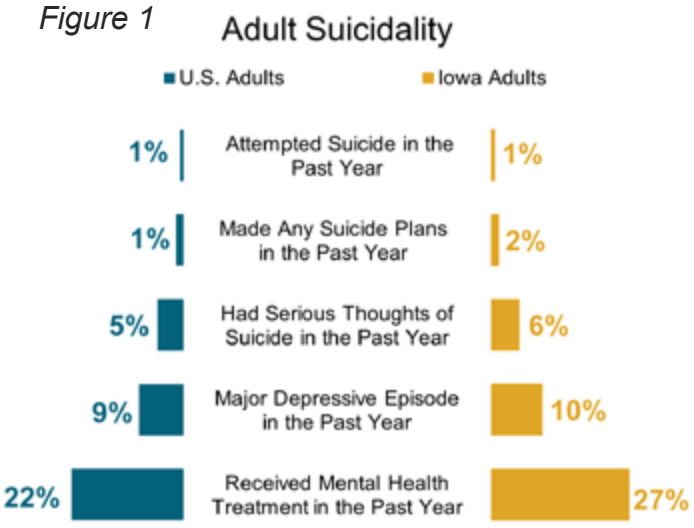
Iowans want to build healthy, resilient families and communities and reduce the number of youths, family members, and neighbors impacted by substance-involvement, overdose or suicide.

Suicide

More adult Iowans received mental health treatment than the national average, but Iowans died by suicide at a higher rate than the U.S. overall.

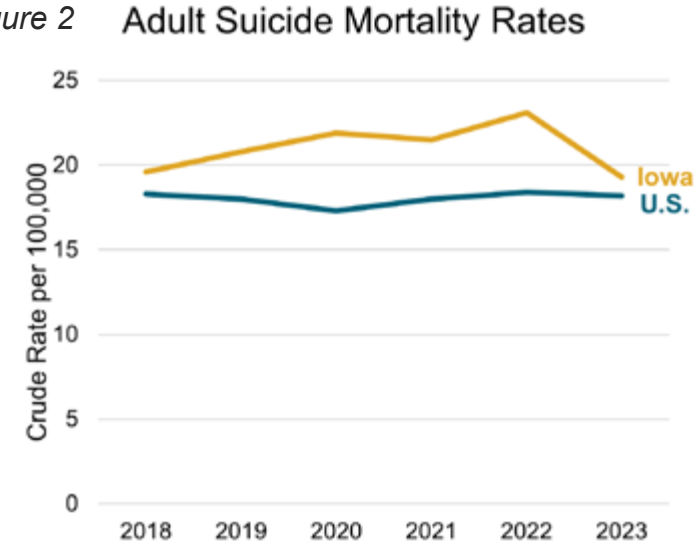
The 2021-2022 National Survey on Drug Use and Health (NSDUH) estimates indicated a similar proportion of Iowa and U.S. adults aged 18 and older attempted suicide, made any suicide plans, had serious thoughts of suicide, or experienced a major depressive episode in the past year *(Figure 1)*. However, a **higher percentage of Iowa adults reported receiving mental health treatment** in the past year than the U.S. overall *(Figure 1)* and the **suicide mortality rates of adult Iowans were higher than the U.S.** from 2018-2023 *(Figure 2)*.

Figure 1



Data source: NSDUH, 2021-2022

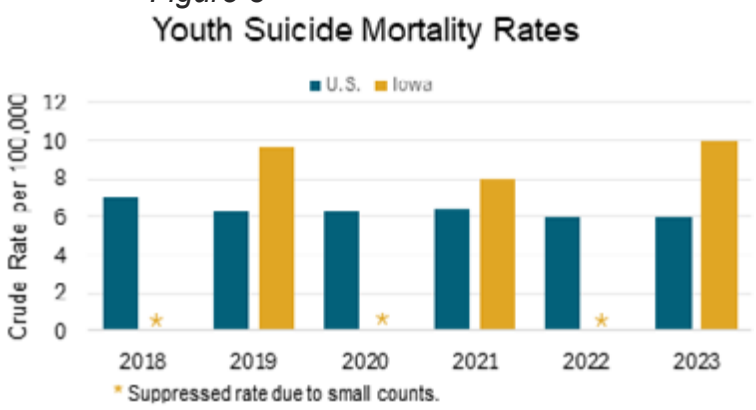
Figure 2



Data source: CDC Wonder, 2025

For Iowa youth aged 12-17, 2021-2022 NSDUH estimates indicate similar percentages of suicidality as the estimates of U.S. youth the same age. Unlike Iowa adults, the percentage of Iowa youth that reported receiving mental health treatment in the past year was similar to U.S. youth of the same age. However, **suicide mortality rates among Iowa youth aged 12-17 were higher than U.S. youth** of the same ages in 2019, 2021, and 2023 *(Figure 3)*.

Figure 3



Data source: CDC Wonder, 2025

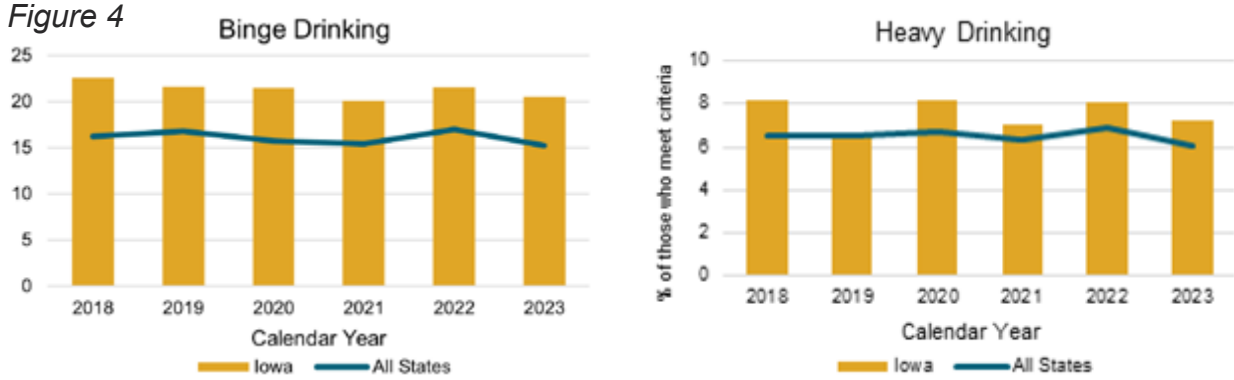
Alcohol

National estimates indicate adult Iowans drink more alcohol than the U.S. overall. Iowa ranks third highest in the nation for adult binge drinking and adult Iowans died by alcohol-induced deaths at a higher rate than the U.S.

The 2021-2022 NSDUH estimates that **more adult Iowans used alcohol** than the U.S. overall (59% of Iowans vs 52% of the U.S.).

Behavioral Risk Factor Surveillance System (BRFSS) survey data from 2018-2023 indicates that **more adult Iowans met criteria for heavy drinking and binge drinking** than the U.S. overall (Figure 4). As of 2023, **Iowa ranks third highest in the nation for adult binge drinking**, after DC (27.1%) and North Dakota (21.2%).

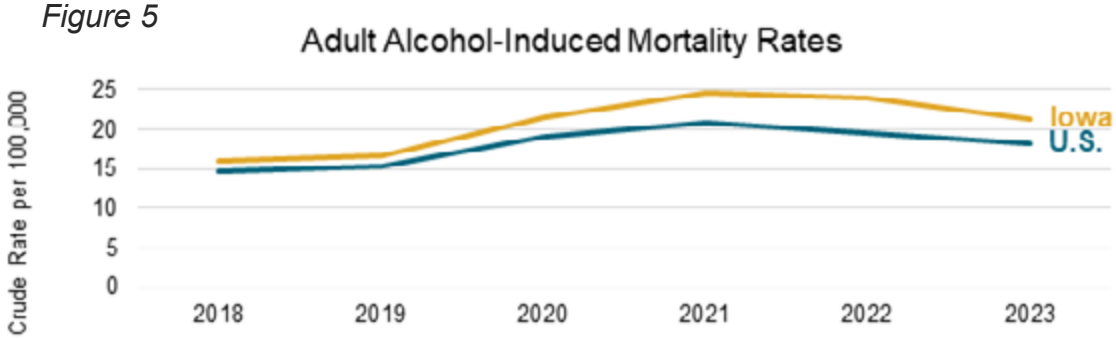
Figure 4



Data source: BRFSS, 2025

Iowa's adult alcohol-induced mortality rates were also higher than the U.S. overall from 2018 to 2023 (Figure 5).

Figure 5



Data source: CDC Wonder, 2025

Substance Use, Treatment Access and Overdose

National estimates indicate that Iowa substance use was similar to the U.S. overall. However, overdose mortality rates were lower in Iowa than the U.S.

The prevalence of **past year and current use of illicit substances, along with past year use disorder and treatment access in Iowa were comparable to the U.S. overall** for adults 18 and older, according to the 2021-2022 National Survey on Drug Use and Health (NSDUH) estimates. Similarly, Iowa youth aged 12-17 were comparable with U.S. youth for past year and current use of illicit substances as well as use disorder and treatment access.

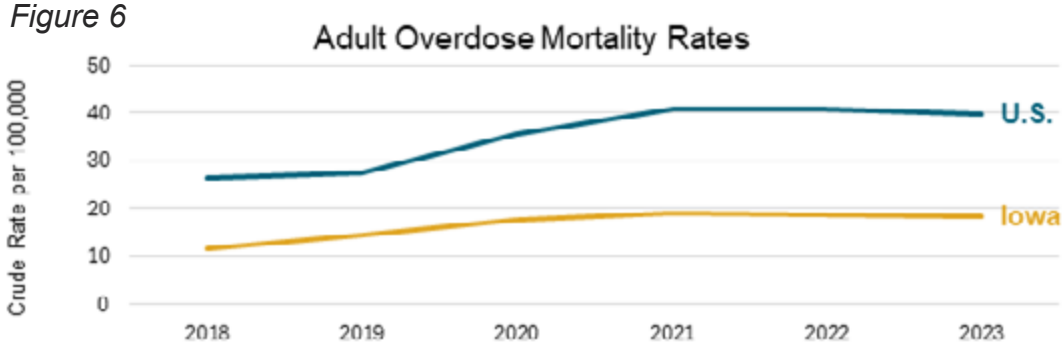
NSDUH 2021-2022 Adult Estimates	Iowa	U.S.
Past Year Use		
Hallucinogen Use in the Past Year	3%	3%
Methamphetamine Use in the Past Year	1%	1%
Prescription Pain Reliever Misuse in the Past Year	3%	3%
Opioid Misuse in the Past Year	3%	3%
Past Month Use (Current Use)		
Illicit Drug Use in the Past Month	14%	16%
Illicit Drug Use Other Than Marijuana in the Past Month	4%	3%
Use Disorder in the Past Year		
Substance Use Disorder in the Past Year	19%	18%
Drug Use Disorder in the Past Year	10%	9%
Pain Reliever Use Disorder in the Past Year	2%	2%
Opioid Use Disorder in the Past Year	2%	2%
Treatment Access		
Received Substance Use Treatment in the Past Year	5%	5%
Classified as Needing Substance Use Treatment in the Past Year	20%	20%
Did Not Receive Substance Use Treatment in the Past Year	73%	77%

Data source: NSDUH 2021-2022

Iowa's overdose mortality rates were almost half the U.S. rates for adults from 2018 to 2023 (Figure 6). However, according to the CDC's State Unintentional Drug Overdose Reporting System (SUDORS), 86% of Iowa's unintentional and undetermined overdose deaths had at least one potential opportunity for intervention in 2023.

Similarly, overdose mortality rates from 2018-2023 among Iowa youth were low. The combined count for all overdose deaths in Iowa among youth aged 12-17 for the years of 2018-2023 was 28, or a combined rate of 1.8, which is comparable to the U.S. rate of 2.1.

Figure 6



Data source: CDC Wonder, 2025

Tobacco

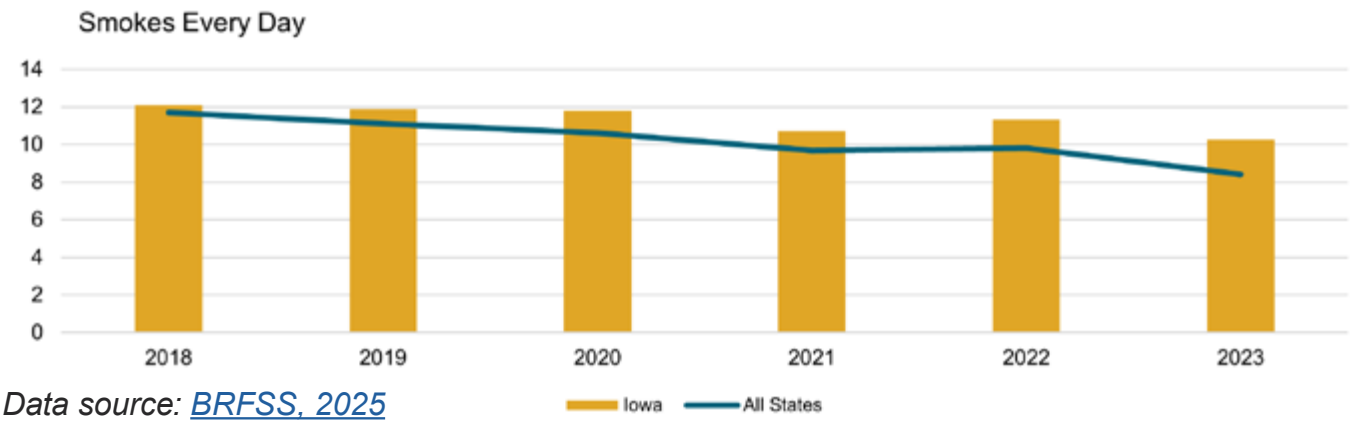
Tobacco use is the leading cause of preventable disease and death in the United States. More Iowans report daily smoking and smokeless tobacco use than the U.S. overall.

Smoking causes many diseases including cancer, cardiovascular and lung diseases. Smokeless tobacco use is a risk factor for cancers of the mouth, esophagus, and pancreas, and tobacco use remains the leading cause of preventable disease and death in the United States (CDC, 2024).

The 2021-2022 NSDUH estimates that almost a quarter of Iowa adults aged 18 years and older (23%) used a tobacco product in the past month, which is slightly higher than the U.S. overall (21%).

In 2022 and 2023 (BRFSS, 2025), there were slightly more current cigarette smokers in Iowa than the U.S. average, and more adult Iowans reported daily smoking than the U.S. overall from 2018-2023 (Figure 7).

Figure 7

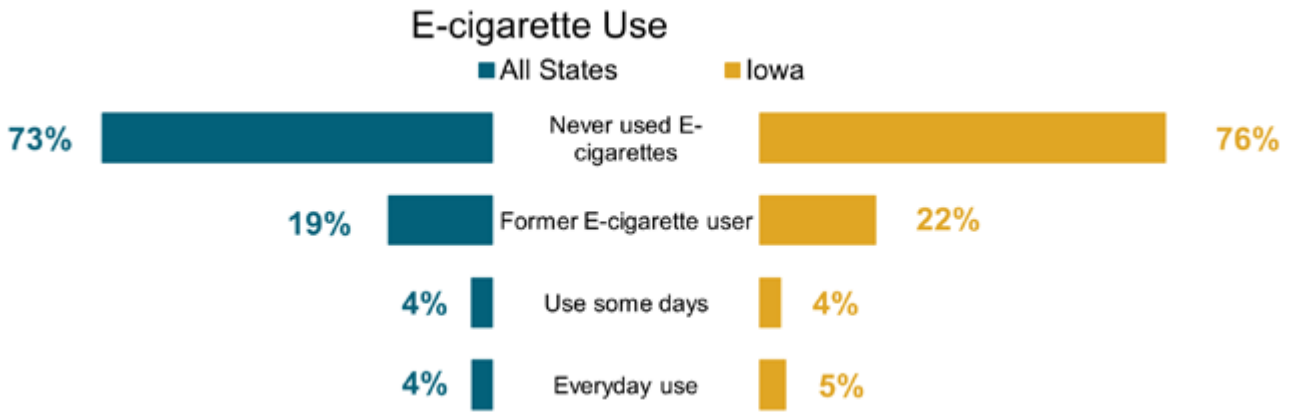


Data source: BRFSS, 2025

In 2023, there were **more adult Iowans reporting everyday e-cigarette use** compared to the U.S, however, Iowans reported a **higher percentage of those who have never used e-cigarettes and former e-cigarette users** (Figure 8).

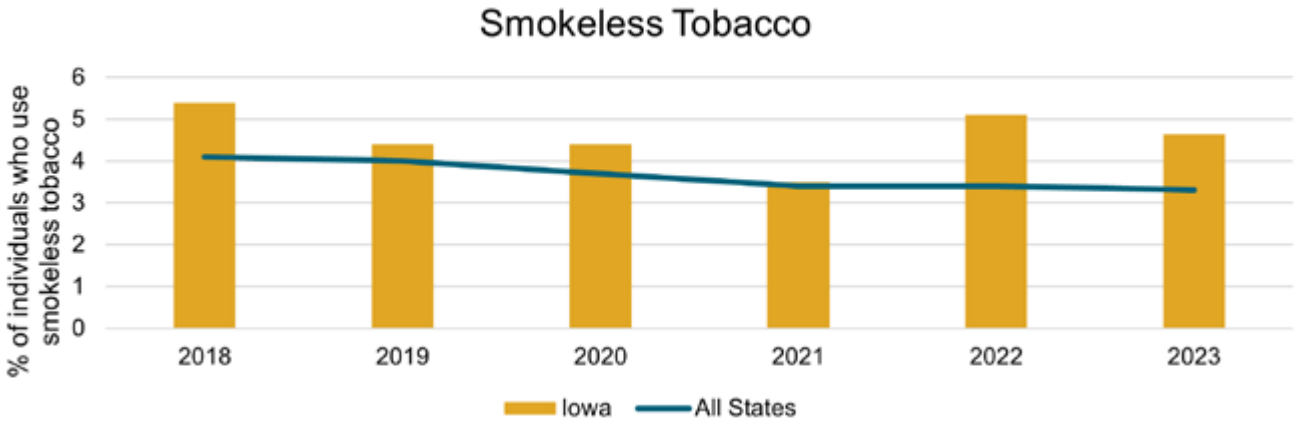
Additionally, **more Iowans reported using smokeless tobacco (chewing tobacco, snuff, and snus)** then the U.S. overall (Figure 9), especially in 2022 and 2023.

Figure 8



Data source: BRFSS, 2025

Figure 9



Data source: BRFSS, 2025

Developing Iowa's Behavioral Health Service System Statewide Plan

In the new Behavioral Health Service System, system partners will work collectively to achieve service system goals. To guide this work Iowa HHS has partnered with stakeholders statewide in the development of this Behavioral Health Service System Statewide Plan.

This plan is intended to be a comprehensive document that outlines our work and a roadmap to achieve our common goals. Linking this Behavioral Health Service System Statewide Plan to other statewide initiatives helps to set service systems up for success. These linkages include Healthy Iowans, Iowa's State Health Assessment (SHA), the State Health Improvement Plan (SHIP), the Iowa HHS Strategic Plan and Iowa HHS' Strategic Plans in Action.

Healthy Iowans

The Healthy Iowans planning process is completed every five years and includes the identification of Iowa's top health issues through a SHA and the development of a SHIP. The most recent SHA identified **substance use and mental health disorders as two of Iowa's top seven health issues**.

Consequently, the Healthy Iowans Partnership Steering Committee and Workgroups selected **access to behavioral health** as one of the top priority areas for the 2023-2028 SHIP. Connection between service systems and the Healthy Iowans Steering Committee and Workgroups initiatives strengthens implementation of strategies and tactics at the district and local level.

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Iowa HHS Strategic Plan

Iowa HHS' Strategic Plan guides all the work of Iowa HHS. Through the strategic planning process, we set priorities for new initiatives, connect our work through identified priorities, reflect and embed our priorities in our communications, and guide our culture and day to day collaboration.

Iowa HHS' strategic priorities for 2024-2027 include

Culture

Elevate organizational health

Operations

Advance operational excellence

Impact

Help Iowa thrive

Connection between service systems and the Iowa HHS Strategic Plan strengthens implementation of strategies and tactics at the state level and bolsters the service system's ability to build system infrastructure.

Stakeholder Engagement and Public Comment

Development of the statewide plan began in mid-August 2024. Iowa HHS, with support from **Health Management Associates (HMA)**, held virtual round table conversations to collect information from a variety of partners and stakeholders. These discussions were designed to gather feedback on the current behavioral health safety net system in Iowa across the behavioral health continuum. A total of 245 individuals, representing over 143 organizations, participated in a virtual round table discussion. The key themes from these discussions were used to help develop the desired outcomes, strategies, and tactics for the Behavioral Health Service System Statewide Plan throughout September and October.

A second stakeholder engagement opportunity took place in late fall 2024. During the last week of October, advisory group meetings were held in each of the seven Behavioral Health Service System districts to gather feedback on draft Behavioral Health Service System Statewide Plan strategies and tactics. Each advisory group consisted of partner and stakeholder representatives from throughout the behavioral health district; over 200 people attended one, or more, of the seven meetings and an additional 400 people attended virtual town hall presentations the following week. Input from this process was collected through November 29th and was incorporated into the strategies and tactics outlined in this plan.

A formal public comment period regarding this plan, including the services system strategies and tactics, took place in March of 2025. Public comment included opportunities to provide both written and verbal comment through virtual public comment meetings. Feedback from the formal public comment period was incorporated in late March and early April of 2025 resulting in this final version of the Behavioral Health Service System statewide plan.

Iowa's Behavioral Health Service System statewide plan is informed by significant stakeholder feedback and the Healthy Iowans planning process and structured based on the Iowa HHS strategic plan. This plan will direct strategies and tactics for the Behavioral Health Service System and will be used to guide the development of district level plans for each of the seven behavioral health districts.

The Behavioral Health Service System Statewide Planning Framework

To develop a comprehensive plan that outlines the work of multiple service system partners and is aligned with both Iowa's SHA/SHIP and the HHS Strategic Plan, Iowa HHS created a framework of four components: **Functions**, **Focus Areas**, and **Strategies and Tactics**.

Functions

Functions define the main aspects of work to be completed by service system partners.

Functions of the Behavioral Health Service System include:

System Operations

The Behavioral Health Continuum

- Prevention
- Early Intervention
- Treatment
- Recovery
- Crisis

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Focus Areas

Focus areas are descriptive topics that categorize related strategies under each of the system's functions. The focus areas align with the Iowa HHS strategic plan priorities.

Partners identified strategies that fell into one of three focus areas:

Operations

To advance excellence.

Operations strategies optimize Behavioral Health Service System efficiency, resilience, and effectiveness through the integration of aligned technology and updated policies and processes, with a focus on team collaboration and coordination. These strategies are directly related to the System Operations function.

Impact

To help Iowa thrive.

Impact strategies describe how service delivery will lead to better access to health and human services resources that help individuals, families, children, and communities thrive. These strategies are directly related to the behavioral health continuum functions.

Culture

To elevate organizational health.

Culture strategies advance and accomplish Behavioral Health Service System initiatives by leveraging responsive leadership, engaged and motivated team, effective internal communication, innovation and positive work culture. The culture of our state system has a direct impact on our behavioral health continuum, and we invest in it.

Strategies and Tactics

Strategies are high-level statements of what will be done within each focus area.

Tactics detail how each strategy will be achieved.

Strategies

Strategies have been identified for each of the focus areas.

Tactics

Tactics describe what will be done by whom. Tactics have been identified for each strategy and the responsible system partners have been identified for each tactic.

Iowa's Behavioral Health Service System Outcomes

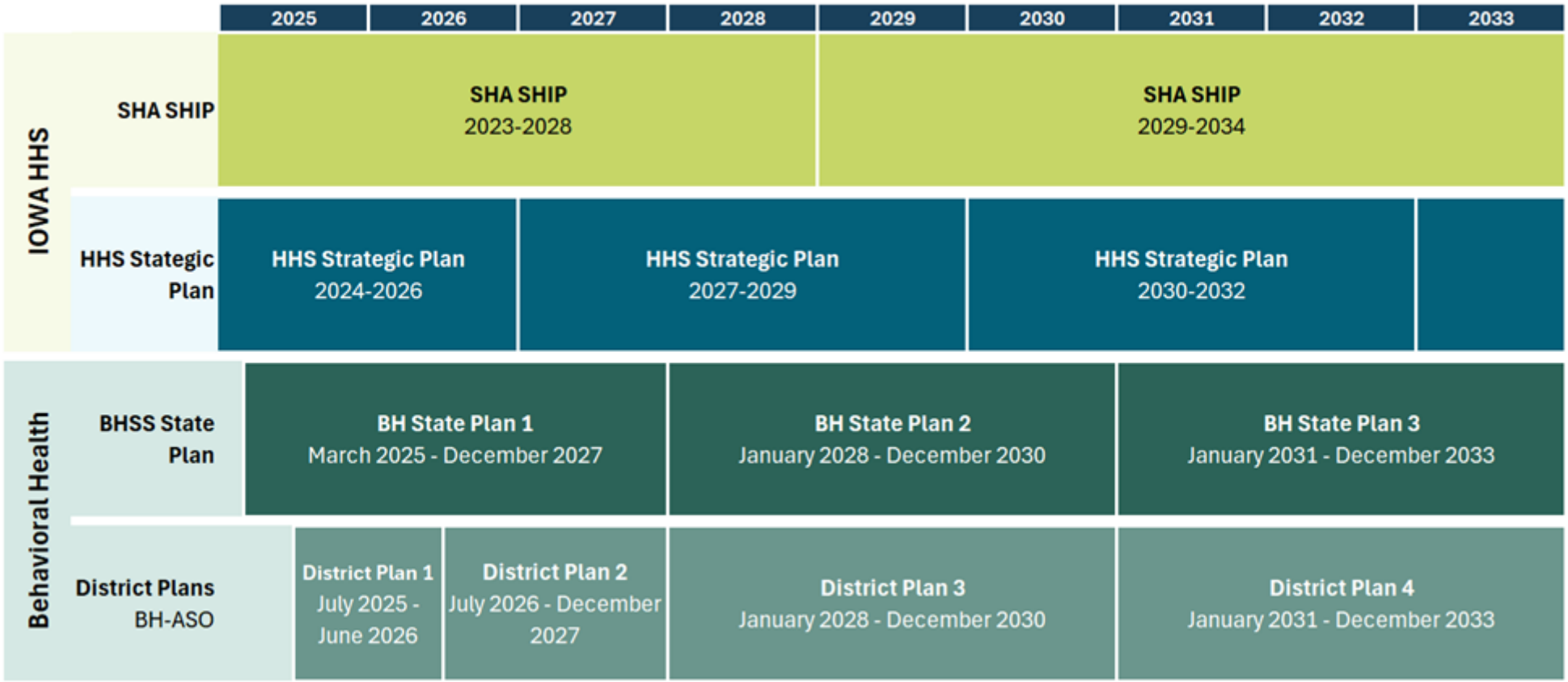
- Build an integrated, comprehensive, statewide system of high-quality behavioral health services.
- Improve access to behavioral health.
- Strengthen Iowa's behavioral health workforce.
- Increase behavioral health wellness and reduce the stigma associated to asking for care and support.
- Improve health outcomes and decrease the number of Iowans who die due to substance-involvement, overdose, or suicide.

The themes for the Operations and the Behavioral Health Continuum are outlined before each section and provide context for this essential work that will support the outcomes.

Planning Schedules

The statewide plan will be finalized in the spring of 2025 and will be in effect through December 2027. It is anticipated that future statewide plans will use a similar, three-year timeframe and will rely on engagement from stakeholders. District plans will follow a one-year timeframe from July 2025 – June 2026, followed by an 18-month timeframe from July 2026 – December 2027.

The statewide plan and district plans will be reviewed on an annual basis and revisions will be made as needed. Below is the projection of this work over the next several years and as always has the potential for change, but Iowa HHS is seeking to commit to this work in a public and transparent way.



System Operations

Themes within Strategies and Tactics to Optimize Behavioral Health Service System Operation

The Division of Behavioral Health has created strategies and tactics for System Operations and each part of the behavioral health continuum: prevention, early intervention, treatment, recovery and crisis.

A formula was used to be able to track throughout the strategies and tactics: Operations (OPS), Prevention (PR), Early Intervention (EI), Treatment (TR), Recovery (RC) and Crisis (CR). For Operation Strategy 1, the formula is OPS-1.

Themes within Strategies and Tactics to Optimize Behavioral Health Service System Operation

To develop a comprehensive plan that outlines the work of multiple service system partners and is aligned with both Iowa's SHA/SHIP and the HHS Strategic Plan, Iowa HHS created a framework of four components: **Functions, Focus Areas**, and **Strategies and Tactics**.

- **Use meaningful data to guide planning and decision-making.**
- **Create, support, and follow plans.**
- **Create and follow consistent policies and protocols.**
- **Develop solutions that address community needs.**
- **Manage financial, human, and technology resources.**
- **Assess how well the system is working and use the data and information to make adjustments.**

Operations Strategy 1 (OPS-1)

Use meaningful data to guide behavioral health planning at the state and community level.

Tactics

OPS 1.1: The Iowa Department of Health and Human Services (Iowa HHS) and the Behavioral Health-Administrative Services Organization (BH-ASO) will collect, interpret, and use data to describe behavioral health needs.

a. Iowa HHS will utilize data to operationalize tactics to expand, establish and sustain each part of the BH continuum.

b. BH-ASO will utilize data to develop district assessment and planning.

OPS 1.2: Iowa HHS and BH-ASO will assess and address disparities in the distribution of risk factors.

a. Iowa HHS will incorporate approaches for addressing identified disparities (such as rural access) into the state plan continuum tactics.

b. BH-ASO will incorporate approaches for addressing disparities into district assessment and planning.

c. Iowa HHS and BH-ASO will work with state, district and community partners to collect, report and use behavioral health data that is relevant to districts and communities experiencing impacts of disparity.

OPS 1.3: Iowa HHS, BH-ASO and community based organizations (CBOs) will conduct and participate in the assessment of state, district, and community needs to identify behavioral health priorities.

a. All parties will participate in the State Health Assessment (Healthy Iowans).

b. Iowa HHS will conduct a statewide need assessment for the behavioral health continuum.

c. BH-ASO will conduct district level assessments to establish behavioral health priorities.

d. CBOs will participate in district (including community level) assessments to provide insight and information on the needs of Iowans.

OPS 1.4: Iowa HHS and BH-ASO will participate in or support surveillance systems to rapidly detect emerging behavioral health issues and threats.

a. Iowa HHS will dedicate resources to quickly identify potential behavioral health threats (such as new substances that present with life threatening effects).

b. Iowa HHS and BH-ASO will develop district level procedures to mitigate potential behavioral health threats within Iowa communities.

Operations Strategy 2 (OPS-2)

Create, support, and follow plans that direct behavioral health work at the state and community level.

Tactics

OPS 2.1: Iowa HHS and BH-ASO will develop plans that guide behavioral health activities.

a. Iowa HHS and BH-ASO will use assessment data and findings to inform plan development.

b. Iowa HHS will develop a statewide Behavioral Health Service System plan and continuum tactics to further develop each part of the continuum.

c. Iowa HHS and BH-ASO will participate in the State Health Assessment and Health Improvement Plan process (Healthy Iowans).

d. BH-ASO will lead the development of district plans with Iowa HHS assistance and oversight.

OPS 2.2: Iowa HHS and BH-ASO will collaborate with CBOs and other organizations integral to the behavioral health system to implement behavioral health plans.

a. Iowa HHS will continue existing stakeholder engagement and communicate how feedback obtained is incorporated into planning activities.

b. BH-ASO will establish and lead district advisory councils (compiled with members from each district).

c. BH-ASO will develop additional stakeholder engagement strategies to ensure community level engagement with the planning processes.

Operations Strategy 3 (OPS-3)

Create and follow policies and protocols that positively impact behavioral health.

Tactics

OPS 3.1: Iowa HHS and BH-ASO will develop policies and protocols that guide the practice of behavioral health.

a. Iowa HHS and BH-ASO will use data and lived experience to inform policy development.

b. Iowa HHS will develop administrative rules, policies, protocols, and/or procedures for behavioral health activities and services to address the following, but not limited to:

- Continuum specific requirements.
- Data collection, use, reporting, and sharing
- BH-ASO oversight.
- Behavioral health service provider oversight.
- Licensure, certification, and accreditation.

c. Iowa HHS and BH-ASO will collaborate with CBOs and other organizations integral to the behavioral health system to inform law and policy development.

d. Iowa HHS and BH-ASO will educate decision makers about the impacts of proposed policies, standards, and regulations of behavioral health activities and services.

e. Iowa HHS and BH-ASO will inform on policies being considered by other governmental and nongovernmental agencies that can improve behavioral health activities and services.

OPS 3.2: Iowa HHS, BH-ASO and CBOs will implement federal regulations and state laws, administrative rules, polices, protocols and procedures.

a. Iowa HHS will designate responsible parties, ensure compliance and monitor for implementation.

b. BH-ASO will function as an instrumentality of the state and ensure compliance and monitor for implementation.

c. CBOs will adhere to compliancy expectations as outlined/identified in their respective regulations/laws that impact organizational work.

Operations Strategy 4 (OPS-4)

Use data, community voices, and evidence-based strategies to create meaningful solutions that address community needs.

Tactics

OPS 4.1: Iowa HHS, BH-ASO and CBOs will strategically address community needs that impact behavioral health, through policy, programs, and services.

a. Iowa HHS will utilize the statewide assessment process to assess the impact of community needs in policy, programs and services.

b. BH-ASO will utilize the district assessment process to assess the impact of community strengths and needs in policy, programs and services.

c. Iowa HHS, BH-ASO and CBOs will utilize assessment information to identify opportunities for improving behavioral health outcomes through policy, program and services.

Operations Strategy 5 (OPS-5)

Manage the financial, human, and technology resources needed to provide behavioral health activities and services statewide.

Tactics

OPS 5.1: Iowa HHS, BH-ASO and CBOs will secure sustainable and adequate funding to support the full continuum of behavioral health activities and services statewide and at the district level.

a. Iowa HHS will administer state and federal funds to deliver behavioral health activities and services.

b. Iowa HHS will develop comprehensive funding opportunities that include both targeted and flexible funds.

c. Iowa HHS and BH-ASO will establish and implement budgeting, auditing, and billing procedures in compliance with federal and state standards and policies

OPS 5.2: Iowa HHS, BH-ASO and CBOs will use robust information technology services that are current, meet privacy and security standards, and assist in collecting, reporting, and sharing data.

a. Iowa HHS will establish and administer a central data repository for collecting and analyzing state, district, and contracted CBO data.

b. Iowa HHS and the BH-ASO will develop a closed-loop referral system to improve system navigation.

OPS 5.3: Iowa HHS and BH-ASO will deploy workforce development practices to build, strengthen, and maintain a skilled and compassionate behavioral health workforce.

a. Iowa HHS and BH-ASO will organize efforts across the continuum tactics to create an efficient and effective design for workforce improvement.

b. Iowa HHS and BH-ASO will establish metrics and tracking functions to measure how or if we are strengthening the workforce.

Operations Strategy 6 (OPS-6)

Assess how well the Behavioral Health Service System works.

Tactics

OPS 6.1: Ensure Iowa HHS, BH-ASO, and provider compliance with federal regulations and state code, rules, policies, and procedures.

a. Iowa HHS and BH-ASO will conduct monitoring activities and utilize outcome information to assess services and system functioning

- Assure the continuum of behavioral health services are provided statewide.
- Ensure the inclusion and proficient use of evidence-based and evidence-informed practices.
- Assure that priority populations and interim services are provided as required.

b. Iowa HHS and BH-ASO will use findings to identify opportunities for improvements with policies and procedures to streamline and reduce administrative burden.

OPS 6.2: Iowa HHS and BH-ASO will conduct continuous quality improvement activities, evaluation and performance management.

a. Iowa HHS will conduct system level evaluation and monitor measures to assess the behavioral health system.

b. Iowa HHS and BH-ASO will create and implement quality improvement projects to improve the performance of the behavioral health system.

c. Iowa HHS and BH-ASO will provide multiple pathways for feedback on the efficacy of the Behavioral Health Service System.

- Develop a standardized multi-pronged approach for the collection of feedback directly from those that use services (i.e. district advisory councils, client satisfaction surveys, etc.).
- Develop a standardized multi-pronged approach for the collection of feedback directly from those that provide services (i.e. district advisory councils, surveys, etc.).

Themes within Strategies and Tactics for the Behavioral Health Continuum

- Create ways to increase behavioral health awareness and reduce stigma.
- Detail how to expand referral systems and increase access to behavioral health services.
- Outline steps for success in building an integrated, statewide Behavioral Health Service System.
- Help increase behavioral health providers' and partners' knowledge, confidence and skills.

Prevention Strategies

- Create and follow an integrated, system-wide approach to behavioral health promotion and prevention.
- Create and use a system-wide communication plan to make behavioral health visible, prevent behavioral health conditions, promote behavioral health services, and reduce stigma.
- Create and follow steps for success in building an integrated, statewide behavioral health promotion and prevention system for mental health, suicide, and addictive disorders.
- Help the behavioral health prevention workforce increase their knowledge and skills.

Prevention includes information dissemination; education; wellness promotion; organizing and enhancing community-based processes; developing environmental approaches; offering alternative activities; and building resiliency skills through structured learning, including support of critical life and social skills such as decision making, coping with stress, problem solving, interpersonal communication, and improving judgment.

Impact Strategies

Prevention Strategy 1 (PRS-1)

Create and follow an integrated, system-wide approach to behavioral health promotion and prevention.

Tactics

PRS 1.1: Iowa HHS and BH-ASO will develop and implement a framework for the delivery of behavioral health promotion and prevention across the human life span.

a. Iowa HHS and BH-ASO will establish priorities for behavioral health promotion and prevention.

b. Iowa HHS, BH-ASO and CBO's will identify/develop activities and interventions utilizing information dissemination, group-level education, community-based engagement, environmental and social policies.

c. Iowa HHS will develop guidance for the use of evidence-based practices, evidence-informed practices, interventions and emerging practices that address:

- Risk factors and protective factors
- Community engagement including peer led and youth engagement.

d. Iowa HHS will develop and disseminate examples of environmental and social policies to reduce risk factors and increase protective factors.

e. Iowa HHS will provide technical assistance to BH-ASO and CBOs providing promotion and prevention.

PRS 1.2: Iowa HHS and BH-ASO will identify, expand, and strengthen collaborative opportunities with behavioral health partners (CBOs and other organizations).

a. Iowa HHS and BH-ASO will foster opportunities to build partnerships with associations, schools, community organizations, faith-based groups, the judicial system, and other stakeholders to enhance behavioral health prevention and promotion efforts and support results-based solutions.

b. Iowa HHS, BH-ASO and CBOs will lead and/or participate in coalitions and workgroups to strengthen and promote prevention and promotion activities.

c. Iowa HHS, BH-ASO and CBOs will develop and nurture public/private partnerships to identify innovative solutions and expand access to behavioral health promotion and prevention interventions.

d. Iowa HHS, BH-ASO and CBOs will organize and/or actively participate in community engagement opportunities that increase positive attachments to family, school, neighborhood and community.

Prevention Strategy 2 (PRS-2)

Create and use a system-wide communication plan to make behavioral health visible, prevent behavioral health conditions, promote behavioral health services, and reduce stigma

Tactics

PRS 2.1: Iowa HHS, BH-ASO and CBOs will promote public awareness of behavioral health through the development and deployment of communication strategies, education campaigns, and publicly available resources that are:

- Based on science, evidence-based health communication strategies (where appropriate/ applicable).
- Tailored to a variety of audiences' specific needs.
  - Include resources designed for all stages of the behavioral health continuum.
  - Include targeted outreach for at-risk individuals, at-risk populations, and early identifiers (e.g. rural, education system, juvenile justice, child welfare).
  - Based on national promotion and education campaigns, as available.
- Contain input from or are created by people with lived experience.
- Incorporate Culturally and Linguistically Appropriate Services (CLAS) standards.
- Widely available and accessible.

a. Prevention focused, to include at a minimum:
  - Messages about preventing behavioral health conditions.
  - Messages that promote positive mental health, norms, and emotional wellbeing.

b. Brain focused, to include at a minimum:
  - Messages about the signs and symptoms of behavioral health conditions and disorders.
  - Messages to increase awareness of early intervention services supports to mitigate the need for crisis services.
  - Messages about where Iowans should go to access early intervention resources (Your Life Iowa).
  - Messages to reduce stigma around behavioral health disorders.

c. Treatment focused, to include at a minimum:
  - Consistent messages to access for care.
  - Messages that make seeking behavioral health normal, just like any other health care.
  - Messages that assist people in understanding what behavioral health treatment is.

d. Recovery focused, to include at a minimum:
  1. Messages that help reduce stigma.
  2. Messages that promote recovery as the expectation instead of the exception.
  3. Messages about the recovery system including messages for professionals who are not associated with the recovery system.
     - Develop messages about how to share information about the system and how professionals can connect with recovery support service providers. (consider rural, urban, micro recovery connections in message development).

e. Crisis focused, to include at a minimum:
- Messages that encourage help-seeking behaviors.
- Messages about crisis resources.
- Messages that raise awareness about crisis services.
- Messages about pathways for accessing crisis services.

PRS 2.2: Iowa HHS, BH-ASO and CBOs will leverage Your Life Iowa (YLI) to carry out the communication plan, and to communicate behavioral health strategies and resources to Iowans.

a. Iowa HHS and BH-ASO will create a centralized repository of resources with an emphasis on promotion, prevention and early intervention strategies.

b. Iowa HHS will develop resources to support the BH-ASO and CBOs with promotion, prevention and education activities, such as media toolkits, communication planning and messaging guides and publicly make available.

c. Iowa HHS and BH-ASO will build and improve on the treatment facility locator.

PRS 2.3: Iowa HHS and BH-ASO will deliver educational presentations to increase knowledge and change attitudes about behavioral health.

a. Iowa HHS and BH-ASO will conduct presentations on the prevention framework and develop materials to provide education on how prevention can shape the future of public health.

Culture Strategies

Prevention Strategy 3 (PRS-3)

Create and follow steps for success in building an integrated, statewide behavioral health promotion and prevention system for mental health, suicide, and addictive disorders.

Tactics

PRS 3.1: Iowa HHS will develop consistent expectations for the behavioral health promotion and prevention system.

a. Iowa HHS will create guidance, including definitions for behavioral health prevention and promotion, for CBOs carrying out activities.

b. Iowa HHS and the BH-ASO will inventory and assess current prevention and promotion approaches (including models, evidence-based or evidence-informed practices, and activities).

c. Iowa HHS and the BH-ASO will align prevention assessment and planning with the State Health Improvement Plan (Healthy Iowans).

d. Iowa HHS and the BH-ASO will support the CBOs in develop and implement a comprehensive behavioral health strategic prevention framework.

Prevention Strategy 4 (PRS-4)

Help the behavioral health prevention workforce increase their knowledge and skills.

Tactics

PRS 4.1: Ensure Iowa HHS, BH-ASO, and prevention providers (CBOs) have the necessary knowledge and skills to administer and deliver effective behavioral health prevention and promotion activities.

a. Iowa HHS and BH-ASO will assess workforce knowledge and skills through a prevention and promotion workforce survey.

b. Iowa HHS and BH-ASO will develop a workforce development plan that includes addressing needs related to training and technical assistance as well as strategies for increasing the prevention and promotion workforce (i.e. behavioral health profession apprenticeship programs).

PRS 4.2: Iowa HHS and BH-ASO will support professionalization of the prevention field.

a. Iowa HHS and BH-ASO will research credentialing for prevention professionals and develop recommendations that would strengthen the prevention and promotion workforce.

b. Iowa HHS will develop and implement a plan for credentialing prevention professionals.

Early Intervention Strategies

- Create and support an integrated, statewide behavioral health early intervention system to assist individuals, families, and communities in accessing behavioral health interventions and services.
- Help early intervention partners increase their behavioral health knowledge and skills.
- Embed low-barrier access through System Navigation and expand the behavioral health early intervention referral system.
- Create and follow an integrated, statewide approach to behavioral health early intervention activities.

Early Intervention are interventions, services and support to at-risk individuals to address early symptoms and prevent the development of behavioral health disorders. This includes identifying problems and offering referrals to reduce impact and improve well-being.

Impact Strategies

Early Intervention Strategy 1 (EIS-1)

Create and support an integrated, statewide behavioral health early intervention system to assist individuals, families, and communities in accessing behavioral health interventions and services.

Tactics

EIS 1.1: Iowa HHS and BH-ASO will assess, identify, and consistently define early intervention for behavioral health.

a. Iowa HHS will create guidance, including definitions for behavioral health early intervention.

b. Iowa HHS and BH-ASO will inventory approaches, identify partners and assess for gaps in early intervention.

c. Iowa HHS and BH-ASO will utilize the district assessment and planning processes to develop and implement strategies for expanding early intervention approaches.

EIS 1.2: Iowa HHS and BH-ASO will establish a network of early intervention partners to identify, provide, and coordinate early intervention activities at the district (community) levels.

a. Iowa HHS and BH-ASO will establish a network of system navigators, system navigators will function as an initial layer of early intervention within each district.

b. Iowa HHS and BH-ASO will identify system partners to collaborate in the development of strategies to promote universal screening, community-based outreach and education.

EIS 1.3: Iowa HHS and BH-ASO will identify, expand, and strengthen collaborative opportunities with behavioral health partners (CBOs and other organizations).

a. Iowa HHS and BH-ASO will foster opportunities to build partnerships with associations, schools, community organizations, faith-based groups, the judicial system, and other stakeholders to enhance behavioral health early intervention efforts and support results-based solutions.

b. Iowa HHS, BH-ASO and/or CBOs will lead or participate in coalitions and workgroups to strengthen and promote early intervention activities.

c. Iowa HHS and BH-ASO develop and nurture public/private partnerships to identify innovative solutions and expand access to behavioral health early intervention services.

EIS 1.4: Iowa HHS and the BH-ASO will build community readiness where early intervention is needed and not established.

a. BH-ASO will identify community readiness levels for early intervention activities in each district.

b. Iowa HHS and BH-ASO will support communities at all levels of readiness.
- Develop resources and technical assistance tools.
- Share resources.
- Provide technical assistance.

Early Intervention Strategy 2 (EIS-2)

Embed low-barrier access through System Navigation and expand the behavioral health early intervention referral system.

Tactics

EIS 2.1: Iowa HHS, BH-ASO and CBOs will develop and expand referral pathways to behavioral health services.

a. Iowa HHS and BH-ASO and CBOs will establish a network of system navigation.

b. Iowa HHS and BH-ASO will utilize district level assessment and planning to identify additional referral pathways to incorporate into the early intervention system within each district.

c. Iowa HHS and BH-ASO will engage with existing statewide partnership to identify and explore application of early intervention services for populations served by the systems that may be at risk of developing behavioral health conditions (Aging and Disability Resource Centers, Department of Corrections, Department of Education, HHS Child Protective Services, Iowa Finance Authority, Iowa Judicial District, Law Enforcement, Veteran's Administration and other state department/state associations).

d. Iowa HHS and BH-ASO will engage with district (community level) organizations such as hospitals, emergency departments, urgent care, law enforcement, schools, primary care providers, crisis service providers, workplaces, jails, and juvenile justice to explore need.

e. Iowa HHS and BH-ASO will identify connections between Thrive and early intervention services.

f. Iowa HHS and BH-ASO will initially connect Thrive with the network of system navigators, and crisis and early intervention providers to ensure follow up and efficacy of next steps beyond just a referral.

g. Iowa HHS and BH-ASO will provide Thrive and Science of Hope training.

EIS 2.2: Iowa HHS and BH-ASO will develop and deploy closed-loop referral systems.

a. Iowa HHS and BH-ASO will assure coordinated referrals from non-traditional pathways including, but not limited to, health (hospitals, emergency departments, urgent care. primary care providers, specialty health such as OG/GYNs, pain specialists, etc.), schools, crisis providers, workplaces and jails.

Impact Strategies

Early Intervention Strategy 3 (EIS-3)

Create and follow an integrated, statewide approach to behavioral health early intervention activities.

Tactics

EIS 3.1: Iowa HHS and BH-ASO will review and establish consistent service access standards that:

- Sets expectations for travel times
- Establishes consistent guidance on access and service delivery
- Improves understanding of appropriate placement criteria
- Helps decrease wait times
- Assures priority population requirements are met (federal regs)

EIS 3.2: Iowa HHS and BH-ASO will create consistency in early intervention planning and service delivery.

a. Iowa HHS and BH-ASO will use early intervention research as well as evidence-based and evidence-informed practices and policies to drive decision making and planning.

b. Iowa HHS and BH-ASO will develop a comprehensive behavioral health strategic early intervention framework and deploy guidance.

c. Iowa HHS and BH-ASO will align early intervention assessment and planning with the State Health Improvement Plan (Healthy Iowans).

EIS 3.3: Iowa HHS and BH-ASO will examine and strengthen pathways for early intervention services and supports.

a. Iowa HHS and BH-ASO will evaluate utilization and develop metrics for monitoring outcomes of early intervention pathways.

b. Iowa HHS and BH-ASO will utilize inventory, evaluation and monitoring to support decision making about early intervention needs.

c. Iowa HHS and BH-ASO will utilize inventory process to gather how current early intervention efforts are funded and explore mechanisms for incentivizing and/or funding early intervention services.

d. Iowa HHS and BH-ASO will provide technical assistance as needed.

Early Intervention Strategy 4 (EIS-4)

Help early intervention partners increase their behavioral health knowledge and skills.

Tactics

EIS 4.1: Ensure Iowa HHS, BH-ASO, and early intervention partners have the necessary knowledge and skills to deliver effective behavioral health early Intervention activities and services.

a. Iowa HHS and BH-ASO will assess current state of knowledge and skillsets related to behavioral health early intervention.

b. Iowa HHS and BH-ASO will conduct an Early Intervention Survey to identify the needs of early intervention partners.

c. Iowa HHS and BH-ASO will develop a workforce development plan.

d. Iowa HHS and BH-ASO will provide education to partners about when and how to identify early signs, develop and share tools and supports to discuss behavioral health wellness and explain how to provide referrals for behavioral health concerns.

e. Iowa HHS and BH-ASO will provide education and training for providers will include how to connect patients to the ASO system.

f. Iowa HHS and BH-ASO will develop consistent training for system navigators.

g. Iowa HHS and BH-ASO will dedicate resources to provide ongoing technical assistance to early intervention partners.

- Promote and offer Mental Health First Aid (MHFA) training, teen Mental Health First Aid and other community-focused education.
- Create and build sustainability for Screening, Brief Intervention and Referral to Treatment (SBIRT).

Treatment Strategies

- Create and support a comprehensive and integrated, statewide behavioral health treatment system.
- Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health treatment system for mental health, and addictive disorders including alcohol use, substance use, tobacco use, and gambling.
- Increase access to behavioral health treatment services.
- Help behavioral health treatment providers increase their knowledge and skills.

Clinical inpatient, outpatient, and residential care for individuals with a behavioral health condition or disorder diagnosed utilizing the most recently published Diagnostic and Statistical Manual (DSM) criteria. The type, length, and intensity or frequency of intervention(s) used by a behavioral health provider is based on the presenting symptoms of the individual.

Impact Strategies

Treatment Strategy 1 (TRS-1)

Create and support a comprehensive and integrated, statewide behavioral health treatment system.

Tactics

TRS 1.1: Iowa HHS, BH-ASO and CBOs will employ human centered design for all treatment services.

a. All parties will utilize a person-centered approach to treatment services from the time of first contact until their last contact with a person and/or their family.
b. Iowa HHS, BH-ASO and CBOs will incorporate the person-centered approach throughout each aspect of care that is a part of the treatment experience.
c. Iowa HHS and BH-ASO will create strategies for enhancing the experience of services.
d. Iowa HHS and BH-ASO will ensure continuity of care for the safety net behavioral health system through implementation of the requirements outlined in House File 2673.

TRS 1.2 Iowa HHS and BH-ASO will ensure the use current and clinically accepted evidence-based and evidence-informed practices and approaches to meet the identified needs of the community.

a. Iowa HHS and BH-ASO will identify and operationalize relevant practices to meet client needs.
b. Iowa HHS and BH-ASO will implement support services based on community needs assessment data.
c. Iowa HHS and BH-ASO will identify linkages to services in addition to treatment (before during and after) through use of system navigation, service coordination, and connection to recovery services and supports.

TRS 1.3: Iowa HHS, BH-ASO and CBOs will develop and implement recommendations and strategies for youth treatment.

a. Iowa HHS, BH-ASO and CBOs will identify treatment gaps for youth and transition-aged youth.
b. Iowa HHS, BH-ASO and CBOs will identify and develop awareness for youth and transition-aged youth specific treatment.
c. Iowa HHS and BH-ASO will leverage Your Life Iowa to promote awareness and create connections to youth and transition-aged youth specific treatment.
d. Iowa HHS and BH-ASO will develop policy recommendations to address identified youth care continuum gaps.
e. Iowa HHS and BH-ASO will engage families and partners in validation of recommendations and strategies.

TRS 1.4: Iowa HHS, BH-ASO and CBOs will identify and address gaps in the behavioral health continuum.

a. Iowa HHS, BH-ASO and CBOs will identify gaps for specific populations throughout the levels of care for treatment (step down, day treatment, intensive outpatient, AH to inpatient versus residential, intensive in-home services for children and youth, etc.).

b. Iowa HHS, BH-ASO and CBOs will identify and develop awareness for population specific treatment (leverage current resources such as Your Life Iowa).

c. Iowa HHS and BH-ASO will define and reinforce the need to serve special populations (outreach and health education). Iowa HHS and the BH-ASO will also inventory and assess and subspeciality care lanes.

d. Iowa HHS will develop policy recommendations to address identified care continuum gaps.

TRS 1.5: Iowa HHS and BH-ASO will identify, expand, and strengthen collaborative opportunities with behavioral health partners (CBOs and other partners).

a. Iowa HHS and BH-ASO will foster opportunities to build partnerships with associations, schools, community organizations, faith-based groups, and other stakeholders to enhance behavioral health treatment efforts, increase access to care, and support results-based solutions.

b. Iowa HHS, BH-ASO and/or CBOs will lead and/or participate in coalitions and workgroups to enhance service delivery.

c. Iowa HHS and BH-ASO will develop and nurture public/private partnerships to identify innovative solutions and expand access to behavioral health treatment services.

TRS 1.6: Iowa HHS and BH-ASO will promote behavioral health parity.

a. HHS and BH-ASO will continue efforts for behavioral health parity through promotion, identification and connection strategies.

Treatment Strategy 2 (TRS-2)

Increase access to behavioral health treatment services.

Tactics

TRS 2.1: Iowa HHS will address costs of treatment and reimbursement

a. Iowa HHS will inventory reimbursement mechanisms.
b. Iowa HHS will identify reimbursement challenges.
c. Iowa HHS will maximize Medicaid and Child Health Insurance Plan (financial, last payor, etc.).
d. Iowa HHS will establish common coding and consistent allowable cost for treatment.

TRS 2.2: Iowa HHS, BH-ASO and CBOs will expand and support the behavioral health treatment provider network.

a. Iowa HHS will simplify licensure/accreditation through regulatory reform.
b. Iowa HHS, BH-ASO and CBOs will build a robust peer support workforce and expand the use of peers across the spectrum of treatment services.
c. Iowa HHS and BH-ASO will build active connection points across the network of behavioral health safety net providers.
d. Iowa HHS and BH-ASO will develop technical assistance and continuing education opportunities.
e. Iowa HHS, BH-ASO and CBOs will promote the practice of behavioral health services as a valuable and fulfilling career path.
f. Iowa HHS and BH-ASO will leverage various workforce-related funding streams.

TRS 2.3: Iowa HHS, BH-ASO and CBOs will leverage innovative treatment options to expand access to care (e.g., telehealth, telepeer support, mobile services, enabling technology).

a. Iowa HHS and BH-ASO will establish the safety network for treatment services and inventory available levels of care/capacity of organizations.
b. Iowa HHS, BH-ASO and CBOs will develop and disseminate informational resources for individuals, families, providers and communities about low barrier, low-cost technology options.
c. Iowa HHS and BH-ASO will inventory existing options that support improved access to technology in public spaces (e.g., libraries, public buildings) for potential use as a telehealth access point.
d. Iowa HHS and BH-ASO will navigate barriers to access at the community level through expanded use of enabling technology and mobile services.

TRS 2.4: Iowa HHS, BH-ASO and CBOs will reduce stigma.

a. Iowa HHS, BH-ASO and CBOs will develop strategies that make seeking behavioral health normal, just like any other health care.
b. Iowa HHS, BH-ASO and CBOs will assist people in understanding what behavioral health treatment is.

Culture Strategies

Treatment Strategy 3 (TRS-3)

Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health treatment system for mental health, and addictive disorders including alcohol use, substance use, tobacco use, and gambling.

Tactics

TRS 3.1: Iowa HHS and BH-ASO will develop definitions and expectations for the behavioral health treatment system.

a. Iowa HHS and BH-ASO will define and reinforce the need to serve special populations (outreach and health education).

b. Iowa HHS and BH-ASO will define system-level roles and responsibilities to enhance collaboration across the treatment system in Iowa.

c. Iowa HHS and BH-ASO will develop roles to coordinate access across sectors and address behavioral health treatment needs.

TRS 3.2: Iowa HHS will research tactics such as incentive funding, strengthening of regulatory requirements or tiered reimbursement models to encourage providers to enhance service delivery.

a. Iowa HHS will utilize operational tactics for quality improvement activities aimed at enhancing service delivery within treatment.

TRS 3.3: Ensure Iowa HHS, BH-ASO, and community providers (CBOs) work collectively to:

a. Iowa HHS and BH-ASO will ensure consistency in treatment protocols and procedures across topic areas.

b. Iowa HHS and BH-ASO will develop and follow consistent implementation guidance, including guidance on fidelity adherence and monitoring.

c. Iowa HHS and BH-ASO will assess treatment services and provide technical assistance to the treatment system.

d. Iowa HHS and BH-ASO will identify emerging treatment trends to develop and implement results-based solutions.

Treatment Strategy 4 (TRS-4)

Help behavioral health treatment providers increase their knowledge and skills.

Tactics

TRS 4.1: Iowa HHS and BH-ASO will ensure providers have the necessary skills to deliver effective behavioral health treatment services.

a. Iowa HHS and BH-ASO will provide education on treatment resources to include first contacts for crisis and primary health providers and psychiatrists.

b. Iowa HHS and BH-ASO will create a warm hand off guide that both providers referring and those receiving referrals operate by to ensure smooth system navigation for people.

TRS 4.2: Iowa HHS and BH-ASO will invest in training and technical assistance to support enhancing the knowledge and skills of Iowa's behavioral health treatment workforce.

a. Iowa HHS and BH-ASO will assess current state of knowledge and skillsets related to behavioral health treatment.

b. Iowa HHS and BH-ASO will conduct a Treatment Partner Survey to identify the knowledge and skill needs.

c. Iowa HHS and BH-ASO will develop a workforce development plan to increase behavioral health knowledge and skills that includes trainings for new partners and information on treatment priorities.

d. Iowa HHS and BH-ASO will create training opportunities through multiple methods such didactic learning opportunities, community-based hands on training, on-demand learning, and virtual reality.

Recovery Strategies

- Create and support a comprehensive and integrated, statewide system of recovery related to the behavioral health needs of individuals, families and communities.
- Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health recovery system.
- Help recovery providers increase their behavioral health knowledge and skills

Non-clinical support that promotes recovery, wellness, and connection, including system navigation, peer services and recovery supports to improve quality of life. The purpose of developing the recovery part of the continuum is to support individuals with multiple pathways of recovery. People access recovery in ways that work for them and for as long as they need, even for the rest of their lives.

Impact Strategies

Recovery Strategy 1 (RCS-1)

Create and support a comprehensive and integrated, statewide system of recovery related to the behavioral health needs of individuals, families and communities.

Tactics

RCS 1.1: Iowa HHS and BH-ASO will expand and support the behavioral health Recovery workforce.

a. Iowa HHS and BH-ASO will develop and deploy workforce recruitment and retention strategies such as training, technical assistance and building professional pathways (e.g., certifications to support peers, community health workers, system navigators and others).

b. Iowa HHS and BH-ASO will develop and nurture career pathways within the recovery workforce.

RCS 1.2: Iowa HHS and BH-ASO will improve statewide awareness and visibility of recovery support services.

a. Iowa HHS and BH-ASO will inventory and map current recovery support services and funding mechanisms.

b. Iowa HHS and BH-ASO will determine the appropriate location for a connections map or resource locator and create one (that functions as a tool for connecting individuals to all available services/resources).

c. Iowa HHS and BH-ASO will leverage Your Life Iowa as a trusted resource to share information about recovery services and supports and connect individuals to recovery supports or to system navigation at the district (community) level.

d. Iowa HHS and BH-ASO will make recovery visible through the promotion of support services and recovery resources (see Prevention and Education strategy #2).

e. Iowa HHS and BH-ASO will utilize communication strategies that are appropriate and relevant to the recovery community and recovery service provider population.

RCS 1.3: Iowa HHS, BH-ASO and CBHOs will improve access to recovery services and supports.

a. All parties will identify populations and link individuals to additional Iowa HHS services and supports, as needed.

b. All parties will ensure recovery support services are accessible.

c. Iowa HHS and BH-ASO will assess current access to recovery services, research recovery service models and make recommendations for community access standards.

f. Iowa HHS and BH-ASO will install recommended access standard requirements through targeted approaches to funding for BH-ASO and community providers that ensure consistent access.

g. Iowa HHS and BH-ASO will expand the number of new providers of recovery services and supports by providing significant training and technical assistance needs and identifying solutions to challenges of retention within Iowa communities

RCS 1.4: Iowa HHS, the BH-ASO and CBOs will support and deploy environmental strategies related to supporting recovery in Iowa's communities.

a. Iowa HHS and BH-ASO will develop and disseminate environmental strategies as well as assist CBHOs in implementing environmental strategies.

b. Iowa HHS and BH-ASO will identify ways to support a recovery-oriented workforce.

RCS 1.5: Iowa HHS and BH-ASO will determine how to create sustainable funding for recovery.

a. Iowa HHS will leverage funding opportunities to reimburse expanded peer support activities.

b. Iowa HHS and BH-ASO will inventory what is reimbursable by insurance providers.

c. Iowa HHS and BH-ASO will determine barriers to sustainable funding, determine changes needed and identify/secure funding to promote and implement recovery in Iowa.

RCS 1.6: Iowa HHS, BH-ASO and CBOs will identify, expand, and strengthen Collaborative opportunities for a unified behavioral health recovery ecosystem promoting safety, resiliency, and health.

a. Iowa HHS and BH-ASO will foster opportunities to build local collaborations to enhance the recovery network.

b. Iowa HHS and BH-ASO will build partnerships with associations, schools, community organizations, faith-based groups, and other stakeholders to enhance behavioral health recovery efforts and support results-based solutions.

c. Iowa HHS, BH-ASO, CBOs and the recovery community will lead and/or participate in coalitions and workgroups to strengthen and promote recovery.

d. Iowa HHS, BH-ASO and CBOs will develop and nurture public/private partnerships to identify innovative solutions and expand access to behavioral health recovery services and supports.

Culture Strategies

Recovery Strategy 2 (RCS-2)

Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health recovery system.

Tactics

RCS 2.1: Iowa HHS, BH-ASO and CBOs will adopt the Substance Abuse Mental Health Services Administration (SAMHSA)'s Working Definition of Recovery to guide Iowa HHS efforts in expanding pathways to recovery.

a. Iowa HHS and BH-ASO will develop and implement HHS' Recovery in Action Plan based on SAMHSA's Working Definition of Recovery.

b. Iowa HHS will define recovery support services and domains.

c. Iowa HHS and BH-ASO will conduct an inventory of current efforts.

- Include Iowa HHS funded SUD and MH recovery services and their funding streams.
- Include SUD and MH recovery services funded outside of Iowa HHS.

e. Iowa HHS and BH-ASO will identify policies and procedures to guide system staff on implementation of behavioral health recovery work.

f. Iowa HHS and BH-ASO will build internal capacity to provide the level of technical assistance and training needed for the recovery network (BH-ASO, CBOs, other organizations and the recovery community).

RCS 2.2: Ensure Iowa HHS, BH-ASO, CBOs and the recovery community work collectively to:

a. Iowa HHS and BH-ASO will develop and follow consistent implementation guidance.

b. Iowa HHS and BH-ASO will work with the recovery community to assess recovery efforts and provide technical assistance to the recovery community.

c. Iowa HHS and BH-ASO will identify emerging recovery needs to develop and implement results-based solutions.

Recovery Strategy 3 (RCS-3)

Help recovery providers increase their behavioral health knowledge and skills.

Tactics

RCS 3.1: Ensure Iowa HHS, BH-ASO, and local partners (CBOs) have the necessary skills to deliver effective behavioral health recovery services based on SAMHSA's Working Definition of Recovery.

a. Iowa HHS and BH-ASO will build multi-disciplinary teams based on best practices.

b. Iowa HHS and BH-ASO will identify appropriate situations for law enforcement involvement.

RCS 3.2: Iowa HHS and BH-ASO will identify and address training and technical assistance needs to support retention of a skilled behavioral health recovery workforce.

a. Iowa HHS and BH-ASO will reevaluate recovery education for providers (consider using a multi-perspective approach to determine training/education).

b. Iowa HHS and BH-ASO will assess impact of certification on the recovery workforce.

Crisis Strategies

- Create and support a comprehensive and integrated, statewide behavioral health crisis system.
- Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health crisis system.
- Increase access to behavioral health crisis services.
- Help crisis providers increase their behavioral health knowledge and skills.

Crisis services are community services that help quickly reduce distress during a behavioral health crisis. These services prevent harm, provide aftercare, and connect individuals to follow-up support, aiming to stabilize them and reduce the need for intensive or restrictive care.

Crisis Strategy 1 (CRS-1)

Create and support a comprehensive and integrated, statewide behavioral health crisis system.

Tactics

CRS 1.1: Iowa HHS, BH-ASO and CBOs (crisis service providers) will expand and support the behavioral health crisis network.

a. All parties will build multi-disciplinary crisis teams based on best practices.

b. Iowa HHS and BH-ASO will identify appropriate situations for law enforcement involvement.

c. Iowa HHS and BH-ASO will build a robust crisis peer workforce.

- Develop capacity for Peer-Operated Respite programs.
- Build a robust disaster response behavioral health workforce.

CRS 1.2: Iowa HHS, BH-ASO, CBOs will identify and maintain a statewide crisis center (e.g., 988) that follows and incorporates best practices.

a. All parties will participate in establishing capacity to answer every contact (call, text, chat).

b. All parties will participate in implementing consistent call assessment and triage with appropriate clinical oversight.

- Centralized dispatch to mobile response, law enforcement, 911, etc.

c. All parties will participate in promoting crisis resources.

d. All parties will participate in educating Iowans about crisis services in their communities.

CRS 1.3: Iowa HHS, BH-ASO and CBOs will connect Iowans to the services and supports they seek.

a. All parties will participate in the development and use of a closed-loop referral system.

b. All parties will educate Iowans about crisis services in their communities.

c. All parties will identify and address crisis needs of diverse populations.

CRS 1.4: Iowa HHS, BH-ASO and CBO's will implement crisis services across the Lifespan with an emphasis on youth and family crisis.

a. Iowa HHS will centralize dispatch for mobile response.

b. All parties will ensure behavioral health crisis care is coordinated across sectors including law enforcement, hospital systems child welfare, education, justice systems, and community-based organizations.

c. All parties will develop and assure comprehensive post crisis follow up and coordination are provided including connecting individuals to ongoing behavioral health services.

Crisis Strategy 1 (CRS-1) continued

CRS 1.5: Iowa HHS and BH-ASO will identify, expand, and strengthen collaborative opportunities with behavioral health partners (CBOs).

a. Iowa HHS and BH-ASO will foster collaboration between CBOs such as mobile crisis teams, law enforcement co-responders, and emergency responders and behavioral health system partners to strengthen partnerships.

b. Iowa HHS and BH-ASO will support connection to ongoing medical and behavioral health.

c. Iowa HHS and BH-ASO will establish crisis planning and follow-up care expectations.

d. Iowa HHS and BH-ASO will nurture and grow crisis response partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS).

Crisis Strategy 2 (CRS-2)

Increase access to behavioral health crisis services.

Tactics

CRS 2.1: Iowa HHS will standardize bed tracking and referral to crisis receiving and stabilization services.

a. Iowa HHS will make bed tracking information visible.

CRS 2.2: Iowa HHS, BH-ASO and CBOs will ensure consistent access to crisis receiving and stabilization services statewide.

a. All parties will work to establish capacity to accept all referrals and to serve additional behavioral health conditions.
   - Do not require medical clearance prior to admission.
   - Standardize client paperwork.

CRS 2.3: Iowa HHS, BH-ASO and CBOs will establish walk-in and first responder drop-off options including development and implementation of no rejection policies.

Culture Strategies

Crisis Strategy 3 (CRS-3)

Create and follow steps for success in building a comprehensive and integrated, statewide behavioral health crisis system.

Tactics

CRS 3.1: Iowa HHS Develop definitions and expectations for the behavioral health crisis system.

a. Iowa HHS will develop acceptable standards for Iowa's crisis care delivery

CRS 3.2: Ensure Iowa HHS, BH-ASO, and local providers (CBOs) work collectively to:

a. All parties will implement recommendations to improve Iowa's Crisis System.

- Collaborate with system partners to implement strategies designed to ensure Iowans have someone to talk to when in crisis.
- Collaborate with system partners to implement strategies designed to ensure people are in place to respond when Iowans need emergency care or assistance.
- Collaborate with system partners to implement strategies designed to ensure Iowans have a place to go when in crisis.

b. All parties will assess crisis response efforts.

c. All parties will identify emerging crisis needs to develop and implement results-based solutions.

Crisis Strategy 4 (CRS-4)

Help crisis providers increase their behavioral health knowledge and skills.

Tactics

CRS 4.1: Iowa HHS and BH-ASO will assess district level workforce and crisis training needs to support recruitment and retention:

a. Iowa HHS and BH-ASO will identify and address areas of need and support

b. Iowa HHS and BH-ASO will provide training and technical assistance.

CRS 4.2: Iowa HHS and BH-ASO will ensure providers (CBOs) have the necessary Skills to deliver effective, integrated behavioral health crisis services:

a. Iowa HHS and BH-ASO will develop and implement a standardized training curriculum for crisis services workers.

b. Iowa HHS and BH-ASO will bolster training on substance use disorder/s (SUD), co-occurring, special populations including youth and families, gambling, tobacco and nicotine use, suicide prevention, harm reduction, recovery needs, trauma-informed care, and evidence-based practices.

CRS 4.3: Iowa HHS and BH-ASO will assure statewide behavioral health and crisis training for first responders and frontline health workers.

a. Iowa HHS and BH-ASO will provide and coordinate training, including the following but not limited to: crisis intervention teams (CIT), crisis de-escalation, MHFA, trauma-responsive & strengths-based service planning and provision).

Appendix A

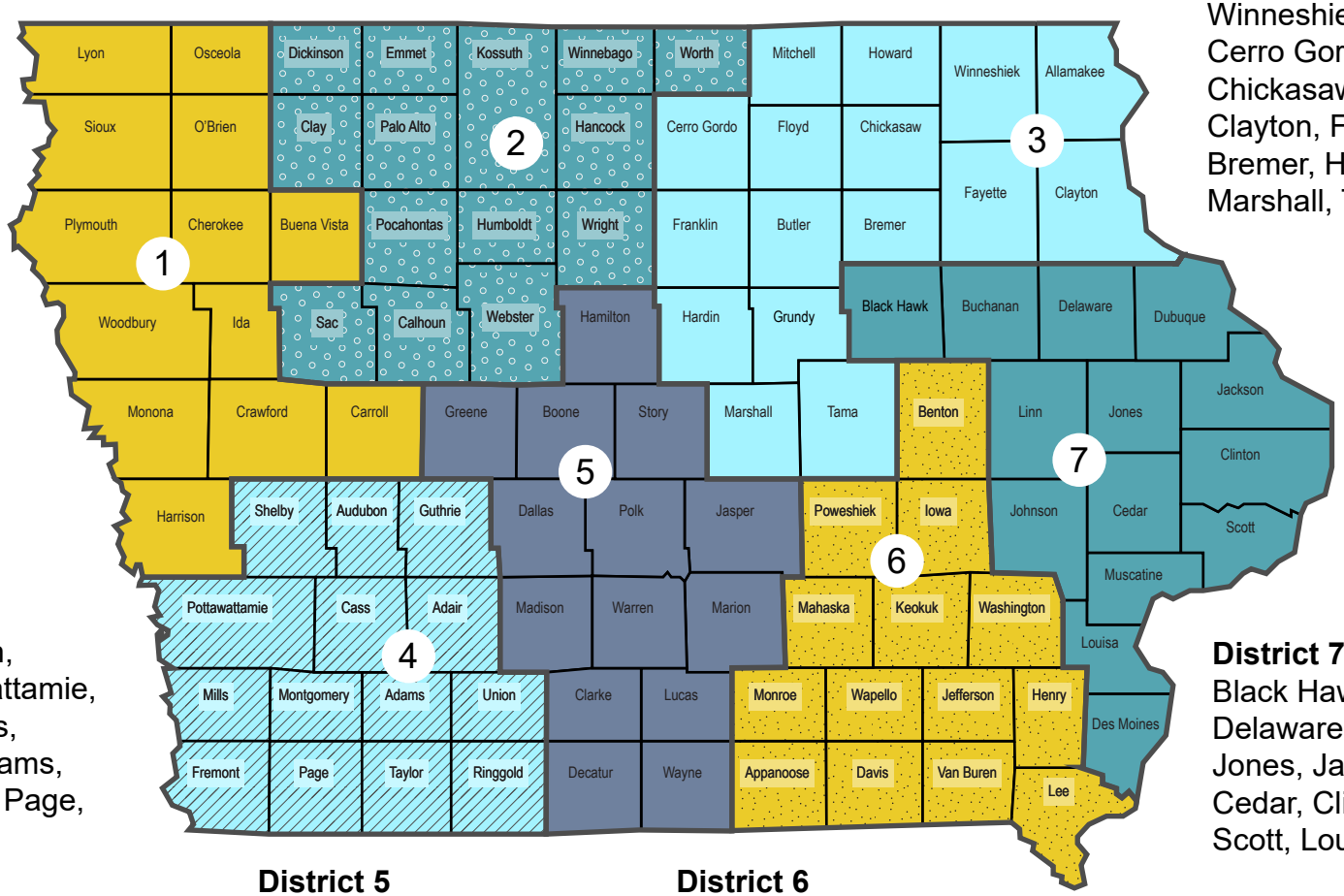
IOWA | Health and Human Services

Behavioral Health Districts

District 2
Dickinson, Emmet, Kossuth, Winnebago, Worth, Clay, Palo Alto, Hancock, Pocahontas, Humboldt, Wright, Sac, Calhoun, Webster

District 3
Mitchell, Howard, Winneshiek, Allamakee, Cerro Gordo, Floyd, Chickasaw, Fayette, Clayton, Franklin, Butler, Bremer, Hardin, Grundy, Marshall, Tama

District 1
Lyon, Osceola, Sioux, O'Brien, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Monona, Crawford, Carroll, Harrison



District 4
Shelby, Audubon, Guthrie, Pottawattamie, Cass, Adair, Mills, Montgomery, Adams, Union, Fremont, Page, Taylor, Ringgold

District 7
Black Hawk, Buchanan, Delaware, Dubuque, Linn, Jones, Jackson, Johnson, Cedar, Clinton, Muscatine, Scott, Louisa, Des Moines

District 5
Hamilton, Greene, Boone, Story, Dallas, Polk, Jasper, Madison, Warren, Marion, Clarke, Lucas, Decatur, Wayne

District 6
Benton, Poweshiek, Iowa, Mahaska, Keokuk, Washington, Monroe, Wapello, Jefferson, Henry, Appanoose, Davis, VanBuren, Lee

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Appendix B

Definitions

Specific to the state plan

“at-risk individuals” means individuals with access limits or functional needs (temporary or permanent) that indicate enhanced risk of development or exacerbation of a Behavioral Health Condition or interferes with their ability to access care.

“at-risk populations” means groups of children, youth, young adults, adults, or older adults at higher risk of developing a behavioral health condition including, but not limited to: individuals with disabilities, pregnant and parenting women, people with limited English proficiency, individuals with limited financial resources, people without access or means to access transportation, or individuals who lack a system of social supports.

“Behavioral Health” means mental health and addictive disorders and is inclusive of, but not limited to, mental illness, substance use, gambling disorder, and tobacco and nicotine dependence.

“Behavioral Health Administrative Services Organization (BH-ASO)” means the lead entity designated by the Agency to plan, develop, coordinate, and assure Behavioral Health Services throughout a District in accordance with the Statewide Behavioral Health Service System Plan.

“Behavioral Health” means an integrated, recovery-oriented approach to care that acknowledges co-occurring conditions are the expectation, not the exception and contemplates the full continuum of behavioral health prevention, education, early intervention, assessment, diagnosis, treatment, recovery, and crisis services and supports.

“Behavioral Health Condition or Disorder” means a substantial limitation in major life activities due to a mental, behavioral, or addictive disorder or condition diagnosed in accordance with the criteria provided in the most current edition of the diagnostic and statistical manual of mental disorders (DSM), published by the American Psychiatric Association.

“Behavioral Health Safety Net Service Providers” means individuals or organizations who primarily provide behavioral health safety net services and supports to uninsured, underinsured, at-risk populations, at-risk individuals, special populations and/or targeted populations.

“Behavioral Health Safety Net Services” means, at a minimum, the following for all children, youth, young adults, adults, and older adults statewide: prevention, education, and crisis services. Subject to need-based, functional, and financial eligibility criteria, Behavioral Health Safety Net Services for uninsured, underinsured, at-risk populations and/or at-risk individuals include, at a minimum: mental health and substance use outpatient treatment services; mental health and substance use high-intensity outpatient treatment services; substance use residential treatment services; sobering services; mental health and substance use inpatient treatment services; recovery supports; care coordination; outreach, education, and engagement services; outpatient competency restoration; hospital alternatives; screening, assessment, and diagnosis, including risk assessment and crisis planning; and additional services as required by Iowa Code or

Administrative Rule or deemed necessary for a behavioral health district or throughout the state as determined by the State Behavioral Health Service System Plan and approved by the Agency in the District Plan. Behavioral Health Safety Net Services are subject to available funds.

"Behavioral Health Services" means any of the following parts of behavioral health continuum: prevention, early intervention, treatment, recovery, and crisis services and supports.

"Behavioral Health Service System" means a statewide system of prevention, education, early intervention, treatment, recovery support, and crisis services related to mental health and addictive disorders, including, but not limited to, alcohol use, substance use, tobacco use, and gambling led by the Agency.

"Behavioral Health Service System Statewide Plan" or "Statewide Plan" means the plan developed by the Agency, subject to public review and comment, that identifies and addresses systemic needs and adopts key strategies, tactics, and goals for the Behavioral Health Service System.

"Central Data Repository" means a data system for collecting and analyzing statewide, Behavioral Health District, and contracted behavioral health provider data.

"Children's Health Insurance Program (CHIP)" is a program that specifically focuses on providing health coverage to children in low-income families.

"Community Based Organizations" are organizations based in local communities that provide behavioral health support and/or services.

"Crisis Services" means community-based services that focus on the immediate de-escalation and relief of the distress associated with a behavioral health crisis, reducing the risk that an individual in a crisis harms themselves or others, and providing after care and connection to ongoing follow up to ensure post-crisis stabilization and reduce the reliance on high acuity care or more restrictive environments.

Crisis services include but are not limited to: immediate access to crisis assessment and evaluation, Access Center, Sobering Units, naloxone administration, 24/7/365 Mobile Crisis Response, Community-Based Crisis Stabilization and Crisis Stabilization Residential Services.

"Culturally and Linguistically Appropriate Services (CLAS) Standards" means to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers.

"District" means a sub-state geographic area determined by the Agency to define the geographic boundaries of the Iowa Behavioral Health Service System.

"District Behavioral Health Advisory Council" or **"District Advisory Council"** means a council established by a BH-ASO to identify opportunities, address challenges, and advise the BH-ASO. The structure of the District Behavioral Health Advisory Council must follow the requirements of legislation4 as outlined in 2024 Iowa Acts, chapter 1161 (House File 2673).

“District Behavioral Health Service System Plan” or **“District Plan”** means a plan developed by the BH-ASO and approved by the Agency to outline the District Plan to assure access to Behavioral Health and Behavioral Health Services throughout the designated District. The District Plans are connected to this Behavioral Health Service System Statewide Plan.

“Early Intervention” are interventions, services and support to at-risk individuals to address early symptoms and prevent the development of behavioral health disorders. This includes identifying problems and offering referrals to reduce impact and improve well-being.

“Education” means disseminating behavioral health knowledge or building resiliency skills through structured learning processes, including support of critical life and social skills such as: decision making, peer resistance and refusal, coping with stress, problem solving, interpersonal communication, and improving judgment capabilities.

“Group level education” means to teach participants about skills that promote behavioral health and wellness.

“Home and Community Based Services (HCBS)” are Medicaid-funded services that allow individuals to receive assistance in their own homes or communities instead of institutions. These services include home health, adult day health, personal care, case management, and other programs that address both medical and daily living needs.

“House File (HF) 2673” under this legislation, Iowa will:

1. Combine the work and funding for mental health and addictive disorders into a Behavioral Health Service System, guided by a statewide plan, focused on ensuring equitable access to prevention, treatment, recovery, and crisis services.
2. Transfer the management of disability services from the local Mental Health and Disability Services (MHDS) Regions to the Division of Aging & Disability Services.
3. Strengthen important system connections to Medicaid, Public Health, and Child Protective Services by gathering meaningful feedback from Iowans to inform system planning.

“Information dissemination” means to increase knowledge and change attitudes through sharing information.

“Minimum Access Standards” means standards established by the Agency, by Iowa Code or by administrative rules to ensure equitable access to Behavioral Health Safety Net Services provided through the Behavioral Health Service System including but not limited to when and where services are made available, service and funding eligibility criteria, and Behavioral Health Safety Net Service Provider requirements.

“National Survey on Drug Use and Health (NSDUH)” means data conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides nationally representative data on the use of tobacco, alcohol, and drugs; substance use disorders; mental health issues; and receipt of substance use and mental health treatment among the civilian, non-institutionalized population aged 12 or older in the United States.

“Prevention” means information dissemination; education; wellness promotion; organizing and enhancing community-based processes; developing environmental approaches; offering alternative activities; and building resiliency skills through structured learning, including support of critical life and social skills such as decision making, coping with stress, problem solving, interpersonal communication, and improving judgment.

“Recovery” means non-clinical assistance that facilitates recovery, wellness, and connection between individuals in recovery, service providers, and other supports known to enhance people's quality of life, including system navigation, peer services, and recovery supports.

“State Health Assessment (SHA)” is a statewide initiative that involves public and private partners as well as people from across Iowa identifying Iowa’s top health issues.

“State Health Improvement Plan (SHIP)” is a statewide initiative that engages public and private partners as well as people from across Iowa to develop a plan for Iowa’s top health issues.

“Substance Abuse Mental Health Services Administration (SAMHSA)” is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

“Special Populations” for the purposes of the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) means pregnant women, women with dependent children, injection drug users, and substance abusers who have tuberculosis.

“System Navigation” means in person, online and telephonic support for problem solving and navigation of the services and supports available. System navigators ensure individuals and families who encounter barriers in accessing services and support are able to navigate health, social services, and legal systems.

“Thrive Iowa” means a Hope-centered initiative to use existing and new resources to make and manage closed-loop referrals that will connect Iowans with health and human services and concrete supports.

“Treatment” means clinical inpatient, outpatient, and residential care for individuals with a behavioral health condition or disorder diagnosed utilizing the most recently published Diagnostic and Statistical Manual (DSM) criteria. The type, length, and intensity/frequency of intervention(s) used by a behavioral health provider is based on the presenting symptoms of the individual.

“Recovery Ecosystem” means is an evidence-based approach that creates the environment that individuals and families need by providing all the necessary tools, services, and supports for recovery to occur.

“SAMHSA’s Working Definition of Recovery” means the ten guiding principles for recovery from mental illness and substance use disorders.

“Strategic Prevention Framework (SPF)” is a comprehensive guide used to plan, implement, and evaluate prevention practices and programs.

“Youth” for the purpose of the state plan this means age 17 and younger.

“Your Life Iowa (YLI)” is the integrated system for free and confidential help and information for alcohol, drugs, gambling and suicide. 24/7/365 (twenty-four hours a day, seven days a week, three hundred sixty-five days a year) resources include a telephone helpline, mobile-friendly internet-based communications (e.g., online chat), texting and social media (@YourLifeIowa).

IOWA | Health and Human Services
Division of Behavioral Health

hhs.iowa.gov

hhs.iowa.gov/mental-health

https://hhs.iowa.gov/initiatives/system-alignment/behavioral-health-service-system

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

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

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

a)	Physical Health	(●) Yes	( ) No
b)	Mental Health	(●) Yes	( ) No
c)	Rehabilitation services	(●) Yes	( ) No
d)	Employment services	(●) Yes	( ) No
e)	Housing services	( ) Yes	(●) No
f)	Educational services	(●) Yes	( ) No
g)	Substance use prevention and SUD treatment services	(●) Yes	( ) No
h)	Medical and dental services	( ) Yes	(●) No

i)	Recovery Support services	(●) Yes	( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes	( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes	( ) No

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

With the CCBHC Demonstration beginning July 1, 2025, there will be more opportunity for coordination between physical and behavioral health providers due to CCBHC requirements to screen for physical health needs of individuals served and connect those individuals with primary care.

3. Describe your state's case management services

Case management for Medicaid-eligible individuals with a serious mental illness or children with a serious emotional disturbance is currently provided through Integrated Health Home (IHH) care coordination teams. Teams consist of a care coordinator, a nurse care coordinator, and a peer support specialist (for adults) or a family peer support specialist (for children with an SED and their families). Teams are to address whole person health and social needs. With the sunsetting of the IHH program by Dec. 31, 2025, Iowa's three MCOs will provide case management for populations previously served by the IHHs. Iowa HHS-TCM will provide case management to fee-for-service Medicaid members. CCBHCs will also provide case management for individuals in need of coordination at a higher level due to transitions from inpatient care or being at risk of suicide/harm. The MCOs also provide community-based case management for individuals with intellectual disabilities, brain injury and other health conditions. For individuals served by SUPTRS designees, services are coordinated by the IPN provider.

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

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

5. Please indicate areas of technical assistance needs related to this section.

N/A

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	133,736	
2.Children with SED	42,116	

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

The state uses the most recent SAMHSA prevalence data from URS Table 1 2023. Adults with SMI prevalence utilized is the 5.4% of the 2023 Civilian Population Age 18+ with SMI, and children with SED prevalence utilized is the upper limit for Level of Functioning (LOF) Score = 60. The state does not calculate expected incidence of the target populations. The state plans services based on actual service usage, data collected from Iowa Medicaid and state behavioral health system sources, input from consumers and stakeholders on strengths and needs of the behavioral health system, and direction of state and legislative leadership regarding overall system goals. Overall system goals are identified in the State's Behavioral Health Plan.

3. Please indicate areas of technical assistance needs related to this section.

n/a

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	○ Yes	◉ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	○ Yes	◉ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

N/A

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

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

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

Iowa's new behavioral health system is managed under one statewide BH-ASO. The BH-ASO is required to provide access to safety net behavioral health services statewide. The state is divided into 7 districts, each with an advisory council that works with the BH-ASO to address needs in that district. Each district includes rural and urban areas of the state.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

Iowa HHS manages the federal PATH program for individuals with a mental illness at risk of experiencing homelessness. Six agencies provide PATH outreach services in rural and urban counties statewide. Iowa HHS staff work with the SOAR project to assist individuals applying for SSI/SSDI to promote financial stability.

The BH-ASO funds transitional housing as well as peer respite, crisis residential, and subacute residential programs that may support those who are experiencing homelessness. ASO system navigators also steer individuals towards General Assistance, Rent Reimbursement and/or Centralized Intake entry points for homeless services. Additionally, the state's Disability Access Points, part of the states Aging and Disability Resource Center (ADRC) Network overseen by Iowa HHS's Division of Aging and Disability Services, includes housing support.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

Iowa HHS oversees the PASSR process which screens all individuals seeking admission to nursing facilities for mental health or intellectual
disabilities. Iowa HHS coordinates training on this process with providers and works with the PASSR contractor to review treatment plans to
ensure that individuals are receiving all appropriate services while in nursing facilities and are also provided supports needed to return to
community settings when indicated. Iowa's PASSR process emphasizes use of short-term stays in nursing facilities to encourage return to lower levels of care when appropriate. Iowa also has an HCBS Elderly Waiver. The waiver allows individuals who qualify for nursing home level of care to remain in their homes with services. Mental health services are a service provided through the waiver.

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

The Iowa Department of Health and Human Services (Iowa HHS) under the leadership of Director Kelly Garcia is the designated State Mental Health Authority (SMHA) and designated Single State Authority for Substance Use Prevention, Treatment, and Recovery (SSA) for Iowa. These two authorities are housed under the Iowa HHS Division of Behavioral Health. Iowa HHS also includes Iowa Medicaid and the Division of Family Well-Being and Protection (child welfare), Human Rights, the Department on Aging, Volunteer Iowa, the Iowa Child Advocacy Board, and Early Childhood Iowa. The estimated MHBG allocation for FY26 and 27 is $7,729,796 per year. The state projects to expend $386,490 per year on administration, $386,490 on crisis services (5% set aside), $772,980 per year on early serious mental illness programs (10% set aside), and $6,183,836 per year on allocations to community mental health centers for services to individuals with an SMI/SED, training on EBPs, peer support/family peer support training, Integrated Health Planning and Advisory Council (I-PAC) support, and other system development projects.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

As a result of the pandemic, most providers greatly expanded their capacity to offer telehealth services and can bill Medicaid for them. Outpatient therapy and medication management are provided via telehealth. Barriers to telehealth include inconsistent broadband capacity in rural areas of Iowa as well as individuals not always having availability to access telehealth due to financial barriers (lack of data plan or equipment.) Providers have informed Iowa HHS that individuals generally prefer not to use telehealth for individual therapy as they prefer face to face contact. They will use telehealth if it is their only option but prefer in-person options for ongoing therapy. Telehealth has been beneficial for individuals with SMI and SED to obtain services and remains useful to extend services to individuals with transportation barriers or where there are workforce shortages. Telehealth is also being offered in school settings to reduce disruption to children's education while increasing access to mental health services.

3. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	(●) Yes	( ) No
ii)	Education	(●) Yes	( ) No
iii)	Brief intervention	(●) Yes	( ) No
iv)	Assessment	(●) Yes	( ) No
v)	Withdrawal Management (inpatient/residential)	(●) Yes	( ) No
vi)	Outpatient	(●) Yes	( ) No
vii)	Intensive outpatient	(●) Yes	( ) No
viii)	Inpatient/residential	(●) Yes	( ) No
ix)	Aftercare/Continuing Care	(●) Yes	( ) No
x)	Recovery support	(●) Yes	( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	( ) Yes	(●) No
ii)	Adolescents?	(●) Yes	( ) No
iii)	Older Adults?	( ) Yes	(●) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? ( ) Yes (●) No

d) Inclusion of recovery support services? ( ) Yes (●) No

e) Health navigators to assist clients with community linkages? ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Four licensed SUD Treatment providers have been designated as recipients of Pregnant Women and Women with Dependent Children (PWWDC) funds. These designated providers assure access to required PWWDC enhanced and ancillary services statewide. Women and children treatment must be readily accessible, comprehensive and appropriate to the persons seeking the services. Women and children treatment must be available when needed, with minimal wait time. Women and children providers must provide all ancillary services and requirements under Code of Federal Regulations (ancillary services and/or treatment specialized for women is provided for pregnant and parenting women and their dependent children). Other treatment services may be funded by Medicaid if the client and/or their children have the necessary Medicaid coverage (consistent with client enrollment). The women and children set aside are utilized as the payor of last resort.

Women and Children providers are monitored in a variety of ways. Primarily, Iowa currently contracts with the University of Northern Iowa (UNI) to conduct research via biannual simulated phone calls to SUBG subrecipients. One aim for these simulated calls, among many, is to evaluate the frequency and fidelity to which potential clients are screened for their inclusion in a priority population, as well as whether those individuals are offered services as prescribed by the SUBG regulations. Individualized simulated call results are provided to each subrecipient, along with a detailed report for the provider network at large. Results are then followed by individualized technical assistance/ corrective action, as needed, for each subrecipient. SFY 2025 will be the final period for these simulated phone calls, and another strategy is being developed to replace it.

The SUPTRS Block Grant planner will also directly monitor PWWDC funding designees via routine site visits to assure adherence to the SUPTRS federal regulations. In addition, Iowa HHS will conduct routine clinical record reviews and provide as-needed and as-requested training and technical assistance regarding PWWDC enhanced and ancillary service availability. Lastly, timely admission will be monitored as a SUPTRS-PWWDC priority indicator.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement? (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services? (●) Yes ( ) No
- **c)** Outreach activities? (●) Yes ( ) No
- **d)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached? (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement? ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support? (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

SUPTRS recipients who offer substance use disorder treatment services must meet all SUPTRS requirements, provide services to individuals who inject drugs, and provide services to individuals per SUPTRS tuberculosis requirements.

SUPTRS recipients must sign annual attestation documentation which outlines the SUPTRS regulations under 45 CFR 96.126 Capacity of Treatment for Intravenous Drug Abusers. These regulations include, but are not limited to, priority admission status, admission requirements, interim services provisions, referrals and counseling regarding HIV and TB, and waiting list requirements. For ease of reporting and tracking, interim services and regulations have been built into the Iowa Behavioral Health Reporting System (IBHRS) data collection system.

Data enhancements have also been made regarding the waitlist for priority populations including Individuals who Inject Drugs and Treatment Services for Pregnant Women. Iowa HHS has provided extensive annual training to providers regarding Priority Admission Preference, Interim Service Provision requirements, and has provided technical assistance to multiple providers.

To assist Iowa HHS in meeting the SUPTRS regulations for tracking treatment capacity for individuals who are pregnant and/or have used any injection drug(s) in the past 30 days, the Iowa Statewide Waitlist was integrated into the Iowa Behavioral Health Reporting System (IBHRS). Iowan's seeking treatment services who meet these criteria sign consent, are placed on the statewide waitlist according to the priority admission status as regulated, and allow programs to refer, admit, pend, reject or close cases. The Iowa Statewide Waitlist system allows for notifications upon referring and/or when cases are admitted or closed. SUPTRS recipients have received extensive training on the statewide waitlist.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers? ( ) Yes (●) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment? ( ) Yes (●) No
- **c)** Established co-located SUD professionals within FQHCs? ( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and

corrective actions required to address identified problems.

Per the Iowa Bureau of Immunization and Tuberculosis, the 2024 TB case rate for Iowa is 1.45 cases per 100,000 persons. This is significantly lower than the national average of 2.9 cases per 100,000 persons. Iowa owes its low TB case rate in part to proficient contact investigations, healthcare providers observance of treatment guidelines, adherence to DOT for active disease cases and the provision of medication for LTBI to more than 1,100 Iowan's annually.
Iowa HHS is the state agency which is responsible for TB Control. The TB Control Program is composed of two full time employees: the Program Manager and the Nurse Consultant. The program provides direct oversight of cases afflicted with latent tuberculosis infection (LTBI) and TB disease from admission to discharge in the TB Control Program. This includes consultation with physicians, nurses, local public health agencies (LPHAs) and other healthcare providers regarding TB transmission, pathogenesis, treatment, signs and symptoms, infection control practices and contact investigations. The purpose and scope of responsibilities is defined by the core functions of the TB Control Program which include:

Disease consultation and education
Investigation of active or suspect TB cases
Case management of LTBI and active TB cases
Administration of Iowa's TB Medication Program
Data management and analysis
Administration and finance

The Annual CDC Report for Iowa Tuberculosis Control indicates that 47 cases of TB were reported in Iowa in 2024.

SUPTRS recipients are required to sign an annual attestation regarding meeting all required SUPTRS requirements. As such, SUPTRS recipients are required to meet SUPTRS "Tuberculosis" and "Persons who inject drugs" requirements including: timeliness standards, capacity notification requirements, outreach efforts, providing or making services available to TB clients (including screening, counseling, education, referral to medical providers, as needed, and reporting to the Bureau of TB any active TB cases (within 1 day) and interim service provisions. Screening and services for persons with tuberculosis are provided directly by SUPTRS recipients or through interagency collaborative agreements with other local agencies. In the case of an individual in need of such treatment who is denied admission by a provider on the basis of the lack of capacity to admit the individual, the original provider will refer the individual to another provider for tuberculosis control procedures and protocols to address TB and other communicable diseases. Iowa HHS has moved from a narrative reporting function to tracking SUBG requirements through the reporting of data to the Iowa HHS data reporting system, IBHRS; effective July 2021.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas? ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services? ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ○ Yes ○ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ● Yes ○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ( ) Yes (●) No

b) Establish a program to provide trauma-informed care ( ) Yes (●) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? ○ Yes ◉ No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ○ Yes ◉ No

c) Updating written procedures which regulate and control access to records? ○ Yes ◉ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ○ Yes ◉ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ◉ Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

1

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? ◉ Yes ○ No

b) Establishment of policies and procedures related to independent peer review? ○ Yes ◉ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ○ Yes ◉ No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ○ Yes ◉ No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

N/A

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ◉ Yes ○ No

c) Performance-based accountability? ◉ Yes ○ No

d) Data collection and reporting requirements? ◉ Yes ○ No

If the answer is No to any of the above, please explain the reason.

N/A

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) SMI Adviser ○ Yes ◉ No

c) Addiction TTC? ○ Yes ◉ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ◉ Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.legis.iowa.gov/docs/code/125.pdf

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

Iowa collects client, program, provider and payment data from multiple state and local reporting systems. Through SFY25, data sources included Medicaid claims, eligibility and program enrollment reporting systems; state administrative and fiscal reporting systems; the state mental health institute medical records system; and regional behavioral health program and payment systems. Starting in SFY26, the SMHA will replace data collected from the regional behavioral health reporting systems on services provided to eligible Iowans without health care coverage with the state's Safety Net Management Information System and administrative service organization reporting system.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

   The SMHA data request for block-grant reporting purposes utilizes data across multiple sources as part of a larger data system for all state (i.e., Medicaid) and local (i.e., region and safety-net) funded programs. However, the data request for block-grant reporting purposes provides parameters specific to mental health services.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   Iowa is able to report data across multiple state and local agencies, allowing a comprehensive report of program and payment data for public mental health programs in Iowa. However, Iowa continues to build capacity to link client-level data across reporting systems to report a distinct cohort of individuals reported across agencies.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   The state does not have specific codes that indicate ESMI services but receives client-level data directly from ESMI providers. The SMHA has the ability to report EBPs at the client level for certain EBPs that have Medicaid payment codes that are specific to the EBP.

5. Briefly describe the limitations of the SMHA 's existing data system.

   Client-level data collection has been a challenge in Iowa, which has been limited to information linked to payment data for Medicaid and local-funded services. Linking data across systems continues to be a challenge to access within the parameters of data sharing agreements and reporting reliable and valid data when utilizing multiple data sources. Iowa is in the process of implementing a new behavioral health system that will streamline payment, programmatic and eventually, client-level data for SMHA mental health services.

6. What strategies are being employed by the SMHA to enhance data quality?

   To mitigate challenges related to reliability and validity of data across data systems, Iowa has developed a standard methodology for identifying eligible mental health service payment and clients served data. Programmatic changes that impact the data request are monitored continuously and reviewed annually for the request. Iowa anticipates the new behavioral health system will streamline payment, programmatic and client-level data for SMHA mental health services.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   Similar challenges in previous years related to reporting client-level data will continue through SFY25. SFY26 may present new challenges with the new state behavioral health Safety Net Management Information System that are expected when implementing a new system; however, Iowa anticipates fewer data reporting barriers in the future with a more streamlined approach to data collection.

8. Please indicate areas of technical assistance needs related to this section.

   Technical assistance is not needed at this time.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Crisis services are provided to individuals experiencing a behavioral health crisis and are aimed at assessment and intervention to stabilize the individual's level of functioning and refer the individual on to any needed services and supports. Crisis services are not subject to financial eligibility requirements and are available to any Iowa resident who needs them. Safety-net crisis service availability includes mobile response, crisis evaluation (including crisis screening and assessment), residential crisis stabilization, community-based crisis stabilization, and 23-hour observation and holding. Iowa's statewide 988 system provided by 2 Iowa 988 centers helps connect individuals in crisis to mobile crisis and other behavioral health and community supports.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

Iowa has two 988 centers that serve the entire state with call, chat, and text capabilities. Iowa also has Your Life Iowa which provides crisis support, information and referral and access to system navigation for all Iowans. Iowa has statewide mobile crisis services but is working on improving consistency of services and standards in the crisis system in alignment with CCBHC standards. Iowa has crisis stabilization services in most areas of the state but people in more rural areas have farther distance to travel to access residential crisis services.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Iowa's efforts to develop and improve the crisis system are consistent with the principles of the national guidelines. Iowa is focusing on increasing access to trauma-informed care by developing training for crisis professionals, reviewing crisis policies and standards to ensure consistent, effective crisis services, promoting inclusion of peer support specialists in the crisis workforce, and soliciting input from Iowans on recommendations to improve the crisis system.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 0
b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 0
c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 10
b. Integrated with public safety first responder structures (police, paramedic, fire): 1
c. Number that utilizes peer recovery services as a core component of the model: 1

Safe place to be

a. Number of Emergency Departments: 0
b. Number of Emergency Departments that operate a specialized behavioral health component: 1
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 0

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also

describe any state-led coordination between the 988 system and CCBHCs.

Iowa is using the 5% crisis set aside to support mobile response dispatch through the 988 centers.

7. Please indicate areas of technical assistance needs related to this section.

N/A

Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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

In addition, there are 10 identified guiding principles of recovery:

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

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

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

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

b) Required peer accreditation or certification? ○ Yes ◉ No

c) Use Block Grant funds for recovery support services? ◉ Yes ○ No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? ◉ Yes ○ No

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

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

Peer support services for adults and family peer support for parents of children with an SED are funded by Medicaid, supported by MHBG and state funds to peer-run organizations and community mental health centers, and are required to be provided by the ten state-certified CCBHCs. Iowa HHS funds statewide training of peer support specialists and family peer support specialists through the University of Iowa Peer Workforce Collaborative.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Please see Step I for a complete narrative of Recovery Support Services funded by SUPTRS and through discretionary grants.

SUPTRS Funded RSS Services:

1) Transportation. Transportation means assistance in the form of gas cards or bus passes, given directly to the patient for the purpose of transportation to and from an activity related to the patient's treatment plan or recovery plan.

Non SUPTRS Funded RSS Services available through SSA system of care:

2) Iowa Treatment for Individuals Experiencing Homelessness (TIEH) (discretionary grant): Educational and Vocational Training, Sober Living Activities, Wellness Needs (eyeglasses/contact lenses, fitness memberships, nutritional training, etc.), and Transportation (gas cards, bus passes, rideshare).

3) Recovery Community Centers: Community centers focused on SUD recovery providing a variety of recovery support group meetings, recovery coaching, referrals and recovery calls. Funded through a combination of state appropriations and the State Opioid Response grant.

4) Iowa Nicotine Free Recovery Project: Beginning in late SFY 2025, Iowa HHS began offering nicotine replacement products (gum, lozenges, patches) to participants at the state-funded Recovery Community Centers, free of charge. RCC staff assist with the collection of a questionnaire which is used to measure efficacy of low-barrier access to NRT products in an environment where individuals are often internally motivated to make change. This project also addresses the "gap" in access to NRT products while individuals wait for shipments sent via Quitline Iowa but may not have the means to purchase over-the-counter NRT products in the meantime.

5) Recovery Housing: efforts to establish an Iowa affiliate of NARR funded by the State Opioid Response grant.

6) State Opioid Response: Care Coordination, Clothing/Personal Hygiene (interview and work clothes, toiletries, laundry), Contingency Management, Copays (for behavioral health services), Dental Services (related to the clients SUD), Education Assistance (GED coursework and testing, ESL classes, etc.), Employment Supports, HIV/HCV testing, Housing assistance, MAT/MOUD (FDA approved options), MAT/MOUD-related medical evaluation, drug testing and follow-up medical care, SUD and MH Counseling(not covered by other sources), Recovery Calls, Recovery Coaching, Recovery Housing, Survivor Advocacy in Recovery(sessions with certified victim advocate), Transportation (gas cards, bus passes, rideshare), Wellness (health related needs not covered by other sources, fitness memberships, tobacco cessation, nutritional counseling, etc.)

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

N/A

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

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

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

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ○ Yes ◉ No

b) The resilience of children and youth with SED? ○ Yes ◉ No

c) The recovery of children and youth with SUD? ○ Yes ◉ No

d) The resilience of children and youth with SUD? ○ Yes ◉ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ○ Yes ◉ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

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

Iowa's behavioral health system is implemented through the state's Administrative Service Organization (BH-ASO). The BH-ASO is

required to make behavioral health safety net services available to eligible children and youth. The SMHA works within Iowa HHS and across other state and local agencies to identify the needs of children and youth and work collaboratively to meet them.

owa Medicaid provides a continuum of mental health service for children including outpatient therapy, psychiatry and medication management, in-home behavioral health services and evidence based practices including functional family therapy and multi-systemic therapy. Iowa's CCBHC Demonstration includes a focus on services to children with an SED and will also provide access to evidence-based services for children in underserved areas. CCBHCs are required to coordinate with educational, child welfare and juvenile justice services to provide services to children and youth. Several CCBHCs and other behavioral health providers provide behavioral health services directly in schools, increasing access for children who might not otherwise receive services. CMHCs also provide coordination and consultation services in school settings to help identify children with behavioral health needs and connect them to appropriate services.

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

N/A

8. Please indicate areas of technical assistance needs related to this section.

N/A

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12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

Continued support of 988, state implementation of Garrett Lee Smith grant, training on screening for suicide risk, safety planning, and connection to services/resources. HHS works with other state agencies on the Governor's Challenge for Suicide Prevention for SMVF. Iowa has a legislative requirement to include Your Life Iowa, a state resource and referral line, on school IDs for all Iowa middle and high school students.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ◉ Yes ○ No

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

If yes, please describe how barriers are eliminated.

Iowa is in the first year (starting July 1, 2025) of the four year CCBHC Demonstration. Iowa has 10 state-certified CCBHCs. These clinics have a responsibility to help coordinate transitions and care for people with suicidal ideation being discharged from inpatient/emergency departments. Iowa has also implemented a statewide system navigation service that is available to anyone in need of behavioral health assistance.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

Yes, statewide suicide prevention training for people who serve youth

6. Please indicate areas of technical assistance needs related to this section.

N/A

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Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

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

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

Effective July 1, 2023, the state agencies that oversee public health, human services, Medicaid, mental health, substance-use prevention, treatment, and recovery, aging and disability services, and human rights are now aligned in one agency, the Iowa Department of Health and Human Services. This alignment promotes collaboration and coordination of essential services to Iowans. This alignment has brought mental health and substance use disorder services under one Division of Behavioral Health, allowing close collaboration across prevention, early intervention, treatment, recovery and crisis service systems. The Division of Behavioral Health also works closely with Medicaid on behavioral health service delivery and funding and has partnered with Medicaid to implement the CCBHC Demonstration.

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

As of July 1, 2025, the Iowa Primary Care Association (Iowa PCA) was installed as Iowa's Behavioral Health Administrative Services Organization and administers safety-net Substance Use Prevention, Mental Health Promotion, Early Intervention, and Crisis Access continuum areas, as well as System Navigation services. Iowa PCA will also provide monitoring, conveyance, training, and technical assistance for all community-based organizations (CBOs) it contracts with. Through the behavioral health system alignment, Iowa HHS combined service maps from various legacy service systems into one. This new map has 7 areas, or "districts", which represent all 99 Iowa counties. Each district now receives its own needs assessment, as well as a district advisory council comprised of stakeholders, law enforcement, elected officials, and people with lived experience. The combination of needs assessment and district advisory council ensures access to services and the quality of services themselves are consistent statewide while recognizing the unique needs of the people each district serves. With information gathered from these resources, Iowa PCA is able to administer safety-net services locally and statewide to the same degree of fidelity and efficacy.

Area Education Agencies (AEA) are significant providers of services to children under IDEA. Iowa's AEAs are regional service agencies which provide school improvement services for students, families, teachers, administrators and their communities. AEAs as educational partners with public and accredited, private schools to help students, school staff, parents and communities meet these challenges. AEAs provide special education support services, media and technology services, a variety of instructional services, professional development and leadership to help improve student achievement. Local Education Agencies also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Programs and 504 plans for children identified as eligible individuals. Iowa CCBHCs are required to have care coordination agreements with the school districts in their service areas to help students and families connect to local resources. Additionally, some CCBHCs directly provide mental health services in schools. Iowa HHS is also working to expand contracts with telehealth providers for school-based services.

4. Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

Iowa HHS met with a subcommittee of the Iowa Integrated Health Planning and Advisory Council twice to review the structure and outline of the combined MH/SUPTRS block grant and to solicit input on strengths and needs of the system. Requirements of each Block Grant were reviewed with the Council. Meeting minutes of the meetings held on 3/10/25 and 4/7/25 between Iowa HHS staff and committee members are attached.

The Council subcommittee met on 7/29/2025 and provided notes (attached) outlining their draft recommendations for Block Grant priorities, which were reviewed by the full Council. Finalized recommendation details and a letter from the Council Chair dated August 15, 2025 are attached. The five recommendations, detailed in the letter, include the following items:
1. expansion of peer support services through peer-run organizations,
2. funding for prevention and early intervention initiatives as an allowable activity,
3. implementation of crisis intervention and mental health education for first responders and law enforcement,
4. increased workforce development and capacity related to behavioral health promotion and prevention, and
5. identification and expansion of Evidence Based Practices beyond those currently supported by the state.

Overall, where allowable by block grant funding, the recommendations align with the priorities identified in the Iowa HHS Behavioral Health Service System State Plan.

Council members and the public will have the opportunity to provide input via public comment on the combined block grant plan prior to submission.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — ( ) Yes (●) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

The Iowa Department of Health and Human Services (Iowa HHS) is under the leadership of Director Kelly Garcia. Marissa Eyanson, who reports to Kelly Garica, is the state Behavioral Health Director and the designated State Mental Health Authority (SMHA). DeAnn Decker, who reports to Marissa Eyanson, is the Deputy Directory of Services, Planning, and Performance, and is the designated Single State Authority (SSA) for Substance Use Prevention, Treatment, and Recovery Services. Mental health and substance-related programs are housed together under the Division of Behavioral Health (DBH). Through this structure, the state

collaboratively plans and implements community mental health treatment, substance use prevention, SUD treatment, and recovery support services with input from the Integrated Health Planning and Advisory Council.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The duties and responsibilities of the Council are described in the Council's bylaws (see attachment). The Council works collaboratively with Iowa HHS and has historically held annual joint meetings with the state Mental Health and Disability Commission. The Mental Health and Disability Commission dissolved in July 2025 due to the Behavioral Health Services System alignment processes outlined in HF2673. The Council provides annual recommendations to Iowa HHS on the strengths and needs of the behavioral health system. Council members are also members of other advocacy organizations, work and volunteer to provide peer support and family peer support, and advocate in many venues for individuals with an SMI or an SED. Attached are meeting minutes from the Council's last three meetings demonstrating their advocacy activities.

7. Please indicate areas of technical assistance needs related to this section.

   N/A

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Footnotes:

Iowa Integrated Health Planning and Advisory Council (I-PAC)
Combined Block Grant Application Committee

March 10, 2025

Committee Members Attending:
Teresa Bomhoff
Jessica Goltz
Todd Lange
Todd Noack

Iowa Department of Health and Human Services Attending:
Justin Edwards justin.edwards@hhs.iowa.gov
Chandra Jennings chandra.jennings@hhs.iowa.gov
Laura Larkin laura.larkin@hhs.iowa.gov
Patti Manna

Meeting Discussion

Justin Edwards and Chandra Jennings reviewed Iowa FY 2024/2025 Combined MHBGSUPTRS BG Application Behavioral Health Assessment and Plan, which can be found here. This is the previously submitted plan. The block grant planners noted that the committee would be focusing on Step 1 and 2 of the application, as well as providing input on priorities.

The block grant planners indicated that the Step 1 section looks at the strengths and organizational capacity of the service system to address the specific populations (Pages 48-96), and that the Step 2 section identifies the unmet service needs and critical gaps within the current system (pages 97-110), specifically the need to look at data for this section. The block grant planners noted that they would be asking the Committee to provide feedback during the two scheduled meetings for these sections. The block grant planners informed members they could send them an email with feedback as well, if they think of something outside of the meeting.

The members of the committee introduced themselves. There was agreement among the members there should be an effort to make the application as easy to read as possible, with suggestions to have shorter paragraphs, bullet points and pictures or graphs or organizational charts as appropriate.

The state behavioral health plan located here will serve as a basis for the integrated health block grant plan, with the drafted version shared here. It was noted that the block grant planners would like feedback on any area to the system that affects individuals with behavioral health needs. It was noted the plan would be developed based on the many changes that have occurred in the past, with there now being one service delivery system instead of the four that were in place in the past. There is also an increase focus on system navigation and crisis services.

It was noted the SUD Block grant is required to set aside at minimum 25% of funds for prevention and there are specific populations that need to be addressed, which includes persons who inject drugs and pregnant women.

The Substance Abuse and Mental Health Services Administration (SAMHSA) site, located here, which provides guard rails for the development of the block grant was shared for review.

There was discussion regarding the peer-run organizations, with Todd Noack encouraging the block grant planners to ensure fidelity and evidence based information. There was a suggestion to ensure there is feedback from local organizations in addition to the national organizations. It was also suggested peer support and its many iterations be an evidence-based practice in the Center for Excellence for all providers to have access to.

There was a suggestion to include the need to strengthen the workforce. There was suggestion to include information on the rising cancer rates in the state and the connection with those rates and alcohol, tobacco use and environmental causes since the Iowa Cancer Consortium is focusing on all possible causes. The block grant planners stated they would

connect with the state epidemiologists. The system alignment has enabled the state to connect the substance use and tobacco use prevention and control departments for increased collaboration.

There was a suggestion to review the state plan for behavioral health and the state plan for aging and disabilities which identifies many of the gaps. There was a question on why there were not dollars allocated to prevention services. The block grant planners noted that current guidelines do not allow for a set aside for prevention. Jessica Goltz noted that the Early Minds Act allows states to allocate up to five percent of their Mental Health Block Grant funding for prevention and early intervention activities. The block grant planners stated they would look into this. The committee noted that the lack of prevention activities is an identified gap.

There was question on whether the block grant planners would take feedback from the District Advisory Councils that are being formed by Iowa Primary Care Association (Iowa PCA). The block grant planners stated there was not a specific method identified at this point to solicit that feedback, but it would be welcome.

There was a question on whether there are measures or data that have been identified to demonstrate the success or opportunities for improvement for past goals. The block grant planners noted there is data available but also there is a need for further data, and the state is aware and working on this.

There was inquiry about the status of American Rescue, Bipartisan Infrastructure and other federal grants which our state relies on to complete its plans and goals. Will this be addressed in the grant?

<u>Next Meeting</u>
Committee members were asked to look at the comments provided by the committee on the previous application (pages 108-109) related to gaps/concerns and determined what suggestions they have for changes and if there is data that they are aware of that supports the gap.

The group will be focusing on Step 1 and Step 2 of the block grants (strengths and gaps) at the next meeting with the I-PAC Block Grant Committee. Members were encouraged to review these sections from the last block grants and come back with feedback for the next meeting.

Next meeting is Monday, April 7th, 2025, at 1pm

Iowa Integrated Health Planning and Advisory Council (I-PAC)
Combined Block Grant Application Committee

April 7, 2025

Committee Members Attending:
Teresa Bomhoff
Jessica Goltz
Todd Noack
Todd Lange
Monica Van Horn
Ellen Schardt
Brad Richardson

Iowa Department of Health and Human Services Attending:
Justin Edwards justin.edwards@hhs.iowa.gov
Chandra Jennings chandra.jennings@hhs.iowa.gov
Patti Manna

Meeting Discussion

Justin Edwards and Chandra Jennings reviewed Iowa FY 2024/2025 Combined MHBGSUPTRS BG Application Behavioral Health Assessment and Plan, which can be found here. This is the previously submitted plan. The block grant planners noted that the committee would be focusing on Step 1 and 2 of the application, as well as providing input on priorities.

There was question as to whether there would be changes to guidance for the Block Grant Application in comparison to the previous application. Chandra Jennings shared that the HHS Block Grant Planners are still waiting for official guidance. Due to multiple changes at the federal level, it is uncertain what changes will be required. The block grant planners will adjust as they receive more information.

The timeframe for the application was reviewed. The due date for submission is September 1, 2025. The block grant planners would like to have the final draft ready for HHS review by August 1, 2025. There will need to be time allotted for public comment over the summer months. The final draft of the Statewide Behavioral Health Plan located here is expected to be posted to the HHS webpage in the next day or so, and the information in there can be used as review for the block grant planners to identify gaps and opportunities.

Teresa Bomhoff shared a document that she had put together that referenced gaps in the service system. Teresa Bomhoff reviewed this document during the meeting. The document provided suggestions such as sharing a picture of the behavioral health system, include a list of the centers that have been created, make recommendations on what MHI's will be required to provide, standardize, fund and mandate assessment tools, include money for children's facilities, raise Medicaid rates for Occupational Therapy and nursing, recommend that the Center for Excellence in Behavioral Health (CEBH) should have Trust Based Relational Intervention (TBRI) interventions, ensure Provider Prevention and Support Services (PPAS) are offered, advise MCO's to fund the I-START model for children, assess the juvenile justice system, and expand the use of peers throughout both the Behavioral Health and Aging and Disabilities Systems.

Todd Lange shared thoughts that the Council should have a list of expenditures of the block grants to gain better insight into how dollars are utilized. There was consensus among the committee members that this information would be beneficial. The block grant planners will review what information is available to share with the I-PAC. Teresa Bomhoff shared that the I-PAC would like to have list of what has been funded by the CARES Act and ARPA funding. Teresa Bomhoff also shared that the I-PAC would like to see the full Crisis Services Summary.

Next Steps

The committee should continue to review the previous block grant plan and share thoughts with the block grant planners. The plan may be found here, and below are the pages where the information most pertinent to the committee can be found.

- Step 1-Assess the strengths and organizational capacity of the service system to address the specific populations (Pages 48-96)
- Step 2-Identify the unmet service needs and critical gaps within.
- Review the planning tales (beginning on p. 119).

Committee members will be invited to the public comment session(s), which will occur in late summer 2025.

Links to Helpful Resources

Iowa's Behavioral Health Service System | Health & Human Services

eCFR :: 45 CFR Part 96 Subpart L -- Substance Abuse Prevention and Treatment Block Grant

Substance Use and Mental Health Block Grants | SAMHSA

42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart i: block grants for community mental health services

Iowa Integrated Health Planning and Advisory Council
Bylaws

Effective May 28, 2008 as amended July 23, 2010; March 21, 2012; March 21, 2018; September 19, 2018; March 15, 2023; and March 20, 2024

ARTICLE I – NAME

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

ARTICLE II – DUTIES AND ACTIVITIES

The purposes of the Iowa Integrated Health Planning and Advisory Council (hereafter the Council, or I-PAC) shall be as set forth in federal law (42 USC 300x-3, Pub. Law 102-321, July 10, 1992, ADAMHA Reorganization Amendments, Public Health Service Act, 106 Stat. 382).

Section 1. Duties

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

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

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

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

Section 2. Activities

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

B. To actively participate in the development of the State's application for the Substance Abuse and Mental Health Service Administration's (SAMHSA) Substance Abuse Prevention, Treatment, and Recovery Services and Community Mental Health Block Grants (hereafter referred to as "Combined Block Grant Application");

C. To provide recommendations on State goals according to the criteria of the Combined Block Grant;

D. To advise on the expenditure of monies received by the State Mental Health Authority and Single State Authority (Iowa Department of Health and Human Services, hereafter abbreviated as Iowa HHS) through Combined Block Grant funding;

E. To advise the State Mental Health Authority and Single State Authority on matters that may affect the stated purposes of this Council;

F. To review the annual submission of the Combined Block Grant Application and comment on it to the Director of Behavioral Health Services;

G. To review the annual submission of the Combined Block Grant Application and comment on it to the Governor of the State of Iowa; and

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

Section 3. Records

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

(1) At the will of the Council, Iowa HHS staff shall take the minutes of all Council meetings. The minutes of a Council meeting will be made available prior to the next meeting for review and feedback from the Council at the next meeting.
(2) If the Iowa HHS staff person cannot be present or designate a replacement, the Chairperson shall appoint a council member to take minutes.

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

ARTICLE III – MEMBERSHIP

Section 1. General

The membership of the Council shall represent the diverse population of the State of Iowa.

Section 2. Requirements

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

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

B. Not less than 50 percent of the members of the Council shall be individuals who are not State employees or providers of mental health or substance abuse prevention, treatment, and recovery services.

(1) A provider of mental health or substance abuse prevention, treatment, and recovery services is an individual who receives money, from any source, to provide said services directly or indirectly to persons with lived experience.

(2) Peer support specialists, although providing paid mental health or substance abuse prevention, treatment, and recovery services, are not, in the spirit of Council representation, to be counted toward the provider total.

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

(4) Volunteers and members of advisory and governing boards (of mental health or substance abuse prevention, treatment, and recovery provider organizations) shall not be considered providers solely because of such status.

Section 3. Membership Categories

Membership shall be the following:

A. Seven (7) members representing the principal State agencies with primary responsibility for the following programs:

- Behavioral Health (Mental Health and Substance Abuse Prevention, Treatment, and Recovery Services)
- Education (Dept. of Education)
- Vocational Rehabilitation (Voc-Rehab)
- Criminal Justice (Dept. of Corrections)
- Housing (Iowa Finance Authority)
- Social Services (Aging and Disability Services)
- Medical Services (Title XIX--Medicaid)

(1) Individuals nominated by the principal State agencies shall be accepted by the Council. If the Council has concerns or feedback to provide to a principal State agency, these concerns will be given to IHHS (the State Mental Health Authority and Single State Authority). IHHS will share the concerns with the several state agencies.

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

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

C. Six (6) members who are adults with serious mental illness and/or substance use disorder and current or past persons with lived experience of mental health and/or substance abuse prevention, treatment, and recovery treatment services.

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

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

F. Four (4) other individuals with an interest in supporting the needs of children with serious emotional disturbance and/or substance use disorder and adults with serious mental illness and/or substance use disorder.

(1) There is an expectation for child advocacy representation provided by a representative knowledgeable about the juvenile justice system.
(2) Iowa Code 225C.4 subsection 1 "t" (2010 General Assembly) provides for one (1) representative by a military veteran who is knowledgeable concerning the mental and behavioral health issues of veterans.

G. Four (4) ex-officio members representing the Iowa General Assembly:

- One representative of Senate Democrats
- One representative of Senate Republicans
- One representative of House Democrats
- One representative of House Republicans

(1) Individuals representing the Iowa General Assembly will be nominated by the Majority and Minority leaders of their respective chambers and shall be accepted by the Council. If the Council has concerns or feedback to provide to Majority or Minority leaders, these can be shared with IHHS. IHHS shall share concerns with the Majority and Minority leaders and inform the Executive Committee of any action to be taken.

(2) Ex-officio members shall attend no less than biannually with at least one attendance coinciding with the fall session of the Assembly and at least one attendance coinciding with the spring Session of the Assembly.

(3) If an ex-officio Assembly member is not able to meet this obligation, the member should notify the Majority or Minority Leader (as appropriate) to nominate a new member.

(4) The Council shall notify IHHS who will notify the Majority or Minority Leader if an ex-officio member is not meeting their obligation, to allow for review of member appointment or making adjustments so that the member can achieve this obligation.

Section 4. Nominations

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

B. The State Mental Health Authority and Single State Authority (IHHS) will notify the Council of their designees.

Section 5. Voting Rights

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

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

C. No proxy voting is allowed.

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

E. If, in the course of business, a vote arises that a member perceives as potentially directly impacting the policies or operations of the entity that the member is employed by or represents, that member may recuse themselves (abstain) from a vote to allow time to seek further input from their governing bodies or executive management.

Section 6. Vacancies

A. Council membership ends when:

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

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

C. Attendance may be accomplished in person (when meetings are held in person rather than virutally), by video conference call, or by telephone conference call.

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

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

Section 7. Terms of Membership

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

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

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

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

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

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

Section 8. Termination for Just Cause

A. A Council member or members who feel just cause exists for another member of the Council to be terminated pursuant to Section 6(A)(4), must present a written statement of the reasons for the proposed termination to the Executive Committee.

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

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

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

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

ARTICLE IV – MEETINGS

Section 1. General

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

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

B. The Council shall meet no less than six (6) times a year.

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

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

D. Members shall be given at least two weeks advance notice of regular meetings. Special meetings may be called and noticed as necessary. Meeting notices must include place, date, and hour. If meetings are virtual or hybrid, notices must also include a link to the virtual meeting space. Meeting agendas shall be posted as required by law.

Section 2. Quorum

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

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

Section 3. Votes

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

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

C. In the process of voting, if a member recuses themselves (abstains) from a vote, it shall count neither for nor against the matter at vote. The vote may then be considered accepted by a majority vote of the remaining quorum of members.

D. Should at any time the passing quorum vote fall below the majority number of the total active council membership due to abstentions, the Council should consider a delay acceptance of the vote until such time as a majority of the active council can be either present or able to affirm the matter of action.

E. If a matter of action does pass with less than a majority number of the total active council, clarification and delineation of such should be made in the minutes of the meeting.

ARTICLE V – OFFICERS AND COMMITTEES

Section 1. Officers

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

B. The outgoing Chairperson may be retained in an ex-officio capacity at the will of the Council.

Section 2. Nomination and Election

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

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

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

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

Section 3. Terms of Office

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

Section 4. Duties

A. The Chairperson shall:

(1) Notify members of meetings with the assistance of IHHS designated staff;
(2) Preside at Council meetings;
(3) Not participate in voting as Chairperson unless called upon in case of tie (Article IV, Section 3 (B)).

B. The Chairperson, in cooperation with the Executive Committee and with assistance from IHHS designated staff, shall:

(1) Establish and publish the agenda for Council meetings;
(2) Establish and publish an annual calendar for Council meetings;
(3) Report to the federal government (SAMHSA), the Governor of Iowa, and designated persons or organizations;
(4) Serve as liaison between the Council and other groups and organizations, including the State Mental Health Authority and Single State Authority;
(5) Communicate with and regularly report to the Council;
(6) Designate ad hoc workgroup membership and monitor such workgroup's areas of focus;
(7) If the Iowa HHS staff person cannot be present or designate a replacement, the Chairperson shall appoint a Council member to take minutes; and
(8) Perform other miscellaneous functions, as determined or designated by the Council.

C. The Vice-Chairperson shall:

(1) Assume the Chairperson's duties for any period of time that the Chairperson is unable to do so;
(2) In the event that the Chairperson is unable to complete his or her term, act as Temporary Chairperson until the Council elects a new Chairperson;
(3) In the absence of the Secretary in a meeting, serve as Secretary; and
(4) Serve as a voting member of the Executive Committee.

D. The Secretary shall:

(1) Monitor the maintenance of minutes and records of the Council's business and ensure that minutes and records are compiled and maintained by the State Mental Health Authority and Single State Authority to be preserved in perpetuity;
(2) Assume the Chairperson's duties for any period of time that both the Chairperson and Vice-Chairperson are unable to do so; and
(3) Serve as a voting member of the Executive Committee;.

Section 5. Standing Committees or Workgroups in General

A. Council members shall each volunteer to be part of at least one standing committee or workgroup. The Executive Committee may appoint uncommitted members to appropriate committees or workgroups.

B. Standing committee/workgroup chairs, who are also voting members of the Executive Committee, shall be elected by majority vote of the committee/workgroup members.

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

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

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

Section 6. Nominations Committee

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

B. The Nominations Committee shall conduct outreach to diverse communities.

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

D. The Nominations Committee shall be responsible for soliciting and reviewing applications for Council membership, and making recommendations to the Council. A Council vote accepts or does not accept the application for membership.

Section 7. Executive Committee

A. The Executive Committee shall consist of: the Chairperson, the Vice-Chairperson, the Secretary, and the Chairs of the Standing Committees. At the will of the Council, the past Chairperson can be an ex-officio member.

B. The Executive Committee shall review Conflict of Interest Disclosures and make recommendations to the full Council on Conflict of Interest issues.

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

D. The Executive Committee shall:

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

Section 8. Monitoring and Oversight Committee

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

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

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

Section 9. Workgroups

A. The Executive Committee shall create and appoint workgroups to carry out any necessary Council business or activities that are not expressly provided for in these bylaws.
B. Workgroups shall reflect the adopted priorities of the Council and may change accordingly.
C. Members of workgroups shall be responsible for setting and attending meetings, if necessary, beyond any workgroup meeting prior to a Council meeting.
D. Workgroups shall prepare and present to the full Council their business or activities at regular intervals as directed by the Executive Committee.

ARTICLE VI – CONFLICT OF INTEREST

Section 1. Conflict of Interest Policy

A. The Iowa Integrated Health Planning and Advisory Council (hereafter, "the Council") respects the rights of all members in their activities outside of their association with the Council, should such activities not conflict with or adversely reflect upon the Council. It is Council policy to place trust in each member's integrity, judgment, and dedication. It is also important to avoid even the perception of a conflict of interest. Accordingly, the policy set forth below has been adopted:

(1) All Council members are expected to declare any financial or personal affiliations that could interfere with their effectiveness in representing the interests of individuals with serious mental illness or serious emotional disturbance and/or substance use disorder on the Council, or on their effectiveness in representing the Council to the public.

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

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

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

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

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

ARTICLE VII – BYLAWS

Section 1. Revision

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

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

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

First reading: May 28, 2008

Second reading: Waived May 28, 2008

Adopted: These By-laws are accepted and adopted by vote of the Iowa Mental Health Planning and Advisory Council on May 28, 2008.

Amended:

By majority vote of the Council on July 23, 2010, Art. III, Sect. 3F Membership.
By majority vote of the Council on March 21, 2012, Art. III, Sec. 6B Vacancies; Art. V, Sec. 4B Duties.
By majority vote of the Council on March 21, 2018: Art. III, Secs. D and E; Art. IV, Sec 3; Art. V, Sec. 4A3, Voting.
By majority vote of the Council on September 19, 2018: Art. V, Sec. 6B: Outreach.
By majority vote of the Council on March 15, 2023, all Articles, formatting and grammar.
By majority vote of the Council on March 20, 2024, all Articles: Iowa Integrated Health Planning and Advisory Council name, Iowa Behavioral Health Services name, Block Grant name, formatting, and grammar.

Appendix A:

Conflict of Interest Disclosure Statement

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

_____
_____
_____
_____
_____

Signed: _____

Date: _____

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

Ethical Considerations of Council Membership:

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

Mental Health Planning Council
January 17, 2024, 9:00 am to 3:00 pm
via Zoom
Meeting Minutes

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Rachel Cecil
Jennifer Day
Linda Dettmann
Jim Donoghue
Jessica Goltz
Jen Gomez
Kyra Hawley-Preston
Theresa Henderson
Vienna Hoang
Michael Kaufman
Todd Lange
Christina Maulsby
Katie McBurney
Mary McKinnell
Todd Noack
Hannah Olson
Brad Richardson
Jennifer Riley
Kristin Rooff
Brianna Steffe
Dr. Shad Swim
Monica Van Horn
Patricia Whitmarsh
Edward Wollner
Joel Wulff

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Sen. Claire Celsi
Sen. Jeff Elder
Lorien Harker
Megan Marsh
Rep. Ann Meyer
Nina Richtman

OTHER ATTENDEES:

Brad Anderson
Theresa Armstrong
Ashley Banes
Wendy DePhillips
Di Findley
Brenna Koedam
Patti Manna
Devon McClurken
Roxanne Petersen
Flora Schmidt
Russell Wood

Materials Referenced:

1.17.24 AARP Presentation - IMHPC
IMHPC Strategic Plan 2023-2025-DRAFT
Mental Health Planning Council Orientation 2024.01.11
MHBG Presentation January 24
MHPC November-15-2023-Meeting-Minutes-DRAFT
MHPC_Bylaws_1-18-23

Welcome

Teresa Bomhoff called the meeting to order at 9:02 am. Quorum was established with 20 members.

Review and Approval of Meeting Minutes

Teresa Bomhoff entertained a motion to approve the November 15, 2023, meeting minutes. Michael Kaufman motioned to approve the minutes. Jen Gomez seconded the motion. There was no discussion, the motion passed, and the minutes were approved.

Review and Approval of Draft Strategic Plan – Vote on Vision & Mission Statements & Service Values and Overall Goal

The IMHPC Strategic Plan 2023-2025-DRAFT, which was developed by the Strategic Plan Steering Committee, was shared with the Council. Changes proposed included members of standing committees can volunteer, rather than needing to be elected while committee chairs will continue to be elected. There was a review of the standing committee duties and proposed changes to the bylaws to align with practice. The Executive Committee will now direct the agenda planning and evaluation processes will be implemented. Also added, conflict of interest statements will need to be completed annually and reviewed by the Executive Committee. There was an opportunity for discussion, which there was none.

Teresa Bomhoff entertained a motion to approve the drafted IMHPC Strategic Plan 2023-2025. Theresa Henderson motioned to approve the plan. Joel Wulf seconded the motion. There was no discussion, the motion passed, and the plan was approved. The Council convened the bylaws work group, which includes Joel Wulf and Michael Kaufman, and they will work on the recommended amendments.

Nominations Committee Report
Jen Gomez welcomed a new member, Jessica Goltz, who fulfills the category of parent, guardian, or primary caretaker of a child/adolescent with serious emotional disturbance. She reported that there are no applications to vote on, with one application in process. Current Vacancies include two for a family member of an adult with serious mental illness or substance use disorder, one for an individual with lived experience or in recovery, and two for other.

Monitoring & Oversight Committee Report – Theresa Henderson
Theresa Henderson reported on the Monitoring & Oversight Committee activities. The Committee met with Julie Maas, HHS contract manager for The Center of Excellence for Behavioral Health (CEBH) contract. The contract started in April 2022, with the first of 2 possible one year extensions beginning in October of 2023.

The goal of the contract is fidelity monitoring and training on evidence based practices (EBP), with three focus areas: Assertive Community Treatment (ACT), Individual Placement and Support (IPS) and Permanent Supportive Housing. An environmental scan and fidelity monitoring was completed in October 2023. A training plan was developed and implemented in response to the findings. No barriers were identified, and positive feedback has been received from providers.

The Monitoring & Oversight Committee is at four members, and requirement is to have five members. Teresa Bomhoff opened up the opportunity to the members of the council and asked for a volunteer. Jessica Goltz volunteered to join the committee.

Recommendations from Name Change/Workgroup Strategic Plan Focus Group
Brad Richardson, Michael Kaufmann, and Kristin Roof shared the work of the Workgroups Workgroup The goal of the workgroup was to review the Council name and ensure the name would communicate the integration of planning and advocacy for Mental Health and Substance Use Disorder. It was recognized there was a desire to have the name communicate identity, values, and purpose with an opportunity to promote accuracy and evidence-based health parity.

The workgroup considered names that meet the following goals: reduce stigma, recognize social determinants of health, readily inform policy, and respects the expanded biopsychosocial model. The top names considered were Iowa Mental Health and Substance Use Disorder Planning and Advisory Council, Behavioral Health Planning and Advisory Council, Mental and Behavioral Health Planning and Advisory Council and Integrated Health Planning and Advisory Council. Pros and cons of each name were discussed, and the recommendation of the committee is to change the name to Iowa Integrated Health Planning and Advisory Council (I-PAC). Discussion was opened to the Council.

Teresa Bomhoff entertained a motion to change the name of the Iowa Mental Health Planning and Advisory Council. Brad Richardson motioned to change the name to Iowa Integrated Health Planning and Advisory Council (I-PAC). Todd Noack seconded the motion. The motion passed, with 17 members voting to approve. The bylaws workgroup will make the change in the bylaws, distribute the changes to the Council and bring a second reading to the March meeting for a vote.

The was also a discussion on recommended Council workgroups. In addition to the standing committees, the workgroup provided a suggestion to convene an additional nine workgroups, some of which are already established and proposed recommended focus areas for each.

IMHPC Member Orientation
Todd Lange, Todd Noack and Jen Riley provided a member orientation with included an overview of the Mental Health Block Grant including its history, purpose, target populations, and funding structure. They provided an overview of the Mental Health Planning Council's purpose and membership, and reviewed conflict of interest disclosures.

Understanding the Iowa Substance Use Prevention, Treatment, and Recovery Services Mental Health Services (MHBGSUPTRS) Block Grant: A Review in Three Parts
Theresa Henderson, Monica Van Horn, and Christina Maulsby provided the first of a three part series on an overview of the Iowa Substance Abuse Prevention Treatment and Community Mental Health Services Block Grant. This presentation will be continued at a the March 2024 Council meeting.

Public Comment
There was an opportunity for public comment, with none offered.

Planning and Advisory Council took a break for lunch from 12:41 p.m. and returned at 1:02 p.m.

Nursing Home Care – Paige Yontz, MHA, LNHA, State Advocacy Manager, AARP and Brad Anderson, Iowa State Director, AARP
Brad Anderson gave an overview of long-term care in Iowa. He described how Iowa is facing a long-term care crisis and shared supporting statistics, identified issues, and areas where changes could be made to improve the system.

Iowa Caregivers Association – Di Findley, Executive Director
Di Findley gave an overview of the Iowa Caregivers Association including its history, vision, and mission. The Iowa Caregivers Association has a goal of providing greater stability to the direct care workforce, so Iowans receive the care and support they need. Recommendations on how to achieve this goal were shared.

HHS/BH Update
Theresa Armstrong provided an update from HHS. Iowa Health and Human Services contracted with Health Management Associates (HMA) to conduct a third-party review of the delivery of 19 health and human service areas in the summer and fall of 2023. Based on HMA's recommendations, HHS will take a phased approach that first focuses on Behavioral Health System Alignment.

Through alignment, HHS plans to ensure Iowans have consistent access to health and human services, use funding more effectively to achieve outcomes, and consolidate and streamline contracting and administration. Legislation, which is expected soon, will direct the framework and this process will take place over the next 2 years. Legislation is also expected to direct spending of opioid settlement dollars.

IMHPC Strategic Plan Next Steps
There was a discussion on the Strategic Plan next steps and future meetings. The Policy & Bylaw Workgroup will make necessary changes to documents based on Council actions at the January

meeting and will send out updated draft documents to the full Council for review and comment prior to voting at the March 2024 meeting.

The Council would like to hear from Iowa HHS Block Grant manager on a breakdown of expenditures, and this is scheduled for March 2024.

Public Comment
There was an opportunity for public comment, with none offered.

Adjourn
Teresa Bomhoff entertained a motion to adjourn the meeting. Jim Donohue motioned and was seconded by Jen Riley There was no discussion and the motion passed. The meeting adjourned at 3:02 pm.

Meeting minutes respectfully submitted by Patti Manna.

Iowa Integrated Health Planning and Advisory Council
Mental Health Planning and Advisory (MHDS) Commission
Joint Meeting
March 19, 2025, 11:40 am to 2:00 pm
via Zoom
Meeting Minutes

IOWA INTEGRATED HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Jennifer Day
Linda Dettmann
Jessica Goltz
Jen Gomez
Theresa Henderson
Nancy Hunt
Michael Kaufman
Todd Lange
Cayleen Mesecher
Todd Noack
Hannah Olson
Brad Richardson
Jennifer Riley
Kristin Rooff
Ellen Schardt
Brianna Steffe
Dr. Shaad Swim
Monica Van Horn
William Veltri
Edward Wollner
Joel Wulf
Kelly Yeggy

IOWA INTEGRATED HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Sen. Claire Celsi
Jenny Erdman
Lorien Harker
Kyra Hawley-Preston
Megan Marsh
Vienna Hoang
Christina Maulsby
Rep. Ann Meyer

MHDS COMMISSION MEMBERS PRESENT:

Betsy Akin
Diane Brecht
Linda Dettmann
Mike Fidgeon
Sue Gehling
June Klein-Bacon
Kellee McCrory
Terri Steinke

MHDS COMMISSION MEMBERS ABSENT:

Sen. Jeff Edler
Kathy Norris
Rep. Megan Srinivas
Jack Seward, Jr.
Sen. Sarah Trone Garriott
Dr. Kenneth Wayne

OTHER ATTENDEES:

Theresa Armstrong
Rod Courtney
Carlyn Crowe
Sarah Dixon
Jeni Hanselman
Kathy Johnson
Laura Larkin
Dree LaToure
Brooke Lovelace

Patti Manna
Rebecca McCrackin
Lori Hancock-Muck
Katie Peck
Kayla Powell
Libby Reekers
Karen Rosengreen
Flora A Schmidt
Aaron Todd
Danielle Workman
Sarah Wurm

Materials Referenced:
Overview of Iowa PCA + ASO MHDS Commission and I-PAC
MHDS_Commission February 20, 2025 Meeting_Minutes_DRAFT
MHDS Commission Sunset Report 2025 DRAFT 20250313
MHDS Commission Sunset Report Appendix B Acronyms
Iowa DD Council Update
2025 summary of I-PAC

Welcome
Teresa Bomhoff called the meeting to order at 11:40 pm after a lunch break from the morning portion of the meeting.

Welcome – Theresa Armstrong, Iowa HHS
Theresa Armstrong welcomed the Iowa Integrated Health Planning and Advisory Council, Mental Health and Disability Services Commission, and Developmental Disabilities Council members. Theresa Armstrong introduced representatives from Iowa PCA, Iowa's Behavioral Health Administrative Service Organization (BH-ASO).

Iowa Primary Care Association (Iowa PCA) – Aaron Todd and Jeni Hanselman
Iowa PCA representatives shared an overview of the organization, which has been selected to serve in a statewide capacity as the Administrative Service Organization (ASO) for the state's redesigned Behavioral Health System. Iowa PCA is a non-profit association with an ongoing commitment to expanding access to quality, affordable, and accessible healthcare to meet local needs. Members include 14 Community Health Centers (CHCs) across the state. Iowa PCA supports a continuum of care including integrated behavioral health, medical, oral health, and pharmacy services. Iowa PCA has experience supporting the continuum of care and a supportive statewide ecosystem. Iowa PCA's statewide staffing model, unified statewide approach, and collaboration and partnership building capabilities were reviewed. Representatives reviewed a summary of the activities in developing District Advisory Councils, Mental Health and Disability Services (MHDS) Region meetings, and upcoming opportunities to gain additional information and provide feedback.

There were follow up questions relating to payment timelines and billing guidance. Iowa PCA stated that they are developing communication plans with training on billing guidance to be offered prior to July 1, 2025.

Introductions – I-PAC, MHDS Commission, and DD Council

Teresa Bomhoff led a roll call of I-PAC and MHDS Commission members as well as the representative from the Iowa Developmental Disabilities (DD) Council.

Iowa Integrated Health Planning and Advisory Council Overview and Update – Teresa Bomhoff

Teresa Bomhoff shared an overview of I-PAC and its activities. She shared the document "2025 Summary of I-PAC" which included the I-PAC purpose, vision, mission, goals, and membership overview.

MHDS Commission Overview and Update – Diane Brecht

Diane Brecht reviewed the current work of the MHDS Commission. In the past year, the Commission has completed the 2024 Biennial Report and has received regular updates on Behavioral Health/System Realignment from Iowa Health and Human Services. The Commission heard about Managed Care Organizations (MCO's) and the Value Added Services offered. The Commission is completing a 2025 Sunset Report and will dissolve as of July 1, 2025.

Iowa Developmental Disabilities Council Overview and Update – Brooke Lovelace

Brooke Lovelace, Executive Director, Iowa DD Council shared a presentation on the DD Council. Brooke reviewed the purpose of the DD Council. She reviewed the Developmental Disability (DD) Assistance and Bill of Rights Act, which established a set of programs to improve the lives of people with developmental disabilities through capacity building and systems change, advocacy, and the enforcement and protection of civil rights. Iowa's DD Councils, along with DD Councils nationally, act in tandem with their state University Center for Excellence in Developmental Disabilities (UCEDD) and state Protection and Advocacy organization. The 2022-2026 state plan was shared, including the goals for advocacy, systems change, and capacity building.

HHS Updates – Laura Larkin

Laura Larkin shared updates from the Iowa Department of Health and Human Services (Iowa HHS). Iowa HHS has announced its intent to award seven individual contracts to entities that will serve as Disability Access Points (DAP) across the state. Disability Access Points are district-level organizations that connect individuals with disabilities to providers who can provide the necessary services to meet their needs.

Laura Larkin shared that the work on the Certified Community Behavioral Health Clinic (CCBHC) Demonstration continues. Iowa HHS is working with providers to complete certification processes, establish billing practices, and ensure providers can meet standards Implementation is scheduled for July 1, 2025. The Stakeholder Engagement Committee meeting is scheduled for March 24th, 2025.

Review and Approval of Meeting Minutes

Diane Brecht entertained a motion to approve the I-PAC February 20, 2025, meeting minutes. Quorum was established with 8 voting members. Mike Fidgeon motioned to approve the

minutes; June Kline-Bacon seconded the motion. There was no further discussion, the motion passed, and the minutes were approved.

MHDS Commission Sunset Report Review and Discussion – Diane Brecht
Diane Brecht led a review of the drafted MHDS Sunset Recommendations Report. an opportunity to vote and approve the report at the April 17th, 2025, meeting. The Commissioners present agreed that the content of the report reflected their thoughts and did not suggest any changes.

Diane Brecht shared that Jack Seward, who was not present, had submitted a suggestion that Commission members write and attach individual letters to the report. There was a discussion that such letters should reflect the commissioners' role and further discussion could occur at the April 2025 meeting.

Planning for Future Meetings – Diane Brecht
Diane Brecht requested that if Commission members have suggestions for the April 2025 meeting, they submit those suggestions to her.

Public Comment
There was an opportunity for public comment, with none offered.

Adjournment
The meeting adjourned at 1:43 pm.

Meeting minutes respectfully submitted by Patti Manna.

Iowa Integrated Health Planning and Advisory Council (I-PAC)
May 21, 2025, 9:00 am to 3:00 pm
via Zoom
Meeting Minutes

IOWA INTEGRATED HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Jennifer Day
Linda Dettmann
Jessica Goltz
Jen Gomez
Theresa Henderson
Nancy Hunt
Michael Kaufman
Todd Lange
Cayleen Mesecher
Todd Noack
Hannah Olson
Brad Richardson
Jennifer Riley
Kristin Rooff
Ellen Schardt
Brianna Steffe
Dr. Shaad Swim
Monica Van Horn
William Veltri
Edward Wollner
Joel Wulf
Kelly Yeggy

IOWA INTEGRATED HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Sen. Claire Celsi
Jenny Erdman
Lorien Harker
Kyra Hawley-Preston
Megan Marsh
Vienna Hoang
Christina Maulsby
Rep. Ann Meyer

OTHER ATTENDEES:

Jacob Appel
Theresa Armstrong
Katie Dunmore
Julie Gibbons
Jessica Goltz
Mandy Hatten
Alicia Karwal
Torie Keith
Eugenia Kendall
Patti Manna
Roxanne Petersen
Libby Reekers
Gabbie Ruggiero
Flora A. Schmidt
Dex Walker

Materials Referenced:

I-PAC March 19, 2025 AM Meeting Minutes DRAFT
I-PAC_MHDS Commission March 19, 2025 Joint Meeting Minutes DRAFT
I-PAC Workgroup Reports Summary 202505
May 21 Draft State Plan on Aging Presentation – Final
Iowa REACH About Us
I-PAC Polk County Opioid Settlement Funds presentation

Welcome

Teresa Bomhoff called the meeting to order 9:02 am. Quorum was established with 23 members at 9:05 am. Twelve members attended in person.

Review and Approval of Meeting Minutes
Teresa Bomhoff entertained a motion to approve the I-PAC March 19, 2025, AM Meeting Minutes and the I-PAC_MHDS Commission March 19, 2025, Joint Meeting Minutes. Jenn Day motioned to approve the minutes; Hannah Olson seconded the motion. There was no further discussion, the motion passed, and the minutes were approved.

Nominations Committee Report
Brad Richardson welcomed Rod Courtney, who fulfills the role of public/private entity, LaShawna Dean, who fulfills the role of a family member of an individual in recovery, and Lori Hancock-Muck, who fulfills the role of public/private entity to the Council.

Brad Richardson shared that the nominations committee has agreed to nominate Alicia Karwal to the Council to fulfill the role of a parent, guardian, or primary caretaker of a child/adolescent with serious emotional disturbance. Alicia was in attendance and introduced herself. Brad Richardson motioned to approve the nomination; Joel Wulf seconded the motion. The motion carried and Alicia Karwal was approved as a member of the Council.

Teresa Bomhoff led a discussion on the current vacancies. The Council has one vacancy for a parent, guardian, or primary caretaker of a child/adolescent with serious emotional disturbance.

Workgroups
Teresa Bomhoff reviewed the Council Committee and Workgroup Reports Summary. The chair, or their representative, of each workgroup gave a short verbal summary of the report.

Todd Lange reported the Certified Community Behavioral Health Clinics (CCBHC) recommend inviting CCBHC provider representatives in the Fall of 2025 to learn how they are educating their staff and their view of the effects of the transition process, inviting a CCBHC provider and community partner in the Spring of 2026 to co-present on their collaborative process, and encouraging I-PAC members to attend CCBHC Stakeholder Engagement Committee meetings.

Jessica Goltz reported that the Children’s Issues workgroup recommends the Council monitor the Behavioral Health State Plan regarding early intervention and prevention efforts for children and youth and monitoring the state legislation affecting children and youth.

Joel Wulf reported that the Older Adults workgroup recommends the Council learn more about consumer education options for older adults and their families, requests presentations from Senator Claire Celsi, John Hale, Dean Lerner and other partners as appropriate to learn about nursing home bills and other related issues. Additional recommendations are that the Council learn more about updates on the Centers for Independent Living, both at the state and federal level and about the HHS Waiver redesign status (HOME Project).

Edward Wollner reported the substance use disorder (SUD) workgroup recommends the Council invites the CEO of Community & Family Resources (CFR) to talk about the nature

wellness recovery campus, continues to monitor the Behavioral Health alignment, continues to monitor federal changes effects on services in Iowa.

Kristin Rooff reported that the Strategic Planning workgroup is working on a drafted logo for consideration and a shared document to track pertinent changes in federal and state action and policy.

Lori Hancock-Muck reported that the Public Safety workgroup recommends that Council members monitor and be aware of the school safety assessment teams recently signed into law, consider future presentations on Competency Restoration, learn about criminal diversion programs for individuals with mental health and substance use conditions, and monitor past and pending litigation related to injuries to staff and patients at the Mental Health Institutes.

Behavioral Health and Disability Services – Theresa Armstrong
Theresa Armstrong, Behavioral Health Division, Iowa Health and Human Services (HHS) provided an overview of the changes occurring with the Iowa HHS Behavioral Health and Disability Services.

The new Behavioral Health Service System starts on July 1, 2025, and will make it easier for mental health and substance use providers to help Iowans get the care they need, no matter where they go for help. Iowa HHS is working with Iowa Primary Care (Iowa PCA) Association to ensure services continue without disruption.

Iowa HHS and Iowa PCA and working on what system navigation will look like and how to ensure access and assistance to navigate the system. Your Life Iowa (YLI) will be the brightly lit front door for assistance. Conversations on where the system navigators will be located have begun.

The final administrative rules have been published for the Behavioral Health Administrative Organization (BH-ASO), system access standards, and services funded. These will also be effective July 1, 2025.

District Advisory Councils have begun meeting. These councils will assist Iowa PCA in planning and identifying gaps. There are still openings left on the councils, especially for individuals with lived experience. The fee schedule for providers has been released, which outlines proposed rates for a comprehensive range of services to support provider planning and operational readiness. Provider contracts have been reviewed and will soon be disseminated.

The Behavioral Health Service System Statewide Plan, Iowa’s guide to improving behavioral health services across the state, was published in April 2025. The plan includes a continuum of services: prevention, early intervention, treatment, recovery and crisis services. Priorities have been placed on prevention and early intervention.

Draft State Plan on Aging – Eugenia Kendall, HHS
Eugenia Kendall provided an overview of the FFY 2026-2029 Draft State Plan on Aging. This included a review of the state plan submission and implementation timeline, with a final draft expected in July of 2025.

The federal and state requirements for the development of the state plan were reviewed. These included completing a needs assessment, completing an aging and disability service assessment, and identifying a priority population. Identified aging network challenges included a decrease in state funds per Iowan aged 60+ with an increase in Iowa's older adult population. Goals and objectives developed for the plan were reviewed with four mail goal areas: maximize independence, improve health and wellness, improve safety and quality of life, and maintain engagement.

Public Comment
There was an opportunity for public comment, with none offered.

Lunch Break
There was a lunch break from 12:10pm-1:00pm.

Iowa REACH – Dex Walker
Dex Walker provided an overview of the Iowa REACH initiative, which is a new Medicaid initiative focused on developing and improving home and community based behavioral health services for children and adolescents with serious emotional disturbances.

Iowa REACH will serve Medicaid-eligible Iowa children under 21 with serious emotional disturbance that is not attributable to an intellectual or developmental disability in need of intensive home and community-based services.

The initiative has developed an implementation plan that outlines the approach Iowa will take to improve the delivery of home and community-based mental health services. The goals of the plan are to develop, improve, and strengthen the relevant services and to implement a quality management and accountability structure.

Polk County Opioid Settlement Funds – Gabbie Ruggiero
Gabbie Ruggiero provided an overview of the Polk County Opioid Settlement Funds**.** Iowa is projected to receive $316 million+ through FY40, with 50% percent of Iowa's opioid settlement funds controlled by the legislature and 50% for the "local share". Use of the funds will include opioid abatement strategies to prevent further opioid misuse and address the effects of those "injured" by the opioid epidemic. Allowable expenditures for core strategies, Polk County's guiding principles, and strategic plan were reviewed.

Planning for Future Meetings – Teresa Bomhoff
Teresa Bomhoff led a discussion on general business and planning for future meetings. Council members were asked to send suggestions for future presentations to the Council Chair.

Public Comment
There was an opportunity for public comment, with none offered.

Adjournment
The meeting adjourned at 2:43 pm.

Meeting minutes respectfully submitted by Patti Manna.

Iowa Integrated Health Planning and Advisory Council (I-PAC)
Combined Block Grant Application Committee

July 29, 2025

Committee Members Attending:
Jessica Goltz
Todd Noack
Todd Lange
Monica Van Horn
Brad Richardson

Meeting Discussion

There was a discussion that the I-PAC Block Grant Recommendations Committee, after reviewing the needs and gaps in the state, should submit recommendations to be included in the 2026-2027 Combined Block Grant Application. A summary of the recommendations in bulleted format will allow for a high-level picture of the recommendations to be included in the draft that should begin to circulate for public comment in the first week of August.

The committee reviewed the summary of the recommendations provided by the Block Grant Recommendations Committee in 2023 and 2024, listed below, and drafted a bulleted list of recommendations for the full committee to review and provide feedback on at the next meeting. The full narrative letter with recommendations should be submitted to HHS by mid-August for uploading into the application. A timeline of activities is included in the next steps section of this document.

2023 Recommendations:

- Our first recommendation is for the continuation and expansion of peer support services in the state.
- The Council's second recommendation for the mental health block grant funds is to provide more services to help teens and young adults transitioning to adult behavioral health services.
- The Council's third recommendation is to increase the availability of services to the elderly population.
- The fourth and final recommendation to the Council is providing education to the community on brain injury and subsequent behavioral health issues.

2024 Recommendations

- Recommendation 1: Expansion of peer support services through peer-run organizations.
- Recommendation 2: Language in CCMHC contracts to promote educations, trainings and services that focus on the needs of the aging population, transitional age youth and youth discharging from crisis services.
- Recommendation 3: Focus on services for the rural population including FEP and SOC

DRAFTED 2025 Recommendations

- Expansion of peer support services through peer-run organizations.
- Funding for prevention and early intervention initiatives as an allowable activity.
- Implementation of crisis intervention and mental health education for first responders and law enforcement.
- Increase workforce development and capacity related to behavioral health promotion and prevention.
- Identify and expand on Evidence Based Practices beyond those currently supported by the state (i.e. permanent supportive housing, individual placements and support, assertive community treatment).

Note from Monica Van Horn on current allowable activities:

Allowable Activities/Contract Services:

- Support for peer support and family peer support, this may include: support for wellness/drop-in centers, training of peer and family peer support specialists, supervisors of peer and family peer support specialists, direct peer and family peer support not otherwise funded by insurance or Medicaid.
- Personnel training for Evidence-Based Practices (EBP) for adults with SMI or children with an SED. This may include reimbursement for Personnel time, training costs, training materials, travel costs to be trained in and implement an EBP.
- Building workforce capacity for services that require professional licensure, this includes:
    - reimbursement of supervision activities of CMHC Personnel for potential mental health professional licensees in master's degree programs or individuals working toward independent licensure.
- Provision of evidence-based education and consultation for the target population to the community including schools, families, community providers and other supports. This may include training, information and referral activities, and consultation to the above groups on services and supports to adults with SMI and children with SED.
- Reimbursement to the provider for copays and deductibles for mental health services for Consumers with an SED or SMI.
- NAVIGATE model program for youth and adults experiencing a first episode of psychosis or early onset of symptoms.

Unallowable Activities:

 Provision of inpatient services.
 Making cash payments to intended recipients of health services.
 Purchase or improvement land; purchase, construct, or permanent improvement (other than minor remodeling) any building or other facility; or purchase of major medical equipment.
 Satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.
 Provision of financial assistance to any entity other than a public or nonprofit private entity.
 Paying for salaries of administrators and supervisors not directly involved in carrying out the Agreement.
 Ongoing overhead costs such as space, utilities, clerical services, and accounting services or cost of any audits.
 Supplant existing resources dedicated to the funding of services.
 Purchase goods for a client (examples: food, phone service, phones, computers, gas cards).

Note from Todd Lange:
Federal Block Grant Appropriations Bill Senate File 626,
https://www.legis.iowa.gov/docs/publications/NOBA/1526474.pdf. Look at the bottom of Page 6 and the top of Page 7.

Next Steps

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Date	Action
July 29, 2025	Draft bulleted recommendations
July 29, 2025 – August 4, 2025	Committee members review drafted recommendations and provide feedback
August 5th, 2025	Finalize bulleted recommendations and submit to HHS Draft narrative recommendations

August 5th, 2025 – August 11th, 2025	Committee members review drafted recommendations and provide feedback
August 12th, 2025	Update narrative recommendations with committee feedback
August 12th, 2025 – August 18th, 2025	Council members review narrative recommendations and provide feedback
August 19th, 2025	Finalize recommendation letter
August 19th, 2025 - August 22nd, 2025	Council members review and vote on recommendation letter by email
August 25th, 2025	Submit final recommendations to HHS

August 15, 2025

Chandra Jennings, PhD, MCHES©
Youth Behavioral Health and Mental Health Block Grant Planner
Division of Behavioral Health
Iowa Department of Health and Human Services
321 E 12th St., Des Moines, IA 50319
Chandra.Jennings@hhs.iowa.gov

Justin Edwards, IADC
Substance Use Block Grant Manager
Project Director – Integrated Provider Network
Division of Behavioral Health
Iowa Department of Health and Human Services
321 E 12th St., Des Moines, IA 50319
Justin.Edwards@hhs.iowa.gov

The Iowa Integrated Health Planning and Advisory Council (referred to as "Council" or "I-PAC") has been reviewing the needs and gaps in care in our state. We would like to make five recommendations for the Iowa 2026-2027 Combined Block Grant funds to fill gaps and meet the needs of all Iowans' behavioral health needs. Outlined in this letter are the five gap areas we propose to be included in the Iowa 2026-2027 Combined Block Grant Application. These five recommendations are:

1. expansion of peer support services through peer-run organizations,
2. funding for prevention and early intervention initiatives as an allowable activity,
3. implementation of crisis intervention and mental health education for first responders and law enforcement,
4. increased workforce development and capacity related to behavioral health promotion and prevention, and
5. identification and expansion of **E**vidence **B**ased **P**ractices beyond those currently supported by the state.

Our first recommendation is for the continuation and expansion of peer support services in the state. Peer-run organizations are filling gaps in local communities and averting crisis. Peer-run organizations serve rural communities and rural areas. Peer support helps to alleviate workforce shortages.

- **Four peer run organizations** received block grant funding that came from Covid funds. All four organizations have been able to increase the amount of people with lived experience they reach and provide peer support services that improve recovery, resiliency and provide an alternative to crisis services.

- **Peer respite houses** are an alternative to hospitalization. Iowa has only one **peer run respite** where other states such as Wisconsin have multiple. These

respites don't bill Medicaid and rely on grants and other funding to continue to provide respite services. Iowa's has served over 725 people in less than seven years.

One example is a person who was hospitalized nine times in 2019 and came to the respite house in January of 2020. He has only been hospitalized one time to date. The reason he was hospitalized was because with the respite house was full.

- **Peer run wellness recovery centers**- the sustainable expansion of these centers is also crucial. These wellness centers are run by peer run organizations and offer a multitude of services like:
    - one on one support,
    - support groups,
    - technology support,
    - resources,
    - social skill building, and
    - many other life structuring skills.

  One recovery center reported that its hours of operation in the evening allowed a person to take and complete their GED. They worked during the day and had no technology that allowed them to do it at home. Everywhere, including libraries, were all closed.

  Another recovery center that is open late night after hours also runs the only virtual recovery center. It enables people on the other side of the state to join. Many have no transportation but do have cell phones.

  Currently there are five peer run recovery centers in Iowa but only four receive some funding from the state and need additional funding to fully support them.

- **The warm line** in Iowa continues to receive adequate funding to provide services 24 hours a day. It would also be beneficial if the warmline could expand their population served to include teenagers ages 13-17. Right now, the warmline serves only adults aged 18+. Sustainable funding for the warmline is crucial now more than ever with the ARPA funding gone.

  Funding could be used to provide additional **training** for the warmline to serve the teenage population and **training** for additional peers when the extension increases call volume.

- Peer support is an evidenced based practice. These services would benefit from **fidelity monitoring** to make sure they stay true to what the service is meant to be. They should be overseen by the peer evidence-based side and not clinical side.

Block grant funds could also help fund **fidelity monitoring** for peer support organizations. A **peer run statewide technical assistance center** (operated by a state peer run organization) would be possible through similar contracts that provide the University of Iowa peer support training and the Center of Excellence.

The Council recommends block grant funding be used to help with the **continuation** and **expansion** of peer support services in Iowa like the peer run organizations, peer respite, recovery centers and warmline. **All save money and all have life altering impacts for their clients.**

March 2021 Research
Nationwide Block Grant Funding of Peer-run Organizations
Replies: 27
Yes: 17
No: 10 (3 States use state funds to support Peer-run Organizations)
Most frequent areas of funding:

- Wellness\Recovery Centers
- Warm Lines
- Peer Respites

The Council's second recommendation - Prevention and early intervention initiatives be an allowable activity.

Prevention and early intervention efforts are often spoken of as measures to reduce the risk of physical illness; however, these measures have not always been discussed when it comes to mental health. Evidence suggests that **providing tools for prevention can help guard against developing more serious mental health challenges.**

As for children, meeting their physical, psychological, and social needs is a key element to supporting **brain development** which can help to improve executive function skills such as **emotional regulation**. Early intervention has been proven to **reduce the likelihood of developing clinical level symptoms in the future.**

In addition to **provider shortages**, a recent local survey, indicated that 53% of individuals in a multi-county service area stated their biggest barrier to improving their mental health is a **"Lack of resources beyond the clinical setting."** Additionally, 43% responded that a **"Lack of knowledge to make changes in their health"** was also a barrier to improving quality-of-life. A lack of therapists means children and families may never receive support.

Additionally, therapists are **not always well trained** in evidence-based integrative practices, nor do they have the **time** to work with youth and families to develop skills. Lack of knowledge and support beyond the clinical and school setting prevents youth from ever adopting practices that have been scientifically proven to be effective in **reducing the effects of stress, anxiety, and depression.**

Promotion, prevention and early intervention is an ideal continuum of care. This can include mental health promotion activities, behavioral health screenings, school-based practices, and community-based prevention programs. There are preventative measures that can be taken to **protect mental health**. The following are examples of evidence-based practices in prevention and early intervention:

- Positive Behavioral Interventions and Supports
- Development of coping skills such as mindfulness and breathing exercises
- Healthy nutrition
- Stable and supportive environments
- Building emotional regulation skills
- Executive function skill development
- Challenging unhealthy thought patterns
- Promoting self-esteem
- Relationship skill building
- Strengthening resilience

Prevention and early intervention are not necessarily the responsibility of the mental health professional alone. Research suggests that a **multidisciplinary approach** is more effective, especially in the early stages of prevention.

For example, **incorporating other disciplines** such as **mental health coaches** can not only lighten the case load of mental health providers but also play a crucial role in early intervention by **preventing issues before they escalate**. Addressing symptoms early can help to build resilience and develop healthy coping mechanisms. The development of **healthy coping mechanisms** could potentially decrease the risk of a mental health diagnosis or future substance abuse.

Historically, block grant dollars have not been used for prevention or early intervention efforts, and the question remains whether funding can be used for this purpose. However, according to the SAMSHA website the following are allowable activities:

- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.

- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

The I-PAC council recommends that the block grant committee review the above statements and investigate the possibility of providing funding for prevention and early intervention activities.

The Council's third recommendation - Statewide implementation of crisis intervention training and mental health education for first responders and law enforcement.

A **statewide regional provider** is **recommended** to be chosen to **organize** the efforts to provide crisis intervention training and mental health education to first responders and law enforcement.

Rural city and county rural law enforcement teams and first responder teams have fewer members and funds so a close **geographical** location for training is conducive to participation.

A law enforcement team or first responder team, wherever their location, can only send a very limited number of participants to training because there has to be enough team members left to cover the unit's normal responsibilities and emergencies.

The statewide plan has to be organized so trainings are repeated - geographically - so more team members and new team members can receive training.

Background:

In the past, Mental Health and Disability Regions had designated funding to arrange for crisis intervention training and mental health education for first responders and law enforcement.

Regions no longer exist.

The designated funding no longer exists.

Other information on efforts to provide training
CIT is offered in the urban areas but not on a consistent basis in the rural areas.

- The firm most often **hired** to provide the CIT and mental health education programs was SolutionPoint+. It was founded in 2017 by two former San Antonio Police Officers and service-connected disabled United States Marine Corps veterans. CEO Joe Smarro and President, Jesse Trevino. SolutionPoint+ is:
  - a Texas training firm and has several programs
  - Crisis Intervention team training (40 hours)
  - De-escalation
  - Trauma-informed care
  - Jail Diversion processes
  - Mental Wellness
  - Telecommunicator's mental health and de-escalation
    Children and Adolescent Crisis training
  - An online course called "Justice Clearinghouse Crisis Intervention Response Online

- The University of Iowa's Simulation in Motion-Iowa (SIM-IA) program has reached the key milestone of educating healthcare providers and **first responders in each of Iowa's 99 counties.**

  SIM-IA, funded through an $8 million grant from The Leona M. and Harry B. Helmsley Charitable Trust, provides valuable hands-on experience for healthcare professionals on procedures they don't often have the opportunity to perform. The grant funded three semi-trailer-sized vehicles, which traverse the state to train medical personnel in their communities, eliminating the obstacles of cost, travel distance, and time away from patient care. Each truck is equipped with a simulated ambulance cabin, a simulated emergency room, four manikins, and a video system for analysis and debriefing.

  Since SIM-IA's launch in 2022, its trucks have logged a total of nearly 100,000 miles, educating more than 14,000 EMS and other emergency providers along the way.

- In the past, the Iowa Law Enforcement Academy in **Johnston** included CIT training and Mental Health education in the new officer basic academy training. The Academy Director is Brady Carney (515-331-5778). The ILEA Basic Academy added CIT in the fall of 2017 so almost all new officers coming through Academy should have it.

- The **Des Moines** Police Academy includes Crisis Intervention Team training and Hearing Voices training in each of their new recruit training programs offered at least twice a year. Sometimes recruits from Des Moines suburbs are allowed to attend the classes. The Des Moines PD has included CIT in all of their Academies since 2013.

- The **Iowa City** Police Dept has had CIT training in the past and will continue to do so in the future. Captain Gardia 319-356-5275 commented they were the first urban area to offer the training. Attendees come from Iowa City and smaller communities in the **Johnson County area**.

- Annie Uetz 515-286-3570 **Polk County** Behavioral Health and Disability Services Dept. has been instrumental in arranging for several CIT trainings over the many years she has been involved in behavioral health services in Polk County.

  Annie explained each Region had to complete quarterly reports for Iowa HHS and she knows their Region included each training they sponsored along with the number trained. To get a statewide number, she recommends reaching out to HHS.

  The **Polk County region** had contracts with Solution Point Plus.

  Polk County also provided a modified CIT training for seasoned officers in 2017 and 2019 – A total of 156 seasoned officers/deputies in Polk County were trained.

  In 2023, trainings were for police dispatchers and law enforcement for a higher level of coordination. When a call came in, the dispatchers needed to know how to judge acuity and whether to send mental health clinicians or a police response team to the call. Often law enforcement sat side-by-side with the dispatchers as the calls came in so they could reach a conclusion together.

Our fourth recommendation - increase **workforce development and capacity** related to behavioral health promotion and prevention.

According to KFF using data current as of December 31st, 2024, Iowa has over 1.5 million residents living in designated Mental Health Care Health Professional Shortage Areas (HPSA), with **15.3% of our need currently being met**. According to an Iowa Health and Human Services snapshot, **there are far fewer mental health providers in the state of Iowa than the national average.** There is a wide difference in provider coverage across the state with 92 rural communities reporting as mental health provider shortage areas. An additional 67 practitioners would be needed to fully remove that HPSA designation. This data relates only to the number of additional psychiatrists it is predicted are needed to provide thorough coverage for Iowans.

However, it is common knowledge that Iowa suffers from a workforce shortage throughout the behavioral health field, in all position levels. **Iowa was recently ranked 45th in the nation for mental health workforce availability**, and the U.S. Department of Health has designated many of Iowa's counties as Behavioral Health Workforce Shortage Areas.

Many individuals needing mental health support must travel 30-60 miles to see a therapist, are placed on waiting lists from 6-12 months, and cannot find a therapist in their insurance network.

Youth residing in rural counties are placed on waiting lists (sometimes multiple waiting lists) for therapists, have long wait times in between appointments, and in some cases never get a call back to schedule appointments. Therapists at local hospitals and organizations are reporting they are currently not accepting new patients with many of them booking out to 2026 or farther.

Thus, creating a need for an innovative approach to supporting behavioral health.

Filling gaps in behavioral health providers is not solvable overnight, creating the need for innovative approaches. Some states, such as the state of California are implementting programs to utilize board-certified health coaches who are certified through the National Board of Medical Examiners and the National Board of Health and Wellness Coaches to fill these gaps. Health coaches who have a bachelor's degree in a human services field such as social work or psychology can be a great asset to the behavioral health field by providing non-clinical support.

Board-certified coaches are also well trained in motivational interviewing, an evidenced based counseling approach that supports individuals through behavior change and helps to adopt healthy behaviors to reduce the risk of developing clinical level symptoms.

Additionally, professionals who hold a bachelor's degree in a human services or healthcare field often have years of experience and the expertise to serve as counselors. The

creation of a bachelor's level internship or bridge program to licensure would be an innovative approach to filling gaps in providers.

In the past several years, block grant funds have been allowed for the reimbursement of supervision of activities of personnel for potential mental health professional licenses in master's degree programs, or individuals working toward independent licensure. The council recommends the following:

 Expanded support for internships and supervision

 Activities for all levels of care within the behavioral health field

 Development of bachelor's level internship programs

 Psychiatric residency support

 Utilization of board-certified health coaches to fill gaps in care and support prevention and early intervention

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The Council's fifth and final recommendation - identify and expand on Evidence Based Practices (EBPs) beyond those currently supported by the state.

This recommendation is directly related to the allowable area for identification and expansion of Evidence Based Practices beyond those currently supported by the state for Behavioral Health and Mental Health Services which include:

- Permanent Supportive Housing (PSH),
- Individual Placements and Support (IPS),
- Assertive Community Treatment, and
- Suicide Prevention.

The rationale for expanding evidence-based practices (EBPs) in the state is based on principles of good governance, fiscal responsibility, and a commitment to improving the health and well-being of the population.

At its core, this recommendation is based on the notion that by using interventions and programs with proven records of success, the state can maximize the impact of taxpayer dollars and achieve better outcomes for its communities.

However, EBPs must align with the needs in the state. Therefore, before expanding EBPs it is recommended that a study be conducted:

- to identify needs and then
- align those needs with the currently available EBPs,
- with an expanded set of EBPs identified to fully address the needs.

Through this process the state may be able to eliminate ineffective spending and ensure cost-

effectiveness. For example: evidence-based prevention programs for substance abuse may have an initial cost, but they yield significant long-term savings by reducing future expenses related to hospitalization, incarceration, and chronic care.

As a result of this approach, the return on investment can be substantial. Data on outcomes can demonstrate program effectiveness and the cost-effectiveness associated with the results that are being achieved (e.g., better health outcomes, reduced recidivism).

The approach we recommend is to use data to identify needs:

- a targeted approach to identify EBPs
- that are specifically designed to address those needs, and
- outcome evaluation that demonstrates effectiveness and
- measures gaps between communities and specific sub-populations.

The Council examined gaps and needs in our state before making these recommend-dations. We fully support funding for our 5 recommendations:

1. expansion of peer support services through peer-run organizations,
2. funding for prevention and early intervention initiatives as an allowable activity,
3. implementation of crisis intervention and mental health education for first responders and law enforcement,
4. increased workforce development and capacity related to behavioral health promotion and prevention, and
5. identification and expansion of **E**vidence **B**ased **P**ractices beyond those currently supported by the state.

The Council appreciates the opportunity to provide input into the application for block grant funds. Please let us know if you have any questions or require clarification. Thank you.

Sincerely,

Teresa Bomhoff
Iowa Integrated Health Planning and
Advisory Council (I-PAC) President

August 15, 2025

Chandra Jennings, PhD, MCHES©
Youth Behavioral Health and Mental Health Block Grant Planner
Division of Behavioral Health
Iowa Department of Health and Human Services
321 E 12th St., Des Moines, IA 50319
Chandra.Jennings@hhs.iowa.gov

Justin Edwards, IADC
Substance Use Block Grant Manager
Project Director – Integrated Provider Network
Division of Behavioral Health
Iowa Department of Health and Human Services
321 E 12th St., Des Moines, IA 50319
Justin.Edwards@hhs.iowa.gov

The Iowa Integrated Health Planning and Advisory Council (referred to as "Council" or "I-PAC") has been asked to provide an explanation of the actions that are being taken to fill Council vacancies.

As of 8/12/25, the Iowa Integrated Health Planning and Advisory Council (I-PAC) has 31 of 33 Council positions occupied. We have two vacancies. Each of the two vacancies is for a parent/caretaker of a child/youth with severe emotional disorder/substance misuse.

How do we recruit new members to fill the vacancies?

Council members are provided an update of current vacancies at each Council meeting. Council members have relationships with a wide variety of organizations. Through these connections with organizations, Council members become aware of individuals who could be viable candidates for a vacancy. It is advantageous for Council members to work with individual candidates, so the applicant has someone to address their questions and concerns. It helps the candidate to achieve a level of comfort with what the Council purposes are. This interaction can also develop into a possible mentor/mentee relationship. Advice on the required application materials can be given and a referral to contact Patti Manna, our agency liaison.

The Council members can contact the Nominating committee giving reliable background and contact information on the applicant. The Council member can also speak up for the applicant when introductions are made to the full Council for candidate approval.

This process has worked well in the past and we intend to continue it in the future. We anticipate this process will allow us to fill the vacancies within this year.

Sincerely,

Teresa Bomhoff, Chair

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Teresa Bomhoff	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Rod Courtney	Advocates/representatives who are not state employees or providers			
Jennifer Day	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
LaShawna Dean	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Linda Dettman	State Employees			
Jenny Erdman	State Employees			
Jessica Goltz	Parents of children with SED			
Lori Hancock-Muck	State Employees			
Lorien Harker	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Kyra Hawley-Preston	State Employees			
Theresa Henderson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Vienna Hoang	State Employees			
Nancy Hunt	State Employees			
Alicia Karwal	Parents of children with SED			
Michael Kaufmann	State Employees			

Todd Lange	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Megan Marsh	State Employees			
Cayleen Mesecher	Parents of children with SED			
Ann Meyer	Advocates/representatives who are not state employees or providers			
Todd Noack	Advocates/representatives who are not state employees or providers			
Hannah Olson	Advocates/representatives who are not state employees or providers			
Brad Richardson	Advocates/representatives who are not state employees or providers			
Jennifer Riley	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kristin Rooff	Providers			
Ellen Schardt	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Brianna Steffe	Persons in Recovery from or providing treatment for or advocating for SUD services			
Shaad Swim	State Employees			
Monica Van Horn	Providers			
William Veltri	Advocates/representatives who are not state employees or providers			
Janice Weiner	Advocates/representatives who are not state employees or providers			
Edward Wollner	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Joel Wulf	Advocates/representatives who are not state employees or providers			
Kelly Yeggy	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	5	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	5	
3. Parents of children with SED	3	
4. Vacancies (individuals and family members)	2	
5. Total individuals in recovery, family members, and parents of children with SED	**15**	**42.86%**
6. State Employees	9	
7. Providers	2	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**11**	**31.43%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	1	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	8	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**9**	**25.71%**
16. Total membership (all members of the council)	**35**	

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Footnotes:

Included in the other category are 2 state legislators who participate as non-voting members of the Council.

The executive committee of the Iowa Integrated Planning and Advisory Council met to discuss a plan and timeline regarding the two vacancies for individuals and family members and submitted a letter dated August 15, 2025. The letter is attached to Environmental Factors and Plan section 14. The letter indicated:

"Council members are provided an update of current vacancies at each Council meeting. Council members have relationships with a wide variety of organizations. Through these connections with organizations, Council members become aware of individuals who could be viable candidates for a vacancy. It is advantageous for Council members to

work with individual candidates, so the applicant has someone to address their questions and concerns. It helps the candidate to achieve a level of comfort with what the Council purposes are. This interaction can also develop into a possible mentor/mentee relationship. Advice on the required application materials can be given and a referral to contact Patti Manna, our agency liaison.
The Council members can contact the Nominating committee giving reliable background and contact information on the applicant. The Council member can also speak up for the applicant when introductions are made to the full Council for candidate approval.
This process has worked well in the past and we intend to continue it in the future. We anticipate this process will allow us to fill the vacancies within this year."

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://hhs.iowa.gov/health-prevention/mental-health/provider-resources/grants

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Yes, https://hhs.iowa.gov/mental-health/provider-resources/grants

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

d) Please indicate areas of technical assistance needs related to this section.

N/A

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Footnotes:

Iowa Behavioral Health Association

2900 100th Street, Suite 200, Urbandale IA 50322
515.309.3315 office
www.ibha.org
Flora@ibha.org

To: IA Department of Health & Human Services
From: Flora A. Schmidt, Executive Director
Date: 8.27.2025
RE: FY2026-2027 MHBG & SUPTRS Combined Block Grant Application

Please accept this letter as comments from the Iowa Behavioral Health Association (IBHA) and our members regarding the IA HHS FY2026-2027 MHBG & SUPTRS Combined Block Grant Application.

We strongly encourage IA HHS to sustain the MHBG and SUPTRS Block Grant funding with the non-profit safety net behavioral health providers including the CMHCs, CCBHCs and SUD programs.

Distribution of the MHBG funds directly to the accredited Community Mental Health Centers is vital for their sustainability to protect both workforce training as well as to help offset the additional costs required to provide services to ALL who request regardless of the individual's ability to pay. We believe this funding is best utilized in the hands of the local CMHCs versus diverted through other third-party vendors to provide one-size fits all generic training programs.

Additionally, we encourage IA HHS to revert support for the Disaster Behavioral Health Response Team back to the local community agencies including the CMHCs who know their communities, are a constant presence within their communities and who are able to maintain a continuity of service and follow up support from impact through recovery for their communities. The CMHCs should be allowed to partner directly with the state department staff on the ground from the onset as well as be able to submit claims for reimbursement of the services they are providing.

The SUPTRS funds directed toward treatment, prevention, early intervention and recovery are critical to supporting the licensed SUD programs located within our local communities and catchment areas. These funds should not be redirected to administrative and other non-service-related expenses. In addition, reimbursement for services needs to be competitive and at sustainable rates for the providers in their respective areas.

Upon federal approval of funding for the Iowa HHS application, IBHA asks that our member providers be included in a collaborative discussion on the best methods and means to implement and achieve the priorities outlined in the application.

Thank you for your time and consideration.

Respectfully,

Flora A. Schmidt, Executive Director
Iowa Behavioral Health Association

IBHA is the leading voice to enhance the effectiveness and resiliency of nonprofit licensed/accredited organizations that provide prevention and treatment services for mental health, substance use, and gambling disorders. We represent 31 agencies across Iowa and a listing of member locations as well as programs and services offered is available at: https://www.ibha.org/preferred-providers/

August 28, 2025
Teresa Bomhoff
Chair
Iowa Integrated Health Planning and Advisory Council (I-PAC)

RE: Comments on 2026-2027 Combined Mental Health & Substance Use Block Grant Application

Teresa:

Iowa HHS extends its gratitude to the I-PAC council members for reviewing the 2026-2027 Combined Block Grant application and offering feedback. This letter will address the five initial recommendations provided to Iowa HHS on August 15, as well as supplemental feedback gathered from the council which was shared with Justin Edwards on August 22. For additional details and context related to these recommendations, the letter containing I-PAC's full explanation will be included as an attachment to the combined application.

I-PAC Recommendations:

1. Expansion of peer support services through peer-run organizations.
2. Funding for Prevention and early intervention initiatives as an allowable activity.
3. Implementation of crisis intervention and mental health education for first responders and law enforcement.
4. Increased workforce development and capacity related to behavioral health promotion and prevention.
5. Identification and expansion of Evidence Based Practices beyond those currently supported by the state.

I-PAC Supplemental Feedback (paraphrased):

1. The format of the grant is notably different from previous applications.
2. I-PAC needs a replacement description within the application narrative.
3. The Iowa Youth Survey is no longer effective.
4. Performance Indicator priority 6, Indicator 2 may contain a typo within its target completion date.

Iowa HHS Response 1: Thank you. Iowa HHS will take this feedback under advisement. Iowa HHS agrees that access to peer support services are crucial to an individuals' recovery and greater access is needed in Iowa's behavioral health system. Iowa HHS

continues to use MHBG funding to support the Iowa Warm Line and Wellness Centers. Iowa's Behavioral Health Continuum includes recovery supports and required for the Behavioral Health Administrative Services Organization (BH-ASO) to administer.

Iowa HHS Response 2: Although these activities are not currently supported via MHBG funding, Iowa HHS has included mental health promotion and early intervention activities within the BH-ASO model. The potential of these behavioral health continuum areas is not yet fully realized; however, these continuum areas are required for the Iowa Primary Care Association (Iowa PCA) to administer statewide as part of the BH-ASO model. The MHBG has been used to support the evidenced based early intervention program, NAVIGATE. Access to these services, however, is very limited across the state.

Iowa HHS Response 3: Thank you. Iowa HHS will take this feedback under advisement. The Iowa PCA has engaged law enforcement across the state on what they need in the behavioral health system and the challenges they face in their communities.

Iowa HHS Response 4: Workforce Development related costs such as training and certification/ licensure costs may be allowable via a funding category called "Access Funds" which is a feature of the BH-ASO model for many behavioral health contractors. Guidance for eligible contractors can be found here: Community Based Organization Guidance - Access Funds - Behavioral Health

Iowa HHS Response 5: By design, the Mental Health and Substance Use Block Grants support some evidence-based practices (EBP's) but primarily offer each Block Grant recipient autonomy to implement EBP's which align best with the needs of the communities they serve. The Strategic Prevention Framework (SPF) model or substance use Prevention, for example, is required by federal regulations. Prevention services provided at the local level are then individualized for each county.

To understand the needs of the individuals served by the behavioral health safety-net, it has been made a requirement for the BH-ASO to conduct District Needs Assessments in collaboration with each of the 7 District Advisory Councils. The first round of District Needs Assessments have yet to be conducted, however if the data and anecdotes collected demonstrate a need for new or additional EBP's to be deployed, Iowa HHS will partner with the BH-ASO to do so.

Iowa HHS Supplemental Response 1: The 2026-2027 Application format saw substantial changes from previous applications as it is outlined in Web Block Grant Application

System (webBGAS). Most of the topic areas which were previously optional to complete were removed from the application outline completely. Also, the narrative portions of the application were required to be typed into active fields within the webBGAS portal which do not have rich text formatting. This led to a simplification of the structure of the document. Lastly, SAMHSA provided guidance related to improving the conciseness of the planning step narratives. As a result, the application length was reduced.

Due to timing constraints related to the scheduled public comment period, the feedback provided by I-PAC had not been included in the public comment draft. The I-PAC feedback, along with these responses, will be included in the final application submission. Iowa HHS found that many areas of I-PAC's feedback align with the Iowa HHS Behavioral Health State Plan. Since many activities are not detailed in the draft application narrative, Iowa HHS hopes that these responses will provide needed insight into how many of I-PAC's recommendations are actively supported in the new behavioral health service system.

Iowa HHS Supplemental Response 2: The description of I-PAC was summarized from the Iowa HHS website and may contain outdated information. Iowa HHS will seek feedback from the I-PAC council to update its description.

Iowa HHS Supplemental Response 3: Thank you. Iowa HHS will take this feedback under advisement.

Iowa HHS Supplemental Response 4: Thank you. Iowa HHS has updated performance indicator priority #6 to correct this error.

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes: