Iowa

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/01/2021 10.21.38 AM)

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

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State DUNS Number

Number 137348624

Expiration Date

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

Agency Name Iowa Department of Human Services

Organizational Unit Division of Mental Health and Disability Services

Mailing Address 1305 E. Walnut

City Des Moines

Zip Code 50319

II. Contact Person for the Grantee of the Block Grant

First Name Marissa

Last Name Eyanson

Agency Name Iowa Department of Human Services

Mailing Address 1305 E. Walnut Street, 5th Floor SE

City Des Moines

Zip Code 50319-0114

Telephone 515-281-8580

Fax

Email Address meyanso@dhs.state.ia.us

III. Third Party Administrator of Mental Health Services

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

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date	9/1/2021 10:19:47 AM
Revision Date	9/1/2021 10:20:45 AM

VI. Contact Person Responsible for Application Submission

First Name	Laura
Last Name	Larkin
Telephone	515-242-5880
Fax	
Email Address	llarkin@dhs.state.ia.us

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2022

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**
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 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.
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
   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: _____

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

November 1, 2019

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

To Whom It May Concern:

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

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

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

Please contact my office if you have any questions.

Sincerely,

Kim Reynolds
Governor of Iowa

IOWA- AMERICAN RESCUE PLAN PROPOSED EXPENDITURES

The state was allocated $11,198,457 in Community Mental Health Block Grant funds from the American Rescue Plan Act of 2021. The state is required to follow existing federal requirements for use of the MHBG including required set-asides listed below.

1. The state proposes to allocate up to 5% for allowable administrative costs-$559,922

2. Proposed expenditures for the 10% ESMI/FEP set aside-$1,119,845:

Start up costs and funding for development and implementation of 1-2 NAVIGATE teams to serve Iowans experiencing FEP or an ESMI	**$942,588**
Technical assistance for existing teams and to support new team implementation	**$52,270**
Additional funding to 3 existing NAVIGATE teams to increase numbers of clients served per year by 10 per team-$45,450 per team	**$124,987**
Total	**$1,119,845**

3. Proposed expenditures for the remaining MHBG funds-:

Priority	**Activity**	**Funding**
Support for peer-run organizations for adults with an SMI and children with an SED. These organizations are operated and staffed primarily by individuals with lived experience of mental illness to provide respite, peer support services, and wellness and recovery centers to individuals with a mental illness.	Continuation of grants made with MHBG COVID funds to up to 4 organizations. Grants are expected to be a maximum of x $200,000 per organization x 4 organizations for a period of approx. 2.5 years.	**$2,066,666**
The state's 988 implementation plan will be completed by Sept. 30, 2021. The purpose of the plan is to ensure that callers to 988, the future number for the National Suicide Prevention Lifeline, will be connected to community-based crisis services and supports in Iowa.	Funding of information technology and other tools needed for 988 call centers to meet expected increased call load and integrate 988 with Iowa's crisis service system. This will include information technology and other tools to ensure timely and accurate delivery of crisis services.	**$4,059,922 (this amount includes the mandatory 5% set-aside for crisis services of $559,922.**
Implementation of new System of Care programs for children	Continuation of grants made with MHBG COVID funds to up	**$880,750**

with an SED not otherwise funded for care coordination and supportive services-	to organizations 2 programs x $145,000 per year x approximately 2.5 years	
Support recruitment and retention of behavioral health workforce employees through activities such as training in evidence-based practices, technical assistance to stakeholders on evidence-based practice implementation and fidelity monitoring, support for telehealth implementation workforce recruitment and retention.	Continuation of MHBG COVID Funding for a statewide Center of Excellence for Evidence-Based Practices to monitor fidelity of EBPs and provide technical assistance for EBP implementation for adults with an SMI and children with an SED	**$2,000,000**
Funding for treatment and supports identified through a gap analysis of the mental health system. Solutions to gaps identified could include support for programs to divert individuals with a serious mental illness (SMI) from jail and inpatient treatment through assisted outpatient treatment (AOT) programs, training of law enforcement to interact with individuals with a mental illness, jail diversion programs.		**$511,352**
Total		**$11,198,457**

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]: Kelly Garcia

Title: Director

Date Signed: 08/25/2021

mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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:

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Footnotes:

Planning Steps

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

Narrative Question:

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

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Footnotes:

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

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

Table of Contents:

I. THE STATE MENTAL HEALTH AUTHORITY

The Iowa Department of Human Services (DHS), Division of Mental Health and Disability Services -Community (MHDS-C) is the designated State Mental Health Authority (SMHA) for Iowa. Marissa Eyanson is the Division Administrator for MHDS-C. and reports directly to the Director of the Iowa Department of Human Services (DHS); Ms. Kelly Garcia. Governor Kim Reynolds appointed Ms. Garcia as Director in November 2019. She was unanimously confirmed by the Iowa Senate on February 26, 2020. On June 30, 2020, it was announced by Governor Kim Reynolds that Director Garcia would take on the role of Interim Director at the Iowa Department of Public Health effective August 1, 2020 following the retirement of the past IDPH director.

The MHDS-C provides leadership and sets the direction of state policy for the system of mental health and disability services in Iowa. MHDS-C plans for and oversees the provision of disability-related services for children and adults with a wide range of disability conditions, including mental illness, serious emotional disturbance, intellectual disabilities, developmental disabilities, and brain injury. The division distributes and oversees the use of federal and state funding through contracts with providers or other agencies that offer services or coordinate projects that promote the division's goals. This includes oversight and distribution of federal funds received through the Community Mental Health Block Grant (MHBG) and the Projects for Assistance in Transition from Homelessness (PATH) grant.

MHDS-C works with service providers to assure quality by setting standards for certain facilities and services that are provided to adults and children with mental illness, intellectual disabilities, developmental disabilities and brain injury and evaluating how well those standards are met through an accreditation process.

MHDS-C staff meet with mental health and disability services regional CEOs on a monthly basis to ensure communication across the system regarding policy issues, service delivery and coverage, and coordination with other entities such as the MCOs and public health. MHDS-C works with the Regions on an annual basis to approve their annual service and budget plans. All amendments to Regional policy and procedure manuals must be approved by the Department. Two MHDS-C staff provide technical assistance and consultation to the regions both in the field or via phone or email as needed. The type of assistance varies from region to region as they continue to expand the array of services provided and the use of evidence-based practices (EBPs).

MHDS-C works collaboratively with other DHS divisions including the Iowa Medicaid Enterprise (IME) and Adult, Child and Family Services (Child Welfare) to coordinate mental health policy and reimbursement and implement mental health services.

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

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

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

When directed by legislation or other mandates, MHDS-C organizes and facilitates workgroups designed to address mental health system gaps and barriers.

Workgroups are typically comprised of other state agency staff, advocates, stakeholders, service providers, Iowans with lived experience and their family members, and family members of children with a serious emotional disturbance (SED).

MHDS-C includes:

- The Bureau of Community Services and Planning (provides oversight of the MHBG)
- The Bureau of Targeted Case Management

MHDS previously included the following facilities which are now overseen by a separate division within DHS, MHDS-Facilities. The two MHDS divisions work closely on mental health policy and services.

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

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

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

A. IOWA DEPARTMENT OF HUMAN SERVICES- MHDS, IME, and ACFS

MHDS:

The role of MHDS Community and Facilities divisions in the public mental health system is described in Section I. The State Mental Health Authority

Medicaid

Medicaid (including the Hawki program for children) is a primary funder of mental health services for Iowans. Medicaid served 826,000 Iowans or 26% of Iowa's population in SFY20. https://dhs.iowa.gov/sites/default/files/IA_SFY2020_Infographic.pdf?120820201816 . Effective January 1, 2014, Iowa expanded Medicaid through the Iowa Health and Wellness Plan (IHWP) for individuals ages 19-64 with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. IHWP-eligible individuals receive a limited set of mental health services. Individuals eligible for IHWP coverage and deemed "medically exempt", which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions may choose between IHWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services, integrated health home care coordination, and other community-based supports not available under the IHWP plans. Access to state-plan Medicaid for the medically exempt IHWP-eligible population has increased access to services for individuals with serious mental health conditions.

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

Adult, Child, and Family Services- ACFS

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

DHS implemented the Family First Act, affecting child welfare and foster care programs starting July 1, 2020. The Family First Act was signed by President Trump February 9, 2019 and changes the way state child welfare agencies are able to administer foster care programs. Federal foster care funding, included in provisions of the Social Security Act Chapter IV-E, has always been for reimbursement of foster care services, including licensed foster families and residential facilities. DHS can not only continue to draw federal funds for certain "stranger" foster care placements, but IV-E funds will also be allowed for services to keep children at home with their parents or with relatives. This means that DHS can draw federal funds to pay for evidence-based family services; services proven to keep children safely with the parent. Specifically, IV-E dollars can be used to purchase high quality mental health, substance abuse and parenting skills training services for the family. A recent Family First activity is called Kinship Caregiver Payments (KCP), effective July 1, 2021; KCP is compensating relative caregivers, when they are

caring for a child who the Iowa juvenile court has determined cannot live safely at home. This payment mitigates financial barriers for the relative being able to care for kin, and the way it is set up can put the caregiver on the path to full licensure, thereby not only increasing support to the family, but also connecting the family to child welfare system supports they might not otherwise have.

B. IOWA DEPARTMENT OF PUBLIC HEALTH (IDPH)

Division of Behavioral Health

Ms. Sarah Reisetter, Deputy Director, serves as the Interim Behavioral Health Director and is selected by and serves as directed by the Interim IDPH Department Director. Ms. DeAnn Decker, Bureau Chief of Substance Abuse, leads all SUD treatment, prevention and recovery support initiatives and has served as the Single State Authority (SSA) for Substance Use Disorders (SUD) since January 2021.

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

The SSA provides support to the Tobacco Use Prevention and Control Division to align tobacco efforts. SSA staff work directly with the Tobacco Division and the Alcoholic Beverages Division on Synar-related activities. SSA staff also work across other IDPH divisions, to ensure cross division collaboration. The division supports a broad range of programs under two bureaus and two offices:

The Bureau of HIV, STD, and Hepatitis works to reduce the impact of communicable diseases in Iowa and to eliminate illness and deaths associated with these diseases. Prevention and care services target chlamydial infection, syphilis, gonorrhea, HIV/AIDS, and viral hepatitis. Program staff guides community-based prevention planning, monitors current infectious disease trends, prevents transmission of infectious diseases, and provides access to medications for these diseases. The bureau also partners with local public health departments, private health care agencies, regional disease prevention specialists, and community-based organizations to provide hepatitis A and B immunizations for adults, behavioral prevention programming, testing, treatment, case management, and other supportive services for persons at risk for or living with these diseases.

Although Iowa is not a federally designated state for HIV, the HIV/AIDS Program coordinates statewide HIV/AIDS prevention and care services for Iowa residents. The HIV/AIDS Program consists of these components: Prevention, Care & Support Services, Data & Disease Reporting, and an HIV/AIDS/Hepatitis Integration Project.

As of December 31, 2019, there were 2,938 Iowans who were diagnosed with HIV and living in Iowa. There were 98 Iowans newly diagnosed in 2019. Males are disproportionately impacted by HIV in Iowa.. There are about four males diagnosed for every female and Iowans who are black/African American and Latino are also disproportionately impacted by HIV in Iowa. This is not because they are more likely to engage in behaviors putting them at risk for HIV, but because of social determinants of health impacting access to care and services. For more information and reports: HIV/AIDS Program - Data and Statistics

The Bureau of Substance Abuse provides technical assistance to individuals, groups, and contracted agencies and organizations; coordinates and collaborates with multiple state agencies and organizations for assessment, planning, and implementation of statewide prevention initiatives; and coordinates, trains, and monitors funding to local community-based organizations for alcohol, tobacco, and other drug prevention services. In addition, the bureau regulates licensure for approximately 100 substance abuse/gambling treatment programs and administers state and federal-funds for substance abuse treatment. Division of Behavioral Health SSA duties, including the SABG, are implemented through the Bureau of Substance Abuse. For more information on the Bureau of Substance Abuse: Bureau of Substance Abuse - Programs

The Office of Disability, Injury and Violence Prevention coordinates' unintentional injury programs within IDPH and houses programs that aim to prevent or reduce interpersonal violence in Iowa. Program staff collaborates with other programs, state agencies and community organizations to address injury and violence using public health strategies. More information and data can be found at: Disability and Health Program - Disability and Health Surveillance

The Office of Gambling Treatment and Prevention works to reduce the harm caused by problem gambling by funding a range of services for Iowans. These services include: outpatient counseling for problem gamblers, concerned persons and family, recovery support services, financial counseling including budgeting and debt reduction plans and a state-wide help line that provides information and referral services. In addition, the program funds prevention and education services for schools, community groups, casino employees, and other at-risk groups.

IDPH, through the Bureau of Substance Abuse Integrated Provider Network, contracts with twenty local agencies to provide problem gambling prevention, treatment and recovery support services in nineteen service regions that together serve Iowans in all 99 counties. Problem gambling treatment programs must be licensed by IDPH and are selected for contracting through a competitive request for proposals process.

C. IOWA DEPARTMENT OF PUBLIC HEALTH AND IOWA DEPARTMENT OF HUMAN SERVICES SYSTEM ALIGNMENT WORK

Governor Reynolds appointed DHS Director Kelly Garcia to serve as interim director of the Iowa Department of Public Health (IDPH) on June 30, 2020. As such, the connections between DHS and IDPH are numerous, and in many cases, the same families access similar services between the departments.

Effective February 2021 DHS and IDPH embarked on a health and human services alignment assessment with a contractor, Public Consulting Group (PCG) to identify shared program goals and align and integrate programs, practices and policies to improve service delivery and most effectively leverage funding between the departments. The contract is expected to have an initial 18-month term with the ability to extend the contract for three additional one-year terms.

Selected public health activities housed within the Department of Public Health are excluded from the redesign scope of work. These include Professional Licensure Boards; Medical Cannabidiol; Infectious Disease; Acute Disease Prevention; and Emergency Response and Environmental Health

Currently, DHS provides services to roughly one million Iowan's on an annual basis. DHS' core services include Medicaid and Children's Health Insurance Program (CHIP), mental health and disability services, child abuse prevention, child and family services, child care assistance, food assistance, child support recovery and is the state mental health authority (SMHA).

The IDPH fulfills its mission as a nationally accredited Public Health Department providing public health services through the core tenets of quality improvement, performance management, workforce development, and application of a health equity lens in program implementation and development. IDPH has oversight of multiple divisions including acute disease prevention, emergency response and environmental health, administration and professional licensure, behavioral health, health promotion and chronic disease prevention, tobacco use prevention and control. The IDPH is the Single State Authority (SSA) for substance use disorders.

Through aligning the two departments, IDPH and DHS will be able to achieve several goals including opportunities to better leverage funding sources and the ability to identify potential for expanded funding sources; break down silos to create a unified, integrated behavioral health system; and better access to services and easier navigation of the system for Iowans served. Ultimately, better alignment will lead to improved outcomes for individuals, communities and the state.

As a result of the future alignment, DHS-Division of MHDS-C and IDPH, Division of Behavioral Health have begun integration efforts; beginning with the alignment and review of the Community Mental Health Services and the Substance Abuse Block Grants. The DHS and IDPH will continue to submit separate applications to SAMHSA for the FY 22-23 years.

Strategies to work collaboratively

- The two departments are holding multiple planning meetings between department staff and leadership
- The two departments have engaged in multiple meetings with the Mental Health Planning Council (Advisory to the Community Mental Health Services Block Grant), the Iowa Board of Health (Advisory to the SABG), Provider Associations, the Integrated Provider Network (IPN), and the Community Mental Health Centers (CMHC's). The goal of these meetings is to seek input and public comment from the mental health and substance abuse providers,

review block grant statutory requirements and identify shared alignment goals between departments.

- The two departments are developing joint system block grant goals. These shared goals are focused on behavioral health workforce development and crisis system development, including 988 implementation work. These goals will be included on both the FY22-23 SABG and Community Mental Health Block grant application.
- Collaboration and meetings will continue to be a priority for both Departments throughout the next several years.

For information related to the Iowa Health and Human Services Alignment, Release for Proposal (RFP) work deliverables, project presentations, project scope, and timelines, visit: Iowa Health and Human Services Alignment | Health and Human Services Alignment https://hhsalignment.iowa.gov/

D. IOWA DEPARTMENT OF EDUCATION

The Iowa Department of Education (DE) works collaboratively with DHS to support mental health services for children. The director of the DE is the co-chair, along with the director of DHS, of the Children's Behavioral Health System State Board. The involvement of the DE with the development of the children's behavioral system informs stakeholders of the effect of children's mental health needs on the education system and encourages cross-system integration of services and supports for children.

In 2020, Senate File 2360 was signed by the Governor. This implemented a therapeutic classroom grant program for Iowa schools. Schools could apply for competitive grants to establish therapeutic classrooms to assist students whose "emotional, social, or behavioral needs interfere with the student's ability to be successful in the current education environment…" Therapeutic supports include such things as social-emotional skill building, skills to cope with stress and trauma, mental health treatment and crisis intervention and follow-up. For the 2021-22 school year, six school districts were awarded grants to establish therapeutic classrooms.

Also in 2020, the Governor signed Senate File 2261 which allowed for school districts to contract with licensed mental health providers to conduct in-person, universal behavioral health screenings with parent/guardian consent. The DE is in the process of developing an approved list of behavioral health screening tools for districts to select from. The bill also authorizes students to receive behavioral health services in the school setting via telehealth with requirements for confidentiality and parent/guardian consent.

As a result of SF2360 and SF 2261, in 2021, the DE adopted administrative rules that address required training for schools for schools for Social Emotional Behavioral Health (SEBH) within a multi-tiered system of supports (classroom management, supplemental and intensive evidence based social emotional behavioral health interventions, trauma and culturally responsive practices, crisis response) family engagement and communication, and required protocols and reporting related to classroom clears and incidents of violence. The rules also defined required components of a therapeutic classroom for the purposes of reporting and reimbursement.

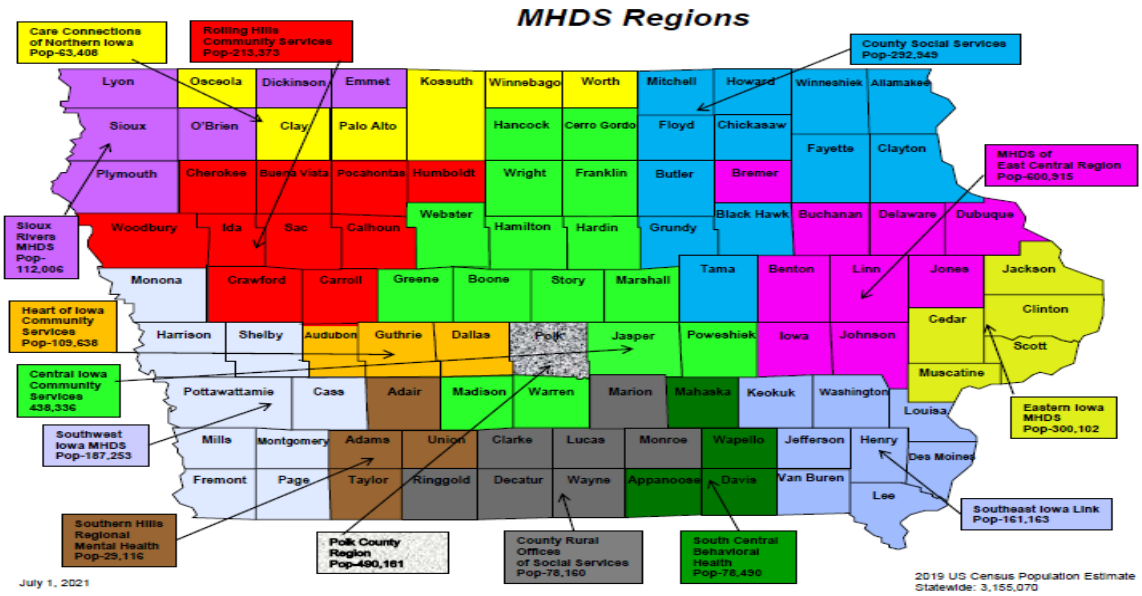
In May 2021 the Department also released the Governor's Emergency Education Fund (GEER) II for Mental Health Supports for Public PK-12 Schools competitive grant. It provides over $8.6 million in grants for school districts to provide mental health services and supports to students and families. https://educateiowa.gov/sites/files/ed/documents/2021-04-30_GEERIIAppContentPK-12.pdf

In 2021, the DE in partnership with the University of Iowa established the Iowa Center for School Mental Health. The new center's focus is on expanding support for mental health, including training, resources, and outreach to educators and schools statewide. Services to be provided include crisis response services, face-to-face and online training and coaching for teachers, strategic planning support, needs assessment and program evaluation of social-emotional learning and positive behavioral interventions and supports (PBIS) implementation.

E. MHDS REGIONAL SERVICES AND FUNDING FOR ADULTS AND CHILDREN

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

Under the regional MHDS system, regions of at least three counties provide services under a regional administrative entity with local access points available to individuals within the region. One county received a waiver to form a region of one county, while the remaining 13 regions are comprised of groups of 3 to 15 counties. Regions use a combination of state funds and local tax dollars to deliver required core services and evidencc-based practices as well as implement additional core services and share administrative responsibilities.



Effective July 1, 2021, Iowa's 14 MHDS regions are required to provide access to the core services listed below. Regions are responsible for funding those services for residents that meet financial guidelines when no other funding is available through Medicaid or private insurance.

MHDS Regions are to ensure that the following services are available for adults in their regions:
a. Access centers.
b. Assertive community treatment.
c. Assessment and evaluation.
d. Case management.
e. Crisis evaluation.
f. Crisis stabilization community-based services.
g. Crisis stabilization residential services.
h. Day habilitation.
i. Family support.
j. Health homes.
k. Home and vehicle modification.
l. Home health aide.
m. Intensive residential service homes.
n. Job development.
o. Medication prescribing and management.
p. Mental health inpatient treatment.
q. Mental health outpatient treatment.
r. Mobile response.
s. Peer support.
t. Personal emergency response system.
u. Prevocational services.
v. Respite.
w. Subacute mental health services.
x. Supported employment.
y. Supportive community living.
z. Twenty-four-hour access to crisis response.
aa. Twenty-three-hour crisis observation and holding.

Regions are also developing and funding additional core services such as civil commitment pre-screening, and jail diversion when funds are available. Regions are also supporting development of crisis services using telehealth in rural areas where mental health professionals may not be available. The regions, the MCOs, and DHS are working collaboratively to ensure that all services that are Medicaid-reimbursable are billed, preserving regional funding for services and individuals not covered by Medicaid.

In 2019, as a result of the passage of HF 690, the development of a children's behavioral health service system was added to the regions' responsibilities. Most of the children's services will be funded by Medicaid and other private insurance.
Effective July 1, 2021, MHDS Regions are required to fund core services for children with a serious emotional disturbance (SED) whose families meet the financial guidelines of income between 150-500% of federal poverty level. Core services for children with an SED include:

a. Assessment and evaluation relating to eligibility for services.
b. Behavioral health inpatient treatment.
c. Behavioral health outpatient therapy.
d. Crisis stabilization community-based services.
e. Crisis stabilization residential services.
f. Early identification.
g. Early intervention.
h. Education services.
i. Medication prescribing and management.
j. Mobile response.
k. Prevention.

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

F. LEGISLATION AFFECTING THE PUBLIC MENTAL HEALTH SYSTEM

988 System

In August 2019, the Federal Communications Commission (FCC) staff—in consultation with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, the Department of Veteran Affairs, and the North American Numbering Council—released a report recommending the use of 988 as the 3-digit code for the National Suicide Prevention Lifeline (NSPL). In July 2020, the FCC adopted rules designating this new phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. In October 2020, the federal National Suicide Hotline Designation Act was signed into law, designating 988 as the 3-digit code for the NSPL. The transition, which will take place over the next two years, will result in phone service providers directing all 988 calls to the existing NSPL by July 16, 2022.

Vibrant, the NPSL contractor, offered states a planning grant opportunity in December 2020 to support development of state 988 implementation plans. The focus of the grant is for the state to develop clear roadmaps to address key coordination, capacity, funding and communication strategies that are foundational to the launching of 988 which will occur on or before July 16, 2022 and plan for the long-term improvement of in-state answer rates for 988 calls. IDPH and DHS worked together to develop the grant application which was awarded to IDPH as the lead agency. IDPH and DHS staff meet weekly to work on overall plan deliverables. Core planning considerations include:

- 24/7 statewide coverage for 9-8-8 calls, chats and texts
- Identify and support funding streams
- Capacity building
- Operational, clinical and performance standards for lifeline centers

- Local resource and referral listings and linkages to local community crisis services
- Follow up services
- Consistent public messaging

As part of the planning grant process, IDPH and DHS are working closely with the crisis centers in Iowa that answer the NSPL to develop a landscape analysis and a plan to build capacity for the increased volume once 9-8-8 is launched. Another key component of the grant is the development of a 9-8-8 coalition. The Iowa 9-8-8 coalition is made up of key stakeholders, who have met monthly starting in April 2021 to provide guidance for the implementation plan and how to integrate 9-8-8 into the current crisis system.

State Legislation:
2020 Legislative Session:
Senate File 2360 implemented a therapeutic classroom grant program for Iowa schools. Schools could apply for competitive grants to establish therapeutic classrooms to assist students whose "emotional, social, or behavioral needs interfere with the student's ability to be successful in the current education environment…". Therapeutic supports include such things as social-emotional skill building, skills to cope with stress and trauma, mental health treatment and crisis intervention and follow-up. For the 2021-22 school year, six school districts were awarded grants to establish therapeutic classrooms.

Senate File 2261 allowed for school districts to contract with licensed mental health providers to conduct in-person, universal behavioral health screenings with parent/guardian consent. The DE is in the process of developing an approved list of behavioral health screening tools for districts to select from. The bill also authorized students to receive behavioral health services in the school setting via telehealth with requirements for confidentiality and parent/guardian consent.

2021 Legislative Session
SF 524-Inpatient Psychiatric Bed Tracking System Study Committee
This legislation required DHS to convene a study committee to examine issues and develop policy recommendations relating to improvements to the state's inpatient bed tracking system. Issues to be considered are expanding the acuity of individuals hospitals are able to serve, increasing reimbursement rates based on level of care provided, and implementation of real-time reporting from participating facilities. DHS is to submit a report from the study committee, which will include a date to implement real-time electronic bed tracking, by December 15, 2021.

SF 532- Statements of Professional Recognition for Licensed Behavior Analysts and Mental Health Professionals by the Board of Educational Examiners
This legislation requires that administrative rules be adopted to establish a statement of professional recognition for behavior analysts and mental health professionals. Mental health professionals who provide services to a school are required to obtain such a statement unless a professional service license or endorsement related to mental health services has been issued by the board of educational examiners.

SF 619-This legislation included several provisions that impacted the mental health system. Division VIII amended the Iowa code relating to insurance coverage of telehealth services by clarifying that telehealth could be provided through real-time interactive audio or video or other real-time interactive media, regardless of the location of the provider of services or the individual receiving services. The legislation did not include audio-only telehealth in the definition of telehealth services. The legislation also required that mental health services delivered via telehealth are to be reimbursed at the same rate as in-person mental health services and bans any requirement for a health care professional to be present in the room with a patient receiving telehealth mental health services.
Division XXV transitioned the MHDS Regions to funding by state dollars through a standing appropriation and ends the authority of counties to levy for mental health and disability services after FY2022.

SFY19 -HF766- Co-Occurring Conditions Enhanced Delivery of Services

House File 766, Division VIII, Section 41 passed in 2019 directed the Directors of the Departments to: "examine the current service delivery system to identify opportunities for reducing the administrative burden on the departments and providers, evaluate the use of an integrated helpline and website and improvements in data collection and sharing of outcomes, and create a structure for ongoing collaboration. The directors shall submit a report including findings, a five-year plan to address co-occurring conditions across provider types and payors, and other recommendations."

The Departments convened a focus group in October 2019 representing co-occurring service providers, mental health and disability services regions, and individuals and family members with lived experience. The following themes emerged from the focus group:

- CCBHC is an effective model for the delivery of co-occurring services
- Community partnerships are essential to providing individualized services
- Flexible funding is needed to provide co-occurring services and current payment structures do not allow flexibility
- Workforce shortages are a barrier to providing effective services
- Provider accreditation and licensure should be streamlined wherever possible and unnecessary paperwork eliminated
- Mental health providers need a data collection system similar to the system used by IDPH for licensed substance use disorder providers
- Systemic barriers should be identified, reviewed, and where possible minimized or eliminated, e.g. professional licensure processes

A Co-Occurring conditions Enhanced Delivery of Services Report was completed and submitted to the Iowa Legislature in December 2019. The report recommends and outlines a Five-Year plan to address co-occurring conditions in Iowa. Highlights from the plan include:

- Explore the certified community behavioral health clinic (CCBHC) model to build a joint statewide network of substance use disorder and mental health safety net providers (Safety Net Providers). The state currently has 12 CCBHC's; three of which are IPN providers.
- Assess and align reimbursement rates for community mental health centers (CMHCs) and the substance use disorder integrated provider network (IPN)

- Evaluate Your Life Iowa at the end of three years allowing for time to gather data and provide a more complete assessment
- Explore the integration of mental health data and providers into Iowa Department of Public Health's integrated data system
- Collaborate on projects designed to reduce stigma in effort to create "no wrong door" access to care.

Consistent with the five-year plan, IDPH and DHS are currently implementing Stage 1- Planning and preparing (years 1-2). The Department staff are currently meeting monthly and are in the process of reviewing the following activities:

- Review the mental health accreditation and substance use disorder licensure processes and review options for a joint review process
- Review and research the current state of CCBHC in Iowa and other states for areas of strength and improvement
- Pilot CMHCs using IDPH's data collection system.
- Continue to review prior authorization requirements for Medicaid services and work with the managed care organizations on aligning paperwork requirements
- Provide recommendations on changes to law related to statewide implementation of Safety Net Providers using the CCBHC model including potential funding sources
- Establish an educational platform for mental health and substance use disorder providers
- Review the current marketing plan for Your Life Iowa and determine how to incorporate content for reducing stigma
- Review professional licensure requirements and identify any workforce barriers that can be eliminated

G. OLMSTEAD PLAN FOR MENTAL HEALTH AND DISABILITY SERVICES 2021-2025

The Olmstead Plan for Mental Health and Disability Services has been in the process of being reviewed, revised, and updated during 2021. A new five-year (2021-2025) plan is scheduled to be completed by the end of the calendar year. The plan is developed and evaluated in collaboration with stakeholders and is designed to continue moving Iowa's mental health and disability services system closer to the vision of fully inclusive life in the community for everyone.

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

Iowa's Olmstead Plan is built on recent systems updates and policy changes and is designed to be flexible in responding to new challenges and opportunities and to enable tracking and reporting on measurable person-centered outcomes that reflect community capacity, choice, and self-determination. The plan framework is also designed to achieve measurable progress toward

target outcomes in nine domains: access to services, community integration, employment, housing, transportation, person-centeredness, health and wellness, quality of life and safety, and family and natural supports.

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

Statistical data related to performance measures and personal experience survey responses from individuals utilizing publicly funded services are tracked and reported on a quarterly or annual basis by the Iowa Medicaid Enterprise, Iowa's Medicaid Managed Care Organizations, the Iowa MHDS Regions, the Iowa Department of Education, and others. The information collected is reviewed at least annually and compiled to create "snapshots in time" updates on Iowa's progress toward the Olmstead Plan goals. The data collected over the period from 2016 through 2020 (since the last Olmstead Plan revision) is currently being analyzed and compiled into a comprehensive report to reflect progress made and identify areas in need of improvement.

H. CONSUMER ADVOCACY ORGANIZATIONS

Access for Special Kids (ASK) Family Resource Center ASK identifies its primary focus as offering advocacy, training, resources, and supports for the benefit of individuals with disabilities and their families throughout the state of Iowa. ASK operates the Parent Training and Information (PTI) Center of Iowa. PTI is a federally funded grant project from the U.S. Department of Education that focuses on the educational needs of children with disabilities in Iowa, particularly those who are underserved or may be inappropriately identified. The goal of the PTI is to help parents, families, and students with disabilities understand their civil rights regarding early intervention services and special education supports so that they can be strong self-advocates in the most effective ways

National Alliance on Mental Illness (NAMI) is a 501c3 non-profit organization offering support, education, and advocacy to persons, families, and communities affected by mental illness. The NAMI organization operates at the local, state and national levels and is the largest grassroots organization of its kind working on mental illness issues.

Besides the state office, Iowa has 13 local affiliates. Each local affiliate offers a variety of educational activities and support groups for individuals, family members, and parents/caregivers of children and adolescents with severe emotional disorder. Local affiliates and the state organization identify and work on issues most important to their community and state. The goal of NAMI is to advocate at the county, state and national levels for non-discriminatory access to quality healthcare, housing, education and employment for people with mental illness. Activities include:

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

The Office of Consumer Affairs (OCA)
OCA is supported by the Mental Health Block Grant and offers a variety of services and supports to persons and families with behavioral health recovery and disabilities challenges, other state agencies and providers.

The Office of Consumer Affairs:

- Serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving, and system navigation.
- Provides input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa.
- Provides an advocacy voice to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons and families with behavioral health recovery and disabilities challenges.
- Assists DHS staff and contractors with disseminating information and gathering feedback from end users of behavioral health services and systems in Iowa.

The Office of Consumer Affairs Director and a statewide Advisory Committee function to represent Iowans across the state.
https://namiiowa.org/iowa-office-consumer-affairs/

Please Pass the Love
Please Pass the Love (PPTL) is an organization committed to increasing school-based mental health supports to improve the quality of life and educational opportunities for children, families, and educators as well as offer culturally responsive comprehensive services and evidence-based supports to school systems. The organization works to bridge positive relationships between the

educational and mental health communities to more effectively prevent and address mental health issues for children and adolescents throughout the state of Iowa. PPTL is offering its 9th annual Iowa School Mental Health Conference in August 2021.

I. EFFECT OF THE COVID-19 PANDEMIC ON THE MENTAL HEALTH SYSTEM

The mental health system was severely impacted by the COVID-19 pandemic. In March 2020, providers of outpatient mental health services had to make a rapid shift to telehealth with little time to prepare staff or recipients of services. Prior to the pandemic, use of telehealth for outpatient mental health services, other than psychiatry, was not common. Individuals who accessed telehealth mental health services usually did that in provider offices or hospital emergency departments, not their homes, due to site of service requirements. These restrictions were waived during the pandemic, allowing providers to work from home and individuals to receive services in their homes. Some providers maintained limited office availability for those who did not have internet access or were not comfortable using telehealth while others only provided telehealth services.

Barriers to telehealth access for individuals included lack of reliable internet access in rural areas and inability to afford internet access or internet-enabled phones or devices. For families with children with mental health needs, challenges included attending virtual school which for some was a positive, while for others it did not meet their educational needs. Receiving mental health services virtually was also not optimal for some children and families, leading to some choosing to delay services until in-person services were available. Families were also challenged with working from home while trying to coordinate school and mental health services. Providers worked hard to reach out to individuals and their families but for some, these stressors along with the financial stressors related to the pandemic, made it difficult for mental health services to be provided at the same level as was available prior to the pandemic. In August 2020, CARES Act funds were made available to providers of HCBS, substance use disorder, and mental health services to help offset impacts of the COVID-19 pandemic.

To ensure that Medicaid-eligible individuals maintained access to health care, Iowa Medicaid submitted multiple waivers to the federal government that included but were not limited to, extended eligibility for Medicaid and HawkI (CHIP) members beyond their certification periods, suspended cost sharing, expanded access to home-delivered meals to individuals receiving HCBS services or who were homebound, allowed out of state providers to serve Iowans, and allowed telehealth for any Medicaid service for which it was appropriate regardless of member location, and allowed use of audio-only telehealth. The expanded telehealth services are in effect statewide through at least 60 days after the public health emergency declaration is lifted. https://dhs.iowa.gov/ime/providers/faqs/covid19/telehealth

III. THE CONTINUUM OF SERVICES

A. PREVENTION

Education for the general public and providers

Iowa offers a wide variety of training opportunities related to mental health. The focus on professional growth and development is a strength of the Iowa mental health and disability system. Individuals with lived experience and their families are integral participants of many of

the training opportunities offered, either as attendees, planners, or presenters. Education on mental health conditions is essential to reduce stigma and increase public awareness of mental health conditions and appropriate interventions, as well as to improve quality and capacity of the mental health provider community. The MHDS regions are also strong supporters of community education with several regions supporting Mental Health First Aid and Youth Mental Health First Aid trainings for their communities and other training in evidence-based practices. CMHCs also use MHBG funds to support training of staff in EBPs for children with an SED and adults with SMI.

EBP training received in FY21 by the CMHCs
Acceptance and Commitment Therapy
Child Parent Psychotherapy
Cognitive Behavioral Therapy/Trauma Focused Cognitive Behavioral Therapy
Cool Kid Training
EMDR
Emotionally Focused Therapy
Exposure and Responsive Prevention Therapy
Heart Math
Mental Health First Aid/Youth Mental Health First Aid
Motivational Interviewing
NAVIGATE
Parent Child Interactive Therapy
Theraplay
WRAP

Availability of in-person training was severely impacted by the COVID-19 pandemic. Providers of education moved to on-line platforms where available but availability of mental health education and training during 2020 and 2021 was negatively impacted. MHDS is planning to expand Relias online behavioral health education, currently available to SUD providers, to CMHCs in the coming year.

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

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

- Preserve life when a person may be a danger to self or others
- Provide help to prevent the problem from becoming more serious

- Promote and enhance recovery
- Provide comfort and support

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

Since 2008, 49,382 Iowans have been trained in MHFA. In Iowa, there are 358 certified Mental Health and Youth Mental Health First Aid instructors. The instructors are located across the state in a variety of settings which include state staff from the Department of Human Services, Division of Mental Health and Disability Services and the Iowa Department of Education (DE), local law enforcement, regional MHDS staff, and providers of substance use disorder and mental health services. Many local education agency staff have also become Youth MHFA instructors due to the federal Project AWARE grants. The DE will also provide YMHFA to school staff and community members through the STOP School Violence Prevention and Mental Health Training program.

Mindspring Mental Health Alliance (formerly NAMI-Greater Des Moines)
Mindspring offers a monthly schedule of webinars on topics related to mental health and self-care. Webinars are free and open to anyone. mindspringhealth.org

NAMI:
NAMI Iowa is a provider of multiple training and education programs for individuals and families of individuals with a mental illness. NAMI Iowa also presents an annual conference that provides training and education on mental health-related topics. This conference was held virtually in 2020 due to the pandemic. A list of available trainings is posted on the NAMI Iowa website.
https://namiiowa.org/

Suicide Prevention / Iowa Suicide Prevention Planning Group
IDPH is the lead agency for Suicide Prevention in Iowa. IDPH's suicide prevention program works with communities and related partners to provide information about suicide risk factors, warning signs and protective factors and promotes the use of evidence based suicide prevention strategies. IDPH leads the Iowa Suicide Prevention efforts in Iowa and the Iowa Suicide Prevention Planning Group. This group of approximately 30 individuals meets quarterly and is comprised of state and local leaders active in suicide prevention, and welcomes members with lived experience. Members provide updates on programs and events, trends and the latest information about suicide prevention in Iowa. DHS staff are active participants in this group and provide key insight and updates on the status of mental health and crisis services in the state.

Members of the Planning Group guide the development of the Iowa Suicide Prevention Plan which is currently in the process of being updated. A subgroup of the Planning Group has been meeting monthly to work on the priorities and objectives for Iowa in

the next 5 years. DHS staff participate in these monthly meetings. Proposed priorities include:

- Building suicide prevention capacity at the organizational, local, and state level
- Integration of evidence informed, culturally sensitive suicide prevention, intervention and postvention strategies in systems serving all people within Iowa.
- Promotion of community resilience through ongoing collaboration, public education, and equitable access to formal and informal supports.

To further support suicide prevention, IDPH received the SAMHSA Zero Suicide grant in September 2018. The five-year grant aims to engage the 19 Integrated Provider Network agencies in implementing the Zero Suicide Framework. The framework is a systems-change model with the core belief that no person under care should die by suicide. IDPH is currently in Project Year 3 of the grant.

Data from the Bureau of Health Statistics indicates that 522 Iowa residents died by suicide in 2019. Suicide was the ninth leading cause of death for all Iowans and the second leading cause of death for ages 15-44.

Trauma-Informed Care Training

Multiple private providers as well as MHDS regions have promoted trauma-informed care trainings to improve understanding and knowledge of trauma-informed care. MHDS regions are required to develop services that are trauma-informed. Connections Matter training is a curriculum available to educate the public on the effects of trauma on children's development. These trainings are available through a variety of providers across the state. http://www.connectionsmatter.org/iowa

Your Life Iowa

Your Life Iowa(YLI), a project of the Iowa Department of Public Health in collaboration with DHS, is the integrated hub/system for free and confidential help and information for alcohol, drugs, gambling and suicide. YLI offers 24/7/365 resources including a telephone helpline, mobile-friendly internet-based communications (e.g., online chat), texting and social media (@yourlifeiowa). Your Life Iowa services are provided by Foundation 2, an Iowa based nonprofit human service agency offering suicide prevention and crisis intervention programs to people of all ages. Foundation 2 has provided crisis counseling by phone since 1970. Effective July 1, 2019, YLI is also available to respond to mental health crises with IDPH and DHS continuing to work together to transition regional MHDS crisis lines into one statewide 24 hour line through YLI. As part of the 988 planning process, IDPH and DHS are working on coordination of YLI functions with 988 requirements.

B. EARLY IDENTIFICATION/INTERVENTION

Crisis Services

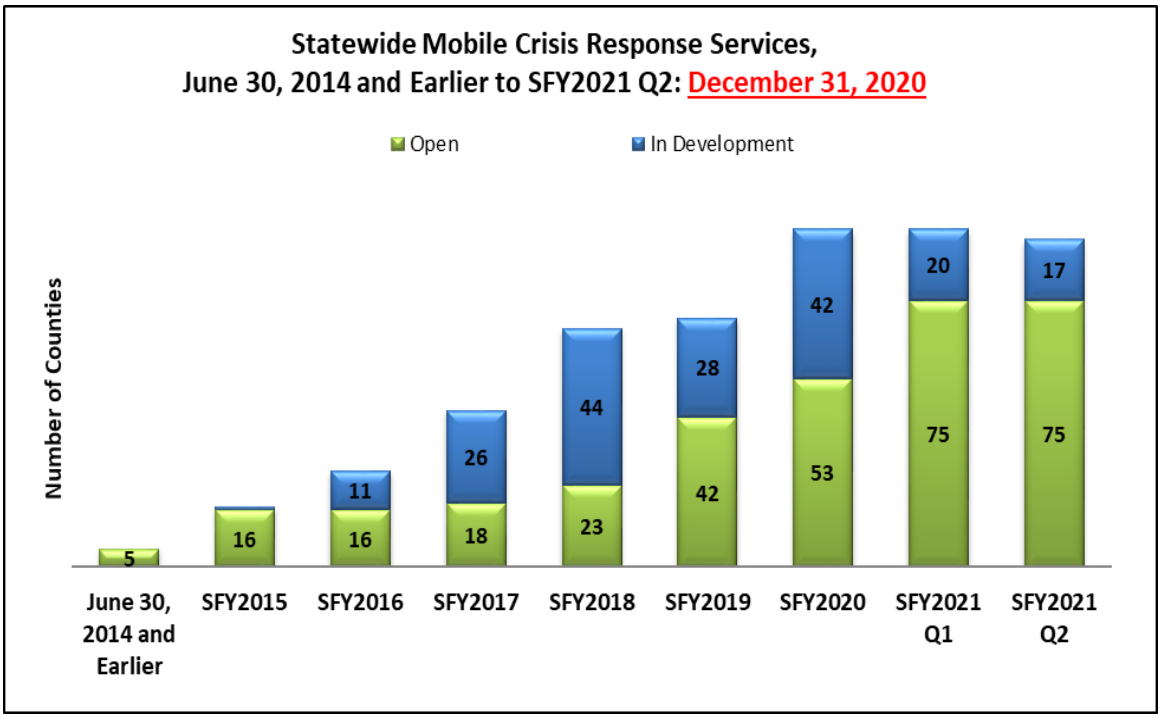
Crisis Services, including 24 hour crisis response, mobile crisis response, crisis assessment and evaluation, 23 hour crisis observation and holding, and crisis stabilization are required services in the MCO contracts. The MHDS regions are required to make the following array of crisis services available to adults effective July 1, 2021.

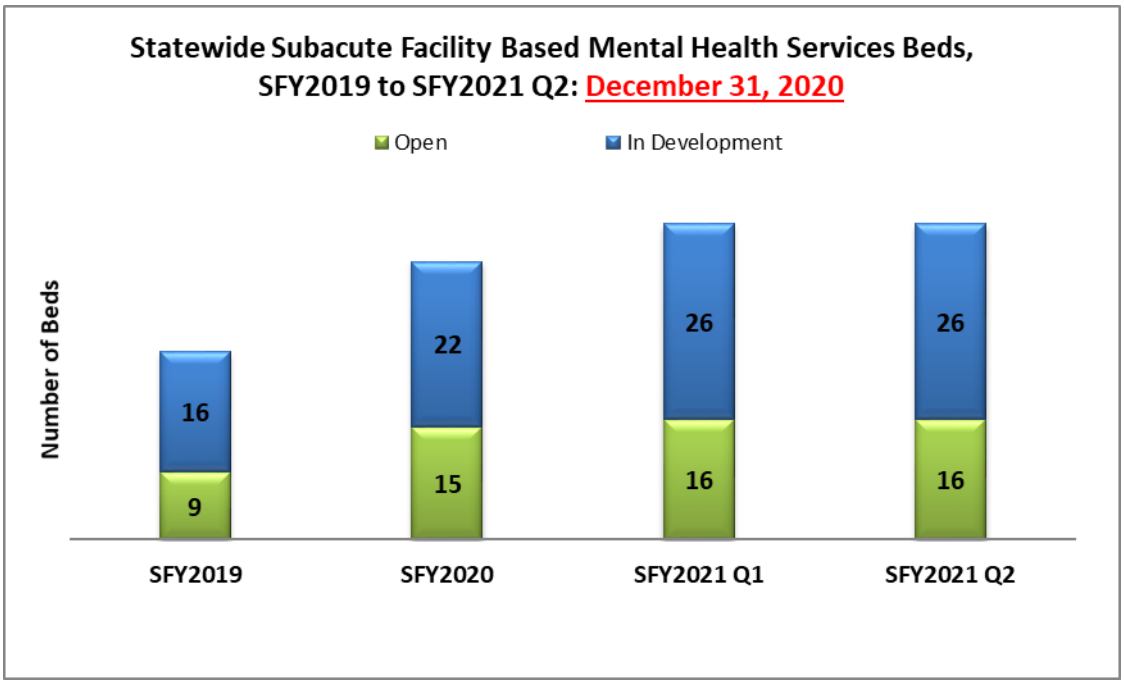
- Access Centers
- Crisis Evaluation
- Crisis stabilization-community and residential
- Mobile Response
- 24- hour access to crisis response
- 23-hour crisis observation and holding
- Subacute mental health facility treatment

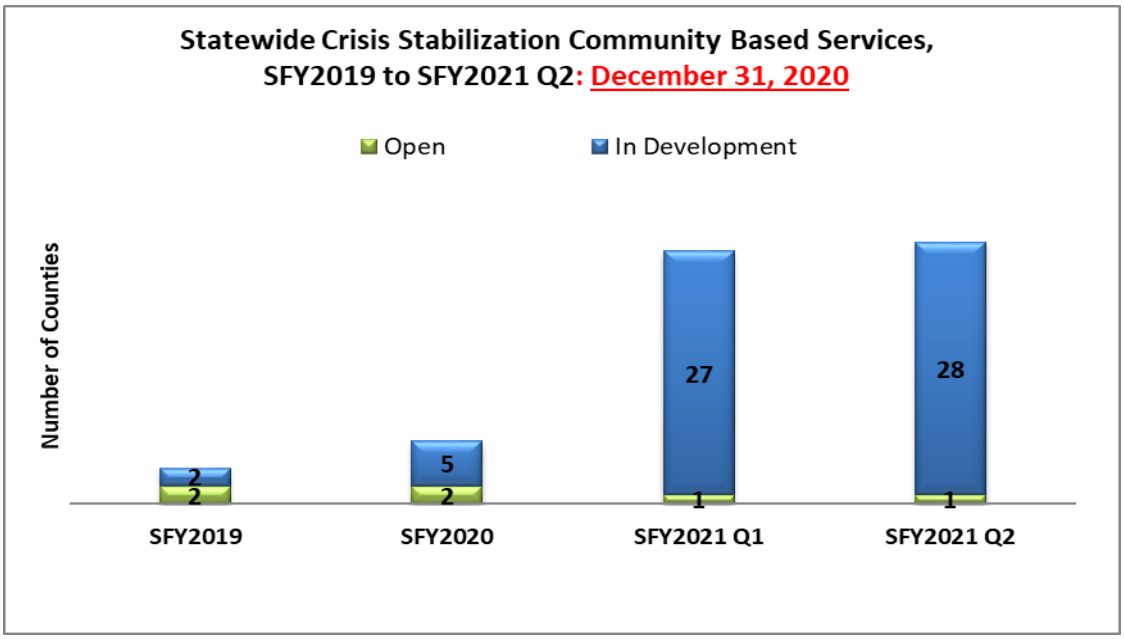
A similar set of crisis services is also mandated to be available for children by July 1, 2021. This includes the following:

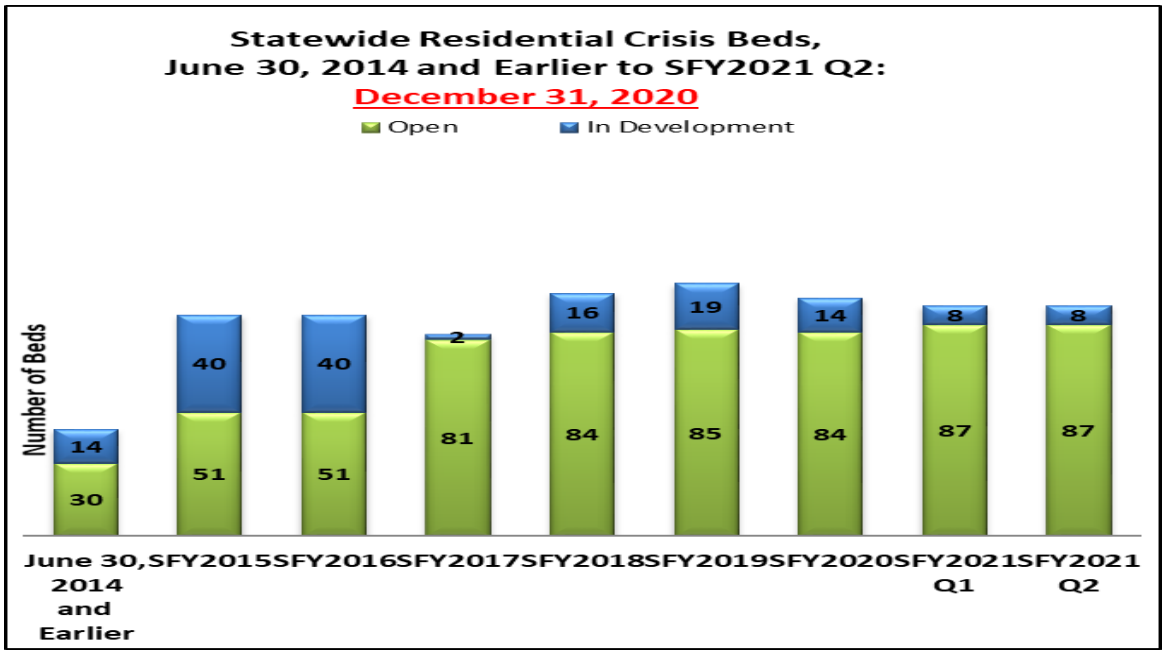
- Assessment and Evaluation
- Crisis stabilization-community and residential
- Mobile Response

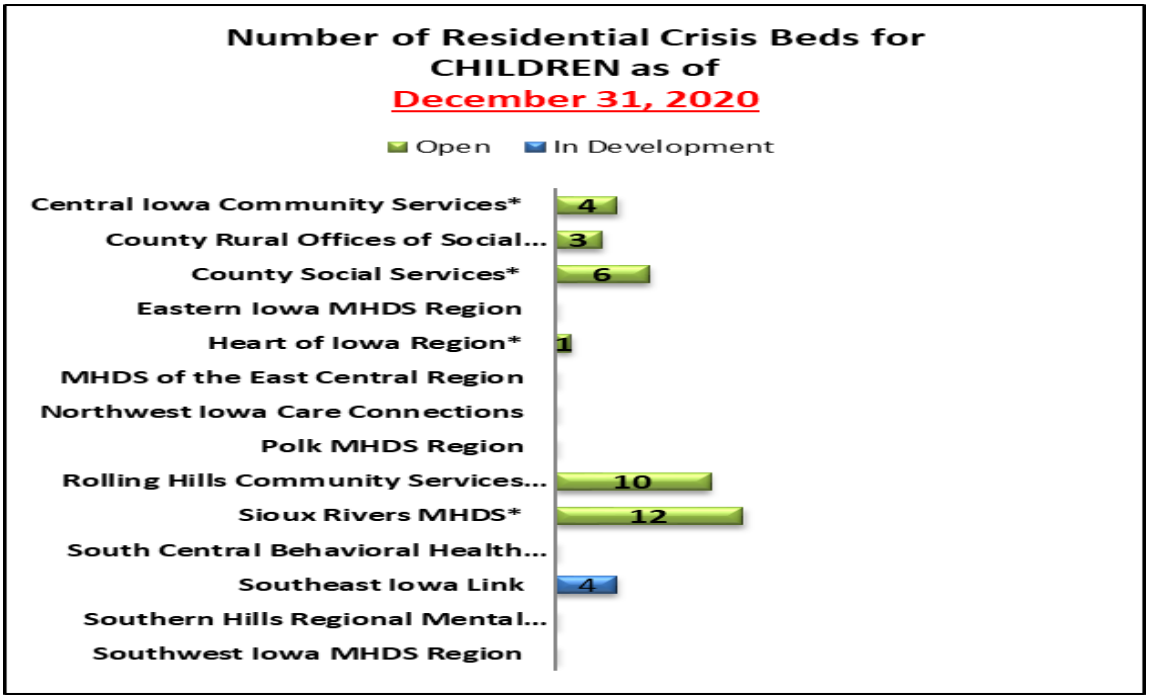
The charts below demonstrate the continued growth in availability of crisis services across the state.

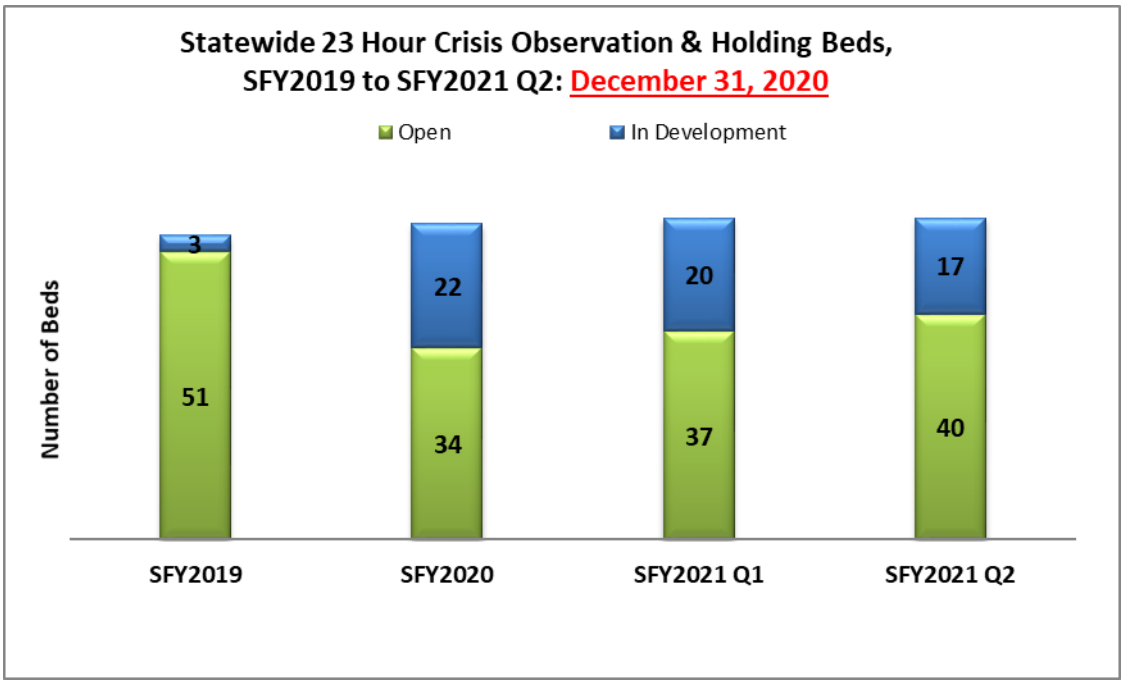



Statewide Subacute Facility Based Mental Health Services Beds,
SFY2019 to SFY2021 Q2: December 31, 2020
Open
In Development
Number of Beds
16
9
22
15
26
16
26
16
SFY2019
SFY2020
SFY2021 Q1
SFY2021 Q2


Statewide Crisis Stabilization Community Based Services,
SFY2019 to SFY2021 Q2: December 31, 2020
Open
In Development
Number of Counties
2
2
5
2
27
1
28
1
SFY2019
SFY2020
SFY2021 Q1
SFY2021 Q2


Statewide Residential Crisis Beds,
June 30, 2014 and Earlier to SFY2021 Q2:
December 31, 2020
Open
In Development
Number of Beds
14
30
40
51
40
51
2
81
16
84
19
85
14
84
8
87
8
87
June 30, 2014 and Earlier
SFY2015
SFY2016
SFY2017
SFY2018
SFY2019
SFY2020
SFY2021 Q1
SFY2021 Q2


Number of Residential Crisis Beds for
CHILDREN as of
December 31, 2020
Open
In Development
Central Iowa Community Services*
4
County Rural Offices of Social...
3
County Social Services*
6
Eastern Iowa MHDS Region
Heart of Iowa Region*
1
MHDS of the East Central Region
Northwest Iowa Care Connections
Polk MHDS Region
Rolling Hills Community Services...
10
Sioux Rivers MHDS*
12
South Central Behavioral Health...
Southeast Iowa Link
4
Southern Hills Regional Mental...
Southwest Iowa MHDS Region

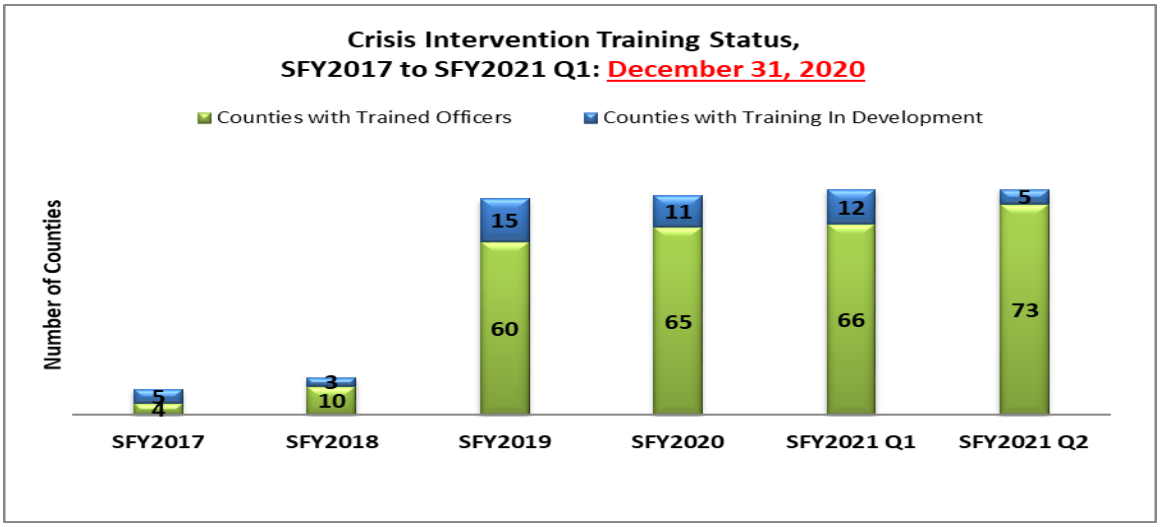


*Source: MHDS Regions Statewide Dashboard SFY21 Quarter 2

Crisis Intervention Team (CIT)

The Iowa Law Enforcement Academy (ILEA) at Camp Dodge, in Johnston, Iowa, is a training facility for new recruits and experienced law enforcement officers from all over the state of Iowa. ILEA has included Crisis Intervention Team (CIT) training (up to 40 hours) in the multi-week training for all new recruits. MHDS Regions have also provided CIT training to local law enforcement agencies.

Multiple city and county law enforcement organizations have begun training their officers as well. The chart below shows the continued growth in counties with CIT-trained officers in the last 2 years.



*Source: MHDS Regions Statewide Dashboard SFY21 Quarter 2

Early ACCESS

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

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

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

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

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

- Iowa Department of Education (lead agency),
- Iowa Department of Public Health,
- Iowa Department of Human Services, and
- University of Iowa's Child Health Specialty Clinics

1st Five Healthy Mental Development

1st Five is a public-private partnership bridging primary care and public health services in Iowa. The 1st Five model supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to 5 and coordinates referrals, interventions and follow-up. 1st Five operates in 88 of Iowa's 99 counties, serving local pediatric and family practice providers. 1st Five promotes the use of standardized developmental tools that support healthy mental development for young children in the first five years. The tools include questions on social/emotional development and family risk factors, such as depression and stress. When a medical provider discovers a concern, the provider makes a referral to a 1st Five coordinator. Shortly after receiving the referral, the coordinator then contacts the family to discuss available resources that will meet the family's needs. Often these intervention services are related to the behavioral health and developmental needs of the child and/or family. 1st Five supports a community-based systems approach to building a bridge between primary care and mental health professionals.

Iowa Association for Infant and Early Childhood Mental Health-Early Childhood Mental Health Consultation

A focus of this organization is to develop professional competency standards for providers of early childhood services and supports. The organization offers endorsement pathways in infant mental health for individuals working with young children using the Michigan Infant Mental Health Competencies. The organization also offers webinars to the public on topics such as young children and autism, and provides resources to providers and the public on infant and early childhood mental health. Organization leaders advocate for inclusion of promotion and prevention activities focused on young children and their families as part of the statewide mental health and disability services system.

C. TREATMENT SERVICES

Iowa Medicaid is a major source of funding for mental health services in Iowa. Most services are managed through IA HealthLink which includes two contracted MCOs, Amerigroup and Iowa Total Care. The contractors are required to provide high quality healthcare services in the least restrictive manner appropriate to a member's health and functional status. Contractors are responsible for delivering coordinated services including, physical health, behavioral health, and long-term services and supports. The program is intended to integrate care and improve quality outcomes and efficiencies across the healthcare delivery system.

Services are provided by appropriately credentialed mental health service providers to address the mental health and substance use needs of both adults and children. MCOs are also required to meet access standards for availability of services.

Medicaid Mental Health and Substance Use Disorder Services

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
- Medication management provided by a professional licensed to prescribe medication;
- In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
- Community-based and facility based sub-acute services;
- Crisis Services including, but not limited to:
    - a 24 hour crisis response;
    - b. Mobile crisis services;
    - c. Crisis assessment and evaluation;
    - d. Non-hospital facility based crisis services;
    - e. Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;

- Care consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated health home mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Peer support services for persons with serious mental illness;
- Family Peer Support for parents of a child with a serious emotional disturbance
- Community support services including, but not limited to:

- a. Monitoring of mental health symptoms and functioning/reality orientation,
- b. Transporting to and from behavioral health services and placements,
- c. Establishing and building supportive relationship,
- d. Communicating with other providers,
- e. Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and / Developing and coordinating natural support systems for mental health support;

- Habilitation program services;
- Children's mental health waiver services;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism;
- Psychiatric Medical Institutions for Children (PMIC).

Medicaid Substance Use Disorder Services

- Outpatient treatment
- Ambulatory detoxification
- Intensive outpatient
- Partial hospitalization (day treatment)
- Clinically managed low intensity residential treatment
- Clinically managed residential detoxification
- Clinically managed medium intensity residential treatment
- Clinically managed high intensity residential treatment
- Medically monitored intensive inpatient treatment
- Medically monitored inpatient detoxification
- Medically managed intensive inpatient services
- Detoxification services including such services by a provider licensed under Iowa Code chapter 135B
- Peer support and counseling
- PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;Emergency services for SUD conditions
- Emergency services for substance use disorder conditions
- Ambulance services for SUD conditions
- Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
- Evaluation, treatment planning, and service coordination
- SUD counseling services when provided by approved opioid treatment programs licensed under Iowa Code Chapter 125
- Substance use disorder treatment services determined necessary subsequent to an EPSDT screening

- SUD disorder, screening, evaluation, and treatment for members convicted of Operating While Intoxicated and members whose driving licenses are revoked, if medically necessary
- Court-ordered evaluation for SUD
- Court-ordered testing for alcohol and drugs
- Court-ordered treatment which meets criteria for treatment services
- Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member.

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

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

Iowa Department of Public Health Substance Use Treatment-Integrated Provider Network (IPN)

The IPN is a competitively procured statewide network of prevention and treatment providers, that offer substance use and problem gambling education, prevention, early intervention, treatment, and recovery support services statewide to individuals at or below 200% of the Federal Poverty Level guidelines. Integrated Provider Network services are funded by the State General Fund appropriation to IDPH for substance abuse and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG). Integrated Provider Network contractors were selected in 2018 through a competitive Request for Proposals process and began providing services January 1, 2019.

IPN Funded Substance Abuse Services

Treatment Covered Services include:

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

Co-occurring Services

There is one PMIC licensed to provide substance abuse treatment and mental health services to individuals up to age 21. Other providers of mental health services are also increasing their co-

occurring capability. Of the 23 accredited Iowa CMHCs, 17 are also licensed substance use disorder services providers and 5 are Integrated Provider Network providers.

Certified Community Behavioral Health Clinic (CCBHC)
CCBHCs are outpatient clinics designed to serve individuals with mental health and substance-use disorders with an array of evidence-based services. Iowa participated in a federal planning grant to develop CCBHCs 6 years ago. While not a recipient of an ongoing CCBHC demonstration grant, the state remains supportive of the CCBHC model and identified CCBHC development in the state's Co-Occurring Plan. Iowa providers have invested in the CCBHC model of integrated and coordinated behavioral health care through training, technical assistance, and application for federal CCBHC expansion grants. Currently, twelve providers in Iowa are recipients of federal CCBHC expansion grants. These providers are implementing the CCBHC model to provide integrated, community-based services for individuals with mental health or SUD needs across the state.

INPATIENT PSYCHIATRIC CARE AND RESIDENTIAL CARE

Inpatient Bed Tracking

Iowa implemented an Inpatient Psychiatric Bed Tracking system effective August 1, 2015. This system was implemented due to concern expressed by stakeholders and advocates regarding difficulty in locating inpatient psychiatric beds, leading to persons having to travel long distances to receive inpatient care. The bed tracking system allows access to an online, searchable database of available psychiatric beds by authorized users, which includes hospitals, law enforcement, regional administrators, and judicial representatives. Legislation enacted in 2017 requires hospitals with inpatient psychiatric units to report into the bed tracking system twice daily, in order to improve reliability of the data base. Subacute mental health facilities were also added as a facility required to report to the bed tracking system.

Inpatient bed availability for individuals with complex needs, including aggressive behavior or intellectual disabilities in conjunction with mental illness remains difficult to obtain. Local hospitals continue to have issues with patients staying in emergency rooms while waiting for an inpatient bed.

Mental Health Institutes (MHI)

The Iowa Department of Human Services, MHDS-Facilities oversees two MHIs, located in Cherokee and Independence. The MHIs provide critical access to quality acute psychiatric care for Iowa's adults and children needing mental health treatment.

The MHIs are licensed as hospitals and provide inpatient mental health services via:
Cherokee Mental Health Institute (CMHI)- short term psychiatric treatment and care for individuals with severe symptoms of mental illness. Cherokee has 24 adult beds and 12 child/adolescent beds.
Independence Mental Health Institute (IMHI) -short term psychiatric treatment and care for individuals with severe symptoms of mental illness. Independence has 40 adult beds and 16 child/adolescent beds.

Specialized Psychiatric Units in General Hospitals

There are twenty eight hospitals in Iowa which have licensed inpatient psychiatric units serving children and adults with a total licensed capacity of 955 beds. Total staffed bed capacity is 734, with 524 adult beds, 65 geriatric beds, and 145 child beds. Two free-standing inpatient psychiatric facilities opened in the state in the last two years, adding 62 beds. While inpatient psychiatric care is concentrated in metropolitan areas, facilities providing inpatient care are generally available within a two-hour drive of an Iowan's residence. Mental health and disability service regions are required to ensure that inpatient psychiatric care is available within the region or within reasonably close proximity (defined in administrative rule as 100 miles or a drive of two hours or less from the county or region).

Residential Care Facilities for Persons with a Mental Illness

The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for Persons with a Mental Illness (RCF/PMI). Eight programs, with 10 locations and 135 beds are currently licensed. These programs provide care in residential facilities to persons with severe mental illness who require specialized psychiatric care. While they are scattered around the state, these programs are not readily available in every locale. Iowa is moving toward less dependency on institutional care, leading to some RCF-PMI providers reviewing their business models and seeking ways to provide care in more community-based settings.

Intermediate Care Facilities for Person with Mental Illness:

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

Psychiatric Medical Institutions for Children (PMIC)

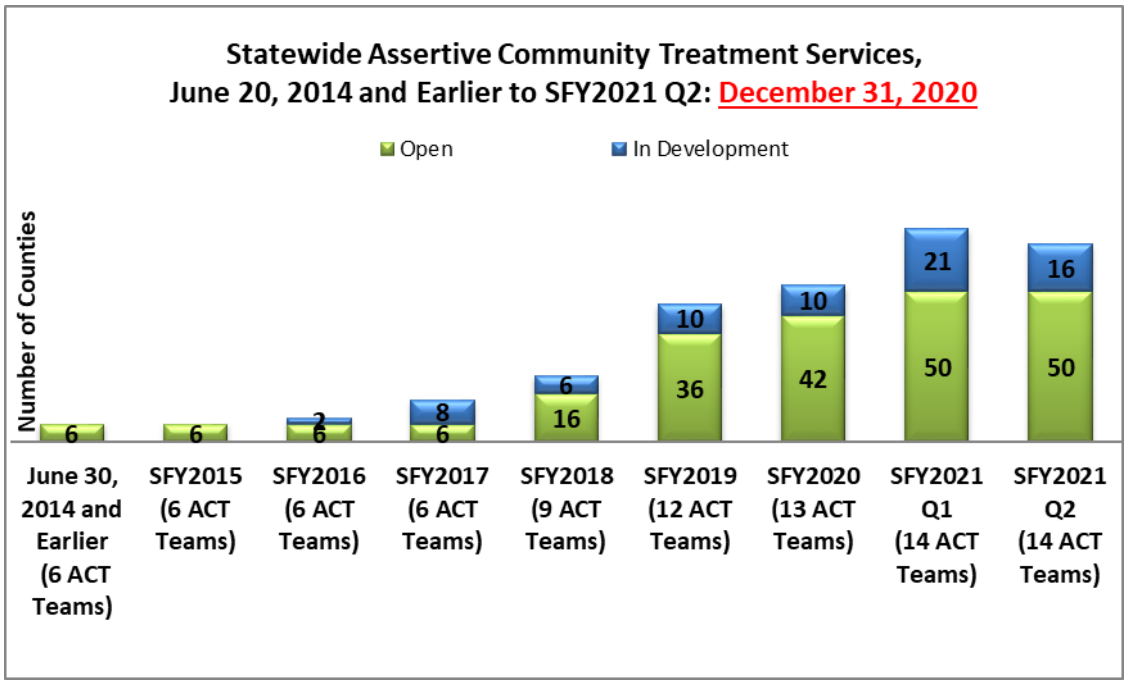
These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are 8 private agencies that operate 378 Medicaid-funded beds. 30 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs.

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

Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa. As of May 2021, 11 children were in out of state PMIC facilities.

COMMUNITY-BASED SERVICES

Assertive Community Treatment (ACT): ACT is an evidence-based practice for individuals with a serious and persistent mental illness who need services outside of standard clinical services. The ACT team of prescribers, mental health professionals, nurses, substance use disorder professionals, and other support providers work with individuals in the community to provide holistic mental health care and supports. The goal is to help individuals with a serious and persistent mental illness be successful in the community and avoid more restrictive treatment settings. MHDS Regions are required to make ACT available in every region as of July 1, 2021. Iowa currently has 14 ACT teams serving 50 of Iowa's 99 counties. This is an increase of 2 teams and 9 additional counties over data reported in the 2019 plan. The following chart demonstrates the growth of ACT services across the state by counties where ACT is available:



*Source-MHDS Regional Dashboards SFY21 Quarter 2

Case Management Services-Integrated Health Home

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

The goal of the IHH is to provide care coordination and integrated services to populations at high risk of poor health outcomes. Development of health homes is part of Iowa's overall goal to increase availability of supports for individuals with serious mental health conditions that allow them to remain in their homes and communities and have improved health and wellness outcomes. Integrated health homes are available to residents statewide. There are 34 IHH programs across the state. 20 of the 34 IHH are CMHCs. Other IHH are providers of children's

residential treatment and community mental health providers. The role of Integrated Health Homes in delivery of services to individuals with an SMI or SED will be further explained in the sections on Children's Mental Health Services and Habilitation.

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

The MCOs are responsible to ensure that required IHH/ case management functions occur for individuals with an SED or an SMI. MCOs also are required to provide community based case management (CBCM) to specified populations such as HCBS waiver participants (other than CMH and Habilitation).

Habilitation Services

The State Plan HCBS Habilitation program is a Medicaid program operated through a 1915(i) state plan amendment. The Habilitation program provides services similar to HCBS waiver services to individuals with functional limitations typically associated with chronic mental illness. The goal of the HCBS Habilitation program is to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. The goal is to separate rehabilitative and non-rehabilitative services into distinct programs in order to continue the services needed by Iowans, while at the same time assuring that the state remains in compliance with federal regulations. Individuals receiving Habilitation also qualify to receive targeted case management.

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

During 2020-21, IME, along with Habilitation providers, MHDS-C staff, and other stakeholders, participated in a collaborative project to revise and update Habilitation administrative rules and processes to address funding concerns, program requirements and eligibility criteria, staff qualifications and training, and use of a new standardized functional assessment tool. As a result of that process, a Medicaid State Plan Amendment was developed and a rules package addressing these issues was filed and is in the rules making process. The legislature also passed a rate increase for Habilitation providers effective July 1, 2021.

Habilitation services include the following:

- Home-based Habilitation which is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living,

community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision.

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

  Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to: the ability to communicate effectively with supervisors, coworkers and customers, an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks, workplace problem-solving skills and strategies; general workplace safety and mobility training, the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment. Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community.

- Supported employment services are the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models

Illness Management Recovery (IMR)

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

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

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

IMR is an EBP that must be available in each MHDS region or county approved to operate as a region. Regions are coordinating training and technical assistance on this EBP to regional staff and providers to develop capacity and competency in IMR. 11 providers in Iowa are offering IMR services.

Intensive Psychiatric Rehabilitation

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

IPR provides services to adults with a serious and persistent mental illness who are interested in making a community 'role recovery' within the next six months to two years. The concept of role recovery is to engage or re-engage individuals in personally meaningful community roles. The purpose of intensive psychiatric rehabilitation services is to assist the person to choose, obtain and keep valued roles and environments. The four specific environments and roles in which psychiatric rehabilitation will assist the individual are living, working, learning, and social interpersonal relationships. There are 13 IPR providers in Iowa.

Supported Employment/Employment Services

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

Iowa Medicaid provides healthcare and community supports and services for financially eligible children and adults with disabilities as well as a number of other target groups. The goal is for members to live healthy, stable, and self-sufficient lives. Long term community services and supports for people with disabilities, including employment services, are funded through the Medicaid 1915 (c) Home and Community Based Services (HCBS) waivers and the 1915(i) State Plan HCBS Habilitation program. The Partnership for Community Integration Project, Iowa's Money Follows the Person (MFP) initiative also has employment as a priority. MFP is a federal Medicaid demonstration grant to assist persons with intellectual disabilities or brain injuries who are currently residing in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) or Nursing Facilities (NF) to transition to the communities of their choice. Employment plays an integral part in community inclusion and the goals of the project.

Iowa Medicaid's Buy-In Program or the Medicaid Program for Employed People with Disabilities (MEPD) is a Medicaid coverage group that allows persons with disabilities to work and continue to have medical assistance. This program has over 15,000 members enrolled.

MHDS-C is responsible for planning, coordinating, monitoring, improving and partially funding mental health and disability services for the State of Iowa. MHDS-C engages in a wide variety of activities that promote a well-coordinated statewide system of high quality disability-related services and supports including employment. Iowa's community-based, person-centered mental health and disability services system provides locally delivered services, regionally managed with evidence-based practices and statewide standards. MHDS Regional leaders, guided by the regional management plan, coordinate quality community services that support individuals with disabilities not otherwise eligible for Medicaid in obtaining their maximum independence.

MHDS has a seat on the leadership teams of the Iowa Coalition for Integration and Employment (ICIE), along with other state agencies. The ICIE coalition includes service providers, as well as service recipients and family members from all parts of the state.

MHDS-C co-led the 2020-2021 Visionary Opportunities to Increase Competitive Employment (VOICE) effort from the U.S. Department of Labor's Office of Disability Employment Policy (ODEP), with the University of Iowa Center for Disabilities and Development (CDD). The emphasis of VOICE was to introduce the Individual Placement and Support (IPS) model of supported employment to stakeholders through a short webinar series led by an IPS expert, since we were unable to hold in-person regional community forums due to COVID19. IPS Supported Employment is an evidence-based practice for individuals with a serious mental illness or multi-occurring conditions. Information shared included the basics of the IPS model, how employment affects social determinants of health, and how working improves peoples' mental and physical health.

Iowa has four IPS pilot teams, led by two pilot providers, which are in their fourth year of operation. Their baseline fidelity reviews reflected "good" fidelity. Quoting from the independent review summary, "The collaboration and integration of employment within the mental health treatment services and care coordination partners reflects the significant work the partner agency staff members and leaders have put into implementing IPS in communities they jointly serve. The partner agencies are congratulated for their commitment to evidence-based practices and using the IPS fidelity scale to provide direction in all aspects of program development and implementation." Prior years of Employment First State Leadership Mentoring Project (EFSLMP) focused on strategic planning for eventual statewide implementation of IPS in Iowa.

MHDS-C and CDD also co-lead the 2021-2022 Advancing State Policy Integration for Recovery and Employment (ASPIRE) effort from ODEP. This effort moves the strategic planning for IPS forward by aligning state policy and funding to better promote competitive integrated employment for people with behavioral health conditions, builds Iowa's infrastructure to deliver IPS by developing and sustainably funding Iowa's first IPS Trainer/Fidelity Reviewer, and builds Iowa's capacity to implement three new IPS teams in 2021-2022. The three new teams will be geographically dispersed from Iowa's existing IPS pilot site teams. The ASPIRE state

steering committee brings together key partners including state agency representatives engaged in Employment-1st, with persons with lived experience and family members, as well as representatives of advocacy groups such as the National Alliance on Mental Illness (NAMI), providers of employment and mental health services, and others. IPS service delivery requires an enhanced partnership among providers, MHDS, Iowa Vocational Rehabilitation, the MHDS Regions and others.

October 2021 Iowa Vocational Rehabilitation Services (IVRS) is making available training and funding for the Customized Discovery model of supported employment, to all their statewide providers. Customized Discovery is a model of Customized Employment developed by Griffin-Hammis Associates which has a fidelity scale and may be described as a promising practice for people with significant disabilities, including those with intellectual and developmental disabilities.

Supported Community Living Programs

Supported Community Living Programs are accredited by MHDS-C, to provide supervised supported living to persons with disabilities. There are approximately 84 accredited programs which currently provide services to persons with various disabilities.

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

D. RECOVERY SUPPORTS

Peer Support Services

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

Peer support services for mental health and peer recovery coaching for SUD are both Medicaid reimbursable services. IDPH and DHS have reviewed the curriculum content for the University of Iowa sponsored peer support training and the Connecticut Community for Addiction Recovery (CCAR) curriculum promoted by IDPH. CCBHC planning grant funds were also used to provide additional CCAR training to expand availability of peer recovery coaching. Iowa will accept either version of the training with an additional 6 hours of specialized training either in substance use disorders or mental health.

In February 2015, MHDS-C contracted with the University of Iowa Center for Child Health Improvement and Innovation to provide training for core and continued education, technical assistance, oversight, and recommendation for a certification process for family peer support and adult peer support This contract also works on workforce development for family peer support and peer support services. Peer Support Services are required in the MHDS Regions. Iowa utilizes certified peer support specialists for employment within the Integrated Health Home, crisis services and peer services.

In June of 2020, the Department of Human Services and the Iowa Department of Public Health collaborated on a Request for Proposal (RFP) to solicit proposals to enable the two departments to select a qualified contractor to build the Peer Support Specialist, Family Peer Support Specialist, and Recovery Peer Coach workforce in Iowa. The two agencies solicited proposals to seek a qualified applicant to recruit, train, coordinate, manage, and monitor peer-led training and to further develop and maintain the certification program for Peer Support Specialists, Family Peer Support Specialists, and Recovery Peer Coaches in Iowa. The contract was awarded to the University of Iowa in June 2021.

Peer-Run Organizations

Life Connections Peer Recovery Services

Life Connections Peer Recovery Services is a non-for-profit organization that supports individuals who are experiencing Mental Health and Substance addiction issues and who want to work on their recovery goals and situations before getting into a crisis situation. Life Connections operates a wellness recovery center and a peer-run respite center. Wellness recovery action planning (WRAP) is offered through the wellness recovery center.

Plugged-In Iowa

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

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

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

Respite

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

Wellness Recovery Action Planning

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

E. PROVIDERS OF MENTAL HEALTH SERVICES

Community Mental Health Centers and other Mental Health Service Providers

Community mental health centers and other mental health service providers who act in lieu of a community mental health center are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 23 CMHC's in Iowa which provide mental health services to adults and children, with the exception of two CMHC's in Polk County, one of which serves only children and one which serves adults. Approximately 74 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHC's receiving MHBG funding, Iowa law mandates that CMHCs use MHBG funds for the development and implementation of evidence based practices and/or direct services to individuals not otherwise covered by insurance or for services not reimbursed by insurance. The CMHC identifies through its contract with the state how the organization will serve adults with an SMI and children with an SED.

EBP's and best practices supported in FY21 through MHBG funding to CMHCs include:

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

CMHCs serve a defined catchment area, ranging from one county to seven counties. Other Mental Health Service Providers generally serve a specific geographic area. Agencies may be accredited to provide any of the following services: partial hospitalization, day treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient psychotherapy, emergency, evaluation, and crisis services. Accreditations rules are located in Iowa Administrative Code 441-Chapter 24. Community mental health centers, crisis providers,

targeted case managers, and certain mental health providers are required to be accredited by the SMHA. Other providers of outpatient mental health services that are housed within larger licensed or accredited health systems such as hospitals, child welfare agencies, or mental health facilities are not included in this count.

Federally Qualified Health Centers

Iowa presently has 72 Federally Qualified Health Centers (FQHC's) sites enrolled as Medicaid providers. These centers are located across Iowa in both rural and urban areas. FQHC's receive an actual cost reimbursement for Medicaid patients rather than the established rate of reimbursement. To qualify to be an FQHC, the clinic agrees to treat all that present, regardless of insurance or method to pay for services. This has become a valuable resource for adults and families that may not have any insurance coverage and do not qualify for any of the Medicaid programs. FQHC's also provide screening and referral to behavioral health services and in some instances, provide direct behavioral health services. Iowa has one agency that is qualified as both an FQHC and a CMHC, encouraging coordinated care for individuals with co-occurring health and mental health needs. Other mental health providers have collaborative relationships with FQHCs to assist individuals to receive integrated health and behavioral health care.

Mental Health Professionals Statewide

According to the Iowa Health Professions Tracking Center, University of Iowa Carver College of Medicine, for calendar year 2019, there were approximately 223 psychiatrists in the state of Iowa. The majority of psychiatrists practice in metropolitan or urban counties. This was a decrease of 9 from 2017. In 2019,there were approximately 216 Advance Practice Nurses and 46 Physicians Assistants with a Mental Health Specialty. Both the number of PNPs and PA's increased over the 2017 previous report.

According to the IDPH Bureau of Professional Licensure, there are: 882 licensed psychologists; 4,971 social workers which includes those at the independent (requires a master's in social work and additional experience), bachelor, and master's levels. There are 444 licensed marital and family therapists and 2,116 licensed mental health counselors, including temporary and fully licensed counselors and therapists. Availability of mental health providers is affected by the aging of the mental health workforce, the numbers of licensed providers who may not be actively practicing, and mental health professionals who work in systems not available to the general public, such as the Department of Corrections, Veterans Affairs facilities, state MHIs, and educational systems. Provider agencies report difficulty hiring Master's level clinicians, especially in rural areas.

The Iowa Department of Public Health /Board of Medical Examiners is responsible for regulating medical and osteopathic doctors. The Iowa Department of Public Health, Bureau of Professional Licensure licenses mental health professionals such as social workers, mental health counselors, and psychologists.

Workforce Initiatives/Mental Health Shortage Area Designation

As of December 2019, the Health Resources and Services Administration listed 88 of 99 Iowa counties as having a Health Professional Shortage Area designation for Mental Health. Lack of

access to qualified mental health professionals at all levels is an identified gap in the service system.

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

Additional psychiatric residency programs have been added in central Iowa to support increased psychiatric capacity in Iowa. In 2021, $600,000 was allocated by the legislature for four rural psychiatric residencies who will provide mental health services in underserved areas of the state. Funding was also allocated to increase access to mental health services through psychiatric training of additional physician assistants and nurse practitioners.

IV. SUPPORTS FOR IDENTIFIED POPULATIONS

A. CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

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

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

The SMHA also oversees four Systems of Care programs in Iowa which serve 14 of Iowa's 99 counties. The SOCs currently serve children with an SED who are not Medicaid-eligible but require additional supports and services to be successful. The SMHA anticipates expanding to 6 SOC programs with the issuance of an RFP in September 2021.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of DHS, each with their own eligibility, funding, and limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as

some areas may have a larger service array and more financial investment in children's mental health services.

DHS includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:

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

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

- •The Juvenile Court System,
- •Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
- •Department of Public Health which includes Title V programs, the Child Health Specialty Clinics, substance use disorder prevention and treatment, community health programs, home visiting, and suicide prevention programs
- •Department of Human Rights
- •Department of Inspections and Appeals

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

Iowa has a shortage of child psychiatrists. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs.

Behavioral Health Intervention Services-

Behavioral health intervention services –BHIS are primarily available to children who are Medicaid-eligible. A limited number of programs fund BHIS for non-Medicaid eligible individuals. BHIS are supportive, directive, and teach interventions designed to improve the individual's level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control.

BHIS enables Medicaid-eligible children and their families, including children receiving the CMH waiver, to access in-home or community-based services in addition to traditional outpatient mental health care without having to enter the child welfare and/or juvenile justice system. BHIS services are also available to children in the custody of the Department of Human Services due to their eligibility for Medicaid.

Specific services available through BHIS include individual, group, and family skill building services, crisis intervention services, and services to children in residential settings. BHIS services are typically provided in the home, school, and community, as well as foster family and group care settings.

Children's Mental Health Waiver

When the Children's Mental Health (CMH) waiver program began in October 1, 2005, it had a capacity of serving 300 children. The current capacity of the CMH waiver is 1,360. The 2021 General Assembly allocated $1,031,530 in additional funds to help decrease the waiting list for the waiver. The following chart shows the current status of the waiver usage and waiting list as of August 2021.

CMH Waiver Statistics

CMS Slot Cap	1,287	Total slots authorized
Reserved CMH Waiver slots per year	20	For children exiting PMICs, MHIs, or out of state placements
Slots approved	1,143	
Applications in process	163	
Waiting list	1,156	The next child to be served has an application date of 11/20/19

https://dhs.iowa.gov/sites/default/files/8.5.21_Monthly_Slot_and_Wait_list_Public.pdf?081820211421

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

Iowa annually makes available 20 reserved slots on the CMH waiver for children being discharged from PMIC's, MHI's, or out of state placements These reserved slots are usually used within the first few months of release. This fact, as well as the large waiting list for the CMH waiver demonstrates the need for coordinated, supportive services in order to divert children from more intensive services, and aftercare services for children returning to their communities from PMIC and out of state treatment and placements. Children leaving high-end,

restrictive types of treatments and placements need immediate access to services to support a successful transition back to their homes and communities.

Educational System Services and Supports

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

AEAs as educational partners with public and accredited, private schools to help students, school staff, parents and communities meet these challenges. AEAs provide special education support services, media and technology services, a variety of instructional services, professional development and leadership to help improve student achievement.

AEAs were established by the 1974 Iowa Legislature to provide equitable, efficient and economical educational opportunities for all Iowa children. AEAs serve as intermediate units that provide educational services to local schools and are widely regarded as one of the foremost regional service systems in the country.

AEA budgets include a combination of direct state aid, local property taxes and federal funds. AEAs have no taxing authority. Funding appears in each local school district's budget and "flows through" the school budgets.

Local Education Agencies also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Programs and 504 plans for children identified as eligible individuals.

The Iowa Department of Education, in collaboration with area and local education agencies, has implemented the Learning Supports Initiative.

Learning Supports are the wide range of strategies, programs, services, and practices that are implemented to create conditions that enhance student learning. Learning supports:

- promote core learning and healthy development for all students,
- are proactive to prevent problems for students at-risk and serve as early interventions and supplemental support for students that have barriers to learning, and
- address the complex, intensive needs of some students.

Systems of Care

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

The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), Four Oaks System of Care, and Tanager Place serve children and youth ages 0-21 who are diagnosed with a mental health disorder and meet the criteria for Serious Emotional Disturbance. The four programs serve non-Medicaid eligible children and youth and provide access to community-based services and supports. The children and youth served by these programs are assessed to be

at risk of involvement with more intensive and restrictive levels of treatment due to their serious behavioral and mental health challenges. All programs provide the following services:

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

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

Referral sources for SOC programs include parents, schools, DHS Child Welfare, Juvenile Court Services, PMIC's, therapists, and other mental health service providers.

The SOC programs are all Integrated Health Homes for Medicaid-eligible children with an SED. IHH care coordination is reimbursed by Medicaid for Medicaid-eligible children allowing the SOC funds to be dedicated to providing similar services to non-Medicaid eligible children and families. In SFY21, 363 children were served by the SOC programs.

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

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

Aftercare is a statewide program which includes pre-exit planning (up to 6 months prior to youth "aging out" of foster care) and case management services for youth ages 18 through 20 who have "aged out" of foster care, court ordered Iowa juvenile detention, or the State Training School. In 2020, the Iowa Department of Human Services extended the upper age to 23, enabling Aftercare to serve youth in a reduced intensity at the participant's age 21 and 22.

Aftercare is voluntary, individualized support to help youth transition successfully to adulthood. Aftercare participants meet at least twice monthly with an Iowa Aftercare Services Network

Self-Sufficiency Advocate. Advocates help assess the needs of participants, set goals, develop important life skills, connect youth with community resources, and strengthen personal relationships. Limited funds are available for each participant to help participants in crisis, such as for shelter, food, or other needs associated with achieving identified goals. Regular payments are provided to aftercare participants who attend work or school and meet certain program requirements. These funds are referred to as Preparation for Adult Living, or PAL, and help with rent, transportation, or other needs determined by the youth to move them closer to self-sufficiency.

Iowa's regional mental health and disability services systems are also involved in ensuring smooth transitions from child to adult services systems. The regional MHDS system can assist youth with the transition to the adult system. The Integrated Health Home program also assists with transitions for Medicaid-eligible children and youth with an SED or an SMI.

B. SUPPORTS FOR OLDER PERSONS

HCBS Elderly Waiver

Iowa Medicaid has an HCBS Waiver for older persons. Elderly Waiver services are individualized to meet the needs of each member. Individuals must meet the Level of Care for nursing facility care. The Elderly Waiver currently serves 7,766 individuals with 2,260 applications in process. There is no waiting list for this waiver.

The following services are available:

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

Preadmission Screening and Resident Review (PASRR):

Iowa has implemented a strong PASRR process by creating a collaboration within DHS between Iowa Medicaid Enterprise (Medicaid Authority, known as IME) and MHDS-C, (the SMHA and SIDA). MHDS-C has a contract with Ascend, a Maximus Company to perform all Preadmission Screening (Level I) and Comprehensive Assessment (Level II) PASRR activity. Preadmission screening is federally mandated for all individuals who may enter a Medicaid-certified nursing

facility everywhere in the country and Iowa's program has made enormous strides toward full federal compliance within the past ten years since contracting with Ascend/Maximus. In SFY20, 37,002 Level 1 PASSRs were completed. Of the total Level I submissions, 12,834 received categorical (short term) exemptions from the full Level II assessment and 2087 received full Level II PASSR assessments.

Iowa has instituted a PASRR program that is among the most robust in the country and includes a very proactive training program for all Iowa hospitals and over 450+ nursing facilities, as well as an increasing number of community based services providers. Statewide webinars on topics important to PASRR providers are offered twice monthly, and face to face full-day training events known as the "PASRR Road Show," events, have historically been offered in four locations across the state in the Spring and Fall of every year. The face to face training events have been suspended since the Spring of 2020, due to the pandemic, and we hope to resume in 2022. On the 22nd anniversary of the Olmstead Decision, June 22, 2021, Iowa's PASRR program was featured in two webinars that celebrated the powerful connection between the PASRR program and the state's goals identified regarding implementation of the Olmstead Decision. One was about the collaboration between Iowa's PASRR and Money Follows the Person (MFP) programs, where linkages have been created to support referrals for MFP as members of the target population are identified in Iowa's PASRR program, and the other had a focus on how Olmstead goals can be achieved when the Community Placement Supports identified in PASRR are implemented to support movement of individuals to lower levels of care.

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

Since February 1, of 2016, Iowa nursing facilities have been required to enter all of their admission, transfer, and discharge notices into an electronic process known as "PathTracker Plus," which is linked to both PASRR and Medicaid (IME). This electronic process sends an overnight notice to the income maintenance workers who process Medicaid eligibility and payments for facility based care. This innovation has increased efficiencies, eliminated a great deal of paper, and increased the speed and accuracy of payments to Iowa nursing facilities, while also increasing PASRR compliance, particularly with the preadmission completion of all PASRR activity.

Iowa has implemented a number of other innovations including an in-depth monitoring process of all the care plans developed for individuals identified at PASRR Level II as being in need of "specialized services." The most commonly identified specialized services are behavioral health services including psychiatric medication monitoring and individual therapy and also includes such things as Peer Support Services, Functional Assessments, and Behavior Based Treatment

Plans. The review process, known as "ServiceMatters," includes multiple training opportunities, offers in-depth technical assistance, and looks at whether the receiving nursing facility has developed a PASRR compliant care plan. It also explores the extent to which PASRR identified services are being delivered to the individual in a manner that will meet their needs and help them move toward recovery. Iowa was the first state in the country to develop a PASRR care planning tool to assist our nursing facilities to write care plans that are fully compliant with PASRR.

Some of the latest PASRR innovations include collaboration with the state's licensing and survey agency and Medicaid Managed Care Organizations around how PASRR service delivery and compliance is looked at collectively. During 2020, the PASRR program has offered four hours of training to all Community Based Care Managers with the Medicaid MCOs and four hours of training to the survey staff within Iowa's Department of Inspection and Appeals.

The Iowa Department on Aging (IDA) serves all Iowans who are 60 and older, with particular emphasis on populations demonstrating the greatest social or economic need. Current projections show that Iowa's population of adults aged 65+ will constitute 19.9% of the state's population by 2050, which makes support for the aging population more important than ever. The Iowa Department on Aging focuses on empowering older adults to maintain their independence and advocates on behalf of older Iowans to ensure their rights, safety, and overall well-being. IDA has a significant collaborative and policy relationship with Iowa's Area Agencies on Aging (AAA), covering all 99 counties. There are six AAA's in Iowa who help Iowans connect to local services such as nutrition support, caregiver support, and case management

Aging and Disability Resource Centers (ADRC)
Iowa's ADRC system has been branded with the name Lifelong Links, and can be found on the web at: https://i4a.org/lifelong-links-iowas-aging-and-disability-resource-center/ and via phone through a statewide toll free phone number: 1-866-468-7887. LifeLong Links is Iowa's network of Aging and Disability Resource Centers, whose purpose is to expand and enhance the state's information and referral resources for older adults, people with disabilities, and caregivers as they begin to think about and plan for long-term care and supports.

A collaborative partnership with Iowa's six Area Agencies on Aging, LifeLong Links is modeled on the "no wrong door" approach, meaning it is available to any Iowan in need of home-based and community services and is accessible through physical locations across Iowa, a toll-free call center (1-866-468-7887) and this website.

C. SUPPORTS FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

PATH

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

PATH funds are used for community-based outreach, mental health, substance use services, case management, and limited housing services for people age 18 and over experiencing serious

mental illnesses—including those with co-occurring substance use disorders, experiencing homelessness or are at risk of becoming homeless. MHDS-C administers contracts with seven provider agencies located in Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City and Waterloo. In recent years each provider agency exceeded goals for numbers of individuals who were contacted, engaged and enrolled in the program; the percent of individuals enrolled who are literally homeless; and percent of enrollees who receive community mental health services. All of the PATH providers are participating in a centralized intake process to house individuals with the most need first.

The Iowa Council on Homelessness (ICH) staffed by the Iowa Finance Authority is committed to ensuring all Iowans have access to safe, decent and affordable housing. The ICH and its 38 members work to identify issues, raise awareness and secure resources that will allow all homeless Iowans to become self-sufficient. The SMHA has a voting member appointed to serve on the council. The SMHA does not directly fund or manage any programs providing services to individuals in emergency shelter, temporary housing, or permanent supportive housing, but it does work closely with and collaborate with the Iowa Finance Authority, the Iowa Council on Homelessness, the three Iowa continuums of care, and local public housing authorities in providing services to Iowans with a mental illness who are homeless.

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

S.O.A.R- SSI/SSDI Outreach, Access, and Recovery -
SSI/SSDI Outreach, Access, and Recovery (S.O.A.R.) is a national project to provide intensive assistance in applying for Social Security disability benefits for adults who are (a) homeless or at risk of homelessness and (b) meet Social Security criteria for not being able to work due to the disability. MHDS-C staff make the recommendation for people to attend the SOAR Leadership Academy paid for by SAMHSA. Currently there are 4 leadership positions across the state to assist the individuals trained to assist people in the application process for disability benefits. These benefits help individuals with serious mental illness and other disabilities obtain access to stable housing and health care.

Housing Supports
Many adults with serious mental illness utilize the “HUD Section 8 Rental Voucher Program”. This program increases affordable housing choices for very low-income households by allowing families to choose privately owned rental housing. The public housing authority (PHA) generally pays the landlord the difference between 30 percent of household income and the PHA-determined payment standard, - about 80 to 100 percent of the fair market rent (FMR). The rent must be reasonable. The household may choose a unit with a higher rent than the FMR and pay the landlord the difference or choose a lower cost unit and keep the difference.

Home and Community Based Services Waiver Rent Subsidy Program

The Iowa Finance Authority administers this program. Rental subsidies are available to various disability populations in the state through the home and community-based waiver programs including: Health and Disability; Elderly; AIDS/HIV; Intellectual Disability; Brain Injury and, Physical Disabilities Waivers. Individuals receiving Habilitation and Money Follows the Person are also eligible. The overall purpose of this program is to encourage and assist eligible persons to live successfully in the community until they become eligible for other local, state or federal rent assistance. In Iowa, the program helps an average of 330 Iowans each month to stay in their home and to remain a part of their community. Iowa does not have a waiver specifically targeted to individuals with mental illness; consequently, individuals with mental illness who do not qualify for one of the listed HCBS waivers or Medicaid programs are not able to take advantage of this opportunity.
https://www.iowafinance.com/renter-programs/home-and-community-based-services-rent-subsidy-program/

MHDS Regions

MHDS Regions are required to make the evidence-based practice of supported housing available in each region. Regions have worked with national experts on permanent supported housing to support programs that provide this service. Most regions provide initial financial support to assist individuals in establishing housing.

D. VETERANS SERVICES

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

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

E. DISASTER BEHAVIORAL HEALTH RESPONSE TEAM / COVID RECOVERY IOWA

MHDS-C is responsible for administering the disaster behavioral health plan for Iowa. MHDS-C staff serves as the liaison between the federal government disaster grant programs and the state of Iowa. In addition to this function, the position provides oversight and management of the Iowa Disaster Behavioral Health Response Team (DBHRT).

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

DBHRT members are trained in a wide range of response skills including but not limited to: Psychological First Aid, Critical Incident Stress Management, Mental Health First Aid and Basic Disaster Training.

COVID Recovery Iowa is a FEMA funded Crisis Counseling Assistance and Training Program grant awarded to Iowa on May 22, 2020. The grant is currently approved through December, 2021. COVID Recovery Iowa is administered by MHDS-C and 5 providers are under contract to provide statewide services: Abbe Center, Heartland Family Service, Iowa State University Extension and Outreach, Pathways Behavioral Health and University of Iowa, Center for Development and Disabilities. COVID Recovery Iowa provides personal support, counseling, support groups, public education opportunities and engagement activities. All services are free and the majority are provided virtually. There are some in-person support services offered as well. COVID Recovery Iowa has provided 21, 779 counseling sessions, 24,345 group counseling/public education sessions and 114,660 brief support contacts.
https://covidrecoveryiowa.org/

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

State Demographic Summary

Iowa, named after the Ioway Indian tribe, became the 29th U.S. state in 1846. Iowa is known as the Hawkeye State and Des Moines, Iowa's largest populous county, is the capital city. The State of Iowa's 99 counties have an estimated population of 3,190,369 in 2020; a 4.7% increase from the 2010 census. https://www.iowadatacenter.org/data/decennial/2020Resident

Iowa's general population characteristics include:

- Male 49.8%/Female 50.2%
- Population under 5 years: 6.0%
- Population 18 years and over: 77.1%
- Populations 65 and over: 17.5%
- Population 85 years and over: 2.4%
- Median age: 38.5 years
- Educational attainment of High School degree or higher 92.6%/Bachelor's degree or higher 29.3%
- Civilian veterans: 7.6%
- Language spoken at home: English only 91.1%/ Spanish 4.4%/Asian and pacific Islander 1.7% and other 2.8%
- Median Household Income: $61,691
- Urban 64.3%/Rural 35.7%
- Individuals below poverty level: 11.2%/Families below poverty level: 7.3%

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

- White alone, 89.9%
- White alone, not Hispanic or Latino, 85.1%
- Black or African American, 4.1%.
- American Indian and Alaska Native 0.4%
- Asian 2.4%
- Native Hawaiian and Other Pacific islander alone, 0.1%
- Hispanic or Latino, 6.3%.
- Two or more races, 2.2%

Unmet service needs and gaps within the current system

Children with Serious Emotional Disturbance (SED)-Identified Needs

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2019, it is estimated that the Iowa SED prevalence ranges from 22,307 to 44,614. The data is provided in a range due to SAMHSA providing prevalence estimates for children at different levels of functioning. The following data compares the prevalence rate to data available regarding services to children with an identified SED in Iowa:

	Number of children approved for the CMH waiver as of 8/1/21*	Percentage of the estimated Iowa SED population	SFY21 -Number of children receiving System of Care services for children with an SED*	Percentage of the estimated Iowa SED population
2019 Estimate of children age 9-17 with a serious emotional disturbance - 44,614	1,143	2.6%	363	<1%

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

The waiting list for the Children's Mental Health Waiver continues to be significant. As of August 5, 2021, 1,156 children were on the waiting list to be considered for a slot. 163 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 over a year. In 2021, legislation was enacted that allocated $1,031,530 to decrease the waiting list for the CMH waiver.
https://dhs.iowa.gov/sites/default/files/8.5.21_Monthly_Slot_and_Wait_list_Public.pdf?081820211421

SOC programs for non-Medicaid eligible children remain limited to 14 of 99 counties in Iowa. The combination of factors including limited waiver slots, limited access to community-based services if not Medicaid-eligible, and lack of providers available to treat children with an SED, places children with an SED at risk of higher-intensity services including out of home treatment and placement.

The National Survey of Drug Use and Health, 2018-2019 reports that 16.69 % of Iowa adolescents had at least one major depressive episode in the previous year. This is an increase from 15.09 in 2017-2018.
National Survey on Drug Use and Health: Comparison of 2017-2018 and 2018-2019 Population Percentages (50 States and the District of Columbia) (samhsa.gov)

The 2018 Iowa Youth Survey, a biannual survey completed by approximately 70,500 Iowa 6th, 8th, and 11th graders provided data regarding students' thoughts of suicide. 10.1% of all students surveyed reported that they had a plan to kill themselves within the past 12 months. This measure increased 2.2% from the 2016 survey. The IYS was scheduled to be administered in

2020. Due to the COVID-19 pandemic, the 2020 Iowa Youth Survey was postponed by Governor Proclamation. With sensitivity to Iowa schools' new priorities during the pandemic and the impact on administrative and academic demands, the Iowa Youth Health Assessment Program will postpone the survey to fall 2021. Due to the absence of data from 2020, this report will not contain documentation of 2020 IYS outcomes. For additional information on the IYS visit: Iowa Youth Survey > Home

Families of children with mental health issues and advocates continue to identify lack of trained providers, lack of crisis services specifically for children, a need for more therapeutic school settings, need for more providers skilled in treating co-occurring MH and SUD , and access to school-based mental health as barriers to children with an SED being able to live successfully in the community

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

The following prevalences were found:

- SAMHSA URS Table 1 2019 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 131,027
- The National Survey of Drug Use and Health, 2018-19, reported that 4.94% of Iowans 18 years or older had serious thoughts of suicide in the past year, 7.82% reported a major depressive episode in the past year, 5.4% had an SMI, and 18.5% reported having any mental illness in the previous year.

National Survey on Drug Use and Health: Comparison of 2017-2018 and 2018-2019 Population Percentages (50 States and the District of Columbia) (samhsa.gov)

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 ratio 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 14 ACT teams.

Early Serious Mental Illness

Starting in 2014, Iowa has worked diligently to develop Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) teams using the Set Aside for Early Serious Mental Illness funds designated in Iowa's MHBG allocation. The current set-aside percentage is 10% of the total award. These funds can only be used for ESMI/FEP services and program support. Iowa has implemented the NAVIGATE model for this population, which is an evidence-based

coordinated specialty care practice. State staff provide technical assistance and contract management for the three programs.

In FY21, 3rd quarter, the 3 teams were serving 106 individuals which is an increase over the FY19 full year number served of 72. SAMHSA URS Table 1 2019 identifies an Iowa prevalence rate for adults with SMI of 5.4% or 131,027. The number receiving NAVIGATE services is a very small percentage of the estimated Iowans with an SMI, 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 plans to add a fourth NAVIGATE team in FY22 using COVID and ARP MHBG funds.

Strengths and opportunities of Iowa's mental health system identified by the Mental Health Planning Council committee members include:

- Significant progress has been made by the Mental Health and Disability Services (MHDS) Regions in relation to the dashboard charts submitted with the FY20-21 MHBG Plan. It was noted that these charts will be updated in Step 1 for the new plan.
- COVID Recovery Iowa –Will need to continue this after the grant ends as it will leave a huge gap.
- Certified Community Behavioral Health Clinics
- Loan repayment program for health care providers has expanded in Iowa and the National Health Service Core has expanded its loan repayment to include substance use counselors to be recognized in the Health Professional Shortage Areas.
- Crisis Intervention Training (CIT) – need to expand this statewide and to existing officers as it is primarily focused on new recruits.
- Serious Emotional Disorder Assessment Tool - universal tool that can be used by all providers. Developed through the Children Behavioral Health System State Board.
- Therapeutic Classroom grants
- Expansion of telehealth, including schools becoming a location for telehealth services
- Medicaid Reference Manual- created by DHS to explain how Medicaid operates in Iowa to lawmakers and stakeholders https://dhs.iowa.gov/sites/default/files/Comm580.pdf?040620211416

Needs and concerns identified by Mental Health Planning Council members:
Overall mental health system:

- Need an easy and obvious way for individuals to search for licensed and accredited providers of mental health services and substance use, possibly being able to filter based on specialty, city/county/region, type of service, etc. There was discussion about the search options and resources listed on the Your Life Iowa website.
- Professional development training in relation to telehealth services.
- Community Collaboration of Supported Re-entry (CCSR) – done in the past and Iowa could benefit from doing this again.
- Services to marginalized or non-traditional populations – (e.g. individuals who lived with parents/caretakers and their parent/caretaker has died or become too frail to care for them,

older adults, individuals with hoarding issues, etc.) It was discussed that these individuals typically don't access services the traditional way, services are often needed to be given in the home and typically their needs are often not known until there is a crisis.

- Services for refugee and minority populations, including a way to search for licensed providers by race/ethnicity.
- Data and resources specific to the LGBTQ population.
- Post-partum mothers only have access to Medicaid for 60 days. For those who have behavioral health conditions it is difficult to maintain services.
- Decrease in workforce, specifically Licensed Independent Social Workers (LISW), psychiatric nurses, Advanced Registered Nurse Practitioners (ARNP), Physician Assistants (PA), Licensed Mental Health Counselors (LMHC), Psychiatrists etc. as well as the direct workforce. There was discussion regarding statistics from Mental Health America that show Iowa as 45th in the nation for mental health workforce availability, and the need to review this report to determine how these statistics were obtained.
- Concerns about future of telehealth, will audio-only telehealth continue to be allowed, plan should reflect pros/cons of telehealth
- Increasing suicide rate and opioid overdose rates per IDPH data

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

- Limited amount of SUD/co-occurring beds for kids. These beds can be found in Psychiatric Medical Institutes for Children (PMICs) both in the Iowa Provider Network (IPN) and outside the IPN, and other residential treatment providers for kids not in the IPN. This information is difficult for parents to find when in need.
- Need to assess if there were educational opportunities for LMSW, LISW, and LMHC to have more of a foundation in substance use disorders so that they are more comfortable with providing treatment to individuals with co-occurring mental health and substance use disorder needs. There was discussion regarding the requirements for licensing of mental health staff.

Children with an SED and their families:

- Systems of Care is a great program, but is not open to enough people, specifically in rural areas.
- Need for data regarding restraint and seclusion in schools
- Access to school-based mental health. The ratio of school counselors and para-professionals to resource officers and the role of school counselors versus mental health providers was discussed as well as the limits of mental health providers in schools.

- Crisis response services for children currently utilize a law-enforcement based model. Need to look at implementing an evidenced-based practice model like the STAR Model in Denver, CO or the CAHOOTS Model in Eugene, OR.
- Concerns about LGBQT behavioral health services and effect on trans kids' mental health of public efforts to curtail their rights.

Adults with SMI/Older Adults/Rural Individuals:

- Lack of funding for peer-run organizations. These organizations fill a special role and are able to do things that no other provider does, including crisis service.
- First Episode Psychosis programs – expand to additional metropolitan areas.
- Lack of BH workforce in general was identified as a concern. Planning Council using UI data as a resource to identify numbers of psychiatrists and other MH professionals in IA.
- Tracking of waiting lists for residential facilities for both mental health and substance use. MHDS does not track specific provider waiting lists only the MHDS Regions waiting lists. IDPH does require tracking for providers on the IPN.
- Concern about state not meeting requirement of 22 ACT teams.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Expand mental health services and supports to children with an Serious Emotional Disturbance and their families

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Expand access to community-based mental health services and supports for children with an SED who are not eligible for Medicaid funded services.

Strategies to attain the goal:

Issue an RFP for up to 2 programs to develop local Systems of Care for children with an SED

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access to community-based mental health services and supports for children with an SED

Baseline Measurement: State currently has 4 SOC programs

First-year target/outcome measurement: Increase to 6 SOC programs through issuance of an RFP for 2 new SOC programs

Second-year target/outcome measurement: Maintain 6 SOC programs

Data Source:

DHS

Description of Data:

SOC programs contract with DHS, DHS maintains data on each SOC program

Data issues/caveats that affect outcome measures:

RFP is projected to be released Sept. 2021 with implementation on Jan. 1, 2022. Outcomes may be affected if there are none or only 1 successful bidder for the program.

Priority #: 2

Priority Area: Crisis Services

Priority Type: SAP, SAT, MHS

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

Goal of the priority area:

IDPH and DHS will work together to Implement the 988 Crisis Line in Iowa

Strategies to attain the goal:

1. Develop a 988 implementation plan with the assistance of the stakeholder coalition
2. Implementation of the 988 plan

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 988 Plan Development and Submission-Collaboration between IDPH and DHS

Baseline Measurement: Plan is in development

First-year target/outcome measurement: Plan submitted to Vibrant and approved for implementation during SFY22

Second-year target/outcome measurement: Plan implemented and Iowa Lifeline centers begin answering calls effective July 16, 2022

Data Source:

IDPH and DHS

Description of Data:

Plan submitted to Vibrant and State agency oversight of 988 activities in Iowa.

Data issues/caveats that affect outcome measures:

Availability of funding and workforce to implement the plan may impact implementation.

Priority #: 3

Priority Area: Support and Development of the Behavioral Health Workforce

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, TB

Goal of the priority area:

Promote retention and recruitment of qualified individuals for the behavioral health workforce. Increase competency of the behavioral health workforce through training and technical assistance.

Strategies to attain the goal:

1. Develop a statewide Center of Excellence to assist providers in implementing evidence-based practices with fidelity.
2. DHS and IDPH will collaborate to expand Relias online training platform to community mental health centers.
3. DHS and IDPH will implement a shared peer support training collaborative for peers serving individuals with an SMI, parents of children with an SED and individuals with an SUD.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: DHS and IDPH will collaborate to expand Relias behavioral health online training available to SUD providers to CMHCs

Baseline Measurement: 0

First-year target/outcome measurement: 13

Second-year target/outcome measurement: 27

Data Source:

IDPH records of users of Relias training.

Description of Data:

Training records

Data issues/caveats that affect outcome measures:

This is voluntary, providers may choose not to access the online training.

Indicator #: 2

Indicator: Increase access to peer support/family peer support/recovery peer coach training through DHS/IDPH joint training collaborative

Baseline Measurement: New peer support training contract effective 6/1/2021

First-year target/outcome measurement: Contractor will provide 6 peer support, 6 family peer support, and 6 recovery peer coach trainings

Second-year target/outcome measurement: Contractor will provide 6 peer support, 6 family peer support, and 6 recovery peer coach trainings

Data Source:

DHS contractor reports

Description of Data:

Contractor reports of training

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: DHS will establish a Center of Excellence for Implementation of Evidence-Based Practices

Baseline Measurement: None currently exists

First-year target/outcome measurement: DHS will issue an RFP and award a contract for Center of Excellence

Second-year target/outcome measurement: The Center of Excellence will provide training and technical assistance to stakeholders and providers on DHS-approved EBPs.

Data Source:

DHS contractual monitoring of Contractor activities and participation in training and TA activities.

Description of Data:

Contractor reports

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: Expand services to individuals experiencing a First Episode of Psychosis or Early Serious Mental Illness

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Expand the number of NAVIGATE teams in Iowa from 3 to 4.

Strategies to attain the goal:

Contract with a new NAVIGATE team provider, provide training and technical assistance to the new team.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: New NAVIGATE team will begin serving eligible individuals

Baseline Measurement: 0

First-year target/outcome measurement: Serve 10 individuals by 9/30/22

Second-year target/outcome measurement: Serve 25 individuals by 9/30/23

Data Source:

Data provided by team to DHS as part of contract

Description of Data:

Numeric and demographic data on individuals served by the team..

Data issues/caveats that affect outcome measures:

The team is new and may experience delays in recruiting eligible individuals for the NAVIGATE team. The team will be provided regular technical assistance from the state's TA provider to support implementation.

Priority #: 5

Priority Area: Develop Peer-Run Organizations

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase the number of peer-run organizations in Iowa

Strategies to attain the goal:

Issue an RFP for peer-run organizations to apply for MHBG funding.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased access to services provided by peer-run organizations through issuance of an RFP for up to 4 grants

Baseline Measurement: 0

First-year target/outcome measurement: State plans to award up to 4 grants to peer-run organizations.

Second-year target/outcome measurement: Peer-run organizations will provide services in accordance with contracts with DHS.

Data Source:

DHS contract monitoring.

Description of Data:

Reports, observation of DHS staff.

Data issues/caveats that affect outcome measures:

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
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: 7/1/2021 Planning Period End Date: 6/30/2022

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[c]		$0.00						$0.00		$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$564,138.00						$648,332.00		$1,119,845.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital								$0.00		$0.00
7. Other 24-Hour Care		$0.00						$0.00		$0.00
8. Ambulatory/Community Non-24 Hour Care		$4,445,178.00						$5,186,653.00		$5,458,768.00
9. Administration (excluding program/provider level)[e] MHBG and SABG must be reported separately		$282,069.00						$324,166.00		$559,922.00
10. Crisis Services (5 percent set-aside)[f]		$350,000.00						$324,166.00		$4,059,922.00
11. Total	**$0.00**	**$5,641,385.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$6,483,317.00**	**$0.00**	**$11,198,457.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

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

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

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

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

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Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems						
2. Infrastructure Support	$628,222.00	$100,000.00	$1,014,756.00	$630,054.00		$1,014,756.00
3. Partnerships, community outreach, and needs assessment	$459,637.00	$50,000.00		$459,637.00		
4. Planning Council Activities (MHBG required, SABG optional)	$80,000.00			$80,000.00		
5. Quality Assurance and Improvement		$183,333.00	$500,000.00		$66,667.00	$500,000.00
6. Research and Evaluation						
7. Training and Education	$562,000.00	$97,088.00	$0.00	$550,000.00	$48,274.00	$6,400.00
8. Total	**$1,729,859.00**	**$430,421.00**	**$1,514,756.00**	**$1,719,691.00**	**$114,941.00**	**$1,521,156.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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

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Footnotes:

Line 2-Five Points psychiatric bed tracking-FY 22 $28,222; FY 23 $30,054
Line 2 IDPH, 24 hour crisis line FY 22 $350,000; FY 23 $350,000
LIne 2 Abbe Center, statewide warmline and peer support services FY22 $250,000 FY23 $250,000
LIne 3 UI-CDD contract FY22 $309,637 FY 23 $309,637
LIne 3 Office of Consumer Affairs FY22 $150,000 FY23 $150,000
Line 4-staff support and expenses for MHPC FY 22 $80,000 FY 23 $80,000
Line 7-UI Peer Support Training FY 22 $500,000 FY 23 $500,000
Line 7-ESMI-NAVIGATE program training FY22 $62,000 FY 23 $50,000

COVID Supplement
Line 2-988 technical assistance and implementationFY22 $100,000
Line 3-SED/SMI needs assessment FY 22 $50,000
Line 5-Center of Excellence development for EBPs FY22 $133,333 FY23 $66,667
Line 5-CCBHC technical assistance- FY 22 $50,000
Line 7-Support for online training of behavioral health providers FY22 $66,667 FY23 $33,333
Line 7-Support for training of First Episode Psychosis programs. FY22 $30,421 FY23 $14,941

ARPA
Line 2-988 technical assistance and implementation FY22 $1,014,756 FY 23 $1,014,756
Line 5-Center of Excellence development for EBPs FY22 $500,000 FY23 $500,000
Line 7-Support for training of First Episode Psychosis programs. FY22$0 FY23 $6,400

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

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[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

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

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

Since 2013, Iowa has implemented Integrated Health Homes (IHH) for adults with a serious mental illness or children with a serious emotional disturbance. The goal of the IHH program is to integrate and coordinate physical health and mental health services to support improved outcomes for the targeted populations. IHH care coordination teams include a care coordinator, a nurse, and a peer support specialist or a family peer support specialist to provide holistic care coordination. Iowa has 36 IHH providers across the state. IHH services are provided by community mental health centers and other mental health providers. One CMHC is also an FQHC and provides medical and mental health services at the same sites. Iowa also has 12 CCBHC expansion grant programs, 9 of which are also IHH providers. The CCBHCs are required to coordinate physical and behavioral health services for individuals served and provide primary care screening and monitoring of key health indicators.

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

Options for Individuals with co-occurring mental health and substance use disorders to access integrated behavioral health services continue to increase in Iowa. Of the 23 accredited community mental health centers in Iowa, 17 are also licensed outpatient substance use disorder providers. This is an increase of 4 dually licensed/accredited CMHCs since the submission of the FY2020-21 MHBG plan. Provider associations represent both mental health and substance-use disorder providers. Twelve providers have been awarded CCBHC state grants to implement the CCBHC model of providing integrated mental health and substance-use disorder care in the same agency. The Departments of Human Services and Public Health (SMHA and SSA) have continued to work together on legislative workgroups and initiatives, including the complex needs workgroup and the children's state board. HF766 enacted in 2019 directed the Directors of the Departments of Human Services and Public Health to develop recommendations for the enhanced delivery of services for co-occurring conditions. The agencies submitted a report and five year plan in December 2019 that identified joint priorities including:
? Explore the certified community behavioral health clinic (CCBHC) model to build a joint statewide network of substance use disorder and mental health safety net providers (Safety Net Providers). The state currently has 12 CCBHC's; three of which are IPN providers for the SSA and 9 of which are CMHCs.
? Assess and align reimbursement rates for community mental health centers (CMHCs) and the substance use disorder integrated provider network (IPN)
? Evaluate Your Life Iowa at the end of three years allowing for time to gather data and provide a more complete assessment
? Explore the integration of mental health data and providers into Iowa Department of Public Health's integrated data system
? Collaborate on projects designed to reduce stigma in effort to create "no wrong door" access to care.

The two state agencies meet regularly to address the co-occurring plan and identify areas of collaboration and coordination.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ○ No

b) and Medicaid? ○ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ○ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ○ No

iii) hypertension ○ Yes ○ No

iv) high cholesterol ○ Yes ○ No

v) diabetes ○ Yes ○ No

c) Recovery supports ○ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ○ No

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

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

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

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

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

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

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

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

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

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

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

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

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

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

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

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

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

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

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

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

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

In 2015, Iowa implemented NAVIGATE, an evidence-based coordinated specialty care model designed to serve individuals experiencing a First Episode of Psychosis. Iowa currently has three teams located in three different population centers of the state.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Through the NAVIGATE team-based model, services are coordinated among the team members as well as with other needed services, including physical health services. Iowa's NAVIGATE programs include a community support worker to assist with access to community services and supports. NAVIGATE teams work in their local areas to expand awareness of the need for early intervention and availability of the NAVIGATE program. DHS staff also promote the program through presentations at conferences, the MHDS Commission, and the Mental Health Planning Council.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery ○ Yes ◉ No

supports for those with ESMI?

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

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

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Iowa continues to implement the NAVIGATE model through three teams with the plan to start a fourth team in FY22. NAVIGATE teams receive monthly technical assistance and fidelity monitoring from the DHS technical assistance provider.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

The state is using COVID19 Supplemental MHBG funds to start a fourth NAVIGATE team in Iowa. The team is expected to start orientation in November 2021 and will serve a part of Iowa currently not served by a NAVIGATE team.
In SFY22, the state is also funding intensive training in Supported Employment and Education (SEE) for the NAVIGATE SEE specialists.

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

Each NAVIGATE team provides data to DHS on a quarterly basis. Data points reported on include:
a. Total number enrolled during the quarter
b. Total number served by age: adult (18 and over), or under age 18.
c. Enrollment status: active or inactive
d. Employment and education status
e. Days of inpatient mental health care during the quarter
f. Number of services provided by each member of the NAVIGATE

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

Diagnostic categories include: Non-affective psychoses-Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, and Psychotic Disorder NOS

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

N/A

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP 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.

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.

N/A

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

Integrated health homes which provide care coordination for Medicaid-eligible individuals with an SED or an SMI and recipients of HCBS services, including the Children's Mental Health Waiver and HCBS Habilitation services are all required to use person-centered planning (PCP) processes. Person centered planning training has been offered to case managers and care coordinators. For HCBS services, PCP is a required in Iowa Administrative Code. Care coordinators and case managers meet with individuals and their families at the location of their choice to develop treatment plans, identify the individual's strengths, needs, preferences, and goals, and develop plans that reflect those goals. At a system level, the state engages consumers and their families through the Office of Consumer Affairs, peer/family support services to help individuals advocate for themselves and their families,, and collaboration with advocacy organizations such as NAMI.

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

The person centered 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 also described in Iowa Administrative Code 441.24 (3).

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

N/A

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

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

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

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

Please respond to the following 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

Please indicate areas of technical assistance needed related to this section

N/A

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DHS provides this policy guidance to CMHCs who use MHBG to assist clients with co-pays and deductibles for mental health services.

1. Agencies may use MHBG funds for services that are not typically reimbursed by third party payers. (examples-IHH care coordination, peer support)
2. MHBG funds can be used to provide direct services that are not funded through other resources if the need for the service is identified and included in the individual service plan. Use of block grant funding for mental health services for adults with SMI and children and youth with SED who are uninsured, underinsured and not eligible for regional funding is acceptable. Budgets need to use cost per unit of service and not personnel time, benefits, etc. Unit of service cost should be no more than allowable by regional funding. Include the CPT code and

unit rate for each service that is proposed for reimbursement.
3. All services are to be billed to appropriate third party payer when available. Third party sources include but are not limited to: private insurance, hawk-i, the Iowa Health and Wellness Plan, other Medicaid resources, CMH Waiver, Medicare, the MHDS Region as identified in the Region Management Plan, and/or other resources dedicated to funding of services before community mental health services block grant funding is used to pay for services.
Agencies are expected to actively assist consumers and parents of children with applying for other available third party resources (as referenced above). At any time a consumer obtains third party resources, those resources are expected to replace block grant funding to support the reimbursable service needs of the adult or child consumer.
4. An adult consumer's or parent's unwillingness or inability to complete an application for Medicaid or Hawki is not sufficient reason to use community mental health block grant funds for services that could otherwise be covered by that payer. The agency should assist the consumer in applying for possible programs. This should be done for services delivered on site and in other community settings such as but not limited to schools, supported employment sites, individuals' or families' homes.

Funds may not be used to:
-Provide inpatient services
-Make cash payments to intended recipients of health services
- Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment
-Satisfy any requirement for the expenditure of nonfederal funds as a condition for the receipt of Federal funds
-Provide financial assistance to any entity other than a public or nonprofit private entity
-Pay for salaries of administrators and supervisors not directly involved in carrying out the contract,
-Ongoing overhead costs such as space, utilities, clerical services, and accounting services or cost of any audits.
-Community mental health block grant funds cannot supplant existing resources dedicated to the funding of services.

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

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

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

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

Please respond to the following items:

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

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

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

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

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

Community-based mental health and substance use disorder (SUD) services:
Outpatient mental health therapy and psychiatry
Outpatient SUD services
Intensive outpatient /partial hospitalization -MH and SUD
Peer support/family peer support services for individuals with a serious mental illness (SMI)/parents of children with a serious emotional disturbance (SED)
Peer recovery coaching for individuals with an SUD
Behavioral Health Intervention Services
Habilitation-1915 I waiver for individuals with functional impairments due to a mental illness
Children's Mental Health Waiver-for children with an SED at risk of hospitalization
Integrated Health Home care coordination for adults with an SMI and children with an SED
Medication Assisted Treatment (MAT) for individuals with an SUD
Crisis Services-mobile crisis response, crisis stabilization-residential, crisis assessment, 23-hour crisis observation and holding
Inpatient mental health and SUD treatment
Assertive Community Treatment
NAVIGATE coordinated specialty care for individuals experiencing First Episode Psychosis (in limited areas)

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

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	( ) Yes (•) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

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

Description of the services are located in Step 1, Assessment of the Behavioral Health System.

3. Describe your state's case management services

Case management for Medicaid-eligible individuals with a serious mental illness or children with a serious emotional disturbance are provided through Integrated Health Homes (IHH) care coordination teams. Teams consist of a care coordinator, a nurse care

coordinator, and a peer support 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 service needs. For persons eligible for services through the Mental Health and Disability Services (MHDS) regions, IHH, or regional coordinators of disability services provide case management of regionally funded services.

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

MHDS Regions are required to have an array of crisis services available for all Iowans. These services include mobile crisis response services, crisis stabilization-community-based and residential, subacute mental health services, and 23 hour observation and holding services. MHDS Regions work closely with local law enforcement and judicial systems to divert individuals from involuntary hospitalization where appropriate by providing pre-commitment mental health evaluations and mental health evaluations in local hospital emergency departments. Local mental health providers who are part of the CCBHC expansion grants have developed coordination plans with inpatient psychiatric units to connect individuals with outpatient services and supports upon discharge.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	131,027	
2.Children with SED	44,614	

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 (2019). The state does not specifically calculate expected incidence of the target populations. The state plans services based on actual service usage, data collected from Iowa Medicaid and the MHDS regions, input from consumers, stakeholders, and funders on strengths and needs of the mental health system and direction of state and legislative leadership regarding overall system goals.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	○ Yes ◉ No
b)	Educational services, including services provided under IDE	○ Yes ◉ No
c)	Juvenile justice services	○ Yes ◉ No
d)	Substance misuse preventiion and SUD treatment services	○ Yes ◉ No
e)	Health and mental health services	○ Yes ◉ No
f)	Establishes defined geographic area for the provision of services of such system	○ Yes ◉ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Most MHDS regions are a combination
of rural and urban counties and are required to meet access standards to core services for all counties in their regions. The MHDS regions are working to increase access to services for individuals with an SMI in rural areas by ongoing support of ACT
teams and crisis mental health services in rural areas.

b. Describe your state's targeted services to the homeless population.

The SMHA manages the federal PATH program for individuals with a mental illness at risk of experiencing homelessness. Seven agencies provide PATH outreach services in rural and urban communities across the state. The MHDS Regions are working to develop supported housing programs to address needs of individuals with an SMI who are notable to maintain or obtain housing. The SMHA also works with the SOAR project to increase capacity of Iowa providers and agencies to assist individual in applying for SSI/SSDI. Access to disability assistance helps individuals obtain and maintain housing.

c. Describe your state's targeted services to the older adult population.

The SMHA provides oversight of the PASSR process which screens all individuals seeking admission to nursing facilities for mental health or intellectual disabilities. The SMHA coordinates training on this process with providers and works with the PASSR contractor to review treatment plans to ensure that individuals are receiving all appropriate services while in nursing facilities and are also provided supports needed to return to community settings when indicated. Iowa's PASSR process also emphasizes use of short-term stays in nursing facilities to encourage return to lower levels of care when appropriate.
Iowa also has an HCBS Elderly
Waiver which as of August 2021 had 7,618 enrolled members with no waiting list and 540 individuals in process to be approved for the waiver. Services provided on the Waiver include:
Adult Day Care
- Assisted Living Service
- Assistive Devices
- Case Management
- Chore
- Consumer-Directed Attendant Care (CDAC)
- Emergency Response System
- Home and Vehicle Modification
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Mental Health Outreach
- Nursing Care
- Nutritional Counseling
- Respite
- Senior Companions
- Transportation
- Consumer Choices Option

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

Describe your state's management systems.

The SMHA is Marissa Eyanson, Division Administrator, Division of Mental Health and Disability Services (MHDS), Iowa Department of
Human Services (DHS). Also housed within DHS are Iowa Medicaid Enterprise, the Divisions of Adult, Child, and Family Services, Fiscal Management, and Information Technology. MHDS works closely with other divisions of DHS to develop mental health policy and programs. The SSA is housed in the Iowa Department of Public Health (IDPH) The Director of DHS is also the interim Director of IDPH. The two agencies are engaged in a cross-agency process to explore options for aligning their programs, services and operations more closely in order to better serve the health and human services needs of Iowans.
DHS' estimated allocation for the MHBG in FY22 and FY23 is $11,282,770 based on the amount of the FY21 MHBG allocation. The state projects to expend $564,138 on administration, $1,128,277 on ESMI/FEP programs, $564,138 for crisis programs (5% set aside), and the remaining $9,026,217 on allocations to community mental health centers for services to individuals with an SMI or an SED not covered by Medicaid or insurance, training on EBPs, peer support/family peer support training, support for the statewide crisis line, MH Planning Council support, and other mental health system development projects.

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11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ○ No

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

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

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

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

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

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

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

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

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

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?	○ Yes ○ No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	○ Yes ○ No
3.	Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?	○ Yes ○ No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?	○ Yes ○ No
5.	Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.	

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

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

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

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

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

2. Crisis Intervention/Stabilization

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

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

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

Effective July 1, 2021, MHDS Regions are required to make a set of core crisis services available for adults and children. Step 1, Overview of the Mental Health System provides more detail on statewide crisis system services and implementation.

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

N/A

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16. Recovery - Required

Narrative Question

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

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

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

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

b) Required peer accreditation or certification? (●) Yes ( ) No

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

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

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

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

Peer support services are funded through Medicaid and are also a core service through the MHDS regions. Family peer support specialists for parents of children with an SED are also funded through Medicaid. Peer support and family peer support may be provided as part of the Integrated Health Home care coordination team for adults with an SMI or children with an SED, or may be provided as a standalone service. The MHBG funds training of peer support and family peer support specialists. Starting in 2021, the training will also include training for recovery peer coaches for individuals with an SUD. MHBG funds and MHDS regional funds also support wellness centers staffed by peers in several parts of the state. The state is planning to use COVID and ARPA MHBG funds to support peer-run organization development and operations.

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

IDPH, the SSA, leads development of recovery supports for individuals with an SUD. IDPH funds training of recovery peer coaches and funds recovery peer coach services through the Integrated Provider Network.

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

N/A

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

N/A

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

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

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

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

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

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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]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.

[65]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.

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

[67]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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ◉ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ◉ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Juvenile justice? ○ Yes ◉ No

c) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

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

The director of DHS is the co-chair, along with the director of the Department of Education of the Children's Behavioral Health System State Board. The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need. The Children's Board consists of 17 voting members appointed by the Governor. The Children's Board is co-chaired by the Department of Human Services and Department of Education. Members of the Children's Board were selected based on their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.
MHDS regions are tasked with providing access to a set of core services for children with an SED in their regions and are required to convene children's behavioral health services advisory committees which include representation from the following: education, parent/relative of a child who utilizes services, early childhood, child welfare, behavioral health service provider, juvenile court, pediatrics, child care, law enforcement and a regional governing board member. MHDS regions have also identified Regional Coordinators of Disability Services for every county who are available to help parents find mental health resources in their local area.

The SMHA also oversees four Systems of Care programs in Iowa which serve 14 of Iowa's 99 counties. The SOCs currently serve

children with an SED who are not Medicaid-eligible but require additional supports and services to be successful. The SMHA anticipates expanding to 6 SOC programs with the issuance of an RFP in September 2021.

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

The Iowa Department of Human Services includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:
• The State Mental Health Authority (the Division of Mental Health and Disability Services-C)
• The State Child Welfare Authority (the Division of Adult, Children, and Family Services)
• The Division of Field Operations which oversees local service areas and De-categorization boards, and
• The State Medicaid authority (Iowa Medicaid Enterprise).

Additional state and local agencies which have funding, service, or regulatory responsibility within the children's mental health system include:
• The Juvenile Court System,
• Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
• Department of Public Health which includes Title V programs, the Child Health Specialty Clinics, substance use disorder prevention and treatment, community health programs, home visiting, and suicide prevention programs
• Department of Human Rights
• Department of Inspections and Appeals

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

Iowa has a shortage of child psychiatrists. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs.
Additional detail about the Children's Mental Health System is located in Step 1-Strengths and Organizational Capacity of the System

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

N/A

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

N/A

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

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

Please respond to the following items:

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

2. Describe activities intended to reduce incidents of suicide in your state.

The Iowa Department of Public Health (IDPH) is the lead agency for Suicide Prevention in Iowa. IDPH's suicide prevention program works with communities and related partners to provide information about suicide risk factors, warning signs and protective factors and promotes the use of evidence based suicide prevention strategies. IDPH leads the Iowa Suicide Prevention efforts in Iowa and the Iowa Suicide Prevention Planning Group. This group of approximately 30 individuals meets quarterly and is comprised of state and local leaders active in suicide prevention, and welcomes members with lived experience. Members provide updates on programs and events, trends and the latest information about suicide prevention in Iowa. DHS staff are active participants in this group and provide key insight and updates on the status of mental health and crisis services in the state. Members of the Planning Group guide the development of the Iowa Suicide Prevention Plan which is currently in the process of being updated. A subgroup of the Planning Group has been meeting monthly to work on the priorities and objectives for Iowa in the next 5 years. DHS staff participate in these monthly meetings.
IDPH received the SAMHSA Zero Suicide grant in September 2018. The five-year grant aims to engage the 19 Integrated Provider Network agencies in implementing the Zero Suicide Framework. The framework is a systems-change model with the core belief that no person under care should die by suicide. IDPH is currently in Project Year 3 of the grant.
Your Life Iowa(YLI), a project of the Iowa Department of Public Health in collaboration with DHS, is the integrated hub/system for free and confidential help and information for mental health, alcohol, drugs, gambling and suicide. YLI offers 24/7/365 resources including a telephone helpline, mobile-friendly internet-based communications (e.g., online chat), texting and social media (@yourlifeiowa).

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

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ○ Yes ◉ No

If so, please describe the population targeted.

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

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

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?

N/A

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

N/A

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

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

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The SSA housed in IDPH leads planning and implementation of the prevention, SUD treatment, and recovery services. The MHPC includes representation from the SSA to encourage coordination and integration of mental health and SUD service systems. The SSA and SMHA regularly work together on issues of mutual concern.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. 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 by-laws which are attached to this document. The Council works collaboratively with the SMHA and has annual joint meetings with the state Mental Health and Disability Commission. MHPC members are also members of other advocacy organizations, work and volunteer to provide peer and family peer support, and advocate at all levels of government for individuals with an SMI or SED.
In response to question #1-SMHA staff held four meetings with a subcommittee of Council members to review the existing MHBG plan and solicit input. These meetings also included the SABG State Planner to provide opportunity for the MHPC to understand similarities and differences in each block grant and to discuss areas where the SMHA and SSA would be coordinating on the plans. Meetings were held on March 3, April 8, May 5, and June 2, 2021. Minutes of the last three council meetings and the four subcommittee meetings with the council are attached. DHS posted the draft plan for review on the DHS website on August 24 and notified the MHPC by email that the plan was available for comment and to send their comments to DHS by 5pm on Aug. 30. No comments were received.

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

N/A

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

June 2, 2021

Committee Members Attending:
Teresa Bomhoff
Ken Briggs, Jr.
Jim Donoghue
Theresa Henderson

Other Attendees:
Laura Larkin, Department of Human Services
Wendy DePhillips, Department of Human Services
Michele Tilotta, Department of Public Health

Meeting Discussion

Laura Larkin invited the committee to review the summary from the last meeting to ensure it correctly reflected the discussion. There was discussion regarding the decrease in workforce, specifically Licensed Independent Social Workers (LISW), psychiatric nurses, Advanced Registered Nurse Practitioners (ARNP), Physician Assistants (PA), Licensed Mental Health Counselors (LMHC), etc. as well as the direct workforce. There was discussion regarding statistics from Mental Health America that show Iowa as 45th in the nation for mental health workforce availability, and the need to review this report to determine how these statistics were obtained.

Laura Larkin reviewed the priority areas that are required by the Mental Health Block Grant (MHBG) including First Episode Psychosis or Early Serious Mental Illness program. There was discussion regarding the MHBG priorities from the 2019-2021 plan, the performance indicators for each priority, and the achievement of benchmarks. There was discussion regarding the difference in the report due to Substance Abuse Mental Health Services Administration (SAMHSA) in December on the 2019-2021 MHBG plan priorities and the priorities for the new MHBG plan for 2022-2023. It was noted that the plan will likely include a child-focused priority, an adult-focused priority, a community-focused priority and a priority that incorporates both mental health and substance use, which would be similar for both the MHBG and the Substance Abuse Block Grant (SABG).

Michele Tilotta reviewed the priority requirements of the SABG, including the set-asides, priority populations and priorities from the 2019-2021 plan. The priority populations and set-asides discussed included; primary prevention, treatment, women, individuals that inject drugs, and tuberculosis. It was noted that the next priorities will include the priority populations and set-asides noted, and will be based on the data that IDPH has received.

There was discussion regarding the new peer support training, which utilizes block grant funds, and is inclusive of mental health and substance use peer support specialists. This will likely be a priority area in the new MHBG plan and does cross over with IDPH. There was discussion regarding co-occurring treatment and the Iowa Provider Network (IPN.) More Community Mental Health Centers (CMHCs) are seeking to be dually accredited for both mental health and substance use. Certified Community Behavioral Health Clinics (CCBHCs) are dually accredited, and are driving this change as well. There was discussion regarding referrals and the need for a list of co-occurring providers. There was additional

discussion regarding Your Life Iowa, mobile crisis response, the implementation of 9-8-8, and the need to make it as simple as possible for people to find services, as there is a lot of confusion, about where to go to get help, or how to access services. There was discussion regarding assessments or evaluations, and where individuals can go to be evaluated so that needed services can be determined, and providers of these services found.

There was discussion regarding the workforce, including difficulty in hiring and retaining Independently Licensed Master's Level staff, as well as the fact that the workforce is aging, and providers are expecting significant retirements in the coming years. There was discussion regarding the need for recruitment and incentive strategies to help alleviate this issue.

There was discussion regarding the need to make sure that children's crisis services are indicated as a priority moving forward. There were conversations regarding the supplemental dollars, and the American Rescue Plan dollars coming into the state, and if these dollars will be addressed in the plan that is submitted.

There was discussion regarding assessing if there were educational opportunities for LMSW, LISW, and LMHC to have more of a foundation in substance use disorders so that they are more comfortable with providing treatment to individuals with co-occurring mental health and substance use disorder needs. There was discussion regarding the requirements for licensing of mental health staff.

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

April 8, 2021

Committee Members Attending:
Teresa Bomhoff
Jim Donoghue
Donna Richard-Langer

Other Attendees:
Laura Larkin, Department of Human Services
Wendy DePhillips, Department of Human Services
Michele Tilotta, Department of Public Health
Stephanie Yeoman, Department of Human Services

Meeting Discussion
The committee discussed the strengths and gaps of the current mental health system in relation to the Mental Health Block Grant (MHBG).

Strengths
- Significant progress has been made by the Mental Health and Disability Services (MHDS) Regions in relation to the dashboard charts submitted with the FY20-21 MHBG Plan. It was noted that these charts will be updated for the new plan.
- Dashboards – the creation and use of dashboards by the Iowa Department of Human Services (DHS). It was noted IDPH was continuing to work on dashboards. The IDPH has a website for public health data for various health reports and data, including substance Use and Gambling at https://tracking.idph.iowa.gov/Reports/Additional-Data-and-Reports
- COVID Recovery Iowa –Will need to continue this after the grant ends as it will leave a huge gap.
- Certified Community Behavioral Health Clinics
- First Episode Psychosis programs – expand to additional metropolitan areas.
- Loan repayment program for health care providers has expanded in Iowa and the National Health Service Core has expanded its loan repayment to include substance use counselors to be recognized in the Health Professional Shortage Areas.
- Crisis Intervention Training (CIT) – need to expand this statewide and to existing officers as it is primarily focused on new recruits.
- Serious Emotional Disorder Assessment Tool - universal tool that can be used by all providers. Developed through the Children Behavioral Health System State Board.
- Therapeutic Classroom grants
- Expansion of telehealth, including schools becoming a location for telehealth services
- Medicaid Reference Manual

Gaps
- Systems of Care is a great program, but is not open to enough people, specifically in rural areas.
- Lack of funding for peer-run organizations. These organizations fill a special role and are able to do things that no other provider does, including crisis service.

- Easy and obvious way for individuals to search for licensed and accredited providers of mental health services and substance use, possibly being able to filter based on specialty, city/county/region, type of service, etc. There was discussion about the search options and resources listed on the Your Life Iowa website.
- Mental health services for children
    - Crisis response services for children currently utilize a law-enforcement based model. Need to look at implementing an evidenced-based practice model like the STAR Model in Denver, CO or the CAHOOTS Model in Eugene, OR.
    - Access to school-based mental health. The ratio of school counselors and para-professionals to resource officers and the role of school counselors versus mental health providers was discussed as well as the limits of mental health providers in schools.
- Professional development training in relation to telehealth services.
- Community Collaboration of Supported Re-entry (CCSR) – done in the past and Iowa could benefit from doing this again.
- Services to marginalized or non-traditional populations – (e.g. individuals who lived with parents/caretakers and their parent/caretaker has died or become too frail to care for them, older adults, individuals with hoarding issues, etc.) It was discussed that these individuals typically don't access services the traditional way, services are often needed to be given in the home and typically their needs are often not known until there is a crisis.
- Services for refugee and minority populations, including a way to search for licensed providers by race/ethnicity.
- Post-partum mothers only have access to Medicaid for 60 days. For those who have behavioral health conditions it is difficult to maintain services.

Next Meeting

Look at strengths and gaps, identified priorities for the SABG. Look at section 1 &2 of the SABG.

Next meeting is May 5, 2021

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

March 3, 2021

Committee Members Attending:
Teresa Bomhoff
Jim Donoghue
Theresa Henderson
Donna Richard-Langer

Other Attendees:
Laura Larkin, Department of Human Services
Wendy DePhillips, Department of Human Services
Michele Tilotta, Department of Public Health

Meeting Discussion

Laura provided an overview of the Mental Health Block Grant (MHBG) requirements including the set-asides, priority populations, maintenance of effort and other federal requirements. There was discussion regarding the new set-aside requirement regarding crisis services. There was discussion regarding the fact that block grant funds are able to be spent over a two year period and the procurement and allocation process for the MHBG.

Michele Tilotta provided an overview of the Substance Abuse Block Grant (SABG) requirements including set-asides, priority populations, maintenance of effort (MOE) and other federal requirements. There was discussion around MOE and why it was done for both block grants

Michele and Laura noted that there were similarities between both block grants, but there were significant differences as well, including;

- Input/Public Comment - Iowa Board of Health is the advisory board for the SABG, and fulfills a similar role as the Iowa Mental Health Planning and Advisory Council (MHPC) does for the MHBG. However the MHPC will have the opportunity to provide public comment into the SABG and the Integrated Provider Network (IPN) will be able to provide input to the MHBG. Please note that other providers as well as the public will be able to provide comment as well for both block grants.
- Additional amendment requirements for the SABG – e.g. Synar Amendment -enactment and enforcement of laws prohibiting the sale or distribution of tobacco products to individuals under the age of 21.
- Contracting differences – SABG funds, including set-asides go out into six year contracts, through a competitive RFP process, with the Integrated Provider Network (IPN.) IDPH is the pass through to the 20 providers who have to provide primary prevention, SUD treatment and Problem Gambling under an integrated RFP. This can include adult and juvenile residential services, women and children treatment, primary prevention, problem gambling, and methadone treatment. MHBG – DHS contracts with providers utilizing a procurement process. Doesn't fund nearly as many services as the SABG. There is a focus on evidence based training and development of those services.

- State Appropriation – IDPH receives a state appropriation for addiction services, but DHS does not receive state appropriation funds related to mental health that can be used to supplement the MHBG.
- Restrictions – MHBG cannot fund residential or inpatient services, but the SABG funds all ASAM levels of care excluding Detoxification inpatient hospital care services.

Laura Larkin reviewed the Mental Health Planning Council portion of the MHBG plan as well as the Council's role. Laura reviewed the plan formats for the SABG and MHBG, noting the similarities between both.

- Same templates are used for both block grants but different areas may or may not need to be completed.
- Planning steps is a section that both plans have do. One of the beginning steps at integrating will be an overview of behavioral health system (one big system) – this section will include shared projects, collaborations, legislative needs and will be a coordinated effort between the two departments.

Laura and Michele reviewed some of the similarities and differences of both the MHBG and SABG.

- IDPH - data drives priorities as well as Director directives.
- Look to identify a joint priority to work on IDPH & DHS – Some suggestions from the Council included:
    - Integration process
    - Crisis services
    - Homelessness
    - 18 of our 23 CMHC are also licensed and accredited substance use providers.

Laura noted that in the past we have reviewed the past MHBG plan, what we did last time and how we did it, what do we want to continue, what are the gaps in the system and update what has changed. Laura noted that data is looked at with regards to gaps in the system, however IDPH has a much more robust data system for the SABG than is available for the MHBG, but data reports are utilized.

<u>Next Meeting</u>

Committee members were asked to look at the comments provided by the MHPC committee on the previous MHBG related to gaps/concerns, and determined what suggestions they have for changes and if there is data that they are aware of that supports the gap.

The group will be focusing on Step 1 and Step 2 of the block grants (strengths and gaps) at the next meeting with the MHPC Block Grant Committee. Members were encouraged to review these sections from the last block grants and come back with feedback for the next meeting.

Next meeting is April 8, 2021

Iowa Mental Health Planning and Advisory Council
Mental Health Block Grant Application Committee

May 5, 2021

Committee Members Attending:
Teresa Bomhoff
Ken Briggs, Jr.
Jim Donoghue
Theresa Henderson
Donna Richard-Langer

Other Attendees:
Laura Larkin, Department of Human Services
Wendy DePhillips, Department of Human Services
Michele Tilotta, Department of Public Health
Stephanie Yeoman, Department of Human Services

Meeting Discussion

Laura Larkin invited the committee to review the summary from the last meeting and provided some updates from the previous meetings including that the Department of Human Services (DHS) is filing for an extension to the FEMA disaster grant, COVID Recovery Iowa, and the adding of another First Episode Psychosis (FEP) program in the state. Teresa Bomhoff mentioned that data related to seclusions and restraints should be added to the gaps for the Mental Health Block Grant plan. This issue or gap was not discussed in the last meeting.

Michele Tilotta reviewed what was currently in the Substance Abuse Block Grant (SABG) for needs and gaps and how they are identified as well as the current planning priorities and key findings. The committee discussed the strengths and gaps of the current health system in relation to the SABG, including what data is used and how recent it is, and how qualitative or anecdotal information is added to both the Mental Health Block Grant (MHBG) and the SABG. There was discussion regarding the differences in SABG versus the MHBG related to goals and data priorities, as well as funding guidelines and restrictions specific to the SABG. There was discussion about how DHS and IDPH could structure parts of the MHBG and SABG similarly to ensure continuity between the two documents

Strengths

- IDPH Data Portal https://tracking.idph.iowa.gov/ which has information and reports that can be found regarding a number of topics related substance use as well as other health topics.
- Increase in free access to Naloxone and education on its use has been very beneficial.

Gaps

- SUD providers are state certified in Iowa, which is not recognized as the same as licensed by insurance companies. There have been an increased number of suicides as well as opioid-related deaths over the past several years.
- Hard to identify providers with Master's-level experience in substance use as there are few or no programs specifically for a degree in substance abuse counseling. Individuals who are licensed at the independent level of practice (LISW, LMHC, LMFT's) can provide SUD services

within the scope of their license and who work within facilities who are licensed to provide SUD evaluation/treatment services.

- Lack of BH workforce in general was identified as a concern. Planning Council using UI data as a resource to identify numbers of psychiatrists and other MH professionals in IA.
- Data and resources specific to the LGBTQ population. This is also a gap for the MHBG.
- Limited amount of SUD/co-occurring beds for kids. IDPH licenses juvenile services and contracts these services through the IPN and there are juvenile services available outside the IPN.
- Tracking of waiting lists for residential facilities for both mental health and substance use. MHDS does not track specific provider waiting lists only the MHDS Regions waiting lists. SABG regulations require tracking of SABG waitlists and the IPN providers track this. In July, the new data system will have a waitlist capacity management system.
- Concerns about future of telehealth, will audio-only telehealth continue to be allowed, plan should reflect pros/cons of telehealth
- Concerns about LGBQT behavioral health services, and the effect on Trans kids' mental health related to current public efforts to curtail their rights.
- Increasing suicide rate and opioid overdose rates per IDPH data
- Concerns about seclusion and restraint of youth in schools.

Next Meeting

Look at planning priorities for the MHBG and the SABG, and bring any additional comments or questions that need to be included when drafting the new plans.

Next meeting is June 2, 2021

Mental Health Planning Council
March 17, 2021 9:00am to 3:30pm
Zoom
Meeting Minutes – Approved May 19, 2021

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs
Rachel Cecil
James Cornick
James Donoghue
Jacquie Easley
Kyra Hawley
Theresa Henderson
Vienna Hoang
Michael Kaufmann
Dawn Kekstadt
Earl Kelly
Anna Killpack
Todd Lange
Katie McBurney
Ed Murphy
Hannah Olson
Donna Richard-Langer
Brad Richardson
Jennifer Robbins
Kristin Rooff
Dennis Sharp
Dr. Shaad Swim
Heather Thomas
Michele Tilotta
Brook Whitney

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Kris Graves
Julie Kalambokidis
Matthea Little Smith

OTHER ATTENDEES:

Theresa Armstrong
Charles Bruner
Wendy DePhillips
Rose Kim
Marisa Mickunas
Todd Noack
Libby Reekers
Jordan Rico
Flora Schmidt
Nancy Tepper
Jenn Wolff
Dale Woolery
Stephanie Yeoman

Materials Referenced:
January 28, 2021 Meeting Minutes
Iowa Mental Health Planning Council March 17, 2021 Agenda
Office of Drug Control Policy (ODCP) PPT Presentation
Office of Statewide Clinical Education Programs (OSCEP) Workforce Overview PPT Presentation
SFY2020 MHDS Regions Statewide Dashboard SFY2021Q2
Iowa Helping Community Policy Group PPT Presentation
Iowa Helping Community Policy Group – Mission and Q&A
Iowa Helping Community Policy Group – Letter on Rescue Act
First Episode Psychosis – RESTORE PPT Presentation
Block Grant Research on Peer Run Organizations

Welcome and Introductions
Teresa Bomhoff called the meeting to order at 9:02 am and led introductions. Quorum was established with 18 members.

January 28, 2021 Minutes Approval
Donna Richard-Langer noted that the minutes should be modified to include direction by the Chair to establish a workgroup to look at peer-run organizations. Todd Lange made a motion to approve the minutes with this modification, Donna Richard-Langer seconded the motion. Minutes were unanimously approved.

Committee and Workgroup Reports
Nominations Committee
Brad Richardson informed the Council that there were currently six vacancies on the Council, four for a parent of a child with Serious Emotional Disturbance (SED) or a provider for children with SED and two vacancies for individuals in recovery. Brad noted that the Nominations Committee had received applications for the two vacancies.

Kris Graves, has previously served on the Iowa Mental Health Planning and Advisory Board and would like to return to fill one of the individual in recovery vacancies. Kris is currently working on completing her training as a Peer Support Specialist.

Edward “Ed” Murphy has also applied for one of the individual in recovery vacancies. His application included several references including a reference letter from Life Connections where he works.

Brad Richardson motioned to approve both individuals for membership, Todd Lange seconded the motion. The motion passed.

Brad noted the Nominations Committee has not received any applications for the four vacancies for a parent of a child with SED or provider for children with SED. There was discussion about reaching out to the University of Iowa Family Support Specialists regarding these vacancies

Teresa Bomhoff reviewed the agenda for the March meeting, including additional pages that include the schedule for future meetings, the 2021 Mental Health Planning Council (MHPC) recommendations to Mental Health and Disability Services (MHDS) for block grant funding from the Monitoring and Oversight Committee, priorities for the current Mental Health Block Grant (MHBG) as well as the Iowa Department of Health’s Substance Abuse Block Grant priorities. Additional pages of the agenda document included the MHBG numbers provided by the Monitoring and Oversight Committee, a listing of current DHS staff in key positions, links to the DHS Community Integration and Strategic Plans, links to a list of substance abuse providers, private mental health providers, Community Mental Health Centers (CMHCs), and Federally Qualified Health Centers (FQHCs), information regarding Certified Community Behavioral Health Clinics (CCBHCs), and a listing of Iowa State Association of Counties (ISAC) legislative priorities, the MHDS Commission priorities, as well as UnityPoint’s legislative priorities, noting the commonality between the three.

Monitoring and Oversight
Donna reported that the committee met in February to look at the current Systems of Care contracts. Currently there are four contracts for Systems of Care, which include Community Circle of Care with the University of Iowa, Orchard Place, Four Oaks and Tanager Place. SOC consists of wrap-around

services for kids and families. It utilizes flexible funding as well as functional assessment tools to determine outcomes of success. It also provides follow-up after discharge. The committee supports the kinds of services that SOC provides, and recommends to look at how we replicate across the state so that other rural areas have the opportunity to access this type of service. It was noted that this was a goal of the Children's Board. Currently the different SOC contractors use a different functional assessment tool which makes it difficult to compare between the programs. The committee recommended that the providers use a similar tool to make the comparison easier.

Donna provided an overview regarding how and why the Mental Health Planning Council (MHPC) provides recommendations for the MHBG. It was noted that Your Life Iowa and the State Warm Line contract meets many of the recommendations that the MHPC has made for services to Iowans as is statewide and available to everyone. Donna reviewed the Monitoring and Oversight Committee's 2021 MHPC Recommendations to MHDS for Block Grant Funding listed on page 2 of the agenda, which include expanding Systems of Care statewide, and expanding access to services and funding to rural communities.

There was discussion regarding adding peer-run organizations as a recommendation specifically when looking at services in rural communities. There was discussion regarding adding recommendations regarding telehealth and refugee mental health services (EMBARC.)

Donna reviewed the purpose of the Peer-Run Organizations Subcommittee, which consists of Donna Richard-Langer, Todd Lange, Hannah Olson and Theresa Henderson. Donna noted that it is an ad-hoc committee of Monitoring and Oversight, and met twice since the last Planning Council meeting. Donna commented that other states have used both Mental Health and Substance Abuse Block Grants to assist peer-run organizations and the group is excited to take a look at this option.

Todd Lange acknowledged the work of the other subcommittee members and provided a summary on block grant research on peer-run organizations. Hannah Olson provided additional information regarding current Medicaid funding of peer support services. Donna indicated that the next step of the group is to meet with the three peer-run organizations to take a second look at the committee's recommendation and what that should look like exactly.

There was discussion regarding funding of peer-support and peer-run organizations, challenges, credentialing, Chapter 24 accreditation, and clinical bias.

Public Safety

Brad Richardson introduced Dale Woolery with the Governor's Office of Drug Control Policy (ODCP) and the Iowa Drug Policy Advisory Council who provided an overview of ODCP and its Advisory Council including its priorities, challenges, state trends, and current pilot projects.

There was discussion regarding SF363, which proposes to use tobacco funds to go towards funding for specialty courts, the Sequential Intercept Model and whether it has been developed for kids, the work being done in the 5th Judicial District towards being more trauma-informed, and treatment courts.

Mental Health Workforce

Greg Nelson, Director/Assistant Dean, from the Iowa Health Professions Tracking Center in the Office of Statewide Clinical Education Programs (OSCEP) with the University of Iowa Carver College of Medicine presented an overview of the mental health workforce in Iowa, specifically as it relates to Physicians (Psychiatrists), Psychologists, Physician Assistants, and Advanced Nurse Practitioners,

including distribution of mental health professionals across the state, age and gender analysis of mental professionals in Iowa, why psychiatrists leave Iowa, and psychiatric residency programs in Iowa.

There was discussion regarding how to increase the number of people of color in the healthcare professions, as well as regarding incentivizing psychologists to obtain the training needed to prescribe medications.

Regional Report
Rose Kim with the Division of Community Mental Health and Disability Services introduced herself and reviewed the SFY2020 statewide report including 2nd quarter regional data. Rose stated the first half of the dashboard is from data that Regions submit in December for FY2020. The second half includes data that the Regions submit on a quarterly basis. The information is self-reported by the Regions who have their way of verifying they meet the access standards. Rose noted that there were some changes in the data due to counties leaving or joining regions, COVID and individuals transitioning to Medicaid.

There was conversation regarding dual diagnosis, how Regions are utilizing peer support (wellness/recovery drop-in centers), drop in expenditures for Intellectual Disability (ID) services, differentiating between service and administrative costs, and mobile crisis.

Iowa Helping Community Policy Group
Charles Bruner and Tammy Nyden of the Iowa Helping Community Policy Group presented an overview of their organization and its mission to advance federal and state policies that recognize and support those in the helping fields – paid and unpaid – in their vital roles in society. The presentation included a brief history of the organization, the who, what, how and why of its activities, current policy opportunities and actions, data on Iowa's helping community workforce, and how the Mental Health Planning Council can help the Policy Group and how they can help the Council.

There was discussion regarding the American Rescue Plan Act, the Mental Health Block Grant, the importance of the work that the Policy Group is doing, direct care staff needing to be an area of focus within the greater workforce issue, importance of the work of direct care staff and the need for a living wage, and recommendation that the Policy Group reach out to the Iowa Business Council.

Presentation on First Episode Psychosis (FEP) Navigate Model
Marisa Mickunas, LMHC with Eyerly-Ball provided a presentation on their First Episode Psychosis (FEP) program, RESTORE. This presentation included a background on FEP, benefits of this service, how many clients served, outreach, and RESTORE team members at Eyerly Ball. Marisa noted that the three FEP programs in the state work collaboratively and with a technical assistance (TA) contractor to ensure fidelity to the Navigate model. Marisa provided more specific information about the model, the successes and challenges for FEP participants as well as treatment interventions.

There was conversation regarding the history of FEP. It was noted that Eyerly Ball was the first FEP program in Iowa, but was also one of the first in the nation as part of the national pilot project.
There was also discussion regarding the engagement team, funding, types of therapies used, and the similarities and differences to Assertive Community Treatment (ACT).

DHS Update
Public Consulting Group was the successful bidder for the contract to work on the alignment of the Department of Human Services and the Iowa Department of Public Health. No information yet on next steps regarding this contract.

DHS just launched DHS Dashboards which has data on specific areas of DHS including Medicaid, Child Welfare and Facilities. MHDS Community doesn't have a dashboard as of yet. The dashboards are an effort to be more transparent with the public and communicating about what DHS does. DHS Dashboards can be found at: https://dhs.iowa.gov/dashboard_welcome.

MHDS Regions

Regional changes beginning July 1, 2021, pending signing agreements; Cerro Gordo, Hancock, Webster and Wright counties have been accepted by the Central Iowa Community Services (CICS) Region; Pocahontas and Humboldt counties have been accepted by the Rolling Hills Region, and Emmett County has been accepted to the Sioux Rivers Region.

Substance Abuse Mental Health Services Administration (SAMHSA) Updates

DHS received a Notice of Award for $6.48M in additional funds for the MHBG through the American Rescue Plan Act (ARPA). These funds are in addition to the regular MHBG allocation and have to follow the same set-aside guidelines (10% for FEP and 5% for crisis services.) These are one-time dollars with two years to spend (3/2021 – 3/2023). MHDS will be accepting feedback on how to utilize these one-time dollars. These funds will be tracked separately from the regular MHBG award which is $5.6M for FY21 with a 10% set-aside for FEP and a 5% set-aside for crisis services. The crisis service threshold is met currently with Your Life Iowa.

The Substance Abuse Block Grant (SABG) will also be receiving funds as well as additional funds for grants for Certified Community Behavioral Health Clinics (CCBHC). March 10, 2021 was the deadline for the CCBHCs to submit a new proposal application. Two providers were recently awarded grants to become CCBHCs. These providers include Community Health Centers of Southern Iowa and Heartland Family Services. This brings the total to 10 CCBHCs throughout the State. There was discussion regarding credentialing of CCBHCs.

In the ARPA there are things that Medicaid will need to analyze and determine how it will affect the State, including 10% increase for Home and Community Based Services, FMAP increase, and enhanced FMAP for qualified mobile crisis intervention services.

988 Planning Grant

IDPH and DHS wrote for and were awarded a planning grant for the implementation of 988 within the State. These grants are from SAMHSA through their contractor Vibrant and support technical assistance to the State to implement 988. IDPH and DHS are working collaboratively and have established a Coalition consisting of family members and individuals with lived experience, as well as individuals from the two current National Suicide Lifeline crisis center providers, the MHDS Regions, mobile crisis response providers, and others. The Coalition will meet monthly beginning in. The Coalition will be developing a strategic plan for the implementation, how to address gaps and funding for 988. The draft plan is due to Vibrant by August 30, 2021 with the final implementation plan due to both Vibrant and SAMHSA by the end of the year.

COVID Recovery Iowa

Behavioral health outreach related to the pandemic and Derecho. Funding is through a FEMA behavioral health disaster grant. DHS received their federal review and have been asked to write for an extension, which is not typical for FEMA grants. The current grant ends in June. The extension would allow for services to continue past June. DHS will be submitting an extension, but doesn't yet have

particulars about how long the extension will be or the amount of additional funding, if any will be provided.

Request for Proposals (RFP)

All bids are in for the Peer Support, Family Peer Support and Recovery Peer Coaching RFP. DHS hopes to announce the successful bidder on April 7, 2021. An RFP for the Projects for Assistance in Transition of Homelessness (PATH) contract was just released. This is a SAMHSA grant that is awarded to every state to provide supports and outreach to individuals that are homeless or at-risk of becoming homeless who also have a serious mental illness. Services include outreach, coordination of services, and assistance with increasing employment and opportunities for individuals. Programs must be within metropolitan areas of the state. Currently have seven contractors with programs in Cedar Rapids, Davenport, Dubuque, Sioux City, Council Bluffs, Des Moines, and Waterloo. Proposals for this RFP are due April 14, 2021, and hope to announce successful candidates on May 12, 2021.

Children's Behavioral Health System State Board

Children's Board met March 9th, with their next meeting scheduled for May 11th. The Board decided to move from quarterly to bi-monthly meetings. Some topics discussed included a presentation by the Department of Education regarding Therapeutic Classrooms and current grant applications pending that are due April 30th, information from Dr. Pedati from the Iowa Department of Public Health (IDPH) about an increase IDPH is seeing in data regarding self-harm in female adolescents. The Board is looking at the intersection of law enforcement and kids, which included a presentation on Sequential Intercept Model (SIM) in February, and a March presentation on national juvenile assessment centers and the developing juvenile assessment center in Scott County as well as a presentation regarding Crisis Intervention Training from Joe Smarro with SolutionPoint +. The Children's Board also had a presentation from Janee Harvey with DHS, Division of Adult Children and Family Services on Families First legislation.

Employment for Persons with Serious Mental Illness

DHS received notification that the state was awarded the Aspire grant, which is a grant from the Office of Disability Employment Policy (ODEP). This grant provides technical assistance for employment for persons with serious mental illness. There will be a stakeholder group that will work to put a plan together to sustain supported employment, specifically Individual Placement and Support Model of Supported Employment (IPS). IPS is an evidenced-based practice of supported employment. There are currently a couple pilots that are occurring in the state that are financed by the MHDS Regions and a current ODEP grant that is ending.

Legislation

The following bills have passed the first funnel.

- SF461 is related to MHDS Regional Governing Boards, would only allow County Board Supervisors to vote on any matters related to expenditures to the MHDS Regions.
- HF773 is related to 1115 waiver that allows funding in the Institutions for Mental Diseases (IMDs). Currently Medicaid cannot fund services for adults in IMDs. The bill instructs DHS to do a scan of the State's current mental health services, and look at the impact and benefits of the waiver, and provide a report to the legislature.
- SF526 is related to access centers. As written, it changes Chapters 125 and 229, with regards to non-voluntary commitments of substance use disorder and mental health, and puts access centers as one of the facilities that can detain individuals on an involuntary hold. There was discussion regarding SF526, current access centers and functioning, as well as issues and concerns of the bill.

- SF524 is related to Inpatient Psychiatric Bed Tracking, would direct DHS to form a study committee of hospital associations, MCOs, law enforcement, private payer of services, a county mental health advocate to look at how to expand the acuity of what hospitals can take to meet the demands of the individuals in need of services. Also includes enhancements to the bed tracking system that would enable it to be more of a real-time system.
- Telehealth related bills (HF294, HF784, and HF731). There was discussion regarding HF431 which is related to audio-only telehealth which also passed the first funnel.
- HF196 is related to expanding the Healthcare Professional Recruitment Program which would expand the program, which is currently only at Des Moines University, to other state universities.
- SF513 is related to reports generated by law enforcement and that reports that are related to mental health or substance-related crisis should be confidential. There was discussion about SF528 which enables an Electronic Health Record (HER) to be used versus filling out the paper committal.

Public Comment
Todd Noack, LifeConnections, provided comment that he and Ed Murphy are currently the only advanced-level facilitators for WRAP in the state, but by the end of June there will be 60 WRAP facilitators throughout the state. Todd also expressed concern regarding an email that he received from LifeConnections CEO regarding questions that DHS had asked about peer-support training and WRAP, and wondered why this information was asked of them and not directly to the DHS-MHDS staff that manages the Peer-Support and Family Peer-Support Training contract with the University of Iowa. There was discussion that CEOs were asked at a recent Regional CEO meeting about good trainings that the Regions are engaging in, and coupled with Todd's experience that this was possibly project management staff outside of DHS-MHDS that are looking for information about strengths across the state and weren't aware of peer-support specialist training or WRAP. Todd also shared that he had a recent meeting with Senators Edler and Costello where they discussed issues related to peer-support, and asked for support.

The Mental Health Planning Council took a break at 12:45 p.m. and reconvened at 1:02 p.m.

Adjourn
Donna Richard-Langer motioned to adjourn, Heather Thomas seconded the motion. The motion passed unanimously. The meeting adjourned at 3:21 p.m.

Mental Health Planning Council
May 19, 2021 9:00am to 12:00 pm
Zoom
Meeting Minutes – Approved July 21, 2021

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Rachel Cecil
James Cornick
James Donoghue
Jacquie Easley
Kris Graves
Kyra Hawley
Theresa Henderson
Vienna Hoang
Michael Kaufmann
Dawn Kekstadt
Earl Kelly
Anna Killpack
Todd Lange
Katie McBurney
Edward Murphy
Hannah Olson
Donna Richard-Langer
Brad Richardson
Jennifer Robbins
Kristin Rooff
Dennis Sharp
Dr. Shaad Swim
Heather Thomas
Brook Whitney
Representative Bob Kressig

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Kenneth Briggs
Julie Kalambokidis
Michele Tilotta
Representative Ann Meyer
Senator Nate Boulton

OTHER ATTENDEES:

Theresa Armstrong
Emily Berry
Wendy DePhillips
Megan Freie
J. Gibbons
Emma Hall
Todd Noack
Denise Rathman
Libby Reekers
Flora Schmidt
Sandy Swanson
Gano Whetstone

Materials Referenced:
March 17, 2021 Meeting Minutes
State Training School Court Monitor Initial Report
Iowa Mental Health Planning Council May 19, 2021 Agenda
SF619 – Division XXV Mental Health Funding

Welcome and Introductions
Teresa Bomhoff called the meeting to order at 9:00 am and led introductions. Quorum was established with 20 members.

March 17, 2021 Minutes Approval
Jacquie Easley motioned to approve the minutes. Todd Lange seconded the motion. Minutes were unanimously approved.

Committee and Workgroup Reports
Nominations Committee
Brad Richardson informed the Council that there were currently five vacancies on the Council, four for a parent of a child with Serious Emotional Disturbance (SED) and one vacancy for individuals in recovery. Brad noted that the Nominations Committee had received one application for a professional supporting the needs of a child with SED.

Jen Gomez, is a family member of an adult with a serious mental illness, and currently works with Sioux City School District as the director of student services and equity education, and was previously the director of special education as well as a counselor. Jen shows a great interest in supporting the mental health needs of children and would help bring diversity to the Planning Council and has a strong involvement in the community.

Brad entertained a motion to accept Jen Gomez for membership to fill one of the vacancies for parent of child with SED due to her work with the school district. Jim Cornick motioned to approve Jen Gomez for membership and was seconded by Jim Donoghue. The motion passed unanimously.

There was discussion regarding vacancies and attendance of membership. It was noted that Matthea Little Smith has resigned her position on the Planning Council and that is why there is an opening for an individual in recovery.

Monitoring and Oversight
Donna Richard-Langer reported on the funding request to DHS regarding the $6.48M additional dollars for the Mental Health Block Grant to be used over the next two years. The turnaround on this request was very quick as the plan had to be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA). Four recommendations for funding were requested including:

- Utilizing a Request for Proposal (RFP) process, fund 3-5 peer-run projects throughout the state. Todd Lange shared background information regarding the presentation of the three peer-run organizations at the January IMHPC meeting and the research completed and presented at the March IMHPC meeting was shared with Council members. Todd also shared a link from a House Human Services/SAMHSA presentation https://www.youtube.com/watch?v=Po09sFE-mas encouraging states to utilize peer-support and peer-run services.
- Expand Systems of Care to additional areas across the state, particularly rural areas.
- Certified Community Behavioral Health Centers (CCBHCs), currently have 10 CCBHCs throughout the state and up to four more considering becoming CCBHCs. Often initial funding is not enough and additional funds were requested to assist with this.
- More outreach and funding opportunities for mental health services for marginalized and non-traditional populations that don't receive services in a traditional manner. Realize this may be a more difficult ask as it is hard to be specific about what is needed.

There was discussion regarding the allocation of the dollars and the process for approval of the plan including what specifically the plan will be when it is approved.

Donna noted that the committee reviewed the new Peer Support, Family Peer Support and Recovery Peer Coaching Training contract at the May meeting. The contract was issued to the University of Iowa, National Resource Center for Family Centered Practice. There will differences in this contract that meet some of the request for changes made previously by the Planning Council including those related to workforce. LifeConnections will be subcontracting, and the University is looking for a peer-support specialist to be the project manager. The plan is to look at qualitative as well as quantitative data. The new name of the contract is Iowa Peer Support Collaboration.

Donna questioned whether the Planning Council members are getting what they need from the Monitoring and Oversight Committee. What do the Council members want to hear? What information do you find important? Donna noted that committee was looking at a more systematic way to review contracts and would be looking at this issue at their next meeting. There was discussion regarding providing all Planning Council members with the minutes to the meeting as well as what information the committee should receive and how often, including financial information and reports. It was noted that DHS has sent a report in the past showing dollars spent for block grant contracts. There was discussion regarding drafting an annual executive summary that would pull information together in a brief statement to show strengths and issues regarding MHBG contracts and dollars spent, and sharing this information with the Planning Council. There was continued conversations regarding tracking on the additional MHBG dollars being issued.

Children's Workgroup

Earl Kelly summarized the concept paper developed last fall that would create a unit at the University of Iowa Hospitals & Clinics that would allow for in-depth evaluation of high-need children/adolescents. The paper was approved by the Planning Council and committee members had a meeting with DHS. The committee received a memo from DHS stating that they have interest in the concept paper and are working on developing intersection points regarding access and gathering stakeholder feedback.

Teresa Bomhoff informed Council members that she attended the March Children's Board meeting and encouraged others to attend if they had interest. Teresa noted some topics included children's crisis services, workforce report and recommendations, overview of the Iowa Youth Survey as well as a metrics and screenings report

Public Safety Workgroup

Brad Richardson indicated the committee was following up with Dale Woolery of the Office of Drug Control Policy (ODCP), who presented at the March meeting. They are circling back regarding their intersection of the ODCP legislative priorities with those of the Planning Council to find common areas to work on together. These priorities include law enforcement and individuals with mental illness, conversations regarding access centers, the Sequential Intercept Model (SIM) and being more trauma-informed in the courts.

Brad noted the committee needed to meet again to have someone assume the leadership role as Matthea Little Smith has resigned her position on the Council.

Mental Health Block Grant Workgroup

Teresa Bomhoff provided an overview of the current work of the Mental Health Block Grant (MHBG) Workgroup to provide input and feedback for the MHBG plan and the Substance Abuse Block Grant

(SABG) plan. The workgroup has been meeting monthly since March, and that the meetings were going well. Teresa stated that it was beneficial to look at these two plans together, noting the overlap, so that the plans can be efficient and effective moving forward. Laura Larkin and Michele Tilotta, who are the block grant planners for their respective departments, work together well. It was noted that there was a lot of good things happening, but there were still significant gaps and questions on why certain programs haven't been or aren't being expanded. Teresa reviewed the topics for the past meetings including a focus on the differences between MHBG and SABG in March, the strengths and gaps in the MHBG, including Systems of Care, peer-run organizations, alternative models for children, telehealth, and supported re-entry, in April, and the strengths and gaps in the SABG as well as additional things happening with the block grants. Laura and Michele will decide if a June meeting is necessary.

In-Person Meetings Discussion
Todd Lange reviewed an email he sent regarding the return to in-person meetings, and the possibility of utilizing a hybrid meeting option that allows individuals to use Zoom to connect. Todd shared his experience with hybrid meetings in the MHDS East Central Region and how this approach could be utilized for public meetings, including the Mental Health Planning Council. Equity and accessibility issues were raised noting that a hybrid option that was not just telephonic would help address these issues. This approach appears to be effective for MHDS Regions, and there could be an opportunity with federal dollars coming in to look at teleconferencing/video capabilities so that a hybrid approach could be utilized by the advisory boards. It was noted that logistics could be an issue and would need to be examined as meeting locations often differ for meetings.

There was discussion about the equipment needed and whether or not it would be shared or if more than one set would be needed. It was noted that DHS is looking at this option for meetings. There was discussion regarding the anticipated timeline to return to in-person meetings. It was noted that DHS is currently looking at what return to work, specifically DHS Central Office will look like, but is open to further discussion.

State Training School (STS) Court Monitor Report
Teresa Bomhoff reviewed the court monitor's report regarding the Boys State Training School (STS) in Eldora and noted that she was encouraged by the direction that STS was going, and impressed with the changes that have been and are being made.

There was discussion regarding the impact with county attorneys not viewing STS as a secure setting and if kids would be referred to the adult detention setting. There was discussion regarding inviting Disability Rights Iowa to speak at a future Planning Council meeting regarding their perspective.

Highlight Agenda Pages
Teresa Bomhoff reviewed the agenda for the May meeting including additional pages that note the schedule for future meetings as well as the 2021 Mental Health Planning Council (MHPC) recommendations to Mental Health and Disability Services (MHDS) for block grant funding from the Monitoring and Oversight Committee. Teresa reviewed information regarding the notification of funds received from the Consolidated Appropriations Act and the requests made by the MHPC on how these funds should be spent. Teresa also noted the estimated award from the American Rescue Plan Act (ARPA) as well as specific priorities noted, priorities for the current Mental Health Block Grant (MHBG) as well as the Iowa Department of Health's Substance Abuse Block Grant. Additional pages of the agenda document included the MHBG numbers provided by the Monitoring and Oversight Committee, a listing of current DHS staff in key positions, links to the DHS Community Integration and Strategic Plans, an update on the alignment of DHS and IDPH, links to a list of substance abuse providers,

private mental health providers, Community Mental Health Centers (CMHCs), and Federally Qualified Health Centers (FQHCs), information regarding Certified Community Behavioral Health Clinics (CCBHCs), information regarding COVID Recovery Iowa, the ASPIRE grant, Request for Proposal updates, recent Children's Board presentations, links to important webpages including the MHPC, MHDS Commission, DHS Dashboards, MHDS Regions and the MHDS Regions and AEA website, InfoNet newsletters as well as the Iowa Community Resources Guide. Teresa also noted statistics related to opioid deaths and suicides, a review of the MHPC current legislative priorities, IDHSP Bureau of Substance Abuse data link, an anti-stigma campaign currently being utilized by the MHDS Regions, notes from recent presentation regarding the State Training School in Eldora, information regarding First Episode Psychosis and Iowa's Helping Community Workforce, as well as additional information about technology for hybrid meetings.

SF619 – Division XXV – Mental Health Funding
Teresa Bomhoff reviewed the overview document related to SF619 Division XXV – Mental Health Funding. Teresa noted that this was compromised proposal passed by both sides of the legislature and was currently waiting for approval by the Governor.

The Mental Health Planning Council took a break at 11:53 a.m. and reconvened for the joint meeting with the Mental Health and Disability Services (MHDS) Commission at 12:31 p.m.

Mental Health Planning Council
January 28, 2021 9:00am to 3:30pm
Zoom
Meeting Minutes – Approved 3/17/2021

MENTAL HEALTH PLANNING COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs
Rachel Cecil
James Cornick
James Donoghue
Kyra Hawley
Theresa Henderson
Vienna Hoang
Michael Kaufmann
Dawn Kekstadt
Earl Kelly
Todd Lange
Hannah Olson
Donna Richard-Langer
Brad Richardson
Jennifer Robbins
Kristin Rooff
Dennis Sharp
Dr. Shaad Swim
Michele Tilotta
Brook Whitney

MENTAL HEALTH PLANNING COUNCIL MEMBERS ABSENT:

Jacquie Easley
Julie Kalambokidis
Anna Killpack
Matthea Little Smith
Heather Thomas

OTHER ATTENDEES:

Theresa Armstrong
Wendy DePhillips
Derek Hess
Randy Hoover
Todd Noack
Jason Orent
Libby Reekers
Cory Turner

Welcome and Introductions
Teresa Bomhoff called the meeting to order at 9:01 am and led introductions. Quorum was established with 19 members.

November 2020 Minutes Approval
Brad Richardson noted that there was one error on the bottom of page 5 of the November minutes. Brad indicated that the minutes noted that the ISAC Board would vote on and “improved” the legislative priorities, but that this should be “approved.” There were no additional changes noted. Jim Cornick made a motion for approval, Michael Kauffman seconded the motion. Minutes were unanimously approved.

Committee and Workgroup Reports
Nominations Committee
Brad Richardson informed the Council that they have had no applications and there are currently six vacancies. Brad stated that Ken Briggs was going was reaching out regarding the four openings for

Parent of a Child with Serious Emotional Disturbance (SED), but he hadn't heard back from him yet. Brad also indicated that he was doing outreach as well, but no applications yet.

Teresa Bomhoff reviewed the agenda for the January meeting, including additional pages that include the schedule for future meetings, priorities for the current Mental Health Block Grant (MHBG) as well as the Iowa Department of Health's Substance Abuse Block Grant priorities. Teresa indicated that DHS and IDPH plan to work together on the plan for next year's MHBG and SABG, which would be discussed in today's meeting. Additional pages of the agenda document included the MHBG numbers provided by the Monitoring and Oversight Committee, listing of current DHS staff in key positions, links to the DHS Community Integration and Strategic Plans, listing of Iowa State Association of Counties (ISAC) legislative priorities, the MHDS Commission priorities, as well as UnityPoint's legislative priorities, noting the commonality between the three.

Mental Health and Substance Abuse Block Grant Applications

Laura Larkin, Department of Human Services (DHS) provided an overview of the process of the Mental Block Grant (MHBG) Plan. Laura indicated that they are in the process of setting new priorities for the next two years in the block grant. The MHBG requires that DHS consult and work with the Mental Health Planning Council to identify gaps in the system, receive input regarding what is going well, what needs improved, and what should be prioritized in the system. At this time, the Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) are looking at ways to integrate the work that they do. Parallel to the MHBG, IDPH receives the Substance Use Block Grant (SABG). DHS and IDPH are completing separate block grant plans, but would include processes in both block grants that were fully integrated. Laura indicated that Michele Tilotta, who is the SABG planner, would be participating in the meetings with the Mental Health Planning Council to gather input for the MHBG as well as the SABG. It was noted that the SABG has a different set of rules that IDPH has to follow in how they complete their plan, and that there are aspects of each block grant that are completely unique to the other.

Michele Tilotta, Iowa Department of Public Health (IDPH), provided background on how IDPH and DHS have worked together on the MHBG and SABG in the past. Michele reviewed the different requirements for the SABG versus the MHBG, and how DHS and IDPH plan to work together to provide more integration to the block grants moving forward.

The reconvening of the Mental Health Block Grant workgroup was discussed. This committee will consult with Laura and Michele and provide input for the plans. These meetings are to occur monthly from February through May, 2021. Committee members will be reviewing past priorities, provide input on future priorities as well as strengths and gaps in the behavioral health system. The MHBG plan is due September 1, 2021 and the SABG plan is due October 1, 2021. The Mental Health Block Grant workgroup was re-established with the members Teresa Bomhoff, Ken Briggs, Theresa Henderson, Jim Donoghue and Donna Richard-Langer.

Legislation Discussion

Teresa Bomhoff shared a record of current legislative bills with the Council, and reviewed bills of interest and whether registered for or against, including health care loan repayment, the current bills on extending the 100% reimbursement for telehealth, increasing staff for the long-term care ombudsman, electronic absentee ballots, bottle bill changes, Medicaid-assisted food, housing discrimination, several guardianship bills, prescription insulin coverage, emergency prescription refills, legal interpreters and

translators for court cases, disability provider income tax exemption, adult changing stations at rest areas, Iowa ABLE transfers, Medicaid improvements, including one that would require Managed Care Organizations (MCOs) to develop and administer a workforce recruitment, retention and training program. Teresa noted that the education bills are being discussed a lot in the legislature and briefly reviewed aspects of those bills. There was discussion regarding the prescription drug price transparency and cost sharing bill and how the Council should register as well as the current bill on absentee ballots. Teresa informed the Council that prior to registering for or against on a bill, she looks at who is for and against on the lobby list.

Boys State Training School Lawsuit & Update on State Resource Centers

Cory Turner, Administrator for the Division of Mental Health and Disability Services, Facilities (MHDS-Facilities) and Dr. Derek Hess, Clinical Director for MHDS-Facilities Central Office introduced themselves to the Council and provided a brief background of their experience as well as their current role with the Department of Human Services. Cory provided a background of the litigation regarding the Boys State Training School which began in 2017. In March 2020 the court order was received by DHS which included the need for DHS to produce a remedial plan, which was approved in July 2020. Cory reviewed aspects of the remedial plan, noting that many areas DHS was already working to address. DHS is working with a court monitor that oversees the work on implementing the remedial plan, and that the monitor will be submitting the first year court report sometime in the next week. Cory provided the Council background on the staff restructuring at the State Training School (STS), with the focus of having a more treatment based focus with more staff on-site, and specifically how this changed policy and practice at STS.

Dr. Hess provided a clinical perspective of the changes at the STS including changes in personnel, evidence-based practices, and structures and procedures. Cory noted that this has really been a "culture shift" for staff and has resulted in a loss of staff, but they have brought more people on-board, and have put recruitment retention practices in place to help with this issue. Dr. Hess noted that work they are doing is not limited to STS, and is having a positive impact on the other facilities and the community.

Teresa Bomhoff stated that she was encouraged by the changes she was hearing, and noted the similar "culture changes" she is seeing in corrections in general and her experience with the Fifth Judicial District. Donna Richard-Langer inquired about how the change in philosophy has impacted how direct care staff are chosen. Cory noted that while they receive many of the same sort of applicants, with corrections experience, but that there is more training on the front end and closer monitoring of individuals to ensure they are accepting and implementing the new philosophy. STS is also seeing more applicants with teaching and psychology backgrounds as well. Dr. Hess discussed ways that they are working to promote from within when possible, in order to continue to shape the culture. There was discussion regarding the supervisor to employee ratio and employee retention including loan repayment and licensing of mental health staff.

Committee and Workgroup Reports (cont.)

Monitoring and Oversight

Donna Richard-Langer reviewed purpose of the Monitoring and Oversight committee and noted that members include: Heather Thomas, Julie Kalambokidis, Jacquie Easley, and Rachel Cecil, as well as herself.

Donna reported that the committee met twice in December and January. In December the committee reviewed the Peer Support and Training contract. This contract, held by the University of Iowa is in its sixth year. The Peer Support RFP was posted on January 16, 2021 and proposals need to be submitted by March 10, 2021. The University of Iowa has agreed to extend their current contract until the new contract is in place. Donna reviewed the focus and expectations of the current contract as well as the Council's support and concerns with the contract in the past, as well as some issues around peer support. Donna notified the Council that the reason a peer support agency wasn't awarded the previous contract was that one did not apply. However they will have an opportunity with this new RFP. Theresa Henderson expressed concerns that she has not seen any future programming planned by the University of Iowa as of yet.

Rachel Cecil shared that the Regional CEOs are engaged in a collaboration regarding the "Brain Health" campaign to change the language around behavioral or mental health. The regions are working on a mass rollout including materials and marking for the language change.

Donna informed the Council that in January the committee reviewed the First Episode Psychosis (FEP) contracts. Three Community Mental Health Centers (CMHCs), Abbe Center, Siouxland and Eyerly-Ball hold these contracts, which are separate deliverables within the agency's block grant contract. The deliverables are the same for all three CMHCs. Donna provided the Council the history of FEP and Iowa's implementation of it in 2014, including the components of the program and its challenges. There was discussion regarding the fact that all three FEP providers are in urban areas and that the rural communities lack access as well as barriers to rural access. The program has shown to have good outcomes for individuals. The Iowa FEP model is named NAVIGATE, and the set-aside has increased from 5% of the MHBG in 2014 to 10% of the MHBG today. The contracts are $159,000 for each CMHC, and there is a $50,000 contract for a technical assistance and training specialist for the FEP program. This specialist provides training and monitoring to ensure the NAVIGATE program stays true to the model.

There was discussion by the Council regarding how people find these programs and who were the referral sources for this program including hospitals, colleges and K-12. It was noted that the name of the program has changed over the years, and that SAMHSA has changed the name from First Episode Psychosis to Early Episode Serious Mental Illness (ESMI).

Donna stated that the Monitoring and Oversight Committee is working on a recommendation to bring to the Planning Council on issues important for Iowans that need to be presented to DHS as they work on funding contracts. The committee is looking at telehealth availability as well as service planning for rural communities. They plan to discuss these items further at the next meeting so that can present their recommendation to the Planning Council in March. There was discussion around the "digital divide" and the barriers to individuals using electronic devices for telehealth, including possession of these devices, internet or broadband issues and training on how to use them.

Children's Workgroup

Earl Kelly stated that the Children's Workgroup presented their concept paper on the development of a children's mental health evaluation center to Director Garcia and Marissa Eyanson on November 23, 2020. Earl indicated that he believed the paper was well-received and that Director Garcia was going to have preliminary discussions with the University of Iowa to determine interest. Earl also stated that he believed that the concept paper was going to be brought to the Children's Board at their December

meeting. There was discussion about the current issues surrounding children's mental health evaluations.

Public Safety

Brad Richardson indicated that the Public Safety Committee has met a couple times and that there has been some discussion regarding the overlap in between the Drug Policy Advisory Council and the Public Safety Committee. Brad has reached out to Dale Woolery with the Governor's Office of Drug Control Policy to share the committee's priorities with him and to ask if he would be willing to present to the Planning Council about their common priorities.

The committee is also looking at de-escalation information and law enforcement encounters with individuals with mental health issues. Jennifer Robbins is in contact with a couple individuals, based out of Austin, who put together a curriculum, and the committee is looking at having them present to the Council in the next few months. Teresa Bomhoff noted that the Iowa Law Enforcement Academy as well as the Des Moines Police Department and the Cedar Rapids Police Academy all have Crisis Intervention Training (CIT), and suggested the committee reach out to one or all of them to see what their training offers. There was continued discussion on de-escalation as well as jail diversion and the Governor's State of the State address. Brad Richardson agreed to be the substitute chair for the Public Safety Committee while Matthea Little Smith is out.

Teresa Bomhoff reviewed the current openings on the Mental Health Planning Council as well as the vacancy on the Nominations committee and those MHPC members who have not volunteered for a committee or workgroup. Vienna Hoang volunteered to join the Nominations committee and indicated that she would send another email to Ken regarding this fact. Kristen Rooff indicated that she would join the Public Safety workgroup.

Legislative Priorities

Teresa Bomhoff reminded the Council that she had shared the record of the current legislation and whether she had registered for or against. Earl Kelly asked about the Wellmark proposal on the current telehealth bill and why they are differentiating between mental health and behavioral health. Teresa indicated that she didn't have any further information. The Council discussed the possible motivations and issues regarding the Wellmark proposal.

Teresa noted that she sent the Council's legislative priorities to Zach Wahl, who is the Senate Minority Leader as well as Edler, Costello, Fry, Meyer and Whitver who are also legislative leaders. At this point she has heard back from Zach Wahls and Joel Fry. Teresa indicated that she planned to try to go through each committee that affects mental health in particular and see if there is anything there that they should be registering for or against.

Teresa shared information with the Planning Council from the NAMI of Greater Des Moines newsletter pointing out data related to suicide and opioid deaths in 2020, which have increased since 2019, as well as the website www.BrainHealth-NOW.org which has a lot of good infographics, statistics and information related to thinking about the words we use. Teresa shared information that she was putting together for a PowerPoint presentation on the Governor's Education bill. Teresa indicated that most of the information and infographics she shared can be found at www.p4gis.org. Teresa provided a short

analysis of the Governor's Budget including appropriations made for the Office of the Long-Term Care Ombudsman, 3 year broadband grants, College Student Aid Commission including the National Guard Education Assistance program and the Des Moines University Assistance Program, Economic Development Authority and the Department of Education. Teresa reviewed the appropriations in the Governor's Budget for the Department of Human Services, including the $15 million for MHDS Regions and $500,000 to ChildServe to expand services. Teresa noted that the General Fund in the Governor's Budget was $8.114 billion for Fiscal Year 2022 and $8.5 billion in federal funds.

Teresa reviewed the Planning Councils legislative priorities that were discussed at the November 2020 meeting:

- Health Equity
- Expanding the Mental Health Workforce
- Expand Changes Occurred Due to Pandemic
- Integration of Public Health, Behavioral Health and Substance Abuse Agency

Peer Support Organizations Presentation

Jason Orent, Plugged-In Iowa, provided background about the history of Plugged-In Iowa which was formed in 2015 in the East Central Region. Jason reviewed the expansion of the program to its peak in 2018. Jason noted that they provided a lot of one-on-one Supported Community Living (SCL) type services as well as providing drop-in services in more rural areas. In the beginning of 2020 they were doing well, but the COVID virus hit them hard. They had to close all of the wellness centers and weren't adding any new one-to-one clients. They began to try to open up in July, but they were still struggling when the derecho hit in the Cedar Rapids area. Jason indicated they are still struggling as they work to get more referrals and retain staff. Jason noted that in the past they had advocated for the ability to bill Medicaid for peer support services. Jason stated that without a regular funding stream it is going to be almost impossible to continue. Teresa encouraged Jason to reach out to Hannah Olson who is on the Mental Health Planning Council, and is also part of Medicaid about possible things in the works. Kate McBurney questioned how the peer support services were currently funded. Jason stated that they receive their funding from the MHDS Regions and with the new services being put in place with regards to complex needs and children's services they are receiving less funding.

Randy Hoover from Freedom Pointe in Fort Dodge spoke about their program which started in 2015 in the County Social Services Region. Randy indicated the program struggled a lot in the beginning, but they are doing well at this time. If they are slow to bill this can translate into very significant problems. Randy spoke about the PIERS program (Prevention, Intervention, Education, Recreation and Support). Randy reported statistics related to helping individuals around finding work, staying or going to school, and preventing suicides. Randy spoke about the comments often heard regarding the fact that peer-run organizations are not professional. Randy indicated that finances continue to be problematic for everyone. Teresa spoke about the possible need for an intervention to keep these kind of businesses going. Peers can often do things or go places that others cannot. Teresa stated she would like to include peer-run organizations as part of the Council's recommendations and directed Donna Richard-Langer to form a subcommittee to look at this issue. Todd Lange, Theresa Henderson and Hannah Olson expressed interest in this subcommittee. There was discussion about how the MHBG could be used with regards to peer-run organizations. There was also discussion about how or if these peer-run organizations were connected with the county's department of public health or hospital associations. Jason Orent reviewed issues they had surrounding contacts with the local hospitals, specifically those surrounding liability. Randy Hoover indicated they had reached out to their public health department in

Fort Dodge without luck. There was discussion regarding the integration of public health and mental health as well as preconceptions of people with mental health issues, and the stigma that surrounds it.

Todd Noack, Life Connections Peer Recovery Services, presented to the Council about his program. Todd noted that they have received technical assistance from Doors to Wellbeing, and the Copeland Center, which revolves around Wellness Recovery Action Plans (WRAP). Todd reviewed what makes up a peer-run organization by the federal government, SAMHSA and the State of Iowa. Todd indicated that all of his staff, including himself, are certified peer support specialists. Todd informed the Council about how they had to educate their Region about the importance of peer-run organizations and what it is they do. Todd shared information about "Rhonda's House" which is a peer run respite house. Todd shared data they collect regarding their services. Todd indicated that he doesn't want to bill Medicaid as this will limit the ability to be a peer-run organization. They would rather contract with MHDS Regions, MCOs, grants, and appropriations through the MHBG, which is how other states are funding peer-run services. Todd shared metrics for Rhonda's House with the Council as well as information around their wellness recovery center and changes that were made within his organization due to the pandemic. Teresa Bomhoff noted that there is an ad for Life Connections Virtual Recovery Center in the NAMI of Greater Des Moines newsletter. This virtual recovery center is 100% virtual and is statewide.

DHS Update
Theresa Armstrong

CARES Act dollars - $30M distributed to all MHDS Regions. As of December 30, 2020, $20.4M has been spent with $9.4M not been spent. The federal deadline for spending funds has been pushed to December 2021 with MHDS Regions having until June 30, 2021 to spend those funds. Some of the ways Regions have spent their funds include:

- Technology (iPads, connection fees for providers and schools, zoom accounts)
- PPE
- Training for Law Enforcement
- Marketing and Stigma Reduction

Teresa Bomhoff questioned if CARES dollars could be used to purchase technology and training. Theresa indicated that technology could be purchased for providers to be used by individuals, but that federal regulations prevented dollars from being spent on purchasing technology directly for individuals.

Substance Abuse Mental Health Services Administration (SAMHSA) received a significant amount of money to help with COVID. Nationally they received $4.25B. At this point, we are not sure how much will come to Iowa or how it will come exactly, but we do know that the MHBG and the SABG will receive more money, the Certified Community Behavioral Health Clinics (CCBHC) expansion grants will be receiving $600M in additional funds. SAMHSA has already released a Request for Applications for those grants. Theresa indicated that Iowa has several providers that are looking at applying for the CCBHC grant. Also received more dollars to expand current emergency grants. Theresa indicated that MHBG will see more money in FY21 with a 5% set-aside for crisis support services and could be to help support the state with the rollout of 988.

Alignment of IDPH and DHS
Theresa spoke about the Request for Proposal for the consultant. The Public Consultant Group (PCG) was the successful bidder. The RFP is online for those who want to see the scope of work. Teresa

asked if anyone from PCG has been to Iowa. Theresa indicated that she had not heard anything and wasn't sure if they had or not.

Peer Support Training
Peer Support RFP has been posted online on www.bidopportunities.iowa.gov with proposals due by 3/10/21 and hope to announce the successful bidder on 4/7/21. DHS worked collaboratively with the Department of Public Health to add Recovery Peer Coaching to the Peer Support and Family Peer Support Training contract. There was discussion around whether WRAP could be a part of this training and how it could fit in.

988
988 will be beginning July 2022 and will be the phone number for the national suicide line. IDPH and DHS wrote for a SAMHSA planning grant and were notified this week that we would receive the grant. The plan was to look at gaps, how we need to plan and where we as a state need to go to respond effectively to 988. A portion of the funds will go to the two providers (Foundation 2 and CommUnity) in Iowa who currently answer national hotline calls.

COVID Recovery Iowa
Virtual grief counseling, education and outreach is still functioning. Funding through a FEMA disaster grant. It continues to grow, there are 100 staff that are employed with five different contractors. DHS oversees these contracts. As of January they have had over 350,000 contacts with Iowans. There may be multiples within this figure. The contracts started 5/2/2020 and will run through 6/31/2021.

Todd Lange commented about a presentation he did with the East Central Region Peer Support Committee as well a peer support survey he was involved in with the Integrated Health Home statewide and wondered if it would be possible to have a broader conversation on peer support with DHS and IDPH staff. Theresa indicated that we will want to make sure that we don't interfere with anyone that might be replying to the Peer Support Training RFP, but that they could look at a meeting after that. There was discussion regarding the presentation given earlier by peer-run organizations and looking at how funding could be found to assist these organizations as well as current barriers to funding.

Public Comment
None

The Mental Health Planning Council took a break at 11:54 a.m. and reconvened at 1:01 p.m.

Adjourn
Ken Briggs motioned to adjourn, Todd Noack seconded the motion. The motion passed unanimously. The meeting adjourned at 3:09 p.m.

Iowa Mental Health Planning and Advisory Council
Bylaws

Effective May 28, 2008 as amended July 23, 2010, March 21, 2012, March 21, 2018, and September 19, 2018

ARTICLE I – NAME

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

ARTICLE II – DUTIES AND ACTIVITIES

The purposes of the Iowa Mental Health Planning and Advisory Council (the Council) shall be as set forth in federal law (42 USC 300x-3, Pub. Law 102-321, July 10, 1992, ADAMHA Reorganization Amendments, Public Health Service Act, 106 Stat. 382).

Section 1. Duties

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

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

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

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

Section 2. Activities

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

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

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

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

E. To advise the State Mental Health Authority on matters that may affect the stated purposes of this Council;

F. To review the annual submission of the CMHS Community Mental Health Block Grant Application and comment on it to the Director of the Center for Mental Health Services;

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

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

Section 3. Records

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

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

ARTICLE III – MEMBERSHIP

Section 1. General

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

Section 2. Requirements

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

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

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

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

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

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

Section 3. Membership Categories

Membership shall be the following:

A. Seven (7) members representing the principal State agencies with primary responsibility for the following programs:

- Mental Health
- Education
- Vocational Rehabilitation
- Criminal Justice
- Housing
- Social Services
- Medical Services (Title XIX)

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

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

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

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

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

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

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

G. Four (4) ex-officio members representing the Iowa General Assembly:

- One representative of Senate Democrats
- One representative of Senate Republicans
- One representative of House Democrats
- One representative of House Republicans

(1) Individuals representing the Iowa General Assembly will be nominated by the Majority and Minority leaders of their respective chambers and shall be accepted and confirmed by the Council. If the Council has concerns or feedback to provide to Majority or Minority leaders, these can be shared with that agency prior to election of the individual nominee.

(2) Ex-officio members shall attend no less than biannually with at least one attendance coinciding with the fall session of the Assembly and at least one attendance coinciding with the spring Session of the Assembly.

(3) If ex-officio is not able to meet this obligation, the member should notify the Majority or Minority Leader to nominate a new member.

(4) The council shall notify Majority or Minority Leader if a ex-officio member is not meeting their obligation to allow for review of member appointment or make adjustments so that member can achieve this obligation.

Section 4. Nominations

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

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

Section 5. Voting Rights

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

B. Members may attend meetings and vote by 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 (abstain) themselves from voting when they have, or anticipate having, a direct financial stake in the outcome of a Council decision, related to, or independent of, their status as a provider of mental health services. (See Article VI – Conflict of Interest)

E. If in the course of business should votes may arise that could directly impact the policies and operations of the entities for which they are employed or representing. If a member perceived that the matter would conflict with or require they feel further review or input from their governing bodies or executive management, members may recuse (abstain) themselves from a vote to allow time to seek further input from their entities.

Section 6. Vacancies

A. Council membership ends when:

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

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

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

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

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

Section 7. Terms of Membership

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

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

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

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

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

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

Section 8. Termination for Just Cause

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

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

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

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

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

ARTICLE IV – MEETINGS

Section 1. General

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

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

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

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

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

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

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

Section 2. Quorum

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

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

Section 3. Votes

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

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

C. In the process of voting, if a member recuses themselves from a vote (abstain), it shall neither count 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 falls below the majority number of the total active council membership number, the Council should consider a delay acceptance of the vote until such time a majority of the active council can be either present or able to affirm the matter of action.

E. If a matter of action does pass with less than a majority number of the total active council, clarification and delineation of such should be made in the minutes of the meeting.

ARTICLE V – OFFICERS AND COMMITTEES

Section 1. Officers

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

B. The outgoing Chairperson may be retained in an ex-officio capacity at the will of the council.

Section 2. Nomination and Election

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

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

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

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

Section 3. Terms of Office

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

Section 4. Duties

A. The Chairperson shall:

(1) Notify members of meetings;
(2) Preside at Council meetings.
(3) Does not participate in voting as Chairperson unless called upon in case of tie (Article IV, Section 3 (B))

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

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

C. The Vice-Chairperson shall:

(1) Assume the Chairperson's duties for any period of time that the Chairperson is unable to do so;
(2) In the event that the Chairperson is unable to complete his or her term, act as Temporary Chairperson until the Council elects a new Chairperson;
(3) In the absence of the Secretary in a meeting, serve as Secretary,
(4) Serve as a voting member of the Executive Committee and

(5) Guide the mentoring process for new members and/or youth members.

D. The Secretary shall:

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

Section 5. Standing Committees or Workgroups in General

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

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

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

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

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

Section 6. Nominations Committee

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

B. The Nominations Committee shall conduct outreach to diverse communities.

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

D. The Nominations Committee shall be responsible for soliciting and reviewing applications for Council membership, and making recommendations to the Council. A Council vote accepts or does not accept the application for membership.

Section 7. Executive Committee

A. The Executive Committee shall consist of: the Chairperson, the Vice-Chairperson, the Secretary, and the Chairs of the Standing Committees. At the will of the Council, the past Chairperson can be an ex-officio member.

B. The Executive Committee shall review Conflict of Interest Disclosures and make recommendations to the full Council on Conflict of Interest issues.

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

D. The Executive Committee shall:

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

Section 8. Monitoring and Oversight Committee

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

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

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

Section 9. Workgroups

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

ARTICLE VI – CONFLICT OF INTEREST

Section 1. Conflict of Interest Policy

A. The Mental Health Planning and Advisory Council (hereinafter, "the Council") respects the rights of all members in their activities outside of their association with the Council, should such activities not conflict with or adversely reflect upon the Council. It is Council policy to place trust in each member's integrity, judgment, and dedication. It is also important to

avoid even the perception of a conflict of interest. Accordingly, the policy set forth below has been adopted:

(1) All Council members are expected to declare any financial or personal affiliations that could interfere with their effectiveness in representing the interests of individuals with serious mental illness or serious emotional disturbance on the Council, or on their effectiveness in representing the Council to the public.

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

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

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

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

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

ARTICLE VII – BYLAWS

Section 1. Revision

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

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

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

First reading: May 28, 2008

Second reading: Waived May 28, 2008

Adopted: These By-laws are accepted and adopted by vote of the Iowa Mental Health Planning and Advisory Council on May 28, 2008.

Amended: By majority vote of the Council on July 23, 2010, Art. III, Sect. 3F Membership.
By majority vote of the Council on March 21, 2012, Art. III, Sec. 6B Vacancies; Art. V, Sec. 4B Duties.

Appendix A:

Conflict of Interest Disclosure Statement

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

_____
_____
_____
_____
_____

Signed: _____

Date: _____

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

Ethical Considerations of Council Membership:

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

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Teresa Bomhoff	Family Members of Individuals in Recovery (to include family members of adults with SMI)		200 SW 42nd St. Des Moines IA, 50312	tbomhoff@mchsi.com
Ken Briggs	Others (Advocates who are not State employees or providers)		1701 Campus Drive Clive IA, 50325	revkbriggsacc@msn.com
Rachel Cecil	Others (Advocates who are not State employees or providers)		2003 N. Lincoln St. Knoxville IA, 50138	Rachel.cecil@crossmhds.org
Jim Cornick	Others (Advocates who are not State employees or providers)		624 Glenview Drive Des Moines IA, 50312	jcornick65@gmail.com
Jim Donoghue	State Employees	Iowa Department of Education	400 E. 14th St. Des Moines IA, 50319	jim.donoghue@iowa.gov
Jacqueline Easley	Others (Advocates who are not State employees or providers)		3113 Southern Hills Drive Des Moines IA, 50321	
Jennifer Gomez	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Kris Graves	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Kyra Hawley	State Employees	Iowa Department on Aging	510 E. 12th St. Des Moines IA, 50319	kyra.hawley1@iowa.gov
Theresa Henderson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Vienna Huong	State Employees	Vocational Rehabilitation	510 E. 12th St. Des Moines IA, 50319	Vienna.hoang@iowa.gov
Michael Kauffman	State Employees	Iowa Department of Human Services	Independence MHI Independence IA, 50644	MKaufma@dhs.state.ia.us
Dawn Kekstadt	State Employees	Iowa Department of Human Services	1305 E. Walnut St. Des Moines IA, 50319	dkeksta@hs.state.ia.us

Earl Kelly	Others (Advocates who are not State employees or providers)		2919 Druid Hill Drive Des Moines IA, 50315	earlpkelly@gmail.com
Anna Killpack	Family Members of Individuals in Recovery (to include family members of adults with SMI)		32356 270th St. Neola IA, 51559	annakillpack@yahoo.com
Todd Lange	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		225 W. 6th St. Dubuque IA, 52001	Tjlange1@yahoo.com
Katie McBurney	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Ed Murphy	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Hannah Olson	State Employees	Iowa DHS, Iowa Medicaid Enterprise	611 5th Ave. Des Moines IA, 50309	holson1@dhs.state.ia.us
Donna Richard-Langer	Others (Advocates who are not State employees or providers)		4105 Belair Drive Urbandale IA, 50323	drldkl@msn.com
Brad Richardson	State Employees		UI School of Social Work Iowa City IA, 52242-5000	Brad-richardson@uiowa.edu
Jennifer Robbins	Others (Advocates who are not State employees or providers)		102 E. Main St. Box 217 Ottumwa IA, 52501	jennifer.robbins@scbhr.net
Kristin Rooff	Others (Advocates who are not State employees or providers)			
Dennis Sharp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1104 River Drive South Apt. 10 Sioux City IA, 51104	dennissharp2007@gmail.com
Shaad Swim	State Employees	Iowa Department of Corrections	420 Mill Street Mitchellville IA, 50169	shaad.swim@iowa.gov
Heather Thomas	Providers	Eyerly Ball Community Mental Health Center		HeatherT@eyerlyball.org
Michele Tilotta	Persons in recovery from or providing treatment for or advocating for SUD services	Iowa Department of Health		michele.tilotta@idph.iowa.gov
Brook Whitney	State Employees	Iowa Finance Authority	State Housing Authority	Brook.Whitney@IowaFinance.com

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**33**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	5	
Others (Advocates who are not State employees or providers)	8	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**23**	**69.70%**
State Employees	9	
Providers	1	
Vacancies	0	
Total State Employees & Providers	**10**	**30.30%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

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

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

The Planning Council was provided the opportunity to review the plan on August 24. The Planning Council was notified via email that the FY22-23 plan was available on the DHS website for review and to send their comments to Laura Larkin, the State MHBG Planner by 5pm, August 30 for inclusion in the plan to be submitted on Sept. 1. No comments were received from members of the planning council.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://dhs.iowa.gov/mhds-providers/providers-regions/block-grant

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

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Footnotes: